CBIZ 2011

Your Benefits Just Got Easier

A Summary of Your Employee Benefits

Introduction

Dear CBIZ Associate,

This 2011 CBIZ Benefit Plan Summary is provided to help you prepare to enroll in the CBIZ employee group benefit plans for effective dates of coverage from January 1, 2011 through December 31, 2011.

You must enroll in the following benefit plans, during **Open Enrollment** from November 1 - November 30, 2010, if you want coverage for 2011:

Medical Insurance Plan
Dental Insurance Plan
Vision Insurance Plan
Tax election: Group Long Term Disability Plan
Cafeteria Plan
Great Health Program

Even if you do not want to make a change to your current elections, you must visit ***www.cbizesc.com*** and follow enrollment instructions to secure 2011 benefits.

CBIZ offers many other benefits that are summarized in this material. You may already be enrolled in some or all of these additional plans. No further action is required on your part at this time if you have already enrolled in the following benefits:

Basic Life & AD&D Insurance
CBIZ 401(k) Retirement Plan
Optional Life Insurance Plan
Optional Long Term Care Insurance
Employee Stock Purchase Plan
529 Plan

If you are not enrolled or are not familiar with these optional plans, please use this time to make decisions. Enrollment is restricted in the Optional Life Insurance Plan and Optional Long Term Care Insurance Plan to once a year, during the **Open Enrollment** period.

Once a year, please review the beneficiaries you have named on your group life insurance plan, optional life insurance plan and 401(k) plan, if applicable. You may change these beneficiaries at any time.

Making Changes

The elections you make during Open Enrollment will remain in place throughout the year, unless you experience a qualifying change in family status.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility from the other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must notify the ESC within 31 days of the date your coverage ends (or the date the employer stops contributing towards the coverage) to make a change.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment through the ESC within 31days of this qualifying event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll in the CBIZ Plan; you must request enrollment within 60 days. Additionally, if you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the CBIZ Plan; you must request enrollment within 60 days.

Please refer to the Cafeteria Plan Summary Plan Description on the CBIZ Employee Service Center website at ***www.cbizesc.com*** for additional information about your special enrollment rights.

Introduction

Who Is Eligible?

Unless otherwise stipulated, you are eligible to participate in the CBIZ benefit program if you are a full-time employee of CBIZ scheduled to work at least 25 hours per week for nine months in a twelve-month period.

You may elect medical, dental, vision, and optional life insurance coverage for your eligible dependents. Eligible dependents include:

- Your spouse.
- Your domestic partner and/or the unmarried dependent children of your domestic partner (through the end of the month they achieve age 26). Please refer to the "CBIZ Domestic Partner Benefit Policy" section of this book for additional information.
- Your unmarried dependent children (through the end of the month they achieve age 26). You are responsible for notifying CBIZ when a dependent no longer is eligible for coverage under the CBIZ plans.
- When approved, your unmarried dependent children over age 19 who are incapable of self-care because of a handicap and who rely on you for support.

Special Note

The purpose of this booklet is to summarize your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official Plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the Plans as described in this material and the official Plan documents, the language of the documents shall govern.

CBIZ also specifically reserves the right to revise, modify or terminate the Plans at any time.

To obtain a copy of the official Plan documents, simply log on to the CBIZ Employee Service Center website at ***www.cbizesc.com***, select the icon for Plan Documents and select from the drop down menu. You can then either view the appropriate Plan document or print a copy for your records. To obtain a hard copy of any Plan document, you can also call the CBIZ Employee Service Center at 1-877-227-4372 to request a copy be mailed to you.

ASSISTANCE

"I HAVE QUESTIONS ABOUT HOW TO ENROLL IN MY EMPLOYEE BENEFITS. HOW CAN I GET ANSWERS?"

Enrollment is both convenient and flexible when done through the internet. To enroll or make changes, simply access the CBIZ Employee Service Center website at ***www.cbizesc.com*** anytime day or night. It is very important that you complete your enrollment during **Open Enrollment** dates. If you do not complete your enrollment by the deadline, you will have no coverage for the plan year.

Who can you call for assistance?

The CBIZ Employee Service Center
Phone: 1-877-227-4372
Fax: 1-972-383-7848
Website: *www.cbizesc.com*
Monday through Friday, 8:30 a.m. - 6:00 p.m. CST

"I HAVE QUESTIONS ABOUT MY EMPLOYEE BENEFITS. HOW CAN I GET ANSWERS?"

Of course, once you have enrolled in the company group benefit plans and voluntary benefit plans, making use of the benefits can sometimes be a challenge. You may have questions and that is why CBIZ makes the Employee Service Center available to you and your dependents.

- Benefit Information - carrier contact numbers and web information and addresses; replacement of Identification Cards or temporary documents to use while you wait for an ID card; general plan information and assistance with large or complicated claims for reimbursement with all group plan benefit carriers (especially if direct contact with carrier representative does not quickly meet your needs).

- Documentation - a website with all plan overview information, Summary Plan Descriptions, Summary Annual Reports, Plan Documents, forms or access to forms, and contact information.

- Changes to benefit enrollments -If a change in your family status occurs during a plan year, it is through the Employee Service Center that you work to make changes to your current enrollment, where allowable. If you marry or divorce, have a change in the number of children you currently insure, or have questions about your options to change your benefits during a plan year - phone the Employee Service Center. They can help.

Customer Service Representatives are the quickest and most efficient resources available to assist you as questions arise or as you need guidance through claim intricacies with the benefit plan carriers! Don't hesitate to call!

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Contacts

We encourage you to call the carrier first for individual questions you may have about your plans, claims and coverage. If you do not get resolution to your satisfaction, please contact the CBIZ Employee Service Center.

UNITEDHEALTHCARE (MEDICAL)
1-800-241-4675
Website: ***www.uhc.com***
Group #188335 (all plans)

OPTUMHEALTH BANK (HEALTH SAVINGS ACCOUNTS)
1-800-791-9361
Website: ***www.myuhc.com***

US BANK (HEALTH SAVINGS ACCOUNTS)
1-877-470-1771
Website: ***www.mycdh.usbank.com***

DELTA DENTAL (DENTAL)
1-800-234-3375
Website: ***www.deltadental.com***
Group #: Dental 80 Plan #90604, Dental 100 Plan #90704

VISION SERVICE PLAN (VISION)
1-800-877-7195
Website: ***www.vsp.com***
Group #12197319

HARTFORD (DISABILITY, LIFE AND FAMILY MEDICAL LEAVE ADMINISTRATION)
To report a Family Medical Leave claim and/or a disability claim or to check the status of a previously submitted claim, call 1-800-549-6514.
For questions on life insurance, conversion and portability, call 1-877-320-0484. For questions on status of life insurance evidence of insurability form, call 1-800-331-7234.

UNUM (LONG TERM CARE, INDIVIDUAL DISABILITY)
Long Term Care: 1-800-227-4165
Individual Disability: 1-800-633-7490

CBIZ PAYROLL, INC. (CAFETERIA PLAN ADMINISTRATOR)
1-800-815-3023
Prompt: Benefits
Prompt: Flex
Website: ***www.myflexonline.com***

CBIZ PAYROLL, INC. (COBRA ADMINISTRATOR)
1-800-815-3023, Option 6
Email: ***cbizcobra@cbiz.com***

RETIREMENT PLAN CONTACTS:
Mass Mutual Retirement Services (Plan Recordkeeper)
1-800-743-5274
Website: ***www.massmutual.com/retire***
Investment Helpdesk
E-mail: ***401KInvestmentSupport@CBIZ.com***

COMPUTERSHARE (EMPLOYEE STOCK PURCHASE PLAN ADMINISTRATOR)
1-888-726-8085
Website: ***www.computershare.com***

ALLIANCEBERNSTEIN (529 BENEFIT PLAN PROGRAM MANAGER)
1-800-227-2900
Website: ***www.collegeboundfund.com***

CBIZ EMPLOYEE SERVICE CENTER
1-877-227-4372
E-mail: ***cbizesc@cbiz.com***

CBIZ GREAT HEALTH
E-mail: ***greathealth@cbiz.com***

SAINT LUKE'S HEALTH SYSTEM (EMPLOYEE ASSITANCE PROGRAM - EAP)
1-800-EAP-1223 or (816) 931-3073

Medical Insurance Plan

Among the most important decisions you will make about the benefit plan options available through CBIZ is the type of medical insurance coverage that is best for you and your family. Medical insurance represents a major part of our benefit program. This important coverage helps to protect you and your family from the financial loss or hardship that could result from illness. With the rising cost of health care, few of us could afford to pay medical expenses out of our own pockets. You may choose coverage through one of the three available insurance plans or you may choose not to participate.

CBIZ has sponsored a wellness program since 2002, now referred to as ***Great Health,*** directly connected to the CBIZ medical plan coverage. This program has expanded over the years to offer the newest information, initiatives and incentives used by employers our size. The foundation of the plan has always been, and remains today, the Health Risk Assessment. The majority of CBIZ associates, over 90% now, participate in the survey once a year during Open Enrollment.

CBIZ uses an online survey available directly through the University of Michigan. This survey, once completed, is submitted electronically and confidentially to the University. Experts at the University aggregate the data and are not only able to direct specific health information to members with health challenges, but also assist us in designing the programs made available through the ***Great Health*** program. Completing the online survey is not required, but it is one step that you must take in order to receive a monthly discount on your 2011 medical plan premiums.

The information you share in the HRA is completely confidential. It takes 20 minutes to complete the survey online, from any computer with internet access and the site is available 24/7. Achieving 100% participation in the survey allows for a complete measure of improvements our associates are making towards wellness year over year. But of greatest importance, securing everyone's participation in the plan is about everyone working towards ***Great Health!***

Basic Information

The CBIZ plan offers you three types of medical plans - a Qualified High Deductible Plan, a $1000 deductible or a $500 deductible plan. All plans cover the same types of procedures and are insured through UnitedHealthcare (UHC). What is different about each plan is the out-of-pocket cost to you. Out-of-pocket costs include the deductible, coinsurance payments, copayments and premium costs. No matter which plan you choose, you may select between four levels of coverage: Employee Only, Employee & Spouse, Employee & Child(ren) or Employee & Family coverage. You have the option at the time of service to choose whether or not you want to utilize network providers. If you do use providers who are in the UHC network, you will be reimbursed at a higher level than you would be for providers who are not in the UHC network. To obtain a list of providers participating in the UHC network simply go to the CBIZ Employee Service Center website at ***www.cbizesc.com***. From the main menu, choose "Website Links." If you want to look for providers in the $1000 deductible or $500 deductible plans, you will need to choose the "Options PPO" network when prompted at the UHC website. If you want to look for providers in the QHDP, you will need to choose the "Choice Plus" network when prompted at the UHC website.

Medical Glossary

Deductible
The deductible is the amount of your covered expenses you must pay each calendar year before the insurance company begins to pay. The individual deductible is the amount each covered family member must pay before the insurance company begins to pay. However, every dollar applied to the individual deductible will also be applied to the family deductible. Once the family deductible is met, the plan will pay benefits for all family members.

Embedded Deductible
All CBIZ plans have an embedded deductible. An embedded deductible is applicable when you are covering any dependents. With an embedded deductible, once an individual family member pays the individual deductible, the insurance company begins to pay for medical expense associated with this individual's services even though the family deductible is not yet met.

Coinsurance
After the deductible is met, you and UHC share in the payment of your medical bills. The coinsurance amount will depend on the plan you choose and whether in-network or out-of-network providers were utilized.

Covered Expenses
Covered expenses are the expenses that are eligible for reimbursement. All of the medical coverage options generally provide benefits for medically necessary services and supplies ordered by a doctor for the treatment of an accidental injury, sickness or pregnancy. Each option also provides benefits for certain routine and preventive services. Under all plans, when benefits are paid for out-of-network covered expenses, UHC will consider payment of those expenses only up to Reasonable and Customary (R&C) limits.





Medical Insurance Plan

Copayment
Copayment refers to a fixed cost that you must pay per occurrence. Copayments are paid directly to the providers (i.e. physician and pharmacy) and do not count towards the out-of-pocket maximum.

In-Network
In-network coverage is provided for covered expenses when you receive treatment or services from a physician or hospital which is a member of UHC's network. In-network coverage is the highest level of coverage provided.

Out-of-Network
Out-of-Network coverage is provided for covered expenses incurred when you receive treatment or services from a physician or hospital which is not a member of the UHC provider network. The plan considers covered expenses only up to Reasonable and Customary (R&C).

Out-of-Pocket Maximum
This maximum limits your out-of-pocket expenses (including deductibles and coinsurance) in any one calendar year. If you reach the individual out-of-pocket maximum for any covered family member, the plan pays 100% of that person's covered expenses for the remainder of the year. If you reach the family out-of-pocket maximum, the plan pays 100% of your entire family's covered expenses for the remainder of the year. Please note that any copayments (i.e. physician's office, prescription drug, emergency room, etc.) as well as expenses not covered by the plan do not count towards the out-of-pocket maximum.

Reasonable and Customary
The UHC plans will not pay for any charge above Reasonable and Customary (R&C) limit when you receive services from out-of-network providers, and these charges do not count towards your out-of-pocket maximums. R&C charges are the fees usually charged for comparable services & supplies in your geographic area. UHC determines whether or not a charge is reasonable and customary and keeps up-to-date with the latest medical practices and fees around the country. Because in-network doctors and hospitals provide services and supplies for agreed-upon rates, you will never exceed R&C charges when you use in-network providers.

Selecting the Right Plan

At CBIZ, we understand that choosing the wrong health care plan can be a costly mistake. That is why we want to provide you as many resources as possible to assist you with that selection.

The custom Plan Cost Estimator gives you the information you need to make the best decision. This tool can help you:

- Compare cost differences between the CBIZ plans and other plan options you may have.
- Get detailed comparisons for premiums, out-of-pocket costs and more.
- Determine how much money to set aside for flexible spending and/or health savings accounts.

