HR

2014 BENEFIT GUIDE

For Salaried, Hourly and W-2
Commissioned Employees (Non-QREAs)

CBRE

EFFECTIVE JANUARY 1, 2014

TABLE OF CONTENTS

Introduction

Enrolling in CBRE Benefits

Medical Program

Disability

Flexible Spending Accounts

Ancillary Benefits

Provider Directory

INTRODUCTION

At CBRE, our employees are our most important asset. We understand how important it is for employees to have a flexible and comprehensive benefits program—one that can fit different stages of life. You can choose the plans that best suit your individual needs, taking into consideration the benefits that are most important to you and your family.

Available Benefit Programs

The availability of the following programs offered by CBRE depends on your state of residence and your employment status:

- Medical Program
- Prescription Program
- Wellness Program
- Dental Program
- Vision Program
- Life Insurance Program
- Accidental Death & Dismemberment (AD&D) Insurance
- Short-Term Disability (STD) Coverage
- Long-Term Disability (LTD) Coverage
- Flexible Spending Accounts – Health Care and Dependent Care
- Ancillary Benefits (Employee Assistance Program, Transit Program, Adoption Assistance Program)
- Business Travel Accident (BTA) Insurance
- 401(k) Plan

This Benefit Guide contains highlights of the CBRE Benefits Program. For more information, refer to the Summary Plan Descriptions for the Welfare Plan and the 401(k) Plan, which can be found on CBRE's online Library via the Navigator. The official and controlling provisions of the Plans are contained in the Plan Documents, which include the master policies with insurance carriers and health maintenance organizations. Should there be a conflict between this guide and the Plan Documents, the Plan Documents will be the final authority. The Plans are administered by CBRE, which has discretionary authority to interpret and apply the Plans' provisions and make the rules necessary for their day-to-day operation.

INTRODUCTION

Who is Eligible for Benefits

Eligible Employees

- Full-time salaried and hourly employees of the company who are scheduled to work a minimum of 30 hours per week. (Note: Employees who reside in Hawaii and work at least 20 hours per week are eligible for coverage.)

- Commissioned employees of the company who receive a W-2. Commissioned employees who receive a 1099 are eligible for certain benefits, as described in a separate Benefit Guide for QREAs.

Eligible Dependents

You may choose to enroll your eligible dependents for medical, dental, child and spouse life, AD&D and vision coverage. The premium you pay for this coverage is based on the options and coverage levels you choose. Your eligible dependents are defined as:

- Your legal spouse; of the same or opposite gender.
- Your domestic partner of the same or opposite gender and his or her dependent children (see also Domestic Partner Coverage below).
- Your single or married children up to age 26.
- Eligible children include married or unmarried, dependent children who may not reside with you in a parent- child relationship but for whom you must provide health coverage as required under a Qualified Medical Child Support Order (QMCSO).
- Children for whom you have been appointed by a court as the legal guardian.
- Children who become mentally or physically disabled before reaching the maximum age limit and who are incapable of self-support may continue to be covered past the age limit of 26, provided you request continued coverage before your child reaches the age limit. Periodic proof of disability may be required.

Domestic Partner Coverage

Medical, dental, vision, long-term care, life and AD&D benefits are available for domestic partners (same or opposite gender) and their dependent children. You must be enrolled in a specific plan before you can enroll your domestic partner in that same plan. Then, your domestic partner's dependent children may be eligible to enroll.

Eligibility requirements include but are not limited to:

- Each partner is at least 18 years of age;
- The couple is not related by blood;
- The couple shares the same regular and permanent residence in a committed relationship for at least a year; and neither partner is married to someone else or is a member of another domestic partnership that has not been terminated, dissolved or nullified.

An employee adding a Domestic Partner and his/her eligible children to the employee's medical, dental or vision plan is subject to the existing four-tiered premium structure:

Employee Only
Employee + Spouse/Domestic Partner
Employee + Child(ren)
Employee + Spouse/Domestic Partner + Child(ren)

However, the premiums deducted for domestic partners who are qualified dependents for tax purposes are taken on an after-tax basis and are therefore subject to federal taxes as well as state taxes in most states.

If you and your domestic partner are registered with a state, you are not required to review and acknowledge the online affidavit of domestic partnership when you enroll for benefits.

INTRODUCTION

Dual Employment – if You and Your Spouse Both Work at CBRE

If you and your spouse work at CBRE and have dependents covered on any of the plans, only one employee can cover all of the dependents. You cannot split dependents with each employee taking employee and child(ren) coverage. CBRE will allow employees who both work for CBRE to determine which coverage will work best for them. For example, married CBRE employees can pick either Employee only for themselves or one can select Employee + Spouse. If they have children, one employee can elect employee and family or they can elect employee only and employee child(ren).

Who Is Not Eligible

- Employees covered by a collective bargaining agreement.
- Part-time employees who are scheduled to work less than 30 hours per week. (Note: Employees who reside in Hawaii and who work less than 20 hours per week are not eligible.)
- Employees who are classified by CBRE as temporary. (Note: temporary employees are eligible to contribute to the 401(k) plan.)
- Non-resident aliens and employees of foreign companies that have not adopted the U.S. programs.
- A spouse, child or domestic partner who is already enrolled in CBRE company benefit plan(s) cannot be covered twice (Example: A spouse/domestic partner cannot cover another spouse/domestic partner who is a CBRE employee. A dependent cannot be covered on both parents' plans or stand alone as the employee and as a dependent).

When Coverage Begins for Newly Eligible Employees*

If you are new to CBRE, you will be eligible for coverage on the first day of the month coinciding with or following your date of hire. For example, if your date of hire is June 1st, you will be eligible for coverage on June 1st. If your date of hire is June 2nd, your eligibility date will be July 1st. If you change to a benefit-eligible status, (e.g., part-time to full-time), the same eligibility rules will apply. If you reside and work in Hawaii, state legislation mandates that you become eligible for benefits on the first of the month following your date of hire or on the date you change to a benefit-eligible status.

* Different effective dates may apply to employees who become benefits-eligible due to an acquisition, transition or change in employment status.

For coverage to begin on your benefit eligibility date you must enroll within the first 30 days from the date you become eligible for benefits. If you do not complete your enrollment within the 30-day period, you are responsible for all premiums retroactive to the effective date of coverage.

When Your Coverage May Be Delayed

If you are on an unpaid leave of absence due to a medical reason when your benefits are scheduled to begin, medical, dental, and vision coverage for yourself and any enrolled dependents will begin as scheduled. All other coverage will begin when you return to active work. Any missed payroll deductions that occur during your unpaid leave status will be deducted from your first paycheck following your return from leave. If you receive paid time off (PTO) payments while on leave, your portion of premiums will be deducted from these payments.

Life and AD&D coverage for your benefit-eligible dependents will be delayed if he/she is totally disabled on the date coverage would normally begin. Life and AD&D coverage will begin after the disabled individual is released from medical care.

INTRODUCTION

Premium Sharing

CBRE pays the full premium of some benefits and shares the premium of other benefits with you. You pay for your voluntary coverage with either pre-tax or after-tax premiums as shown below.

Coverage	Who Contribute	How You Pay
Basic Employee Life	CBRE	CBRE pays 100% of premium (refer to Life Insurance section for information about imputed income for coverage amounts in excess of $50,000)
Business Travel Accident	CBRE	CBRE pays 100% of premium
Short Term Disability (STD)	CBRE	CBRE pays 100% of premium
Employee Assistance	CBRE	CBRE pays 100% of premium
Medical	CBRE & you	Pre-tax payroll premium
Dental	CBRE & you	Pre-tax payroll premium
Vision	You	Pre-tax payroll premium
Flex Spending Accounts	You	Pre-tax payroll contributions
Supplemental Employee Life	You	After-tax payroll premium
Spouse Life Insurance	You	After-tax payroll premium
Child Life Insurance	You	After-tax payroll premium
Employee AD&D	You	After-tax payroll premium
Spouse AD&D	You	After-tax payroll premium
Child AD&D	You	After-tax payroll premium
Long-Term Disability (LTD)	CBRE & you	CBRE pays 100% of premium for coverage of 40% of compensation with a 90-day waiting period. Employee may choose to impute income for the coverage so that benefits will be tax-free.
Transit program	You	Pre-tax payroll premium

Pre-tax Advantage

CBRE allows most employees to deduct medical, dental and vision premiums on a pre-tax basis. This means you do not pay federal, state, or Social Security and Medicare (FICA) taxes on your premiums, thereby reducing your taxable income. Some domestic partner coverage is deducted post-tax, please refer to page 2.

Benefit Pay Periods

Employees classified as Salaried or Hourly – Premiums are deducted from the first two paychecks of each month. If you do not receive a scheduled paycheck, or if earnings do not cover the premiums, your missed premiums will be deducted from your next scheduled paycheck.

Commissioned Employees paid via W-2 – Premiums are deducted from the first paycheck of each month. If you receive draw payments, your premiums will be deducted from the first two scheduled paychecks of each month.

If you do not receive a scheduled paycheck, or if earnings do not cover the premiums, your missed premiums will be deducted from your next scheduled paycheck.

Please note, if you are immediately eligible for benefits due to an acquisition, transition, change in employment status, or because you were hired on the first day of the month, your benefit premiums will begin with your first paycheck from CBRE. If payroll premiums are delayed for any reason, any missed premiums will accumulate and will be deducted as soon as possible.

Termination of coverage

An employee that loses coverage due to a qualifying event will be offered continuation of coverage through COBRA. The employee and any dependents enrolled in coverage may continue COBRA coverage for 18 months.

ENROLLING IN CBRE BENEFITS

Before You Enroll

It's important that you understand all of your benefit options before you enroll. For this reason, you have several resources to which you can turn for your benefit information.

New Hire Orientation

For an overview of the CBRE benefit plans, eligibility rules, and important deadlines, please attend the weekly New Hire Orientation call. This virtual training is conducted by live CBRE HR professionals who provide valuable information and answer your questions.

Meeting occurs every Thursday

Time: 11:00 AM Pacific/12:00 PM Mountain/1:00 PM Central/2:00 PM Eastern
Dial In: 888.535.0454; Conference Code: 212 984 6641 WebEx Link: Click here

Meeting Number: 258 948 145
Meeting Password: training

You can view the presentation materials here.

Benefit Resources

The following reference materials are available online on the Navigator:

- New Hire Benefit Orientation Online Recording
- Summary Plan Descriptions
- CBRE 401(k) Plan Information
- Cigna Statement of Health Form for Life & LTD Coverage
- Claim Forms

These resources also are available within the BenefitConnect system under Benefit Resources at www.cbrebenefitconnect.com.

Online Medical Plan Comparison Tools

You can use your records from past medical and pharmacy claims to help estimate your future needs and choose a medical plan that makes sense to you. Please follow the instructions below for accessing the comparison tool for the plan(s) that apply to you.

To Compare Cigna Medical Plan Options

1. Go to www.myCignaplans.com
2. Log in with the following information:
   UserID: CBREBenefits
   Password: cigna
3. Click on the Compare Medical Plan Costs link to estimate your annual medical expenses under each option

To Compare A Medical Plan Options

1. Go to www.cbrebenefitconnect.com
2. Log in, select *Evaluate* from the Main Menu
3. Use the Medical Plan Model Comparison tool to compare plan premiums

ENROLLING IN CBRE BENEFITS

Using the BenefitConnect Enrollment System

You can access the online benefit enrollment system by logging on to www.cbrebenefitconnect.com. If you do not have a computer with access to the internet, call the HR Service Center at (866) 225-3099 for enrollment assistance. However, keep in mind you must enroll via the internet as there are no paper forms to complete.

Creating or Resetting a Password

Log on and click on Create or Reset Your Password.

You will need your Employee ID to create your password. You can obtain your Employee ID number from your paycheck stub in myHR or by calling the HR Service Center at (866) 225-3099.

After you read and accept the terms of the Online Authorization, the Enrollment Page will appear. Please note if you do not accept the terms of the agreement, you will not be enrolled in any CBRE benefit plan.

Enrollment – 4 Easy Steps

1. Read the directions on each page and make your benefit elections. As you elect a benefit, click Save & Continue at the bottom of the page.
2. Note that the system is automatically set to "waive" for the voluntary coverage options. To keep the "waive" election, simply click Save & Continue. If you want to enroll in the voluntary benefit, change the election and click Save & Continue.
3. After you've completed your benefit elections, review your choices on the Enrollment Confirmation page for accuracy.
4. Print the Enrollment Confirmation page using your browser tools and keep a copy for your records.

