THE hydrafacial COMPANY

2017-2018

EMPLOYEE BENEFITS OVERVIEW

BIGGER,
BETTER
BENEFITS.

BIGGER, BETTER BENEFITS.

At The HydraFacial Company we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional, and financial—is the reason The HydraFacial Company offers you this benefits program. This benefits overview will help you understand the benefit choices available to you and allow you to be the best healthcare consumer possible as you take an active role in managing your health. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

The benefits in this overview guide are effective:

October 1, 2017 – December 31, 2018

WHAT YOU'LL FIND

Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices on pages 32-33 for more details.

ELIGIBILITY

WHO IS ELIGIBLE?

In general, full-time, regular employees working 30 or more hours per week are eligible for the benefits outlined in this overview.

You can enroll the following family members in our plans.

- Your spouse (the person who you are legally married to under state law)
- Your Domestic Partner, where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit
- Your children (including children of a domestic partner):
  - Up to the age of 26 are eligible to enroll in medical coverage
  - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law

WHO IS NOT ELIGIBLE?

Members who are not eligible for coverage include (but not limited to):

- Parent, grandparents, and siblings
- Employees who work less than 30 hours per week, contract employees, or employees residing outside the United States

NEW SPOUSAL SURCHARGE

Employees electing medical coverage for spouses that are eligible for medical insurance through their own employer will be charged a monthly surcharge of $100 to continue enrollment for their spouse through The HydraFacial Company.

WHEN CAN I ENROLL?

Coverage for full-time employees working 30 hours or more per week are eligible for benefits on the 1st of the month, following date of hire.

Open Enrollment for current full-time employees is held in September. It is the one time each year that employees can make changes to their benefit elections without a qualifying event.

Make sure you notify Human Resources right away if you have a qualifying event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child
- Marriage or Divorce
- Loss of other healthcare coverage
- Your child reaches the maximum age limit
  - You or your child loses coverage under your spouse's employer plan
  - Your spouse or child gains eligibility for benefits through his/her employer
  - Your eligible family member gains or loses coverage under Medicaid or under a state children's health insurance program (CHIP)

Be prepared to provide documentation to support the qualifying event (i.e. marriage certificate, birth or adoption certificate, divorce decree). If changes are not submitted within 30 days of the qualifying event, you will not be allowed to make changes until the next open enrollment period.

MAKING THE MOST OF YOUR BENEFITS

Our goal is to help you and your family members stay healthy and use your benefits program to its best advantage. Here are a few things to keep in mind.

PREVENTIVE OR DIAGNOSTIC CARE

Getting preventive care is one of the most important steps you can take to manage your health. That's because when a condition is diagnosed early, it is usually easier to treat. And regular checkups can help you and your doctor identify lifestyle changes you can make to avoid certain conditions. Our plans cover preventive visits at no costs.

Preventive visits can include annual exams, wellness visits, immunizations, screenings, well-baby/child exams, and well-woman exams. Refer to your benefit summary for a complete list of covered services.

IN-NETWORK CARE

Your copay or coinsurance will be lowest when you go to an in-network provider. If you go to an out-of-network provider, they may balance bill you for additional charges if their fees are more than the carrier's maximum allowed amount, or they may not be covered at all depending on the plan you select. You will be responsible for covering this out-of-pocket expense.

EMERGENCY ROOM VS. URGENT CARE CLINICS

Emergency visits should be used for a true medical emergency – such as any situation of a life threating condition, chest pain, shortness of breath, serious bodily injury, severe abdominal pain, or loss of consciousness. Otherwise, for non-emergencies, call your doctor, your nurse line, or go to an urgent care clinic for basic illness/injury, stiches/sutures, fever. This will save you a lot money and time.

REVIEW YOUR MEDICAL BILLS AND EXPLANATION OF BENEFITS (EOB)

Make sure you always check your medical bills and explanation of benefits for accuracy. Medical billing is complicated and mistakes can easily happen. Make sure to contact your provider and/or carrier if you believe there may be an error.

PRESCRIPTIONS

If you need a medication, you can save money by asking your doctor if there are generics or generic alternatives for your specific medication. Generics are safe and effective. They are the equivalent of brand-name drugs and usually cost less than brand drugs. You can also use the mail order program for maintenance drugs which provides three times the quantity of a retail prescription at only twice the cost.

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MANAGE YOUR HEALTH

MEDICAL

Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

The HydraFacial Company offers you medical plan options through Blue Shield of California.