It is easy to get started - simply log on to the CBIZ Employee Service Center website at ***www.cbizesc.com***. On the right side of the main menu, select "Website Links" then select "Plan Cost Estimator" to be directed to the custom Plan Cost Estimator website. Once you are at this website, you will need to enter "CBIZ" as the Employer ID and "benefits" as the Security Code. After you have logged in, you will be asked to take the following three steps:

- Step I: Enter the family members to be covered. Enter basic details about yourself, your family members and dependents, including employment and demographic details.
- Step 2: Specify health care usage by each family member. Enter your yearly health care usage estimate for all your covered family members. You will first specify low, medium or high care usage for each member. Your estimate will then provide a list of pre-defined health services, and you will be able to remove services that are not relevant to your situation. You will also have the opportunity to enter additional services including procedures, conditions, prescriptions and medical equipment.
- Step 3: View and compare plan cost estimates. You will be able to compare premiums, health care usage costs, annual plan costs, print estimates, download plan summaries or add your own plan estimate.

Additionally, we have provided the following examples which show various levels of health care expenses and how much you would pay out of your pocket for each of the three medical plans. For simplicity, each of the examples assumes you have selected single coverage and have used in-network providers. These examples do not take in to account any expenses covered by a copayment (i.e. office visit and prescription drugs).

The ***Plan Cost Estimator*** tool is not intended to determine the actual medical expense you will incur in 2011. CBIZ is not attempting to recommend or endorse any particular medical plan for you or your family. The decision about which plan is right for you is yours alone to make. CBIZ is not responsible for your final medical costs in 2011 regardless of the estimates you gather in using this or any other estimator tools provided during this Open Enrollment period or at any time by CBIZ.

Medical Insurance Plan

EXAMPLE #1: YOU INCUR ONLY $300 OF ELIGIBLE HEALTH CARE EXPENSES DURING THE PLAN YEAR.

	QHDP	$1,000 Deductible Plan	$500 Deductible Plan
Your Eligible Medical Expenses	$300	$300	$300
Your Share (Deductible Expenses)	$300	$300	$300
Remaining Expenses	0	0	0
Coinsurance Paid by UHC	0	0	0
Coinsurance You Paid	0	0	0
Summary:			
Your Deductible & Coinsurance	$300	$300	$300
Your Annual Premium for Single Coverage*	$0**	$576	$1,344
Your Annual Cost	**$300**	**$876**	**$1,644**

EXAMPLE #2: YOU INCUR $2,500 OF ELIGIBLE HEALTH CARE EXPENSES DURING THE PLAN YEAR.

	QHDP	$1,000 Deductible Plan	$500 Deductible Plan
Your Eligible Medical Expenses	$2,500	$2,500	$2,500
Your Share (Deductible Expenses)	$2,400	$1,000	$500
Remaining Expenses	$100	$1,500	$2,000
Coinsurance Paid by UHC	$100	$1,200	$1,600
Coinsurance You Paid	0	$300	$400
($1,000 deductible: 20% of $1,500)			
($500 deductible: 20% of $2,000)			
Summary:			
Your Deductible & Coinsurance	$2,400	$1,300	$900
Your Annual Premium for Single Coverage*	$0**	$576	$1,344
Your Annual Cost	**$2,400**	**$1,876**	**$2,244**

EXAMPLE #3: YOU INCUR $5,000 OF ELIGIBLE HEALTH CARE EXPENSES DURING THE PLAN YEAR.

	QHDP	$1,000 Deductible Plan	$500 Deductible Plan
Your Eligible Medical Expenses	$5,000	$5,000	$5,000
Your Share (Deductible Expenses)	$2,400	$1,000	$500
Remaining Expenses	$2,600	$4,000	$4,500
Coinsurance Paid by UHC	$2,600	$3,200	$3,600
Coinsurance You Paid	0	$800	$900
($1,000 deductible: 20% of $4,000)			
($500 deductible: 20% of $4,500)			
Summary:			
Your Deductible & Coinsurance	$2,400	$1,800	$1,400
Your Annual Premium for Single Coverage*	$0**	$576	$1,344
Your Annual Cost	**$2,400**	**$2,376**	**$2,744**

* Assumes you have completed the requirements necessary to receive a $20/month premium discount.

** Based on a monthly premium only – does not include any contribution you might make to your HSA.

Medical Insurance Plan

EXAMPLE #4: YOU INCUR $10,000 OF ELIGIBLE HEALTH CARE EXPENSES DURING THE PLAN YEAR.

	QHDP	$1,000 Deductible Plan	$500 Deductible Plan
Your Eligible Medical Expenses	$10,000	$10,000	$10,000
Your Share (Deductible Expenses)	$2,400	$1,000	$500
Remaining Expenses	$7,600	$9,000	$9,500
Coinsurance Paid by UHC	$7,600	$7,200	$7,600
Coinsurance You Paid	0	$1,800	$1,900
($1,000 deductible: 20% of $9,000)			
($500 deductible: 20% of $9,500)			
Summary:			
Your Deductible & Coinsurance	$2,400	$2,800	$2,400
Your Annual Premium for Single Coverage*	$0**	$576	$1,344
Your Annual Cost	**$2,400**	**$3,376**	**$3,744**

*Assumes you have completed the requirements necessary to receive a $20/month premium discount.

** Based on a monthly premium only – does not include any contribution you might make to your HSA.

Qualified High Deductible Plan Option

One of the medical plan options that CBIZ offers to you is a Qualified High Deductible Plan (QHDP). The Qualified High Deductible Health plan is often referred to as a consumer-centric plan. This means the consumer is financially motivated to take personal responsibility for maintaining good health and working to improve one's health. The first health expense you incur is out-of-pocket as you pay through a high deductible. When the first dollars are yours to spend for your care, studies show you will begin to look at your health care service needs like other consumer products and services; looking for the best providers, at a cost you understand and making lifestyle changes that maximize your personal health and minimize unnecessary use of the health care system.

Highlights of the QHDP include:

1. Annual preventive/wellness exams are not subject to the deductible and are covered at 100% if services are received from UHC participating providers. Diagnostic office visits and hospital services will apply to your deductible.
2. Prescription drugs are also subject to the deductible (with the exception of certain Tier 1 preventive prescription drugs). Once the deductible has been satisfied, prescriptions will be covered at 100%.
3. If you remain in-network, you will still benefit from UHC's contracts with their network providers. Only the discounted "allowable" amount will apply to your deductible, not the full bill.
4. When selecting coverage under this Qualified High Deductible Health plan, you may be eligible to open a Health Savings Account. Information about the health savings account options are noted on page 24, as a part of the Cafeteria Plan Benefit Plan.

Medical Insurance Plan

Qualified High Deductible Plan

	In-Network	Out-of-Network
Annual Deductible		
Individual	$2,400	$4,800
Family	$4,800	$9,600
Per Hospital Confinement	None	None
Coinsurance Percentage	UHC Pays 100% - You Pay 0%	UHC Pays 80% - You Pay 20%
Out-of-Pocket Maximum		
Individual	$2,400	$9,600
Family	$4,800	$19,200
Lifetime Maximum	Unlimited	Unlimited
Physician Services		
Office Visits (Primary Care & Specialist)	UHC pays 100% after deductible	UHC pays 80% after deductible
Diagnostic Lab & X-Ray	UHC pays 100% after deductible	UHC pays 80% after deductible
Urgent Care	UHC pays 100% after deductible	UHC pays 80% after deductible
Preventive Care Services		
Routine Physical Exams	UHC pays 100%	Not Covered
Well Child Care/Immunizations	UHC pays 100%	Not Covered
Annual Well Woman Exam	UHC pays 100%	Not Covered
Routine Mammograms	UHC pays 100%	UHC pays 80% after deductible
Routine Vision Exam (limited to 1 exam every 2 years)	UHC pays 100%	UHC pays 80% after deductible
Routine Colonoscopies	UHC pays 100%	UHC pays 80% after deductible
Outpatient Diagnostic Services		
Lab & X-Ray	UHC pays 100% after deductible	UHC pays 80% after deductible
Mammograms	UHC pays 100% after deductible	UHC pays 80% after deductible
Colonoscopies	UHC pays 100% after deductible	UHC pays 80% after deductible
Outpatient Surgery	UHC pays 100% after deductible	UHC pays 80% after deductible
Inpatient Hospital Care	UHC pays 100% after deductible	UHC pays 80% after deductible
Emergency Care		
Hospital Emergency Room	UHC pays 100% after deductible	
Ambulance Services (Emergency & Non-Emergency)	UHC pays 100% after deductible	

Prescription Drug Services	**In-Network**	**In-Network**	**Out-of-Network**
Retail Pharmacy	**Preventive List***	**Not on Preventive List**	
Tier 1	UHC pays 100%	UHC pays 100% after deductible	Not Covered
Tier 2 & Tier 3	UHC pays 100% after deductible	UHC pays 100% after deductible	Not Covered
Mail Order (90-Day Supply)	**Preventive List***	**Not on Preventive List**	**Out-of-Network**
Tier 1	UHC pays 100%	UHC pays 100% after deductible	Not Covered
Tier 2 & Tier 3	UHC pays 100% after deductible	UHC pays 100% after deductible	Not Covered
Contraceptives (covered through both retail & mail order)		Oral, diaphragms and self-administered injectibles covered	

If you have questions regarding coverage for a service that is not listed above, please call UnitedHealthcare at 1-800-241-4675.

Notes:

1. Deductibles and out-of-pocket maximums are separate for in-network and out-of-network and do not cross-apply. The out-of-pocket maximums shown above already include the annual deductible amounts.
2. Expenses not covered by the plan do not count towards the out-of-pocket maximum.
3. For further details regarding the plan, please refer to your Summary Plan Description and any Amendments or call UnitedHealthcare at 1-800-241-4675.

* Certain prescription medications are covered by UHC at 100% and are not subject to the medical plan deductible. For further information about this program and a list of qualified medications, please refer to the CBIZ ESC website at ***www.cbizesc.com***.

Medical Insurance Plan

	$1,000 Deductible Plan		$500 Deductible Plan	
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***
Annual Deductible Individual Family Per Hospital Confinement	$1,000 $2,000 None		$500 $1,000 None	
Coinsurance Percentage	UHC Pays 80% You Pay 20%	UHC pays 80% UHC pays 20%	UHC Pays 80% You Pay 20%	UHC pays 80% UHC pays 20%
Out-of-Pocket Maximum Individual Family	$6,000 $12,000		$2,500 $5,000	
Lifetime Maximum	Unlimited		Unlimited	
Physician Services Office Visits - Primary Care Physician Office Visits - Specialist	$30 Copayment $50 Copayment	$30 Copayment $50 Copayment	$30 Copayment $50 Copayment	$30 Copayment $50 Copayment
Diagnostic Lab & X-Ray	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible
Urgent Care	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible
Preventive Care Services Routine Physical Exams	UHC pays 100%	UHC pays 100%	UHC pays 100%	UHC pays 100%
Well Child Care/Immunizations	UHC pays 100%	UHC pays 100%	UHC pays 100%	UHC pays 100%
Annual Well Woman Exam	UHC pays 100%	UHC pays 100%	UHC pays 100%	UHC pays 100%
Routine Mammograms	UHC pays 100%	UHC pays 100%	UHC pays 100%	UHC pays 100%
Routine Vision Exam (limited to 1 exam every 2 years)	UHC pays 100%	UHC pays 100%	UHC pays 100%	UHC pays 100%
Routine Colonoscopies	UHC pays 100%	UHC pays 100%	UHC pays 100%	UHC pays 100%
Outpatient Diagnostic Services Lab & X-Ray	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible
Mammograms	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible
Colonoscopies	UHC pays 100%	UHC pays 80% after deductible	UHC pays 100%	UHC pays 80% after deductible
Outpatient Surgery	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible
Inpatient Hospital Care	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible
Emergency Care Hospital Emergency Room	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible
Ambulance Services Emergency	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible
Non-Emergency	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible	UHC pays 80% after deductible

Medical Insurance Plan

	$1,000 Deductible Plan			$500 Deductible Plan		
Prescription Drug Services	**$100 individual/$300 family annual deductible, then you pay:**			**$100 individual/$300 family annual deductible, then you pay:**		
Retail Pharmacy	**In-Network Value Based****	**In-Network All Others**	**Out-of-Network**	**In-Network Value Based****	**In-Network All Others**	**Out-of-Network**
Tier 1	$5 Copayment	$10 Copayment	Not Covered	$5 Copayment	$10 Copayment	Not Covered
Tier 2	$15 Copayment	$30 Copayment	Not Covered	$15 Copayment	$30 Copayment	Not Covered
Tier 3	$50 Copayment	$50 Copayment	Not Covered	$50 Copayment	$50 Copayment	Not Covered
Mail Order (90-Day Supply)						
Tier 1	$12.50 Copayment	$25 Copayment	Not Covered	$12.50 Copayment	$25 Copayment	Not Covered
Tier 2	$37.50 Copayment	$75 Copayment	Not Covered	$37.50 Copayment	$75 Copayment	Not Covered
Tier 3	$125 Copayment	$125 Copayment	Not Covered	$125 Copayment	$125 Copayment	Not Covered
Contraceptives (Covered through both retail and mail order)	Oral, diaphragms and self-administered injectibles covered		Not Covered	Oral, diaphragms and self-administered injectibles covered		Not Covered

** Benefits paid based on UHC's reasonable and customary limits.*

*** Employees, spouses and/or children who meet certain requirements may be eligible to receive specific prescription medications at a reduced copayment without having to meet the prescription drug deductible. For more information on the value-based program, please refer to the CBIZ ESC website at **www.cbizesc.com**.*

If you have questions regarding coverage for a service that is not listed above, please call UnitedHealthcare at 1-800-241-4675.

Notes:

1. Deductibles and out-of-pocket maximums are separate for in-network and out-of-network and do not cross apply. The out-of-pocket maximums shown above already include the annual deductible amounts.
2. Medical plans and costs detailed here do not apply to CBIZ associates working in the State of Hawaii. Plan/cost information for Hawaii-based employees are posted at **www.cbizesc.com**.
3. Neither copayments nor expenses not covered by the plan count towards the out-of-pocket maximum.
4. For further details, please refer to your Summary Plan Description, and any Amendments, posted at **www.cbizesc.com** or call UnitedHealthcare at 1-800-241-4675.

What CBIZ Contributes

You and CBIZ share in the cost of the medical coverage. Please refer to the Enrollment Worksheet for the monthly cost for coverage.

