Employee Benefits Guide

2017-2018

CVR Core Values

Compassionate commitment to community

Value-driven, state of the art vascular care

Respect & appreciation for our patients & each other

Welcome to Center for Vein Restoration's Benefit Enrollment!

We are committed as a company to providing our eligible employees with a comprehensive and high quality benefits package to help meet individual and family needs. Our benefit options include a choice of medical plans, a health savings account, dental insurance, vision insurance and additional voluntary benefit plans through Cigna. We also offer an Employee Assistance Program, 401(k), Paid Time Off (PTO), paid holidays and more!

Please take time to review all plan options available to you prior to making selections. Then consider each benefit and the associated cost carefully to choose the benefits package that will best meet the needs for you and your family throughout the year.

Our employees are our most valuable asset.

That's why we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure and maintain a work/life balance.

Stay Healthy

- Medical Insurance - Cigna
- Dental Insurance - Cigna
- Vision Insurance - EyeMed

Feeling Secure

- Health Savings Account (HSA) - (Bank of your choice)
- Life/AD&D - Cigna
- Short Term Disability - Cigna
- Long Term Disability - Cigna
- Accident Insurance - Cigna
- 401(k) - Principal

Work/Life Balance

- Health Advocate
- Employee Assistance Program - ADP LifeCare
- ADP LifeMart Discounts
- Paid Time Off
- 8 Paid Holidays

Who is Eligible?

If you are a full-time, active employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide. The following family members are eligible for coverage: legal spouse and dependent child/ren (to the age of 26 and their coverage ends at the end of the month of their 26th birthday). It is your responsibility to notify Human Resources of any changes in your eligible dependent's status (i.e. no longer married, child reached limiting age, etc.). Benefits for new hires begin the first of the month following 60 days of continuous full-time employment.

When to Enroll

CVR's Open Enrollment for 2017 Benefits is being held August 31, 2017 through September 11, 2017. All enrollments must be made during this time to become effective October 1, 2017 and remain in effect through September 30th, 2018.

New hires have 30 days from date of hire to enroll in benefits. Human Resources will advise you of your appropriate effective date.

How to Make Changes

Unless you have a qualifying event, you cannot make changes to the benefits you elect until the next open enrollment period. Qualifying events include marriage, divorce, birth or adoption of a child and a dependent losing or gaining health coverage. Changes due to a qualifying event must be completed within 30 days of the event date.

Employee Contributions

CVR is pleased to offer employees a comprehensive health and wellness plan. Both CVR and employees share in the cost of these coverages through payroll contributions which are based on your coverage selection.

Some benefit deductions may be made on a pre-tax basis. This means that you do not pay state, federal, and social security taxes on eligible premiums paid using a payroll deduction. Bottom-line, this means more money in your pocket. Your payroll deductions for medical, dental, vision, and 401(k) will be made on a pre-tax basis where applicable. Please contact Human Resources if you do not wish to pay your premiums with pre-tax income.

How to Enroll

- Access www.cbizems.com to log in to the Employee Portal Homepage.
- Enter your User ID and Password. Returning users login name is firstname.lastname
- If it's your first time on the site, or if you do not know your account information, please click on the *"First Time User? Forgot/Reset User ID or Password?"* link. The system will prompt you to enter your SSN and date of birth to verify your identity. The system will then advise you of your account credentials. Going forward, your username will be first name.last name (example maria.casas) and you will create your password.
- Once you have logged in, select the "*Change Events*" icon at the bottom of the left of the homepage to commence the enrollment process. New hires have 30 days from date of hire to enroll.
- Review information on each tab, beginning from the "*Instructions*" through the "*Confirmation*" tabs. You will be required to click "*Save and Continue*" through each tab and submit this event to complete your online enrollment.
- Should you wish to make changes to personal information, dependent, beneficiary and/or emergency contacts, you will be allowed the opportunity to do so on each of the tabs. Please note – you must update the relationship types on the dependents tab for any children you wish to enroll in benefits. If you do not update the relationship type, you cannot enroll children under the applicable benefit plan.
- Under the "*Benefits*" tab, you may choose to elect a different plan, coverage level or waive elections.
- Please complete the enrollment process and submit your enrollment on the "*Confirmation*" tab.
- You will receive a notification via email when the event is reviewed and processed by your Human Resources Department.
- Compliance notices begin on Page 18 here within. More compliance notices and detailed plan design information can be found in the document section on www.cbizems.com.

Medical Insurance

Medical and Prescription Drugs

CIGNA will administer the medical benefits plan. The plans differ in cost sharing, networks and the options to go out of network. Employees have the option to set up a Health savings Account (HSA) through the bank of their choice . More details about HSAs can be found on Page 7 here within. By offering a choice of THREE High Deductible plans there's sure to be a plan that works for you. Each plan has its own advantages.