Waiving Medical Coverage

If you choose not to enroll for medical coverage, you will be prompted to certify and accept the appropriate legal disclaimer when you access the enrollment website at www.cbrebenefitconnect.com.

Additional Enrollment Sites

The following programs have a separate enrollment process. You may call or visit or visit the 401(k) website to enroll. To enroll in the commuter parking or commuter transportation programs, please contact WageWorks at 1855-774-7441 Monday through Friday from 8 a.m. to 8 p.m. Eastern and request a Commuter Administration Services (Parking and Transportation) Election Form to complete.

Plan	Enrollment Website
401(k)	www.benefits.ml.com or (888) 363-2385
WageWorks Transit Program—all locations except CT, NJ, NY	www.wageworks.com or (855) 774-7441

Making Changes After Your Initial Enrollment

It is important to carefully consider all your benefit options before you enroll. Once you enroll, your elections will remain in effect for the entire calendar year unless you have one of the following qualified family status changes:

Family Status Changes

- You marry or begin a domestic partnership
- You gain an eligible dependent child as a result of a birth, adoption, legal custody, guardianship which you have gained through appointment by a court, or a court order makes you responsible for your child's health care coverage
- Your dependent child becomes ineligible due to passing the maximum age limit, or you lose legal custody, guardianship, or a court order releases you from being responsible for your child's health care coverage
- Death of a spouse/domestic partner or dependent child
- Divorce/annulment/legal separation or termination of a domestic partnership
- Change in employment status
- You or your spouse/domestic partner gains or loses coverage under another group health plan
- A spouse, dependent or domestic partner becomes a CBRE employee and is currently covered as your dependent in a CBRE benefit plan(s)

Some family status changes may allow you to add or remove dependents from a particular benefit plan, but may not allow you to switch medical plans or other benefits. Changes in benefit elections must be consistent with the family status change. For example, if your spouse/domestic partner begins a new job and becomes eligible for his or her new employer's benefits program, you may remove him or her from your health coverage. However, you may not make changes to any other coverage that is not related to the family status change.

You may be required to provide documentation of certain family status events (e.g., birth certificate, certificate of marriage, divorce documents from court, certificate of death).

Family Status Changes Must Be Processed Within 31 Days from the date the Event Occurs*

To request a family status change:

1. Log on to www.cbrebenefitconnect.com. Do not enter the event in the system until after the event has actually occurred.

2. Enter your Employee ID and password. If you have forgotten your password or you don't have one, follow the instructions under Creating a Password.

3. Click Family Status Change from the Main Menu page and enter the "type" of family status change and event date as prompted.

4. Note: Only allowable changes for the specific event selected will be shown or have active links. Benefits that cannot change as a result of the event are identified by an "x".

5. When you are finished making allowable changes, click Continue to review a summary of your changes. This is your last chance to make corrections. If the summary page is accurate, click Save and Submit at the bottom of this page to process your elections. NOTE: Your changes will not be processed until you click Save and Submit.

6. Print your enrollment confirmation page and keep it for your records.

ENROLLING IN CBRE BENEFITS

Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act (HIPAA), you and your family have a special opportunity to enroll in the medical plan mid-year in two situations:

- If you lose other coverage (including COBRA coverage).
- If you have a new spouse/domestic partner or dependent.

In these two situations, you or your spouse/domestic partner or dependent child(ren) can be enrolled in the plan even if the plan would not normally allow enrollment at that time. You also can enroll yourself and/or your dependent in the plan even if you are not currently participating in the plan. You must request enrollment within 31 calendar days of the event and documentation of the event (e.g., certificate of marriage) may be required.

Pursuant to the Children's Health Insurance Reauthorization Act of 2009, certain eligible employees may be entitled to additional special enrollment rights. If you are eligible for but not enrolled a health plan, you may be eligible to enroll in a health plan option if you or your dependent child either:

- lose coverage under a Medicaid Plan under Title XIX of the Social Security Act;
- lose coverage under the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or
- become eligible for group health plan premium assistance under Medicaid or SCHIP.

Removing Ineligible Dependents

It is your responsibility to remove an ineligible dependent in a timely manner. If your spouse/domestic partner or child ceases to be eligible for benefits due to divorce, termination of a domestic partnership, if the child reaches the maximum age allowed under the plans, make sure to remove your dependent within 31 days of the date they became ineligible. Any claims incurred for an ineligible individual are your responsibility.

To enroll in CBRE group health plan coverage, you must initiate a Family Status Change (FSC) within 60 days from the date coverage terminates under the Medicaid or SCHIP plan or from the date you or your dependent child is determined eligible for state premium assistance.

Changes in Tobacco User Status

The supplemental life insurance premium for yourself or your spouse/domestic partner depends on the covered person's tobacco user status. Be sure to report any changes in tobacco user status immediately so that the premiums are accurately deducted from your paycheck.

Massachusetts Employees: Fair Share Contribution

The Commonwealth of Massachusetts generally requires that an employer with eleven or more full-time equivalent employees make a Fair and Reasonable Premium Contribution to full-time employees in Massachusetts. In most cases, to meet this requirement, an employer must offer to contribute at least 33 percent towards the premium of employer-sponsored group health plan offered to its full-time employees no more than 90 days after such employee's date of hire. CBRE meets and generally exceeds this requirement.

Open Enrollment

Open Enrollment is held annually during the fourth quarter and provides an opportunity for you to change your benefit elections for the next calendar year. Employees who do not change benefit elections during the Open Enrollment period will default to their existing coverage for the following calendar year, except for the Health Care and Dependent Care Flexible Spending Accounts and any plans that will no longer be offered in the next Plan Year. IRS regulations require employees to make active Flexible Spending Account elections each year.

MEDICAL PROGRAM

CBRE offers you a number of medical plan choices, each designed to meet a different set of needs. Below is a brief description of the plans available to you. The specific details of your medical coverage depend on the plan you select. You can refer to the Medical Plan Comparison Charts to learn more.

Medical Program Options

Your medical plan options depend on your state of residence as shown below. QREAs are not permitted to enroll in a plan with an HRA per IRS regulations:

Where You Live	Your Medical Plan Option(s):
Hawaii	University Health Alliance (UHA) PPO Kaiser HMO
Michigan	Blue Care HMO OAP with HAS Cigna Choice HRA Plan Cigna Enhanced HRA Plan Cigna Cigna Standard Plan Cigna Out-of Area (Indemnity) Plan (if no other medical plans are available)
Washington state	Cigna OAP with HSA Cigna Choice HRA Plan Cigna Enhanced HRA Plan Cigna Standard Plan Group Health Alliant Plus Plan (Point of Service-POS) Cigna Out-of-Area (Indemnity) Plan (if no other medical plans are available)
Pennsylvania	Keystone HDHP Plus (CCS Only) Cigna OAP with HAS Cigna Choice HRA Plan Cigna Enhanced HRA Plan Cigna Standard Plan Cigna Out-of-Area (Indemnity) Plan (if no other medical plans are available)
All other states	Cigna OAP with HSA Cigna Choice HRA Plan Cigna Enhanced HRA Plan Cigna Standard Plan Cigna Out-of-Area (Indemnity) Plan (if no other medical plans are available)

MEDICAL PROGRAM

Types of Medical Plans Offered

Preferred Provider Option (PPO)

CBRE offers four national PPO plans through Cigna, called the Open Access Plan (OAP) with Health Spending Account (HSA), Choice Health Reimbursement Account (HRA) Plan, Enhanced HRA Plan, and Standard Plan.

A PPO allows you to see the physician of your choice. With a PPO plan, you pay a deductible for most covered services before the plan begins paying a percentage of eligible charges. Your deductible and coinsurance amounts (your share of covered expenses) depend on whether you use in-network or out-of-network providers. You will pay less when you use providers from Cigna's Network Providers.

> Locating a Cigna Network Provider
>
> Go to www.cigna.com. Click on Find a Doctor.
>
> Click on type of provider you are researching (physician, hospital, facility/ancillary).
>
> Enter your ZIP code or your city and state, and then the number of miles you are willing to travel. On the next screen, click on Open Access Plus ONLY.

Key Features of the Standard Plan:

This plan is a traditional PPO with a mid-level deductible administered by Cigna. You pay a deductible for covered services before the plan begins paying a percentage of eligible charges. You can receive care in-network or out-of-network. You pay less when you use an in-network provider.

Key Features of the Choice HRA and Enhanced HRA Plans:

These plans combine either a low or a high deductible PPO medical plan and a company-funded health reimbursement account (HRA). Both components of the medical plan and HRA are administered by Cigna.

Here are the highlights of the HRA:

- The amount CBRE contributes to your account depends on your coverage level ($750 for single or $1,500 for family).
- You may not contribute to this account.
- The HRA amounts will be prorated for new hires based on the month of hire.
- As you incur covered medical expenses, the plan automatically deducts money from this account to help you pay for a portion of your deductible.
- You can have an HRA and participate in the Health Care Flexible Spending Account (FSA). Your HRA account must be used first before your FSA can reimburse eligible medical expenses, so be sure to keep this in mind when calculating how much to set aside in your Health Care FSA. This does not apply to expenses eligible under the FSA but not eligible under the medical plan.

Key Features of the Open Access Plus (HSA)

There are two components of this plan: the high deductible plan, which is administered by Cigna, and the Health Savings Account (HSA), which is maintained by Bank of America.

If you enroll in the HSA, the Cigna OAP with HSA plan must be your only medical plan. You or your dependent cannot be enrolled in another medical plan, including Medicare or your spouse/domestic partner's employer's medical plan or participate in a Health Care Flexible Spending Account (FSA), except a limited FSA, which is not offered by CBRE.

Please note the OAP with HSA Plan is designed for those individuals who can afford the high deductible. You must make an annual contribution each Open Enrollment.

How HRAs and HSAs Differ

Upon enrollment in the OAP with HSA Plan, an HSA account will be opened in your name automatically through Bank of America. You save money in your HSA to pay for future covered medical expenses via pre-tax payroll contributions. Here are the highlights:

Each year, you can contribute up to IRS regulatory limits for contributions to an HSA. For 2014, the limits are $3,300 for self-only coverage and $6,550 for family coverage, including the company contribution of $250/$500. If you will be least age 55 by December 30, 2014, you can contribute an additional $1,000 on a pre-tax basis.

The money in your HSA earns tax-free interest. Investment options become available once the HSA reaches a $1,000 balance. You will have a choice of investment options. Investment earnings also grow tax-free. (Please consult your tax advisor for potential tax liability with your specific state.)

The money in your HSA remains tax-free when you use it to pay for eligible medical expenses. Money in your HSA can be withdrawn for ineligible expenses; however, regular taxes and a 10% penalty will apply.

Any unused balance in your Bank of America HSA will roll over from year to year—even if you choose not to re-enroll in the Open Access Plus (HSA) plan. When you leave CBRE, your HSA remains open with Bank of America and you can still access your HSA funds or transfer your account balance to another qualified HSA.

While you participate in the OAP with HSA as a CBRE employee, CBRE pays the monthly administration fee for your HSA. Other nominal fees may apply for certain transactions as outlined in the Bank of America information packet provided to new plan participants.

CBRE will "Fund" the HSA each year with a contribution of $250 for employee coverage and $500 employee+ dependent coverage. The amounts will be prorated for new hires based on the month of hire.