What to Do

- Review all of your options for medical coverage. Consider the UHC options as well as any other coverage options you have, such as through a spouse's employer.
- Review the Selecting the Right Plan section and the tools available at **www.myuhc.com** to help determine which CBIZ plan is the best for you.
- Review the participating physicians and hospitals in the UHC network. Is your physician on the list? If not, is there a network physician who could meet your needs just as well? Keep in mind, providers may change their status with an insurance company at any time. You may want to check with your current physicians about their status with UHC before enrollment.
- Make your medical selection - Qualified High Deductible, $1000 Deductible, $500 Deductible or no coverage.
- Questions? Visit the CBIZ Employee Service Center website at **www.cbizesc.com** or call the CBIZ Employee Service Center at 1-877-227-4372 Monday through Friday between 8:30 a.m. and 6:00 p.m. CST for direction on where best to get the information you need.

Medical Insurance Plan

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at CBIZ, Inc., 11440 Tomahawk Creek Parkway, Leawood, KS, 66211. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or ***www.dol.gov/ebsa/healthreform***. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Notes

Dental Insurance Plan

Good dental health is critical to your overall health. The CBIZ plan is flexible enough to respond to a variety of dental care needs. Whether you need a check-up, a filling, or major dental work, the dental plan covers you.

Your Options

The CBIZ plan provides you with three choices when it comes to your dental coverage – Dental 80, Dental 100 or no coverage. Delta Dental Plan administers the dental plans.

There is a network of participating dentists available to you through Delta Dental. The name of this network is Delta Premier. If you choose to see a dentist who participates in this network, you will realize a cost savings. Participating dentists cannot bill you for any charges that are in excess of Delta's reasonable and customary amount, and they have discounted the fees that they do charge. In addition, participating dentists will file your claims directly with Delta eliminating the need for you to deal with any paperwork.

However, should you choose not to see a dentist in the network, there will be no difference in the percentage that Delta will pay for your services. Just remember that a non-participating dentist can bill you for any charges that are in excess of Delta's allowable amount and may require you to pay for your entire services up front, leaving you to file a claim for reimbursement directly with Delta.

To obtain a list of dentists participating in the Delta Dental network, simply go to the CBIZ Employee Service Center website at ***www.cbizesc.com***. From the main menu, choose "Dental Plan" then select "Delta Dental Providers."

Terminology

Before we tell you about your dental benefit choices, there are some terms you will need to understand.

Deductible
The amount of covered expenses you pay each calendar year before benefits become payable by Delta.

Coinsurance
After the deductible is met, you and Delta share in the payment of your dental bills. The percent of covered charges depends upon the option you choose.

Annual Maximum
For all services, other than orthodontia, there is a maximum benefit that Delta will pay each calendar year per individual. Once this maximum is reached, no further benefits will be payable during the calendar year. The amount of the annual maximum depends on the option you choose.

Lifetime Maximum
For orthodontics there is a maximum benefit that Delta will pay for each individual. Once this maximum is reached, no further benefits will be payable.

Reasonable and Customary (Allowable Amount)
The Delta plans will not pay for any charge above the allowable amount when you receive services from out-of-network providers. For each service, payment to out-of-network providers is based on an average of all of the fees submitted by in-network providers for that service. Because in-network providers provide services and supplies for agreed-upon rates, you will never exceed the allowable amount when you use in-network providers.

Dental Classes
Each dental option provides different coverage levels for each class of dental service. The classes are described briefly below.

Class I – Preventive
Care provided to promote good oral health and prevent serious dental problems.
- *Oral examinations*
- *Fluoride treatments (for dependents up to age 19)*
- *Diagnostic bite-wing x-rays*
- *Routine cleaning*
- *Sealants (Dental 100 Plan only for dependents up to age 14)*

Class II – Basic
Care necessary for maintenance of teeth.
- *Fillings*
- *Periodontics*
- *Minor oral surgery*
- *Simple and surgical extractions*
- *Minor restorative services*

Class III – Major
More extensive dental services.
- *Inlays*
- *Onlays*
- *Crowns*
- *Bridgework*
- *Dentures*
- *Dental Implants*

Class IV – Orthodontics
These services involve the movement of teeth with orthodontic appliances to correct imperfect position or abnormal bite. Cosmetic orthodontics are not covered. Orthodontic services are only covered for dependent children up to age 19. Please note that any dependent child who is currently receiving orthodontia treatment (defined as the child having bands on his/her teeth) will not be eligible for the orthodontia benefit under the CBIZ Dental 100 Plan.

Dental Insurance Plan

	Class I Preventive Services	Class II Basic Services	Class III Major Services	Class IV Orthodontia Services
Dental 80 Deductible	None	$50 per person ($150 per family) each calendar year. This deductible applies to services from Classes II and III combined.		No Coverage
Coinsurance	Delta Pays 80% You Pay 20%	Delta Pays 80% You Pay 20%	Delta Pays 40% You Pay 60%	No Coverage
Maximum Benefit	$1,000 per person per calendar year for Classes I, II and III combined.			No Coverage
Dental 100 Deductible	None	$50 per person ($150 per family) each calendar year. This deductible applies to services from Classes II and III combined.		None
Coinsurance	Delta Pays 100% You Pay 0%	Delta Pays 80% You Pay 20%	Delta Pays 50% You Pay 50%	Delta Pays 50% You Pay 50%
Maximum Benefit	$1,500 per person per calendar year for Classes I, II and III combined.			$1,500 lifetime maximum per dependent child for Class IV.

Important Information

Please make note of the following aspects of the CBIZ dental plans:

1. If you enroll in the Dental 100 Plan, you (and any dependents you cover) must remain in that plan until the next plan anniversary date following the date you have been enrolled in the 100 Plan for at least 2 years unless you have a qualifying event.
2. If you enroll in the Dental 80 Plan, you will be eligible to change to the Dental 100 Plan at the next enrollment time. However, once you do enroll in the Dental 100 Plan, you (and any dependents you cover) must remain in the Dental 100 Plan until the next plan anniversary date following the date you have been enrolled in the 100 Plan for at least 2 years unless you have a qualifying event.
3. Any dependent child who is currently receiving orthodontia treatment (defined as the child having bands on his/her teeth) will not be eligible for the orthodontia benefit under the CBIZ Dental 100 Plan.

What CBIZ Contributes

You and CBIZ share in the cost of dental coverage. Please refer to the Enrollment Worksheet for the monthly cost for coverage.

What to Do

- Consider your family's need for dental care. How much do you spend each year on preventive dental services? Will any of your dependents need orthodontia coverage?
- Do you have other dental coverage options available to you, such as through your spouse's employer? How do these plans compare?
- Review the list of participating network dentists. Is your dentist on the list? If not, is there a network dentist who could meet your needs just as well?
- Make your dental selection – Dental 80, Dental 100 or no coverage.
- Indicate your selection on the Enrollment Worksheet included in the enrollment packet.
- Questions? Visit the CBIZ Employee Service Center website at ***www.cbizesc.com***, or call the CBIZ Employee Service Center at 1-877-227-4372 Monday through Friday between 8:30 a.m. and 6:00 p.m. CST.

Great Health Program

The ***Great Health*** program is offered in partnership with ***Great People, Great Place***. You are valued as a CBIZ employee and we recognize the contribution you make to our business. It is an important part of our mission as a company to make CBIZ the very best it can be for our associates and that includes bringing you resources to assist you in managing your overall well-being.

Research shows the majority of employees want to do their very best work for their employer. However, sometimes there are personal matters or personal health problems that interfere with our best efforts on the job.

Great Health is more than just a discount on your medical plan premiums. It is a long-term plan, designed solely to highlight the important role you play in your health and the health of your dependents. When you make the decision to engage and take personal responsibility for the management of your health and wellness, the results can be far-reaching. We understand the impact good health can have on your personal growth and happiness as well as the growth and strength of our business. For these reasons, we strongly encourage you to get involved.

Through a variety of venues, employees and their immediate family members have access to personal and motivational support, personalized health resources, 24-hour access to health information and confidential, professional direction for any personal issues. Participation in the ***Great Health*** program is certainly voluntary but you, your co-workers and future co-workers win as we increase participation and move towards creating a 'culture' of wellness in our company.

The Health Risk Assessment (HRA) is still the foundation of the ***Great Health*** program. During Open Enrollment for 2011, you will access the University of Michigan's HRA through the CBIZ Employee Service Center website. As always, your personal health information is and will remain completely confidential and will not be shared directly with us.

Data collected through the HRA will be combined with that of other users and provided to CBIZ in the form of an aggregate report. It is this data that dictates the varying components of the ***Great Health*** program. Since CBIZ began annual health assessments in 2002, we have learned that a large number of associates are considered to be "well". We have also learned there are a number of participants with increasing risk factors year after year. The ***Great Health*** program is targeting both these groups. We know some individuals who consider themselves "well" may be at risk and not know it. We want all associates to be aware of their current health status and take advantage of the services provided to help maintain good health, such as free preventative screenings (i.e. mammograms and colonoscopies), annual wellness exams and age appropriate wellness exams. We encourage members to select a medical home so they build a relationship with a physician and feel comfortable discussing risk factors, lifestyle choices, current medication use and compliance.

Each individual who can be encouraged through this program to stay healthy or take the appropriate steps to improve their health will impact the metrics of our total employee population. With your help, we can change the culture of our company.

For those enrolled in a CBIZ medical plan, we will be using the many tools at ***www.myuhc.com*** to ensure you have convenient access to all the tools, plans and resources available through ***Great Health***.

Through UnitedHealthcare, you can:

- Create and store your personal health information within a confidential *Personal Health Record (PHR)*.
- Compare different health plans and identify the best plan for you and your family.
- Access an expansive health library to encourage healthy living, provide decision support, interactive trackers and tools such as *Symptom Checker, Drug Guide* and *Health Calculators*.
- Receive a discount of up to 50% off health and wellness-related services not covered by most health plans. Access the program, powered by *UnitedHealth Allies*, through the 'Extra Programs and Discounts' link on the homepage.
- Enroll in an *Online Health Coaching* program. These programs are available to all participants and blend fitness and nutrition with stress management, smoking cessation, weight loss, diabetes and heart health.
- Personalize your homepage with health and wellness information that relates to your daily life or provides the most current information on health topics of interest to you.
- Receive *Personal Health Support* as you work to manage chronic conditions such as asthma, coronary artery disease, congestive heart failure or diabetes. Your eligibility for this program is determined by UHC when you experience certain health events that require medical attention. If you are eligible for the program, you will be contacted by a Personal Health Support Nurse with expertise to help you.

Great Health Program

- Make informed decisions about your upcoming health care needs with the help of the *Treatment Decision Support* center. To learn more about this program, simply phone the Nurseline at 1-866-923-9981.
- Get personal support and education through all stages of pregnancy and delivery with the *Health Pregnancy* Program. Enrollment includes several complimentary gifts for you and your baby. Call 1-800-411-7984 prior to your 33rd week of pregnancy to enroll.
- Access to *Care24*, an anytime, anywhere Nurseline staffed with registered nurses who can assist you and your family with a wide range of health care questions and concerns. Call toll-free 24/7, 1-866-923-9981 and choose the 'talk to a nurse' prompt.
- Access special services if you have been diagnosed with, or are undergoing treatment for, cancer. Support is available through *Cancer Resource Services*; details at 1-866-936-6002.

Employee Assistance Program (EAP)

We know our employees want to provide their very best effort when on the job, but, from time to time, situations occur to individuals or in families that can interfere with an employees' ability to stay focused while at work. The *Employee Assistance Program (EAP)*, provided through Saint Luke's Health System and sponsored by CBIZ, is available to confidentially address any personal concerns with a trained professional and get assistance or referrals to other professionals with expert training to make a difference.

This benefit provides four free sessions with an EAP professional, for employees, their spouses/domestic partners and/or their dependent children. Contact is simply a phone call to 1-800-EAP-1223 or (816) 931-3073. Services are provided by experienced, professionally trained staff through an extensive local, regional and national network; with more than 40,000 offices globally.

If additional assistance is warranted, the EAP counselor will facilitate a referral to a self-help group, a behavioral health professional, an attorney, financial planner, physician, hospital or other necessary resource at the expense of the individual.

With professional and confidential direction from EAP staff, 77% of those employees who use the EAP do not require further referrals. Of those employees who have worked through the *Employee Assistance Program*, 97% report a positive experience.

Additionally, our employees and dependents have access to the Saint Luke's Health System award-winning website: ***http://www.saintlukeshealthsystem.org***. You can always find the most current health tips and tools at this site and link to the EAP home page by entering key words: 'Employee Assistance Program' in the Search Box.

At the EAP homepage you can:

- Learn more about your *EAP Services*.
- Watch a presentation highlighting the *EAP as an Employee Benefit*.
- Access the *EAP Library* articles, self-assessment tools and resources aimed at helping you achieve your personal and professional goals.
- Research *Frequently Asked Questions* about your EAP.

CBIZ is working to provide to you, and your dependents, the industry's most skilled resources in health care and prevention. We expect you will find this confidential network to be a valuable tool when the need arises for you and your family.

Great Health

Managing Your Health Just Got Easier.

Life and AD&D Insurance

Basic Life and AD&D Insurance

Basic Life and AD&D Insurance protects your family or other beneficiary in the event of your death. Your coverage amount will be paid to the beneficiary or beneficiaries of your choice in the event of your death while you are still actively employed at CBIZ.

If your death is due to accidental causes (as defined by the plan) your beneficiary will receive an additional amount through the Accidental Death and Dismemberment (AD&D) coverage. The AD&D coverage is equal to your life insurance coverage amount. AD&D coverage also provides a portion of the benefit in the event of certain accidental injuries not resulting in death.

To help protect your financial security, you will automatically receive group life insurance coverage equal to one times your annual salary to a maximum of $50,000 at no cost to you. Your amount of life insurance will decrease by 50% on the plan anniversary date which occurs on or next follows the date you attain age 70. The reduction applies to the amount of life insurance you had in force immediately prior to the scheduled reduction and will be rounded to the next higher multiple of $500, if not already such a multiple. This coverage is insured through Hartford.

Travel & Accident Insurance

Some employees of CBIZ are occasionally asked to travel on business away from their home office location. The company provides Travel and Accident Insurance to full-time employees as follows:

- Class I. Business Unit Presidents, Corporate Senior Management. Principal Sum: $250,000
- Class II. All other active full-time employees. Principal Sum: $100,000.

You are covered for injuries sustained while on a business trip made on behalf of the company, excluding travel to and from work. Accidental Death & Dismemberment Insurance accompanies this benefit.