Find out if your Doctors are in the Cigna Network – **To Find a Doctor:**

Go to http://www.cigna.com/
Click on "Find a Doctor" at the top right of the screen in the small orange box
Click "Find a Doctor using This Directory" in the large orange box
Click "Doctors"
Type in Search Location or Enter your Provider Name in the "Looking For" box
Click "Pick" under Select A Plan, then Medical Plans

Select the first OAP option, Open Access Plus, OA plus, Choice Fund OA Plus
Select this OAP option for all 3 of CVR's plans, click Choose
Click "Search"

If you need assistance, feel free to call 1-800-Cigna24 (1-800-244-6224).

OAP Health Savings Account Plan (HSA) In Network Only Plan (Deductible $5,000/10,000)

The OAP HSA plan is an Open Access medical plan that offer discounted rates when you obtain medical care **within the plan's network** of health care providers. There is no need to select a primary care physician, nor do you need a referral to see a specialist. You must meet the annual deductible (**Individual $5,000 /Family $10,000**) before the plan begins to pay benefits (including prescriptions), except for preventive care when received from network providers. **Care received from non network providers will not be covered under this plan.**

OAP Health Savings Account Plan (HSA) In Network Only Plan (Deductible $2,000/4,000)

The OAP HSA plan is an Open Access medical plan that offer discounted rates when you obtain medical care **within the plan's network** of health care providers. There is no need to select a primary care physician, nor do you need a referral to see a specialist. You must meet the annual deductible (**Individual $2,000 /Family $4,000**) before the plan begins to pay benefits (including prescriptions), except for preventive care when received from network providers. C**are received from non network providers will not be covered under this plan.**

OAP Health Savings Account Plan (HSA) PPO Plan

The OAP plan is an Open Access Plus medical plan that offer discounted rates when you obtain medical care within the plan's network of health care providers. This plan has the same features as the OAP HSA In Network Only plans above but with an option to use non network providers. You must meet the annual deductible (In Network :**Individual $2,000 /Family $4,000 Out of Network Individual $4,000 / Family$8,000**) before the plan begins to pay benefits (including prescriptions), except for preventive care when received from network providers. There is no need to select a primary care physician, nor do you need a referral to see a specialist. You can use providers outside the network and still receive benefits from the plan, but you may be required to pay the provider at the time of service, and you may incur higher out-of-network costs.

Plan Design	Cigna OAP HSA In-Network Only	Cigna OAP HSA In-Network Only	Cigna OAP HSA Out-of-Network Option	
	In-Network	In-Network	In-Network	Out-of-Network*
Annual Deductible (Oct– Sept) **- Individual** **- Family**	$5,000 $10,000	$2,000 $4,000	$2,000 $4,000	$4,000 $8,000
Annual Out-of-Pocket Maximum: **- Individual** **- Family**	$6,550 $13,100	$3,000 $6,000	$3,000 $6,000	$6,000 $12,000
Coinsurance: *Employee Responsibility*	5%	5%	5%	25%
Office Visits: **- Preventive Care** **- Primary Care Physician** **- Specialist**	$0 Ded, then 5% Ded, then 5%	$0 Ded, then 5% Ded, then 5%	$0 Ded, then 5% Ded, then 5%	Ded, then 20% Ded, then 25% Ded, then 25%
Hospitalization: **- Inpatient** **- Outpatient** **- Lab and X-ray (free standing)** **- Accident/Medical Emergency** **- Urgent Care**	Ded, then 5% Ded, then 5% Ded, then 5% Ded, then 5% Ded, then 5%	Ded, then 5% Ded, then 5% Ded, then 5% Ded, then 5% Ded, then 5%	Ded, then 5% Ded, then 5% Ded, then 5% Ded, then 5% Ded, then 5%	Ded, then 25% Ded, then 25% Ded, then 25% In-Net Ded, then 5% Ded, then 5%
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Prescription Drugs: RETAIL **- Tier 1 (Generic)** **- Tier 2 (Formulary Brand)** **- Tier 3 (Non Formulary Brand)**	Ded, then $5 Ded, then $15 Ded, then $30	Ded, then $5 Ded, then $15 Ded, then $30	Ded, then $5 Ded, then $15 Ded, then $30	Ded, then 20% Ded, then 20% Ded, then 20%
Prescription Drugs: MAIL ORDER **- Tier 1 (Generic)** **- Tier 2 (Formulary Brand)** **- Tier 3 (Non Formulary Brand)**	Ded, then $15 Ded, then $45 Ded, then $90	Ded, then $15 Ded, then $45 Ded, then $90	Ded, then $15 Ded, then $45 Ded, then $90	Ded, then 20% Ded, then 20% Ded, then 20%

*While the plan offers the option to use either in-or out-of-network providers, your costs will be generally lower when using an in-network provider. Out-of-network benefits are subject to reasonable and customary charges. This is the amount the carrier will allow as payment for out-of-network services. Any amounts over reasonable and customary will be your responsibility.

