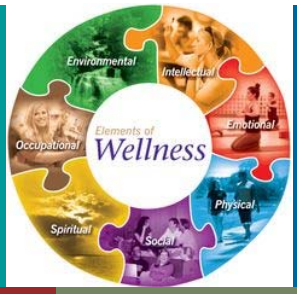
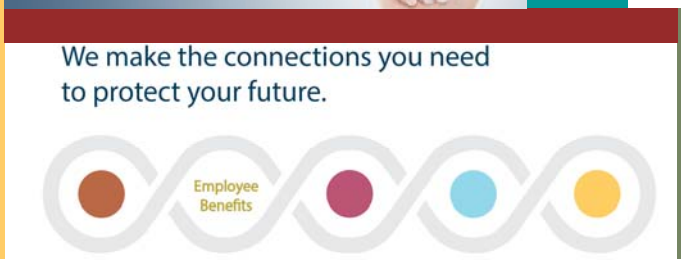
PROGRESSIVE MEDICAL

Innovative Products. Uncommon Attention.

Sales
2015 Employee Benefits Guide





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

2015 Benefits Guide

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Progressive Medical, Inc.

CONTACT INFORMATION

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COVERAGE	**VENDOR**	**PHONE NUMBER**	**WEBSITE**
MEDICAL	United Healthcare Policy Number: 01U7411	(866) 755-3901	www.myuhc.com
DENTAL - PPO	Delta Dental Policy Number: 1950-1386	(800) 335-8266	www.deltadentalmo.com
VISION	Vision Benefits of America Policy Number: 1621	(800) 432-4955 For Lasic Savings: (877) 437-6105	www.visionbenefits.com
LIFE / AD&D **VOLUNTARY LIFE**	UNUM Policy Number: 498165	(866) 679-3054	www.unum.com
LONG TERM DISABILITY	UNUM Policy Number: 498165	(866) 679-3054	www.unum.com
BENEFITS TEAM			
Donna Clifton Rusty Besancenez	CBIZ	(314) 692-5812 Toll Free (800) 844-4510	dclifton@cbiz.com rbasancenez@cbiz.com
Glenda Krueger	Progressive Medical, Inc.	(314) 961-5786	gkrueger@progressivemedinc.com

UNDERSTANDING YOUR BENEFITS

As a sales employee of Progressive Medical, Inc., you are offered the choice of two benefit package options. Package 1 includes Medical, Dental, Vision, Basic Life and Accidental Death & Dismemberment (AD&D). Package 2 includes Medical, Vision, Basic Life and AD&D. Participation in the benefit plans is offered during your initial enrollment opportunity or annually during the open enrollment period. If you elect to enroll your dependents, they will be enrolled in all benefit plans, with the exception of the Basic Life and AD&D. However, if you are covered elsewhere and wish to enroll in one or two specific plans, please discuss this with Human Resources. There is a contribution for your elected coverage, which is based upon the family members you elect to cover.

To assist with the cost of the package options, PMI has decided to increase the amount contributed towards the monthly coverage to $300 per month ($150 per paycheck) as a contribution for your elected coverage. If you participate, the cost will be deducted on a pre-tax basis under our Section 125 Plan. If you do not participate in one of the package options, the $150 per paycheck contribution will be taxable income.

Progressive Medical, Inc. also offers Long Term Disability (LTD). The LTD benefit is made available to eligible sales employees, however, you are responsible for the entire cost. Pricing is based upon your annual salary. The advantage to your paying the full premium is, if you do receive the LTD benefit, the benefit is non-taxable.

Progressive Medical, Inc. has placed into effect an insurance eligibility rule for spouses. If a spouse has access to medical and/or dental insurance through their employer, they must enroll in their employer sponsored benefit program. This policy will not affect children or spouses who are not employed or do not have access to employer subsidized medical and dental insurance. A Working Spousal Affidavit will be required from those who choose to cover a spouse.