MEDICAL PROGRAM

Key Features	Choice HRA Plan/ Enhanced HRA Plan	OAP with HSA Plan
Participation in Other Medical Plans	You can participate in other medical plans, including a Health Care Flexible Spending Account, at the same time.	You may not participate in another medical plan at the same time, including your spouse/domestic partner's employer's plan, Medicare, or any Health Care Flexible Spending Account.
Account Set-Up	HRA is established automatically through Cigna when you enroll.	HSA is established automatically with Bank of America when you enroll.
Who Contributes?	CBRE funds the HRA: $750 for employee only coverage or $1,500 if you enroll dependents. You may not contribute to the HRA account.	CBRE funds the HSA: $250 for employee only coverage or $500 if you enroll dependents. You contribute on a pre-tax basis (commission employees classified as QREAs deduct the contributions from their gross income): Up to $3,300 for employee-only coverage or up to $6,550 if you enroll dependents, less the company contribution of $250/$500. If you will attain age 55 by December 31, 2014, you can contribute another $1,000 on a pretax basis.
Interest Earnings	None.	Your Bank of America account earns tax-free interest (state taxes may apply); you have investment choices once the account balance reaches $1,000.
Using the Money in Your Account	When you incur a medical expense, HRA dollars are used *first* to help you satisfy the deductible.	When you incur a medical expense, you may pay from your HSA account for the expense or save that money to pay future health care expenses. Money can be used for non-medical expenses; however, income and penalty taxes will apply.
Debit Card Feature	Available for Rx purchases only.	Available .
Unused Account Balance	Account balance rolls over from year-to-year provided you continue to participate in one of the HRA medical plan options. However, the balance does not go with you when you leave CBRE.	Account balance rolls over from year to year and does not require you to stay in the Open Access Plus (HSA). You can maintain your HSA account with Bank of America after you leave CBRE.
Administration Fees	Administered by Cigna. You pay no separate fees for the HRA account other than your payroll deductions for the plan.	CBRE pays monthly administration fees while you are an employee; you may have nominal transaction fees charged by Bank of America.
PPO Plan Differences		
Annual Deductible	HRA dollars will be used to help meet the deductible provided the expenses are eligible under the medical plan.	You choose whether or not to use your HSA dollars to meet some or all of the deductible.
Benefit Levels	After the deductible, plan pays 80% in-network and 60% out-of-network.	After the deductible, plan pays 80% in-network and 60% out-of-network.
Prescription Drugs	Deductible does not apply.	Deductible applies before the plan begins to pay for prescriptions.
Annual Out-of-Pocket Limit	Separate out-of-pocket limit for network and non-network expenses.	Combined out-of-pocket limit for network and non-network expenses.

MEDICAL PROGRAM

Cigna STANDARD PLAN – Available nationwide

These are summaries of the plans offered by CBRE and are subject to the terms and conditions of the actual contracts. In case of conflict, the terms and conditions of the contracts apply.

CIGNA STANDARD PLAN		
BENEFIT	Network Providers	Non-Network Providers
Choice of physician	Any physician in Cigna's Open Access Plus network	Any non-network physician (you pay less if you see a network physician)
Eligible charges	Based on negotiated network fees	Based on reasonable & customary (R&C) charges as defined by Cigna
Annual deductible	Combined network and non-network: $750/person; $1,500/family	
Annual out-of-pocket maximum – medical	Combined network and non-network: $5,000/person; $10,000/family (excluding annual deductible and prescription drug co-insurance)	
Annual out-of-pocket maximum – prescription	Combined retail and mail order (network and non-network): $1,200/person; $2,400/ family	
Office visit	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Preventive care	Plan pays 100% (no deductible)	Plan pays 100% (no deductible) up to $250; thereafter, Plan pays 60% after deductible
Maternity care	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Non-hospital lab/X-ray	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Hospital benefits		
Inpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Outpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Emergency room visit	After deductible, Plan pays 80%	After deductible, Plan pays 80%
Skilled nursing facility	After deductible, Plan pays 80%, up to 120 days/year	After deductible, Plan pays 60%, up to 120 days/year
Home health care	After deductible, Plan pays 80%, up to 240 days/year (combined network/non-network)	After deductible, Plan pays 60%, up to 240 days/year (combined network/non-network)
Physical therapy – outpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Pharmacy Deductible	$50/person, $100/family (aggregate)	$50/person, $100/family (aggregate)
Prescription drugs – retail(30-day supply)	After pharmacy deductible Plan pays 70% for generic; 65% for preferred brand; 50% for non-formulary (provided by CVS Caremark Pharmacy)	After pharmacy deductible Plan pays, 60% for generic; 60% for preferred brand; 50% for non-formulary brand
Prescription drugs – mail order (90-day supply)	Deductible does not apply Plan pays 70% for generic; 65% for brand; 50% for non-formulary	Not covered
Mental health/Substance abuse (MH/SA)		
Inpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Outpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Lifetime maximum	Unlimited	Unlimited

Cigna Choice HRA plan – Available Nationwide

These are summaries of the plans offered by CBRE and are subject to the terms and conditions of the actual contracts. In case of conflict, the terms and conditions of the contracts apply.

CIGNA CHOICE HRA PLAN		
Benefit	Network Providers	Non-Network Providers
Choice of physician	Any physician in Cigna's Open Access Plus Network	Any non-network physician (you pay less if you see a network physician)
Health Reimbursement Account (HRA)	CBRE contributes $750 for "employee only" coverage or $1,500 for "employee+ spouse/domestic partner," or "employee + child(ren)," or "employee + spouse/domestic partner and child(ren)" coverage**	
Eligible charges	Based on negotiated network fees	Based on reasonable & customary (R&C) charges as defined by Cigna
Annual deductible	Combined network and non-network: $2,250/ person; $4,500/ family	
Annual out-of-pocket maximum- medical	$4,000/person; $8,000/family (excluding annual deductible and prescription drug copays)	$9,000/person; $18,000/family (excluding annual deductible and prescription drug co-insurance)
Annual out-of-pocket maximum- prescription	Combined retail and mail order (network and non-network): $1,200/person; $2,400/family)	
Office visit	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Preventive care	Plan pays 100% (no deductible)	Plan pays 100% (no deductible) up to $250; thereafter, Plan pays 60% after deductible (HRA may be used to offset the deductible)
Maternity Care	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Non-hospital lab/X-ray	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Hospital benefits Inpatient Outpatient	 After deductible, Plan pays 80% After deductible, Plan pays 80%	 After deductible, Plan pays 60% After deductible, Plan pays 60%
Emergency room visit	After deductible, Plan pays 80%	After deductible, Plan pays 80%
Skilled nursing facility	After deductible, Plan pays 80%, up to 120 days/year	After deductible, Plan pays 60%, up to 120 days/year
Home health care	After deductible, Plan pays 80% up to 240 days/year (combined network/non-network)	After deductible, Plan pays 60% up to 240 days/year (combined network/non-network)
Physical therapy outpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Prescription drugs- retail+ (30-day supply)	Deductible does not apply Plan pays 70% for generic; 65% for preferred brand; 50% for non-formulary	Deductible does not apply Plan pays 60% for generic; 60% for preferred brand; 50% for non-formulary brand
Prescription drugs- mail order (90-day supply)	Deductible does not apply Plan pays 70% for generic; 65% for brand; 50% for non-formulary	Not covered
Mental health/Substance abuse (MH/SA) Inpatient Outpatient	 After deductible, Plan pays 80% After deductible, Plan pays 80%	 After deductible, Plan pays 60% After deductible, Plan pays 60%
Lifetime Maximum	Unlimited	Unlimited

Cigna Enhanced HRA Plan – available nationwide

These are summaries of the plans offered by CBRE and are subject to the terms and conditions of the actual contracts. In case of conflict, the terms and conditions of the contracts apply.

	CIGNA ENHANCED HRA PLAN	
BENEFIT	Network Providers	Non-Network Providers
Choice of physician	Any physician in Cigna's Open Access Plus network	Any non-network physician (you pay less if you see a network physician)
Health Reimbursement Account (HRA)	CBRE contributes $750 for "employee only" coverage or $1,500 for "employee + spouse/domestic partner", or "employee + child(ren)", or "employee + spouse/domestic partner and child(ren)" coverage**	
Eligible charges	Based on negotiated network fees	Based on reasonable & customary (R&C) charges as defined by Cigna
Annual deductible	Combined network and non-network: $1,500/person; $3,000/family	
Annual out-of-pocket maximum – medical	$3,000/person; $6,000/family (excluding annual deductible and prescription drug copays)	$6,000/person; $12,000/family (excluding annual deductible and prescription drug co-insurance)
Annual out-of-pocket maximum – prescription	Combined retail and mail order (network and non-network): $1,200/person; $2,400/ family	
Office visit	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Preventive care	Plan pays 100% (no deductible)	Plan pays 100% (no deductible) up to $250; thereafter, Plan pays 60% after deductible (HRA may be used to offset the deductible)
Maternity care	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Non-hospital lab/X-ray	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Hospital benefits		
Inpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Outpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Emergency room visit	After deductible, Plan pays 80%	After deductible, Plan pays 80%
Skilled nursing facility	After deductible, Plan pays 80%, up to 120 days/year	After deductible, Plan pays 60%, up to 120 days/year
Home health care	After deductible, Plan pays 80%, up to 240 days/year (combined network/non-network)	After deductible, Plan pays 60%, up to 240 days/year (combined network/non-network)
Physical therapy – outpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Prescription drugs – retail (30-day supply)	Deductible does not apply Plan pays 70% for generic; 65% for preferred brand; 50% for non-formulary (provided by CVS Caremark Pharmacy)	Deductible does not apply Plan pays, 60% for generic; 60% for preferred brand; 50% for non-formulary brand
Prescription drugs – mail order (90-day supply)	Deductible does not apply Plan pays 70% for generic; 65% for brand; 50% for non-formulary	Not covered
Mental health/Substance abuse (MH/SA)		
Inpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Outpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Lifetime maximum	Unlimited	Unlimited

Cigna OAP with HSA Plan – available nationwide

These are summaries of the plans offered by CBRE and are subject to the terms and conditions of the actual contracts. In case of conflict, the terms and conditions of the contracts apply.

	CIGNA OAP WITH HSA PLAN	
BENEFIT	Network Providers	Non-Network Providers
Choice of physician	Any physician in Cigna's Open Access Plus network	Any non-network physician (you pay less if you see a network physician)
Health Savings Account (HSA)	You can contribute to your HSA up to $3,300 if you elect "employee only" coverage or $6,550 if you elect "employee + spouse/domestic partner", employee + child(ren), or "employee + spouse/domestic partner and child(ren)" coverage CBRE contributes $250 for "employee only" coverage or $500 for "employee + spouse/domestic partner", or "employee + child(ren)", or "employee + spouse/domestic partner and child(ren)" coverage (pro-rated for new hires) (Contributions are pre-tax unless you are a QREA) If you will attain age 55 by December 31, 2014, you may also contribute an additional $1,000 on a pre-tax basis. You must make an annual contribution amount each Open Enrollment.	
Eligible charges	Based on negotiated network fees	Based on reasonable & customary (R&C) charges as defined by Cigna
Annual deductible	Combined network and non-network: $3,000/person; $6,000/family	
Annual out-of-pocket maximum	$6,000/person, up to $12,000 family maximum (in- and non-network combined, includes annual deductible)	
Office visit	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Preventive care	Plan pays 100% (no deductible)	Plan pays 100% (no deductible) up to $250; thereafter, Plan pays 60% after deductible
Maternity care	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Non-hospital lab/X-ray	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Hospital benefits		
Inpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Outpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Emergency room visit	After deductible, Plan pays 80%	After deductible, Plan pays 80%
Skilled nursing facility	After deductible, Plan pays 80%, up to 120 days/year	After deductible, Plan pays 60%, up to 120 days/year
Home health care	After deductible, Plan pays 80%, up to 240 days/year (combined network/non-network)	After deductible, Plan pays 60%, up to 240 days/year (combined network/non-network)
Physical therapy – outpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Prescription drugs – retail* (30-day supply)	After deductible… Plan pays 70% for generic; 65% for preferred brand; 50% for nonformulary (provided by CVS Caremark)	After deductible… Plan pays, 60% for generic; 60% for preferred brand; 50% for nonformulary brand
Prescription drugs – mail order (90-day supply)	After deductible… Plan pays 70% for generic; 65% for brand; 50% for nonformulary	Not covered
Mental health/Substance abuse (MH/SA)		
Inpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Outpatient	After deductible, Plan pays 80%	After deductible, Plan pays 60%
Lifetime maximum	Unlimited	Unlimited

Cigna Out-of-Area Plan

These are summaries of the plans offered by CBRE and are subject to the terms and conditions of the actual contracts. In case of conflict, the terms and conditions of the contracts apply.

