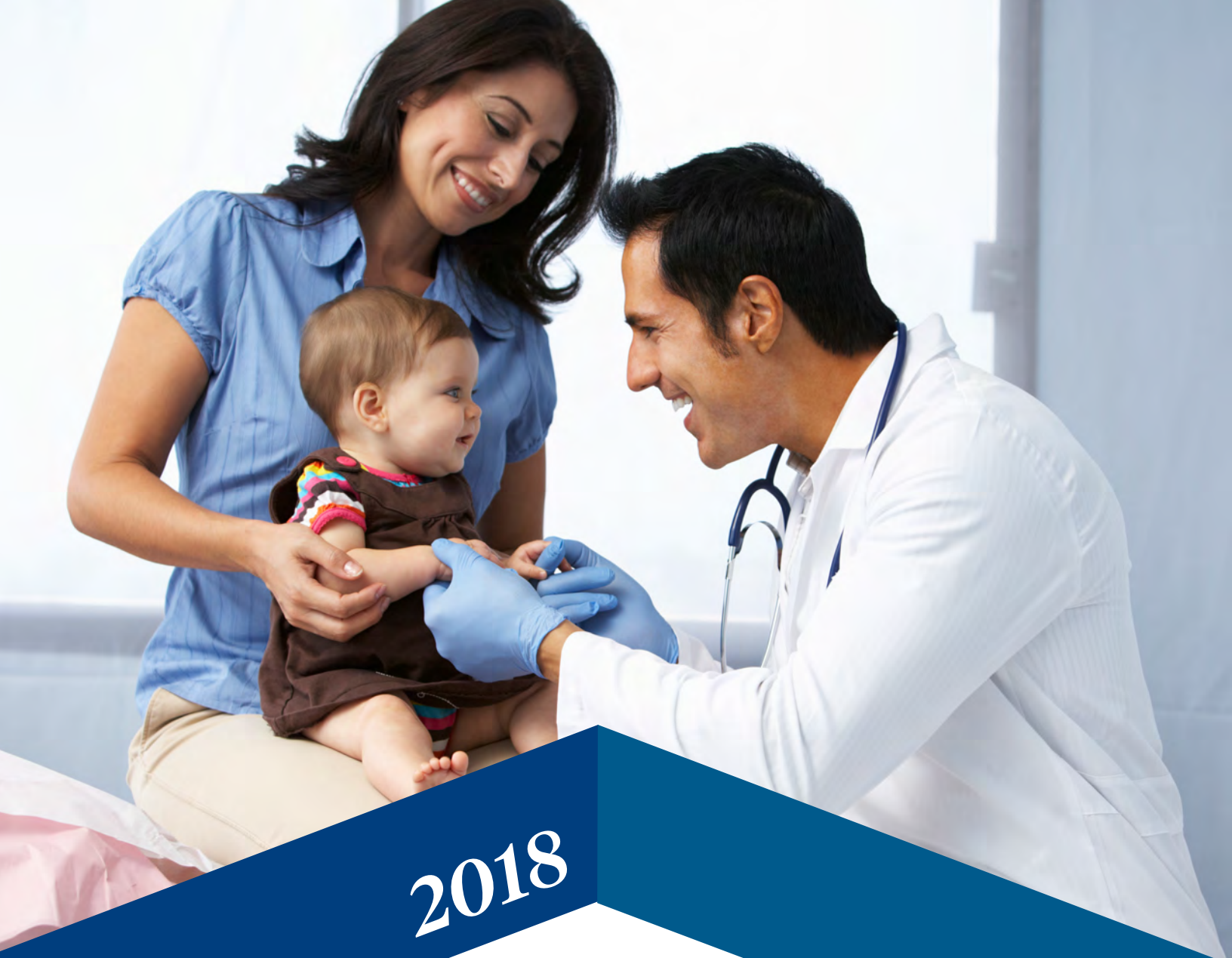


2018 Benefits Guide

Pioneer Medical Group, Inc. (PMG)
Preferred Diagnostic Imaging LLC (PDI)
Eagle Business Performance Services LLC (Eagle)

Your Better Health • Your Benefits • Your Choices

Pioneer Medical Group

preferred diagnostic imaging

Eagle Business Performance Services

Welcome!

We're so glad you're part of the team.

Inside this guide, you can check out the competitive plans that are available to you and their pricing. When you make your choices, take into account any upcoming changes to your health care needs. This will help you choose the right plans for you and your family. You're part of a company that strives to improve the lives of patients and we want you to be healthy too.

Are you using this guide for Annual Enrollment? If yes, that's perfect because you'll find just what you need to make informed choices for 2018 coverage. Don't miss this once-a-year opportunity to enroll in plans that fit your needs.

Whether you're just joining the team or have been part of it for a while, we sincerely encourage you to use the resources you have available to improve your overall health and well-being. Get started on being the healthiest you can be by making informed choices during your enrollment.

Whenever you'd like more details than what's in this guide, look at the legal plan documents on your HR/Benefits website — it's available to you 24 hours a day, 7 days a week. You can also get in touch with HR/Benefits by phone or email during normal business hours.

Best wishes from Pioneer Medical Group and affiliated employers.

HR/Benefits Website
PMG.mybenefits.teamcreativa.com

HR/Benefits Phone
562.229.9452 ext 1068

HR/Benefits Email
bmedina2@pioneermedicalgroup.com
acardena@pioneermedicalgroup.com

What's Inside

What's New for 2018

Additional UHC Programs

In addition to the six UHC medical plan options that are available to choose from, UHC offers no-cost reward programs for all UHC members. More information is provided on page 12 and on the HR/Benefits website.

Real Appeal Program (Weight Loss)
Real Appeal is a voluntary weight loss program that is offered to participants age 18 and over as part of their benefit plan.

SimplyEngaged
A personal health and wellness program that allow you to earn rewards when you complete health and wellness actions.

New Short Term Disability plan for Staff

New 20% buy-up STD option

Health Savings Account Contribution Limits Increased

$3,450 for 2018

employee only coverage

$50 more than in 2017

$6,850 for 2018*

family coverage

** IRS Regulation update March 5, 2018*

Health Care FSA Contribution Limit Increased

$2,650 for 2018

$100 more than in 2017

401(k) Contribution Limit Increased

$18,500 for 2018

$500 more than in 2017

Eligibility and Enrollment

Your employer offers an array of health and welfare benefits, including:

- Medical Insurance.
- Dental Insurance.
- Vision Insurance.
- Disability Insurance.
- Life and Accident Insurance.
- Flexible Spending Accounts (Health Care and Dependent Care).
- Employee Assistance Program.

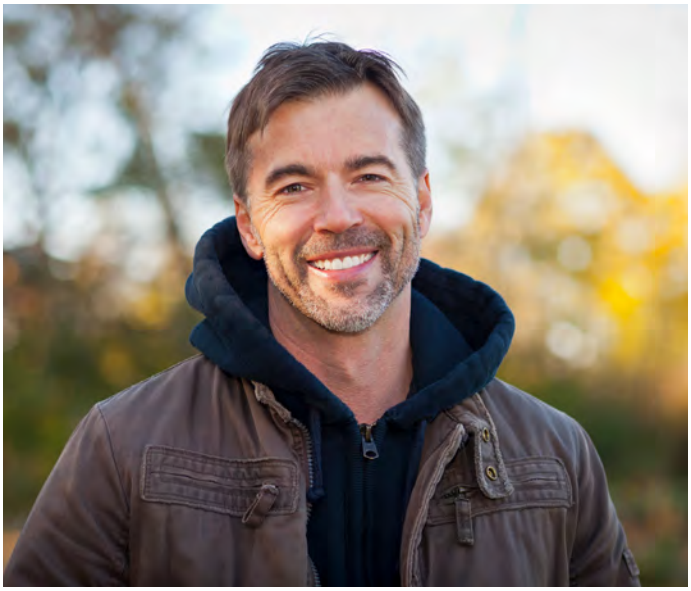
Some benefits are paid entirely by your employer. Other benefits require that you share in the cost for your coverage. In addition to the traditional health and welfare plans, your employer also provides you with a 401(k) plan, several voluntary plans, paid time off and holidays.

Refer to the section titled *"Important Phone Numbers and Websites"* or contact HR/Benefits if you have questions or require additional information.

HR/Benefits Website
PMG.mybenefits.teamcreativa.com

HR/Benefits Phone
562.229.9452 ext 1068

HR/Benefits Email
bmedina2@pioneermedicalgroup.com
acardena@pioneermedicalgroup.com



Benefit Plan Eligibility

You are eligible to participate in the health and welfare employee benefit plans if you are regularly scheduled to work 24 or more hours per week.

You are not eligible for the employee benefit plans if you are:

- An employee who is not regularly scheduled to work 30 or more hours per week.
- An individual who has signed an agreement, or has otherwise agreed, to provide services to your employer as an independent contractor, regardless of the tax or other legal consequences of such an arrangement.
- A leased employee compensated through a leasing entity, whether or not you fall within the definition of leased employee as defined in Section 414(n) of the Internal Revenue Code (IRC).
- An employee who is classified as temporary or per diem.

Certain plans also permit you to cover your eligible dependents, which include your:

- Legal spouse (unless legally separated) or same/opposite sex domestic partner.
- Your child who is less than age 26, including:
  - Biological child.
  - Stepchild.
  - Legally adopted child.
  - A child who has been placed with you in anticipation of adoption.

In addition, you can also cover the following dependents if they are claimed as your dependent for federal income tax purposes:

- Your domestic partner's child*.
- A child for whom you are the legal guardian/legal custodian.

** Special guidelines apply when covering a domestic partner or the child of a domestic partner. Refer to the Domestic Partner Qualifications and Guidelines on the HR/Benefits website for additional information.*

Your dependent children who are age 26 or over and physically or mentally incapable of self-support may continue coverage under certain plans beyond age 26 if they remain totally incapacitated and dependent on you for support.

If your spouse/domestic partner works for your employer, either you or your spouse/domestic partner can elect to cover your dependent children, but not both of you. Your dependent (spouse/domestic partner or child) is not eligible if they are covered as an employee, on active duty in the military service of any country or if you are not enrolled for coverage.

Eligibility and Enrollment

Initial Eligibility Period

You have 15 days to enroll yourself and your eligible dependents for coverage. This 15-day initial eligibility period begins on your employment date and ends 14 days after that date. If your enrollment is not completed on or before the end of your initial eligibility period:

- You will have to wait until the next Annual Enrollment period to change your benefit elections (except as summarized in the section titled *"Making Changes During the Year"*).
- You will be automatically enrolled in the core benefit plans that are paid in full by your employer.

For example: If you are hired on April 2, 2018, your initial eligibility period begins on April 2, 2018 and ends on April 17, 2018. Your benefit plan elections made during this period will be generally effective June 1, 2018, subject to you providing proper documents as required under the plans.

Special enrollment rules apply if you terminate employment and are then rehired. Contact HR/Benefits for additional information.

How to Enroll

Enrolling into the benefit programs is easy! Shortly after you are hired, you will receive a benefits package. This benefits package will provide you with all the information you need to enroll for benefits.

Our benefit enrollment process is primarily paperless, except of course for documents you must provide to validate your dependent information (e.g., birth certificates, etc.). You should keep in mind that if you are enrolling any dependents, you will need their name, Social Security number, date of birth and written documentation to verify their eligibility (e.g., birth certificate, marriage license, etc.).

After making your benefit elections, be sure to view and print a benefits confirmation statement. You will not receive a separate confirmation statement from HR/Benefits. If you need assistance enrolling for benefits, contact HR/Benefits via phone during normal business hours and via email anytime to assist you with your HR and benefits questions.

When Coverage Begins

The table on the next page shows the dates your coverage will be effective under the various benefit plans for:

- Newly hired employees.
- Employees who experience a qualifying event.
- Changes made during the Annual Enrollment period.

For more details on when coverage begins for a specific employee benefit plan, refer to the applicable section of this guide.

Eligibility and Enrollment

Effective Date of Coverage for Selected Events			
Plans	**New Hire Enrollment**	**Qualifying Event (Reported within 30 days)**	**Annual Enrollment**
Medical, Dental, Vision	First day of the month following 30 days of employment (enrollment required)	First day of the month following qualifying event (birth or adoption is date of qualifying event)	January 1 following Annual Enrollment period
Short Term Disability	First day of the month following 30 days of employment (enrollment required)	Not applicable	January 1 following Annual Enrollment period, subject to insurance company EOI approval
Long Term Disability	First day of the month following 30 days of employment (automatic enrollment)	Not applicable	Not applicable
Basic Life, Basic AD&D	First day of the month following 30 days of employment (automatic enrollment)	Not applicable	Not applicable
Optional Life – Employee	If coverage elected is $250,000 or less, first day of the month following 30 days of employment (enrollment required) If coverage elected is more than $250,000, coverage in excess of $250,000 is effective on the date approved by the insurance company (enrollment required)	First day of the month following qualifying event (birth or adoption is date of qualifying event), subject to insurance company EOI approval	January 1 following Annual Enrollment period, subject to insurance company EOI approval
Dependent Life – Spouse/DP	If coverage elected is $25,000 or less, first day of the month following 30 days of employment (enrollment required) If coverage elected is more than $25,000, coverage in excess of $25,000 is effective on the date approved by the insurance company (enrollment required)	First day of the month following qualifying event (birth or adoption is date of qualifying event), subject to insurance company EOI approval	January 1 following Annual Enrollment period, subject to insurance company EOI approval
Dependent Life – Child(ren)	First day of the month following 30 days of employment (enrollment required)	First day of the month following qualifying event (birth or adoption is date of qualifying event)	January 1 following Annual Enrollment period
Optional AD&D – Employee, Spouse/DP, Child(ren)	First day of the month following 30 days of employment (enrollment required)	First day of the month following qualifying event (birth or adoption is date of qualifying event)	January 1 following Annual Enrollment period
Flexible Spending Accounts	First day of the month following 30 days of employment (enrollment required)	First day of the month following qualifying event (birth or adoption is date of qualifying event)	January 1 following Annual Enrollment period
Employee Assistance Program (EAP)	First day of the month following 30 days of employment (automatic enrollment)	Not applicable	Not applicable
401(k)	First day of the month following 30 days of employment (automatic enrollment)	Not applicable	Not applicable
Voluntary Critical Illness Insurance (VCII)	First day of the month following 30 days of employment (enrollment required)	Not applicable	January 1 following Annual Enrollment period
Voluntary Accident Insurance (VAI)	First day of the month following 30 days of employment (enrollment required)	Not applicable	January 1 following Annual Enrollment period
LegalGUARD and InfoArmor	First day of the month following 30 days of employment (enrollment required)	Not applicable	January 1 following Annual Enrollment period

The effective dates shown in this table assume enrollment has been completed timely and any required paperwork or documentation has been provided. If you complete your enrollment after your effective date of coverage, retroactive payroll deductions will be calculated and withheld from your first paycheck after elections are made. It is for this reason you should enroll early to avoid retroactive payroll deductions. If any enrollments require evidence of insurability (EOI), the effective date of coverage will be the date the insurance company approves insurability. The effective date of coverage may also be delayed due to the actively at work or confinement for care provisions of the plans.

Making Changes During the Year

Generally, after you have made your benefit plan elections, you may change those elections only during the next Annual Enrollment period.

However, if you experience a qualifying event or other allowable event during the year, you may change certain benefit plan elections before the next Annual Enrollment period. You must properly advise HR/Benefits (along with providing the required supporting documentation) and make the change using the online benefits website within 30 days of the event (date of event plus 29 days) in order for your mid-year change to be approved.

Your new election must be on account of the event and must correspond with that gain or loss of coverage. A qualifying event is defined as an event that results in the gain or loss of eligibility by you or your dependents. For example:

- A change in legal marital status.
- A change in number of dependents.
- A change in employment status.
- Your dependent satisfies or ceases to satisfy the requirements for dependents, including a domestic partner or domestic partner's child.
- A change in residence or worksite by you or your dependent that causes a loss or gain of coverage.