Your Medical Insurance Cost in 2017-2018

Effective October 1, 2017, the full-time employee contributions will be as follows:

Per Pay Employee Cost To get monthly costs, multiply these rates by 2.	Cigna OAP HSA $5,000/$10,000	Cigna OAP HSA $2,000/$4,000	Cigna Out of Network Option
Employee	$25.00	$48.59	$153.13
Employee/Spouse	$190.00	$244.16	$574.94
Employee/Children	$85.00	$181.44	$453.16
Employee/Family	$250.00	$374.95	$710.25

Health Savings Accounts (HSA)
A great way to pay for medical expenses!

What is a Health Savings Account (HSA)?
An HSA is a special type of bank account that the IRS allows you to set up if you are enrolled in a qualified high deductible health plan. The HSA is an individually owned tax advantaged account. Center for Vein Restoration allows you to set aside contributions from your pay through direct deposit into your HSA at the bank of your choice.

What are eligible medical expenses?
Generally, your HSA funds can be used for deductibles, copays, dental and vision bills. For a complete list, see IRS Publication 969 which can be found on www.cbizems.com. You can use the money in your HSA for all of your tax dependents even if they are not covered in your health plan.

Do I have a deadline to use the money in my HSA?
No, the money in your HSA can be used for current or future expenses and rolls over from year to year.

How much can I contribute to the HSA?
The amounts can differ from year to year and are based on the calendar year. For 2017, the maximum contribution for an individual is $3,400 and $6,750 for those that cover their dependents. For 2018, the maximum contribution for an individual is $3,450 and $6,900 for those that cover their dependents If you are over age 55 you can contribute an extra $1,000.

Can I use the HSA for non-medical expenses?
If you use the money in your HSA for non-medical expenses, you will pay income tax plus a 20% penalty. This penalty applies if you are under age 65. At age 65, if you choose to use your HSA funds for non-medical expenses, you are required to pay only the income tax and no penalty is applied.

What documentation should I keep?
You will need to keep the receipts for the medical expenses you have paid with your HSA. This should be kept with your other tax receipts.

What happens if I change health plans or jobs and am no longer enrolled in a qualified high deductible plan?
The money in your HSA will always be yours to keep and use for eligible medical expenses. Additional contributions will no longer be allowed into the account if you are no longer enrolled in a qualified high deductible plan.

Can everyone open an HSA bank account ?
IRS states members can open an HSA Bank Account if the following is true:

- Member is enrolled in a High Deductible Health Plan (HDHP)
- Not enrolled in Medicare (Any Letter)
- Not enrolled in any other Health Insurance*
- Not claimed as another persons dependent (Tax Return)

*Other health insurance does not include: specific disease or illness insurance, accident, disability, dental care, vision care and long-term care insurance.

What are the advantages of an HSA?

- Only *triple-crown* of tax benefits
- Member owned and directed
- Encourage consumerism; stretch dollars with research and knowledge
- Dollars are eligible to pay for medical, dental, vision and over-the-counter (with Rx) expenses
- Other qualified expenses include acupuncture and out-of-network costs
- Members save premium costs as HSA high deductible health plans are lower than traditional health plans
- Investment options exist allowing for control of health care dollars

Members do not "lose it" at the end of the plan year; dollars roll over year after year earning *tax-free interest* to pay for future medical expenses or possibly *retirement.*

Ineligible Medical Expenses
Expenses that are considered "ineligible" include:

- Insurance premiums
- Cosmetic procedures and costs
- Expenses covered by another insurance plan
- General health items such as tissues, toiletries, hand sanitizer

Links to Useful Resources:
Eligible IRS Medical Expenses
HSA Bank
Additional Health & Wellness Resources

HSA Scenario No. 1

Meet Jen - the Every Girl!

Jen uses her Cigna insurance to STAY healthy! She takes advantage of her free annual appointments - annual physical, well women's OB-GYN appointment, & flu shot. She gets sick occasionally too, and it's great that she can go to her doctors and specialists when she needs it!