Benefits	Cigna Out-of-Area Plan
Choice of physician	Any physician
Eligible charges	Based on reasonable & customary (R&C) charges
Annual deductible – medical	$400/person; $800/family
Annual deductible – prescription	$50/person; $100/family
Annual out-of-pocket maximum – medical	$5,000/person; $10,000/family (includes annual deductible)
Annual out-of-pocket maximum – prescription	None
Office visit	After deductible, Plan pays 80%
Office visit – Specialist	After deductible, Plan pays 80%
Preventive care	Plan pays 100%, no deductible
Maternity care (Outpatient)	After deductible, Plan pays 80%
Non-hospital lab/X-ray	After deductible, Plan pays 80%
Hospital benefits	
Inpatient	After deductible, Plan pays 80%
Outpatient	After deductible, Plan pays 80%
Emergency room visit	After deductible, Plan pays 80%
Urgent Care Facility Visit	After deductible, Plan pays 80%
Skilled nursing facility	After deductible, Plan pays 80%, up to 120 days/year
Home health care	After deductible, Plan pays 80%, up to 240 days/year
Physical therapy – outpatient	After deductible, Plan pays 80%
Prescription drugs – retail* (30-day supply) (provided by CVS Caremark)	After prescription drug deductible, Plan pays 80%
Prescription drugs – mail order (90-day supply)	After prescription drug deductible, Plan pays 80%
Mental health/Substance abuse (MH/SA)	
Inpatient	After deductible, Plan pays 80%
Outpatient	After deductible, Plan pays 80%
Lifetime maximum	Unlimited

MEDICAL PROGRAM

Regional Plans

These are summaries of the plans offered by CBRE and are subject to the terms and conditions of the actual contracts. In case of conflict, the terms and conditions of the contracts apply.

Benefits	Blue Care HMO (Michigan only)	Group Health Alliant Plus (Washington only)	
		Network Providers	Non-Network Providers
Choice of physician	Any Blue Care network provider	Choice of network or non-network provider	
Eligible charges	Based on negotiated network fees	Based on negotiated fees	Based on usual, customary and reasonable (UCR) charges
Annual deductible	None	None	$200/person; $400/family
Annual out-of-pocket maximum	$6,350/person; $12,700/family	$2,000/person; $4,000/family (excludes prescription drug and mental health/substance abuse treatment premiums)	
Office visits	Plan pays 100% after you pay $15 copay	Plan pays 100% after you pay $15 copay	Plan pays 80% after you pay $15 copay and deductible
Preventive care	Plan pays 100%	Plan pays 100%	Plan pays 80% after you pay deductible, up to annual benefit of $150/person ($300/family)
Maternity care	Plan pays 100% after you pay $15 copay/ office visit (hospital copay applies to delivery)	Covered like any other covered service	
Outpatient lab and X-ray	Plan pays 100% (office visit copay may apply)	Plan pays 100%	Plan pays 80% after deductible
Hospital benefits			
Inpatient	Plan pays 100% after you pay $250 copay/ admission	Plan pays 100%	Plan pays 80% after deductible
Outpatient	Plan pays 100%	Plan pays 100% after $15 copay	Plan pays 80% after you pay $15 copay and deductible
Emergency room visit	Plan pays 100% after you pay $50 copay (network or non-network)	Plan pays 100% after $75 copay per emergency room visit (waived if admitted)	Plan pays 100% after $75 copay per emergency room visit (waived if admitted)
Skilled nursing facility	Plan pays 100%, up to 45 days/year	Plan pays 100%, up to 60 days/year (combined in- and out-of-network)	Plan pays 80% after deductible, up to 60 days/year (combined in- and out-of-network)
Home health care	Plan pays 100% after you pay $15 copay/visit	Plan pays 100%	Plan pays 80% after deductible
Physical therapy – outpatient	Plan pays 100% after you pay $15 copay, up to 60 consecutive days/ episode	Plan pays 100% after $15 copay/visit, up to 60 visits/year (combined in- and out-of-network)	Plan pays 80% after you pay $15 copay and deductible, up to 60 visits/year (combined in- and out-of-network)
Prescription drugs – retail (30-day supply)	Plan pays 100% after you pay $5 copay for generic, $15 copay for brand (if no generic), $15 copay + premiums difference between brand and generic; $25 copay for non-formulary brand	Plan pays 100% after you pay $10 copay for generic, $20 copay for brand, $40 non-formulary	Plan pays 100% after you pay $15 copay for generic, $25 copay for brand, $45 non-formulary
Prescription drugs – mail order (90-day supply)	Plan pays 100% after you pay $5 copay for generic, $15 copay for brand (if no generic), $25 copay for non-formulary brand	Plan pays 100% after you pay $30 generic, $60 brand, $90 non-formulary	Not available
Mental health and substance abuse			
Inpatient	Plan pays 100%	Plan pays 100%	Plan pays 80% after deductible
Outpatient	Plan pays 50%	Plan pays 100% after $15	Plan pays 80% after $15 copay
Lifetime maximum	Unlimited	Unlimited	

Medical Plan Options – Hawaii

These are summaries of the plans offered by CBRE and are subject to the terms and conditions of the actual contracts. In case of conflict, the terms and conditions of the contracts apply.

Benefits	Kaiser - Hawaii	UHA PPO – Hawaii	
		Network Providers	Non-Network Providers
Choice of physician	You may choose any primary care physician in the Kaiser network	Choice of network or non-network provider	
Eligible charges	Based on negotiated network fees	Based on negotiated network fees	Based on usual, customary and reasonable (UCR) charges
Annual deductible	None	None	
Annual out-of-pocket maximum	$2,000/person; $6,000/family	Combined network and non-network: $2,500/person; $7,500/family	
Office visits	You pay $15 registration fee	Plan pays 90%	Plan pays 70%
Preventive care	Plan pays 100%	Plan pays 100%	Plan pays 70%
Maternity care	Plan pays 100% after confirmation of pregnancy	Physician/Hospital: Plan pays 90% Birthing room: Plan pays 100% Nurse-Midwife: Plan pays 100%	Plan pays 70%
Outpatient lab and X-ray	Plan pays 90%	Plan pays 80%	Plan pays 70%
Hospital benefits			
Inpatient	Plan pays 100%	Plan pays 90%	Plan pays 70%
Outpatient	Plan pays 100% after you pay $15 registration fee	Plan pays 90%	Plan pays 70%
Emergency room visit	Plan pays 100% after $75 copay	Plan pays 90%	Plan pays 70%
Skilled nursing facility	Plan pays 100% up to 60 days/ benefit period	Plan pays 90%, up to 120 days/year combined in- and out-of-network benefit	Plan pays 70%, up to 120 days/year combined in- and out-of-network benefit
Home health care	Requires pre-approval by treating physician	Plan pays 100%, up to 150 visits/year combined in- and out-of-network benefit	Plan pays 70%, up to 150 days/year combined in- and out-of-network benefit
Physical therapy – outpatient	Plan pays 100% after you pay $15 registration fee	Plan pays 90%	Plan pays 70%
Prescription drugs – retail (30-day supply)	Plan pays 100% after you pay $12 copay; Plan pays 50% for contraceptive drugs and devices	Plan pays 100% after you pay $7 copay for generic, $15 copay for preferred brand, and $30 copay for nonpreferred brand	Not covered
Prescription drugs – mail order (90-day supply)	Plan pays 100% after you pay $24 copay	Maintenance drugs only through Longs Drugstore: Generic: Plan pays 100% after you pay $7 copay (90-day supply) Preferred brand: $15 copay (60-day supply) Non preferred brand: Not covered	
Mental health and substance abuse			
Inpatient	Plan pays 80%	Plan pays 90%	Plan pays 70%
Outpatient	Plan pays 80% of R&C	Plan pays 90% (80% for psychological testing)	Plan pays 70%
Lifetime maximum	Unlimited	Unlimited	

BENEFIT PREMIUMS

2014 MONTHLY BENEFIT PREMIUMS

For Salaried, Hourly and Commissioned Employees Who Receive a W-2

Per the below model, employee medical premiums will continue to be tiered into three bands, based on the employee's annual benefits rate (ABR). ABR includes base salary/regular hourly pay, overtime, bonuses and commissions. Employees in the higher ABR band will pay more in medical premiums than employees in the lower ABR bands. CBRE's 2014 ABR bands are:

- Less than $50,000.00
- $50,000.00 to $100,000.00
- Greater than $100,000.00

Employee Monthly Premium Band One (Less than $50,000.00)				
	Employee Only	EE+Spouse	EE+(Child)ren	EE+Spouse+ Children
Cigna OAP with HSA	$99.00	$177.00	$174.00	$284.00
Cigna Choice HRA	$109.00	$210.00	$200.00	$345.00
Cigna Enhanced HRA	$152.00	$324.00	$307.00	$551.00
Cigna Standard	$201.00	$442.00	$405.00	$717.00
Cigna Out of Area	$161.00	$364.00	$334.00	$583.00

Employee Monthly Premium Band Two ($50,000.00 to $100,000)				
	Employee Only	EE+Spouse	EE+(Child)ren	EE+Spouse+ Children
Cigna OAP with HSA	$103.00	$188.00	$183.00	$303.00
Cigna Choice HRA	$113.00	$223.00	$212.00	$368.00
Cigna Enhanced HRA	$160.00	$345.00	$327.00	$591.00
Cigna Standard	$213.00	$474.00	$434.00	$771.00
Cigna Out of Area	$170.00	$389.00	$357.00	$626.00

Employee Monthly Premium Band Three (Greater than $100,000.00)				
	Employee Only	EE+Spouse	EE+ (Child)ren	EE+Spouse+ Children
Cigna OAP with HSA	$107.00	$ 198.00	$193.00	$322.00
Cigna Choice HRA	$118.00	$235.00	$224.00	$391.00
Cigna Enhanced HRA	$168.00	$366.00	$347.00	$632.00
Cigna Standard	$225.00	$506.00	$462.00	$825.00
Cigna Out of Area	$178.00	$414.00	$381.00	$670.00

BENEFIT PREMIUMS

2014 MONTHLY BENEFIT PREMIUMS

For Salaried, Hourly and Commissioned Employees Who Receive a W-2

Employee Monthly Premium				
	Employee Only	EE+Spouse	EE+ (Child)ren	EE+Spouse+ Children
Blue Care HMO (MI)	$246.00	$592.00	$565.00	$798.00
Group Health Alliance Plus Plan (WA)	$285.00	$535.00	$512.00	$794.00
University Health Alliance (UHA) PPO – Hawaii**	$211.00**	$488.00	$426.00	$754.00
Kaiser – Hawaii**	$76.00**	$327.00	$301.00	$434.00

All premiums are quoted as monthly amounts. Your actual payroll deductions may differ based on your pay group and/or pay frequency. (Salaried/Hourly employees have 24 payroll deductions per year and Commissioned Employees who receive a W-2 have one payroll deduction per month.)

**Pursuant to Hawaii Prepaid Health Care Law, if the premium for Employee Only (EO) is less than 1.5% times ABR, than the employees pay the premium above. If the premiums for EO is greater than 1.5% times ABR, then the employees pays 1.5% times ABR.

BENEFIT PREMIUMS

Determining Your Annual Benefit Salary for 2014

Your basic benefit rate (BBR) is determined differently than your annual base salary, and is different from your annual benefits rate (ABR).Your BBR is used to calculate insurance premiums for basic life insurance. Your ABR is used to calculate coverage amounts for your supplemental life, supplemental AD&D, short- and long-term disability coverage and Cigna medical premium banding. Your ABR is established at the end of September, is effective the first day of the following year, and will not change if your compensation increases or decreases during that year. The following two tables indicate how BBR and ABR are determined.

2014 Basic Benefits Rate (used for Basic Life Insurance only)

	Employees classified as hourly or salaried	Employees classified as commissioned
Hired before October 1, 2012	Eligible salary* as of 09/30/13	Greater of: Average of the annual sum of commissions paid during the period from 10/01/11 through 09/30/13, or $100,000
Hired on or after October 1, 2012	Eligible salary* as of 09/30/13 or as of hire date if hire date is after 09/30/13	Greater of: Sum of commission paid during the period from 10/01/12 through 09/30/13, or $100,000

*Eligible salary includes annual base salary rate or annualized regular rate of pay for hourly employees.