The rules regarding changes after your new hire enrollment and the Annual Enrollment period are very specific; therefore, you should refer to the information provided on the HR/Benefits website or contact HR/Benefits if you require assistance.

Special Enrollment Rules

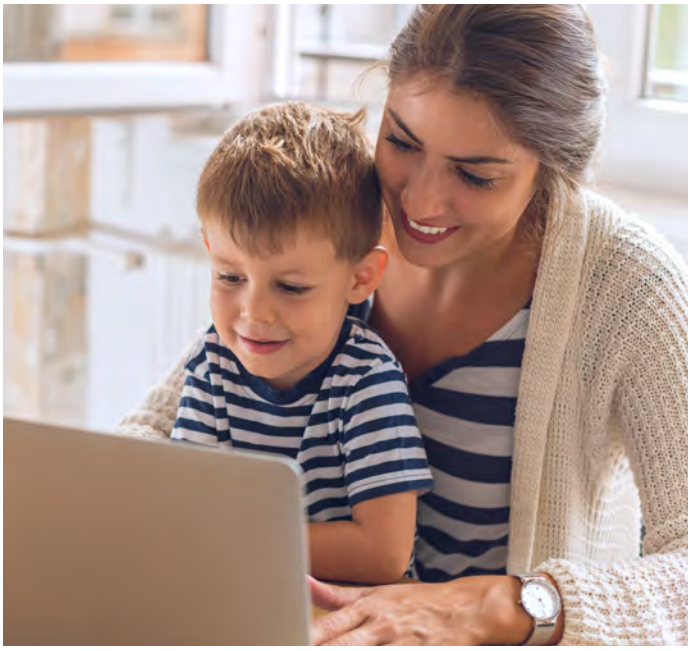
If you originally declined medical, dental or vision coverage because you had other health coverage, you may be eligible to change your elections under the following circumstances:

- If the other coverage was COBRA and it is now exhausted; or
- The other coverage was not COBRA and either the coverage terminated due to loss of eligibility or employer contributions toward such coverage terminated. Loss of eligibility includes legal separation, divorce, termination of domestic partner status, death or termination of employment.
- The other coverage was Medicaid or state Child Health Insurance Program (CHIP) and coverage terminated due to loss of eligibility.
- You or your dependent becomes eligible for state premium assistance under a Medicaid or CHIP plan. (This is an optional state program under Medicaid or CHIP that pays the employee's share of the premium for group health plan coverage.)

If your dependents also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated for cause (including failure to timely pay the required premiums).

In addition to the changes described above, you may enroll yourself and your spouse/domestic partner (with or without the new dependent) in a medical plan following marriage or the adoption, placement for adoption or birth of a child. You must be enrolled in order to cover your dependents.

Eligibility and Enrollment



Special Enrollment Procedure

You must enroll for coverage within 30 days of the special enrollment event (60 days for CHIP) by going online and making the appropriate change. Supporting documentation must be sent to HR/Benefits.

If you enroll and provide any required documentation within this period, the effective date of coverage will be on the first day of the month following the date of the qualifying event (for birth or adoption, the effective date is the date of the birth or adoption). Your employee contributions will be deducted retroactive to the date of the special enrollment event.

If you do not enroll and provide supporting documentation within 30 days of the special enrollment event (60 days for CHIP), you may not enroll until the next Annual Enrollment period.

For more information on how your benefits are affected by these life changes, contact HR/Benefits.

When Coverage Ends

The following table shows the dates your coverage ends under the various employee benefit plans:

Benefit Plans	Last Day of Coverage
Medical Dental Vision Employee Assistance Program LegalGUARD and InfoArmor	On the last day of the month in which you are no longer employed
Short Term Disability Long Term Disability Life and AD&D Health Care FSA Dependent Care FSA Voluntary Critical Illness Insurance Voluntary Accident Insurance	On your last day of active employment

Coverage for your dependents will end on the date your dependent no longer meets the definition of an eligible dependent or when your coverage ends, whichever comes first. Premiums for the last month of coverage are not prorated even if coverage ends prior to the end of a month.

Under certain circumstances, you may be able to continue certain benefit coverage (medical, dental, vision and health care FSA) for yourself and your dependents through COBRA. You may also be able to convert or port the life, accident and voluntary plans, as permitted by the insurance companies.

When employment terminates, you have up to 90 days to file claims for any FSA eligible charges incurred prior to your termination date. This 90-day period is extended for the health care FSA if you elect COBRA continuation coverage. The dependent care FSA is not subject to COBRA.

Medical

The medical plans are designed to help protect you and your covered dependents against financial loss by paying for a substantial portion of eligible expenses incurred for medically necessary care and treatment. The medical plans are insured by UnitedHealthcare.

You can select from the following options:

- Option 1 - PPO Plan 494 ($500 deductible).
- Option 2 - PPO Plan 521 ($1,000 deductible).
- Option 3 - HDHP HSA Plan 557 ($2,700 deductible).
- Option 4 - HDHP HSA Plan 552 ($3,000 deductible).
- Option 5 - HMO Value Network Plan ($0 deductible).
- Option 6 - HMO Full Network ($0 deductible).

If you enroll for coverage within your initial eligibility period, your coverage will be effective on the first day of the month following 30 days of employment.

If you do not enroll for coverage within your initial eligibility period, you may enroll for coverage during the next Annual Enrollment period or in accordance with the section titled *"Making Changes During the Year"*.

High Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs)

If you enroll in one of the HDHPs (Option 3 or Option 4), you will be given the opportunity to establish an HSA.

In 2018, the maximum amount you can contribute to your HSA cannot exceed the IRS allowable amount of:

- $3,450 for individual coverage; or
- $6,850 for 2-party or more coverage.

If you are age 55 or older you can also make catch-up contributions of $1,000 per year, in accordance with federal regulations.

An HSA is an account that allows you to contribute and set aside pretax dollars to pay for eligible health care expenses either in the current year or at a later date, such as during retirement.

In deciding your HSA contribution amount, be sure to keep in mind your medical plan's premium, deductible and out-of-pocket maximum. You can start, stop or change your HSA contribution amount at any time. Changes are applied to your remaining pay periods in the current year.

Once you have enrolled in one of the HDHP HSA plans, you should open your account by visiting ***optumbank.com***. Once your account is open, Optum Bank will mail you a welcome packet and your debit card. You can then use your new card to access your HSA funds. You will be permitted to use your account dollars now or in retirement to pay for eligible medical, prescription drug, dental and vision expenses, including those not normally covered by your medical plan.

HSAs are fully portable. This means that if you terminate employment, the money is yours and stays in your account until you use it, become deceased or close the account. You can continue to contribute up to the maximum amount each year, as long as you remain eligible and enrolled in a qualified HDHP.

In subsequent years, if you decide not to enroll in a qualified HDHP, you can continue to use your HSA for qualified medical expenses, but you will no longer be able to contribute to the HSA.

Your Cost

Your employer and you share the cost of medical coverage. Your cost is generally deducted from your pay on a pretax basis. (Contributions for domestic partners are generally deducted on an after-tax basis, unless otherwise permitted by state or federal law.) Refer to the section titled *"Employee Contributions"* for the applicable cost. If you enroll in one of the HDHPs you will decide if you wish to establish an HSA and how much to contribute, subject to IRS maximums.

Medical

Summary of Medical Plan Provisions

The following table summarizes the key features of the medical plans available to you and your dependents. To receive the highest level of benefits, you should use in-network providers and fully understand what is expected of you.

Website Access

The medical plans provide substantial benefit levels to protect you from catastrophic loss in the event of illness or injury. The plans also offer additional value-added benefits as described on the UnitedHealthcare website.

Medical Plans (UnitedHealthcare)						
Key Features	Option 1		Option 2		Option 3	
	PPO Plan 494		PPO Plan 521		HDHP HSA Plan 557	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	You pay	You pay	You pay	You pay	You pay	You pay
Calendar Year Deductible (ded.)						
Individual	$500	$1,000	$1,000	$2,000	$2,700	$5,200
Family	$1,000	$2,000	$2,000	$4,000	$5,400	$10,400
Calendar Year Out-of-Pocket Maximum						
Individual	$2,500	$5,000	$3,000	$6,000	$3,900	$10,400
Family	$5,000	$10,000	$6,000	$12,000	$7,800	$20,800
Physician Services						
Office visits	$20 copay	40% after ded.	$15 copay	30% after ded.	0% after ded.	20% after ded.
Specialist visits	$20 copay	40% after ded.	$15 copay	30% after ded.	0% after ded.	20% after ded.
Urgent care	$50 copay	40% after ded.	$50 copay	30% after ded.	0% after ded.	20% after ded.
Preventive Care						
Routine physical exams	No copay	Not covered	No copay	Not covered	No copay	Not covered
Immunizations	No copay	Not covered	No copay	Not covered	No copay	Not covered
Well-woman exams	No copay	Not covered	No copay	Not covered	No copay	Not covered
Hospital						
Inpatient hospital services	20% after ded.	40% after ded.	10% after ded.	30% after ded.	0% after ded.	20% after ded.
Emergency						
Hospital emergency room	$100 copay	$100 copay	$100 copay	$100 copay	0% after ded.	0% after ded.*
Other Medical Services						
Laboratory and x-ray services	No copay	40% after ded.	No copay	30% after ded.	0% after ded.	20% after ded.
Imaging (MRI, CAT, PET scans)	20% after ded.	40% after ded.	10% after ded.	30% after ded.	0% after ded.	20% after ded.
Prescription Drugs (Retail) – Up to a 31 Day Supply						
Tier 1	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay after ded.	$10 copay after ded.
Tier 2	$30 copay	$30 copay	$30 copay	$30 copay	$30 copay after ded.	$30 copay after ded.
Tier 3	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay after ded.	$50 copay after ded.
Prescription Drugs (Mail Order) – Up to a 90 Day Supply						
Tier 1	$25 copay	Not covered	$25 copay	Not covered	$25 copay after ded.	Not covered
Tier 2	$75 copay	Not covered	$75 copay	Not covered	$75 copay after ded.	Not covered
Tier 3	$125 copay	Not covered	$125 copay	Not covered	$125 copay after ded.	Not covered

** In-Network deductible applies.*

The PPO and HDHP HSA plans have embedded deductibles and out-of-pocket maximums.

This summary is provided for general information only. Since exclusions, dollar/frequency limitations and prior authorization apply in many cases, you should refer to the specific plan documents for detailed information on complete plan provisions, exclusions and limitations.

Summary of Benefits and Coverage

The Patient Protection and Affordable Care Act (also known as Health Care Reform) requires that you receive a Summary of Benefits and Coverage (SBC). The SBC is designed to help you understand and evaluate your health plan choices. You can download the SBC from the HR/Benefits website or contact HR/Benefits and request a copy be sent to you.

Medical

PPO
A Preferred Provider Organization (PPO) is a type of health plan that contracts with hospitals, doctors and other providers. You determine at time of service whether to use an in-network or out-of-network provider. When you use an in-network provider, you will pay lower medical out-of-pocket costs and will not be subject to balance billing.

Medical Plans (UnitedHealthcare)					
Option 4		Option 5		Option 6	
HDHP HSA Plan 552		HMO Value Network Plan UM4/3IF		HMO Full Network Plan U90/3IF	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
You pay	You pay	You pay	You pay	You pay	You pay
$3,000 $6,000	$5,000 $10,000	$0 $0	Not covered Not covered	$0 $0	Not covered Not covered
$4,000 $8,000	$6,000 $12,000	$1,500 $3,000	Not covered Not covered	$1,500 $3,000	Not covered Not covered
0% after ded. 0% after ded. 0% after ded.	20% after ded. 20% after ded. 20% after ded.	$20 copay $20 copay $20 copay	Not covered Not covered $75 copay	$20 copay $20 copay $20 copay	Not covered Not covered $75 copay
No copay No copay No copay	Not covered Not covered Not covered	No copay No copay No copay	Not covered Not covered Not covered	No copay No copay No copay	Not covered Not covered Not covered
0% after ded.	20% after ded.	No copay	Not covered	No copay	Not covered
0% after ded.	0% after ded.*	$150 copay	$150 copay	$150 copay	$150 copay
0% after ded. 0% after ded.	20% after ded. 20% after ded.	No copay $100 copay	Not covered Not covered	No copay $100 copay	Not covered Not covered
$10 copay after ded. $30 copay after ded. $50 copay after ded.	$10 copay after ded. $30 copay after ded. $50 copay after ded.	$10 copay $25 copay $50 copay	Not covered Not covered Not covered	$10 copay $25 copay $50 copay	Not covered Not covered Not covered
$25 copay after ded. $75 copay after ded. $125 copay after ded.	Not covered Not covered Not covered	$20 copay $50 copay $100 copay	Not covered Not covered Not covered	$20 copay $50 copay $100 copay	Not covered Not covered Not covered

HMO
A Health Maintenance Organization (HMO) only covers care rendered by doctors and other professionals who have agreed to treat patients in accordance with the HMO's guidelines and restrictions. A doctor who is responsible for your care is called a primary care physician (PCP). HMO plans require you to select a PCP at the point of enrollment. HMO's generally do not cover any medical care by providers who are not part of the HMO network, except in the case of an emergency.

HDHP HSA A high deductible health plan (HDHP) is a high deductible PPO plan that meets IRS requirements with regard to minimum deductibles and maximum out-of-pocket amounts. A Health Savings Account (HSA) is an account that allows you to contribute and set aside pretax dollars to pay for eligible health care expenses. You must be enrolled in an HDHP HSA to be eligible to establish this type of tax preferred account.

Medical

UHC Simply Engaged Program

SimplyEngaged is a personal health and wellness program that allows you to earn rewards* when you complete health and wellness actions.

These health and wellness reward programs are sponsored by UHC as long as you are an active benefit eligible employee enrolled in one of the six UHC plans. If you have a spouse/domestic partner covered in your plan, they are also eligible to participate in the health and wellness programs.

Below are brief summaries of the different programs and rewards available to participating members:

Biometric Health Screening: Participate in the Biometric Screening not only to receive a **$75** reward but to get a better understanding of your health numbers and what they may mean to your overall risk.

Health Survey: Take a confidential health survey and receive results on how to better improve your health. The health survey takes approximately 15-20 minutes to complete and you will earn a **$25** reward.

Rally Missions: Once you complete your Biometric Health Screening and Health Survey, Rally Missions are health action missions that will help you to reach your health and wellness goals. Complete three Rally Missions and you earn a **$50** reward.

Gym Reimbursement: Get a **$20** reward each month that you visit a participating fitness center at least 12 times per month. You can see the participating gyms on ***myuhc.com***.

Telephone-Based Health Coaching Program: Call a wellness coach at 800.478.1057 to begin working on your personal health goals. Allow an average of 2-5 months to complete the program. Earn **$75** once the program is complete.

myHealthcare Cost Estimator: Use the myHealthcare Cost Estimator on ***myuhc.com*** to estimate the cost of an upcoming procedure and earn a **$25** reward.

Getting Started

1. Log in to ***myuhc.com*** and click on the Health & Wellness tab
2. Launch Rally to access the Reward Program Overview
3. Begin participating

** $200 annual maximum for employee; $200 annual maximum for spouse/DP if enrolled.*

Find a Medical Provider

Visit ***connect.werally.com/plans/uhc*** to find a Medical Provider in your area and follow the steps below:

1. Click on **Medical Directory**
2. Click on **All UnitedHealthcare Plans**
3. Click on the:
   - **Choice Plus** option for PPO & HSA plans
   - **SignatureValue Plans** for HMO plans
     - **Medical Directory**
     - State where you live **California**
     - California federal employee - **No**
     - **SignatureAdvantage HMO** for Option 5 - HMO Value Network Plan
     - **SignatureValue HMO** for Option 6 - HMO Full Network Plan
4. Select your Location: **Zip Code** or **City & State**
5. Find your Health care by Category: (**People**, **Places**, **Test and Imaging**, **Services and Treatments or Care by Condition**)

Instructions are also provided on the HR/Benefits website.