EMPLOYEE PER PAY PERIOD CONTRIBUTIONS

PACKAGE 1

Includes:
Medical
Dental
Vision
Basic Life/ AD&D

MEDICAL	Deduction Amount	Less PMI Contribution	Net Per Pay Period Deduction
Employee Only	$230.29	$150.00	$80.29
Employee & Spouse	$480.38	$150.00	$330.38
Employee & Child(ren)	$455.16	$150.00	$305.16
Employee & Family	$705.38	$150.00	$555.38

PACKAGE 2

Includes:
Medical
Vision
Basic Life/ AD&D

MEDICAL	Deduction Amount	Less PMI Contribution	Net Per Pay Period Deduction
Employee Only	$208.65	$150.00	$58.65
Employee & Spouse	$436.63	$150.00	$286.63
Employee & Child(ren)	$405.36	$150.00	$255.36
Employee & Family	$633.31	$150.00	$483.31

ELIGIBILITY

An eligible employee is one who works 30 plus hours per week. Benefits begin the first of the month following 60 days after your date of hire.

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

- **Legal Spouse**
- **Domestic Partners**
- **Natural and Adopted Children up to age 26**
- **Your Stepchildren**
- **Children placed in your custody for adoption**
- **Children under your legal guardianship**
- **Children under a qualified medical child support order**
- **Disabled children 26 years or older**

Ineligible

- **Divorced or legally separated spouse**
- **Common law spouse**
- **Foster children**
- **Sisters, brothers, parents, or in-laws, grandchildren, etc.**

FREQUENTLY ASKED QUESTIONS

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

Generally, you may only enroll in the plan, or make changes to your benefits, during the re-enrollment period or when you are first hired. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must have your paperwork turned in within 31 days of the qualifying event or you will have to wait until the next annual open enrollment period. Premiums and enrollment eligibility may change; see your Human Resources department for details.

EXAMPLES OF QUALIFYING EVENTS?

- Your dependents or you lose health coverage because of loss of eligibility or loss of employer contributions
- You get married, divorced, or legally separated (with court order)
- You have a baby or adopt a child
- You or your spouse take an unpaid leave of absence
- You or your spouse dies
- Gain or loss of Medicaid entitlement
- You become eligible for Medicare

DOES THE DEDUCTIBLE RUN ON A CALENDAR YEAR OR A POLICY YEAR BASIS?

Our policy year starts every year on October 1st. This should not be confused with when the annual deductible under the plan begins. The deductible runs on a calendar year and begins every January 1st.

WHAT IF I USE AN OUT-OF-NETWORK PROVIDER?

It is important to ask if your medical provider is a participant of the United Healthcare Choice Plus Network. If your provider is not a participating provider, your claim may be processed based upon what Medicare allows. Non-network claims may be based upon 175% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service. Non-network benefits are then applied to the eligible charges. This means you may be balanced billed for non-eligible charges.

WHAT CAN I DO TO KEEP MY MEDICAL COSTS DOWN?

Use Network doctors and facilities

- Check www.myuhc.com to find network providers near you.
- Ask your provider if they participate in the United Healthcare Choice Plus Network
- Before you have any procedure, be sure to talk to your doctor or the facility you are referred to and sure they are in-network.
- If you are balanced billed by an out-of-network provider, contact them and ask if they will lower the charge if you set up a payment plan.

Understand your benefits

- Always review your health plan documents to fully understand your benefits. If you are not sure, contact United Healthcare customer service at the phone number on the back of your ID card.
- Go online at www.myuhc.com. Click on the "Benefits & Coverage" menu, then click on "Coverage Documents".

Ask the provider about their fees before you receive services

- You can ask about fees before you receive services or pharmacy benefits. Contracted fees are not the same for all providers. You have the right to ask before you receive services so you are aware of what your expenses will be. This may not always be possible, however, when it is...ask.
- To estimate and compare costs you can also go online at myuhc.com and look for "Estimate Health Plan Costs".

HOW DO I FIND A UNITED HEALTHCARE PROVIDER?

It's simple to look for medical providers in your area.

