Your chance to change HealthDentalVision insurance.

Review the Open Enrollment guide on CrateNews or CrateConnect.
Only associates who are making changes need to re-enroll.

forms to you

forms due

May 2014						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Crate&Barrel CB2

Open Enrollment

Open Enrollment 2014

▶ Throughout this guide, Crate and Barrel and CB2 will be referred to as the "Company."

Benefits Open Enrollment Overview

Crate and Barrel and CB2 realize the impact our benefits program has on our associates' quality of life. We strive to offer comprehensive plans that meet your health care needs while remaining affordable. Over the last year, our health-care costs have continued to increase due to medical inflation, utilization and compliance with the Affordable Care Act (ACA). Over the next year, we will need to account for additional cost increases directly tied to the Affordable Care Act—largely seen in additional or increased payment of fees and taxes. However, our commitment to our associates remains unchanged—to provide quality health care options while balancing costs.

To accomplish this objective, there will be increases to your biweekly health-care deductions. Historically, the Company has paid approximately 75% of participants' total health care costs.We expect total medical expenses to reach over $24 million. Of this total, the Company will absorb over $18 million, averaging more than $7,500 per associate.

The 2014 Open Enrollment period is for plan year effective June 1, 2014 through May 31, 2015. This is your once-a-year opportunity to:

- Change your health, dental or vision plan option;
- Add eligible dependents not currently covered;
- Drop current dependents; and/or
- Enroll or cancel coverage.

As you read more about our benefit plans for 2014, you will see changes in the design of our plans, which include some important improvements as well.

2014 Benefit Change Highlights

- **Increase to health insurance premiums**
- **Pre-existing condition limitations under the medical plan are removed for members age 19 and over**
- **In-network medical co-payments, co-insurance and deductibles will count against the annual out-of-pocket maximum**
- **Acupuncture has been added as an allowed benefit as of June 1, 2014**
- **Increase to pharmacy nonpreferred brand-name drug co-pay and an aggregate family maximum has been added**
- **Introduction of the ExtraCare® Health Card for savings on regularly priced CVS pharmacy brand health-related items**
- **CVS Prescription Savings Guides will be mailed to associates who may be able to save money on their prescriptions**
- **The DHMO dental co-pay schedule is changing as of June 1. The co-pay schedule can be found at CrateNews and CrateConnect.**

Take Action—May 2 through May 16, 2014

- Elect or change your 2014 benefits by completing the Open Enrollment form located in the back of this guide.
- Forms due to HR by May 16, 2014
- No action is required if you are not changing your benefits.

No changes?

Human Resources will maintain your current elections unless you submit an Open Enrollment form indicating your requested change. Even if you want to maintain your current enrollment, you still should review the important plan changes in this guide.

Keep in mind…

The next opportunity you will have to change your coverage will be June 2015, unless you experience a Qualifying Life Event, as described in your Associate Guide.

Please review this guide carefully for specific coverage and plan design changes. We encourage you to use the information provided in this guide to help you make thoughtful decisions regarding the benefits you select for next year.

If you have any questions, see your manager or contact Human Resources at 800.521.7340

Changes This Year

Affordable Care Act Changes—Medical and Pharmacy

Total health-care costs to the Company, which influences associate contribution levels for medical insurance, have increased by several factors. These include increased utilization, rising medical inflation and several coverage mandates under the Affordable Care Act (ACA) that require expanding insurance coverage.

The Company strives to keep costs down and balance the out-of-pocket costs to associates. As we head further into compliance with the ACA, additional costs will need to be paid. The ACA's goal of increasing access to health care for all Americans comes with additional increases seen in fees and taxes. The two types of taxes that the Company will need to pay include:

- The Patient-Centered Outcomes Research Institute Fee (PCORI Fee): This fee is required to be paid by health-plan sponsors, such as Crate and Barrel/CB2, for research to be conducted by the Patient-Centered Outcomes Research Institute. The PCORI research will compare different medical treatments and interventions to provide evidence on which strategies are most effective in different populations and situations. The PCORI fee is $1 per covered individual per year and goes up to $2 per covered individual per year.
- Transitional Reinsurance Program Fee: This fee is used to fund a transitional reinsurance program, established by the ACA to stabilize the individual health-insurance market during the first three years the state health insurance exchanges are in operation (2014-2016). The program will collect contributions from self-funded group health plans, like Crate and Barrel/CB2's. The Department of Health and Human Services has established this fee to be $63 for each covered individual (including participants and their dependents) for 2014.

The other changes that go into place per the ACA include:

- Removing the pre-existing condition clause and waiting periods for members age 19 and over
- In-network medical co-payments, co-insurance and deductions will count against the annual out-of-pocket maximum (this does not include pharmacy).
- Introduction of a family co-pay maximum for pharmacy costs. The aggregate or total family maximum is $12,700 (no one family member needs to satisfy more than $2,750).

Due to the additional costs of the ACA, health-care inflation and our need to balance costs, we have made the difficult decision to increase the biweekly health-insurance contributions.

