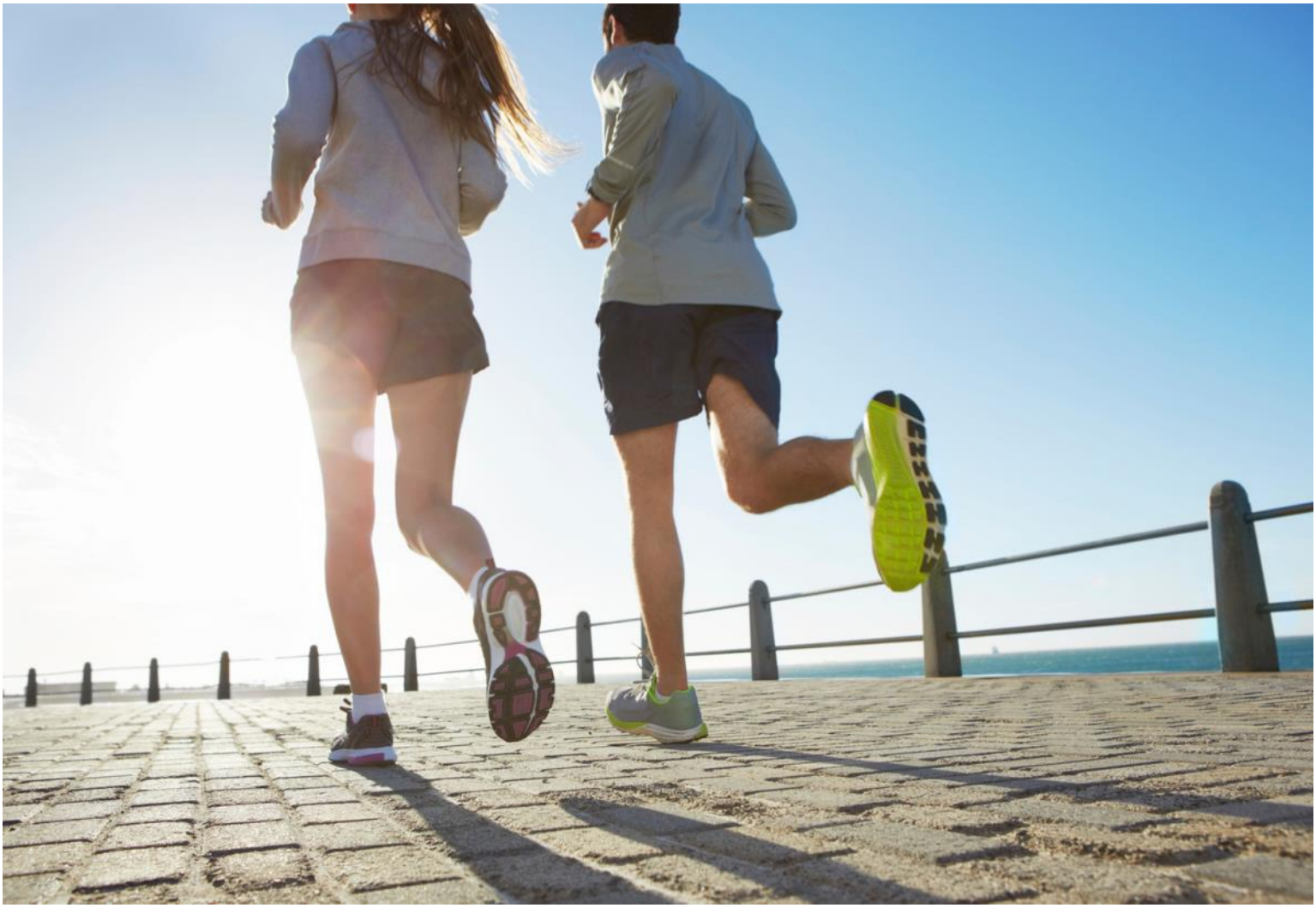


Employee Benefits Guide

2016-2017 plan year

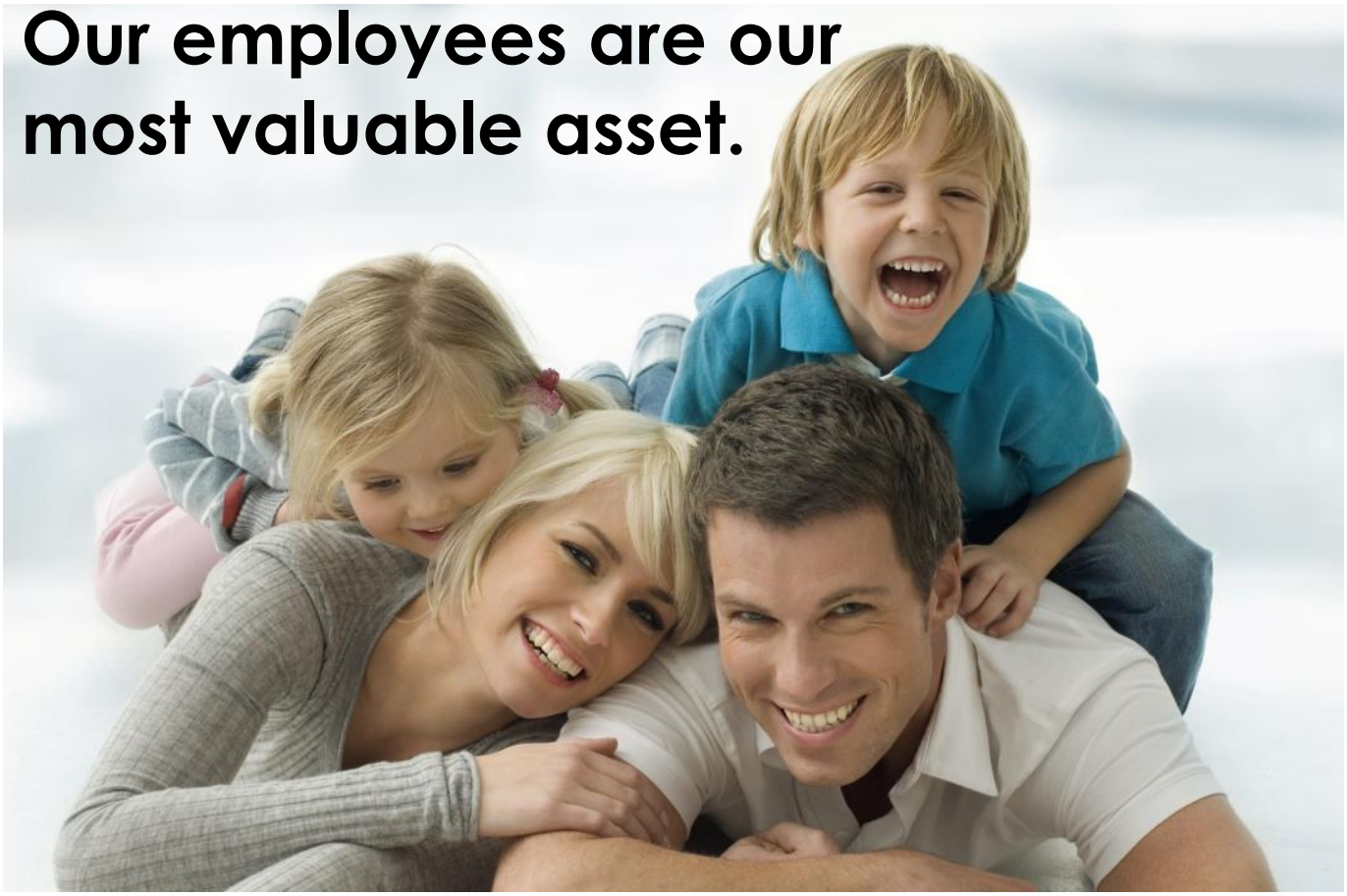
CBIZ

Center for Vein Restoration

Welcome to Annual Enrollment for your Benefits!

Welcome to Center for Vein Restoration! 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 UNUM. We also offer an Employee Assistance Plan, 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.



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) - BB&T HSA Administration
- Life/AD&D - Unum
- Short Term Disability - Unum
- Long Term Disability - Unum
- Critical Illness Insurance - Unum
- Accident Insurance - Unum
- 401(k) - Principal

Work/Life Balance

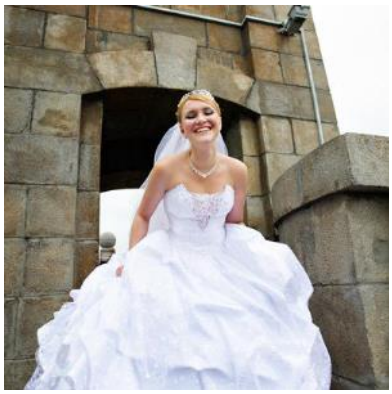
- Employee Assistance Program - ADP LifeCare
- 8 Paid Holidays
- Paid Time Off

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.