2014 Annual Benefits Rate (ABR)

(used for Supplemental Life Insurance, Supplemental Accidental Death & Dismemberment (AD&D), Short Term Disability (STD), Long Term Disability (LTD) and Cigna Medical Premium Banding)

	Employees classified as hourly or salaried	Employees classified as commissioned
Hired before October 1, 2012	Eligible earnings** paid during the period from 10/01/12 through 09/30/13, or Eligible salary (defined in prior table) as of 9/30/13	Greater of: Average of the sum of eligible earnings** paid during the period from 10/01/11 through 09/30/13; or $100,000
Hired on or after October 1, 2012	Greater of: Eligible earnings paid during the period from 10/01/12 through 09/30/13, or Eligible salary (defined in prior table) as of 09/30/13 or as of hire date if hire date is after 09/30/13	Greater of: Sum of eligible earnings** paid during the period from 10/01/12 through 09/30/13, or $100,000

PRESCRIPTION BENEFITS

Prescription Benefit Plan

CBRE's prescription benefit plan is administered by CVS Caremark. If you are enrolled in any Cigna plan (except International), you will automatically be enrolled in the corresponding CVS Caremark prescription plan. Prescription plan coverage information is provided in Exhibit 1 Medical Plan Comparison. Your prescription plan offers two ways to get your medication:

Retail network (short-term medications)

Use a participating retail pharmacy when filling short-term prescriptions for medication such as antibiotics. CVS Caremark networks include more than 64,000 pharmacies nationwide, including chain pharmacies and 20,000 independent pharmacies.

Mail service pharmacy (long-term medications)

Use the CVS Caremark Mail Service Pharmacy to fill your long-term prescriptions. Mail service is a cost- effective choice for long-term medications because you can get up to a 90-day supply for less than what you would pay for the same supply at retail.

Maintenance Choice®

Maintenance Choice® lets you choose how to get long-term medications; through mail service or at a CVS/pharmacy store. Either way, you pay mail service prices. Long-term medications are those medications you take regularly for chronic conditions such as high blood pressure, asthma, diabetes or high cholesterol. You will generally save money by using mail service for these prescriptions. You have two ways to save:

- CVS Caremark Mail Service Pharmacy – medications delivered to you by mail
- CVS pharmacy – pick up prescription from one of the 7,100 CVS pharmacy locations

ExtraCare® Health Card

The Extracare® Health Card provides you and your family with a 20% discount on CVS Brand health- related products, from cough and cold medication to pain and allergy relief.

Caremark.com is an easy way to make the most of your prescription benefits:

- View and print your temporary prescription benefit card
- Sign up for automatic refills and renewals
- Find Savings and Opportunities to explore lower-premium options
- Sign up to receive notifications by email, phone or text message
- Access the latest health and wellness information

If you have questions, you can contact CVS Caremark at www.caremark.com or 855-299-3258

WELLNESS PROGRAM

myHealth
Invest in You

The CBRE Wellness Program, myHealth, is designed to help you manage your health and well-being. You will have access to a wealth of information to make healthier lifestyle choices or manage an ongoing condition. There are online plans to help you meet your fitness, nutrition, tobacco cessation, stress, and/or weight management needs. Well-Being Connect www.myhealth.cbre.com is the online portal to access all of the program's resources at your fingertips, you will find access to an abundance of health education, news and tools associated with exercise, nutrition, health risk awareness, and much more. You can access additional myHealth information on the Navigator.

The program offers a medical premium reduction to eligible employees who complete certain steps by the deadlines :

- Complete a Biometric Screening and the Well-Being Assessment to receive one-third of the medical premium reduction ($200 annually prorated).
- If your Biometric Screening does NOT indicate high-risk results, you will receive the additional two-thirds of the medical premium reduction ($400 annually prorated) without completing Health Coaching.
- If your Biometric Screening indicates high-risk results, you can complete 3-5 Healthways Health Coaching sessions between October 1, 2013 - May 31, 2014, to earn the additional two-thirds of the medical premium reduction ($400 annually prorated). **Your personal health information will not be shared, see p.32**

Medical Premium Reduction Details

If your Biometric Screening does NOT indicate high-risk results, your medical premium reduction will be $50 per month beginning in January 2014.

Pay Period	Reduction Per Pay Period
Weekly	$12.50
Bi-Weekly	$25
Monthly	$50

If your Biometric Screening indicates high-risk results, your medical premium reduction will be $16.67 per month beginning in January 2014 until Health Coaching is completed.

Pay Period	Reduction Per Pay Period
Weekly	$4.17
Bi-Weekly	$8.34
Monthly	$16.67

Approximately 30-45 days after completing Health Coaching, you will receive a lump sum medical premium reduction retroactive to January 2014. Going forward, your medical premium reduction will be $50 per month

Eligibility

All benefit-eligible employees participating in a CBRE medical plan (excluding CCS and QREAs) are eligible to receive a medical premium reduction beginning in January 2014 after completing the Biometric Screening, Well-Being Assessment and Health Coaching sessions, if needed, during the allotted timeframes. QREAs are eligible to participate in all wellness activities but not eligible for the pre-tax medical premium reduction.

Newly Eligible

If you are a new hire/rehire/have a status change between September 2- December 1, 2013, you will have 30 days from your benefits eligibility date to complete the Biometric Screening and Well-Being Assessment. You will have until May 31, 2014, to complete 3 – 5 Healthways Health Coaching sessions if needed.

If you are a new hire/rehire/have a status change as of December 2, 2013, you will have 60 days from your benefits eligibility date to complete the Biometric Screening and Well-Being Assessment. You will not need to complete Health Coaching sessions to earn the medical premium reduction. The premium reduction will begin within 60-90 days after your submission of both the Biometric Screening and the Well-Being Assessment. It could

be longer depending on how long it takes you to submit your information to the medical plan.

Deadlines

Biometric Screening: October 15, 2013
Well-Being Assessment: October 30, 2013
Health Coaching: May 31, 2014

Please note that the Biometric Screening and Well-Being Assessment deadlines do not apply to newly eligible employees as defined earlier.

Biometric Screening

The Biometric Screening includes a finger stick for blood sample collection, and is an excellent opportunity to know key facts about your health—like your blood pressure, cholesterol, waist circumference and blood sugar—and what they mean for you. Provant is our Biometric Screening vendor.

If your Biometric Screening indicates high-risk results (below, in orange), you will need to complete 3-5 Healthways Health Coaching sessions in order to earn the additional medical premium reduction.

Biometric Optimal Health Range Charts

Total Cholesterol	Value
Optimal	<200 mg/dL
Moderate Risk	200-239 mg/dL
High Risk	≥240 mg/dL

Cotinine (tobacco)
Negative - Non-Tobacco User
Positive - Tobacco User

Blood Pressure	Systolic (mm Hg)		Diastolic (mm Hg)
Optimal	<120	*and*	<80
Pre-Hypertension	120-139	*or*	80-89
Stage 1 Hypertension	140-159	*or*	90-99
Stage 2 Hypertension	≥160	*or*	≥100

Body Mass Index (BMI)	Weight Status
Below 18.5 kg/m²	Underweight
18.5 - 24.9 kg/m²	Normal
25.0- 29.9 kg/m²	Overweight
30.0 kg/m² and above	Obese

* Optimal values are supported by the National Institute of Health; National Heart, Lung and Blood Institute

Newly Eligible:

- If you have had a preventative exam in the past 12 months you can have your physician complete a Biometric Screening Results form. Additional information can also be found at http://provantevents.com/CBRE.
- If you have not had a preventative exam in the past 12 months you may request a lab screening kit from Provant by calling 1.877.BEWELL7.
- If you are a new hire/rehire/have a status change as of December 2, 2013, you will not need to complete Health Coaching to earn the medical premium reduction.

WELLNESS PROGRAM

Well-Being Assessment (WBA)

The Well-Being Assessment is an online survey about your health that can alert you if you are at risk for certain health issues. The Well-Being Assessment lets you notify your doctor of your risk factors so together you can develop an early prevention or treatment plan. Information you provide is kept confidential, as required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Healthways is our Well-Being Assessment vendor.

Newly Eligible:

- You should complete the Well-Being Assessment at http://www.myhealthcbre.com/ as soon as you have access to enroll in benefits.

Health Coaching

Depending on the program you participate in, the support and guidance you receive from a coach may include:

- Controlling conditions such as high blood pressure, diabetes, and high cholesterol
- Setting specific goals for weight control, physical activity, & nutrition, in to lower risks
- Learning and practicing new behaviors to help support goals
- Tracking your progress as you go

Every improvement, large or small, is a step in a positive direction that may lower your risk of having costly, bothersome health problems and give you more time to enjoy a fuller life. Health

Coaching is a confidential resource that is available at no cost to you if you qualify. Your participation is voluntary.

To earn the additional medical premium reduction: If your Biometric Screening indicates high-risk results, you will need to complete three Health Coaching sessions if your high-risk area(s) is/are Total Cholesterol, Blood Pressure or BMI. You will need to complete five Health Coaching sessions if you tested positive for tobacco use. The deadline to complete Health Coaching is May 31, 2014.

You can sign up by calling (866) 556.4707. A Healthways Health Coach will also call you starting November 14 if you are eligible to participate in Health Coaching.

Note: If you are a new hire/rehire/have a status change as of December 2, 2013, you will not need to complete Health Coaching to earn the medical premium reduction.

Sweepstakes

Each quarter, employees who log into Well-Being Connect and participate in the activities shown below will be entered for a chance to win a prize in our drawing! There will be multiple winners each quarter. Look for more details coming to your inbox each quarter, and be sure you complete the activities in time to be entered. QREAs are eligible to participate in sweepstakes.

	Activity	Timeframe	Prize
Ready, Set, Go!	Complete WBA and Well-Being Plan	10/1/13-12/31/13	Fitbit
Keep it Going!	Complete 24 approved Well-Being Action Items	1/1/14-3/31/14	$300 Gift Card
Getting Stronger	Update Life Style Profile & Biometrics	4/1/14-6/30/14	FitBit Personal Activity Tracker and FitBit Aria Scale
Home Stretch	Qualify for Sweepstakes 1, 2, 3 (in 2014) and Complete 16 Action Items from your Action Plan in Well-Being Connect	7/1/14-8/31/14	$500 Gift Card

Click here to view the sweepstakes map.

Disease Management Programs

The medical plans all offer disease management programs and you can find more information about non-Cigna plans on your plan's website.

The **Cigna Well Aware Disease Management Program** is available to **all** Cigna plan participants. This program will assist those plan participants who are being treated for asthma, heart disease, chronic obstructive pulmonary disease (COPD), diabetes or low back pain. The program is designed to help plan participants manage their conditions through personalized phone support, education tools and periodic health reminders provided by highly trained health professionals. There are a few ways in which you can access one of these disease management programs: Self-refer via the toll-free number on the Cigna ID card. Your physician can contact Cigna to refer you.

Protecting Your Privacy

Your personal health information is important and should be kept confidential. That is why CBRE, Healthways and Provant have a strict policy in place to protect your privacy rights. All personal health information that you share through the myHealth **support services will remain confidential and will only be used as permitted by law. Please take advantage of the well-being improvement tools and support that are available to you, confident that your personal information is private and safeguarded from unauthorized access.**

Is My Privacy Protected?

Yes. Healthways and Provant protect the confidentiality of your information, in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which prohibits anyone from receiving your personal health information without your permission. Healthways and Provant may provide CBRE with collective data about its population as a whole, but not any individual health information unless you consent to provide. Healthways and Provant do not sell your information and are not telemarketing services.

What are the Biometric Screening and Healthways Well-Being Assessment™?

The biometric screening and Well-Being Assessment give you the information you need to improve your overall well-being. CBRE has partnered with Provant and Healthways to deliver this program and ensure your privacy. By participating in a screening and completing a confidential questionnaire, you will learn more about your current health status, how your lifestyle habits affect your well-being, and what you can do to make healthier choices. The program is voluntary and completely confidential. It is important to answer all questions as accurately as possible. This ensures the results reflect your true health status. Biometric measurements are not necessary to complete the Well-Being Assessment; however, having this detailed information allows the experience to be more personalized for you.

What Happens During the Biometric Screening?

At the biometric screening, a health professional will measure your height, weight, waist circumference, and resting blood pressure. A small sample of blood will be collected to determine your cholesterol, glucose levels, triglycerides, and other factors that can lead to lifestyle-related health complications. The screening does not test for illicit drugs, HIV/AIDS, or hepatitis. The screening is administered by Provant. All information is kept confidential, in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Who Administers the Screening?

Experienced health professionals who represent Provant will conduct the screening. A national laboratory will process blood tests.

Will My Discussions with a Healthways Health Coach Be Kept Confidential?