The business trip begins when you leave your residence or regular place of employment, whichever last occurs, for the purpose of going on the business trip. The trip ends when you return to your residence or regular place of employment. The term "on a business trip made on behalf of the company" means travel and sojourn authorized by or at the direction of the company.

No action on your part is required to specifically enroll in this benefit. The beneficiary, in the case of claim, is the same beneficiary you name for the Group Life Insurance Policy (in effect on the date of the accident).

What CBIZ Contributes

CBIZ will pay the entire premium for these plans.

What to Do

- Determine who your beneficiaries will be. Will you identify both a primary beneficiary and a contingent beneficiary? Make sure that you have their names and social security numbers available when you enroll.
- Questions? Visit the CBIZ Employee Service Center website at ***www.cbizesc.com***, or call the CBIZ Employee Service Center at 1-877-227-4372 Monday through Friday between 8:30 a.m. and 6:00 p.m. CST.

Disability Insurance

One of the most important items to insure is your ability to earn a living. Many times this area is overlooked. However, CBIZ provides you with a core disability plan through Hartford to continue a portion of your income if you become unable to perform your regular job duties due to illness or injury.

Salary Continuation Plan

If you are absent from work because you are sick or injured due to a non-work related circumstance or cause, the salary continuation plan will provide you with a benefit equal to 60% of your pay. Benefits will begin on the later of the 8th day of disability due to an illness or accident or the exhaustion of sick leave. Benefits may continue for up to 26 weeks. (Please note: If you are employed in a state that has a state-mandated disability plan, your disability benefits will be subject to state law. The states affected are Hawaii, California, Colorado, Rhode Island, New Jersey, New York and Puerto Rico. Please contact your Human Resources Representative for additional information.)

To qualify for benefits, and to continue receiving benefits, your claim must be approved by Hartford. Please visit the CBIZ Employee Service Center website at ***www.cbizesc.com***, or see your Human Resources Representative should you need assistance with filing a claim.

Long Term Disability Insurance

The long term disability (LTD) plan provides income replacement in the event you are disabled for longer than 180 days. The plan begins after your salary continuation plan is completed.

The plan begins to pay you a monthly benefit six months after the start of your disability. The CBIZ plan provides you with a benefit equal to 60% of your earnings to a maximum benefit of $10,000 per month. Should you or any of your dependents receive a benefit from Social Security due to your disability, the Social Security award will offset the benefit you receive from the CBIZ plan. Additionally, should you ever terminate your employment with CBIZ, you will have the option to convert a portion of this plan to an individual disability plan through Hartford.

You have two options in paying for your LTD coverage:

- Pre-Tax – CBIZ will pay the entire premium for you. This means that any disability benefit you receive will be taxed.
- Post-Tax – You will pay the entire premium with after-tax dollars. However, CBIZ will "gross-up" your monthly salary by the amount of your premium. If you choose this option, any disability benefit you receive may be on a tax-favored basis.

What CBIZ Contributes

CBIZ will pay the entire premium for these plans.

What to Do

- Decide how you want your long term disability benefit paid should you become disabled. If you elect the pre-tax option, your benefit will be taxed. If you elect the post-tax option, your benefit may be tax-favored. Indicate your election on the Enrollment Worksheet.
- Questions? Visit the CBIZ Employee Service Center website at ***www.cbizesc.com***, or call the CBIZ Employee Service Center at 1-877-227-4372 Monday through Friday between 8:30 a.m. and 6:00 p.m. CST.

Retirement Savings Plan

How will you reach your retirement goals? Social Security may provide some of the income you'll need at retirement, but you'll need to do your part. Save as much as you can and start as early as you can.

If you are already enrolled in the CBIZ, Inc. Retirement Savings Plan (the Plan), you may be well on your way to your retirement goals by saving through this valuable benefit. If you have not yet enrolled and are eligible to participate, the information below will prepare you to enroll.

Regardless of your current situation, all employees should carefully review the Plan's features to ensure you understand how to take full advantage of this valuable retirement savings vehicle.

Key Points about Eligibility, Automatic Enrollment and Declining Enrollment

Who is eligible to enroll in the plan?
All regular full-time employees age 21 or older with at least two (2) calendar months of service are eligible to participate in the Plan. Once you have achieved eligibility, enrollment materials - including a Personal Identification Number (PIN) - will be mailed to your home. All other CBIZ associates (regular part-time, seasonal or temporary) age 21 or older are eligible to participate after twelve (12) months of service.

If you are eligible and wish to enroll in the Plan…
Please review the enrollment materials you received via mail. Use your PIN to access MassMutual's website - ***www.massmutual.com/retiresmart*** - which will provide you with personalized retirement savings and benefit projections and investment information.

If you are eligible to enroll, but do not enroll on your own…
By the first day of the month following your eligibility date, you will automatically be enrolled in the Plan. Through automatic enrollment, 3% of your compensation will automatically be withheld from your pay and contributed to your 401(k) account each pay period. Your contributions will be invested in an age-rated T. Rowe Price Retirement investment and will remain there until you elect a change by calling MassMutual or accessing their website. Your enrollment materials provide detailed instructions for making changes to your account.

If you do not want to be automatically enrolled, you must decline Automatic Enrollment…
You may decline automatic enrollment after you receive your enrollment materials by calling 1-800-743-5274 or logging on ***www.massmutual.com/retiresmart***. Your enrollment materials include your PIN, which is required in order to change your automatic 3% contribution to 0% deferred or any % or flat dollar amount that you wish.

Ongoing Access to Your Retirement Plan Account

You can enroll in the Plan or access your account (existing participants) online or by phone.[1]

Online: Log on to ***www.massmutual.com/retiresmart***. Enter your Social Security number and Personal Identification Number (PIN).

Phone: Call 1-800-743-5274 and press 0 to speak with a customer service representative.

Retirement Savings Plan

Plan Benefits for New Enrollees and Current Investors

Whether you're just enrolling in the Plan or are already investing in your 401(k) the table below will help you understand the benefits offered based on your investment style.

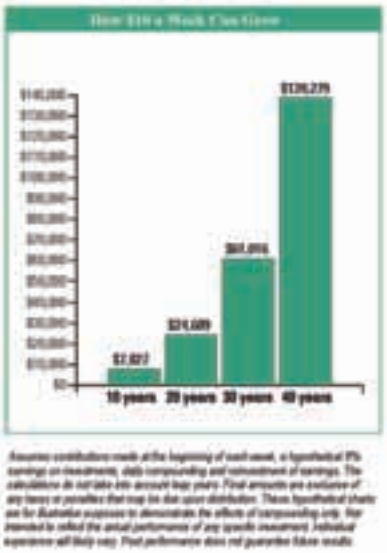
	For New Enrollees:	For Current Participants:
For the confident investor who feels comfortable building an investment portfolio	Express enrollment, which lets you specify savings amounts, choose investment options and enter beneficiary information.	Investing services through MassMutual's Planning Tools. Click on the Research tab under Planning Tools to explore your Plan's investment options.
For the aware investor who would welcome some guidance	Investing services through guided enrollment: **Express Solution** contains a brief investor quiz and suggests an asset allocation mix based on your answers. **Guided Solution** provides a third-party planning center, which can help you set detailed goals and suggests an investment mix.	Investing services through MassMutual's Planning Tools. Click on the Solutions tab under Planning Tools to find Express or Guided Solutions mentioned at left.
For the investor who wants MassMutual to do it all	Guided enrollment offers the Express Solution, which contains a brief investor quiz and the various investment options offered within the Plan, including the T. Rowe Price Retirement series.	Investing services through MassMutual's Planning Tools. Click on the Solutions tab under Planning Tools to find the Express solution and the various investment options offered within the Plan, including the T. Rowe Price Retirement series. The T. Rowe Price Retirement options are single investment solutions that combine professional management and monitoring, as well as diversification, all in one investment.

Plan Features

Pre-tax Saving and Compounding

You make contributions automatically from your paycheck before current federal income taxes are deducted. Pre-tax (or tax-deferred) saving lowers your current taxable income, which lowers the current federal and state income taxes[2] you pay during the years you contribute.[3] In fact, you don't pay taxes on your plan savings, or earnings on those savings, until you begin withdrawing money from your account. You'll also benefit from compounding. Contributions and earnings on those contributions can grow tax-deferred and can then generate more earnings, and so on. Money making money: that's the theory behind compounding.

You can contribute up to 80% of your eligible pay on a pre-tax basis. However, in order to stay within government restrictions, your annual pre-tax contributions are limited. Pre-tax contributions are limited to $16,500 for 2010. If you are age 50 or older, you can make additional contributions, known as "catch-up" contributions. Catch-up contributions are limited to $5,500 for 2010.



Retirement Savings Plan

Roth 401(k)

You may also choose to make after-tax contributions to a Roth 401(k) account through the Plan. As with pre-tax contributions, your Roth account contributions are immediately 100% vested and are available for loans and a company match. Distributions from your Roth account, including any investment earnings, may be tax-free if you meet certain criteria. Your Roth contributions are also subject to the same required minimum distribution rules as pre-tax contributions. Here are some scenarios where making after-tax contributions to your Plan's Roth account may make sense for you:

- If your retirement tax level may be higher than it is now
- You want to diversify your retirement savings into pre-tax and after-tax accounts
- You are not eligible to contribute to a Roth IRA
- You expect your income to rise and you have a longer time horizon to save
- You want flexibility in retirement

Company Match

To help you grow your retirement savings account and increase your net savings before investment earnings, CBIZ, Inc. will match what you contribute to the Plan at $.50 for every dollar you contribute on the first 6% of your personal earnings that you save. You will be able to receive the company match beginning on the first of the next financial quarter, after the completion of one year of service working at least 1,000 hours. Consider taking full advantage of your match by contributing up to the maximum 6% contribution for which you can receive match.

Vesting

If you decide to leave the company before retirement, you can take the value of your vested Plan account with you. You are always 100% vested in your contributions, rollover contributions and any earnings they generate. Company match contributions and their earnings are vested based on your years of service. You are not vested with less than three years of service. After working at least 1,000 hours in each of three years, you are 100% vested.

Rollovers

You may combine retirement savings from additional accounts into the Plan. All you need to get started is 15 minutes at a time convenient to you, your Social Security number and statement(s) from any separate IRAs or prior employer retirement account(s). Maintaining one account may make it easier to track your retirement savings. Rollover instructions appear on the first enrollment page on MassMutual's website - ***www.massmutual.com/retiresmart*** - or you can obtain a rollover form by calling 1-800-743-5274.

Once contributions have been deferred to the Plan, they cannot be withdrawn until termination of employment or retirement occurs; however loans and hardship withdrawals are permitted under certain circumstances.

Enroll today by logging on to *www.massmutual.com/retiresmart*.

1 *You'll need to use your Personal Identification Number (PIN) and Social Security number to enroll online or via phone. If you are eligible to enroll, or you are already participating in the plan, you have been given a PIN. If you have misplaced your PIN (and you are eligible to enroll or are already participating in the plan), call 1-800-743-5274 and a representative will establish a temporary PIN for you.*

2 *Varies by state*

3 *You will pay taxes on your plan savings and the earnings on those savings when you withdraw money from your account.*

Cafeteria Plan

You know a portion of the pay you earn on your job is withheld to pay income taxes. After you pay taxes, you know another portion of your income is not really available to you because it automatically is paid to an insurance company for medical, dental and/or vision insurance you elect. For some of us, that income will immediately be used to cover the cost of day care for our children so we are able to work.

This benefit plan allows you to estimate those expenses before the tax year begins and pay those expenses from your income before you pay income taxes. When those expenses are withheld first, you have less taxable income. So, you pay less tax. You still meet your expenses but have more money to take home because you weren't taxed on money you earned that has already been spent. The result is that you pay less in taxes, and keep more of what you earn.

Choose from the plans below based on the specific needs of your family.

A. Premium Only Plan

The Cafeteria Plan allows you to pay for some of your CBIZ-sponsored benefits with pre-tax dollars. This portion of the Cafeteria Plan is called the "premium only" plan. If you and any of your dependents are covered by the CBIZ medical, dental and/or vision plans, the portion of the premium you pay is automatically deducted pre-tax.

B. Health Savings Account

If you enroll in the Qualified High Deductible Health plan, you may be eligible to establish a Health Savings Account (HSA). An HSA is like a 401(k) for medical expenses; a tax-favored savings account established by you. The savings in your HSA are immediately available to you to pay for qualified medical expenses not covered by insurance. Or, you may choose to contribute to an HSA but not use the funds today; rather save them for medical expense in later years or retirement expenses. Funds in your HSA are for medical expenses unpaid by the insurer as you must first reach the plan deductible. Eligible medical expenses include costs of physician visits, over-the-counter drug costs prescriped by a physician, prescriptions and expenses for diagnosis, cure, mitigation, treatment or prevention of disease.** You may also use your Health Savings Account for eyeglasses and hearing aids.

The amount you choose to defer into this account on a per paycheck basis is deducted pre-tax. Why pay more in taxes when you can pay less? You may change your election monthly and stop contributing at any time.

There is no use-it or lose-it provision like a Medical Flexible Spending Account (FSA). Unused funds in your HSA account can carry year-to-year so you don't have to worry about losing your money if you don't spend it. **IRS Publication 502 provides a full list of eligible expenses.

Who provides Health Savings Accounts?

Although you may arrange for an HSA with any qualified service provider, CBIZ offers pre-tax, payroll deduction HSA options through OptumHealth and US Bank. In order to payroll deduct contributions on a pre-tax basis, you should select from one of the two providers associated with the CBIZ benefit plans.

OptumHealth Bank was chartered in 2004 by UnitedHealth group with a specific focus on health care. All deposits are FDIC insured up to $100,000. With an OptumHealth account, you receive two free Health Savings Account Master Card Prepaid Debit Cards to conveniently access your money at any point-of-service location (such as a pharmacy) that accepts MasterCard or at any ATM displaying the MasterCard brand mark. To pay a bill from a provider who accepts MasterCard, just write your debit card number in the space provided. A set up fee to open an account and monthly fees may apply, depending on the type of account you choose. Investment options and interest rates on your savings vary depending on the type of account you choose. Checks are available at an additional cost and fees may apply when using your debit card at an ATM machine.