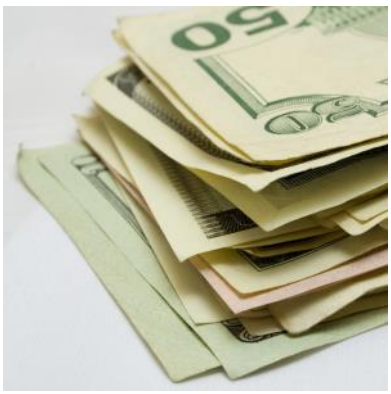
When to Enroll

This year's annual open enrollment period runs from **September 1, 2016 through September 12, 2016**. The benefits you elect during annual enrollment will be effective from **October 1, 2016 through September 30, 2017**. If you are a new hire, Human Resources will advise you of your appropriate effective date. **New hires have 30 days from date of hire to enroll in benefits.**



How to Make Changes

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



Employee Contributions

Center for Vein Restoration (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 or want to reset your 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. Please note, the Open Enrollment link will only be activated during the active Open Enrollment window. You will not have access to the Open Enrollment event outside of this enrollment window. 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 and detailed plan design information can be found in the document section on www.cbizems.com.

Medical Insurance

Medical and Prescription Drugs

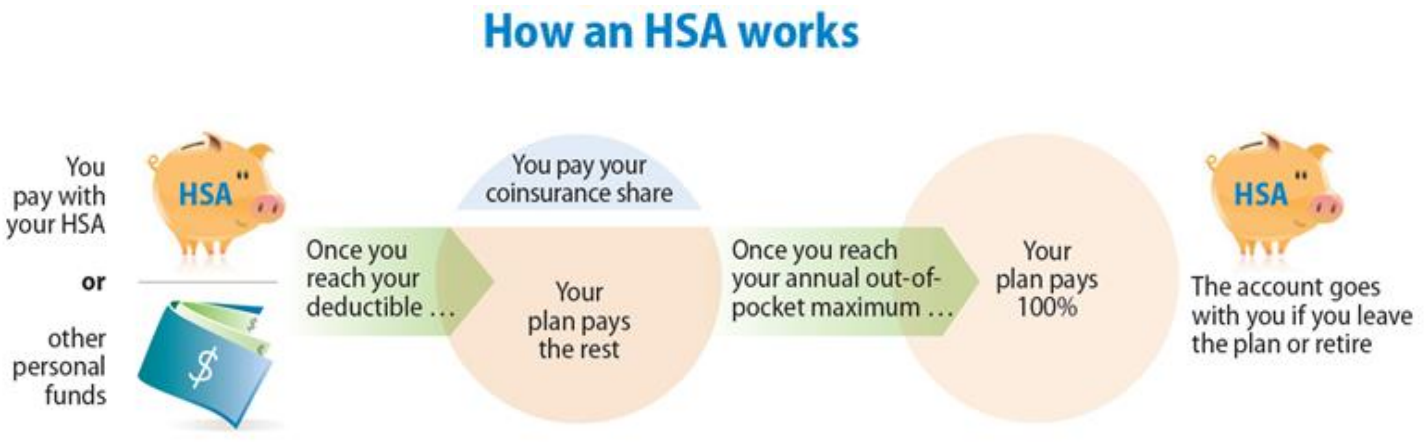
CIGNA will administer the medical benefits plan and the bank of your choice will administer the health savings account (HSA). CVR employees have the option to set up an HSA account through the bank of their choice or CVR can provide access through BB&T.

By offering a choice of THREE plans there's sure to be a plan that works for you. Each plan has its own advantages. You can find a network provider online at www.cigna.com before you sign up or go to your personalized website to search for providers and register for your member portal at www.mycigna.com after you sign up or call 1-800-Cigna24 or 1-800-244-6224.

OAP 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 doctors and other health care 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.

OAP In Network only 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 doctors and other health care providers. There is no need to select a primary care physician, nor do you need a referral to see a specialist. Care received from non network providers will not be covered under the OAP plan.

OAP Health Savings Account Plan (HSA) In Network Only Plan
The High Deductible Health Plan, or HDHP, has the same features as the OAP In Network Only plan above but with a higher annual deductible. You must meet the annual deductible before the plan begins to pay benefits (including prescriptions), except for preventative 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. Care received from non network providers will not be covered under the HSA OAP plan.