1. Go to myuhc.com
2. Click on Find Physician, Laboratory or Facility on the right hand side of the page.
3. Select United Healthcare Choice Plus Plan as the plan name.
4. On the next screen you can personalize your search by zip code and physician type.

Progressive Medical, Inc.

MEDICAL INSURANCE

Plan E9F Balanced, Rx K4

Benefit / Service	In-Network	Non-Network
Annual Deductible *Individual / Family*	$1,000 / $2,000	$3,000 / $6,000
Coinsurance	You Pay 20% After the Deductible	You Pay 50% After the Deductible
Annual Out-of-Pocket Maximum *Individual / Family*	$4,000 / $8,000	$8,000 / $16,000
Office Visit *Primary Care* *Specialist*	 $30 Co-Pay $60 Co-Pay	 You Pay 50% After the Deductible
Preventive Care	You Pay 0% No Deductible	You Pay 50% After the Deductible
Inpatient Hospital	You Pay 20% After the Deductible	You Pay 50% After the Deductible
Outpatient Services *Includes X-Ray, Lab, & Diagnostics (See Major Diagnostics)*	You Pay 20% After the Deductible	You Pay 50% After the Deductible
Major Diagnostics, X-Ray, Lab, *CT, PET, MRI, MRA, & Nuclear*	You Pay 20% After the Deductible	You Pay 50% After the Deductible
Emergency Room	You Pay $300 Co-Pay Per Service	You Pay $300 Co-Pay Per Service
Urgent Care	You Pay $100 Co-Pay Per Service	You Pay 50% After the Deductible
Lifetime Maximum	Unlimited	Unlimited
Prescription Drug - Retail *Tier 1* *Tier 2* *Tier 3* Prescription Drug - Mail Order *90 Day Supply*	 $10 Co-Pay $25 Co-Pay $40 Co-Pay 2.5 Co-Pays	 $25 Co-Pay $62.50 Co-Pay $100 Co-Pay Not Covered

PLAN HIGHLIGHTS

- Co-Pays, Coinsurance, Prescription Drug Co-Pays, and Deductibles accumulate towards the Out-of-Pocket Maximum.
- Lab, X-Ray, and other preventive tests for Preventive care are covered at 100% with no deductible.
- You can visit a Walgreens Take Care clinic for a Primary Care Office Visit Co-Pay.
- If you use a non-network pharmacy you will be responsible for any difference between what the non-network pharmacy charges and the amount UHC would have paid for the same prescription drug product dispensed by a network pharmacy.
- You should read and review the certificate of coverage and the Summary of Benefit and Coverage to know your exact benefits. You can also contact United Healthcare at the phone number on the back of your ID card.

SERVICES AND TOOLS AVAILABLE TO UNITED HEALTHCARE PARTICIPANTS

ONCE YOU SET UP YOUR SITE ACCESS ON MYUHC.COM YOU CAN:

- Locate information on your benefits and coverage - Learn what is covered and what is not.
- Consider a doctor's premium designation status - Helps you chose a doctor who treats other patients of your age and gender with similar health conditions and cost efficiency.
- Manage your claims - Search for claims, track claims you need to watch, and mark claims you've already paid. You can even pay online for any claims that has a "You Owe" amount using the "Make Payment" feature.
- Manage prescriptions - Order your refill medications online and track refill status and price.
- Track your medical expenses - Account balances and spending history.
- Estimate health care cost - Before you have a test or procedure you can view treatment options and see variations in cost and quality by provider or facility all before seeking care. Visit myHealthcare Cost Estimator.
- Health4Me™ - Is a go-to resource for mobile phone when you want to find a physician near your, check the status of a claim, or speak directly with a health care professional using your mobile phone. Available on the App Store or Google Play.

BENEFITS ARE OFFERED IN TWO PACKAGE OPTIONS. EMPLOYEE CONTRIBUTIONS FOR EACH PACKAGE CAN BE FOUND ON PAGE 2

When to Use Primary Care, Convenience Care, Urgent Care, or Emergency Care

PRIMARY CARE

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You may also pay the least amount out of pocket when you receive care in your doctor's office.