OptumHealth offers three account options to suit the varying needs of members:

Health eAccess HSA- A low-cost HSA designed for active health care spenders who do not carry a large balance and prefer a lower monthly maintenance fee. No interest is paid on account balances. All new OptumHealth accounts are established as Health eAccess HSA accounts. After 90 days OptumHealth provides each account holder with information at their home address about the other account options and how to move to a different option if desired, at no cost.

Health eSaver HSA - A good choice for a broad range of needs - easy access to pay current expenses, competitive interest rates, moderate fees and the option to invest balances in no-load mutual funds with no additional fees.

Cafeteria Plan

Health eInvestor HSA - Designed for employees with less need to spend now, and who plan to contribute to and grow their HSA balances. Ability to invest more money in mutual funds by paying an additional investment fee.

US Bank is the other HSA provider being offered by CBIZ, with the ability to payroll deduct your per paycheck contribution. US Bank is a full service bank, with other traditional banking services available to employees. All deposits are FDIC insured up to $100,000. With the US Bank account, you receive two free Debit Cards and the first book of 25 checks are free. Set up fees to open an account and a monthly fee applies to the account but is waived once your account balance is $2,500 or more.

Once you have a $2000 balance in the core HSA account, the bank offers 20 no-load, no-transaction fee mutual funds. The minimum investment is $100. Interest rates vary depending on your investment selections.

How do I enroll in a Health Savings Account?
If you select the OptumHealth account: logon at ***www.cbizesc.com***, use the drop down menu under Health Savings Account, to locate the Health Savings Account Payroll Election Form. Print this form. Then, select the link under Website Links>OptumHealth to be directed to the OptumHealth site to enroll. In most cases your enrollment is immediately confirmed. The bank will mail to your home address a Welcome Kit and your new account number. Once you have an account number from the bank, complete the Payroll Election Form including the new bank account number and mail or fax this form to your Payroll Specialist. In order to impact your first paycheck in January 2011, you must complete this process by January 1st.

If you select the US Bank account, during your online enrollment at the CBIZ ESC website you will be asked to review certain bank information. You will then be asked to enter the per payroll deduction amount you want to begin as a payroll deduction in January 2011. Several weeks later you will receive a Welcome Kit from the bank for your records.

If you already have a Health Savings Account through CBIZ, whether with US Bank or OptumHealth Bank, at the beginning of each year a new Payroll Change Form must be completed to once again start your payroll deduction. You may change your account at any time. Contact either bank directly to learn how to close an existing account and transfer balances. Your Health Savings Account is actually a personal account with either bank so actions such as these must be done by you rather than for you through CBIZ.

Because a Health Savings Account may be funded either by payroll deduction through CBIZ or with direct deposits to the bank, CBIZ is unable to monitor your annual contributions relative to the maximum allowable contribution. Exceeding the maximum allowable contribution will have tax implications. Because you are allowed to make pre-tax or post-tax contributions to a Health Savings Account, you receive two year-end statements documenting your contributions. Box 12B on your W-2 reflects the total amount you contribute via payroll deduction in the tax year. The IRS allows a Health Savings Account participant to contribute for 15.5 months rather than just 12 months in the plan year, so the bank issues the Form 5498-SA after April 15th of the following plan year. The 5498-SA reflects total contributions including those made directly to the bank. Please see your tax advisor on how these forms impact your annual tax filing obligations.

Contributions withheld from pay are wired to the applicable bank on a semi-monthly basis. This schedule may impact the immediate availability of your funds following a pay date. See your Payroll Specialist for further details.

Once enrolled, you may change or stop your per-paycheck contributions by notifying your Payroll Specialist with a newly executed Payroll Election Form. The maximum allowable contribution into a Health Savings Account for the calendar year of 2011 is $3050 for those with employee only coverage and $6150 for those insuring dependents. Participants at age 55 this year are allowed to make a $1,000 catch up contribution.

C. Limited Flexible Spending Accounts (with a Health Savings Account)

If you choose to establish a Health Savings Account, you are not eligible to participate in the Medical Flexible Spending Account. You are, however, eligible to participate in the Limited Flexible Account. It is through the balance in your Health Savings Account, or other income, that medical costs incurred until the deductible is met must be paid. However, we offer the Limited Flexible Account for post-deductible medical expense and eligible expenses associated with dental and vision care. All rules that apply to the traditional Medical Flexible Spending Account also apply to the Limited FSA, i.e. once you make your annual election your contributions will remain unchanged unless you experience a qualifying change in family status; you can file claims for any amount up to your total annual contribution amount at any time, even if you have not yet had that amount withheld from your pay, and any unused amounts at the end of the plan year and grace period are forfeited.

Cafeteria Plan

D. Medical Flexible Spending Account (without a Health Savings Account)

Eligible Health Care Expenses

Generally, any health expense that is considered tax deductible can be paid through your Medical Flexible Spending Account. You can use your Medical Flexible Spending Account to pay expenses for you, your spouse, and your eligible children, even if they are not enrolled in CBIZ health-care plans. You can file claims for any amount up to your total annual contribution amount at any time from January 1, 2011 thru March 15, 2012, even if you have not yet had that amount withheld from your pay. You will receive a reimbursement for your entire claim. You will simply continue to make your contributions each paycheck to cover the claim.

Examples of eligible health care expenses include:

- Medical plan deductibles, copayments and coinsurance;
- Dental deductibles and coinsurance;
- Vision exams, prescription glasses and prescription contact lenses;
- Hearing aids and exams;
- Chiropractic treatments;
- Crutches and wheelchairs; and
- Prescription drug copayments & variable over-the-countermedicines (if prescribed by a physician to treat a medical condition).

Examples of ineligible health care expenses include:

- Health club dues;
- Cosmetic surgery (except to repair the results of birth defects or injury);
- Cosmetics;
- Medical expenses for which you take an itemized deduction on your federal tax return;
- OTC medicines used for prevention or without a prescription from a physician; and
- Medical or dental insurance premiums.

E. Dependent Care Spending Account (with or without a Health Savings Account)

Eligible Dependent Care Expenses

Expenses paid through your dependent care spending account must be incurred solely for the purpose of either:

- Allowing both you and your spouse to work or look for work; or
- Allowing you to work while allowing your spouse to attend school full-time.

Furthermore, these expenses must be for the care of a child under age 13, or for a dependent who is not capable of self-care. If you are paying an individual for day care services, that person will need to report any income received from you to the IRS. You will need to provide the name, address and social security number of your day care provider on your claim form and federal income tax forms.

You will be reimbursed from the Dependent Care Flex Account only up to the amount you have contributed at any given time. If you submit a claim that is larger than your account balance at that time, you will be reimbursed your full account balance and then continue to be reimbursed from your account as new contributions are made.

Examples of eligible expenses include:

- Costs for a day care center;
- Costs for a caregiver for dependent day care provided inside or outside your home; and
- Costs for day care provided to legally dependent adults who are physically or mentally unable to care for themselves. (Legally dependent adults must spend a minimum of eight hours a day in your home.)

Ineligible Expenses

Examples of ineligible expenses include:

- Weekend babysitting that is not work-related;
- Nursing home expenses;
- Amounts paid to an immediate family member under age 19 or to another dependent; and
- Tuition expenses for schooling beginning with the first grade.

Federal Child Care Tax Credit

There are two tax breaks available to you when paying for day care: your Dependent Care Flex Account and the federal child care tax credit. You can use the Dependent Care Flex Account instead of the tax credit if you determine that the Flex account will result in higher savings. Any payments you receive from the Flex account will reduce, dollar for dollar, amounts that can be considered for the tax credit. You must decide which choice provides the most savings for you.

Following is an example comparing the federal tax credit and the Dependent Care Flex Account. The example is based on a married couple who are both employed, with two children under the age of 13, a combined income of $30,000, and total dependent care expenses of $5,800.

Cafeteria Plan

	Using the Dependent Care Flex Account	Paying Dependent Expenses with After-Tax Dollars
Gross Family Income	$30,000	$30,000
Pre-Tax Allocation to Spending Account	- $5,000	- $0
Adjusted Gross Income	$25,000	$30,000
Taxes: Social Security Tax	- $1,912	- $2,295
Federal Income Tax	- $1,163	- $1,913
After-Tax Cost for Dependent Care	- $800	- $5,800
Federal Tax Credit(Maximum)	N / A	+ $960
Final Take Home Pay	$21,125	$20,952
Tax Savings	**$173**	**$0**

This example assumes a standard deduction of $7,100 and four personal exemptions totaling $10,800. Social Security taxes are based on the 1998 rate of 7.65%. Savings may be greater than shown in the example due to state and local taxes.

How Spending Accounts Work

Our plans let you redirect a portion of your pay, through the convenience of payroll deduction, to create spending accounts. The money that goes into your spending accounts will be deducted on a pre-tax basis. Since your contribution is deducted on a pre-tax basis, this means that the money is deducted from your pay before federal, state and FICA taxes are calculated. Because you do not pay these taxes on money that goes into your Flex accounts, you decrease your taxable income – and potentially increase your spendable income.

How Much Can You Set Aside?

- You can put up to $5,000 per year into your Medical Flexible Spending Account.
- You can put up to $5,000 per year ($2,500 if you are married and you and your spouse file separate tax returns) into your Dependent Care Flex Account.
- You can put up to $5,000 per year into the Limited Flexible Spending Account.

How much money should you put into your accounts each month? That depends on your expenses. We recommend you review eligible expenses for the last few years to predict your expenses for the coming plan year. During the annual enrollment, divide the total predictable expenses by twelve months to obtain your monthly contribution amount.* You are then reimbursed for eligible expenses from the money that accumulates in each account. Although your contributions occur through payroll deduction in the plan year (January through December) you can be reimbursed for expenses incurred from January through March 15 of the following year.

** For newly hired employees, please note your elections should be calculated based on your anticipated expenses from your benefit effective date through the end of this calendar year. To determine your monthly contribution amount, simply divide your anticipated expenses by the number of months remaining in this calendar year.*

When You Enroll

When you enroll, you will decide how much to set aside into each Flexible account for the applicable plan year. Consider this decision carefully.

- Once you make your choices, your contributions will remain unchanged unless you experience a qualifying change in family status. Please refer to the Cafeteria Plan Summary Plan Description on the CBIZ Employee Service Center website at ***www.cbizesc.com*** for a list of events that would qualify for a mid-year change in benefits.
- You can use the money in your reimbursement accounts only for expenses that are incurred from January 2011 through March 15, 2012.
- Internal Revenue Service regulations prevent unused money in your accounts from being returned to you; any unused amounts are forfeited.
- As you plan, it is also important to remember that your Medical Flexible Spending Account and Dependent Care Flex Accounts are separate. You cannot transfer money from one account to the other.

Cafeteria Plan

CBIZ offers the *Take Care*® card for members enrolled in any of the flex plans: Medical Flexible Spending Account, Limited Flexible Spending Account, the Dependent Care Flex Account, and/or the Qualified Transportation Benefit Plan.

Debit cards are issued annually; you will receive a new debit card in late December 2010 for use from January 1, 2011 through December 31, 2011 and for any dollars designated for the 2011 plan year.

The *Take Care*® card is a debit card that is linked to your flexible spending account balance(s) allowing you to use the card instantly instead of paying for qualified expenses out of your own pocket. Using the *Take Care*® card is easy and, when used at participating retailers (see ***www.myflexonline.com*** for a list of merchants), with some exceptions, there is no need to submit receipts to verify qualified purchases made with your card. Qualified locations include doctor's offices, pharmacies, online drug stores and online stores for contacts, optical shops, dentist offices, hospitals and day care facilities. The money is instantly deducted from your flexible benefit account for expenses up to the annual election amount in the Medical Flexible Spending Account and Limited Flexible Spending Account. Day care expense may also be met with the debit card, but spending is allowed only up to the current account balance, not the annual election amount. Simply swipe your card and keep your receipts for your records; you may need them for claim substantiation.

In limited cases, the plan administrator will notify you if a purchase on your debit card requires substantiation. The notice explains steps you must take to verify the purchase as qualified under the plan rules. For this reason, it is important to keep all the receipts for purchases you make with your Take Care Card. You may learn more at ***www.myflexonline.com*** and view your accounts. There is nothing you need to do to take advantage of this feature and there is no additional expense to you. Although all account holders will receive the debit card, you are not required to use it.

You may instead choose to submit your claims for reimbursement using ***www.myflexonline***; the plan administrator's website. All of your account information is viewable, and claim forms can quickly and accurately be completed before you fax the claims to the administrator.

The first time at the site, you will create your confidential account. Logon to ***www.myflexonline.com*** and click New User. Complete the requested information to include your social security number, date of birth and email address. You may select your own username and password; remember these should be confidential and secured for your personal reference. Your homepage offers four tabs from which to choose: View Account, Request Payment, User Information, Contact Us and Help.

View Account - this is where you can view all the activity on your account, to include current balances, deposits made and pending payments as well as completed payments to date. The plan year dates and claims deadlines are documented here as reminders. The expenses that qualify for reimbursement, for both the Medical Flexible Spending Account and a Dependent Care Flex Account, are also available here.

Request Payment - this is where you are able to complete your claim form online, then print and simply fax this form with receipts as directed on the form.

User Information - details demographic information about you contained in the record keepers system. If there are changes to be made to this information, please contact your CBIZ HR Contact directly. Changing your password is also done at this tab. Contact Us and Help tabs both offer further information to assist you. If you would rather speak to someone regarding the details of your account, you may phone 1-800-815-3023, Option 4. But many users now find online access, available 24/7, is a convenient way to remain informed about your account.

NEW FOR 2011 - HEALTHCARE REFORM ACT CHANGES

In March 2010, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively "the Act"). The Act includes a number of modifications to employee benefit programs.

One provision that will affect the cafeteria plans beginning January 1, 2011 is the requirement for over-the-counter (OTC) drugs, medicines and biologicals to be accompanied by a physician's prescription in order to be reimbursed under health flexible spending accounts (FSAs) or health savings accounts (HSAs).

Under the Act, OTC drugs, medicines and biologicals will continue to be eligible for reimbursement as long as the request is accompanied by a doctor's prescription. This means items such as cough medicines, pain relievers, acid controllers, and diaper rash ointment will now require a doctor's prescription to be submitted along with the reimbursement request. Insulin and select OTC items, such as band-aids, will continue to be eligible without a prescription.