Cigna

	Cigna OAP HSA In-Network Only	Cigna OAP In-Network Only	Cigna OAP*	
Annual Deductible (Oct—Sept):	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
- Individual	$1,500	$500	$1,000	$2,000
- Family	$3,000	$1,000	$2,000	$4,000
Annual Out-of-Pocket Maximum (Oct—Sept):				
- Individual	$3,000	$2,500	$2,000	$4,000
- Family	$6,000	$5,000	$4,000	$8,000
Coinsurance: *Employee Responsibility*	5%	0%	0%	20%
Office Visits:				
- Primary Care Physician	Ded, then 5%	$30 Copay	$5 Copay	Ded, then 20%
- Specialist	Ded, then 5%	$40 Copay	$30 Copay	Ded, then 20%
Hospitalization:				
- Inpatient	Ded, then 5%	Ded, then covered	Ded, then $300/ admission	Ded, then 20%
- Outpatient	Ded, then 5%	Ded, then covered	Ded, then covered	Ded, then 20%
- Lab and X-ray (free standing)	Ded, then 5%	Ded, then covered	Ded, then covered	Ded, then 20%
- Accident/Medical Emergency	Ded, then 5%	$100	$150	Ded, then 20%
- Urgent Care	Ded, then 5%	$40	$50	Ded, then 20%
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Prescription Drugs:	**RETAIL**			
- Tier 1 (Generic)	Deductible, then $5	$15	$15	
- Tier 2 (Formulary Brand)	Deductible, then $15	$35	$35	
- Tier 3 (Non Formulary Brand)	Deductible, then $30	$60	$60	
MAIL ORDER				
- Tier 1 (Generic)	Deductible, then $15	Deductible, then $20	Deductible, then $20	
- Tier 2 (Formulary Brand)	Deductible, then $45	Deductible, then $70	Deductible, then $70	
- Tier 3 (Non Formulary Brand)	Deductible, then $90	Deductible, then $120	Deductible, then $120	

*While your 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 2016-2017

Per Pay Employee Cost	Cigna HSA OAP In Network Only	Cigna OAP In Network ONly	Cigna PPO OAP
Employee	$48.46	$124.70	$199.29
Employee/Spouse	$235.96	$546.29	$733.40
Employee/Children	$189.61	$384.48	$553.04
Employee/Family	$359.38	$581.92	$837.03

Effective October 1, 2016, the full-time employee contributions will be as follows:

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 or at **BB&T Bank**. Contributions you make to your HSA will be adjusted to a tax-favored basis when you file your tax return.

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 502 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 2016, the maximum contribution for an individual is $3350 and $6750 for those that cover their dependents. For 2017, the maximum contribution for an individual is $3400 and $6750 for those that cover their dependents If you are over age 55 you can contribute an extra $1000.

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.

How do I open my HSA?
Contact the bank of your choice or contact HR to set up an account through BB&T Bank. Be sure to confirm what the bank's fees are.

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.

You can 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

Cigna DHMO

Cigna DHMO: When you sign up in the DHMO plan, you select a network general dentist, who will handle 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 large, nationwide DHMO Network.

When you enroll in the DHMO plan, **you are required to select and visit a network general dentist (provider) for all your dental care needs**.

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 may not be covered at all.

Plan Design	Cigna Dental			
	Cigna dHMO	Total Cigna DPPO		
		Cigna DPPO Advantage	Cigna DPPO	Out-of-Network
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 2016-2017

Effective October 1, 2016, the full-time employee contributions will be as follows:

Per Pay Employee Cost	Cigna dHMO	Cigna PPO
Employee	$5.01	$14.90
Employee + 1	$9.86	$30.67
Employee/Family	$13.05	$44.52

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.

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.

To locate network vision providers go to portal.eyemedvisioncare.com or call 866-939-3633.

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 2016-2017

Effective October 1, 2016, the full-time employee contributions will be as follows:

Per Pay Cost	Total Cost
Employee	$2.63
Employee + Spouse	$5.93
Employee + Child(ren)	$4.62
Employee + Family	$7.25

Basic Life & Supplemental AD&D Insurance

Basic Life and AD&D Insurance

As a full-time employee of Center for Vein Restoration, you are eligible for company-sponsored life insurance. 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, so 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. You will be eligible for lower group rates and the premium is conveniently deducted from your payroll. Employees may elect in up to 5x basic annual earnings in $10,000 increments, up to a maximum of $500,000. Evidence of Insurability is required for amounts requested in excess of $130,000. You may enroll for supplemental AD&D coverage at the equivalent amount of the elected supplemental life coverage.

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, or any amount elected after your initial enrollment period or any amount if denied in the past.

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. The dependent child amount cannot exceed 50% of the employee amount. 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

Short-Long Term Disability, Accident and Critical Illness

Disability Insurance

Disability benefits can help protect your income. Unum'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 $1,000 per week. This benefit takes effect on the 8th day of absence due to illness and the 1st day of absence due to an accident. The benefit maximum duration is 13 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 UNUM 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 $5,000 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. 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. These benefits are also available for your spouse and/or dependent children. Rates are based on age and income and 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.