CONVENIENCE CARE

Sometimes, you may not be able to get to your doctor's office, and your condition is not urgent or an emergency. In these situations, you may want to consider a Convenience Care Center that can be an alternative to seeing your doctor.

Convenience Care Centers are conveniently located often in malls or some retail stores, such as CVS Caremark, Walgreens, Wal-mart and Target, and offer services without the need to schedule an appointment. Services at a Convenience Care Center may be provided at a lower out of pocket cost than an urgent care center visit and are subject to primary care physician office visit copays and/or deductible/coinsurance.

Services at a Convenience Care Center are generally available to patients 18 months of age or older. Services that are available may vary per center. We do, however, recommend that you seek routine medical care from your primary care physician whenever possible.

To find an in-network Convenience Care Center near you, visit our website at www.myuhc.com.

Convenience Care Center

Typical conditions that may be treated at a Convenience Care Center include:

- Common infections (e.g.: bronchitis, bladder infections, ear infections, pink eye, strep throat)
- Minor skin conditions (e.g.: athlete's foot, cold sores; minor sunburn, poison ivy)
- Flu shots
- Pregnancy tests

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

URGENT CARE

Sometimes you may need medical care fast, but a trip to the emergency room may not be necessary. Of course, during office hours you may be able to go to your doctor for any urgently needed service; however, if you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately, you may consider going to an urgent care center. At an urgent care center, you can generally be treated for many minor medical problems faster than at an emergency room.

We do however, recommend that you seek routine medical care from your primary care physician whenever possible.

Services that are available for Urgent Care may vary per center. If you choose to use an urgent care center, please make sure it is in-network by calling the toll-free number on the back of your medical ID card or visiting the carrier's website at www.myuhc.com.

URGENT CARE

Typical conditions that may be treated at a Urgent Care Center include:

- Sprains
- Strains
- Mild asthma attacks
- Minor infections
- Vaccinations
- Small cuts
- Sore throats
- Rashes
- Preventive Screenings
- Back Pain or Strains

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

EMERGENCY ROOM

If you think you or your loved one may be experiencing an emergency medical condition, you should go to the nearest emergency room or call 911. Emergency services are always considered at the in-network benefit level.

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in:

- Serious jeopardy to your or your loved one's health, including the health of a pregnant woman or her unborn child
- Serious impairment to your or your loved one's bodily functions
- Serious dysfunction of any of your or your loved one's bodily organ or part

If you obtain care at an emergency room, you will likely pay more out of pocket than if you were treated at your doctor's office, a Convenience Care Center or urgent care facility.

*If you receive treatment for an emergency in a non-network facility, you may be transferred to an in- network facility once the condition has been stabilized.

Some examples of emergency conditions may include the following:

- Heavy bleeding
- Chest pain
- Major burns
- Severe head injuries
- Sudden weakness or trouble walking
- Large open wounds
- Sudden change in vision
- Spinal injuries
- Difficulty breathing

This list only provides examples and is not intended as an exclusive list. If you believe you or your loved one is experiencing an emergency medical condition, you should go to the nearest emergency room or call 911, even if your symptoms are not described here.

PREVENTIVE CARE

Certain preventive services will be covered without charging a deductible, copayment, or coinsurance when these services are provided by a **network provider**. The types of preventive services covered are defined by federal law and can vary based on your age, gender, and health status. There may be services you had in the past that will now be covered as preventive at no cost to you. The preventive services included in this provision are described at www.healthcare.gov.