HMO Plans

	Blue Shield Access+ HMO SaveNet	Blue Shield Access+ HMO Full Network
	In-Network	In-Network
Annual Deductible		
Individual	None	None
Family	None	None
Annual Out-of-Pocket Max		
Individual	$3,000	$3,000
Family	$6,000	$6,000
Preventive Services	No Charge	No Charge
Office Visits		
Primary Care Physician (PCP)	$25 copay	$25 copay
Specialist	$25 copay	$25 copay
Access+ Specialist℠	$40 copay	$40 copay
Urgent Care	$25 copay	$25 copay
Lab and X-ray		
CT, MRI, PET scans	No Charge	No Charge
Other labs and x-ray tests	No Charge	No Charge
Inpatient Hospitalization	$100 copay + 25% coinsurance	$100 copay + 25% coinsurance
Outpatient Surgery	25% coinsurance	25% coinsurance
Emergency Room	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)
Prescription Drugs (30 days)		
Generic	$10 copay	$10 copay
Preferred Brand	$30 copay	$30 copay
Non-Preferred Brand	$50 copay	$50 copay
Specialty Drugs	20% up to $200 per prescription	20% up to $200 per prescription
Mail Order Pharmacy (90 days)		
Generic	$20 copay	$20 copay
Preferred Brand	$60 copay	$60 copay
Non-Preferred Brand	$100 copay	$100 copay

MEDICAL, CONTINUED

PPO Plan

	Blue Shield PPO	
	In-Network	Out-of-Network
Plan Year Deductible Individual Family	 $750 $1,500	 $1,500 $3,000
Plan Year Out-of-Pocket Max Individual Family	 $4,750 $9,500	 $9,500 $19,000
Preventive Services	No Charge	Not Covered
Office Visits Primary Care Physician (PCP) Specialist Chiropractic Services (limited to 12 visits per year)	 $25 copay $25 copay $25 copay	 40% after deductible 40% after deductible 40% after deductible
Urgent Care	$25 copay	40% after deductible
Lab and X-ray CT, MRI, PET scans Other labs and x-ray tests	 $25 copay (lab) / $50 copay (outpatient) $25 copay (lab) / $50 copay (outpatient)	 40% after deductible (limited to $350/day) 40% after deductible (limited to $350/day)
Inpatient Hospitalization	$100 copay + 20% coinsurance	40% after deductible (limited to $600/day)
Outpatient Surgery	20% after deductible	40% after deductible (limited to $350/day)
Emergency Room	$100 copay + 20% coinsurance (copay waived if admitted)	
Prescription Drugs (30 days) Generic Preferred Brand Non-Preferred Brand Specialty Drugs	 $10 copay $30 copay $50 copay 20% up to $200 per prescription	 $10 copay + 25% $30 copay + 25% $50 copay + 25% 20% up to $200 per prescription
Mail Order Pharmacy (90 days) Generic Preferred Brand Non-Preferred Brand	 $20 copay $60 copay $100 copay	 Not Covered Not Covered Not Covered

MEDICAL, CONTINUED

	HDHP Plan	
	Blue Shield HDHP	
	In-Network	Out-of-Network
Plan Year Deductible[1] Individual Family	Employee only: $2,250 Employee + Dependents: $2,600 / Individual $4,500 / Family	Employee only: $2,250 Employee + Dependents: $2,600 / Individual $4,500 / Family
Plan Year Out-of-Pocket Max[2] Individual Family	Employee only: $3,000 Employee + Dependents: $3,000 / Individual $6,000 / Family	Employee only: $6,000 Employee + Dependents: $6,000 / Individual $12,000 / Family
Preventive Services	No Charge	Not Covered
Office Visits Primary Care Physician (PCP) Specialist Chiropractic Services (limited to 12 visits per year)	 20% after deductible 20% after deductible 20% after deductible	 50% after deductible 50% after deductible 50% after deductible
Urgent Care	20% after deductible	50% after deductible
Lab and X-ray CT, MRI, PET scans Other labs and x-ray tests	 $100 copay + 20% coinsurance $25 copay + 20% coinsurance	 50% after deductible (limited to $350/day) 50% after deductible (limited to $350/day)
Inpatient Hospitalization	$100 copay per admit + 20% coinsurance	50% after deductible (limited to $600/day)
Outpatient Surgery	20% after deductible	50% after deductible (limited to $350/day)
Emergency Room	$100 copay + 20% coinsurance	
Pharmacy Deductible	Incorporated in Plan Deductible (must meet deductible before prescription copay applies)	
Prescription Drugs Generic Preferred Brand Non-Preferred Brand Specialty Drugs	 $10 copay $25 copay $40 copay 20% up to $200 per prescription	 $10 copay after plan deductible + 25% $25 copay after plan deductible + 25% $40 copay after plan deductible + 25% 20% up to $200 per prescription
Mail Order Pharmacy Generic Preferred Brand Non-Preferred Brand	 $20 copay $50 copay $80 copay	 Not Covered Not Covered Not Covered

[1] There is an individual deductible within the family deductible. Blue Shield will pay benefits for any family member who meets the individual medical deductible before the family medical deductible is met.