2014 Biweekly Health Insurance Contributions

	Standard PPO	*Standard Surcharge*	Premium PPO	*Premium Surcharge*
Individual	$31	*$51*	$42	*$62*
Individual + Spouse /Domestic Partner	$103	*$123*	$130	*$150*
Individual + Child(ren)	$88	*$108*	$110	*$130*
Family	$131	*$151*	$163	*$183*

Additional enhancements and changes to Medical and Pharmacy Plans include:

- Acupuncture now will be a covered benefit like chiropractic care. Please refer to the Health Plan Comparison Chart for further details. This has been a requested benefit for many years, and we are happy to be able to provide additional coverage for this benefit.
- An increase to pharmacy nonpreferred brand-name drug co-pays. These changes are in bold in the Comparison Chart.

New ExtraCare® Health Card with CVS Caremark

The Company is happy to introduce an additional way to save money for items that you and your family use each day through the ExtraCare Health Card.

Q&A

What is the ExtraCare® Health Card?

The ExtraCare Health Card is a program from CVS Caremark and the Company that gives you 20 percent savings on thousands of regularly priced CVS/pharmacy brand health-related items valued at $1 or more.

What is the difference between my ExtraCare® Health Card and the CVS ExtraCare Card?

Your ExtraCare Health Card gives you all the benefits of a CVS ExtraCare Card, including special weekly savings and the opportunity to earn ExtraBucks® on purchases and prescriptions. You can earn 2 percent in ExtraBucks on all purchases and one ExtraBuck for every two prescriptions filled with your ExtraCare Health Card, plus the 20 percent health-product savings.

Where can I use my ExtraCare® Health Card?

Simply present the card at any CVS/pharmacy register to receive your discount. You also can enjoy these savings on all eligible items purchased online at CVS.com.

Do I have to pay for the card?

No. It is provided at no cost to you.

What kind of savings can I expect?

The card gives you 20 percent off the already low price of CVS/pharmacy brand health-related products. You and your family may save hundreds of dollars each year

On what products do I receive the 20 percent savings?

The card can be used on thousands of CVS/pharmacy brand health-related items valued at $1 or more, including cough and cold remedies, pain relief, first aid, vitamins, skin care, baby care and many more of the items you and your family use every day. See the eligible items on CrateNews and CrateConnect under the 2014 Open Enrollment section.

Does the card expire?

If you change employers or if your employer changes prescription benefit managers, your card will no longer give you a 20 percent discount on health-related items. However, you still can use it to get the same benefits as a regular CVS ExtraCare® Card.

Can I transfer my ExtraCare® loyalty program rewards to my ExtraCare® Health Card account?

Yes. Please call the toll-free number on the back of your ExtraCare Health Card or key tag for questions about the program or to transfer existing ExtraCare loyalty program rewards.

Does every family member receive a card?

Each household will receive two key tags for the whole family to use. These cards are different from your CVS Caremark benefit ID cards and will be mailed separately.

Is my CVS Caremark ID number printed on the ExtraCare® Health Card?

No. Your ExtraCare Health Card has its own ID number printed on the card

For additional information on this new benefit, please see the Frequently Asked Questions on CrateNews and CrateConnect under the 2014 Open Enrollment Section.

CVS Caremark Prescription Savings Guide

Another way associates will be educated on potential savings for prescription costs will be a custom savings guide. CVS Caremark will identify associates who have savings opportunities with their current prescriptions and highlight ways they can save money, which may include moving to a generic, a preferred brand or getting a 90-day supply. Associates who may have a savings opportunity will receive letters at their home address in late June.

New DHMO Co-Pay Schedule

The co-pay schedule for the DHMO is changing effective June 1. Although the cost of most preventive services and office visit co-pays are not changing, please review the new co-pay schedule for specific services, available on CrateNews and CrateConnect under the 2014 Open Enrollment section.

▶ Keeping you healthy, giving you options, and providing large, high-quality networks, comprehensive coverage and affordable premiums are our primary concerns.

Physical Exam Biweekly Surcharge

For the last two years, we have asked all associates enrolled in our health insurance to obtain an annual physical exam to continue at the current biweekly health insurance deduction. We are excited to report a 90 percent participation rate by associates.

For 2014, we will continue the biweekly deduction surcharge of $20. Associates who have not obtained an annual physical exam within the last seven months or who do not get an annual physical exam by October 31, 2014 will pay a $20 biweekly health insurance deduction surcharge. This does not include dependents.

To help assist you in this process, BlueCross BlueShield of Illinois will send confirmation of associates who have their annual physical exam from November 1, 2013 through October 31, 2014. This data will be sent in a secure format and will contain minimal information such as associate name and whether he/she received a physical. It will not include any personal health information as the Company is committed to safeguarding your privacy.

Q&A

What are the physical exam requirements and deadline?

In order to continue at the current deduction, you are required to obtain an annual physical exam as determined appropriate between you and your physician. The deadline for receiving the physical exam is October 31, 2014. Exams that were obtained by associates from November 1, 2013 through October 31, 2014 will qualify.

How much is the biweekly surcharge?

If an associate does not receive an annual physical exam by the October 31, 2014 deadline, his/her biweekly deduction will be increased by $20 per pay period beginning on the check dated November 14, 2014.

Is there a cost for the physical exam?