DENTAL INSURANCE

Benefits	PPO Network You Pay	Premier Network You Pay	Non-Network You Pay
Deductible Individual	$50	$50	$50
Family	$150	$150	$150
Deductible Applies To:	Basic & Major Services	Basic & Major Services	Basic & Major Services
Coinsurance Preventive • Oral Exams • Bitewing x-rays • Full-mouth x-rays • Cleanings	0%	0%	0%
Basic Services • Fillings • Periodontics • Simple extractions • Sealants • General anesthesia	10%	20%	20%
Major Services • Bridges • Crowns • Oral Surgery • Root Canal	40%	50%	50%
Annual Maximum	$1,000 Per Person		
ORTHODONTIA Child Only to Age 26	50%	50%	50%
Ortho Lifetime Maximum	$1,000 Per Child		

Plan Highlights

- Delta Dental offers three network options for your dental care.
- The PPO Network offers higher benefits and contracted fees to lower cost.
- The Premier Network dentist will not balance bill beyond your deductible and co-insurance responsibility.
- If you elect a non-participating dentist, benefits are paid based on Delta Dentals maximum allowance. You may experience balance billing and higher out-of-pocket expenses.
- Locate a participating provider at www.deltadentalmo.com.
- The dental plan offers an enhancement called “MAXAdvantage. Charges for exams, cleanings, x-rays and fluoride treatments do not apply towards the annual maximum.

BENEFITS ARE OFFERED IN TWO PACKAGE OPTIONS. EMPLOYEE CONTRIBUTIONS FOR EACH PACKAGE CAN BE FOUND ON PAGE 2

VISION INSURANCE

Benefit/Service	In Network	Non-Network
	You Pay	Reimbursement Up To
Exam Co-pay	0%	$35
Frequency		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Lenses	$5 Co-pay then	
Single	0%	$40
Bifocal	0%	$50
Trifocal	0%	$75
Lenticular	0%	$100
Frames	0%	
	$50 Wholesale	$50
	$125 to $150 Retail	
Contacts		
Medically Necessary	UCR*	$300
Cosmetic	$150	$150

NOTE: Contact allowance shown is applied to all services/materials associated with the contact lenses. This includes exam, fitting, dispensing, lenses, etc.

* UCR refers to Usual Customary and Reasonable charges. To determine the UCR, Vision Benefits of America takes the procedural charge of area providers and calculates an average. Charges above this average become your responsibility.

PLAN HIGHLIGHTS

- If you visit one of VBA's providers you do not have to obtain a voucher. Your vision provider can receive your benefits electronically.
- Non-Network benefits are based on a reimbursement schedule.
- You are eligible for savings on Lasik vision services. Savings range from 40% to 50% off the national average price of traditional Lasik.
- You MUST contact QualSight to obtain Lasik services. Phone number is (877) 437-6105.

BENEFITS ARE OFFERED IN TWO PACKAGE OPTIONS. EMPLOYEE CONTRIBUTIONS FOR EACH PACKAGE CAN BE FOUND ON PAGE 2

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

Our Life/AD&D benefit is $10,000 (age reduction schedule applies to those age 65 and older). The coverage is through UNUM insurance company. This benefit is provided for you at **no cost.** In addition to this coverage, UNUM offers Life Planning Financial & Legal Resources.

We ask that you make sure your beneficiary information is up to date with Human Resources at all times.

LONG TERM DISABILITY INSURANCE

Our Long Term Disability coverage is offered through UNUM insurance company. This coverage is available to you at your own expense. Premium is based on your individual income.

Your Benefit Is: If disabled for 60 days, this plan could provide you with a monthly disability benefit. The benefit is 60% of salary to a maximum monthly benefit of $9,000.

SECTION 125 PREMIUM ONLY PLAN

PMI offers a way for you to have a portion of the cost of insurance (your payroll deduction for medical, dental and vision) deducted from your pay on a pre-tax basis. This can provide an approximate 30% savings depending on your tax bracket. You are automatically enrolled in this program unless you tell us otherwise.

ADDITIONAL BENEFITS

- Worldwide emergency travel assistance service is available by Assist America.
- An Employee Assistance Program (EAP) through Life Balance is included with this benefit. The EAP provides up to three face to face assessment and counseling sessions for Work Life services.