Jen looked back at her appointments from last year to decide which plan to choose this year -

Jen's Doctor's Appointments over one year	CVR's Lowest Cost Plan from Last Year ($1,500 Deductible)	CVR's New Lowest Cost Plan ($5,000 Deductible)
Annual Physical with Regular Doctor	FREE	FREE
Dermatologist Appointment	$200.00	$200.00
Flu Shot	FREE	FREE
Sinus Infection – Jen went to Urgent Care	$155.00	$155.00
Generic Z-Pack Antibiotic for Sinus Infection	$19.00	$19.00
Bad Cold – Jen went to Doctor's office	$65.00	$65.00
Annual Well Women's Health Appointment	FREE	FREE
Generic Allergy Medicine (12 months)	$192.00	$192.00
Total Amount Jen paid at her appts	$631.00	$631.00
Jen's Payroll Deductions for the year	$48.46 x 24 = $1,163.04	$25 x 24 = $600.00
Amount Jen paid to her doctors & pharmacy at her appointments	$631.00	$631.00
Total amount Jen paid over the year (amount taken out of paycheck + amount paid to doctors)	$1,794.04	$1,231.00 - **$563.04** ***LESS* than last year!**

The new plan brings her costs way down!!! Jen will save $563.04 - WOW! And since Jen did not come close to meeting her deductible last year – she might as well take advantage of the New plan with $5k deductible savings.

HSA Scenario No. 2

Meet Theresa – Family Matters!

Theresa and her family are on CVR's plan. Theresa also looked back at her family's appointments from last year to decide which plan to choose this year. Last year, her daughter had a hospital stay, and may have another one this year since she is sick from time to time. Her husband is also accident prone, and has some back issues that he may need help with this year.

Theresa & her family's doctor's appts over the year	CVR's Lowest Cost Plan from Last Year $3000 Deductible	CVR's New Lowest Cost Plan $10,000 Deductible	CVR's Buy-Up Plan - Mid Cost $4,000 Deductible	CVR's New Out of Network Plan $4,000 Deductible
Theresa took her daughter to have an annual physical	FREE	FREE	FREE	FREE
Theresa thought she had the flu - went to Doctor	$65.00	$65.00	$65.00	$65.00
Theresa went to an Ear Nose Throat doctor	$200.00	$200.00	$200.00	$200.00
Theresa's husband broke his leg - Emergency Room visit	$900.00	$900.00	$900.00	$900.00
Theresa's husband needed crutches	$600.00	$600.00	$600.00	$600.00
Theresa's daughter was sick - went to Pediatrician	$65.00	$65.00	$65.00	$65.00
Generic antibiotic for Theresa's daughter	$9.00	$9.00	$9.00	$9.00
Theresa's husband went to the dermatologist	$200.00	$200.00	$200.00	$200.00
Theresa went to her annual Well Women's visit	FREE	FREE	FREE	FREE
Theresa went to the Dermatologist	$200.00	$200.00	$200.00	$200.00
Theresa's husband went to an orthopedic doctor for back pain	$200.00	$200.00	$200.00	$200.00
In-patient Hospital Stay for Theresa's Daughter	$1,830.00	$5,500.00	$1,514.75	$1,514.75
Theresa's daughter needed an MRI	$256.00	$256.00	$256.00	$256.00
Amount Theresa paid at her family's appts	$4,525.00	$8,195.00	$4,209.75	$4,209.75
Theresa's Payroll Deductions for the year	**$8,625.12**	**$6,000.00**	**$8,998.80**	**$17,049.60**
Amount Theresa paid to her doctors & pharmacy	$4,525.00	$8,195.00	$4,209.75	$4,209.75
Total amount Theresa paid over the year (amount taken out of paycheck + amount paid to doctors)	$13,150.12	$14,195.00	$13,208.55 – **Buy up plan = same cost as last year!**	$21,259.35

For Theresa's family, CVR's new mid-cost buy up plan would be great! She will pay the same as last year with no increases – AND if her daughter or husband need more care than last year due to being sick and having back issues, she'll have less of a deductible to meet. Theresa is planning to set up and put money into her HSA account to have funds ready for unexpected expenses, in case her daughter or husband break a bone, or get sick, like they did last year.

Telehealth Services

Cigna Telehealth Services is the care you need - when, where and how you need it. Telehealth services gives you access to talk to a doctor via online video or phone, from the comfort of your home. Cigna now provides access to two telehealth services as part of your medical plan - AmWell and MDLIVE. Register for one or both today so you'll be ready to use a telehealth service when and where you need it.

AmWellforCigna.com (855) 667-9722	MDLIVEforCigna.com (888) 726-3171

Signing up is easy!

1. Set up and create an account with one or both AmWell and MDLIVE
2. Complete a medical history using their "virtual clipboard"
3. Download vendor apps to your smartphone/mobile device

Coach by Cigna

Coach by Cigna is a health and fitness app that's all about you. Coach by Cigna gets people focused on what matters most in 5 integrated lifestyle areas: Exercise ❖ Food ❖ Sleep ❖ Stress ❖ Weight

It's like having a team of health experts in the palm of your hand. The app provides you with:

- **Recommended programs** that fit personal needs and goals
- **Team of health coaches** who provide motivational and instructional video messaging
- **Dashboard** features active programs and daily to-do lists
- **Library** filled with health and wellness articles

Download the FREE Coach by Cigna app available on both iOS and Android mobile devices.