Routine physical exams at an in-network provider are covered with no out-of-pocket costs to associates. Be sure to bring your health plan ID card to your appointment. Annual physical exams at an out-of-network provider will be billed at the out-of-network level.

Are there special instructions I should give my medical provider?

Yes, ask your provider to code your visit as an annual physical. Associates should not be paying a co-pay if the proper coding is submitted to BCBSIL.

Do I need to receive an annual physical exam from an in-network provider?

Associates are not required to go to an in-network physician. Proof of a physical exam received from an out-of-network physician will be recognized, however, the associate will need to submit a paper claim directly to BlueCross BlueShield.

Can I use a recent physical exam to meet the requirement?

Yes, a physical exam that was completed on or after November 1, 2013 will qualify for the October 31, 2014 deadline.

How can I find an in-network physician?

Associates can log on to *bcbsil.com* and click on Provider Finder® or you can contact BCBS customer service at 800.318.4567.

Are my eligible dependents required to obtain an annual exam?
Although we highly encourage your dependents to receive an annual physical exam as well, they are not required to do so.

What happens if I do not receive my physical exam by the October 31, 2014 deadline?
If an associate does not receive an annual physical exam by the October 31, 2014 deadline, his/her biweekly deduction will be increased by $20 per pay period beginning on check dated November 14, 2014.

If you have your annual physical between November 1, 2013 and October 31, 2014 you will save $20 per paycheck. You have 90 days from October 31, 2014 to ensure your medical provider coded your annual physical exam correctly.

How long does the deduction surcharge last?
The premium surcharge will last from November 1, 2014 through October 31, 2015. The next opportunity you will have to lower your biweekly deduction will be November 2015.

Is the medical information from my annual physical exam kept confidential?
Yes. The Company is committed to ensuring the privacy and confidentiality of our members' Protected Health Information (PHI) and will not have access to your personal health records. Any information gathered during a health screening or preventive exam is considered PHI and is treated in accordance with our strict confidentiality policies and federal and state laws designed to maintain privacy, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Health Insurance Open Enrollment

▶ To add/drop coverage or change plans, submit your Open Enrollment form to Human Resources by May 16.

As a participant in the Company's medical plan, you have an important role to play. You can help keep costs manageable by staying healthy, managing ongoing conditions, and being a smart health-care consumer. Thank you for all your efforts in helping to keep health-care costs down and for the outstanding 90% participation rate of associates who received their physical exam. Again, we are requiring associates enrolled in our health insurance to get an annual physical exam to avoid the biweekly deduction surcharge.

The Company offers a choice between two PPO plans—the Standard Plan and the Premium Plan. While the Company continuously strives to provide associates with two very competitive, affordable health care plan options, it is anticipated that the effects from medical inflation and the Affordable Care Act will increase costs by 9 percent to 12 percent. This next year, we expect total medical expenses will reach over $24 million. Of this total, the Company will absorb over $18 million, averaging more than $7,500 per associate, or approximately 75% of the total cost. Associates pay the remaining percentage through their biweekly deductions.

The Two Plans—Standard and Premium

The main differences between the two plans are the biweekly deductions, deductibles, co-pays, and coverage for hospitalization and labs. The Standard Plan has a lower biweekly deduction but higher co-pays and deductible, and 80% coverage for network hospitalization and labs. The Premium Plan costs more out of your paycheck but has lower co-pays, a smaller deductible, and 90% coverage for network hospitalization and labs. Both plans cover preventive office visits at 100%.

Choosing the Right Plan For You

When deciding between the two plans, you should carefully consider your anticipated health-care expenses and the financial risk you're willing to take over the next 12 months. Reviewing the costs and features of each plan will help you decide which is best for you.

Our CVS/Caremark pharmacy plan provides coverage for 30-day fills of your long-term medications at any network pharmacy or you can choose to save money with a lower co-pay by ordering 90-day supplies through mail order or pickup at any neighborhood CVS/pharmacy. To choose the savings of 90-day supplies, visit *caremark.com* and click on Find Savings and Opportunities, or call Customer Care at 800.966.5772. Customer Care will contact your doctor directly for a new 90-day prescription. CVS/Caremark will mail your medication to you, or let you know when it is available to pick up at your local CVS/pharmacy.

2014 Biweekly Health Insurance Contributions

	Standard PPO	*Standard Surcharge*	Premium PPO	*Premium Surcharge*
Individual	$31	*$51*	$42	*$62*
Individual + Spouse /Domestic Partner	$103	*$123*	$130	*$150*
Individual + Child(ren)	$88	*$108*	$110	*$130*
Family	$131	*$151*	$163	*$183*

The example below compares costs under both plans, using participating network providers (assumes prescription drug cost of $150):

▶ Create an account at *bcbsil.com* to locate providers, view your Explanation of Benefits and other helpful health-related information.

Example (without biweekly deduction surcharge)		
	Standard	**Premium**
Preventive office visit	100%	100%
Routine lab work	(covered at 100%)	(covered at 100%)
Specialist office visit	$50 co-pay	$40 co-pay
Pharmacy—Generic	$12 co-pay	$12 co-pay
Pharmacy—Preferred Brand	$45 co-pay *(30%)*	$37.50 co-pay *(25%)*
Pharmacy—Non-Preferred Brand	$60 co-pay *(40%)*	$52.50 co-pay *(35%)*
Your estimated co-pay cost:	$167	$142
Your annual payroll deduction:	$546 +	$962 +
Your estimated annual cost:	**$713**	**$1,104**

So far, the Standard Plan would be less expensive. Now, let's add a two-day hospital stay to the example above.