Real Appeal (Weight Loss Program)

Real Appeal is voluntary weight loss program available to UHC members age 18 and over. This program provides you with a full year of support for lasting weight loss which includes:

Personal Transformation Coach: Your transformation coach will provide you with step-by-step guidance and customization for a program that fits your needs and goals. A personalized dashboard that keeps track of your calories, fitness and goals is provided.

24/7 Convenience: The Real Appeal program will help you stay accountable to your goals by making things easier than ever such as goal trackers, weekly tips by health experts and much more.

Success Kit: After you complete your first class, Real Appeal will deliver you a Success Kit that includes: workout DVDs, recipes, nutrition guides and more.

Getting Started

Create your Real Appeal profile and begin your program today at ***success.realappeal.com***.

Dental

Dental

The dental plans are designed to assist you and your covered dependents by paying a portion of eligible expenses incurred for a wide range of dental services. The dental plans are insured by Guardian.

You can select from the following options:

- Option 1 - PPO Low Plan.
- Option 2 - PPO Medium Plan.
- Option 3 - PPO High Plan.
- Option 4 - DHMO Plan.

If you enroll within your initial eligibility period, your coverage will be effective on the first day of the month following 30 days of employment.

If you do not enroll for coverage within your initial eligibility period, you may enroll for coverage during the next Annual Enrollment period or in accordance with the section titled *"Making Changes During the Year"*.

Your Cost

Your employer and you share the cost of dental coverage. Your cost is generally deducted from your pay on a pretax basis. (Contributions for domestic partners are generally deducted on an after-tax basis, unless otherwise permitted by state or federal law.) Refer to the section titled *"Employee Contributions"* for the applicable cost.

Website Access

The plans also offer additional value-added benefits as described on the Guardian website. After registering online with Guardian, you will be provided with the online tools to:

- Find a network dentist and receive driving directions.
- Verify eligibility and view benefit information.
- Print an ID card and download claim forms.
- Find the average cost of a dental procedure in your area.
- Access dental tips and other oral health information.
- Contact customer service and subscribe to online services.
- Get answers to frequently asked questions.
- View specifics related to any of your claims.

Guardian
guardiananytime.com

First time visitors: You will need to establish a user ID and password. Then, information is available 24/7.

Rollover Provision

If you enroll in Option 3 (PPO High Plan), Guardian will automatically rollover unused dental funds into the next year as follows:

- If you only use in-network providers and your claims for the current year do not exceed $700, $500 will be rolled over into the following year for your use.
- If you use any out-of-network providers and your claims for the current year do not exceed $700, $350 will be rolled over into the following year for your use.

Each covered person in a family has a separate rollover account. The maximum amount that can be rolled over is $1,250.

To find out the amount of Rollover dollars you received from last year, register online with Guardian at ***guardiananytime.com***.

Dental

Summary of Dental Plan Provisions

The following table summarizes the key features of the dental plans available to you and your dependents. To receive the highest level of benefits, you should use in-network providers and fully understand what is expected of you.

Finding an In-Network Dentist Provider

Visit ***tinyurl.com/6llq4fl*** to find a Dental Provider in your area and follow the two steps below:

1. Enter Your Location: **Zip Code**
2. Select Your Dental Network: **PPO**

Instructions are also provided on the HR/Benefits website.

Dental Plans (Guardian)							
Key Features	**Option 1**		**Option 2**		**Option 3**		**Option 4**
	PPO Low Plan		**PPO Medium Plan**		**PPO High Plan**		**DHMO Plan**
	In-Network	**Out-of-Network****	**In-Network**	**Out-of-Network****	**In-Network**	**Out-of-Network****	**In-Network Only**
	You Pay		**You Pay**		**You Pay**		**You Pay**
Calendar Year Deductible (ded.)							
Individual	$50		$50		$50		None
Family	$150		$150		$150		None
	Plan Pays		**Plan Pays**		**Plan Pays**		**Plan Pays**
Calendar Year Maximum Benefits (per person, excluding orthodontia)	$1,000		$1,250		$1,500 plus maximum rollover***		No maximum
Lifetime Orthodontia Maximum	Not Covered		$1,000		$1,250		No maximum
Diagnostic and Preventive Oral exams (once/6 mos); Cleanings (once/6 mos); Fluoride treatments (once/6 mos, up to age 14)	100%*	100%*	100%*	100%*	100%*	100%*	$5 office copay plus any copays applicable to specific procedures
Basic Services X-rays; Fillings; Simple extractions; Sealants (up to age 16, once/30 mos); Space maintainers	80% after ded.	80% after ded.	80% after ded.	80% after ded.	90% after ded.	90% after ded.	$5 office copay plus any copays applicable to specific procedures
Major Restorative Services Bridges & dentures; Endodontic services; Single crowns; Complex extractions; Crown, bridge & denture repair; General anesthesia; Perio maintenance (once/6mos); Combined cleanings/Perio maintenance (twice/12 mos); Periodontal surgery; Inlays, onlays & veneers	Not covered	Not covered	50% after ded.	50% after ded.	60% after ded.	60% after ded.	$5 office copay plus any copays applicable to specific procedures
Orthodontia	Not covered	Not covered	50%* (children only)	50%* (children only)	50%* (children and adults)	50%* (children and adults)	Varies by schedule

* *Deductible waived.*

** *Out-of-Network claims are reimbursed at the maximum allowable charge as determined by Guardian. Using out-of-network providers may result in you being balance-billed by the provider.*

*** *You may be eligible to rollover unused benefit dollars each year you are continuously enrolled under this plan. Refer to the section titled "Rollover Provision" or call Guardian for more information.*

This summary is provided for general information only. It does not provide coverage details, exclusions or limitations. Refer to the plan documents available on the HR/Benefits website for complete plan provisions, exclusions and limitations.

Vision

The vision plans provide preventive care through regular eye exams and early corrective treatment. You have the option of enrolling for a plan that covers your vision exam and provides an allowance for materials or a full-feature plan. In addition to selecting the plan design you want, you will also need to select either the Davis or VSP provider network. The vision plans are insured by Guardian.

You can select from the following options:

- Option 1 - Exam Plus Allowance (Davis Network).
- Option 2 - Exam Plus Allowance (VSP Network).
- Option 3 - Full Feature (Davis Network).
- Option 4 - Full Feature (VSP Network).

Practice good vision health. Obtain an eye exam every year and help stop vision loss before it starts.

If you enroll for coverage within your initial eligibility period, your coverage will be effective on the first day of the month following 30 days of employment.

If you do not enroll for coverage within your initial eligibility period, you may enroll for coverage during the next Annual Enrollment period or in accordance with the section titled *"Making Changes During the Year"*.

Your Cost

You pay the full cost of vision coverage. Your cost is generally deducted from your pay on a pretax basis. (Contributions for domestic partners are generally deducted on an after-tax basis, unless otherwise permitted by state or federal law.) Refer to the section titled *"Employee Contributions"* for the applicable cost.

Summary of Vision Plan Provisions

The following table summarizes the key features of the vision plans available to you and your dependents. To receive the highest level of benefits, utilize in-network providers and fully understand what is expected of you.

Vision Plans (Guardian)

Key Features	Option 1 Exam Plus Allowance Davis Network		Option 2 Exam Plus Allowance VSP Network		Option 3 Full Feature Davis Network		Option 4 Full Feature VSP Network	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	You Pay		You Pay		You Pay		You Pay	
Exam Copay	$0		$0		$10		$10	
Materials Copay	$0		$0		$25		$25	
	Plan Pays		Plan Pays		Plan Pays		Plan Pays	
Frequency	Exam: Every 12 months Materials: Every 12 months		Exam: Every 12 months Materials: Every 12 months		Exam: Every 12 months Lenses: Every 12 months Frames: Every 24 months		Exam: Every 12 months Lenses: Every 12 months Frames: Every 24 months	
Exams	100%	Up to $46	100%	Up to $39	100%	Up to $50	100%	Up to $39
Lenses								
Single	Up to $50 allowance on frames and lenses		Up to $50 allowance on frames and lenses		100%	Up to $48	100%	Up to $23
Bifocal					100%	Up to $67	100%	Up to $37
Trifocal					100%	Up to $86	100%	Up to $49
Lenticular					100%	Up to $126	100%	Up to $64
Medically Necessary					100%	Up to $210	100%; after $25 copay	Up to $210
Elective					Up to $130	Up to $105	Up to $130	Up to $100
Frame Benefit					Up to $130 then 20% discount	Up to $48	Up to $130 then 20% discount	Up to $46

This summary is provided for general information only. It does not provide coverage details, exclusions or limitations. Refer to the plan documents available on the HR/Benefits website for complete plan provisions, exclusions and limitations.

Vision

Dual Option Provider Network

When you make your vision plan election (either Exam Plus Allowance or Full Feature), you will also need to select a provider network. Both provider networks cover a significant number of vision providers. Many individuals prefer private practice vision care specialists, while other individuals prefer large retailers. The choice is up to you.

VSP Vision Network	Davis Vision Network
Over 71,000 access points, more than 4,600 retail chain locations like Costco, Visionworks, Pearle Vision and the largest nationwide network of independent doctors.	Over 55,000 provider locations including retailers like WalMart, Sam's Club, J.C. Penney, Sears and Pearle Vision.

For more information and to find a vision provider go to ***guardiananytime.com***.

Guardian
guardiananytime.com

First time visitors: You will need to establish a user ID and password. Then, information is available 24/7.

Finding an In-Network Vision Provider

Visit ***tinyurl.com/d2el9hn*** to find a Vision Provider in your area and follow the steps below:

1. Select your Vision Plan: **Davis Vision** or **VSP**
2. Your Location: Enter **Zip Code** or **Street Address**, **City and State**
3. Distance: Enter mile radius (**5**, **25**, **50** or **100** miles)
4. If selecting a VSP plan, choose the **VSP Choice Network**

Whether you use an in-network or out-of-network provider, benefit authorization is required before you receive services.

Using an In-Network Versus an Out-of-Network Provider

		In-Network	Out-of-Network
The plan gives you a choice when it comes to receiving eye care. You may receive services from either in-network or out-of-network providers. Although you are not required to use in-network providers, your out-of-pocket costs will be lower when in-network providers are used. This table compares some of the key differences between receiving care from an in-network versus an out-of-network provider.	**Provider**	Must use an in-network provider	Use any licensed eye care provider outside the network
	Benefit Authorization	Your network provider obtains authorization from your vision plan when you make your appointment and identify yourself as an enrolled member	You must contact your provider to obtain authorization before you visit your out-of-network provider
	Benefits	The plan pays a higher benefit level, which means less out-of-pocket cost for you	The plan pays a lower benefit level, which means more out-of-pocket cost for you
	Claims	Your provider files claims on your behalf	You must file your own claims with your vision provider
	Additional Discounts and Savings	Available, which means your share of the cost for additional purchases will be less (e.g., Lasik surgery, etc.)	Not available

Disability

Disability

The disability plans are designed to replace a portion of your income if you are unable to work due to an accident or illness. These plans cover you continuously with both short term and long term benefits for qualifying disabilities. These coverages also provide the vital support, services and assistance you need to get back to work and to an independent lifestyle.

The following table summarizes the key features of the plans.

Disability Plans (STD and LTD)			
Plan	**Benefit Percentage**	**Benefit Begins**	**Maximum Benefit**
Short Term Disability			
Staff	20% of pay	1st day of accident or 8th day of sickness	$1,000 per week (up to 13 weeks)
Providers	60% of pay	31st day of absence	$2,500 per week (up to 9 weeks)
Long Term Disability			
Staff	60% of pay	91st day of disability	$10,000 per month
Providers			$25,000 per month

This summary is provided for general information only. It does not provide coverage details, exclusions or limitations (e.g., preexisting condition limitation). Refer to the plan documents available on the HR/Benefits website for complete plan provisions, exclusions and limitations.

Short Term Disability (STD)

Staff — If you enroll for coverage and your enrollment is received within your initial eligibility period, your coverage will be effective on the first day of the month following 30 days of employment.

Once your initial eligibility period has passed, you may only enroll or change benefit plan options during the next Annual Enrollment period. You should also keep in mind that if you enroll after your initial enrollment period, you will be required to provide evidence of insurability satisfactory to the insurance company before the coverage will become effective.

STD benefits generally begin the first day of an accident or eighth day of sickness if you are unable to perform all of the material and substantial duties of your own occupation and as long as you are not engaged in any occupation for wage or profit, as determined by the insurance company. STD benefits pay up to 20% of pay to a maximum of $1,000 per week.

STD benefits continue for up to 13 weeks as long as you remain disabled as determined by the insurance company.

Providers — You are automatically enrolled for STD insurance on the first day of the month following 30 days of employment. STD benefits generally begin the 31st day of an absence if you are unable to perform all of the material and substantial duties of your own occupation and as long as you are not engaged in any occupation for wage or profit, as determined by the insurance company. STD benefits pay up to 60% of pay to a maximum of $2,500 per week.

STD benefits continue for up to 9 weeks as long as you remain disabled as determined by the insurance company.

Provider STD benefits will be reduced by any other benefits you may be eligible for such as state disability benefits (e.g., California).

Disability

Long Term Disability (LTD)

You are automatically enrolled for LTD insurance on the first day of the month following 30 days of employment. LTD benefits begin after you have been disabled for 90 days, as determined by the insurance company. LTD benefits pay up to:

- Staff: 60% of your pay to a maximum of $10,000 per month.
- Providers: 60% of pay to a maximum of $25,000 per month.

LTD benefits generally continue as long as you remain totally disabled, up to age 65 (longer if your disability begins at age 60 or later). LTD benefits will be reduced by any other benefits you may be eligible to receive such as state disability benefits, workers' compensation or Social Security disability benefits.

There are several other additional special benefit provisions available under the LTD plan as follows:

- Social Security assistance.
- Rehabilitation during disability.
- Return to work incentive benefits.
- Survivor benefits.

Your Cost

Staff — You pay the entire cost of the STD plan and your employer pays the entire cost of the LTD plan.

Providers — Your employer pays the entire cost of the STD plan and LTD plan.

Refer to the section titled *"Employee Contributions"* for the applicable cost. In addition to STD and LTD costs, you are responsible for the full cost of California State Disability Insurance.

Annual Pay

For purposes of the life, accident and disability plans "pay" or "annual pay" is defined as:

- Staff: Current base pay excluding any forms of extra compensation.
- Providers: The greater of current base pay or prior year W-2 earnings.

Life and Accident

The life and accident insurance plans provide you with basic life and accident insurance paid for by your employer. In addition, optional life, dependent life and accidental death and dismemberment (AD&D) insurance coverage is available at group rates. The life and accident plans are insured by Sun Life.

The following table summarizes the key features of the plans available to you and your dependents.

Life and Accident Plans (Sun Life)					
Plan	Coverage Available			Enrollment Required	Paid By
	Employee	Spouse/Domestic Partner	Each Child		
Basic Life	2 times annual base pay (maximum $50,000)	–	–	No	Employer
Optional Employee Life & Dependent Life	1 – 8 times annual base pay (maximum $750,000)	$25,000 – $250,000 (increments of $25,000)	$5,000 – $25,000* (increments of $5,000)	Yes	Employee
Basic AD&D	2 times annual base pay (maximum $50,000)	–	–	No	Employer
Optional Employee AD&D & Dependent AD&D	1 – 8 times annual base pay (maximum $750,000)	$25,000 – $250,000 (increments of $25,000)	$5,000 – $25,000* (increments of $5,000)	Yes	Employee

* *Coverage for a child from birth to 6 months is limited to $5,000.*

This summary is provided for general information only. It does not provide coverage details, exclusions or limitations (e.g., certain maximums apply to each level of coverage and evidence of insurability may be required). Refer to the plan documents available on the HR/Benefits website for complete plan provisions, exclusions and limitations.