[2] There is an individual out-of-pocket maximum within the family and any family member who meets the individual out-of-pocket maximum will receive 100% benefits for covered services once the respective out-of-pocket maximum is met.

MEDICAL, CONTINUED

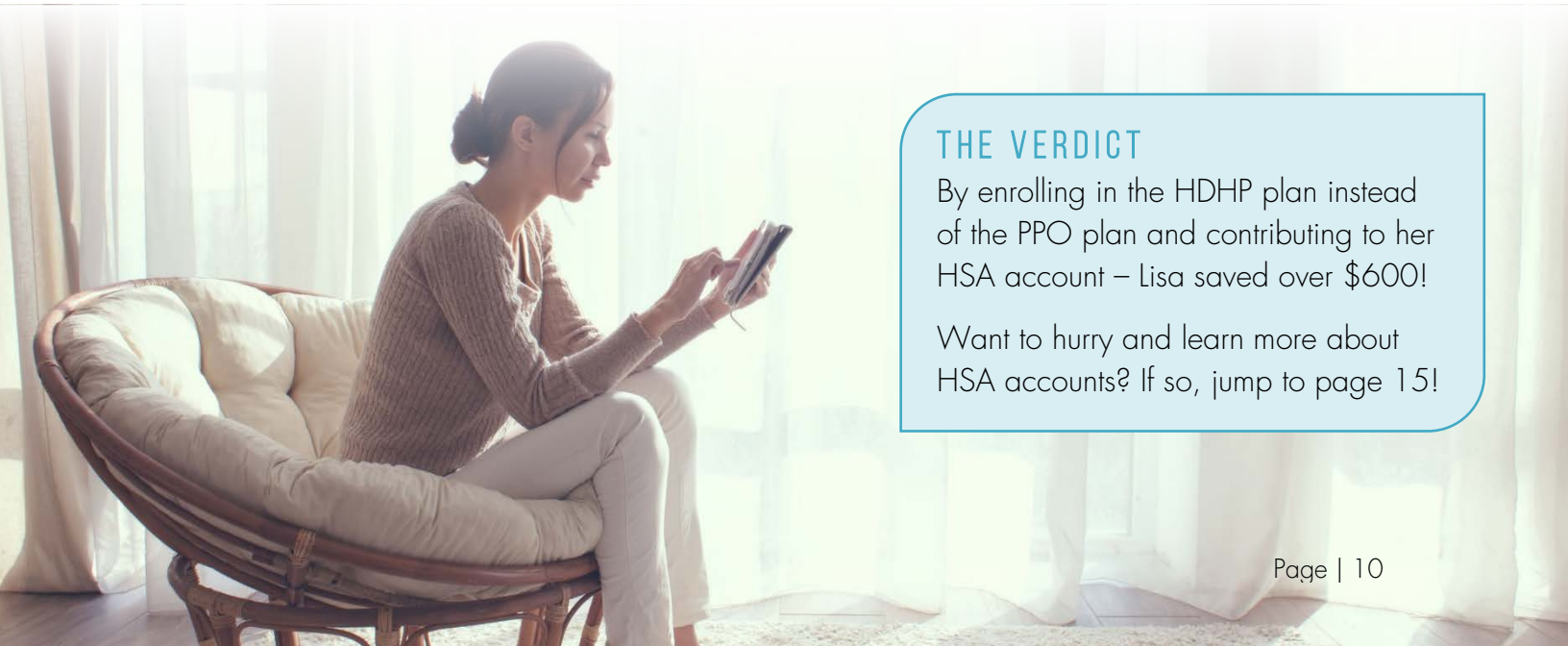
HDHP EXAMPLE – INDIVIDUAL COVERAGE

Lisa is a healthy 35-year old. She has an annual well-woman exam and takes a maintenance medication daily; apart from that, she has little or no contact with her doctor for the rest of the year. She is considering enrolling in the HDHP plan to take advantage of the low paycheck deductions and the tax savings benefit of the HSA (we'll learn more about this later on in this overview).

LISA'S HSA PLAN

Lisa knows that if she enrolls in the HDHP plan that all services are subject to her $2,250 deductible except for Preventive Services as defined by the medical plan. She is also planning on contributing $20 per paycheck (pre-tax) into her HSA account which will total $1,000 for the year. She can use this money for any out of pocket costs and any balance in the account is hers to keep for the future. She will save $200 in payroll taxes by making the HSA contribution.