MyCigna.com Mobile Site and App

MyCigna.com mobile site and app deliver health information on the go. All customers can access myCigna via mobile device using internet browser. There is also a myCigna mobile app available through on both iOS and Android mobile devices.

Features include:

- Find a doctor, dentist, pharmacy or facility
- View, print, and email ID card information
- Search and view claims
- Prescription Drug Search
- View plan coverage and authorizations
- Organize and manage personal health information with Health Wallet

Reliable and personal service when you need Cigna

Call us anytime, day or night

- Customer Service and Health Information Line are 24/7
- We speak your language

1.866.494.2111

Find all of your information when you need it at http://www.mycigna.com/

- Coverage details
- Claim information and history
- Directory of doctors, hospitals, facilities
- Print a temporary ID card or order a new ID card
- Health information and tools
- Frequently asked questions
- Cost of care and quality comparison tools
- Cigna Telehealth Connection consisting of both AmWell and MDLive

Mobile site and myCigna app deliver information on the go*

- All customers can access myCigna via mobile device using internet browser
- myCigna mobile app -also available

Remember these tips to help save money

Keeping you and your finances healthier

Prescription drugs	Care Options
➢ Find the complete list of covered medications on mycigna.com ➢ Convert your maintenance medication to mail order	➢ Use the emergency room for true emergencies ➢ Don't wait: locate a convenience care clinic or urgent care facility near you, before you need it
Healthcare professional choice	**Proactive measures**
➢ Use the health care professional most appropriate for your care ➢ Use Cigna Care Designation fo find quality, cost-effective physicians ➢ Using preferred labs can save you money	➢ Utilize the health improvement tools available to you ➢ Get information on the cost of treatment to ensure there are no surprises ➢ Utilize your preventive care benefit

Dental Insurance

Cigna DPPO

The Cigna DPPO plan covers dental expenses both in and out-of-network with a national network of dentists. You can go to a non-participating dentist as well, but there will be higher out of pocket costs. Each family member is entitled to $1000 of benefits each Plan year. In-network preventive services are covered in full with no deductible.

Search the "Find a Doctor or Service Directory" to find a dentist online at www.cigna.com before you sign up or go to your personalized website to search for dentists and register for your member portal at www.mycigna.com after you sign up or call 1-800-Cigna24 or 1-800-244-6224

Employees will only need to provide DOB and SSN to their dental provider, even for spouse and children, at the time of service. You will not receive a dental ID Card.

Cigna DHMO

Cigna DHMO: When you sign up in the DHMO plan, you are required to select a network general dentist, who will handle all of your dental care needs. You then receive a Patient Charge Schedule, or "PCS," that lists the specific dental procedures covered by the plan and the amount you would pay the dentist (your copays). These are **special, reduced fees** that apply only when you receive treatment from the dentists or dental specialists in our DHMO Network.

Choosing a Dentist for the DHMO:

- Search the "Find a Doctor or Service Directory'" online at www.cigna.com
- Or call 1.800.Cigna24 to speak to a Cigna Representative for assistance
- You can change your network dentist anytime at www.mycigna.com or by phone at 1.800.Cigna24
- Changes go into effect the following month after changing your network dentist
- **Remember, if you visit a non-network dentist, your treatment will not be covered at all**

Plan Design	Cigna Dental			
		Total Cigna DPPO		
	Cigna DHMO Employee Responsibility	**Cigna DPPO Advantage** Employee Responsibility	**Cigna DPPO** Employee Responsibility	**Out-of-Network** Employee Responsibility
Class I – Preventive & Diagnostic	0%	0%	20%	20%
Class II – Basic Services	Patient charge	20%	35%	35%
Class III – Major Services	Patient charge	50%	60%	60%
Class IV - Orthodontia Services	N/A	50%	50%	50%
Annual Deductible (Oct—Sept)	N/A	$50/$150	$50/$150	$50/$150
Annual Maximum (Class I – III)	N/A	$1,000	$1,000	$1,000
Orthodontia Lifetime Maximum	N/A	$1,500	$1,500	$1,500

Your Dental Insurance Cost in 2017-2018

Effective October 1, 2017, the full-time employee contributions will be as follows:

Per Pay Employee Cost To get monthly costs, multiply these rates by 2.	Cigna DHMO	Cigna PPO
Employee	$5.01	$15.64
Employee + 1	$9.86	$32.20
Employee/Family	$13.05	$46.74

Vision Insurance

EyeMed Vision Plan

Eligible employees may sign up for vision coverage, which allows participants to get an examination every 12 months and discounted lenses and frames or contact lenses. The office visit copay is $10 when seeing an in-network provider such as Lens Crafters, Pearle Vision, Target Optical, Sears Optical, etc.