What is the Right Amount of Life Insurance?

How much is enough life insurance? To begin to determine how much you need, consider both your family's immediate and long-term financial needs, such as:

- Mortgage expenses.
- Day care and everyday expenses.
- Credit card debt.
- College costs.
- Charitable giving goals.
- Financial goals.
- Final expenses for a simple funeral, which can cost $10,000 or more.

Visit the Sun Life Financial online life insurance calculator to determine the amount of insurance you need at ***tinyurl.com/gm8sfv3***.

Term Insurance vs Whole Life Insurance

Term Insurance (Sun Life)

This type of life insurance tends to be a more popular choice because it's less expensive. Once you elect a coverage level (based on a multiple of your pay), the coverage stays in place as long as you are employed. When your pay increases, your coverage amount increases. Your rates are age rated. This means as you get older your rates (and cost) increase. When you terminate employment you can port your coverage and take it with you. Term insurance doesn't build any cash value.

Whole Life Insurance with LTC Rider (Transamerica)

This type of life insurance has some advantages over term life insurance policies. Once you enroll, your coverage remains fixed. It builds cash value, which means you can borrow against your policy or even cash it in if at some point you feel you no longer need the insurance. And, unlike term insurance, the premium will never change as long as you live. In addition, the Transamerica policy comes with a long term care (LTC) rider that pays a benefit if the insured is confined in a licensed nursing or assisted living facility and has a physician-certified chronically ill diagnosis.

The Transamerica whole life and long term care insurance product is an employee-paid program. Your employer is not the plan sponsor or the plan fiduciary. As a result, this program is not covered by the Employee Retirement Income Security Act of 1974, as amended (ERISA). All administration of the program is performed by Transamerica and the writing agent.

Term Life vs Whole Life - Cost Difference

The difference in cost of the two life insurance products is significant. You should carefully review the cost differences as well as features and then select the product that best fits your financial goals. The following examples show the monthly cost of $50,000 of insurance at ages 30, 40 and 50.

Monthly Cost Examples - Various Ages				
Age	Coverage	Term Life	Whole Life/LTC	
			Non-Tobacco	Tobacco
30	$50,000	$3.00	$34.76	$47.10
40	$50,000	$5.50	$56.46	$76.86
50	$50,000	$14.00	$100.88	$132.94
60	$50,000	$40.50	$187.62	$234.10

Life and Accident

Accelerated Death Benefit and Long Term Care Rider Information

This provision of the Transamerica whole life insurance policy allows the insured to receive 4% of the face amount of the policy for up to 25 months if the insured is confined in a licensed nursing or assisted living facility or 2% of the face amount of the policy for up to 50 months if the insured receives home health care or adult day care services. The benefit can only be triggered by a chronically ill diagnosis that must be certified by a licensed physician. Any benefits paid under this rider reduce the amount otherwise payable under the policy at time of death. For more complete information, refer to the Transamerica policy.

Protect Your Family

Most people agree that protecting their loved ones' lifestyle in the event of death is very important. So why do so many Americans insure their possessions more carefully than their family's future? Consider what would happen to your dependents if they no longer had your income to rely on. Could they maintain their lifestyle? Life insurance can help secure the plans for your child's future such as college funding and medical expenses. Proceeds from a group term life insurance policy can also help supplement retirement income for a surviving spouse.

Upon enrollment, you must provide your beneficiary designations. You should keep in mind that changes in your family status (such as marriage, divorce or new children) do not automatically alter or revoke your previous designations. Therefore, it is important that you review your beneficiary designations from time to time.

Annual Pay

For purposes of the life, accident and disability plans "pay" or "annual pay" is defined as:

- Staff: Current base pay excluding any forms of extra compensation.
- Providers: The greater of current base pay or prior year W-2 earnings.

Basic Life

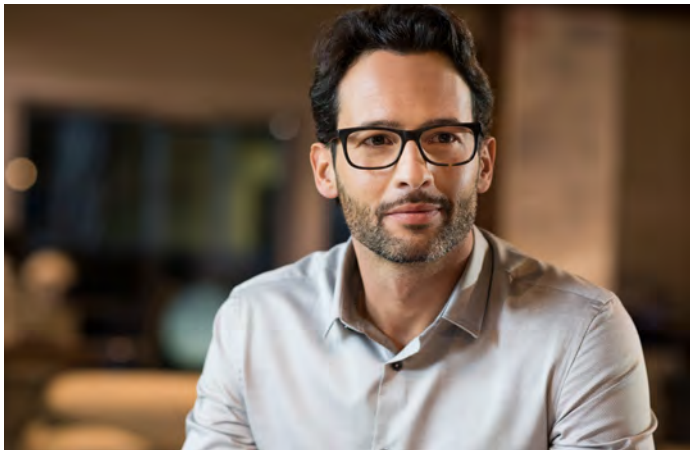
You are automatically enrolled for basic life insurance on the first day of the month following 30 days of employment. Basic life insurance is equal to two times your annual base pay rounded to the next higher multiple of $1,000, if the coverage amount is not a multiple of $1,000. The maximum amount of basic life insurance is $50,000.

Your basic life insurance coverage reduces automatically upon attainment of the specific age in the following table.

Age	Percentage of Available Amount
70	65%
75	50%

For example, if you are age 69 and have $50,000 of coverage, your benefit payable would be the full $50,000. Upon turning age 70, your benefit payable would be $32,500 (calculated as $50,000 x 0.65 = $32,500).

If your annual base pay changes (either increases or decreases), your basic life insurance will automatically change to the new coverage amount on the first of the following month.



Things to Consider About Life Insurance

Most people don't like to think about needing life insurance. But when an unexpected death happens to a wage earner, we realize how important life insurance can be. You can minimize the impact of an unexpected death by selecting the right amount of life insurance.

Optional Life – Employee

Optional life insurance is available in amounts from 1 – 8 times your annual base pay, rounded to the next higher multiple of $1,000, if the coverage amount is not a multiple of $1,000. The maximum amount of optional life insurance is $750,000.

Your optional life insurance coverage reduces automatically upon attainment of the specific age in the following table.

Age	Percentage of Available Amount
70	65%
75	50%

For example, if you are age 69 and have $100,000 of coverage, your benefit payable would be the full $100,000. Upon turning age 70, your benefit payable would be $65,000 (calculated as $100,000 x 0.65 = $65,000).

If you enroll for coverage and your enrollment is received within your initial eligibility period, your coverage amount for optional life insurance of up to $250,000 will be effective on the first day of the month following 30 days of employment.

If your enrollment in optional life insurance results in over $250,000 of coverage, you will be required to provide evidence of insurability satisfactory to the insurance company before coverage in excess of $250,000 will become effective.

Once your initial eligibility period has passed, you may only enroll during the next Annual Enrollment period or within 30 days of a qualifying event.

You should also keep in mind that if you enroll or increase coverage after your initial eligibility period (including during the Annual Enrollment period), you will be required to provide evidence of insurability satisfactory to the insurance company before the new or increased coverage will become effective.

If your annual base pay changes (either increases or decreases), your optional life insurance will automatically change to the new coverage amount on the first of the following month. Your employee premiums will also change as of the date your optional life insurance coverage changes.

Dependent Life – Spouse/Domestic Partner

If you enroll for optional life insurance, you are eligible to enroll for dependent life insurance for your spouse/domestic partner. Dependent life insurance is available in amounts from $25,000 – $250,000 in increments of $25,000. However, spouse/domestic partner coverage may not exceed 100% of your combined basic and optional life insurance coverage. Your spouse/domestic partner life insurance coverage terminates when your spouse/domestic partner attains age 70.

If you enroll for dependent life insurance for your spouse/domestic partner and your enrollment is received within your initial eligibility period, your coverage amount for dependent life insurance of up to $25,000 will be effective on the first day of the month following 30 days of employment.

If your enrollment in dependent life insurance for your spouse/domestic partner results in over $25,000 of coverage, your spouse/domestic partner will be required to provide evidence of insurability satisfactory to the insurance company before coverage in excess of $25,000 will become effective.

Once your initial eligibility period has passed, you may only enroll during the next Annual Enrollment period or within 30 days of a qualifying event.

You should also keep in mind that if you enroll or increase coverage after your initial eligibility period (including during the Annual Enrollment period), your spouse/domestic partner will be required to provide evidence of insurability satisfactory to the insurance company before the new or increased coverage will become effective.

Dependent Life – Children

If you enroll for optional life insurance, you are eligible to enroll for dependent life insurance for your children. Dependent life insurance is available in amounts from $5,000 – $25,000* in increments of $5,000. If you enroll one child, all eligible children are covered.

**Coverage for a child from birth to 6 months is limited to $5,000.*

If you enroll for dependent life insurance for your children and your enrollment is received within your initial eligibility period, your coverage amount for insurance of up to $25,000 will be effective on the first day of the month following 30 days of employment.

If you do not enroll for dependent life insurance for your children during your initial eligibility period, you may enroll for coverage during the next Annual Enrollment period or within 30 days of a qualifying event. (Evidence of insurability is not required for dependent children.)

Your Cost

Your employer pays the entire cost of basic life insurance. You pay the entire cost of any optional life insurance and dependent life insurance. Your cost is deducted from your pay on an after-tax basis. Refer to the section titled *"Employee Contributions"* for the applicable cost.

Basic AD&D

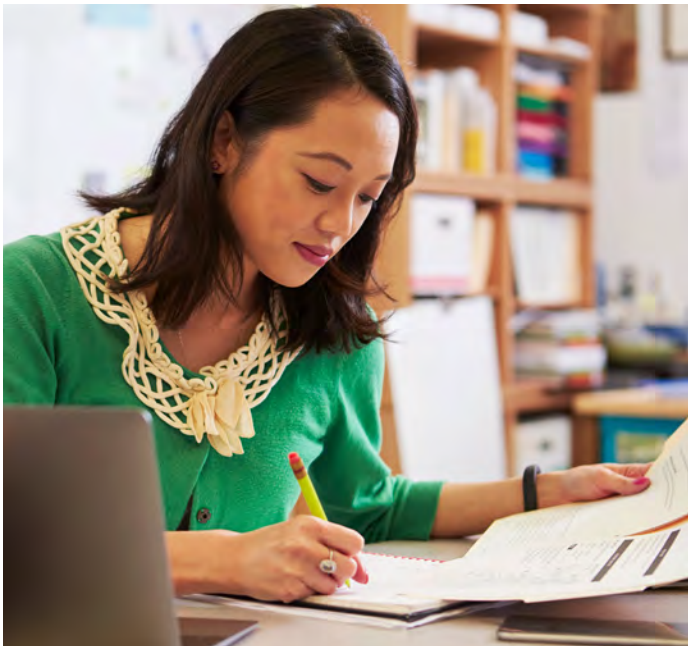
You are automatically enrolled for basic accidental death and dismemberment (AD&D) insurance on the first day of the month following 30 days of employment. The principal amount of basic AD&D is equal to two times your annual base pay rounded to the next higher multiple of $1,000, if the coverage amount is not a multiple of $1,000. The maximum amount of basic AD&D insurance is $50,000.

Your basic AD&D insurance coverage reduces automatically upon attainment of the specific age in the following table.

Age	Percentage of Available Amount
70	65%
75	50%

For example, if you are age 69 and have $50,000 of coverage, your benefit payable would be the full $50,000. Upon turning age 70, your benefit payable would be $32,500 (calculated as $50,000 x 0.65 = $32,500).

If your annual base pay changes (either increases or decreases), your basic AD&D life insurance will automatically change to the new coverage amount on the first of the following month.



Optional AD&D – Employee

Optional AD&D insurance is available in amounts from 1 – 8 times your annual base pay, rounded to the next higher multiple of $1,000, if the coverage amount is not a multiple of $1,000. The maximum amount of optional AD&D insurance is $750,000.

Your AD&D insurance coverage reduces automatically upon attainment of the specific age in the following table.

Age	Percentage of Available Amount
70	65%
75	50%

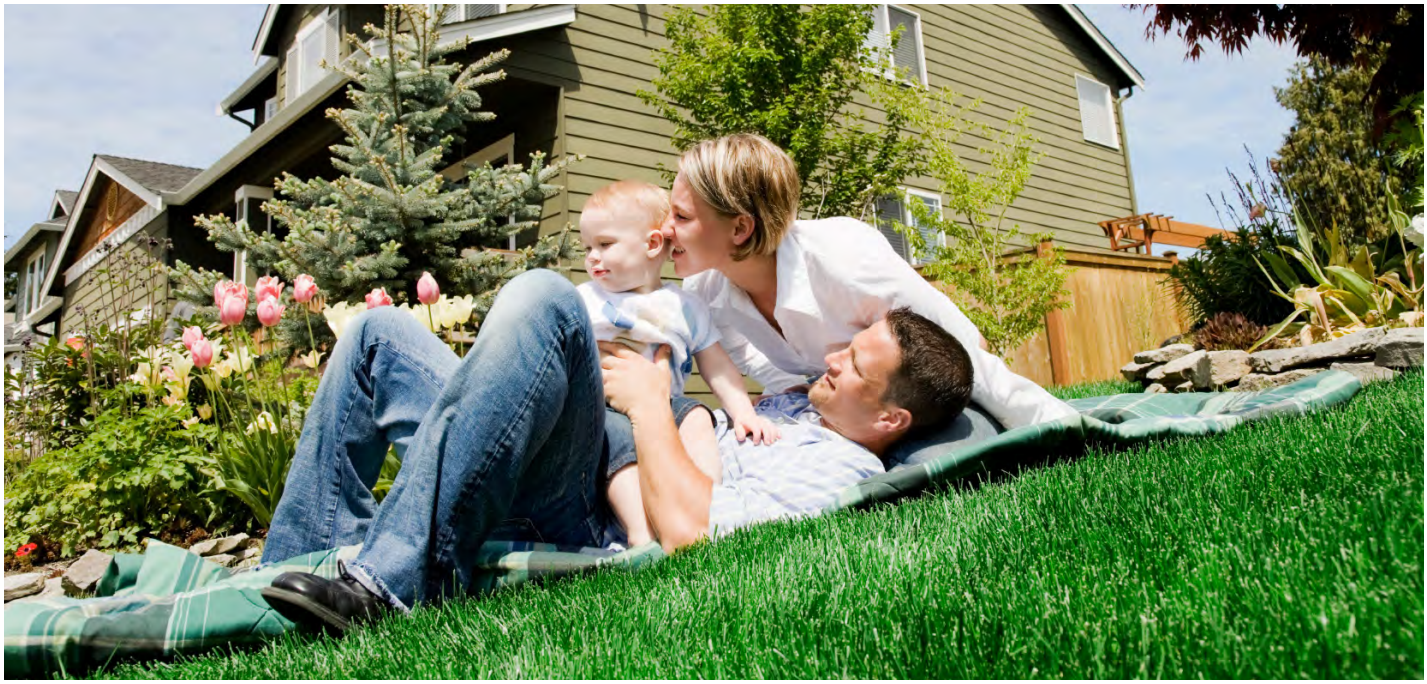
For example, if you are age 69 and have $100,000 of coverage, your benefit payable would be the full $100,000. Upon turning age 70, your benefit payable would be $65,000 (calculated as $100,000 x 0.65 = $65,000).

If you enroll for AD&D insurance and your enrollment is received within your initial eligibility period, your coverage amount will be effective on the first day of the month following 30 days of employment.

Once your initial eligibility period has passed, you may only enroll during the next Annual Enrollment period or within 30 days of a qualifying event.

If your annual base pay changes (either increases or decreases), your optional AD&D insurance will automatically change to the new coverage amount on the first of the following month. Your employee premiums will also change as of the date your optional AD&D insurance coverage changes.