	Standard		**Premium**
Hospital cost *$10,800* (2-day stay)	$100/day co-pay + 20% $750 deductible	after	$100/day co-pay + 10% after $500 deductible
Your estimated out-of-pocket cost:	**$2,920**		**$1,710**
Your estimated annual cost (from above):	$713		$1,104
Your total estimated annual cost:	**$3,633**		**$2,814**

You can see that if you need an inpatient hospital stay, the Premium Plan would cost less than the Standard Plan.

Your decision is similar to buying car insurance: You can pay more for a lower deductible, which means you'll pay less if you have an accident; OR you can pay a smaller premium for a larger deductible, but then you'll pay more if you have an accident.

Provider Network

The network for both plans is the BlueCross BlueShield PPO network.

There are two ways to find a network provider:

1. Call BlueCross at 800.318.4567.
2. Visit the website: *bcbsil.com*.
3. Download the Provider Finder mobile app

▶ Examples of maintenance drugs are heart medication, birth control, mental health drugs, etc.

▶ When you receive 90-day prescriptions through mail order or at a local CVS/pharmacy, you receive the supply for only 2½ times the co-pay.

CVS/Caremark Maintenance Choice Opt-Out
You are allowed two 30-day fills at any network pharmacy, after which you will be encouraged to transition from a 30-day retail pharmacy supply to a 90-day supply either through mail order or a local CVS/pharmacy. Letters from CVS/Caremark will be sent to your home address before the fill limit is reached to help you make an informed decision about the option that best fits your lifestyle.

After 2 fills, you may continue to receive 30-day supplies of maintenance medications at any participating network pharmacy, however to do so, you must first call Customer Care at 800.966.5772 to opt-out of the program.

If you continue ordering 30-day supplies of long-term medications at a network retail pharmacy without calling Customer Care first, you will pay the full cost of your prescriptions.

The Maintenance Choice Opt-Out program offers convenience, lower co-pays for associates who receive long-term medications and lower cost for the Company.

Q&A

Is there a different network for the two plans?
No. Both plans use the BlueCross BlueShield PPO network.

What is the difference between co-insurance and co-pays?
Your co-pay is a flat, per-visit fee. Co-insurance is the percentage of a provider's total charges that you pay after your co-pay and once you've met your deductible.

Do I need a referral to see a specialist?
No. Neither plan requires a referral to see a specialist.

Will we get new ID cards?
No. Only members who add coverage or change plans will receive ID cards by June 1.

Why do my BlueCross BlueShield identification cards and Explanations of Benefits (EOBs) say "Illinois" on them when I do not live in Illinois?
Your ID cards, EOBs and other communication materials, including the website, say "Illinois" because BlueCross BlueShield of Illinois is the claims administrator for your health insurance plan. This means BlueCross BlueShield of Illinois will process claims and answer questions regardless of where you live. You have access to PPO network providers across the country, which includes more than 94% of all physicians and hospitals.

Health Plan Comparison Chart

2014 Plan Design Changes noted in bold.

Overall Plan Benefits	*Annual Deductible*	Individual
		Individual + 1 Dependent
		Family
	Annual Coinsurance Maximum	Individual
		Individual + 1 Dependent
		Family
	Plan Maximum	Maximum Benefits Payable
General Medical Benefits	*Hospital Inpatient*	Per Day Co-payment
		Annual Co-payment Maximum
		Benefit Percentage Payable
	Inpatient Physician Services	Primary Care Physician Benefit Percentage Payable
		Specialist Benefit Percentage Payable
	Outpatient Hospital	Per Procedure Co-payment
		Benefit Percentage Payable
Emergency Services Benefits	*Hospital Emergency Room Urgent Care Services*	Per Visit Co-payment (waived if admitted)
		Benefit Percentage Payable
	Ambulance	Benefit Percentage Payable
Outpatient Physician Services Benefits		Co-payment per Primary Care Physician Office Visit
		Co-payment per Specialist Office Visit
		Benefit Percentage Payable
	Wellness Care	Preventive Office Visit
		Wellness Labs/X-Ray
		Benefit Percentage Payable
Mental Health/Chemical Dependency Benefits	*Inpatient*	Per Day Co-payment
		Annual Co-payment Maximum
		Benefit Percentage Payable
	Outpatient	Per Visit Co-payment
		Physician's Office Benefit Percentage Payable
		Outpatient Hospital Benefit Percentage Payable