If you qualify for Health Coaching by phone, anything you share with a Health Coach will be held in the strictest confidence. To get the most out of the myHealth program, it is important that you are as honest and open as possible in your discussions. Your personal health data and the information you disclose to a Health Coach will not be shared with CBRE.

Questions? Call the HR Service Center at 866.225.3099

DENTAL PROGRAM

Dental

CBRE offers two voluntary dental programs administered by Cigna: the indemnity (PPO) plan and the prepaid dental plan (DHMO). You do not need to enroll in one of the company's medical plan options to be eligible to enroll in a dental plan.

Indemnity (PPO) Dental Plan

This plan allows you to use any licensed dentist. If you choose a dentist that has a contract with Cigna, you will enjoy the added value of network discounts. The plan pays the same benefit level regardless of whether you seek care in- or out-of-network. To access the

Cigna dental provider directory, log on to www.cigna.com or call Cigna Member Services at (800) 351-4598.

Prepaid Dental Plan (DHMO)

If you elect this plan, you must choose a PDP (Primary Dental Provider) at the time you enroll. If you do not choose a PDP, one will be assigned to you and you will be able to select another PDP at a later date.

Things to Think About Before Enrolling in the Prepaid Dental Plan

First-time enrollees: Before enrolling in the prepaid dental plan, be sure to verify that the PDP you are selecting is accepting new patients.

Please note that a PDP may terminate his/her contract with Cigna at any time. If this occurs, Cigna will automatically reassign you to a new PDP or you can select a new PDP.

Plan Provisions	Indemnity Dental (PPO)	Prepaid Dental (DHMO)
Calendar year deductible	$50/person; $150/family	None
Annual benefit maximum	$1,500/person	None
Lifetime benefit maximum for orthodontia	$1,500/person	Copay applies to first 24 months only; treatment in excess of 24 months will be subject to additional payment by participant
Coverage	Plan pays…	Plan pays…
Preventive/Diagnostic care	100% of R&C* (no deductible)	100%
Basic restorative care	80% after deductible	Copays apply**
Major restorative care	50% after deductible	Copays apply**
Orthodontia	Dependent children under age 19 only: 50% after deductible	100% after applicable copay Additional copays may apply**

*R&C refers to reasonable and customary charges, which are typical service fees charged in your area.

Dental monthly premiums	EE Only	EE+Spouse	EE+ Child(ren)	EE+Spouse +(Child)ren
Cigna Indemnity/PPO	$21.00	$44.00	$42.00	$63.00
Cigna Prepaid Dental	$12.00	$22.00	$26.00	$38.00

**See Patient Charge Schedule for Copay amounts, located in the Library on the Navigator.

VISION PROGRAM

Vision

You may enroll in this optional benefit plan without enrolling in one of the company's medical plans Coverage is provided by Vision Service Plan (VSP) and offers both in-network and out-of-network benefits.

Benefit	Network Provider	Out-of-Network Provider
Frequency of Service	Exams and lenses: every 12 months Frames: every 24 months Elective contact lenses: in lieu of eyeglass lenses and frames	
Copays	Exams: $10 copay Materials: $20 copay	Not applicable
Eyeglass Lenses	Fully covered after copay	Plan pays the following allowances: Up to $45: Single lens Up to $65: Bifocal lens Up to $85: Trifocal lens Up to $125: Lenticular lens
Elective Contact Lenses	Plan pays up to $120 after copay	Plan pays up to $105 allowance
Medically Necessary Contact Lenses	Covered in full after copay	Plan pays up to $210 allowance
Eyeglass Frames	Plan pays up to $120 retail after copay	Plan pays up to $47 allowance

Low Vision Benefits

The vision plan also offers benefits for individuals whose vision cannot be corrected by regular lenses. For more details, see the vision plan summary plan description located on the Navigator via myCBRE.

Benefit	Frequency	Coinsurance	Network Provider	Out-of-Network Provider
Supplemental Testing	Combined $1,000 benefit every 2 years	You pay 25%	Covered in full after coinsurance	Up to $125 allowance after coinsurance
Supplemental Care Aids		You pay 25%	Plan pays 75% of premium	Plan pays 75% of premium

Vision Monthly Premiums

Vision	EE Only	EE+Spouse	EE+ Child(ren)	EE+Spouse+(Child)ren
VSP	$6.48	$10.06	$10.76	$17.20

LIFE INSURANCE AND AD&D PROGRAM

CBRE provides basic life insurance for you. In addition, you can purchase supplemental life and Accidental Death and Dismemberment (AD&D) insurance for yourself and your benefit-eligible dependents.

Coverage amounts for basic life, employee and spouse/domestic partner supplemental life, and AD&D insurance reduce automatically starting when the employee turns age 70.

Life Insurance Highlights

Plan Name	Coverage Amount
Basic Life	1.5 times annual benefits rate* (excluding bonus and incentive pay) up to $1,000,000
Supplemental Employee Coverage	You may select coverage from among 14 tiers up to a maximum of 5 times your annual benefits rate*: $25,000, $50,000, $75,000, $100,000, $150,000, $200,000 $300,000, $400,000, $500,000, $600,000, $700,000, $800,000, $900,000, $1,000,000
Supplemental Spouse/Domestic Partner Coverage	Available if you elect at least $50,000 of supplemental employee life insurance. You may select coverage from among 10 tiers: $25,000, $50,000, $75,000, $100,000, $150,000, $200,000 $250,000, $300,000, $400,000, $500,000
Supplemental Child Coverage	Available if you elect supplemental employee life insurance. $5,000. $10,000, $15,000, $20,000, $25,000. The premium is the same whether covering one or more than one eligible dependent child.

* Definitions of annual base rate and annual benefits rate can be found on page 27

Basic Life Insurance

CBRE provides you with basic life insurance coverage equal to 1.5 times your Basic Benefits Rate, up to $1,000,000. (Refer to page 27 for more information on determining your Basic Benefits Rate.)

Imputed Income Tax May Apply

Please be aware that if your basic life insurance exceeds $50,000, the IRS requires that a small portion of the premium of this benefit be treated as taxable income and added to your Form W-2 as "imputed income". Keep in mind the tax rate applied to the benefit amount over $50,000 is minimal. For example, for someone who is age 40 with basic life insurance coverage of $97,000, the imputed income amount is approximately $4.70 per month. If this person were in a 25% tax bracket, he/she would pay approximately $1.18 per month in additional tax for this company-paid coverage. (The tax tables are subject to change at any time by the IRS.)

Imputed income is calculated for Basic and Supplemental Life coverage greater than $50,000. The volume of coverage in excess of $50,000 is multiplied by the Table 1 rates and then reduced by the employee's after-tax Supplemental Life cost. Imputed income will be calculated as a part of the payroll export.

LIFE INSURANCE AND AD&D PROGRAM

Age of Employee	Monthly Cost per $1k of Excess Coverage
Under 25	.05
25 to 29	.06
30 to 34	.08
35 to 39	.09
40 to 44	.10
45 to 49	.15
50 to 54	.23
55 to 59	.43
60 to 64	.66
65 to 69	1.27
70 and over	2.06

Imputed Income Calculation Steps :

1) Subtract $50,000 from the Basic Life Insurance + Supplemental Life Insurance coverage amount to determine the Excess coverage; subject to Imputed Income
2) Divide the Excess coverage by 1,000
3) Determine the monthly (age-based) rate for the employee imputed age
4) Multiply the result of step 2 by the rate from step 3
5) Multiply the (monthly) result of step 4 * 12 and divide by the number of pay periods
6) Subtract the (per pay period) after-tax cost of the employee's supplemental life coverage from the result of step 5

Example:

Basic Life Insurance Coverage Amount is $116,000, Supplemental Life Insurance Coverage Amount is $100,000; Imputed Age is 43

1) $116,000 + 100,000 - $50,000 = $166,000
2) $166,000 / $1,000 = 166
3) 0.1
4) 166 * 0.1 = $16.60 is the monthly (full) imputed income amount.
5) $16.60 * 12 / 24 = $8.30 is the per-pay period (full) imputed income amount.
6) $8.30 - $5.10 (per pay period Supplemental life cost) = $3.20 is the (net) imputed income amount that will be reported to payroll.

LIFE INSURANCE AND AD&D PROGRAM

Supplemental Life Insurance

You can purchase voluntary supplemental life insurance for yourself. If you cover yourself, you may then purchase coverage for your benefit-eligible dependents.

Certain coverage levels will require you to provide a statement of health before the insurance company will approve the coverage level. Please refer to page 49 for more information on statement of health requirements.

Life Insurance Age Reduction Schedule

Covered amounts for basic life, supplemental life, and spouse life insurance are based on age of the employee (not the spouse/domestic partner) and reduce as the employee ages. At age 70, coverage declines to 60%; at age 75, coverage declines to 40%; and at age 80, coverage declines to 30%.

Important Notes About Life Insurance

- If you are a smoker and you select non-smoker coverage and subsequently pass away, your beneficiary will be required to repay the additional premium that would have been assessed for a smoker.

- If you are not actively at work on the date your benefits would otherwise begin, your life insurance and that of your covered dependents will not be effective until you return to work and assume your normal job duties.

- If your spouse/domestic partner or your child is totally disabled on the date coverage would normally begin, the coverage will begin on the date they are released from medical care.

Accidental Death and Dismemberment (AD&D) Highlights

If you or a covered family member is dismembered, loses sight or hearing, or is paralyzed in an accident, the AD&D plan pays a benefit amount that depends on the type of injury suffered.

Plan Name	Coverage Amount
Employee AD&D	You may select coverage from among 14 tiers up to a maximum of 5 times your annual benefits rate*: $25,000, $50,000, $75,000, $100,000, $150,000, $200,000 $300,000, $400,000, $500,000, $600,000, $700,000, $800,000, $900,000, $1,000,000
Spouse AD&D	Available if you elect employee AD&D insurance. $25,000, $50,000, $100,000, $150,000, $200,000, $250,000, $300,000, $400,000, $500,000, up to 50% of employee's AD&D coverage
Child AD&D	Available if you elect employee AD&D insurance. $5,000, $10,000, $15,000, $20,000, $25,000

* Definitions of basic benefit rate and annual benefit rate can be found on page 27.

Employee AD&D

You can purchase employee AD&D insurance for yourself. If you cover yourself, you may then purchase coverage for your benefit-eligible dependents.

AD&D Insurance Age Reduction Schedule

Covered amounts for employee AD&D and spouse AD&D insurance are reduced as the employee (not the spouse/domestic partner) ages. At age 70, AD&D coverage declines to 60%; at age 75, coverage declines to 40%; and at age 80, coverage declines to 30%.

LIFE INSURANCE AND AD&D PROGRAM

Business Travel Accident Insurance

CBRE provides you with business travel accident (BTA) insurance in the event you are involved in an accident while you are traveling on company business. This insurance pays benefits for accidental loss of life, paralysis, or loss of limb, sight, hearing or speech. CBRE pays the full premium of BTA Insurance and you are automatically enrolled in this coverage. Depending on your employee classification, coverage ranges from $100,000 to $1,000,000. This is a separate benefit from other life insurance you may have through CBRE.

Life Insurance Monthly Premiums

for Salaried, Hourly and Commissioned Employees Who Receive a W-2 and Spouses/Domestic Partners

Employee Supplemental Life			Spouse Supplemental Life	
14 coverage options ranging from $25,000 to $1,000,000. Coverage elected cannot exceed 5 times annual benefit rate. Amounts in excess of $300,000 are subject to Evidence of Insurability. Premiums are per $1,000 of coverage per month.			9 coverage options ranging from $25,000 to $500,000. Coverage elected cannot exceed 50% of employee's supplemental life coverage. Amounts in excess of $50,000 are subject to Evidence of Insurability. Premiums are per $1,000 of coverage per month.	
Age Band	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
< - 29	$ 0.04	$ 0.06	$ 0.06	$ 0.072
30-34	0.046	0.08	0.08	0.08
35-39	0.063	0.09	0.09	0.102
40-44	0.092	0.12	0.171	0.351
45-49	0.145	0.223	0.172	0.355
50-54	0.229	0.34	0.278	0.578
55-59	0.387	0.57	0.43	0.802
60-64	0.477	0.66	0.66	1.135
65-69	0.808	1.27	1.27	1.999
70-74	1.706	2.228	2.11	3.042
75-79	2.06	3.343	4.426	5.333
80+	2.06	6.411	4.426	5.333

LIFE INSURANCE AND AD&D PROGRAM

Child Supplemental Life Insurance Monthly Premium	
Coverage Amount	Monthly Premium*
$5,000	$0.45
$10,000	$0.90
$15,000	$1.35
$20,000	$1.80
$25,000	$2.25

* Based on a monthly rate of $.09 per $1,000 of coverage. Coverage applies to one child or more.