Life and Accident



Dependent AD&D – Spouse/Domestic Partner

If you enroll for optional AD&D insurance, you are eligible to enroll for dependent AD&D insurance for your spouse/domestic partner. Dependent AD&D insurance is available in amounts from $25,000 – $250,000 in increments of $25,000. However, spouse/domestic partner coverage may not exceed 100% of your combined basic and optional AD&D insurance coverage. Your spouse/domestic partner AD&D insurance coverage terminates when your spouse/domestic partner attains age 70.

If you enroll for dependent AD&D insurance for your spouse/domestic partner and your enrollment is received within your initial eligibility period, your coverage amount will be effective on the first day of the month following 30 days of employment.

Once your initial eligibility period has passed, you may only enroll during the next Annual Enrollment period or within 30 days of a qualifying event.

Dependent AD&D – Children

If you enroll for optional AD&D insurance, you are eligible to enroll for dependent AD&D insurance for your children. Dependent AD&D insurance is available in amounts from $5,000 – $25,000* in increments of $5,000.

**Coverage for a child from birth to 6 months is limited to $5,000.*

If you enroll for dependent AD&D insurance for your children and your enrollment is received within your initial eligibility period, your coverage amount for insurance of up to $25,000 will be effective on the first day of the month following 30 days of employment.

If you do not enroll for dependent AD&D insurance for your children during your initial eligibility period, you may enroll for coverage during the next Annual Enrollment period or within 30 days of a qualifying event.

AD&D Benefit Schedule

The following table shows losses that are covered under the basic, optional and dependent AD&D insurance and the corresponding benefit amounts as a percentage of the principal amount. These benefit amounts will be paid only if:

- Death occurs within 365 days from the date of the accident; or
- Injury results in one or more covered losses listed below within 365 days from the date of the accident.

Covered Loss	Benefit Amount (Percentage of Principal Amount)
Life Speech and hearing Quadriplegia	100%
Paraplegia	75%
Hemiplegia One limb Sight of one eye Speech or hearing	50%
Thumb and index finger of same hand	25%

If a person suffers more than one covered loss as a result of the same accident, only the largest benefit amount will be paid. Refer to specific plan documents available on the HR/Benefits website for complete plan provisions, exclusions and limitations.

Injury means bodily impairment resulting directly from an accident and independent of all other causes.

Loss of limb means severance of hand or foot at or above the wrist or ankle joint. Loss of sight, speech or hearing must be total and irrecoverable. Loss of thumb and index finder means severance through or above the metacarpophalangeal joints.

Quadriplegia means the total and permanent paralysis of both upper and lower limbs. Paraplegia means the total and permanent paralysis of both lower limbs. Hemiplegia means the total and permanent paralysis of the upper and lower limbs on one side of the body.

AD&D Special Benefits

There are several additional special benefit payments provided under the AD&D plans, which may be payable in the event of a covered loss, as follows:

- **Air Bag Benefit** — This benefit is payable if a seat belt benefit is payable and the insured person was positioned in a seat protected by a supplemental restraint system which inflated on impact.
- **Bereavement Counseling Benefit** — This benefit will pay a bereavement counseling benefit during an insured person's immediate family member's period of bereavement for up to 12 months after an employee's death.
- **Business Travel Benefit** — This benefit is payable if an employee's loss of life occurs while traveling on business for the employer.
- **Dependent Education Benefit** — This benefit is payable if a dependent child enrolls as a full-time student at a post-secondary school before reaching age 26 and within one year after the employee's date of death. A dependent spouse is eligible for an education benefit if the dependent spouse enrolls in any school for the purpose of retraining or developing skills needed for employment within one year after the employee's date of death.
- **Disappearance** — This benefit is payable if an insured person disappears as a result of an accidental wrecking, sinking or disappearance of a conveyance in which the insured person was known to be a passenger and the body of the insured person is not found within 365 days after the date of the conveyance's disappearance.
- **Helmet Benefit** — This benefit is payable if an insured person dies as a result of a motorcycle accident while wearing a helmet and an accidental death benefit is payable.
- **Seat Belt Benefit** — This benefit is payable if the insured person was wearing a seat belt at the time of the accident.

The following table provides more details regarding the AD&D special benefits.

AD&D Special Benefits	Basic	Optional
Air Bag Benefit The lesser of $5,000 or 10% of the amount of accidental death benefit payable.	✓	✓
Bereavement Counseling Benefit $250 per immediate family member, to a maximum of $1,000 per insured person's death.	✓	✓
Business Travel Benefit The lesser of $25,000 or 25% of the amount of accidental death benefit payable.	✓	✓
Dependent Education Benefit Child: The lesser of 5% of the employee accidental death benefit payable, the amount of incurred expenses or $2,500. The dependent child education benefit is payable at the end of each semester per dependent child, for a maximum of four consecutive years per child. Spouse: The lesser of $3,000 or the actual expenses paid to the school.	✓	✓
Disappearance 100% of the amount of accidental death benefit payable.	✓	✓
Helmet Benefit The lesser of $25,000 or 50% of the amount of accidental death benefit payable.	✓	✓
Seat Belt Benefit The lesser of $25,000 or 25% of the amount of accidental death benefit payable.	✓	✓

Your Cost

Your employer pays the entire cost of basic AD&D insurance. You pay the entire cost of any optional AD&D insurance and dependent AD&D insurance. Your cost is deducted from your pay on an after-tax basis. Refer to the section titled *"Employee Contributions"* for the applicable cost.

Flexible Spending Accounts

Flexible Spending Account (FSA) Plans

Flexible spending accounts (FSAs) provide a great opportunity to get more for your dollars. Every FSA dollar you spend saves you money — not because the services cost less — but because you use dollars that have not been taxed.

The following accounts are available:

- Health care FSA* — for out-of-pocket medical, prescription drug, dental and vision expenses (not available to employees enrolled in medical plans Options 4, 5 and 6).
- Health savings account (HSA) compatible FSA* — for out-of-pocket dental and vision expenses (for employees enrolled in medical plans Options 4, 5 and 6).
- Dependent care FSA — for dependent care expenses, such as charges for child day care or elder care while you are at work.

** You cannot be enrolled in both the health care FSA and HSA compatible FSA at the same time. HSA compatible FSA is also referred to as a "Limited-Purpose" FSA.*

The FSAs are administered by WageWorks.

If you enroll in an FSA within your initial eligibility period, your coverage will be effective on the first day of the month following 30 days of employment.

If you do not enroll in an FSA within your initial eligibility period, you may enroll for coverage during the next Annual Enrollment period or as summarized in *"Making Changes During the Year"*.

FSA Tools
wageworks.com

- View eligible expenses.
- Use the savings calculator to help you decide how much to contribute – visit ***FSAWorks4Me.com***.
- If you choose to participate, be sure to register for an online account. It's easy and you'll have 24/7 access to your account.

WageWorks Toll Free
877.924.3967

Tax Savings

Federal regulations allow FSA contributions to be deducted from your pay on a pretax basis. This means that you do not pay federal or state (in most states) income taxes or employment taxes (such as FICA) on your contributions.

Your actual savings depend on your personal tax situation. The example below highlights how your take-home pay could change if you participate in the plan. You should talk with a tax advisor to find out how this plan will affect your specific tax situation.

	Health Care FSA*	HSA Compatible FSA*	Dependent Care FSA
	Not available to employees enrolled in a high deductible medical plan with an HSA option	Only available to employees enrolled in a high deductible medical plan with an HSA option	Available to all eligible employees
Maximum Contribution	**$2,650**	**$2,650**	**$5,000**
If you contribute this much:	$1,200	$1,200	$2,500
And your tax rate is:	25%	25%	25%
Your estimated annual savings are (your actual savings will vary):	$300	$300	$625

** You cannot be enrolled in both the health care FSA and HSA compatible FSA at the same time. HSA compatible FSA is also referred to as a "Limited-Purpose" FSA.*

Flexible Spending Accounts

FSA Options at a Glance

	Health Care FSA*	HSA Compatible FSA*	Dependent Care FSA
	Not available to employees enrolled in a high deductible medical plan with an HSA option	Only available to employees enrolled in a high deductible medical plan with an HSA option	Available to all eligible employees
Contribution Amounts	$100 to $2,650		$100 to $5,000** ($2,500 if you and your spouse file separate tax returns)
Eligible Expenses	You and your eligible dependents' health care expenses that you pay out of pocket and are not reimbursed by any other source (such as insurance). For example, you can use FSA dollars for medical, dental and vision copays, coinsurance and deductible amounts.	You and your eligible dependents' dental and vision expenses that you pay out of pocket and are not reimbursed by any other source (such as insurance). For example, you can use FSA dollars for dental and vision copays, coinsurance and deductible amounts.	Out-of-pocket costs for licensed nurseries or day care centers, babysitting services, day camp and after-school programs, and caregivers for an elderly or incapacitated dependent. The expenses must be necessary to allow you — and, if applicable, your spouse — to work, look for work or go to school full time.
Access to Contributions	As soon as participation begins, you can be reimbursed in full for eligible expenses up to your annual contribution amount minus any reimbursements you have already received regardless of the current balance in your account.		You can be reimbursed for eligible expenses only up to the amount available in your account at the time of the claim. The remainder will be reimbursed after you make additional contributions.

* *You cannot be enrolled in both the health care FSA and HSA compatible FSA at the same time. HSA compatible FSA is also referred to as a "Limited-Purpose" FSA.*

** *You may not contribute more than your earned income or that of your spouse, whichever is less. For example, if you earn $25,000 per year and your spouse earns $4,000 per year, your maximum contribution is limited to $4,000 per year. In addition, your contribution amount may be reduced if the plan fails one of several IRS benefit limitation tests. You will be advised if this occurs.*

When you enroll in the health care FSA, you will receive a debit card that has been preloaded with your enrollment information. When you have eligible expenses, you can use your debit card just like a credit card, providing you instant access to your account. This method of accessing your account balance helps to reduce the hassle of filing paper claims, but you must remember to keep your receipts in the event you are required to provide documentation for the transaction. The debit card cannot be used to access funds from your dependent care FSA.

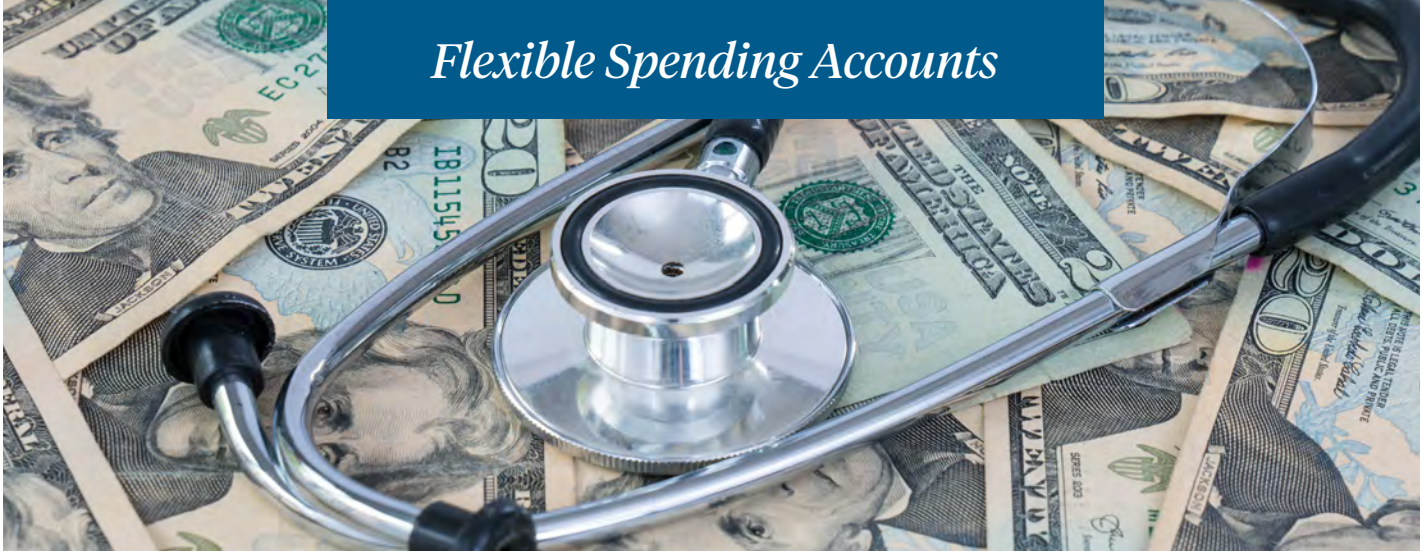
Make your flexible spending account choices before your enrollment deadline

You may:

- Choose to contribute from $100 to $2,650 per calendar year to the Health Care FSA or HSA Compatible FSA.
- Choose to contribute from $100 to $5,000 per calendar year to the Dependent Care FSA ($2,500 if you and your spouse file separate tax returns).

Specify an annual contribution amount for each FSA. The annual amount is divided by 26 pay periods during the year to determine the deduction to be made from each of your paychecks. Your contribution amount may be reduced or your participation may be terminated if the plan fails one of several IRS benefit limitation tests. You will be advised if this occurs.

Flexible Spending Accounts



Claim Filing Deadline

There is no grace period for this plan, therefore, you must spend your funds by the close of the plan year (December 31, 2018) and claims must be filed by March 31, 2019. If you do not spend your funds by December 31, 2018, the claim administrator will automatically rollover up to $500 of unused health care FSA funds into the following plan year. Any additional balance in your account after December 31, 2018 must be forfeited. Rollover dollars will not be available until approximately 2 weeks after the 2018 claim filing deadline. Keep in mind that if you do not elect to participate in the new plan year and you lose your debit card, you will need to file paper claims (via mail or via the smart phone app).

For FSA questions or to confirm the eligibility of your expenses, contact WageWorks. You can visit ***wageworks.com*** or call 877.924.3967.

Rollover dollars will automatically be classified as HSA compatible FSA dollars if you enroll in a high deductible medical plan with an HSA for the following year.

WageWorks
wageworks.com
877.924.3967

Important FSA Rules and Restrictions

When you enroll in an FSA midyear, your contribution amount applies to the remaining part of the year — not a full year. This means that you cannot file claims for expenses incurred before you are enrolled in the FSA. (An expense is "incurred" on the date the service is provided or the supply is purchased.)

You can enroll in an FSA or update your FSA contribution amount after your enrollment deadline only if you experience a qualifying event as summarized in *"Making Changes During the Year"*.

If your change allows you to enroll in an FSA midyear, your contribution amount applies only to the period remaining in that year — you cannot file claims for expenses incurred before your enrollment in the FSA becomes effective.

- You must save all of your receipts even if you use the FSA debit card for your purchases; under IRS regulations, you may be required to submit receipts to WageWorks and/or to the IRS.
- If you take an unpaid leave of absence, your FSA participation stops; if you take a paid leave of absence, participation may continue in the health care FSA, but will generally stop for the dependent care FSA.
- If your FSA participation ends midyear because you experience a qualifying event or you leave your employer, you can submit claims only for expenses incurred through your last day of participation; you may be able to continue your health care FSA participation through COBRA.*

** Dependent Care FSA may not be continued under COBRA.*

Flexible Spending Accounts

Important FSA Hints

Retain Your FSA Debit Card Receipts

The IRS requires FSA administrators to carefully audit transactions. Therefore, you should retain your receipts in the event WageWorks auditors need to prove your transaction was for eligible expenses. Failure to provide requested receipts will result in FSA debit card suspension and may require you to reimburse funds to the plan.

FSA vs. IRS Tax Credit

Determining which option to use — the Dependent Care FSA or the IRS Tax Credit for Child and Dependent Care Expenses — depends on your personal tax situation. You should contact your tax advisor before deciding to participate in the plan.