Standard Network	Standard Non-Network	Premium Network	Premium Non-Network
$750 combined network and non-network		$500	$1,000
$1,500 combined network and non-network		$1,000	$2,000
$2,250 combined network and non-network		$1,500	$3,000
$2,000*	$4,000	**$1,500***	$3,000
$4,000*	$8,000	**$3,000***	$6,000
$6,000*	$12,000	**$4,500***	$9,000
Unlimited	Unlimited	Unlimited	Unlimited
$100	$200	$100	$200
$1,000	$2,000	$1,000	$2,000
80% after deductible	60% after deductible	90% after deductible	70% after deductible
80% after deductible	60% after deductible	90% after deductible	70% after deductible
80% after deductible	60% after deductible	90% after deductible	70% after deductible
$100	$200	$100	$200
80% after deductible	60% after deductible	90% after deductible	70% after deductible
$150	$150	$150	$150
80% after deductible	80% after deductible	90% after deductible	90% after deductible
80%	80%	90%	90%
$35	N/A	$25	N/A
$50	N/A	$40	N/A
100%	60% after deductible	100%	70% after deductible
100%	N/A	100%	N/A
100%	100%	100%	100%
100%	60% after deductible	100%	70% after deductible
$100	$200	$100	$200
$1,000 combined with all other hospital co-payment maximums	$2,000	$1,000 combined with all other hospital co-payment maximums	$2,000
80% after deductible	60% after deductible	90% after deductible	70% after deductible
$35	N/A	$25	N/A
100%	60% after deductible	100%	70% after deductible
80% after deductible	60% after deductible	90% after deductible	70% after deductible

** As of 6/1/14, the total network out-of-pocket maximum includes deductible, co-insurance for essential health benefits and all co-pays except pharmacy. The total non-network out-of-pocket maximum includes deductible and co-insurance for essential health benefits.*

- *The annual deductible does not count toward satisfying the annual co-insurance maximum. Co-payments do not apply toward the annual deductible or co-insurance maximum. The deductible, co-insurance maximum and prescription co-pay maximums apply to the calendar year.*
- *Some services may require prior authorization by BlueCross BlueShield. Failure to call the BlueCross toll-free number in these instances may result in a reduction in otherwise eligible expenses. Reduction in benefits because of non-notification does not apply to the deductible or the co-insurance maximum.*
- *Emergency admission to non-network facilities will be reimbursed at the network level of benefit coverage until the patient is medically stable to transfer to a network facility.*
- *This Plan Benefits Chart is intended as a convenient overview of the health plans. It does not cover all the provisions, definitions, limitations and exclusions of your benefit plan. Your Summary Plan Description is the governing document.*

2014 Plan Design Changes noted in bold.

Health Plan Comparison Chart *continued*

Long-Term Care Benefits	*Skilled Nursing Facility*	Annual Maximum
		Benefit Percentage Payable
	Hospice Care	Benefit Percentage Payable
	Home Health Care/ Private Duty Nursing	Annual Maximum
		Benefit Percentage Payable
Outpatient Therapy Benefits	*Chiropractic Care/ Acupuncture*	Per Visit Co-payment
		Benefit Percentage Payable
		Annual Maximum
	Physical/Occupational/ Speech Therapy	Benefit Percentage Payable
		Annual Maximum
	Physical/Occupational/ Speech Therapy for children with developmental delays	Benefit Percentage Payable
		Annual Maximum
	Hearing Aid Fitting/Therapy	Benefit Percentage Payable
		Annual Maximum
Prescription Drugs		Maximum Out-of-Pocket
Retail Pharmacy Benefit	*Generic Drug*	Co-payment per Prescription (30-day supply)
	Preferred Brand-name Drug	Co-payment per Prescription (30-day supply)
	Non-Preferred Brand-name Drug	Co-payment per Prescription (30-day supply)
Mail-Order Pharmacy Benefit	*Generic Drug*	Co-payment per Prescription (90-day supply)
	Preferred Brand-name Drug	Co-payment per Prescription (90-day supply)
	Non-Preferred Brand-name Drug	Co-payment per Prescription (90-day supply)
Transplant Benefits	*Hospital Inpatient*	Plan Maximum Transplant Benefit
		Benefit Percentage Payable
	Travel Expenses	Per Transplant Maximum
Ancillary Coverage	*Radiology, Anesthesiology, Pathology, Non-Routine Lab and X-Ray*	Inpatient and Outpatient Benefit Percentage Payable
	TMJ/Orthognathic Services	Benefit Percentage Payable
	Vision Examination (1 exam every 12 months)	Per Visit Co-payment
		Benefit Percentage Payable
	DME (Durable Medical Equipment)/Prosthetics	Benefit Percentage Payable
		Hearing Aid Maximum
	Wigs	Plan Maximum
		Benefit Percentage Payable
Infertility		Plan Maximum
		Benefit Percentage Payable

▶ Women's generic contraceptive drugs will be covered at 100% with no co-pay.

▶ **What Is Mail-Order Pharmacy?**
Mail-Order allows you to receive a three-month supply of maintenance prescriptions at a less expensive cost than through retail pharmacies other than CVS/pharmacy. You can order 90-day supplies of maintenance medications at any local CVS/pharmacy. Both options have lower co-pays and offer the convenience of having prescriptions shipped directly to your home or available for pick up at your local CVS/pharmacy.

Examples of maintenance drugs are heart medication, birth control, mental health drugs, etc.