	THC PPO	THC HDHP
Plan Deductible	$750	$2,250
Medical services received:		
• Preventive Well-woman exam and lab tests (100% covered)	$0	$0
• Doctor's visit for flu	$25	$100
• Prescription drugs – Preferred Brand (cost $125/month)	$360	$1,500
Total Medical Care Cost	**$385**	**$1,600**
Lisa's annual medical plan payroll deductions	$2,925	$1,308
Lisa's contribution to HSA is $1,000 resulting in tax savings	$0	($200)
Lisa' total annual health care cost (including payroll deductions)	$3,310	$2,708



THE VERDICT

By enrolling in the HDHP plan instead of the PPO plan and contributing to her HSA account – Lisa saved over $600!

Want to hurry and learn more about HSA accounts? If so, jump to page 15!

THE VERDICT

By enrolling in the PPO/HSA plan instead of the PPO plan and contributing to his HSA account – Karl saved over $4,600!

MEDICAL, CONTINUED

HDHP EXAMPLE – FAMILY COVERAGE

Karl knows that all his services are subject to the $2,600/individual or $4,500/family deductible. He is planning to make the IRS maximum contribution of $130 per paycheck ($6,750/year) into his HSA account. He will use the money to pay for any out of pocket costs and any balance in the account is his to keep for the future.

	THC PPO	THC HDHP
Plan Deductible	$750/$1,500	$2,600/$4,500
Medical services received:		
• Two annual physicals and well-child exam	$0	$0
• Three specialist office visits for Karl	$75	$300
• Prescription drugs - Generic ($30/month)	$120	$360
• Hospital and surgery charges: $14,500		
Deductible remaining	$750	$1,940
Expenses remaining after deductible	$2,850 ($13,750 x 20%) + $100 copay	$2,612 ($12,560 x 20%) + $100 copay
Total Medical Care Cost	**$3,795**	**$5,212**
Karl's annual medical plan payroll deductions	$11,329	$6,639
Karl's contribution to HSA is $6,750 resulting in tax savings	$0	($1,350)
Karl's total annual health care cost	$15,124	$10,501

DENTAL

Regular visits to your dentist can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

The HydraFacial Company provides you with two comprehensive dental options through Anthem Blue Cross: the Dental Net HMO (available in California only) and the Dental Complete PPO.

	Dental Net HMO (CA Only)	Dental Complete PPO	
	In-Network	In-Network	Out-of-Network
Plan Year Deductible			
Individual	None	$50	$50
Family	None	$150	$150
Plan Year Maximum	None	$1,000	$1,000
Waiting Period	None	None	None
Diagnostic and Preventive	$0 - $60 copay	100%	100%
Basic Services			
Fillings	$0 - $55	100%	80%
Root Canals	$70 - $140 copay	100%	80%
Periodontics	$0 - $115 copay	100%	80%
Major Services			
Crowns	$5 - $170 copay	60%	50%
Dentures	$0 - $315 copay	60%	50%
Oral Surgery	$0 - $350 copay	60%	50%
Orthodontic Services			
Lifetime Maximum	Unlimited	$1,000	$1,000
Dependent Children up to age 19	$1,695 copay	50%	50%
Adults	$1,895 copay	Not Covered	Not Covered

MAXIMUM ROLLOVER

- Your annual max and max rollover will transfer from your prior dental carrier for the remainder of the year in addition to fresh calendar year deductible and maximums for 10/1/2017 to 12/31/2017
- Rollover dollars will be in addition to your annual max up to $1,000
- To qualify for the maximum rollover account in a given year, you must submit at least one claim during the calendar year, such as exam or cleaning

VISION

Early detection of problems and treatment can help prevent diabetes-related vision loss. People with diabetes are more susceptible to glaucoma and other serious conditions, like heart disease and stroke. To find an EyeMed doctor who's right for you, call Customer Service at (866) 723-0513 or visit eyemed.com. Online, you can also view your benefits, verify eligibility, and claims status.

	EyeMed Vision Plan	
	In-Network	Out-Of-Network
Vision Exam	$10 copay	Up to $40 allowance
Frequency	Once every 12 months	Once every 12 months
Eyeglass Lenses		
Single Vision Lens	$25 copay	Up to $30 allowance
Bifocal Lens	$25 copay	Up to $50 allowance
Trifocal Lens	$25 copay	Up to $70 allowance
Frequency	Once every 12 months	Once every 12 months
Frames		
Benefit	$130 allowance*	Up to $91 allowance
Frequency	Once every 24 months	Once every 24 months
Contacts (In-lieu of glasses)		
Benefit	$130 allowance	Up to $130 allowance
Frequency	Once every 12 months	Once every 12 months

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MASTER YOUR FINANCES

HEALTH SAVINGS ACCOUNT (HSA)

Do you want to save money on taxes? A Health Savings Account (HSA) is a tax-advantaged, portable (you own it!) savings account that is offered only if you enroll in the Blue Shield HDHP plan. Health Equity administers this program. You contribute pre-tax money to your account to save for out-of-pocket healthcare expenses. Plus, any money that you don't spend grows year after year and can be used in the future, even after you retire. To compare the cost between our HDHP plan with the HSA with our other plans click here: comparemyhsa.com/hydrafacial.