HOW TO ESTIMATE LONG TERM DISABILITY PREMIUM

$50,000 W-2 Earnings	÷	24 Paychecks per year	=	$2,083 Per Paycheck Earnings	÷	100 Premium is based on each $100	=	$20.83	X	$0.59 Rate	=	$12.29 Approximate Per Pay Cost

NOTE: This calculation offers an approximate per paycheck premium. Contract provisions apply in determining your monthly earnings. This should only be used to determine an estimated premium

ENROLLMENT WORKSHEET

	Package 1	Package 2			Per Paycheck
Employee	$80.29	$58.65			
Employee & Spouse	$330.38	$286.63			
Employee & Child(ren)	$305.16	$255.36			
Family	$555.38	$483.31			
Long Term Disability					
TOTAL DEDUCTIONS PER PAYCHECK					

DEPENDENT PARTICIPATION DETAIL

Legal Name	SS#	Relationship	Gender	DOB	Medical Yes or No	Dental Yes or No	Vision Yes or No

BENEFICIARY INFORMATION

Basic Life Primary Beneficiary - Total Must Equal 100%

Name	SS#	Relationship	%
Name	SS#	Relationship	%

Basic Life Contingent Beneficiary(s) - Total Must Equal 100%

Name	SS#	Relationship	%
Name	SS#	Relationship	%

IMPORTANT INFORMATION REGARDING YOUR PRESCRIPTION DRUG BENEFIT

United Healthcare Pharmacy Benefit mandates utilization of their mail order service for maintenance medications through OptumRx Mail Service Pharmacy or at a retail pharmacy. You will be allowed to receive the first two fills of your prescription at a participating pharmacy. After the first two fills, you are required to receive your prescription drug through mail service. If you continue to fill your prescription at the pharmacy you will pay full price for your prescription.

YOU CAN OPT OUT

You can opt out of the mail service by contacting United Healthcare customer service at the phone number on the back of your ID card. If you opt out you will be allowed to continue to receive your prescription beyond the first two fills at your participating pharmacy. **THE OPT OUT IS ONLY GOOD FOR ONE YEAR AND MUST BE RENEWED ANNUALLY.**

HOW THE MAIL ORDER PHARMACY BENEFIT WORKS

You fill your first prescription at a retail pharmacy.
Pharmacy staff will receive a message advising that you need to contact OptumRx. Claim will process at the retail pharmacy using the

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You will receive a letter.
In two or three weeks you will receive a letter encouraging you to accept the OptumRx Mail Service Pharmacy or decline the service.

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If you do not decline the mail order service and fill the prescription for a second time
Pharmacy staff will receive a message advising that you need to contact OptumRx. Claim will process at the retail pharmacy using the appropriate tier co-pay.

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You will receive a phone call or a letter
In two or three weeks you will receive a phone call if a phone number is available or a letter encouraging you to accept the OptumRx Mail Service Pharmacy or decline the service before the third retail fill to avoid paying 100% of the drug's retail or usual and customary cost.

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If you fill the prescription for a third time at the retail pharmacy

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If you declined the mail order service
You will be able to continue filling at the retail pharmacy for one year from the notification date to OptumRx without paying more for your prescription. A month before the annual opt out period ends, you will receive a letter stating action is again needed.

If you did not decline the mail order service
Your claim will be rejected at the retail pharmacy and you will be required to pay 100% of the drug's retail or usual and customary cost for your medication. You will receive notice to contact OptumRx for more Information about the mail service pharmacy.

IF YOU WANT TO IMMEDIATELY RECEIVE YOUR PRESCRIPTION THROUGH MAIL SERVICE.