Group Critical Illness

Group critical illness coverage provides a lump-sum benefit upon the diagnosis of not only one covered illness, but for each covered illness. These benefits can also help pay for non-medical and out of pocket medical expenses upon diagnosis of a specified critical illness, such as heart attack or stroke. Benefit amounts available are $5,000—$50,000 and your spouse and dependent children may also be covered. Rates are based on age and income and can be found online at www.cbizems.com. Enrollment in Group Critical Illness Insurance is available only one time per year, at the annual open enrollment period.

Additional Benefit:
Health Advocate Services

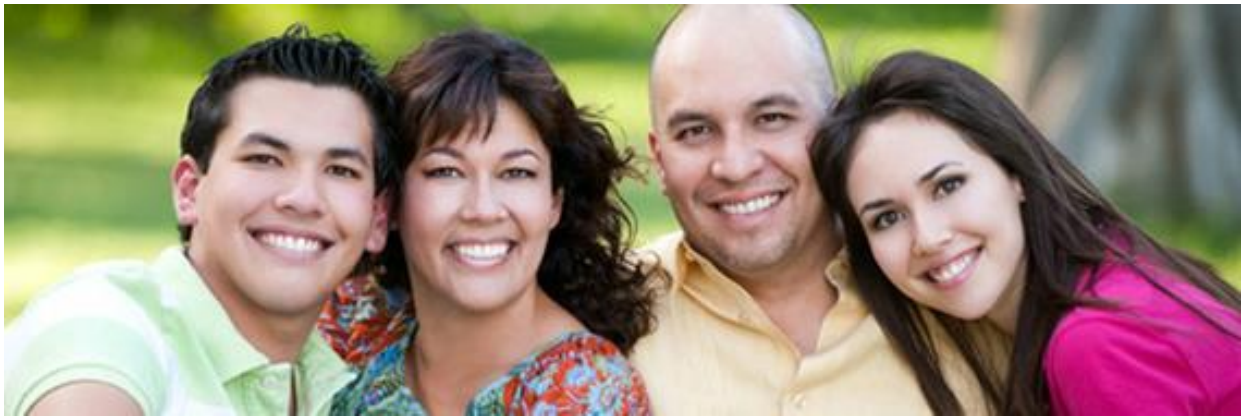
HealthAdvocate
Always at your side

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 coverageSave 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 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.



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)	Annual allowance per year (hours)	Carryover Maximum (hours)
0 - 1	4.33	104	104
1 - 2	4.66	112	168
2 - 3	4.98	120	180
3 - 4	5.31	128	192
4 - 5	5.63	136	204
5 +	5.96	144	216

Additional Company Benefits

- 401(k) Retirement Plan
- Tuition Reimbursement
- Employee Referral Program
- And More! See the Employee Handbook on the Cloud for More Information.

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.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours as applicable. In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

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

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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, 2016**
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:	**240-965-3877**

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, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

COLORADO – Medicaid

Medicaid Website: https://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

INDIANA – Medicaid

Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY: 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://www.dhs.state.mn.us/id
Click on Health Care, then Medical Assistance
Phone: 800-657-3629

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA – Medicaid

Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

Website: http://hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: http://www.health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any more states have added a premium assistance program since January 31, 2015, 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

OMB Control Number 1210-0137 (expires 10/31/2016)

Benefit Assistance

Contacts

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

BB&T
888-777-3783

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

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

Life and Disability - Unum
800-858-6843
www.unum.com

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

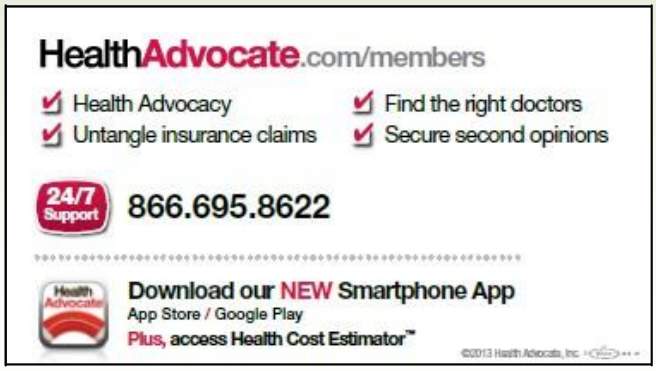
LifeCare - Employee Assistance Program
800-697-7315

COBRA - CBIZ COBRA
800-815-3023, Option 6

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

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

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



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