ACCOUNT CONTRIBUTIONS

	You May Contribute*
Employee	Up to $3,400 (2017 Federal limit) per calendar year
Employee + Family[1]	Up to $6,750 (2017 Federal limit) per calendar year

* The IRS has set limits on the total amount you can contribute to a HSA each calendar year. If you're over 55, the IRS allows you to contribute an additional $1,000—this is called a "catch-up contribution."

[1] Includes Employee + Spouse, Employee + Children

USING YOUR MONEY

You can use the money in your account to pay for qualified medical expenses that are not paid for by your high deductible health plan (HDHP). For a full list of those expenses, go to irs.gov.

When possible, use your HSA debit card to pay for qualified expenses. Make sure that you keep records of your receipts and any over-the-counter (OTC) prescriptions. You will need them to prove that you spent the money on qualified expenses if you are audited by the IRS.

ELIGIBILITY

You are not eligible to open or contribute to an HSA account if you are:

- Covered by a non-high deductible health plan
- Enrolled in a regular healthcare flexible spending account (you or your spouse count)
- Covered under Medicare or Medicaid
- Claimed as a dependent on someone else's tax return

- For more information, please contact Health Equity at (866) 346-5800 or visit Health Equity's site: healthequity.com.
- Use the health plan calculator comparison tool to help you make an informed decision regarding your health plan selection.
- If you use HSA funds for non-qualified expenses before you are age 65, you will owe a 20% penalty tax PLUS income tax on the withdrawal. After age 65, if you use HSA funds for non-qualified expenses, you will owe income tax only.

FLEXIBLE SPENDING ACCOUNT (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. Paychex administers our FSA plans. You are eligible to enroll in the Flexible Spending Accounts (FSA) first of the month, following 30 days of employment and you must re-enroll in this program each year. Estimate your annual contributions conservatively as unused funds at the end of the Plan Year may be forfeited under the IRS "Use-it-or-Lose-It" rule. Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).

	Healthcare FSA	Dependent Care FSA
Annual Contribution Maximum	A minimum of $100 up to $1,000 per year.	Up to $5,000 per year or $2,500 if married and filing separately.
Plan Year	January 1, 2017 through December 31, 2017.	January 1, 2017 through December 31, 2017
Funds Available	Your full elected amount is available at the start of the plan year, regardless if you have contribute that amount.	You can access money only after it is placed into your dependent care FSA account, just like a bank account.
Eligible Participants	All benefit eligible employees except participants enrolled in the Blue Shield HDHP plan. You can also obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on The HydraFacial Company's health plan. You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents.	Dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. You cannot obtain reimbursement for eligible expenses for your domestic partner's children, unless they qualify as your tax dependents.
Eligible Expenses	Out-of-pocket medical, dental, and vision care expenses for you and your family. Examples include medical, dental, and vision deductibles, copays and coinsurance, eye care materials, orthodontics, etc.	Eligible expenses may include daycare centers, in-home child care, and before or after school care.
You Should Also Know	Expenses must be incurred between January 1st and December 31st and submitted for reimbursement no later than March 31st. There is also a rollover provision for active employees at the end of the run-out period of up to $500.	All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan.

- **Keep your receipts!** In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.
- If you have questions about the tax status of your dependents, please address these with your tax advisor.
- Please refer to the eligible expense listing at irs.gov or call Paychex Customer Service at (877) 244-1771.
- Manage your Paychex Account Online! Once enrolled, you can manage your FSA in real-time, file a claim for reimbursement by snapping a photo of the receipt, check claim status and more.

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CREATE YOUR SAFETY NET

LIFE INSURANCE

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

EMPLOYER-PAID LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D insurance provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, hearing, or if you die in an accident.

Coverage is provided by Mutual of Omaha and is paid in full by The HydraFacial Company.

Basic Life and AD&D Amount	$10,000

Notes: Benefit amount reduces by 35% at age 65; 50% at age 70.

VOLUNTARY LIFE AND AD&D

Voluntary Life and AD&D Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Mutual of Omaha.

Employee Voluntary Life and AD&D Amount	5 times annual salary, up to $300,000
Spouse Voluntary Life and AD&D Amount	100% of Employee's benefit, up to $250,000
Child(ren) Voluntary Life and AD&D Amount	Increments of $1,000 up to $10,000

Notes:

- Benefit amount reduces by 35% at age 65; 50% at age 70.
- Anyone over the Guarantee Issue (GI) will be grandfathered. Any amounts you elect over your current grandfathered amounts will be subject to EOI.