Online - Within the pharmacy section of myuhc.com, or directly from optumrx.com you can select Transfer Prescription, which will generate a form that you can print and take to your doctor.
Mail - You can ask your doctor for a new prescription for up to a 3-month supply. Then download an order form from myuhc.com and mail in the new prescription.
Provider - Your doctor can fax or e-prescribe a new order to the mail service pharmacy.
Customer Service - Advocates can initiate the transfer by contacting your provider.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL PLAN

REQUIRED UNIFORM MODIFICATION NOTICE FROM UNITED HEALTHCARE

EFFECTIVE OCTOBER 1, 2015
THE FOLLOWING CHANGES TO YOUR MEDICAL PLAN WILL GO INTO EFFECT

United Healthcare has made benefit changes to our medical plan. These benefit changes include:

- If you utilize out-of-network benefits for:
  - Laboratory Services - If you receive services from an out-of-network provider, the out-of-pocket costs will be higher. The claim will be processed using 50 percent of the published rate allowed by the Centers for Medicare & Medicaid Services (CMS). The rate is based on the same or similar services.
  - Durable Medical Equipment - If a member receives durable medical equipment from an out-of-network provider, the out-of-pocket costs will be higher. The claim will be processed using 45 percent of the published rate allowed by (CMS). The rate is based on the same or similar equipment.
- Prior Authorization - A member must receive prior authorization or approval before services are received. The following services need prior authorization:
  - Outpatient surgery for cardiac catheterization, pacemaker insertion and implantable cardiovascular defibrillators:
  - Rehabilitation services - physical, occupational and speech therapy;
  - Prosthetic devices that cost more than $1,000;
  - Lab, X-ray and major diagnostics - CT, PET, MRI, MRA, and Nuclear Medicine - outpatient; and
  - Sleep studies

Other coverage changes:

The following coverage changes will also be implemented:

- There is a difference in how certain claims are processed when a member receives services from out-of-network providers. If a member receives non-emergency services in a network facility from an out-of-network provider, they are responsible for the difference between the amount charged by the provider and the eligible expense. The eligible expense is the amount the plan determines can be paid for a health care service. If emergency services are received from any out-of-network providers the member is responsible for the difference between the amount charged by the provider and the eligible expense, which is based on the median network rate or a higher rate required by law. For emergency and non-emergency services, the member is also responsible for the deductible, co-insurance or co-pay. This amount is determined by using the network cost share level.

IMPORTANT NOTICES

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans. If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. If coverage is lost, you must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact Glenda Krueger.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. The benefits must be provided and are subject to the health plan's regular co-pays, deductibles, and co-insurance. You may contact our health carrier at the phone number on the back of your ID card for additional benefit information.

NOTICE OF MATERIAL CHANGE (also Material Reduction in benefits)

Progressive Medical, Inc. or United Healthcare has amended the Medical benefit plan. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you need a copy, please submit your request to Glenda Krueger or go online to www.myuhc.com .

MARKETPLACE OPTIONS

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by *Progressive Medical*.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance which meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit which lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October through February 15.

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

You may qualify to save money and lower your monthly premium. Savings depends on your household income.

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

Yes. If you have an offer of health coverage from your employer which offers minimum essential coverage and meets affordability standards, you will not be eligible for a tax credit through the Marketplace. If you purchase health coverage through the Marketplace, you may lose any employer contribution offered for the employer-offered coverage. Employer and employee contributions for employer-offered coverage are often excluded from Federal income tax. Payment for Marketplace coverage is made on an after-tax basis.

More Information

New employees will receive a notice of Marketplace Coverage Options advising the standards of offered coverage. Please visit HealthCare.gov for more Marketplace information.

MEDICAID CHIP NOTICE

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 our health coverage 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 believe 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 go to www.insurekidsnow.gov website 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, you will be allowed to enroll in our medical 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 1-866-444-3272.

Link to the latest form: **http://www.dol.gov/ebsa/pdf/chipmodelnotice.pdf**

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-3272
Menu Option 4, Ext 61565

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

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Ph: 1.573.751.2005

PENNSYLVANIA - Medicaid
Website: http://www.dpw.state.pa.us/hipp
Ph: 1.800.692.7462

FLORIDA - Medicaid
Website: https://www.flmedicaidtplrecovery.com
Ph: 1.877.357.3268

TEXAS - Medicaid
Website: https://www.gethippatexas.com
Ph: 1.800.440.0493

MEDICARE PART D CREDITABLE COVERAGE.