Cafeteria Plan/QTFB Plan

OTC drug expenses incurred on or after January 1, 2011 will require a doctor's prescription in order to be reimbursed under a health FSA or HSA. Expenses incurred prior to January 1, 2011 will not.

- For example, for a calendar year plan with a final claims deadline date of March 31, 2011, an OTC drug purchased on December 31, 2010, could be submitted before a plan's final claims deadline date of March 31, 2011, and still be reimbursed without a prescription.

This provision will also impact the use of the Take Care debit cards. Beginning January 1, 2011, participating merchants will need to modify the list of items eligible for payment; this is because of the doctor's prescription requirement. Purchases of OTC drugs, medicines and biologicals will require another form of payment and the participant can submit a claim to CBIZ Flex along with the doctor's prescription for the OTC drug, medicine or biological purchased. This change affects only OTC drugs, medicines and biologicals - bandages, home health-aids and select OTC items will still be eligible and can be purchased using the card without further documentation.

You may learn more and read the most up to date approved qualified medical expense list by logging on to the CBIZ ESC at ***www.cbizesc.com***

A FINAL WORD ON THE FLEXIBLE SPENDING ACCOUNTS

The pre-tax reimbursement accounts are designed to save you money. While they do not eliminate your out-of-pocket health care and dependent expenses altogether, they can reduce your expenses significantly - for most people by 20%, 30% or more. If you are like most people, that 20% or 30% savings can add up to hundreds or even thousands of dollars a year. If that kind of savings is worth a little of your time to plan ahead and calculate your eligible expenses for the coming year, the spending accounts may make sense for you. Do not let the rules and regulations intimidate you. The federal government imposes those rules simply to prevent people from abusing the tax break the accounts offer. If you estimate your expenses carefully - even conservatively - and submit your claims regularly, you can work within the rules and manage to save yourself a great deal of money in the process.

What to Do

- If you are not opening an HSA, make a list of the eligible out-of-pocket health care expenses you are likely to incur during the plan year (based on the date of service, not the date you receive the bill). Be conservative with your estimates. The Medical Flexible Spending Account does have the "use it or lose it" provision. For additional assistance, you can use the worksheets found on the CBIZ Employee Service Center website at ***www.cbizesc.com***.
- If you are opening an HSA, consider eligible out-of-pocket expense associate with dental and vision care as well as any post deductible medical expense and qualified over-the-counter medicine expenses you could incur. Medical expense covered by the QHDP is not eligible for reimbursement.
- Consider any dependent care daycare expenses you are likely to incur during the plan year to determine if you might realize a tax savings by participating in this plan.
- Evaluate your expected expenses for the next year to determine if you will realize a tax savings by participating in a flexible spending account.
- Indicate your selections on the Enrollment Worksheet included in the enrollment packet.
- Questions? Visit the CBIZ Employee Service Center website at ***www.cbizesc.com*** or call the CBIZ Employee Service Center at 1-877-227-4372 Monday through Friday between 8:30 a.m. and 6:00 p.m. CST.

Qualified Transportation Fringe Benefit Plan

Full-time associates have the opportunity to direct a portion of their salary into reimbursement accounts to pay for certain qualified commuting expenses with pre-tax dollars. Qualified commuting expenses include payments for use of mass transit and for parking. Mass transit is a bus, commuter vehicle, ferry, subway or train. The current maximum monthly pre-tax contribution is $230.00 for mass transit.

Parking qualifies for this tax-free treatment only if it is at or near your employer's place of business, or at a location where you drive to get mass transportation or a commuter van pool to travel to work. Parking near your home does not qualify for tax-free treatment. The maximum monthly pre-tax contribution is currently $230.00 for parking.

Voluntary Plans

Elections for the Qualified Transportation Fringe Benefit plan are made on a month-to-month basis. Associates are only reimbursed for claims up to the amount they have in their Qualified Transportation Fringe Benefit account at the time the claim is made or the monthly maximum established by the IRS, whichever is less. A claim form may be completed and is available at the CBIZ Employee Service Center website at ***www.cbizesc.com***. Another option for paying these expenses may be the Take Care® Card. See ***www.cbizesc.com*** for more information.

Initial elections must be made by completing the election form found on the CBIZ Employee Service Center website at ***www.cbizesc.com***. Your completed form should be turned in to your Human Resources Contact. Your initial monthly election will be carried over on a monthly basis, unless you notify your Human Resources Contact in writing (by completing a change authorization form that is available from your Human Resources Contact) that you want to make a change.

Optional Life Insurance

If you already have Optional Life coverage and do not wish to make changes, there is nothing required for you to do during the annual Open Enrollment period. Your current policy continues uninterrupted.

You have the opportunity to purchase additional group term life insurance through Hartford for yourself and your dependents. Group term life insurance is one way of providing financial protection for survivors. Following are some of the highlights of the optional life plan that is available to you and your dependents:

Employee Coverage

- Coverage is available in $10,000 increments from a minimum benefit of $20,000 to a maximum benefit of the lesser of five times your annual salary or $750,000.
- FOR NEWLY HIRED EMPLOYEES ONLY: If you enroll when you are first eligible for benefits, you may purchase up to the lesser of three times your annual salary or $500,000 on a guarantee issue basis. This means that you will not have to answer any medical questions for life insurance amounts up to this guarantee issue level. For amounts in excess of the guarantee issue level, you will be required to complete a medical questionnaire, and your excess insurance will be pended subject to approval by Hartford.
- Should you ever terminate your employment with CBIZ, you may continue your coverage by paying premiums directly to Hartford.

Spouse Coverage

- Coverage on your spouse is available in increments of $5,000 from a minimum benefit of $10,000 to a maximum benefit of the lesser of 50% of your optional life insurance amount or $250,000.
- FOR NEWLY HIRED EMPLOYEES ONLY: If you elect to enroll your spouse when you are first eligible for benefits, the guarantee issue level for your spouse's coverage is $25,000.

Child(ren) Coverage

- Coverage on your dependent children is available in increments of $2,000 from a minimum benefit of $2,000 to a maximum benefit of $10,000.
- FOR NEWLY HIRED EMPLOYEES ONLY: If you elect to enroll your child(ren) when you are first eligible for benefits, the guarantee issue level for dependent children coverage is $10,000.
- Available for eligible dependents up to age 25.

DURING ANNUAL ENROLLMENT ONLY:

- If you are not currently participating in the optional life plan, you may sign up for coverage at this time. If this is not your initial enrollment, you will be required to complete a medical questionnaire and your coverage will be pended subject to approval by Hartford. This applies to your spouse and dependent children as well if they are not currently participating and wish to join.
- If you are currently participating in this plan and want to increase your coverage, you may do so at this time as well. You may increase your coverage by $10,000 or $20,000 without completing a medical questionnaire as long as this increase in coverage does not take your optional life insurance amount over the guarantee issue limit (identified above). If you want to increase your coverage by more than $20,000, you will be required to complete a medical questionnaire and your additional coverage will be pended subject to approval by Hartford.
- If your spouse is currently participating in this plan and wants to increase his coverage, he may do so at this time as well. Your spouse may increase his coverage by $5,000 without completing a medical questionnaire as long as this increase in coverage does not take your spouse's optional life insurance amount over the guarantee issue limit (identified above). If your spouse wants to increase his coverage by more than $5,000, he will be required to complete a medical questionnaire and his additional coverage will be pended subject to approval by Hartford.

Voluntary Plans

The amount of life insurance for you and your spouse (when applicable) will decrease by 50% on the plan anniversary date which occurs on or next follows the date you attain age 70. The reduction applies to the amount of life insurance you had in force immediately prior to the scheduled reduction and will be rounded to the next higher multiple of $500, if not already such a multiple.

Please note that you must enroll in the Optional Life Insurance Plan in order to purchase coverage on your dependents.

Also, should you or your spouse purchase coverage that is over the guarantee issue limit, please note that the amount of life insurance you have requested that is over the guarantee issue limit will not be effective until the date of approval (if approved). Accordingly, the additional premiums will not be payroll deducted until the first of the month following approval.

Should you and/or your dependents elect not to participate in the Optional Life Plan at this time, any future amounts of life insurance that you wish to purchase will require the completion of a medical questionnaire and will be subject to approval by Hartford.

What to Do

- Determine who your beneficiaries will be. Will you identify both a primary beneficiary and a contingent beneficiary? Make sure that you have their names and social security numbers available when you enroll.
- Will you purchase Optional Life Insurance on yourself and your dependents? If so, make sure to indicate your selection on the Enrollment Worksheet included in the enrollment packet.
- If you are purchasing Optional Life Insurance coverage on yourself and/or your dependents that requires medical underwriting, you will need to complete a medical questionnaire. This questionnaire is available through the CBIZ Employee Service Center website at ***www.cbizesc.com***, or by request from the CBIZ Employee Service Center.
- Questions? Visit the CBIZ Employee Service Center website at ***www.cbizesc.com***, or call the CBIZ Employee Service Center at 1-877-227-4372 Monday through Friday between 8:30 a.m. and 6:00 p.m. CST.

Long Term Care Insurance

If you already have Long Term Care coverage and do not wish to make changes, there is nothing required for you to do during the annual Open Enrollment period. Your current policy continues uninterrupted.

Unexpected events, such as a serious illness or accident, as well as the aging process, can leave you in a vulnerable position – both personally and financially. You may know of someone who is caring for a family member, or you may be caring for someone yourself. Who would take care of you if you needed help, and how would you pay for that care?

To help ease this burden, CBIZ offers a Long Term Care Insurance Plan through Unum Life Insurance Company of America. What is long term care? It is the type of care received either at home or in a facility, when someone needs assistance with activities of daily living (bathing, dressing, toileting, transferring, continence and eating) or suffers severe cognitive impairments (such as Alzheimer's disease).

UNUM's long term care plan allows you to maintain choice and control over your life by allowing you to choose who will give you care and where you will receive care. It also allows you to maintain control of how your benefits and assets are used. Not only can you purchase long term care insurance for yourself, you can also purchase it for your spouse, parents, grandparents, siblings and in-laws (the maximum issue age is 80).

Once you qualify for benefits, UNUM pays a benefit each month. The money can be used for any reason you choose. There are no invoices to keep track of or bills to submit.

Why buy now? Buy now because the younger you are when you buy UNUM's Long Term Care Insurance, the lower the cost. Also, if you are a newly eligible employee, you are guaranteed coverage (within limits) during your initial enrollment period. If you want to learn more about the specific benefits available under this plan, please go to the CBIZ Employee Service Center website at ***www.cbizesc.com***. From the main menu, choose "Long Term Care Plan."

Voluntary Plans

Enrollment in this plan is offered one time each year during the CBIZ Open Enrollment period. It is only during Open Enrollment you can enroll and add/change existing coverage.

If you are a newly eligible employee who has never had an opportunity to enroll in the coverage, you may enroll with certain levels of coverage guaranteed. You can purchase coverage beyond the "guarantee issue" level, but it will be subject to medical underwriting and approval by UNUM.

If you are a current employee who has had an opportunity to join this plan in the past, but declined to participate, you can enroll at this time. However, any coverage you elect will be subject to medical underwriting and approval by UNUM.

If you are a current participant, but want to change your coverage, you can do so during the annual enrollment, however, any coverage that you elect will be subject to medical underwriting and approval by UNUM.

Every employee can purchase coverage at this time for your spouse, parents, grandparents, siblings and/or in-laws, but the entire amount of their coverage will be subject to medical underwriting and approval by UNUM.

To enroll in this coverage, please go to the CBIZ Employee Service Center website, select "Enrollment Information" from the main menu. You will then be taken to the customized website UNUM provides CBIZ employees to review the benefits and costs and print off the enrollment forms and medical underwriting forms (if applicable) that need to be completed in order to enroll in this coverage. Once you have completed the forms, please return them directly to UNUM at the address indicated. Payroll deductions will not begin, and any coverage that you have purchased over the guarantee issue limit (if applicable) will not be effective, until CBIZ receives notification from UNUM that your coverage has been approved.

Vision Insurance Plan

At CBIZ, we are concerned with your overall health. That is why we are offering two vision plan options through Vision Service Plan (VSP) – a comprehensive voluntary plan and a discount plan.

Voluntary Plan

Through the voluntary VSP plan, you have coverage for routine eye exams, materials (including eyeglasses and contact lenses) and laser vision correction. You are free to see any provider you wish, however, you will receive a higher level of benefits should you receive your care from a participating VSP provider. To obtain a list of providers participating in the VSP network, simply go to the CBIZ Employee Service Center website at ***www.cbizesc.com***. From the main menu, choose "Website Links," then select "VSP."

Benefit Summary

In addition to the benefits described above, the voluntary VSP plan offers the following:

- There is no paperwork for you to hassle with if you utilize VSP providers. Simply let your provider know you are a VSP member when you make your appointment. Then at the time you receive your services all you do is pay your appropriate copayment(s) and any other out-of-pocket expenses you may be responsible for.
- VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers.
- VSP also offers valuable savings on annual supplies of certain brands of contacts. You can receive these VSP member preferred prices, even if you have used your coverage for glasses.
- You can receive 20% savings when you purchase non-covered pairs of prescription glasses including prescription sunglasses from the same VSP provider within 12 months of your last eye exam.
- If you choose a frame valued at more than the $160 plan allowance, you'll save 20% on your out-of-pocket costs for frames.
- Once you enroll in this plan, you and any dependents you cover must remain in the plan for the entire year unless you have a qualifying change in family status.

Voluntary Plans

Following is a brief summary of this plan:

Voluntary Vision Insurance Plan

	VSP Provider	Non-VSP Provider
Copayment for:		
Exam	$10.00	$10.00
Materials	$25.00	$25.00
Frequency of Service:		
Vision Exam	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 24 Months	Once every 24 Months
Contact Lenses*	Once every 12 Months	Once every 12 Months
Coverage		
Vision Exam	Covered in full after copayment	VSP covers up to $50.00
Basic Lenses*		
Single Vision	Covered in full after copayment	VSP covers up to $50.00
Bifocal	Covered in full after copayment	VSP covers up to $75.00
Trifocal	Covered in full after copayment	VSP covers up to $100.00
Progressives/Blended Bifocal	Covered in full after copayment	Not Covered
Frames	Up to $160 retail cost covered in full after copayment	VSP covers up to $70.00
Prescription Contact Lenses (in lieu of lens and frame)	Up to $150.00 allowance**	VSP covers up to $105.00**

**A member can choose elective contact lenses instead of spectacle lenses and a frame.*

***Allowance to assist with doctor's professional fees including fitting, evaluation and materials.*

Access Discount Plan

For those employees who choose not to enroll in the voluntary VSP plan, CBIZ will provide you and your eligible dependents with a discount plan through VSP at no cost to you. This plan provides a discount of 15-20% on eye exams, contact lens exams and prescription eyewear (lenses, frames and contact lenses) obtained from a participating VSP provider. You will be automatically enrolled in this plan as long as you do not enroll in the CBIZ voluntary VSP plan that is described above.