YOU SHOULD ALSO KNOW...

BENEFICIARY REMINDER

Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

EVIDENCE OF INSURABILITY

Depending on the amount of coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.

TAXES

Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit.
You will see the value of the benefit included in your taxable income on your paycheck and W-2.

GUARANTEED ISSUE

Guaranteed Issue Amount is the level of benefit you can elect without medical underwriting as a new hire and is subject to an "active service requirement" for you, your spouse, and dependents. If you apply for coverage while hospitalized, in hospice care, in a facility or confined to home under the care of a physician, your effective date of coverage will be after you, your spouse or dependents are no longer hospitalized, in hospice care, in a facility or confined to home.

DISABILITY

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind. Coverage is provided by Mutual of Omaha.

VOLUNTARY SHORT-TERM DISABILITY INSURANCE (STD)

Voluntary Short-Term Disability (STD) plan pays you a benefit if you temporarily cannot work because of an injury, illness, or on maternity leave. Benefits may be reduced by income from other sources such as paid time-off. Your doctor and Mutual of Omaha will work together to determine how long benefits are payable based on your condition.

PLAN PROVISIONS

Class I: Non-CA Employees[1]	60% of weekly earnings
Class II: CA Employees[2]	30% of weekly earnings
Maximum Weekly Benefit	$2,500 per week
Maximum Benefit Duration	25 weeks

[1] Benefit is offset for the following states: NY, NJ, RI and Puerto Rico.
[2] Benefit is not offset by California SDI.

DEFINITION OF DISABILITY

Disability means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to generate current earnings which exceed 99% of weekly earnings of your regular job.

LONG-TERM DISABILITY INSURANCE (LTD)

Long-Term Disability (LTD) plan pays you a certain percentage of your income if you cannot work because of an injury or illness prevents you from performing any of your job functions over a long period of time. It is important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

Coverage is provided by Mutual of Omaha and is paid in full by The HydraFacial Company.

PLAN PROVISIONS

Monthly Benefit	60% of monthly earnings
Maximum Monthly Benefit	$10,000 per month
Elimination Period	180 days
Maximum Benefit Duration	Reduction Benefit Duration to SSNRA*

*Social Security Normal Retirement Age

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LIVE A BALANCED LIFE

EMPLOYEE ASSISTANCE PROGRAM

Sometimes a personal or professional issue can affect your work, health, and general well-being. When facing life's challenges, you often turn to family or friends for support. But sometimes that's not enough. Sometimes you need an experienced professional to talk with to know you're not alone.

Mutual of Omaha's Employee Assistance Program (EAP) provides you and your eligible dependents with access to in-person behavioral health assistance, telephonic counseling, online tools and much more. This program is available to employees enrolled in the Basic Life and AD&D plan.

PERSONAL AND EMOTIONAL WELL-BEING

- Unlimited telephonic counseling with an EAP professional 24/7
- Up to three (3) face-to-face counseling sessions* with a licensed and/or certified mental health professionals
- Access to a robust network of licensed mental health professionals

LEGAL AND FINANCIAL SERVICES

- Online will preparation
- Legal library and online forms
- Financial tools and resources
- Telephonic consultations

COMMUNITY RESOURCES

- Access to a library of educational articles and handouts
- Resources for work/life balance
- Substance abuse and addiction
- Dependent and elder care assistance and referral services
- Health & wellness coaching

HELP IS AVAILABLE 24/7

Mutual of Omaha Employee Assistance Program (EAP) is available 24 hours a day, 7 days a week by calling toll-free at (800) 316-2796 or by visiting mutualofomaha.com/eap.

*Face-to-face visits also can be used toward consultations.

California Residents: Knox-Keene Statute limits no more than three face-to-face sessions per six-month period per person.

OTHER PROGRAMS

Here are some other valuable programs that you are eligible to participate in at no additional cost to you:

LIFE REFERRALS 24/7

Everyone can use a hand sometimes, and LifeReferrals 24/7℠ offers convenient support to help you meet life's challenges. A simple phone call connects you with a team of experienced professionals ready to assist you with a wide range of personal, family, and work issues.

Personal Issues

- Unlimited free phone access 24/7
- In-person help for short-term issues; up to three (3) sessions with a counselor

Financial, Legal, and Mediation

- Request referrals for consultations with professionals about legal matters such as wills, landlord/tenant issues, retirement planning and tax preparation
- Unlimited telephonic financial consultations
- 60-minute consultation with an attorney per issue and receive 25% discount on additional consultations

Community Resources

A specialist can provide you with useful information and referrals to a wide range of resources, including:

- Child and elder care
- Transportation assistance
- Meal programs
- Smoking cessation programs

Life Referral Is Available 24/7
Call (800) 985-2405

IDENTITY PROTECTION

As an eligible Blue Shield medical plan member, you can now get identity protection services through AllClear ID.