Participants have the option of receiving care from an in-network or out-of-network provider; however, if you use an out-of-network provider, you will incur higher out-of-pocket expenses.

This plan uses the ADVANTAGE Network. For a complete list of in-network providers near you, use EyeMed's Advantage Provider locator on www.eyemed.com or call 1-888-203-7437. For Lasik providers, call 1-877-5LASER6.

Benefit Description	Frequency	Participating	Non-Participating
Exam	Every 12 months	$10 copay	Up to $45 reimbursement
Lenses	Every 12 months	$0 copay; $60 copay for progressive lenses	Varies by Lens
Frames	Every 12 months	$0 copay; $110 Allowance	Up to $88 reimbursement
Contact Lenses (in lieu of lenses and frames)	Every 12 months	$0 copay; $110 Allowance	Up to $110 reimbursement

Your Vision Insurance Cost in 2017-2018

Effective October 1, 2017, the full-time employee contributions will be as follows:

Per Pay Cost To get monthly costs, multiply these rates by 2.	Total Cost
Employee	$2.63
Employee + Spouse	$5.93
Employee + Child(ren)	$4.62
Employee + Family	$7.25

Additional Benefit: Health Advocate Services

Health Advocate is an employer-paid benefit provided to you and your dependents through its staff of Personal Health Advocates (PHA). Members requiring assistance call a special toll-free Health Advocate telephone number (1-866-695-8622). Members talk with a PHA, who then becomes “their” Personal Health Advocate, personally helping them with their issues, problems or other needs for assistance. After obtaining the required HIPAA authorization form, the PHA, assisted by a staff of medical directors and administrative coordinators, researches and resolves the inquiry and establishes a time and method for getting back to the member. Health Advocate helps members:.

- Access community resources, including senior care services that fall outside traditional healthcare coverage. Save considerable time and money
- Helps members eliminate the hassles and frustrations typically encountered when dealing with the healthcare system
- Resolve claims, billing and related administrative problems
- Assists members in finding the best doctors, hospitals and other healthcare providers
- Handles problems and addresses issues quickly and professionally
- Protects your privacy and confidentiality
- Facilitates access to centers of medical excellence
- Cuts through administrative red tape

Hours of Operation - Health Advocate’s offices are open Monday - Friday between 8am and 7pm Eastern Time. After hours and during weekends, you can still call Health Advocate’s offices and leave a message for your PHA. Your message will be relayed to a staff member who is on call and your call will be answered as soon as practical.

Members requiring assistance can call a special toll-free Health Advocate telephone number (1-866-695-8622) Monday - Friday between 8am and 7pm Eastern Time. Members can also visit the website at www.HealthAdvocate.com/members.

Life & Disability Insurance and 401K

Basic Life and AD&D Insurance

As a full-time employee of Center for Vein Restoration, you are eligible for company-sponsored Life Insurance thru CIGNA. Center for Vein Restoration pays 100% of the cost for your Basic Life and Accidental Death & Dismemberment Insurance (AD&D). This amount is equal to a flat $50,000. The CBIZ EMS system is the only record of beneficiary information, all full-time employees need to log onto www.cbizems.com to designate a beneficiary, even if you do not elect any other benefits.

Voluntary Term Life and AD&D Insurance

Center for Vein Restoration offers an additional Voluntary Life and AD&D Insurance benefit that you can purchase for yourself and your dependents thru CIGNA. You will be eligible for lower group rates and the premium is conveniently deducted from your payroll. You may elect in up to 5x your basic annual earnings in $10,000 increments, up to a maximum of $500,000. Evidence of Insurability is required for

Spouse and Dependent Life Insurance

Insurance is available for your spouse in $5,000 increments or 100% of the employee's Voluntary Term Life Insurance amount, whichever is less. Evidence of Insurability is required for amounts requested in excess of $25,000 for your spouse.

Coverage for a child 6 months to 19 years is available in $2,000 increments up to $10,000 or 100% of the employee's Voluntary Term Life Insurance amount, whichever is less. One monthly rate covers all of your dependent children. Evidence of insurability is not required for children. Dependent children are eligible for Life benefits and covered up to the age of 19 if unmarried or up to age 26 if a full-time student.

Voluntary Disability Insurance

Disability benefits can help protect your income. Cigna's Group Short Term Disability insurance can replace a portion of your salary if you become ill or injured and can't work. It can help you cover your expenses and protect your finances at a time when you're not getting a paycheck and have extra medical bills. Rates are based on age and income and can be found online at www.cbizems.com.