	Standard Network	Standard Non-Network	Premium Network	Premium Non-Network
	60 days combined network and non-network		60 days combined network and non-network	
	80% after deductible	60% after deductible	90% after deductible	70% after deductible
	80% after deductible	60% after deductible	90% after deductible	70% after deductible
	120 visits combined network and non-network		120 visits combined network and non-network	
	80% after deductible	60% after deductible	90% after deductible	70% after deductible
	$50	N/A	$40	N/A
	100%	60% after deductible	100%	70% after deductible
	20 visits for either service; combined network and non-network		20 visits for either service; combined network and non-network	
	80% after deductible	60% after deductible	90% after deductible	70% after deductible
	20 visits per incident combined network and non-network		20 visits per incident combined network and non-network	
	80% after deductible	60% after deductible	90% after deductible	70% after deductible
	20 visits per calendar year combined network and non-network		20 visits per calendar year combined network and non-network	
	80% after deductible	60% after deductible	90% after deductible	70% after deductible
	$2,000 combined network and non-network		$2,000 combined network and non-network	
	$2,750*	Not covered	$2,750*	Not covered
	$12	Not covered	$12	Not covered
	30%/$30 minimum	Not covered	25%/$30 minimum	Not covered
	40%/**$45** minimum	Not covered	35%/**$45** minimum	Not covered
	$30	Not covered	$30	Not covered
	25%/$75 minimum	Not covered	20%/$75 minimum	Not covered
	35%/**$112.50** minimum	Not covered	30%/**$112.50** minimum	Not covered
	Unlimited	Unlimited	Unlimited	Unlimited
	80% after deductible	60% after deductible	90% after deductible	70% after deductible
	$10,000 combined network and non-network		$10,000 combined network and non-network	
	80% after deductible	80% after deductible	90% after deductible	90% after deductible
	80% after deductible	60% after deductible	90% after deductible	70% after deductible
	$50	$50	$40	$40
	100%	100%	100%	100%
	80% after deductible	80% after deductible	90% after deductible	90% after deductible
	1 aid every 24 months		1 aid every 24 months	
	$750 combined network and non-network		$750 combined network and non-network	
	100%	100%	100%	100%
	$15,000 combined network and non-network–applies to Assisted Reproductive Technology (ART); all other services are unlimited			
	80% after deductible	60% after deductible	90% after deductible	70% after deductible

** The aggregate family maximum is $12,700 (no one family member can satisfy more than $2,750).*

Dental Insurance Open Enrollment

▶ To add/drop coverage or change plans, submit your Open Enrollment form to Human Resources by May 16.

Choosing network providers and getting routine checkups play a big part in controlling costs. Your smart decisions over the last year determine whether the biweekly deductions will remain the same.

Take Note of Plan Changes

DHMO co-pay schedule: The co-pay schedule for DHMO services is changing effective June 1, 2014. Although the cost of most preventive services and office visit co-pays are not changing, please review the new co-pay schedule for specific services, available on CrateNews and CrateConnect.

The Two Plans—DHMO and PPO

▶ **ID cards**
Associates who remain enrolled in the same plan after Open Enrollment should continue using the same ID cards. New ID cards will be distributed to all associates who make a plan election change.

The DHMO Plan requires you to select a provider from the participating dental network. There is no coverage for non-network providers. Services are provided at a substantial savings through a co-pay schedule. Preventive and diagnostic services are covered at 100% after a $5 office visit co-pay. There is no deductible and no maximum dollar limit for benefits.

Choosing the Right Plan For You

The PPO Plan premium costs more than the DHMO Plan, but allows you to select either a network or non network provider. The PPO plan offers a larger network of providers in CIGNA's CORE network than the DHMO Plan. Services are provided at a co-insurance percentage, and coverage is greater for network services.

2014 Biweekly Dental Insurance Contributions

	Dental HMO (DHMO)	PPO
Individual	$6	$9.50
Individual + Spouse/ Domestic Partner	$11.50	$21
Individual + Child(ren)	$12	$22
Family	$14	$26.50

Don't forget about the WellnessPlus® from CIGNA Dental

When you or your family members receive any preventive care service in one plan year, the annual dollar maximum will increase in the following plan year. Currently the calendar year maximum under the PPO dental plan is $1,500. On June 1, 2013, we began rewarding individuals in the PPO dental plan who receive Class I-Preventive dental care. *Preventive services include oral exams, routine cleanings, full mouth/bitewing/panoramic/ periapical X-rays, fluoride application, sealants, and space maintainers*. Associates who receive preventive care in one calendar year will receive a $250 increase of their plan maximum in the following calendar year. The $250 increase will continue year after year until you reach a maximum of $2,000.

Dental Plan Comparison Chart

	DHMO Network Provider Only	PPO Network Provider	PPO Non-Network Provider
Annual Deductible	None	$50	$75
Class I **Co-insurance** *Preventive/Diagnostic*	Plan covers 100%* after $5 office visit co-payment	100%	80% of R&C** *Diagnostic*
Class II *Basic Restorative*	Plan covers 80%* after $5 office visit co-payment	80% after deductible	70% of R&C** after deductible
Class III *Major Restorative*	Plan covers 50%* after $5 office visit co-payment	50% after deductible	40% of R&C** after deductible
Orthodontia *Children and Adults*	Plan covers 50%* after $5 office visit co-payment up to 24 months lifetime maximum	Plan covers 50% with a $1,000 orthodontia lifetime maximum	No benefit
Calendar Year Maximum	Unlimited	Year 1: $1,500 combined network and non-network Year 2: $1,750 combined network and non-network*** Year 3 and beyond: $2,000 combined network and non-network****	

Attention Minnesota Residents: Due to state regulations, your DHMO plan covers 50% of the value of the network benefit for services at non-network providers.