Eligible members can receive services such as identity repair assistance, identity theft insurance, and credit monitoring for you and your covered family members. It makes good sense and best of all, it's no charge!

You can access these services by calling (855) 904-5733 or visit blueshieldca.allclearid.com.

DISCOUNT PROGRAMS

To help you save money while you're working on your health, Blue Shield members can receive discounts on various health and wellness programs.

Blue Shield members can take advantage of discounted monthly dues at 24 Hour Fitness, special online savings on Weight Watchers subscription, save up to 25% off on acupuncture and chiropractic services and much more.

For details on Blue Shield's Discount Programs, log on to blueshieldca.com/wellnessdiscounts.

HEALTH & WELLNESS

Blue Shield of California also offers wellness programs to supplement our plans and is available to eligible employees enrolled in the Blue Shield plans.

TELADOC

Teladoc provides 24/7 access to a network of board-certified doctors who can treat many of your non-emergency medical issues when your doctor is not available. You can talk to a Teladoc doctor anytime, through the convenience of your smartphone, tablet, or computer with a webcam.

Sign up for free today at Teladoc.com/bsc or call (800) 835-2362 and get:

- 24/7 access to doctors to assess your condition
- Medical conditions such as cold, flu, allergies and more
- Teladoc doctors can send a prescription to the pharmacy of your choice

NURSE HELP 24/7SM

Call NurseHelp 24/7SM and speak with a registered nurse anytime you have health-related questions. Experienced registered nurses are available 24 hours a day, 7 days a week to answer your health questions at no charge and all calls are confidential.

Call (877) 304-0504 and get private, personalized assistance 24 hours a day.

WELLVOLUTION®

We know we could be healthier, but life is busy and things get in the way. Wellvolution® is the simplest way to work wellness into your day.

Wellvolution® is an online, interactive program that reward you when you adopt and maintain a healthy lifestyle habit focusing on healthy eating, physical activity, stress management, and smoking cessation.

DAILY CHALLENGE®

- Receive daily emails that include suggestion for simple and fun wellness-related tasks that can help improve your well-being.

QUITNET®

- Get the help you need to quit smoking with encouragement and support from the longest-running online support community in the world.

WELL-BEING ASSESSMENT

Complete a short questionnaire and receive a confidential, personalized report of your overall well-being including ways you can improve your health. Sign up at mywellvolution.com to join the Wellvolution® today.

1

KNOW YOUR OPTIONS

COST OF COVERAGE

You share the cost of coverage for these plans and coverage levels. In general, you pay for health coverage before federal, state, and social security taxes are withheld, so you pay less in taxes.

MEDICAL

Blue Shield Access+ HMO SaveNet	Your Weekly Cost
Employee only	$15.48
Employee + Spouse	$71.20
Employee + Child(ren)	$52.62
Employee + Family	$89.77
Blue Shield Access+ HMO Full Network	**Your Weekly Cost**
Employee only	$21.92
Employee + Spouse	$93.81
Employee + Child(ren)	$69.34
Employee + Family	$118.28
Blue Shield PPO	**Your Weekly Cost**
Employee only	$56.26
Employee + Spouse	$172.79
Employee + Child(ren)	$127.72
Employee + Family	$217.87
Blue Shield HDHP	**Your Weekly Cost**
Employee only	$25.16
Employee + Spouse	$101.26
Employee + Child(ren)	$74.84
Employee + Family	$127.67

VISION

EyeMed Vision	Your Weekly Cost
Employee only	$1.68
Employee + Spouse	$3.20
Employee + Child(ren)	$3.37
Employee + Family	$4.95

DENTAL

Dental Net HMO (CA Only)	Your Weekly Cost
Employee only	$1.71
Employee + Spouse	$5.11
Employee + Child(ren)	$4.91
Employee + Family	$9.20
Dental Net PPO	**Your Weekly Cost**
Employee only	$4.39
Employee + Spouse	$12.85
Employee + Child(ren)	$17.93
Employee + Family	$26.39