Employee AD&D		Spouse AD&D	
Coverage	Monthly Premium	Coverage	Monthly Premium
$25,000, $50,000, $75,000, $100,000, $150,000, $200,000 $300,000, $400,000, $500,000, $600,000, $700,000, $800,000, $900,000, $1,000,000 with maximum of 5 times your annual benefits rate	$0.020 per $1,000 of coverage	$25,000, $50,000, $100,000, $150,000, $200,000, $250,000, $300,000, $400,000, or $500,000 Maximum: 50% of employee coverage	$0.02 per $1,000 of coverage

Child AD&D Monthly Premium	
Coverage Amount	Monthly Premium
$5,000	$0.125
$10,000	$0.250
$15,000	$0.375
$20,000	$0.500
$25,000	$0.625

DISABILITY PROGRAM

If you need to miss work due to a disability, the disability plans replace some or all of your pay for a period of time. The plan vendor, Cigna, determines if you meet the criteria for a disability.

Short Term Disability Coverage (STD)

CBRE pays the full premium of STD coverage for hourly and salaried employees, and coverage is not available to employees classified as commissioned or salaried employees who participate in the "Highly Compensated Executive PTO Program." The STD benefits described in this guide are for hourly and salaried employees whose annual base salary is less than $100,000.

STD Coverage Amount

The STD program is administered by Cigna and provides a benefit to eligible employees up to the first 12 weeks of an approved, non-work related disability, depending on the nature of the disability. STD benefits begin after a seven day waiting period and equal 70% of your annual benefit salary, up to a maximum weekly benefit of $2,500. *(See Page 27 for more information on determining your annual benefits rate for 2014.)*

In most cases, you will be required to use up to five days of available Paid Time Off (PTO) during the first 30 calendar days of an approved leave.

If you expect your disability to last longer than five work days, call Cigna at (800) 362-4462 to begin the claim filing process.

Long-Term Disability Coverage (LTD)

CBRE provides you with Long Term Disability (LTD) coverage of 40% pay replacement with a 90-day waiting period. You have the option to buy-up to 60% pay replacement with a 90-day waiting period. Additionally, you have the option of receiving the benefit on a taxable or nontaxable basis, depending on whether or not the premiums reduce your income.

LTD coverage provides financial protection for you and your family in the event you become disabled and are unable to perform your job duties for longer than 90 continuous calendar days.

A supplemental Long-Term Disability plan is available to those employees with an annual salary of $300,000 or more. Premiums for this supplemental plan are paid directly to the carrier.)

LTD claims are filed via paper claim form directly with Cigna. If Cigna approves your disability claim, you will begin to receive benefits after you are disabled for 90 continuous calendar days. LTD benefits are offset by other disability benefits, such as Workers' Compensation, Social Security or state disability insurance.

If you are not actively at work on the date your benefits would otherwise begin, your LTD coverage will not be effective until you return to work and assume your normal job duties.

If you choose not to buy-up to the 60% with 90-day waiting period as a newly eligible employee, you will be required to satisfy Statement of Health requirements should you elect the buy-up option during a future Open Enrollment. Refer to page 49 for further details on statement of health requirements.

DISABILITY PROGRAM

Disability Benefit Offsets

All STD and LTD benefits will be offset by the amounts received from a state disability program. California, New York, New Jersey, Rhode Island, Hawaii, and Puerto Rico have state disability programs. If you receive a disability benefit from a state, your disability benefits from the CBRE Plans will be adjusted appropriately. Please call Cigna at (800) 362-4462 to see how this process will impact you or refer to the Summary Plan Description, located on Navigator > Library—use keyword search "SPD".

LTD Insurance Premiums for Salary, Hourly, and Commission Employees (W-2)		
Plan	Benefit Amount	Monthly Premium
Buy-up to 60% with 90-day waiting period	60% of Monthly Benefit Salary up to a maximum monthly benefit	$.20 per $100 of covered Monthly Benefit Salary

Additional Benefits with Cigna

All CBRE employees enrolled in life (including basic life), accident or disability coverage have additional benefits with Cigna at no additional premium.

Will Preparation Program – the will preparation services support an important overall financial planning process and provide a valuable first stop to help protect your family's financial future. It is easy, go to CignaWILLCenter.com and complete the online registration. Once completed, you can start building your will and other legal documents.

Identity Theft Program – this program provides resolution services to help you work through critical identity theft issues. Call (888) 226-4567 if you suspect you might be a victim of identity theft. Please indicate that you are a member of Cigna's Identity Theft Program and Group #57.

FLEXIBLE SPENDING ACCOUNTS (FSA)

CBRE offers two Flexible Spending Accounts (FSAs) that provide you with a tax-advantaged way to pay for eligible out-of-pocket health care and dependent day care expenses. You set aside money on a pre-tax basis to one or both FSAs, and the money remains tax-free when you reimburse yourself for qualified expenses.

FSA elections do not roll over from year to year. If you want to participate in an FSA, you need to re-enroll each year.

You do not have to participate in a CBRE medical plan in order to participate in a FSA. However, participants in the OAP with HSA plan are not permitted to elect a Health Care FSA.

The FSAs are easy to use. Simply estimate your out-of-pocket health care and/or dependent day care expenses for the upcoming calendar year; then indicate the annual flat dollar amount you want to contribute to each FSA. Your pre-tax FSA payroll contributions will be prorated based on your pay period cycle.

Health Care Flexible Spending Account

You can set aside up to $2,500 per year in pre-tax dollars to cover eligible health care expenses for yourself and your eligible dependents. Examples of eligible expenses include medical, dental, and vision expenses you pay out of your own pocket (such as deductibles and copays) and most health care expenses that are not covered by any medical, dental, or vision plan but that are considered tax-deductible by the IRS. You can pay for over-the-counter drugs and medicines only if prescribed by a doctor.*

Immediate Reimbursements

You can be reimbursed from your Health Care FSA prior to the money being deposited into your FSA. As long as your year-to-date claims do not exceed your annual contribution election, you will be reimbursed right away.

For example, let's assume you begin participating in the Health Care FSA on August 1 and you elect to contribute $2,500 between August 1 and December 31. If you incur $2,000 in eligible expenses on August 2, you can be reimbursed in full, even though your FSA contributions to date are less than $2,000.

Extended Claims Filing Period

Even though the FSA plan year operates on a calendar year basis, the Health Care FSA has an extended claims filing period. Eligible health care expenses may be incurred between January 1, 2014 of one and March 15, 2015 of the following calendar year, and you have until May 15, 2015 at midnight Eastern to file your claims. For example, if you elect to participate for the 2014 plan year, you have until March 15, 2015, to incur eligible health care expenses, and you have until May 15, 2015, at midnight (EST) to file your final claim for the 2014 plan year. If you enroll in the Health Care FSA for the 2014 plan year, which begins on January 1, 2014, the claims administrator will continue reimbursing you from your 2013 account balance until the balance is zero or until May 15, 2014, at midnight (ET) whichever is earlier, before beginning to reimburse you from your 2014 account balance.

*Over The Counter (OTC) medicines and drugs are not eligible for FSA reimbursement under the health flexible spending account (FSA) unless prescribed by a doctor (or another individual who is legally authorized to issue a prescription) in the state in which the OTC drug expense is purchased. Any claims you submit for reimbursement that include OTC drug expenses must be accompanied by appropriate documentation.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Claims Processing

Cigna can automatically process your out-of-pocket medical and dental expenses under your FSA. Other Health Care FSA eligible expenses, including those for over-the-counter medications and vision care expenses, cannot be processed via the automated process and must be submitted via a paper FSA claim form. You may activate or deactivate the Cigna automatic processing feature at any time throughout the year by contacting the CBRE HR Service Center at: HRServicecenter@cbre.com.

"First In/First Out" Claims Processing

Cigna, the administrator for the FSA, will process claims on a "first in/first out" basis. This means that if you have a 2013 FSA carryover balance in January 2014, the system will reimburse your claims from the 2013 balance before it reimburses from your 2014 contribution election. Once the 2013 balance is exhausted, the system will then begin reimbursing you from your 2014 elected contribution amount.

If you do not wish to use the "first in/first out" claims process, you can elect to turn off Cigna's automatic processing feature for claims submitted electronically by medical providers or pharmacists. In this case, you would submit your FSA claims manually (via manual claim form located on the CBRE Benefits page). This will give you greater control over how your FSA claims are submitted and processed.

If you turn off Cigna's automatic claims processing feature, make sure to submit all 2013 health care expenses before any 2014 expenses. If 2014 claims are processed before 2013 claims, they will be paid from your 2013 FSA account balance, if any, which may not leave enough money in your FSA account to reimburse your remaining 2013 expenses.

Dependent Care Flexible Spending Account

The Dependent Care FSA is designed to provide you with a tax-free way to pay dependent care expenses that you incur in order to work. You can set aside up to a maximum of $5,000 per year (if married and filing separate tax returns the maximum contribution is $2,500 per spouse per year) to cover dependent care expenses. You have until March 31 at midnight Eastern Time (ET) of the following year to file Dependent Care FSA claims.

Eligible expenses include day care for your dependent child under age 13, a disabled spouse, or another qualified dependent adult who lives with you, such as a parent. Expenses must be incurred while you are at work. If you are married, your spouse must also work full-time or be a full-time student, unless the care required is for a spouse who is disabled. A qualified dependent adult is one who resides in your home for a minimum of eight hours a day and whom you claim on your tax return.

Only expenses charged by qualified, licensed child or adult day care centers and day care providers who report their earnings to the IRS are eligible for reimbursement. Expenses can be reimbursed up to the current balance in your Dependent Care FSA. If your FSA does not have sufficient funds at the time your claim is processed, Cigna will reimburse the remainder of your claim when additional payroll contributions have been made.

Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not participating in a Dependent Care Flexible Spending Account. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account. Ask your tax adviser which is better for you.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Using the FSAs

An important aspect of using the FSAs successfully is to only set aside money for expenses you know you will have during the calendar year. For this reason, your election to participate in the FSAs is made on an annual basis.

Before you enroll, carefully estimate the health care and/or dependent care expenses that you expect to incur during the next plan year. If you are enrolling as a newly eligible employee, be sure you only consider expenses incurred between your benefit effective date and the end of the current plan year.

During enrollment, elect your contribution amount for the year. Your election will be prorated to a payroll contribution based on the number of benefit pay periods remaining in the calendar year.

During the year, incur an eligible expense and file a claim. After you incur an eligible expense and know how much you are responsible for paying, file a claim with Cigna. Be sure to attach proof of your expense by attaching a receipt or an Explanation of Benefit (EOB) statement from your health plan provider. If you have authorized auto-reimbursement with Cigna, your medical and dental claims will be processed automatically. You may also submit your FSA reimbursement requests online via Cigna's online reimbursement request process at www.Cigna.com. You can obtain a paper claim form by downloading it from the Cigna site, by calling the HR Service Center at (866) 225-3099, or from the online library via CBRE Navigator.

Important Notes About the FSAs

You must make an annual election during each annual Open Enrollment period in order for you to participate in either FSA the following year.

If you have both types of FSAs, the money in your Health Care FSA cannot be used to reimburse dependent care expenses and vice versa.

Expenses reimbursed from your FSAs cannot be claimed as deductions or credits on your income tax returns.

As with your other benefits paid with pre-tax dollars, you cannot change your Health Care and Dependent Care FSA contributions during the year unless you experience a qualified family status change.