What to Do

- Consider your vision expenses for the upcoming year. Will the amount you anticipate spending offset the cost of the premium for the voluntary plan?
- View the list of vision providers. Does your vision provider participate in this plan? If not, is there a network provider who could meet your needs just as well?
- Indicate your selection on the Enrollment Worksheet included in the enrollment packet.
- Questions? Visit the CBIZ Employee Service Center website at ***www.cbizesc.com***, or call the CBIZ Employee Service Center at 1-877-227-4372 Monday through Friday between 8:30 a.m. and 6:00 p.m. CST.

Employee Stock Purchase Plan

CBIZ is a publicly traded company on the New York Stock Exchange. And, through the Employee Stock Purchase Plan (ESPP) our employees can purchase shares of CBIZ stock at a discounted price. The Plan provides a convenient and economical way to purchase shares of CBIZ common stock through payroll deduction or supplemental purchase.

You are eligible to participate in the ESPP if you customarily work more than five months per calendar year and for more than 20 hours per week; have been employed by CBIZ for at least 90 days prior to the beginning of a purchase period; and do not own 5% or more of the total voting power or value of the Company, any parent or subsidiary of the Company.

You may contribute the minimum of $25 of each paycheck on an after-tax basis. The maximum contribution allowable in any one calendar year is $25,000. CBIZ, Inc. funds the cost of the 15% discount that is included in this maximum. So, the maximum contribution by an employee is approximately 85% of $25,000 or $21,250. Your payroll deductions are held by CBIZ in a non-interest-bearing account through what is typically a thirty day "purchase period" and at the end of the purchase period shares are purchased. Typically, the purchase period will be between the 16th of a month and the 15th of the next month. The purchase price is 85% of the closing stock price of CBIZ stock on the last business day prior to the 15th of the month (assuming the typical purchase period).

You may increase, decrease or cancel your contribution only once during a purchase period; any change is processed as soon as administratively possible. You may stop your contributions at any time prior to the payroll deadline immediately preceding the last day of the purchase period.

Once a Plan account is established, you may also purchase shares of CBIZ discounted stock by making optional cash investments, in accordance with the provisions of the Plan, at any time by mail. The minimum purchase by mail is $100.

After achieving eligibility, you may logon at ***www.cbizesc.com*** to print plan materials and the CBIZ ESPP Election Form. If you wish to enroll in the Plan, simply complete and submit the CBIZ ESPP Election Form to your Payroll Specialist. You may enroll anytime after achieving eligibility.

CBIZ requires you to hold stock purchased under this Plan for a minimum holding period of one year. You can not sell or transfer this stock during the 1-year holding period. Earnings associated with the disposal of your shares of stock are subject to taxation but will vary depending on how long you have held them. Please consult with your tax advisor for the tax impact to you.

A Prospectus is available through the CBIZ Employee Service Center website at ***www.cbizesc.com***. The agent for the plan, Computershare, is also available at 1-888-726-8085 for any questions.

CBIZ, Inc. pays all expenses associated with Plan purchases. You will pay all commission fees on the sale of your stock. Participants receive a quarterly statement from Computershare to include the market value of your account and information regarding purchases and sales made during the quarter. If you have previously participated in the Employee Stock Purchase Plan, you will find the statement reflects plan activities separately.

If you already have a payroll deduction established for purchasing CBIZ common stocks, and wish to continue in 2011 with the same election, there is nothing required for you to do during the Open Enrollment Period.

529 Plan

CBIZ, Inc. understands that saving for higher education can be a daunting task. As parents or grandparents, you want to be able to provide the benefit of college to your children or grandchildren. That is why CBIZ is pleased to tell you about CollegeBound*fund*SM, a flexible, tax-advantaged 529 college savings program managed by AllianceBernstein. Here are a few of the many benefits that CollegeBound*fund*SM offers:

- Tax-free earnings growth: There is no federal income tax due on earnings while they are in your CollegeBound*fund*SM account.
- Tax-free distributions: Distributions for qualified education expenses are federal income tax free.
- Any institution in the U.S.: Your CollegeBound*fund*SM assets can be used at any accredited institution of higher learning in the U.S., as well as at many foreign institutions.
- No income limits: There are no income limits restricting who is eligible to participate.
- Investment choice: Choose from a variety of investment options managed by AllianceBernstein.
- High contribution limit: You can contribute to your CollegeBound*fund*SM account until the total account value equals $365,000 (contributions and earnings).
- Low minimums: Employees may sign up for automatic monthly contributions of $50 per month.

For additional information, log on to ***www.cbizesc.com*** and on the right side menu, click on 2011>Forms>529>Education Strategies.

Just follow these simple steps to enroll online and begin taking advantage of this exciting opportunity. The entire enrollment process should take about 15 minutes to complete. Before you begin, please be sure to have your beneficiary's date of birth and social security number.

Log on ***https://corporate.collegeboundfund.com***

- Select "Company" as your ID Type.
- Enter the following User ID and Password: User ID: CBIZ Password: CBIZ529
- You will be prompted to enter a personal User ID and Password, which you will use during subsequent visits to the site.
- Click on "Open Account/Enrollment" and follow the instructions. If you haven't already done so, please take a minute to review the CollegeBound*fund*SM Program Description.

Once you have completed the online enrollment process, print and sign two copies of the Enrollment Confirmation. Please keep one for your records, and return the other to CollegeBound*fund*SM. Your account will not be activated until CollegeBound*fund*SM receives your signed original Enrollment Confirmation.

We hope you take advantage of this exciting opportunity to save for college!

529 Plan

A Word About Risk

*You should consider the investment objectives, risks, charges and expenses of CollegeBoundfund[SM] carefully before investing. For a free copy of the Program Description, which contains this and other information, visit our website at **www.collegeboundfund.com**, or call your financial representative or AllianceBernstein Investments at (888) 324-5057. Please read the Program Description carefully before you invest.*

If you are not a Rhode Island resident or if you have taxable income in another state, please note that depending on the laws of your or your beneficiary's home state, favorable state tax treatment or other benefits offered by such home state for investing in 529 college savings plans may be available only for investments in the home state's 529 plan. Any state-based benefit offered with respect to this plan should be one of many appropriately weighted factors to be considered before making an investment decision. Please consult our financial, tax or other advisor to learn more about how state-based benefits (including any limitations) would apply to your specific circumstances. You may also wish to contact your home state or another state's 529 plan to learn more about its features, benefits and limitations before investing. Statements in this material concerning taxation are not offered as individual tax advice.

The investments in CollegeBoundfund[SM] are not guaranteed by the State of Rhode Island, the Rhode Island Higher Education Assistance Authority (which established and implemented CollegeBoundfund[SM] and makes rules and regulations governing the program), the Rhode Island State Investment Commission (which oversees the investments of the assets of CollegeBoundfund[SM]), the Federal Deposit Insurance Corporation (FDIC) or any instrumentality thereof. CollegeBoundfund[SM] is managed by AllianceBernstein L.P. and distributed by AllianceBernstein Investments, member FINRA.

Investment Products Offered:	• Are Not FDIC Insured	• May Lose Value	• Are Not Bank Guaranteed

CBIZ Domestic Partner Benefit Policy

Types of Benefits

Domestic partners of current employees, including both same-sex and opposite-sex partners, are eligible for medical, dental, vision, optional life and long term care benefits.

Eligibility Requirements

The employee and domestic partner are eligible for certain benefits where both partners have registered and provide proof of such registration of domestic partnership. If domestic partner registration is not obtained the employee and domestic partner must complete, sign, and notarize the Declaration of Domestic Partnership, and attest to all of the following:

1. They have resided together in the same residence for six consecutive months, and intend to do so indefinitely.
2. They are each at least 18 years of age, and mentally competent to consent to this declaration.
3. They are not related by blood or marriage to a degree of closeness that would prohibit legal marriage in the state in which they legally reside.
4. Both the employee and the domestic partner are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.
5. Neither person has a different domestic partner now, and neither person has had a different domestic partner within the last six months from the date of the execution of the declaration.
6. Neither person is currently legally married to or legally separated from anyone else.

In addition to all of the above requirements, at least two of the following criteria must be maintained at all times:

1. The partners have executed a domestic partnership agreement in a jurisdiction that authorizes such agreements.
2. The employee has named his/her domestic partner as a beneficiary under his/her will, or the domestic partner has named the employee as a beneficiary under his/her will.
3. The employee has granted his/her domestic partner powers under a durable power of attorney, or the domestic partner has granted the employee powers under a durable power of attorney.
4. The employee has named his/her domestic partner as a beneficiary on his/her life insurance policy, or the domestic partner has named the employee as a beneficiary on his/her life insurance policy.
5. The partners have a joint bank account.
6. The partners are co-signers of a lease or deed.
7. The partners are named on the same car insurance policy.

Once covered, a domestic partner will cease to be eligible for health benefits in the event that one of the above requirements is no longer satisfied.

CBIZ Domestic Partner Benefit Policy

Enrollment Procedures

To enroll a domestic partner in medical, dental, vision, optional life and/or long term care benefit program(s), the employee must:

1. Complete the "Declaration of Domestic Partnership" affidavit which can be found on the CBIZ Employee Service Center website at ***www.cbizesc.com***. The affidavit must be notarized.
2. Return the notarized affidavit to:

   CBIZ ESC - Enrollment
   4851 LBJ Freeway
   Suite 800
   Dallas, TX 75244
3. After the affidavit has been received by the CBIZ ESC, your demographic information will be entered into the CBIZ enrollment website. This information will be based on the information you supplied in your affidavit.
4. To enroll in benefits, log on to the CBIZ enrollment website (specific enrollment instructions can be found in the "How to Enroll" section of this booklet). When you reach the dependent screen on the enrollment website, your domestic partner and/or children of you and/or your domestic partner will be visible on the dependent screen. (Please contact the CBIZ ESC at 1-877-227-4372 if they do not show up on this screen and two weeks has passed since you sent in your affidavit to the ESC.)
5. To enroll your dependents, simply select the name of each dependent and choose the coverage(s) you would like.
6. Continue through the entire enrollment and confirm your enrollment elections. Make sure to print a copy of your confirmation number and confirmation statement showing your elections for your records.

Termination Procedures

If there is a change in status in the domestic partnership, the employee must do the following within 31 days of the change.

1. Complete the "Declaration of Termination of Domestic Partnership" which can be found on the CBIZ ESC website at ***www.cbizesc.com***.
2. Return the completed form to:

   CBIZ ESC - Enrollment
   4851 LBJ Freeway
   Suite 800
   Dallas, TX 75244
3. Changes to your enrollment will be processed and coverage on the appropriate dependents will be terminated.

If you have any questions about the termination procedure, please contact the CBIZ ESC at 1-877-227-4372.

Confidentiality

Information regarding domestic partners will be maintained in accordance with CBIZ policy regarding privacy of personal information. CBIZ cannot guarantee a greater level of security or confidentiality than is provided other employee data. Access to this information will be given only to those whose jobs require it. Lists or reports will not be generated using your name, but records must be maintained for tax purposes. Outside of CBIZ, insurance carriers will need information on your domestic partner, and as an example, the doctors your domestic partner sees will have their own records naming you as the provider of coverage.

Medicare Part D Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CBIZ, Inc. and prescription drug coverage that first became available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage, and wondered how it would affect you. UnitedHealthcare has determined that your prescription drug coverage with CBIZ, Inc. is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Starting January 1, 2006, prescription drug coverage became 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 might also offer more coverage for a higher monthly premium.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

People with Medicare may enroll in a Medicare prescription drug plan during select times in the year. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year you have the opportunity to enroll in a Medicare prescription drug plan between November 15th and December 31st.

If you do decide to enroll in a Medicare prescription drug plan and drop your prescription drug coverage, be aware that you may not be able to get this coverage back.

If you drop your coverage with CBIZ, Inc. and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of you current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with CBIZ, Inc. and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month after May 15, 2006 you did not have that coverage. For example, if you go nineteen months without coverage, your 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 coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact the CBIZ Employee Service Center at 1-877-227-4372.

Medicare Part D Notice

More detailed information about Medicare plans that offer prescription drug coverage is available. You can get more information about Medicare prescription drug plans from these places:

- Visit ***www.medicare.gov*** for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their 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. For more information about this extra help, visit Social Security Administration (SSA) online at ***www.socialsecurity.gov***, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	November 2010
Name of Entity/Sender:	CBIZ, Inc.
Contact--Position/Office:	CBIZ Employee Service Center
Address:	4851 LBJ Freeway, Suite 800, Dallas, Texas 75244
Phone Number:	(877) 227-4372

COBRA Notice: To you (& your spouse, if applicable)

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

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

CBIZ, Inc.
11440 Tomahawk Creek Parkway
Leawood, KS 66211
ATTN: Human Resources Dept.

COBRA Continuation coverage for the Plan is administered by:

COBRA Administrator: CBIZ Payroll, Inc. ATTN: COBRA Department
P.O. Box 20, Roanoke, VA 24002
(800) 815-3023, Option 6 (Phone) or (800) 584-4223 (Fax)

&

CBIZ ESC
4851 LBJ Freeway, Suite 800
Dallas, TX 75244
1-877-227-4372

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. A qualified beneficiary must elect coverage by the date specified on the COBRA Enrollment Form. This date is based on 60 days from the date of the notice or your coverage end date (whichever is greater). Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

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

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

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

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

COBRA Notice

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

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

If the Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title II of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to CBIZ, Inc., and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or if the Plan provides retiree health coverage: commencement of a proceeding in a bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

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

CBIZ Employee Service Center
4851 LBJ Freeway, Suite 800
Dallas, TX 75244

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

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

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

COBRA Notice

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must notify the plan administrator of receiving the disability determination on:

1. The latest of 60 days following:
   a. Receipt of the determination,
   b. The date of the qualifying event,
   c. The date of loss of coverage, or
   d. Receipt of explanatory notice of qualified beneficiary notice obligations; and
2. Prior to the end of the 18 month period.