Short-Term Disability (STD): Your STD benefit equals 60% of your weekly earnings up to $2,000 per week. This benefit takes effect on the 8th day of absence due to illness or accident. The benefit maximum duration is 12 weeks.

Please note: Some states such as CA, HI, NJ, NY, PR and RI require state-mandated STD benefits. This means the state plan will pay a portion of the benefit and Cigna will pay the difference up to the benefit amount listed above. In some cases, you are responsible for paying the state mandated STD premium through payroll taxes.

Long-Term Disability (LTD): Your LTD benefit equals 60% of your monthly base earnings to a maximum benefit of $10,000 per month. This benefit has a 90-day elimination period. Age at disability determines benefit period.

Group Accident Insurance

Group Accident Insurance pays a benefit for the treatment of injuries suffered as a result of a covered accident, regardless of any other health insurance benefits you may have thru CIGNA. In addition, they may help offset the direct and indirect expenses such as deductibles, co-payments and other costs not covered by traditional health plans. The plan includes a hospital and wellness rider. The well rider is not available to employees in CT, NH, NM, ND and VT. These benefits are also available for your spouse and/or dependent children. Rates can be found online at www.cbizems.com. Enrollment in Group Accident Insurance is available only one time per year, at the annual open enrollment period.

401(k) Retirement Plan

If you are 21 years old, you are eligible to participate in the 401(k) plan on the first day of the month following 60 days of your employment. Through Principal, you can enroll, make changes, or discontinue contributions to the 401(k) plan at any time. You can enroll via phone by calling 800-547-7754 or by going online at www.principal.com. For more information, please contact Human Resources.

Employee Assistance Program (EAP)

ADP LifeCare

ADP LifeCare is a benefit, provided to you at no cost, to assist with work, life, and personal issues. LifeCare's experienced and helpful specialists are available to help with life's most important needs 24/7, 365 days a year. LifeCare specialists can help you with resources and information, providers, products and services in parenting, senior care, legal and financial services, home services, wellness, etc. LifeCare services are completely confidential and are available to you and the family members in your household. 1-800-697-7315.

Paid Time Off (PTO)

All full-time employees accrue 13 (8-hour) days of Paid Time Off (PTO) and receive eight (8-hour) paid holidays per year. PTO accruals increase to the maximum based on the chart below. Please see the employee handbook for more information.

Regular Full-Time Employee - Annual PTO Accrual (24 pay periods per year):

Length of Employment (years)	Accrued per pay period (hours) (40 hours)	Accrued per pay period (hours) (30-39 hours)	Annual allowance per year (hours)	Carryover Maximum (hours)
0 - 1	4.33	3.34	104	104
1 - 2	4.66	3.50	112	168
2 - 3	4.98	3.66	120	180
3 - 4	5.31	4.33	128	192
4 - 5	5.63	4.66	136	204
5 +	5.96	4.98	144	216

Additional Company Benefits

- 8 Paid Holidays
- Tuition Reimbursement
- Employee Referral Program
- And More! See the Employee Handbook on SharePoint for More Information.

Insurance Terminology

Deductible - The deductible is the amount of your covered expenses you must pay each policy year before the insurance company begins to pay.

Coinsurance - After the deductible is met, you and the insurance carrier will share in the payment of your healthcare related bills. The coinsurance amount will depend on the plan you choose and whether in-network or out-of-network providers are utilized.

Covered Expenses - Covered expenses are the expenses that are eligible for reimbursement. All the insurance plans generally provide benefits for medically necessary services and supplies ordered by a doctor or dentist. Each option also provides benefits for certain routine and preventive services. Under all plans, when benefits are paid for out-of-pocket covered expenses, the insurance companies will consider payment of those expenses only up to the Reasonable & Customary (R&C) limits.

Copayment - Copayment refers to a fixed cost that you must pay per occurrence. Copayments are paid directly to the providers (i.e. physician or pharmacy).

Out-of-Pocket Maximum - This maximum limits your out-of-pocket expenses (including deductible, coinsurance and copays) in any one plan year. (October 1— September 30)

Reasonable & Customary - The insurance company will not pay for any charge above the Reasonable and Customary (R&C) limit when you receive services from out-of-network providers, and these charges do not apply towards your out-of-pocket maximums. R&C charges are the fees usually charged for comparable services and supplies in your geographic area. If your service with an out-of-network provider exceeds R&C, the provider may bill you for the excess. Because in-network providers charge agreed-upon rates, you will never exceed R&C charges when you use in-network providers.