Changing your HSA Compatible FSA to a Full FSA

If you enrolled in one of our high deductible medical plans and you also enrolled in the health care FSA, your health care FSA was automatically classified as an HSA compatible FSA (otherwise known as Limited-Purpose FSA). In this type of FSA, your FSA dollars can only be used to pay for vision and dental expenses.

Once you have met at least $1,350 of your HDHP medical deductible ($2,700 if you have family coverage), you can convert your HSA compatible FSA to a Full FSA. Then your Full FSA can be used for medical expenses as well as vision and dental expenses.

To make this change, complete and submit the HSA/HDHP Deductible Form to WageWorks. The form can be downloaded from our employee benefits website. Contact WageWorks if you have any questions concerning this process.

Manage Your 2018 FSAs with WageWorks

You'll find valuable tools at ***wageworks.com*** to help you manage your account and use your FSA dollars. In addition to reviewing your FSA activity online, you can:

- Request reimbursement for eligible out-of-pocket expenses.
- Review a complete list of eligible expenses.
- Schedule payments to health care and dependent care providers.
- View your transaction and account history.
- Order complimentary WageWorks health care cards (debit card) for your eligible dependents.
- Update your account preferences.
- Manage your account via the WageWorks mobile website and EZ Receipts mobile app.

Pay and File Claims Online

You can pay many of your eligible health care and dependent care expenses directly from your FSA without having to pay out-of-pocket or file paper claims. It's quick, easy, secure and available online at any time. To pay a provider:

- Log on to your account at ***wageworks.com***.
- Click "Submit Receipt or Claim".
- Select "Pay My Provider" and follow the instructions.
- Scan or take a photo of your receipts, EOBs and other supporting documentation.
- Attach supporting documentation to your claim by using the upload utility.

Use the EZ Receipts Mobile App

You can file and manage your claims as well as review your WageWorks health care card usage with a click of your smartphone or mobile device camera. You have control with the EZ Receipts mobile app from WageWorks. To use EZ Receipts:

- From your smartphone, download the app from ***wageworks.com***.
- Log on to your account.
- Choose the type of receipt from the simple menu.
- Enter some basic information about the claim or card transaction.
- Use your smartphone camera or device to capture the documentation.
- Submit the image and details to WageWorks.

Employee Assistance Program

Employee Assistance Program (EAP)

The EAP is designed to help you and your household members identify and find resources to solve personal problems — such as family, alcohol, drug, emotional, stress, legal or financial problems, which if not resolved, could adversely affect the quality of your life. The EAP is administered by ComPsych.

You are automatically enrolled in the EAP on the first day of the month following 30 days of employment.

Your use of the program is on a confidential basis. Through the EAP, you and your family members have up to five free sessions per person, per issue, per year. These sessions will be face-to-face with licensed counselors close to your work or home. In addition, you have unlimited, telephonic legal and financial information available. If you require legal representation, a referral to a qualified attorney in your area will be provided, along with a free 30 minute consultation and a 25% reduction in legal fees thereafter.

Your EAP also provides access to a variety of work/life resources. These resources include referrals to child adoption, elder care and pet care providers in your community.

The EAP line is always open — 24 hours a day, 365 days a year and can be accessed via the toll-free number that provides immediate support in times of crisis and access to all EAP services.

Your Cost
Your employer pays the entire cost of the EAP.

ComPsych Website
guidanceresources.com
When you register as a first time user, your organization ID is "**EAPComplete**" and the first 5 characters of the company name is "**MED30**"

ComPsych Phone Number
877.595.5284
When you call ComPsych for EAP services, make sure to say **MED3000** as the company name.

401(k) Plan

The 401(k) plan provides a means for you to build savings for the future by giving you the opportunity to:

- Reduce your taxable income.
- Contribute through payroll deductions.
- Receive employer matching contributions of 100% on the first 4% of eligible pay that you contribute.
- Choose from a range of investment options that are professionally managed and monitored.
- Build a tax deferred accumulation of dividends, interest and other earnings.

You are eligible to participate in the plan on the first day of the month following 30 days of employment. You will receive an information packet with instructions on how to enroll and set up your 401(k) when you become eligible to participate in the plan. You can save up to 90% of your eligible pay on a pretax basis, up to the IRS annual dollar limits. You can also make after-tax contributions into a Roth 401(k) account, in accordance with plan provisions.

In addition to the annual pretax contribution limits imposed by the IRS (18,500 in 2018), you will be able to make "catch-up" contributions in the amount of $6,000 per year starting in the year you attain age 50.

Automatic Enrollment

If you take no action when you receive your 401(k) plan information packet, you will be automatically enrolled for a pretax savings amount of 4% of your eligible pay. You will have the option to opt-out if you do not wish to enroll.

Employer Matching Contributions

Your employer will match $1.00 for each dollar that you contribute up to 4% of your eligible pay calculated on a per pay period basis. Employer matching contributions are invested in the same funds as your employee contributions.

You should carefully review your contribution strategy so that you can maximize both your employer matching contributions and your pretax contributions. Your tax advisor can help you in this regard.

Employer Match Example

For example, an employee having $1,000 in eligible pay per period and deferring 10% of pay ($100), the 401(k) employer matching contribution would be $40 calculated as follows:

$1,000 eligible pay x 4% of eligible pay = $40 match = $40 employer matching contribution. Although the employee deferred $100, $140 was invested.

The following table shows employee and employer contributions, assuming the employee has $1,000 in pay per pay period.

% Deferral	Employee	+	Employer	=	Total Contribution
0%	$0	+	$0	=	$0
1%	$10	+	$10	=	$20
3%	$30	+	$30	=	$60
4%	$40	+	$40	=	$80
5%	$50	+	$40	=	$90
6%	$60	+	$40	=	$100

Carefully Determine Your 401(k) Contribution Amount

In deciding upon the contribution amount you wish to make, keep in mind that once you reach the annual contribution limit (as determined by the IRS), your employer match stops. For example, if you are less than age 50 and reach the IRS pretax contribution limit by September, you will receive no employer match for the rest of the year. Therefore, in order to maximize your employer's matching amount you receive during the year, you should select a contribution amount to be deducted per pay period that results in your reaching the IRS contribution limit as close to year-end as possible.

401(k) Plan

Vesting
You are immediately vested in your own contribution, the company's safe harbor matching contribution and related investment earnings at 100%.

Investment Options
You can spread your investments among several options to take advantage of what each has to offer and help balance different types of risk. For more complete information about the available investments through the plan, including fees and expenses, log on to MykPlan at ***mykplan.com*** or call 866.695.7526 to speak to a representative.

For investment direction or consulting please contact our financial advisors at KLK Capital Management. Contact H. Kim at **949.379.1985**.

Loans
Within specific guidelines, loans may be approved against your vested account balance. Loan approvals are subject to certain IRS restrictions and limitations. Any loan made to you is secured by your vested interest. The total of all outstanding loans cannot exceed the lesser of 50% of your vested account balance or $50,000. The minimum loan amount is $800.

Plan Administration
Administration and recordkeeping services are provided by ADP. ADP can be contacted by calling 866.695.7526 or visiting ***mykplan.com***. Refer to the section titled "*Important Phone Numbers and Websites*" for your group number.

ADP Website
mykplan.com
First time visitors: You will need to establish a user ID and password. Then, information is available 24/7.

Voluntary Critical Illness Insurance (VCII)

It is important to plan ahead when considering your health care needs. Even though you may have health care coverage, your out-of-pocket expenses could reach into the thousands of dollars, after health insurance pays for your covered services for a serious health problem, such as a stroke, heart attack or cancer.

VCII is available in benefit amounts of $5,000, $10,000, and $15,000. If you enroll for coverage, you can also enroll your spouse/domestic partner (up to age 64) for a benefit amount of $5,000. Unmarried dependent children (up to age 25) are automatically covered at 25% of the amount you choose for yourself ($1,250, $2,500 or $3,750).

If you enroll for coverage during your initial enrollment period, coverage will be effective on the first day of the month following 30 days of employment.

Once your initial eligibility period has passed, you may only enroll during the next Annual Enrollment period for up to $5,000 of coverage. This plan does not permit mid-year enrollments or changes and once you enroll your coverage cannot be increased at a later date. If you enroll for coverage, and at some point in the future decide to reduce your coverage level, your reduced coverage will be changed to your new attained age at that time.

How VCII Works

This plan pays a lump sum benefit directly to you — not to a doctor or health care provider — at the first diagnosis of a covered condition. Family coverage is available.

You can use this coverage more than once. If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions. The diagnosis of a new covered illness must occur at least 90 days after the most recent diagnosis. Each condition is payable once per lifetime. You choose the amount of that protection when you enroll. In order to enroll for VCII, you must have comprehensive health coverage, either through your employer or another source.

Your Cost

Your cost for VCII coverage depends on your age at the time of enrollment, whether you use tobacco, the amount of coverage you choose, and on whether you enroll your spouse/domestic partner (and his or her age at the time of enrollment). Once you enroll, your cost will not change on account of your age, unless you decide to lower your coverage level at a future date.

You pay the entire cost of VCII. Refer to the section titled *"Employee Contributions"* for the applicable cost.

VCII Benefits

VCII provides lump sum payments of $5,000, $10,000, or $15,000 when you are diagnosed with any of these medical conditions: benign brain tumor, blindness, cancer, end-stage kidney failure, heart attack, major organ failure or stroke. You will also receive payments if you suffer an injury that results in a coma. Benefits are paid at 25% of your coverage amount for carcinoma in situ and coronary artery bypass surgery.

In addition to the diagnoses previously mentioned, children are also covered for cerebral palsy, cleft lip/palate, cystic fibrosis, Down syndrome or spina bifida.

If you suffer more than one covered illness, you can receive a full benefit payout for each as long as the other diagnosis is medically unrelated and separated by 90 days or more.

Refer to the HR/Benefits website for a complete list of covered illnesses.

VCII Wellness Benefits

VCII includes a Wellness Benefit to encourage you to visit your doctor for important diagnostic and preventive tests. The plan pays $75 (limit one payment per insured person, per year) in addition to payments made by any other insurance, when you receive any of these health screening tests:

- Blood test for triglycerides.
- Bone marrow aspiration/biopsy.
- Carotid Doppler.
- Certain blood tests for cancer (breast, colon, myeloma, ovarian, prostate).
- Chest x-ray.
- Colonoscopy.
- Echocardiogram or electrocardiogram.
- Fasting blood glucose test.
- Fasting plasma glucose.
- Flexible sigmoidoscopy.
- Hemoccult stool analysis.
- Hemoglobin A1C test.
- Mammography.
- Pap smear (including thin prep pap smear).
- Serum cholesterol test.
- Skin cancer biopsy.
- Thermography.
- Treadmill/bicycle stress test.
- Two hour post-load plasma glucose.
- Virtual colonoscopy.

VCII Benefit Limitations and Exclusions

You should be aware of certain limitations and restrictions to the VCII plan, including:

- No benefits will be paid for a diagnosis received in the first 30 days after your effective date of coverage.
- If you have a preexisting condition — a condition for which you've received advice or treatment in the 12 months prior to your effective date of coverage — no benefits will be paid until 12 months after your effective date of coverage.
- Benefit amounts reduce by 50% on the January 1st following your 70th birthday.

Refer to the HR/Benefits website for a complete list of exclusions and limitations.

Voluntary Critical Illness Insurance is a limited benefit policy underwritten and administered by Unum. Your employer is not the plan sponsor or the plan fiduciary. As a result, this program is not covered by the Employee Retirement Income Security Act of 1974, as amended (ERISA). All administration of this program is performed by Unum.

Voluntary Accident Insurance (VAI)

We all know accidents and injuries can strike at any time and without warning. The VAI plan helps protect you and your family against some of the financial consequences of covered accidents that occur on or off the job. VAI pays lump sum benefits to plan members directly.

All eligible employees who are actively at work, may enroll. Your spouse/domestic partner may also be covered. Coverage is available to children (including stepchildren and legally adopted children) up to age 25 as long as they are not disabled or married.

If you enroll for coverage during your initial enrollment period, your coverage will be effective on the first day of the month following 30 days of employment.

If you do not enroll for coverage during your initial enrollment period, you may enroll for coverage during the next Annual Enrollment period. This plan does not permit mid-year enrollments or changes.

Your Cost

Your cost for VAI coverage depends on who you choose to insure: yourself, yourself and your spouse/domestic partner, yourself and your child(ren) only, or your entire family.

You pay the entire cost of VAI. Refer to the section titled *"Employee Contributions"* for the applicable cost.

VAI Benefits

VAI benefits are based on a schedule of amounts that outlines the injuries, types of treatment and services eligible for payment. One accident may trigger payment of several associated benefits. These payments are made directly to the covered employee in a lump sum.

VAI payments are in addition to any received from other insurance such as medical, accidental death & dismemberment and business travel accident insurance coverage.

Here are some typical accidents and injuries, as well as the applicable payments under VAI:

- Ambulance trip: $400 ($1,500 for air ambulance).
- Catastrophic injury (loss of sight, hearing or speech, or arms or legs):
  - $100,000 for an employee through age 64.
  - $50,000 for a spouse/domestic partner (up to age 64) or child.

- Dislocations:
  - Up to $6,000 for an open dislocation.
  - Up to $3,000 for a closed dislocation.
- Doctor's office initial visit: $75.
- Emergency dental work:
  - $100 for an extraction.
  - $300 for a crown.
- Emergency room treatment: $150.
- Fractures:
  - Up to $7,500 for an open fracture.
  - Up to $3,750 for a closed fracture.
- Hospital admission: $1,000.
- Knee cartilage torn: $750.
- Laceration: From $25 to $600.
- Loss of one finger or toe: $750.
- Repair of a rotator cuff tendon/ligament: $800.

Refer to the HR/Benefits website for a complete list of covered injuries and accident-related expenses.

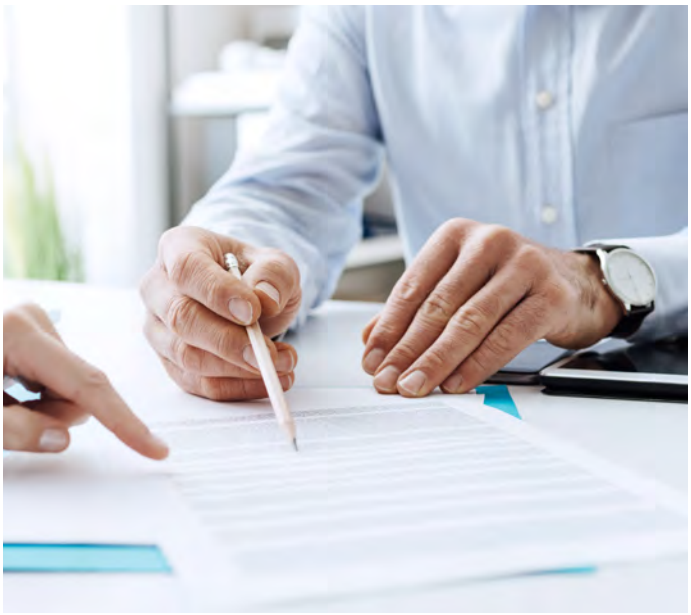
VAI Benefit Limitations and Exclusions

You should be aware there are certain kinds of accidents not covered by this plan. They include:

- Intentional injury or attempted suicide.
- Hang-gliding.
- Bungee jumping.
- Parachuting.
- Sail gliding.
- Parasailing or similar activities.
- Practicing for or participating in any semi-professional or professional athletic contest.
- Participating or attempting to participate in any illegal activity.

Refer to the HR/Benefits website for a complete list of exclusions and limitations.

Voluntary Accident Insurance is a limited benefit policy underwritten and administered by Unum. Your employer is not the plan sponsor or the plan fiduciary. As a result, this program is not covered by the Employee Retirement Income Security Act of 1974, as amended (ERISA). All administration of this program is performed by Unum.