The Social Security Disability Determination notice should be sent to:

COBRA Administrator: CBIZ Payroll, Inc.
ATTN: COBRA Department
P. O. Box 20
Roanoke, VA 24002
(800) 815-3023, Option 6 (Phone)

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:**

COBRA Administrator: CBIZ Payroll, Inc.
ATTN: COBRA Department
P. O. Box 20
Roanoke, VA 24002
(800) 815-3023, Option 6 (Phone)

Qualified Beneficiary Notice Procedures

The qualified beneficiary is obligated to notify CBIZ, Inc. of the occurrence of any of these following events:

1. Divorce or legal separation
2. Death
3. Medicare entitlement (Parts A, B or both)
4. Loss of dependent child status under the plan
5. Social Security determination of disability, or revocation of Social Security disability determination.

The qualified beneficiary is obligated to provide this notice within 60 days of the occurrence of any of these events, or within 60 days of loss of coverage.

COBRA Notice

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator, CBIZ, Inc.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact CBIZ Payroll or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website at ***www.dol.gov/ebsa***.

Plan Contact Information

Additional information about your group health plan and COBRA can be obtained upon request by contacting the Plan Administrator:

CBIZ, Inc.
11440 Tomahawk Creek Parkway
Leawood, KS 66211

The HIPAA Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted into law, and we want you to know about some of its provisions as they may affect decisions you make about your participation in the Group Health Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). HIPAA's provisions fall into these areas:

Under COBRA, if the qualifying event is a termination or reduction in hours of employment, affected qualified beneficiaries are entitled to continue coverage for up to 18 months after the qualifying event, subject to various requirements. Before HIPAA, this 18-month period could be extended for up to 11 months (for a total COBRA coverage period of up to 29 months from the initial qualifying event) if an individual was determined by the Social Security Administration. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must notify CBIZ, Inc. of receiving the disability determination on:

1. The latest of 60 days following:
   a. Receipt of the determination,
   b. The date of the qualifying event,
   c. The date of loss of coverage, or
   d. Receipt of explanatory notice of qualified beneficiary notice obligations; and
2. Prior to the end of the 18 month period.

Under HIPAA, if a qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The disabled individual can be a covered employee or any other qualified beneficiary. However, to be eligible for the 11-month extension, affected individuals must still comply with the notification requirements in a timely fashion.

A child that is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the employer's group health plan(s) and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.

In addition to changing some of the COBRA requirements, HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations.

If you were covered by a group health plan(s) prior to your employment with us, your previous employer's insurance carrier should have provided you with a Certificate of Creditable Coverage, a form required by the HIPAA law that describes the health coverage you and your dependents, if any, have or had, and the dates you were covered. IF YOU HAVE NOT RECEIVED A CERTIFICATE OF CREDITABLE COVERAGE AND ARE ENTITLED TO ONE, PLEASE CONTACT YOUR FORMER EMPLOYER. Once you deliver the Certificate of Creditable Coverage to CBIZ, Inc., your entitlement to restriction from pre-existing condition exclusions in our group health plan(s), as long as you had twelve months of creditable coverage (eighteen months if a late enrollment) and have not had more than a sixty-three day gap in coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Group Health Plan may terminate your COBRA coverage.

HIPAA coordinates COBRA coverage with these new limits as follows: Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be immediately terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the employer's group health plan(s) may terminate your COBRA coverage. If you have any questions about COBRA, or if you have changed marital status, or you or your spouse have changed addresses, please contact CBIZ, Inc. or the COBRA Department at (800) 344-3954.

How to Enroll

PLEASE NOTE NEW LOGIN PROCESS FOR 2011!

Enrolling on the web is a fast and easy way to get the benefits you want. It is truly as simple as point and click. Follow the steps below to see how Your Benefits Just Got Easier!

- Complete your Enrollment Worksheet for yourself and any covered dependents; this will ensure that you have made all the necessary decisions to enroll.
- Go to the Employee Service Center website at ***www.cbizesc.com*.**
- Enter the first initial of your first name and the first initial of your last name along with the last 4 digits of your Social Security number.
- Enter your PIN. If you have never been to the site or you have not changed your PIN, enter your entire birth date, i.e. 09101971. If you can't remember your PIN or have problems logging on, call the Employee Service Center at 1-877-227-4372.
- For employees hired on or before January 1, 2010, in order to receive a reduction in your medical plan premium, you must complete the three requirements of the ***Great Health*** program. The first two requirements were to select and complete one additional wellness activity and have a clinical screening prior to September 30, 2010. Please refer to any of the ***Great Health*** newsletters for information on how these activities are tracked and your participation is recorded. The last requirement is to now complete the Health Risk Assessment. Do this from the ESC website. Select "University of Michigan" under ***Great Health***. Then select the "Click here to take the EMPLOYEE HRA" link.
- For employees hired after January 1, 2010, if you plan to participate in the ***Great Health*** program and receive a reduction in premium, you must first complete the Health Risk Assessment. From the ESC website select "University of Michigan" under ***Great Health.*** Then select the "Click here to take the EMPLOYEE HRA" link.
- If your spouse plans to participate in the ***Great Health*** program and receive a reduction in premium, he/she must first complete the Health Risk Assessment. From the ESC website select "University of Michigan" under ***Great Health.*** Then select the "Click here to take the SPOUSE HRA" link.
- Once you and/or your spouse have completed the HRA you will each receive a confirmation number. ***Write these numbers down*** as you will need them during the enrollment process.
- Return to the Employee Service Center website. On the left side of the Main Menu, select "How to Enroll/Change your Benefits."
- On the drop-down Menu, click "Health & Welfare Benefits 2011."
- Follow the instructions to enroll.
- Once you have completed your enrollment, a confirmation statement will appear on the page. Print this page for your records and/or have it emailed to yourself for your records.
- If the information is accurate, click "Confirm." You will then receive a confirmation number. Write this number down or print the page and keep it for your records.
- If the information is incorrect, click "Change."

Once you receive your confirmation number, you have finished the enrollment process. It is important to note that your enrollment is not complete until you have your confirmation number.

Note: If you plan to enroll your domestic partner and/or nondependent children, please refer to the "Domestic Partner Benefit Policy" section of this book for the steps you must take to complete that enrollment.

How to Complete the Health Risk Assessment (HRA)

If you are an Employee completing the HRA:

- Login to the CBIZ Employee Service Center website at ***www.cbizesc.com.***
  - Your new user ID will be the first initial of your first name and the first initial of your last name along with the last four digits of your Social Security number.
  - Your PIN is your date of birth, i.e. 09101971 unless previously changed.
- Under "Great Health" click on "University of Michigan."
- Select "Click here to take the EMPLOYEE HRA."

Take the HRA:

- Read the disclaimer at the top of the page.
- Fill in your last name and social security number, select "Employee" from the options listed, indicate your gender and smoking status, then click on "Enter."
- Once you have completed the HRA, record your 2011 confirmation number on your enrollment worksheet to use during the on-line enrollment process.

If you are a Spouse Completing the HRA

- Login to the CBIZ Employee Service Center website at ***www.cbizesc.com.***
  - Your new user ID will be the first initial of the employee's first name and the first initial of the employee's last name along with the last four digits of the employee's Social Security number.
  - Your PIN is the employee's date of birth, I.E. 09101971 unless previously changed.
- Under "Great Health" click on "University of Michigan."
- Select "Click here to take the SPOUSE HRA."

Take the HRA:

- Read the disclaimer at the top of the page.
- Fill in **the CBIZ employee's last name and social security number**, select "Spouse" from the options listed, indicate your gender and smoking status, then click on "Enter."
- Once you have completed your HRA, record your 2011 confirmation number and provide that to your spouse so that it can be used during the on-line enrollment process.

Enrollment Worksheet

For Reference Only • All costs shown are employee monthly costs

UNIVERSITY OF MICHIGAN HRA: **EMPLOYEE PARTICIPATING (CIRCLE ONE) YES NO**
IF EMPLOYEE PARTICIPATING, 8-DIGIT CONFIRMATION NUMBER __ __ __ __ __ __ __ __

SPOUSE PARTICIPATING (CIRCLE ONE) YES NO
IF SPOUSE PARTICIPATING, 8-DIGIT CONFIRMATION NUMBER __ __ __ __ __ __ __ __

MEDICAL: (CIRCLE ELECTION)	QHDP	$1,000 Deductible	$500 Deductible	WAIVE COVERAGE
EMPLOYEE*	$20.00	$68.00	$132.00	
EMPLOYEE & SPOUSE**	$198.00	$300.00	$435.00	
EMPLOYEE & CHILD(REN)*	$157.00	$253.00	$378.00	
FAMILY**	$364.00	$522.00	$732.00	

DENTAL: (CIRCLE ELECTION)	DENTAL 80	DENTAL 100	WAIVE COVERAGE
EMPLOYEE	$5.68	$21.65	
EMPLOYEE & SPOUSE	$20.44	$52.57	
EMPLOYEE & CHILD(REN)	$17.60	$47.33	
FAMILY	$29.52	$71.70	

VOLUNTARY VISION: (CIRCLE ELECTION)		WAIVE COVERAGE
EMPLOYEE	$11.22	
EMPLOYEE & SPOUSE	$17.81	
EMPLOYEE & CHILD(REN)	$18.18	
FAMILY	$29.30	

NOTE: YOUR MEDICAL, DENTAL & VISION ELECTIONS CAN ALL BE DIFFERENT LEVELS OF COVERAGE

SECTION 125 PREMIUM TAX ELECTIONS: (CIRCLE ELECTION)

MEDICAL:	PRE-TAX***	WAIVE COVERAGE
DENTAL:	PRE-TAX***	WAIVE COVERAGE
VISION:	PRE-TAX***	WAIVE COVERAGE

MEDICAL FLEXIBLE SPENDING ACCOUNT (WITHOUT AN HSA)*:**
PARTICIPATING (CIRCLE ONE) YES NO
IF PARTICIPATING: ANNUAL CONTRIBUTION AMOUNT THROUGH 12-31-11 $ _____

LIMITED FLEXIBLE ACCOUNT (WITH AN HSA)***
PARTICIPATING (CIRCLE ONE) YES NO
IF PARTICIPATING: ANNUAL CONTRIBUTION AMOUNT THROUGH 12-31-11 $ _____

DEPENDENT CARE FLEX ACCOUNT*:**
PARTICIPATING (CIRCLE ONE) YES NO WAIVE COVERAGE
IF PARTICIPATING: ANNUAL CONTRIBUTION AMOUNT THROUGH 12-31-11 $ _____

LONG TERM DISABILITY: (CIRCLE ELECTION)
PAYMENT ELECTION: PRE-TAX (BENEFIT TAXED) POST-TAX (BENEFIT TAX-FAVORED)

* Deduct $20.00 from the monthly premium if the employee chooses to participate in the ***Great Health*** program.

** Deduct $20.00 from the monthly premium if only the spouse chooses to participate in the ***Great Health*** program. Deduct $40.00 from the monthly premium if both the employee and spouse choose to participate in the ***Great Health*** program.

*** Premiums for insurance coverage and spending account contributions will be deducted pre-tax. Please contact the ESC with questions, or if your preference is a post-tax deduction.

Enrollment Worksheet

DEPENDENT PARTICIPATION DETAIL

LEGAL NAME	SS#	RELATIONSHIP	GENDER	DOB	MEDICAL	DENTAL	VISION

BENEFICIARY INFORMATION FOR BASIC LIFE AND OPTIONAL LIFE INSURANCE*

BASIC LIFE PRIMARY BENEFICIARY

NAME SS# RELATIONSHIP %

NAME SS# RELATIONSHIP %

BASIC LIFE CONTINGENT BENEFICIARY

NAME SS# RELATIONSHIP %

NAME SS# RELATIONSHIP %

OPTIONAL LIFE PRIMARY BENEFICIARY

NAME SS# RELATIONSHIP %

NAME SS# RELATIONSHIP %

OPTIONAL LIFE CONTINGENT BENEFICIARY

NAME SS# RELATIONSHIP %

NAME SS# RELATIONSHIP %

* If you are currently enrolled in CBIZ Benefits, beneficiary information previously provided to us is on file. During this Open Enrollment process you will be asked to confirm the information on file as still correct. It is not necessary to enter beneficiary information unless you would like to make a change. Beneficiary information can be changed at any time during the year at ***www.cbizesc.com***.

Enrollment Worksheet

OPTIONAL LIFE:

EMPLOYEE PARTICIPATING? (CIRCLE ONE) YES OR NO AMOUNT OF COVERAGE: $ _____

EMPLOYEE COST

AGE OF EMPLOYEE	UNIT COST PER $1,000
< 30	$0.07
30-34	$0.08
35-39	$0.108
40-44	$0.135
45-49	$0.225
50-54	$0.315
55-59	$0.558
60-64	$0.89
65-69	$1.675
70-74	$3.13
75+	$6.30

$ _____ ÷ 1,000 X $ _____ = $ _____
AMOUNT OF COVERAGE UNIT COST FROM ABOVE EMPLOYEE MONTHLY COST

SPOUSE PARTICIPATING? (CIRCLE ONE) YES OR NO AMOUNT OF COVERAGE: $ _____

SPOUSE COST

AGE OF SPOUSE	UNIT COST PER $1,000
< 30	$0.07
30-34	$0.08
35-39	$0.108
40-44	$0.135
45-49	$0.225
50-54	$0.315
55-59	$0.558
60-64	$0.89
65-69	$1.675
70-74	$3.13
75+	$6.30

$ _____ ÷ 1,000 X $ _____ = $ _____
AMOUNT OF COVERAGE UNIT COST FROM ABOVE SPOUSE MONTHLY COST

CHILD(REN) PARTICIPATING? (CIRCLE ONE) YES OR NO AMOUNT OF COVERAGE: $ _____

AMOUNT OF COVERAGE	MONTHLY COST*
$2,000	$0.20
$4,000	$0.40
$6,000	$0.60
$8,000	$0.80
$10,000	$1.00

** COST INCLUDES COVERAGE FOR ALL CHILDREN*

CBIZ®