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan. All Medicare drug plan provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

UHC has determined that the prescription drug coverage offered by *Progressive Medical* is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pay and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage will not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

If you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

A notice will be provided to you prior to the October 15 Medicare open enrollment period. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at www.socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

Keep all Creditable Coverage notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the 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).

GLOSSARY OF TERMS

Coinsurance – Your share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. The plan pays any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays – A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care, or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible – The amount of money you pay before service are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services as required under the Affordable Care Act.

Emergency Room – Services you receive from a hospital for any serious condition requiring immediate care.

Lifetime Benefit Maximum – All plans are required to have an unlimited lifetime maximum.

Medically Necessary – Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider - A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services

Out-of-Pocket Maximum – This most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance, and co-pays are included in the out-of-pocket maximum.

Preauthorization – A process by your health insurer or plan to determine if any service, treatment plan, prescription drug, or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval, or precertification.

Preferred Provider – A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Prescription Drugs – Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail Order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before a copays are applied.

Preventive Services – All services coded as Preventive must be covered 100% without a deductible, coinsurance, or co-payments.

UCR (Usual, Customary and Reasonable) – The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

TOP 10 THINGS YOU SHOULD KNOW ABOUT YOUR HEALTH PLAN

1 HOW TO ACCESS INFORMATION

Visit www.MYUHC.com to:

- Search the online provider directory
- Review the status of medical and pharmacy claims
- Search or download the formulary drug list
- Request new ID card or print a temporary card
- Verify your benefits
- Update your personal information

2 PHARMACY

- Tier 1 - Lowest cost drugs. Some brand name and generics are included.
- Tier 2 - Mix of brand name and generics.
- Tier 3 - Higher-cost brand name as well as some select generic drugs.
- Tier 4 - Specialty Drugs. These are high cost drugs for specialized health care.

3 OUT-OF-NETWORK BENEFITS

If you utilize a non-network provider, you will experience higher out-of-pocket expenses. United Healthcare uses 175% of Medicare allowable charges as their base for reimbursing claims. Without the benefit of the contract agreements provided by network providers, UHC uses Medicare allowable charges as the base for reimbursing claims. **YOU** pay the deductible, co-insurance, **PLUS** any amounts above the allowable charges.

4 IS IT OR IS IT NOT COVERED

- Consult your Certificate of Coverage for a complete list of covered and non-covered services.
- A copy of your certificate can be located online through United Healthcare at www.MYUHC.com or ask Human Resources.

5 PRIOR APPROVAL

Some services must be approved in advance by United Healthcare. When obtaining services in the network, your provider will contact UHC to get approval before delivering care. If you go out-of-network, consult a customer service representative to find out which services must be approved in advance before receiving services. Penalties may apply if you do not make the call.

6 APPEALS & COMPLAINTS

- If you have a complaint or concern, call United Healthcare Customer Service at the number on the back of your ID card.
- If you wish to appeal a decision made by United Healthcare on a claim, write to:

  United Healthcare - Appeals
  P. O. Box 30432
  Salt Lake City, UT 84130-0432
- Call Customer Service to file an urgent appeal.

7 MEMBER ID CARD

Present your member ID card to the provider at the time of service and ask if they **participate** in the **UHC Choice Plus Network**. Do not ask if the accept United Healthcare. Providers may accept whatever the insurance company will pay but if they do not participate in network your coverage will be considered out-of network and you will have unexpected, higher out-of-pocket expenses.

8 BEHAVIORAL HEALTH & SUBSTANCE ABUSE

- Some services may require prior authorization by United Healthcare. Call **866-844-4864** for assistance or to locate a provider.

9 OUT-OF-AREA COVERAGE

- Out-of-Area coverage is available in a true emergency. You will be responsible for the co-pays associated with your elected plan.

10 CUSTOMER SERVICE

- If you have questions, call the toll-free number at

  866-844-4864