***The DHMO coverage is in the form of fixed fees; the approximate equivalent percentage displayed above is for comparison purposes only. Out-of-pocket cost is limited to the co-payment schedule.**

***R&C: Reasonable and Customary charges are based upon average dental fees in the community*
****Increase contingent upon receiving Preventive Services in Plan Year 1*
*****Increase contingent upon receiving Preventive Services in Plan Year 1 and 2*

Provider Network
The DHMO and PPO Plans have different networks through CIGNA. There are two ways to find a network provider:

1. Call CIGNA at 800.244.6224.
2. Visit the website: *www.cigna.com*.

Q&A

Can I change dental offices?
DHMO Plan—Yes, select another available dentist office by contacting CIGNA by the 15th of any month in order for the change to be effective on the 1st of the following month.

PPO Plan—As long as you see any CORE network dentist, you will be covered at the higher level. Since the PPO Plan does not require you to select a particular dentist, you can change at any time without informing CIGNA. You always have the option to see a non-network provider; although, you will receive a lower level of coverage.

How much do I have to pay for a treatment?
DHMO Plan—Review the co-pay schedule located on CrateNews to determine the charge for each covered service. Your co-payment is paid at the time of service.

PPO Plan—After satisfying your annual deductible you pay a percentage of the cost of the procedure. CIGNA will pay up to the calendar year maximum. If the provider is out-of network, they may or may not submit the claim for you, depending on their office policies.

How often can I have my teeth cleaned?
DHMO Plan—Once every six months is covered at 100% with a $5 office visit co-pay.

PPO Plan—Once every six months with no deductible is covered at 100% in-network and 80% of reasonable and customary out-of-network.

My former dentist was treating me for an ongoing condition. Will the rest of the treatments be covered?
DHMO Plan—CIGNA will not cover any work in progress for basic and major services. Orthodontia is reviewed and covered on a case-by-case basis. Please contact CIGNA at 800.244.6224 to inquire.

PPO Plan—Work in progress is covered as long as it is a covered expense on the plan. Orthodontia is also covered if performed by a network provider. CIGNA will pay for monthly adjustment visits from the effective date until either the treatment plan ceases or until the orthodontia maximum is reached, whichever comes first.

Is there a waiting period for major dental work or for pre-existing conditions?
DHMO Plan—No, as long as treatment has not been started.

PPO Plan—There is a missing tooth limitation of 50% on bridges and dentures for the first 24 months.

Find a provider on *cigna.com*:

1. Select ***Provider Directory*** on the left-hand side of the page.
2. Select ***Dentist***.
3. Search by ***Name, ZIP, State*** or ***Distance*** willing to travel.
4. Click ***Next*** and select ***HMO*** or ***PPO***. When searching for a PPO dentist, select CORE network.
5. Use the scroll bar to select ***Specialty*** as applicable.
6. Click ***Search*** to view the list of dentists.

Vision Insurance Open Enrollment

▶ Associates currently enrolled in BlueCross BlueShield health insurance will still be eligible to receive one vision examination every 12 months and have access to Davis Vision disounts.

Vision coverage is available through UnitedHealthcare (UHC).

Routine vision exams for you and your family are important to maintaining healthy vision and can often detect serious medical conditions in the early stages of development, such as diabetes and high blood pressure as well as glaucoma and cataracts.

Four reasons to consider UHC's Vision Plan.

1. **Affordable.** You may save up to 60% off retail costs on the exam, frame, lens and contacts.
2. **Flexible.** You can choose to cover just yourself, you and your spouse, or your entire family.
3. **Convenient.** You pay for your coverage through biweekly payroll deductions.
4. **Additional discounts.** Coverage includes valuable savings on services like LASIK surgery.

Here's how the plan works when using a UHC network provider:

- Fully covered comprehensive eye exam every 12 months with $15 co-pay.
- Eyeglass lenses or contact lenses are covered in full, after your $30 co-pay. If you choose contact lenses outside of the fully covered selection an allowance of $150 is provided. Please see In-Network Benefits at a Glance.
- The frame benefit of $150 offers you a choice of most frames on the market, with many frames fully covered. The frame allowance can be used once every 12 months.
- If you choose to see an out-of-network provider, you must pay in full at the time of service. UHC will reimburse you for services received based on the fixed dollar amount shown in your Vision Benefit Summary.

Co-pays for in-network services	
Exam	$15.00
Materials	$30.00
Benefit frequency	
Comprehensive Exam, Spectacle Lenses, Frames, Contact Lenses in Lieu of Eyeglasses	Once every 12 months
Frame benefit	
Private Practice or Retail Chain Provider	$150.00 retail frame allowance
Eyeglasses lens options	
Standard scratch-resistant coating, Polycarbonate lenses for dependents up to age 19—covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)	
Contact lens benefit	
Covered-in-full elective contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full (after co-pay). If you choose disposable contacts, up to 6 boxes are included when obtained from a network provider.	
All other elective contact lenses A $150.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials co-pay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts.	