Qualifying Events - As a reminder, you may change your elections outside of the annual enrollment period only if you have a qualifying event. Qualifying events are the birth of a child, adoption, marriage, death, divorce, a court order requiring provision of insurance to a dependent, loss of coverage (if you or your spouse/dependents are covered under another plan and then lose that coverage), Medicare eligibility, going from part-time to full-time, move or transfer out of the plan's service area, or a reduction in hours that makes you ineligible for coverage. All qualifying event changes must be consistent with the change in status. If you experience a qualifying event, it is YOUR responsibility to contact Human Resources within 30 days of the qualifying event for the appropriate forms.

Why might an HSA be the right choice for you?

- It **saves you money**. For individuals with few regular health expenses, paying a traditional health plan premium can feel like **throwing money out the window**. HDHPs come with much lower premiums than traditional health plans, meaning less money is deducted from your paychecks. Plus, HSAs are basically "cash" accounts, so you may be able to negotiate pricing on many medical services.
- It's **portable**. Even if you change jobs, you get to keep your HSA.
- It's a **tax saver**. Contributions to your HSA are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you pay less in taxes.
- It allows for an **improved retirement account**. Funds roll over at the end of each year and accumulate tax-free, as does the interest on the account. Also, once you reach the age of 55, you are allowed to make additional "catch-up" contributions to your HSA until age 65.
- It puts **money in your pocket**! You never lose unused HSA funds. They always roll over to the next year.

Compliance Notices

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment with 30 days after your other coverage ends. If you are declining coverage for yourself andor your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

Non-Medical

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. Marriage, divorce, or legal separation;
2. Birth or adoption of a child;
3. Death of a spouse or child;
4. Change in residence or work location that affects benefits eligibility for you or your covered dependent(s);
5. Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes);
6. You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job);
7. Loss or eligibility for Medicaid or CHIP.

Women's Health and Cancer Rights Act Notice

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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 240-965-3877

Important Notice from CVR About Your 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 with CVR 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:

1. 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.

2. CVR has determined that the prescription drug coverage offered by Cigna 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 to 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 **CVR** coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current **CVR** coverage, be aware that you and your dependents may not be able to get this coverage back.

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 **CVR** 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 November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information.

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 **CVR** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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 www.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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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 1, 2017**
Name of Entity/Sender:	**Center for Vein Restoration**
Contact--Position/Office:	**Human Resources**
Address:	**7474 Greenway Center Drive, Suite 1000, Greenbelt, MD 20770**
Phone Number:	**240-965-3200**

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 **www.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 or dial **1-877-KIDS NOW** or **www.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 **www.askebsa.dol.gov** or call **1-866-444-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 January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**KANSAS – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
ALASKA – Medicaid	**KENTUCKY – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ARKANSAS – Medicaid	**LOUISIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**MAINE – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
FLORIDA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120
GEORGIA – Medicaid	**MINNESOTA – Medicaid**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739
INDIANA – Medicaid	**MISSOURI – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IOWA – Medicaid	**MONTANA – Medicaid**
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

NEBRASKA – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA – Medicaid	**SOUTH DAKOTA - Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW HAMPSHIRE – Medicaid	**TEXAS – Medicaid**
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW JERSEY – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW YORK – Medicaid	**VERMONT– Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
NORTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
OKLAHOMA – Medicaid and CHIP	**WEST VIRGINIA – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
OREGON – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
PENNSYLVANIA – Medicaid	**WYOMING – Medicaid**
Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
RHODE ISLAND – Medicaid	
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Notes:

Benefit Assistance

Contacts

Cigna Medical & Dental
1-800-Cigna24 or 1-800-244-6224
www.mycigna.com

Cigna 24 Hour Nurse Line
1-866-949-2111

EyeMed Vision Care
866-939-3633
portal.eyemedvisioncare.com

HealthAdvocate
866-695-8622
www.healthadvocate.com/members

Life and Disability - Cigna
1-800-Cigna24 (800-244-6224)
www.mycigna.com

Principal– 401K
800-547-7754
www.principal.com

LifeCare - Employee Assistance Program
800-697-7315
https://wl.lifecare.com/home

BB&T HSA Account Information
888-777-3873

COBRA - CBIZ COBRA
800-815-3023, Option 6
https://enroll.cbiz.com

Jennifer Church, Associate VP, HR
240-965-3877
jennifer.church@centerforvein.com

Diane Kraus, HR Generalist
240-965-3211
diane.kraus@centerforvein.com

Theresa Boyce, HR Generalist,
240-965-3886
theresa.boyce@centerforvein.com

Enrollment instructions, links to webinars and the benefits flipbook can also be found on ADP's homepage, http://workforcenow.com/portal.

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This benefits summary describes the highlights of our benefits in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in the materials and the official plan documents, the language of the official plan documents shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information.