LegalGUARD and InfoArmor

The American Bar Association indicates that half of all consumers who need a lawyer do not seek legal help partly because they don't know how to find a good attorney. When it comes to our identity, most of us are very careful to insure our homes, cars, and businesses against unexpected disaster. However, in today's world we realize the need to exercise extra vigilance over our personal information. On-line and off, it's critical to have the best protection for your personal identity, privacy, and credit.

If you enroll for coverage during your initial enrollment period, coverage will be effective on the first day of the month following 30 days of employment.

If you do not enroll for coverage during your initial enrollment period, you may enroll for coverage during the next Annual Enrollment period. This plan does not permit mid-year enrollments or changes.

You can select from the following options:

- Option 1 - LegalGUARD (Legal plan).
- Option 2 - InfoArmor (Identity theft plan).
- Option 3 - LegalGUARD and InfoArmor (Legal and Identity theft plans).

Your Cost

You pay the entire cost of the legal and identity theft programs. Refer to the section titled *"Employee Contributions"* for the applicable cost.

LegalEASE (LegalGUARD)
legaleaseplan.com/content/med3000
888.416.4313

InfoArmor (Identity Theft)
800.789.2720

LegalGUARD Benefits

Being a LegalGUARD member helps you save time and costly legal fees. But most importantly, it gives you confidence and provides coverage for many legal services, including:

- Home & Residential: Purchase, sale, refinancing, for primary residence or vacation home, foreclosure, tenant dispute.
- Auto & Traffic: Traffic ticket, license suspensions (administrative proceedings), first-time vehicle buyer, vehicle repair and lemon law litigation.
- Financial & Consumer: Cell phone contract dispute, document preparation, debt collection, tax audits, bankruptcy.
- Family: Divorce, separation, name change, prenuptial agreement, adoptions.
- Estate Planning & Wills: Will or codicil, complex will, probate, living will, Health Care Power of Attorney, living trust document, buying, selling and refinancing for your primary residence and vacation or investment home.

With a LegalGUARD plan, you get:

- Access to a national network of attorneys with exceptional experience and expertise that are specifically matched to meet your needs.
- Concierge help navigating common individual or family legal issues.
- Up to 10 hours of financial counseling per year.

If you enroll for LegalGUARD, you will receive a member welcome kit that contains all the information you need to get started. Refer to the HR/Benefits website for a complete list of covered legal services.

InfoArmor Benefits

InfoArmor offers industry-leading employee identity protection. Members have 24/7 access to a personal online dashboard to update, or change identity information and solicitation reduction opt outs, and access the Identity tool. Plan features include:

- SNAPD2.0 Identity Monitoring: InfoArmor monitor identities to uncover identity fraud at its inception. More fraud is detected sooner, including unauthorized account access, fund transfers and password resets.
- Internet Surveillance: By scouring an ever-evolving network of compromised machines, this service detects information misuse in the Underground Internet and alerts consumers with unparalleled accuracy.
- Digital Identity: This interactive, easy-to-read report summarizes what a real-time deep Internet search finds out about a subscriber, offers a Privacy Grade and tips to better secure personal information.
- WalletArmor: This secure, online document repository makes lost wallet replacement quick and easy.
- Privacy Advocate Remediation: Privacy Advocates are CITRMS® Certified and ITRC Trained to be experts in identity restoration. If suspicious activity is detected, a Privacy Advocate will act as a dedicated case manager to act on behalf of the victim and resolve the issue from start to case completion.
- Identity Theft Insurance Policy: Members are insured from financial damages of identity theft with an Identity Theft $25,000 Insurance Policy for associated costs, legal defense expenses, and lost wages.
- Solicitation Reduction: InfoArmor reduces the root cause of up to 20% of identity theft.
- IdentityMD: Whether it is learning about ID theft, setting fraud alerts, or restoring an identity, IdentityMD is designed to offer interactive, step-by-step assistance.

If you enroll for InfoArmor, you will need to call to receive instructions on setting up your profile to begin utilizing your InfoArmor services. Refer to the HR/Benefits website for a complete list of covered identity theft services.

LegalEASE administers both the LegalGUARD and InfoArmor programs. As a result, this program is not covered by the Employee Retirement Income Security Act of 1974, as amended (ERISA). All administration of this program is performed by LegalEASE.

Paid Time Off and Leave of Absence

Paid Time Off Policy

Your employer understands employees need time off for necessary rest and relaxation. You are encouraged to use your earned PTO time each year. PTO accruals are based on length of service. Employees on a leave of absence do not accrue PTO time. The table below shows the accrual rate for full-time employees. Part-time employees (working 24-39 hours a week) accrue a prorated amount of PTO time.

Completed Years of Service	Hours Accrued Per Pay Period	PMG Cap	Eagle and PDI Cap
0 – 4	4.62	264 hours	224 hours
5 – 9	6.15	304 hours	280 hours
10 – 14	7.69	384 hours	296 hours
15+	9.23	384 hours	360 hours

Once the PTO accrual maximum or cap has been reached, additional PTO will not accrue until some PTO time is used. You should plan your use of PTO time accordingly. All PTO time must be scheduled in advance with your manager. Every effort will be made to schedule PTO in accordance with your wishes. However, department priorities may take precedence, and the PTO needs of your co-workers will also be considered.

Holiday Policy

Holidays, will be observed on the calendar day designated by the Company for observance.

You are eligible for holiday pay on the first day you are actively at work. Holiday pay is calculated at your base pay rate. Normally, you must work the regularly scheduled workday immediately before and after the holiday in order to be paid for the holiday.

For pay purposes, if a holiday occurs during your paid vacation, it will be treated as a holiday and not as a vacation day.

The following holidays are recognized by your employer:

Holiday	Date of Observance
New Year's Day	Monday, January 1
Memorial Day	Monday, May 28
Independence Day	Wednesday, July 4
Labor Day	Monday, September 3
Thanksgiving Day	Thursday, November 22
Christmas Eve	Monday , December 24
Christmas Day	Tuesday, December 25

Special note for Eagle employees:
In addition to the above schedule, Eagle employees are provided an additional day off for their birthday and two floating holidays. The birthday must be taken during the two week pay period in which it falls or it's forfeited. The first floating holiday must be taken during the first six months of the year. The second floating holiday must be taken during the second half of the year. Floating holidays do not rollover into the new calendar year and must follow the same guidelines as PTO requests.

Leave of Absence

At some point in your career, you may need to take a leave of absence. A leave of absence may be granted under certain circumstances. Certain leaves are provided for by law, whereas others are granted by your employer. The length of time allowed and paid/unpaid status will be determined by the type of leave. The following are the types of leaves that may be granted:

- Medical.
- Pregnancy disability.
- Family.
- Military.
- Personal.

The Family and Medical Leave Act (FMLA) and certain state leave laws allow workers to take up to 12 work weeks of unpaid leave in a 12-month period to care for themselves or family members, who are seriously ill or who are unable to take care of themselves.

Job protection while on leave will be determined by an employee's eligibility for FMLA or other applicable state or federal law.

To request a leave, visit the HR/Benefits employee benefits website and read the applicable leave policy and discuss any questions with HR/Benefits. Then, when you are ready to apply for a leave, call or email HR/Benefits to request your leave.

Legal Notices

HIPAA Special Enrollment Rights

You have special enrollment rights if you acquire a new dependent, or if you decline coverage under your employer's health plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse/domestic partner) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in your employer's plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse/domestic partner) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in your employer's plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents in your employer's plan. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under your employer's plan, you may be able to enroll yourself and your dependents in the plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

HIPAA Privacy Notice

Your employer is committed to protecting the privacy and security of participants' health information and has undertaken efforts to comply with all applicable laws and regulations intended to protect the privacy and security of such information, including the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended. If you have questions regarding the plan's privacy policies and procedures, please contact HR/Benefits.

The plan's privacy practices may be changed any time at the plan administrator's sole discretion. If any material revision is made to the plan's Notice of Privacy Practices, the revised notice will be distributed in accordance with applicable law.

Genetic Information Nondiscrimination Act

Congress passed the Genetic Information Nondiscrimination Act (GINA) establishing a national and uniform standard to protect workers from genetic discrimination. In addition to prohibitions on discrimination in employment practices, GINA prohibits group health insurers and group health plans from adjusting premiums or contributions based on genetic information. Also, GINA amended the HIPAA privacy rules to include genetic information in the definition of protected health information.

Notice Under the Women's Health and Cancer Rights Act

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

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

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

Important Notice About Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage available under the medical plans offered by your employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Your employer has determined that the prescription drug coverage offered under your employer's medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current medical coverage will not be affected. When your current medical plan coordinates benefits with Medicare, the combined benefits from Medicare and your current medical coverage will equal, but not exceed, what your current plan would have paid if you were not eligible to receive Medicare.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back until January 1 following the next Annual Enrollment period.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage, contact the person listed below. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

More information about your options under Medicare prescription drug coverage and more detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit ***medicare.gov***.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800.633.4227 (Medicare). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at ***socialsecurity.gov***, or call them at 800.772.1213; TTY 800.325.0778.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 15, 2017
Name of Entity/Sender:	Eagle Business Performance Services, LLC Pioneer Medical Group, Inc. Preferred Diagnostic Imaging, LLC
Contact-Position/Office:	HR/Benefits
Address:	17777 Center Court Drive Suite 400 Cerritos, CA 90703
Phone Number:	562.229.9452 ext 1068

Continuation of Health Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

COBRA generally requires that group health plans sponsored by employers with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end. This coverage, however, is only available when coverage is lost due to certain specific events ("qualifying events") that would cause an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA.

Plans must give covered individuals an initial general notice informing them of their rights under COBRA and describing the law. The law also obliges plan administrators, employers, and qualified beneficiaries to provide notice of certain "qualifying events". In most instances of voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events, the employer must provide a specific notice to the COBRA administrator. The COBRA administrator must then advise the qualified beneficiaries of the opportunity to elect continuation coverage.

If you have any questions regarding continuation of health coverage, please contact HR/Benefits.

Health Insurance Marketplace Coverage Options and Your Health Coverage

There is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What Is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on My Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all, or does not offer coverage that meets certain standards. Your employer's health plan does meet the standards established under the law with regard both to the plan's minimum value and its affordability.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its costs. Please visit ***healthcare.gov*** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

What This Means For You

- Our plans are affordable. You'll hear about new coverage options available in the Health Insurance Marketplace, but in most cases, your employer's coverage will continue to provide the greatest value. And because our plans exceed the federally required "minimum value standards," it is unlikely that employees will be eligible for federal subsidies.
- We'll keep you updated. As we get updates, we'll provide resources and support to help you understand the impact of health care reform and to feel confident about your personal coverage decisions.

Questions?

Call ***800.318.2596***; TTY **855.889.4325** or visit ***healthcare.gov***.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office, dial 877.KIDS.NOW (543.7669) or visit ***insurekidsnow.gov*** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at ***askebsa.dol.gov*** or call 866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your state for more information on eligibility.

Alabama – Medicaid

Website: http://myalhipp.com
Phone: 855.692.5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com
Phone: 866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

Arkansas – Medicaid

Website: http://myarhipp.com
Phone: 855.MyARHIPP (855.692.7447)

Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: www.healthfirstcolorado.com
Health First Colorado Member Contact Center: 800.221.3943/ State Relay 711
CHP+: www.colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 800.359.1991/State Relay 711

Florida – Medicaid

Website: http://flmedicaidtplrecovery.com/hipp
Phone: 877.357.3268

Georgia – Medicaid

Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404.656.4507

Indiana – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: www.in.gov/fssa/hip
Phone: 877.438.4479
All other Medicaid
Website: www.indianamedicaid.com
Phone: 800.403.0864

Iowa – Medicaid

Website: www.dhs.state.ia.us/hipp
Phone: 888.346.9562

Kansas – Medicaid

Website: www.kdheks.gov/hcf
Phone: 785.296.3512

Kentucky – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 800.635.2570

Louisiana – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888.695.2447

Maine – Medicaid

Website: www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 800.442.6003
TTY: Maine relay 711

Massachusetts – Medicaid and CHIP

Website: www.mass.gov/eohhs/gov/departments/masshealth
Phone: 800.862.4840

Minnesota – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/healthcare/health-care-programs/programs-and-services/medicalassistance.jsp
Phone: 800.657.3739

Missouri – Medicaid

Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

Montana – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800.694.3084

Nebraska – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

Nevada – Medicaid

Medicaid Website: http://dwss.nv.gov
Medicaid Phone: 800.992.0900

New Hampshire – Medicaid
Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603.271.5218

New Jersey – Medicaid and CHIP
Medicaid Website:
www.state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid Phone: 609.631.2392
CHIP Website: www.njfamilycare.org/index.html
CHIP Phone: 800.701.0710

New York – Medicaid
Website: www.nyhealth.gov/health_care/medicaid
Phone: 800.541.2831

North Carolina – Medicaid
Website: www.ncdhhs.gov/dma
Phone: 919.855.4100

North Dakota – Medicaid
Website: www.nd.gov/dhs/services/medicalserv/medicaid
Phone: 844.854.4825

Oklahoma – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888.365.3742

Oregon – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
www.oregonhealthcare.gov/index-es.html
Phone: 800.699.9075

Pennsylvania – Medicaid
Website: www.dhs.pa.gov/provider/medicalassistance/
healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 800.692.7462

Rhode Island – Medicaid
Website: www.eohhs.ri.gov
Phone: 855.697.4347

South Carolina – Medicaid
Website: www.scdhhs.gov
Phone: 888.549.0820

South Dakota - Medicaid
Website: http://dss.sd.gov
Phone: 888.828.0059

Texas – Medicaid
Website: http://gethipptexas.com
Phone: 800.440.0493

Utah – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov
CHIP Website: http://health.utah.gov/chip
Phone: 877.543.7669

Vermont – Medicaid
Website: www.greenmountaincare.org
Phone: 800.250.8427

Virginia – Medicaid and CHIP
Medicaid Website:
www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 800.432.5924
CHIP Website:
www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 855.242.8282

Washington – Medicaid
Website: www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 800.562.3022 ext. 15473

West Virginia – Medicaid
Website: http://mywvhipp.com
Phone: 855.MyWVHIP (855.699.8447)

Wisconsin – Medicaid and CHIP
Website: www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 800.362.3002

Wyoming – Medicaid
Website: https://wyequalitycare.acs-inc.com
Phone: 307.777.7531

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)

Employee Contributions

Your cost for coverage depends on how many eligible dependents you enroll and what benefit choices you make.

- Medical, dental, vision, FSA, HSA and 401(k) contributions are generally deducted from your pay on a pretax basis. Contributions for domestic partners are generally deducted on an after-tax basis, unless otherwise permitted by state or federal law.
- All other plans are deducted from your pay on an after-tax basis.

Your employer pays the full cost of basic life, basic AD&D, LTD and the EAP.

The table below shows monthly contributions/rates. However, employee contributions are deducted from your first two paychecks each month.