	Biweekly Vision Deduction
Individual	$2.94
Individual + Spouse/ Domestic Partner	$5.41
Individual + Child(ren)	$5.95
Family	$8.19

In-Network Benefits at a Glance

In-network, covered-in-full benefits (after applicable co-pay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eyeglasses.

When you enroll, you'll receive a member ID card. When you go to a network provider, simply tell them you're a UHC Vision member and show them your member ID card to receive services.

Visit *myuhcvision.com* to find the most convenient network provider, details of your plan and view frequently asked questions.

Dependent Eligibility

Dependent Eligibility

Dependents that are eligible for health, dental and vision care coverage are:

- Your legal spouse.
- Your qualified same-sex domestic partner, which includes unmarried, same-sex partners who live together, are financially interdependent and are jointly responsible for each other's common welfare. An Affidavit of Domestic Partnership is required to qualify for benefits (this form and additional details about qualifications and requirements about this policy are available from Human Resources).
- Your dependent children up to age 26, regardless of student status, marital or financial dependence. This includes your biological children, legally adopted children and stepchildren and children who are dependent upon you for support or maintenance because of physical or mental handicap, regardless of age, with proof of incapacitation.
- Because federal law does not recognize domestic partners as legal dependents, the part of your insurance premiums that applies to your domestic partner and the children of your domestic partner must be deducted from your paycheck on an after-tax basis. The portion of your deductions that applies to you or your dependent children will continue on a pre-tax basis. Also, unless your domestic partner is considered a dependent for tax purposes under Section 152 of the Internal Revenue Code, the Internal Revenue Service currently treats the portion of domestic partner premium paid by the Company as imputed income.

Duty to Notify of Ineligibility

The associate is responsible for notifying the Company in writing within 30 days of any change that affects an associate's dependent's eligibility. A medical, dental and vision plan member ceases to be a covered dependent on the date that the member no longer meets the definition of a dependent, regardless of when notice is given to the Company. Failure to provide timely notice to the Company can jeopardize COBRA benefits and result in additional cost to the associate. There also may be tax consequences when coverage is provided for ineligible dependents.

Important Note About Dependent Documentation

For any newly covered dependents, you must attach documentation to your enrollment form. The documentation may be a government-issued birth certificate, adoption decree, marriage certificate or Affidavit of Domestic Partnership.

Open Enrollment Form

Effective Date: June 1, 2014

ASSOCIATE INFORMATION—Please complete all fields

Associate Number #	Social Security #	Last Name	First Name

Address (☐ New)	Apt. #	City	State	ZIP Code

Telephone	Email Address	Marital Status–*circle one*	Location #
		Single Married	

BENEFIT ELECTIONS

				Health*		Dental*		Voluntary Vision*
	Social Security #	Gender M/F	Date of Birth	Standard PPO	Premium PPO	DHMO** Office# _____	PPO	
Self				Add Drop	Add Drop	Add Drop	Add Drop	Add Drop
Spouse/Domestic Partner				Add Drop	Add Drop	Add Drop	Add Drop	Add Drop
Child				Add Drop	Add Drop	Add Drop	Add Drop	Add Drop
Child				Add Drop	Add Drop	Add Drop	Add Drop	Add Drop
Child				Add Drop	Add Drop	Add Drop	Add Drop	Add Drop

**Circle "Add" or "Drop" where applicable.*
***Go to cigna.com or call CIGNA at 800.244.6224 to select a DHMO office.*

Associates enrolling dependents in health, dental or vision insurance will be required to provide documentation to prove their relationship. Documentation may include government-issued copies of birth certificates, marriage certificates, adoption decrees or Affidavits of Domestic Partnership. Please attach documentation to this enrollment form (if it is not already on file). Enrollment cannot be processed until documentation is received.

Important Dental Notice—I accept the coverage/insurance benefits provided by this group dental plan and authorize the processing of my enrollment in the dental coverage as indicated on this form. I authorize deductions from my earnings of any required contributions toward the cost of the coverage. I authorize payment of dental benefits to the provider of dental care. I authorize any participating dental office to release dental records and billing information concerning me or my dependents to CIGNA Dental Health and Connecticut General Life Insurance Company for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize CIGNA Dental Health and Connecticut General Life Insurance Company to release any records or information concerning my dependents or myself to its designee, for purposes of plan administration and customer service. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. CIGNA Dental Health and Connecticut General Life Insurance Company do not require such tests in any state as a condition of obtaining dental coverage. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of insurance fraud. (In Florida, this is a felony in the third degree.)

This is to certify that the foregoing information is true, accurate and complete. Any person who knowingly presents false claims, statements or documents, or conceals a material fact may be prosecuted under applicable laws. I authorize deductions from my earnings of any required contributions toward the cost of the coverage.

Signature Date

PLEASE FAX COMPLETED FORM TO HUMAN RESOURCES AT 847.272.9314 BY MAY 16, 2014 OR SCAN AND EMAIL TO KATHRYN CZAJA AT KCZAJA@CRATEANDBARREL.COM.

June 2014