As noted earlier, you may not participate in the Cigna OAP with HSA and a Health Care FSA in the same calendar year (unless the FSA is a "limited" Health Care FSA, which is not offered by CBRE). Also if you have a Health Care FSA in the current year and enroll in the Cigna OAP with HSA for the following calendar year, your Health Care FSA balance must be zero by December 31 of the current year.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Examples of Eligible Health Care FSA Expenses	Examples of Ineligible Health Care FSA Expenses
Copays, coinsurance and deductibles for your medical plan	Cosmetic expenses
Copays, coinsurance and deductibles for your dental and vision plans	Expenses claimed on your income tax return
Expenses in excess of medical, dental or vision plan limits	Expenses not eligible to be claimed as an income tax deduction
Expenses not covered by your medical plan	Expenses reimbursed by other sources, such as insurance companies
Prescriptions	Fees for fitness clubs where there is no specific medical reason for membership
Diabetic supplies, respirators and other medical supplies	Hair transplants
Smoking cessation programs, nicotine patches and gum	Illegal treatments, operations or drugs
Acupuncture, chiropractic expenses or physical therapy	Insurance premiums
Childbirth preparation classes	Over the counter medications*
Counseling and psychotherapy	Weight reduction programs for general well-being
Routine Physical exams and annual checkups	
Eye exams, eyeglasses, contact lenses and solutions	
Vision correction surgery	
Dental exams, cleanings, X-rays and fillings	
Orthodontics	
Hearing aids	

*For a complete list of eligible and ineligible expenses, please visit ww.cigna.com/expenses

Examples of Eligible Dependent Care FSA Expenses	Examples of Ineligible Dependent Care FSA Expenses
• Daycare centers (must comply with state and local laws) • Babysitters • Nursery school • Pre-school (before Kindergarten) • After-school programs • General-purpose day camps	• Food • Transportation • Activity fees • Education expenses (Kindergarten or higher) • Overnight camps (including daytime portion) In addition, your care provider cannot be: • Your spouse • Your child under the age of 19

For a complete list of eligible and ineligible expenses, *please visit www.cigna.com/expenses*

ANCILLARY BENEFITS

CBRE provides other benefit programs to employees to help with life issues, commute to work less expensively, and adopt a child.

Employee Assistance Program

The Employee Assistance Program (EAP) provides you and family members living in your household with services designed to enhance your personal well-being. ComPsych can help address a variety of issues, including:

- Depression
- Marital and family conflicts
- Job pressures
- Stress and anxiety
- Alcohol and drug abuse
- Saving for college
- Getting out of debt
- Retirement planning
- Estate planning

You can access a professional ComPsych counselor at any time of day or night, seven days a week, by calling (888) 243-6404. After briefly discussing your situation over the telephone, the counselor will refer you for a face-to-face session within 72 hours of your call or, in an emergency, provide immediate access (within 24 hours) to counseling services.

Through ComPsych, CBRE provides up to five EAP visits at no charge to you or your family members. CBRE also will provide additional EAP visits per situation to the extent mandated under applicable state law.

In addition to calling a representative for assistance, you can visit ComPsych's website at www.GuidanceResources.com, and enter the Company Code CBRE0509. The website provides you and your family members with a variety of tools designed to assist with issues related to health, work, family, and interpersonal relationships.

Transit Program

The transit program has two components:

- A parking reimbursement account, and
- A voucher and fare media (mass transit) purchasing program.

Depending on where you live, you can participate in one or both portions of the transit program, which allows you to use pretax dollars (up to statutory limits) to pay for your public transportation and parking expenses. After-tax deductions also are permitted for both transit and parking expenses, so you can set aside more than the IRS limit.

This program is available to CBRE employees who are classified as hourly or salaried. Employees classified as temporary or commissioned paid via W-2 or 1099 (QREA) are not eligible for this program.

The administrator for the transit program depends on where you live, as follows:

All Locations Except Connecticut, New Jersey and New York. WageWorks administers the transit and parking program for all U.S. locations except this tri-state area. To enroll in the commuter parking or commuter transportation programs, please contact WageWorks at (855) 774-7441 Monday through Friday from 8 a.m. to 8 p.m. ET for questions about your Commuter Administration Services.

Residents of Connecticut, New Jersey, and New York. The transit program in this area is administered through TransitChek. (Please note that the parking program is not available in Connecticut, New Jersey and New York.) For more information and enrollment assistance, contact the TransitChek administrator at (212) 984-6641.

Adoption Assistance Program

CBRE provides financial assistance for employees who adopt a child. Upon the completion of your adoption, CBRE will reimburse up to $5,000 of your eligible adoption expenses. (In the case of a special needs child, as defined in the policy, the maximum benefit is $6,000 per child.) To request reimbursement under the Adoption Assistance Program contact the HRSC at (866) 225-3099.

ANCILLARY BENEFITS

401(k) Plan

When it comes to saving for your future, time is on your side. That's why it is important for you to start investing early, and let your money grow over time. CBRE is committed to helping you prepare for your future and giving you the information you need to help you make your retirement what you want.

When you become eligible	You are eligible to participate in the Plan the day you begin working at CBRE or as soon thereafter as is administratively feasible. As of 1/1/2014, CBRE will match up to 50% on the dollar up to 4%.
How to enroll	Enroll online at www.benefits.ml.com or call Merrill Lynch Participant Services at (888) 363-2385. Allow 10-14 business days after your hire date before contacting Merrill Lynch.
How much you can contribute	You can contribute from 1% to 75% of your pretax pay, up to an annual maximum of $17,500 for 2014. (These are annual limits imposed by the IRS and may change year-to-year.)
Catch-up contributions	If you will be age 50 or over during the 2014 Plan year, you will be eligible to contribute an additional $5,500 to the Plan. (These are annual limits imposed by the IRS and may change year-to-year.)
When you become vested	You are always 100% vested in your contributions. CBRE employees who were hired in 2006 and years prior are 100% vested in the discretionary matching contribution. For the company matching contribution that began April 1, 2007, and ended January 1, 2009, but was reinstated as of January 1, 2011, you become 20% vested for each year of service with CBRE. If you became an employee through an acquisition, your prior years of service with your former employer will count toward vesting credit.
Your investment options	You may invest in a variety of funds. Also, you can change funds at any time by calling Merrill Lynch Participant Services at (888) 363-2385 or going online at www.benefits.ml.com.
Rollovers into the Plan	Participants may roll over funds from qualified plans into the CBRE 401(k) Plan by providing the rollover check, a distribution statement from the former plan (typically accompanies the rollover check), a copy of the former plan's determination letter, and a completed Merrill Lynch Rollover Contribution Form, which may be obtained by calling Merrill Lynch Participant Services at (888) 363-2385 or going online to www.benefits.ml.com.
Receiving money from the Plan	You may receive a distribution from the Plan if you retire, leave CBRE, experience a serious financial hardship, are 59-1/2 or older, have rollover monies in the Plan, or die.
Borrowing from the Plan	You can take out a loan from the Plan for any reason. You may have only one loan outstanding at a time. The minimum you can borrow is $1,000, and the maximum is 50% of your vested account balance (not to exceed $50,000).

For more detailed information, refer to the CBRE 401(k) Summary Plan Description.

ANCILLARY BENEFITS

Statement of Health

A statement of health (also known as evidence of insurability) is a statement required by Cigna Insurance Company that verifies the good health of the applicant. If you elect a voluntary life insurance or an LTD coverage level that requires a statement of health, you must complete a Cigna Statement of Health Form to be insured for the full amount of your election. Approval of the elected coverage is made by the insurance company. Evidence of insurability is required on coverage amounts as follows:

- Supplemental Life Insurance – Evidence of insurability is required for all coverage amounts.
- Employee Coverage – Evidence of insurability is required for coverage elected greater than $300,000 when you are first eligible to enroll. If you waive coverage as a new hire, all future new elections or increases in coverage volume will be subject to evidence of insurability requirements.
- Spouse/Domestic Partner Coverage – Evidence of insurability is required for coverage elected greater than $50,000 when first eligible to enroll. If coverage is waived when first eligible, all future elections or increases in coverage volume will be subject to evidence of insurability requirements.
- Long-Term Disability Coverage – If you do not buy-up to the 60% with 90-day waiting period when first eligible, any future election will be subject to evidence of insurability requirements.

Completing the Statement of Health Form

You may complete the Statement of Health Form at the following website:

Online Enrollment website at: www.cbrebenefitconnect.com Select the Statement of Health form.	Employee and Spouse/Domestic Partner — Hard copy of the form is available on Navigator. You must complete and submit to CBRE Benefits Department.
myCBRE Select the Human Resources Department, Benefits, Reference Materials, Forms	Employee and Spouse/Domestic Partner — Hard copy of the form is available on Navigator. You must complete and submit to CBRE Benefits Department.

If you are newly eligible, you must complete the Statement of Health Form no later than 60 days after your benefits eligibility date. If it is not received by the specified due date, your application will not be accepted. If approved, the effective date of your coverage increase will be the first of the month following the approval date. If your request for coverage is denied, your existing coverage will remain unchanged.

For elections made during annual Open Enrollment, you can complete the Statement of Health Form. You must complete the paper Statement of Health Form. Evidence of Insurability (EOI) for Supplemental Life Insurance must be completed by December 16, 2013. If you fail to complete your EOI application by this date, it will be closed and you will have to make a new election during Open Enrollment for 2014.

If you need to contact a carrier to access care or obtain more information, call the carrier's member service phone number located below. Identify yourself as a benefit-eligible employee of CBRE and provide them with your Subscriber Number (located on your ID card) or your Social Security number. If your information is not in the vendor's system, call the HR Service Center at (866) 225-3099 for additional assistance.

Provider Directory

Group Name	Policy/Plan Number	Member Service Number	Website
Cigna Medical, Dental, and Retail Prescriptions Flexible Spending Accounts (FSAs) Health Care FSA Dependent Care FSA	2465054	(800) 351-4598	Modeling tool (all states except HI, MI and WA): www.mycignaplans.com user ID = CBREBenefits, password = cigna Modeling tool (HI, MI and WA residents only): www.cbrebenefitconnect.com Personal Claims History: www.mycigna.com General information: www.cigna.com
Prescriptions – CVS Caremark	Rx 6386 HRA/HSA 6387	855-299-3258	www.caremark.com email to customerservice@caremark.com
Bank of America (Health Savings Account manager for the Open Access Plus (HSA))	N/A	(866) 791-0250	www.bankofamerica.com/benefitslogin
Blue Care HMO (Michigan)	00124110	(800) 662-6667	www.mibcn.com Modeling tool: www.cbrebenefitconnect.com
Group Health Alliant Plus Plan	51275/ 58161	888-901-4636	www.ghc.org Modeling tool: www.cbrebenefitconnect.com
University Health Alliance PPO (Hawaii)	2483	Oahu: 532-4000 Neighbor islands: (800) 458-4600	www.uhahealth.com Modeling tool: www.cbrebenefitconnect.com
Keystone Health Plan HMO (Pennsylvania)	318064	800-453-2566	www.ibx.com
IBC Personal Choice PPO (Pennsylvania)	462195	800-453-2566	www.ibx.com
Kaiser HMO (Hawaii)	31565/02/ 01	(866) 868-7220	www.kaiserpermanente.org Modeling tool: www.cbrebenefitconnect.com
Vision Service Plan	12-082782 0001 0001	(800) 877-7195	www.vsp.com
Provant		(877) 239-3557	http://provantevents.com
Healthways - Wellness		866-556-4707	www.myhealthcbre.com

Provider Directory

If you need to contact a carrier to access care or obtain more information, call the carrier's member service phone number located below. Identify yourself as a benefit-eligible employee employed by CBRE and provide them with your Subscriber Number (located on your ID card) or your Social Security number. If your information is not in the vendor's system, call the HR Service Center at (866) 225-3099 for additional assistance.

Group Name	Policy/Plan Number	Member Service Number	Website
Cigna Short-Term Disability Long-Term Disability Life Insurance AD&D Insurance	FLK980105 FLK980247 OK980267	(800) 362-4462 (Disability) (800) 238-2125 (Life)	http://mycigna.com
ComPsych Guidance Resources (Employee Assistance Program)	Company ID # CBRE0509	(888) 243-6404	www.guidanceresources.com company code: CBRE0509
CONEXIS (COBRA & Retiree Continuation of Coverage)		(877) 864-9546	https://mybenefits.conexis.com
WageWorks Transit Program (except NY, NJ & CT) TransitChek Transit Program (NY, NJ & CT only)		(855) 774-7441 (212) 984-6641	https://www.wageworks.com/ N/A
Merrill Lynch – 401(k) Plan Cigna HealthCare 24-Hour Health Information Line	610080	(888) 363-2385 (800) 564-9286	www.benefits.ml.com