Medical					
Plan	**Total Premium Per Month**	**Employer Cost Per Month**	**Employee Cost Per Month**	**Employee Cost Per Pay Period***	**Domestic Partner Imputed Income Per Pay Period***
Option 1 PPO (Plan 494)					
• Employee Only	$817.60	$451.32	$366.28	$183.14	-
• Employee + Spouse/DP	$1,905.01	$835.16	$1,069.85	$534.93	$173.22
• Employee + Child(ren)	$1,553.43	$641.26	$912.17	$456.09	-
• Employee + Family	$2,485.50	$1,115.00	$1,370.50	$685.25	$173.22
Option 2 PPO (Plan 521)					
• Employee Only	$808.09	$446.07	$362.02	$181.01	-
• Employee + Spouse/DP	$1,882.84	$825.44	$1,057.40	$528.70	$171.20
• Employee + Child(ren)	$1,535.37	$633.81	$901.56	$450.78	-
• Employee + Family	$2,456.60	$1,102.03	$1,354.57	$677.29	$171.20
Option 3 HDHP HSA (Plan 557)					
• Employee Only	$651.03	$359.36	$291.67	$145.84	-
• Employee + Spouse/DP	$1,516.90	$665.01	$851.89	$425.95	$139.45
• Employee + Child(ren)	$1,236.96	$510.62	$726.34	$363.17	-
• Employee + Family	$1,979.12	$887.83	$1,091.29	$545.65	$139.45
Option 4 HDHP HSA (Plan 552)					
• Employee Only	$646.16	$356.67	$289.49	$144.75	-
• Employee + Spouse/DP	$1,505.55	$660.03	$845.52	$422.76	$136.90
• Employee + Child(ren)	$1,227.70	$506.80	$720.90	$360.45	-
• Employee + Family	$1,964.32	$881.19	$1,083.13	$541.57	$136.90
Option 5 HMO Value Network (Plan UM4/3IF)					
• Employee Only	$594.64	$515.96	$78.68	$39.34	-
• Employee + Spouse/DP	$1,308.24	$908.31	$399.93	$199.97	$180.53
• Employee + Child(ren)	$1,070.37	$754.17	$316.20	$158.10	-
• Employee + Family	$1,843.37	$1,256.07	$587.30	$293.65	$180.53
Option 6 HMO Full Network (Plan U90/3IF)					
• Employee Only	$995.65	$631.24	$364.41	$182.21	-
• Employee + Spouse/DP	$2,189.08	$1,116.00	$1,073.08	$536.54	$223.23
• Employee + Child(ren)	$1,791.05	$926.16	$864.89	$432.45	-
• Employee + Family	$3,084.62	$1,543.86	$1,540.76	$770.38	$223.23

** Payroll deductions for all benefit plans, except 401(k), will deducted from your first two paychecks each month.*

Employee Contributions

Dental					
Plan	**Total Premium Per Month**	**Employer Cost Per Month**	**Employee Cost Per Month**	**Employee Cost Per Pay Period***	**Domestic Partner Imputed Income Per Pay Period***
Option 1 PPO Low Plan					
• Employee Only	$16.31	$13.13	$3.18	$1.59	-
• Employee + Spouse/DP	$35.44	$23.52	$11.92	$5.96	$5.20
• Employee + Child(ren)	$42.67	$27.40	$15.27	$7.64	-
• Employee + Family	$63.72	$38.20	$25.52	$12.76	$5.20
Option 2 PPO Medium Plan					
• Employee Only	$30.41	$24.49	$5.92	$2.96	-
• Employee + Spouse/DP	$61.12	$40.56	$20.56	$10.28	$8.04
• Employee + Child(ren)	$80.37	$51.61	$28.76	$14.38	-
• Employee + Family	$114.18	$68.45	$45.73	$22.87	$8.04
Option 3 PPO High Plan					
• Employee Only	$38.39	$30.92	$7.47	$3.74	-
• Employee + Spouse/DP	$76.54	$50.79	$25.75	$12.88	$9.94
• Employee + Child(ren)	$100.96	$64.84	$36.12	$18.06	-
• Employee + Family	$142.95	$85.70	$57.25	$28.63	$9.94
Option 4 DHMO Plan					
• Employee Only	$10.46	$7.74	$2.72	$1.36	-
• Employee + Spouse/DP	$20.72	$11.93	$8.79	$4.40	$2.10
• Employee + Child(ren)	$29.23	$17.11	$12.12	$6.06	-
• Employee + Family	$40.34	$20.70	$19.64	$9.82	$2.10

** Payroll deductions for all benefit plans, except 401(k), will deducted from your first two paychecks each month.*

Vision					
Plan	**Total Premium Per Month**	**Employer Cost Per Month**	**Employee Cost Per Month**	**Employee Cost Per Pay Period***	**Domestic Partner Imputed Income Per Pay Period***
Option 1 Exam Plus Allowance (Davis Network)					
• Employee Only	$4.53	$3.06	$1.47	$0.74	-
• Employee + Spouse/DP	$7.62	$3.22	$4.40	$2.20	$0.08
• Employee + Child(ren)	$7.77	$4.65	$3.12	$1.56	-
• Employee + Family	$12.30	$3.59	$8.71	$4.36	$0.08
Option 2 Exam Plus Allowance (VSP Network)					
• Employee Only	$4.20	$2.84	$1.36	$0.68	-
• Employee + Spouse/DP	$7.07	$2.99	$4.08	$2.04	$0.08
• Employee + Child(ren)	$7.21	$4.32	$2.89	$1.45	-
• Employee + Family	$11.41	$3.33	$8.08	$4.04	$0.08
Option 3 Full Feature (Davis Network)					
• Employee Only	$6.26	$4.23	$2.03	$1.02	-
• Employee + Spouse/DP	$10.53	$4.45	$6.08	$3.04	$0.11
• Employee + Child(ren)	$10.74	$6.43	$4.31	$2.16	-
• Employee + Family	$17.00	$4.96	$12.04	$6.02	$0.11
Option 4 Full Feature (VSP Network)					
• Employee Only	$6.95	$4.70	$2.25	$1.13	-
• Employee + Spouse/DP	$11.70	$4.94	$6.76	$3.38	$0.12
• Employee + Child(ren)	$11.93	$7.15	$4.78	$2.39	-
• Employee + Family	$18.87	$5.50	$13.37	$6.69	$0.12

** Payroll deductions for all benefit plans, except 401(k), will deducted from your first two paychecks each month.*

Employee Contributions

Optional Life and Dependent Life (Monthly Cost Per $1,000 of Coverage)				Optional AD&D (Monthly Cost Per $1,000 of Coverage)		
Age	Employee	Spouse/ DP*	Dependent Child(ren)	Employee	Spouse/ DP*	Dependent Child(ren)
<25	$0.06	$0.06	$0.205 Regardless of the number of children covered	$0.02	$0.02	$0.02 Regardless of the number of children covered
25 – 29	$0.06	$0.06				
30 – 34	$0.06	$0.06				
35 – 39	$0.08	$0.08				
40 – 44	$0.11	$0.11				
45 – 49	$0.17	$0.17				
50 – 54	$0.28	$0.28				
55 – 59	$0.49	$0.49				
60 – 64	$0.81	$0.81				
65 – 69	$1.35	$1.35				
70 +	$2.70	N/A				

** The cost for spouse/DP coverage is based on the spouse/DP age.*

Short Term Disability (Staff) (Monthly Cost Per $10 of Weekly Benefit)	
Plan	Employee
Option 1 (20%; max $1,000/week)	$0.983

Voluntary Critical Illness Insurance (VCII) — Employees (Monthly Cost)						
Employee Age*	Non-Tobacco			Tobacco		
	$5,000	$10,000	$15,000	$5,000	$10,000	$15,000
<25	$5.30	$8.20	$11.10	$6.75	$11.10	$15.45
25 – 29	$5.55	$8.70	$11.85	$7.65	$12.90	$18.15
30 – 34	$6.55	$10.70	$14.85	$9.80	$17.20	$24.60
35 – 39	$8.05	$13.70	$19.35	$13.25	$24.10	$34.95
40 – 44	$10.40	$18.40	$26.40	$18.35	$34.30	$50.25
45 – 49	$13.40	$24.40	$35.40	$24.40	$46.40	$68.40
50 – 54	$16.90	$31.40	$45.90	$31.80	$61.20	$90.60
55 – 59	$21.50	$40.60	$59.70	$39.85	$77.30	$114.75
60 – 64	$26.85	$51.30	$75.75	$47.25	$92.10	$136.95
65 – 69	$29.90	$57.40	$84.90	$49.15	$95.90	$142.65
70 +	$51.70	$101.00	$150.30	$77.75	$153.10	$228.45

** Attained age of employee as of effective date of coverage. Once enrolled, cost does not increase on account of age.*

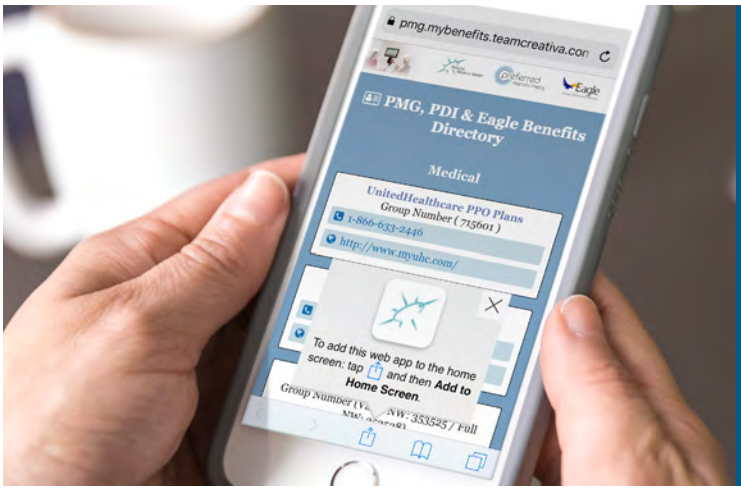
Voluntary Critical Illness Insurance (VCII) — Spouse/DP (Monthly Cost)		
Spouse/DP Age*	Non-Tobacco	Tobacco
	$5,000	$5,000
<25	$5.30	$6.75
25 – 29	$5.55	$7.65
30 – 34	$6.55	$9.80
35 – 39	$8.05	$13.25
40 – 44	$10.40	$18.35
45 – 49	$13.40	$24.40
50 – 54	$16.90	$31.80
55 – 59	$21.50	$39.85
60 – 64	$26.85	$47.25

** Attained age of spouse/DP as of effective date of coverage. Once enrolled, cost does not increase on account of age.*

Voluntary Accident Insurance (VAI) (Monthly Cost)			
Employee Only	Employee + Spouse/DP	Employee + Child(ren)	Employee + Family
$16.29	$26.34	$30.42	$40.47

LegalGUARD and InfoArmor (Monthly Cost)		
Plan	Employee Only	Employee + Spouse/DP
LegalGUARD	$19.78	$19.78
InfoArmor	$8.45	$13.25
LegalGUARD and InfoArmor	$26.63	$32.03

Important Phone Numbers and Websites

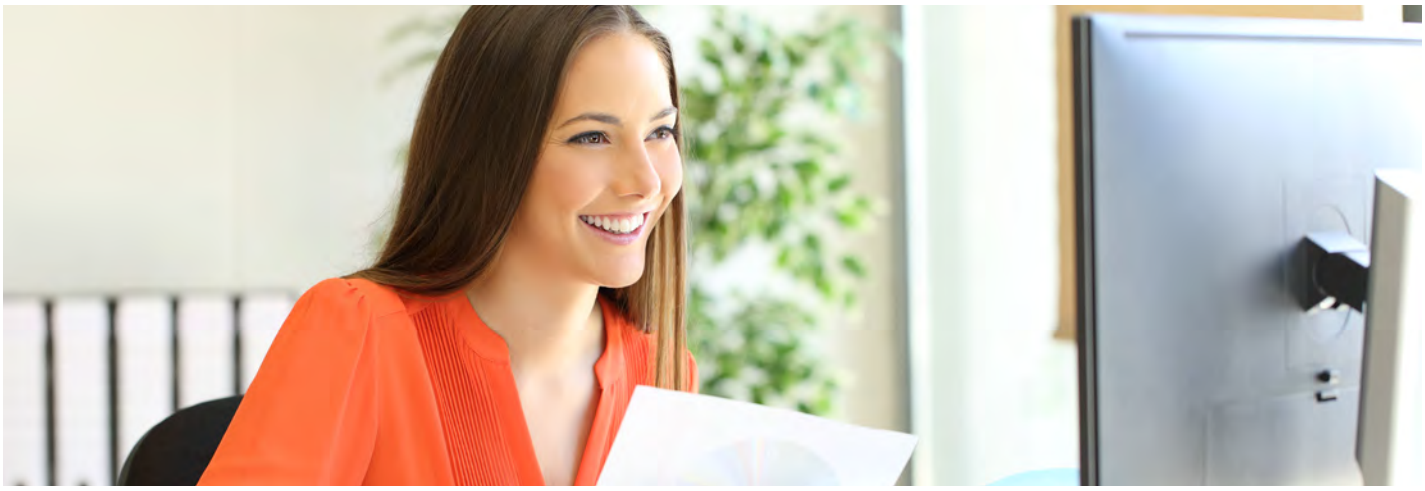


Put important phone numbers and websites in the Palm of Your Hand

- Go to: ***pmg.mybenefits.teamcreativa.com/vendorcontacts***
- Then simply follow the on-screen instructions to add an app to your home screen that contains our important phone numbers and websites

Plan/Program	Insurance Company/Administrator	Group/Policy #
Medical (UnitedHealthcare)	PPO Plans 494 and 521: 866.633.2446 HDHP HSA Plans 557 and 552: 866.314.0335 HMO Plans: 800.624.8822 myuhc.com	715601 715601 Value NW 353525 and Full NW 353528
Health Savings Account (Optum Bank)	866.234.8913 optumbank.com	
Dental (Guardian)	PPO Plans: 800.541.7846 DHMO Plan: 888.618.2016 guardiananytime.com	504434
Vision (Guardian)	Davis Network: 877.393.7363 VSP Network: 877.814.8970 guardiananytime.com	504434
STD and LTD (Sun Life)	800.247.6875 sunlife-ams.com	215617
Life and Accident (Sun Life)	Contact HR/Benefits 562.229.9452 ext 1068	215617
Life and Accident (Transamerica)	310.318.1362 lsr730@gmail.com	
Flexible Spending Accounts (WageWorks)	877.924.3967 wageworks.com	N/A

Important Phone Numbers and Websites



Plan/Program	Insurance Company/Administrator	Group/Policy #
Employee Assistance Program (ComPsych)	877.595.5284 guidanceresources.com	MED3OOO
401(k) Plan (ADP)	866.695.7526 mykplan.com	PMG: 421480 PDI: 422646 Eagle: 421481
Voluntary Critical Illness Insurance and Voluntary Accident Insurance (Unum)	800.635.5597	R0563866
LegalGUARD (LegalEASE)	888.416.4313 legaleaseplan.com/content/med3000	MED3OOO
InfoArmor (LegalEASE)	800.789.2720	
COBRA (Benefit Concepts)	866.629.6478 mybenefits.benefitconcepts.com	
HR/Benefits	562.229.9452 ext 1068 Email: bmedina2@pioneermedicalgroup.com acardena@pioneermedicalgroup.com Monday-Friday 8:00am-5:00pm PT	
HR/Benefits Website	PMG.mybenefits.teamcreativa.com	

This guide provides a brief summary of the employee benefit plans in effect during the January 1, 2018 through December 31, 2018 plan year for the Practice Groups in California that are included in the MED3OOO Group, Inc. Multiple Employer Welfare Arrangement (MEWA). It is not a Summary Plan Description (SPD). However, this guide serves as the "Summary of Material Modification" to our benefit plans in accordance with the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). If there is a discrepancy between this guide and the applicable insurance contract, agreement, SPD or plan document, the applicable insurance contract, agreement, SPD, or plan document will prevail.

This guide is not intended to be interpreted as a legal promise of benefits or guarantee of future or continued employment or as stating provisions and terms of employment. MED3OOO, the participating Practice Groups and employees recognize their mutual right to end their employment relationship at any time and acknowledge that such relationship is one of at-will employment.

MED3OOO as the MEWA plan sponsor, at its sole discretion, reserves the right to change (including, but not limited to, the right to amend, suspend or terminate) or make exceptions to its personnel policies, procedures and employee benefit plans, or to change employee contributions at its discretion at any time and without prior notice. The policies and employee benefit plans described in this document may vary from location to location to conform to applicable law or business unit needs. Please refer to the revision date below, and keep in mind a more current version may be available on the HR/Benefits website.

Important Information About Medicare Prescription Drug Coverage

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please refer to pages 42-43 for more details.