COST OF COVERAGE, CONTINUED

VOLUNTARY LIFE AND AD&D

Voluntary Life And AD&D Rates Per $1,000	Employee / Spouse Monthly Rates
Age 15 - 29	$0.076
Age 30 - 34	$0.085
Age 35 - 39	$0.125
Age 40 - 44	$0.217
Age 45 - 49	$0.336
Age 50 - 54	$0.510
Age 55 - 59	$0.814
Age 60 - 64	$1.361
Age 65 - 69	$2.208
Age 70 - 74	$3.588
Age 75 - 79	$6.352
Age 80 - 84	$12.516
Age 85 - 89	$20.603
Age 90 - 94	$32.264
Age 95 - 99	$32.264
Child Voluntary Life Monthly Rate per $1,000	$0.167
Child Voluntary AD&D Monthly Rate per $1,000	$0.042

SHORT TERM DISABILITY

Voluntary Short-Term Disability (STD)	Your Monthly Rates
Age 0 - 24	$0.58
Age 25 - 29	$0.58
Age 30 - 34	$0.58
Age 35 – 39	$0.58
Age 40 – 44	$0.58
Age 45 – 49	$0.58
Age 50 – 54	$0.58
Age 55 – 59	$0.58
Age 60 – 64	$0.58
Age 65 – 69	$0.58
Age 70 & over	$0.58

BENEFITS ON THE FLY

Did you know that most of our carriers offer mobile applications allowing you to access your benefits information 24/7 on the fly? Make sure to download these apps on the App store or Google Play on your phone and share with your dependents!

BLUE SHIELD OF CALIFORNIA

View ID cards, find a doctor or urgent care facility, view benefits and your annual deductibles, access NurseHelp 24/7 and more!

ANTHEM BLUE CROSS DENTAL

Find a network dentist, get estimates for most procedures, view your benefits and ID card, search claims, and more!

You must be registered on Anthem's secure member site (Anthem.com/ca) and have a username and password to log on the app.

EYEMED VISION

Search for providers in the networt, get turn-by-turn directions from your location, set eye exams, and save prescription information.

BEN-IQ™

Coming soon! Ben-IQ is a free app that includes much of the information that's listed in this overview, but in a place that's always at your fingertips - your smartphone. With Ben-IQ, you can review plan summaries, important contacts, and store ID cards for all your carriers and much more! An official launch is coming soon so stay tuned!

FOR ASSISTANCE

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical HMO	Blue Shield of CA	(888) 256-1915	blueshieldca.com	W0053801
Medical HDHP	Blue Shield of CA	(888) 256-1915	blueshieldca.com	W0053801
Teladoc	Blue Shield of CA	(800) 835-2362	Teladoc.com/bsc	W0053801
NurseHelp 24/7	Blue Shield of CA	(877) 304-0504	blueshieldca.com	W0053801
Flexible Spending Accounts	Paychex	(877) 244-1771		
Dental HMO	Anthem Blue Cross			281373
Dental PPO	Anthem Blue Cross			281373
Vision	EyeMed	(866) 723-0513	eyemed.com	
Basic Life/AD&D	Mutual of Omaha			
Voluntary Life/AD&D	Mutual of Omaha			
Voluntary Short-Term Disability (STD)	Mutual of Omaha			
Long-Term Disability (LTD)	Mutual of Omaha			
Employee Assistance Program (EAP)	Mutual of Omaha	(800) 316-2796	mutualofomaha.com/eap	
Life Referrals 24/7	Blue Shield of CA	(800) 985-2405	blueshieldca.com	W0053801
Identity Protection	Blue Shield of CA	(855) 904-5733	blueshieldca.allclearid.com	W0053801

Call your dedicated Benefit Advocate Team for **all** your benefits questions.

(866) 761-3116 / HydraFacial@alliant.com

Available Monday through Friday 8:30 am to 5:00 pm

KEY TERMS

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The dollar amount a family must pay each year before the plan will pay benefits for covered services.

FSA – A Flexible Spending Account (FSA) is one of a number of tax-advantaged financial accounts that can be set up through a cafeteria plan of an employer in the United States to pay for copayments, deductibles, prescriptions and other health care costs.

HDHP – A HDHP is a high-deductible health plan with lower premiums and higher deductibles than a traditional health. Being covered in a high-deductible health plan (HDHP) is also a requirement for having a health savings account (HSA).

HSA – A Health Savings Account (HSA) is an account created for individuals who are covered under HDHP plans to save for medical expenses that HDHP's don't cover. Contributions are made into the account by the individual or the individual's employer and are limited to a maximum each year.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services.

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

Summary Plan Description (SPD) – Required by Employee Retirement Income Security Act (ERISA) law to make available to employees of The HydraFacial Company's medical, dental, voluntary life and disability plans, and flexible spending accounts. These documents summarize each insurance plan and provide valuable information on plan coverage, services, and legal rights.

KEY TERMS, CONTINUED

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer, and HIV/AIDS.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

Diagnostic and Preventive Services - Generally include routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Endodontics - Commonly known as root canal therapy.

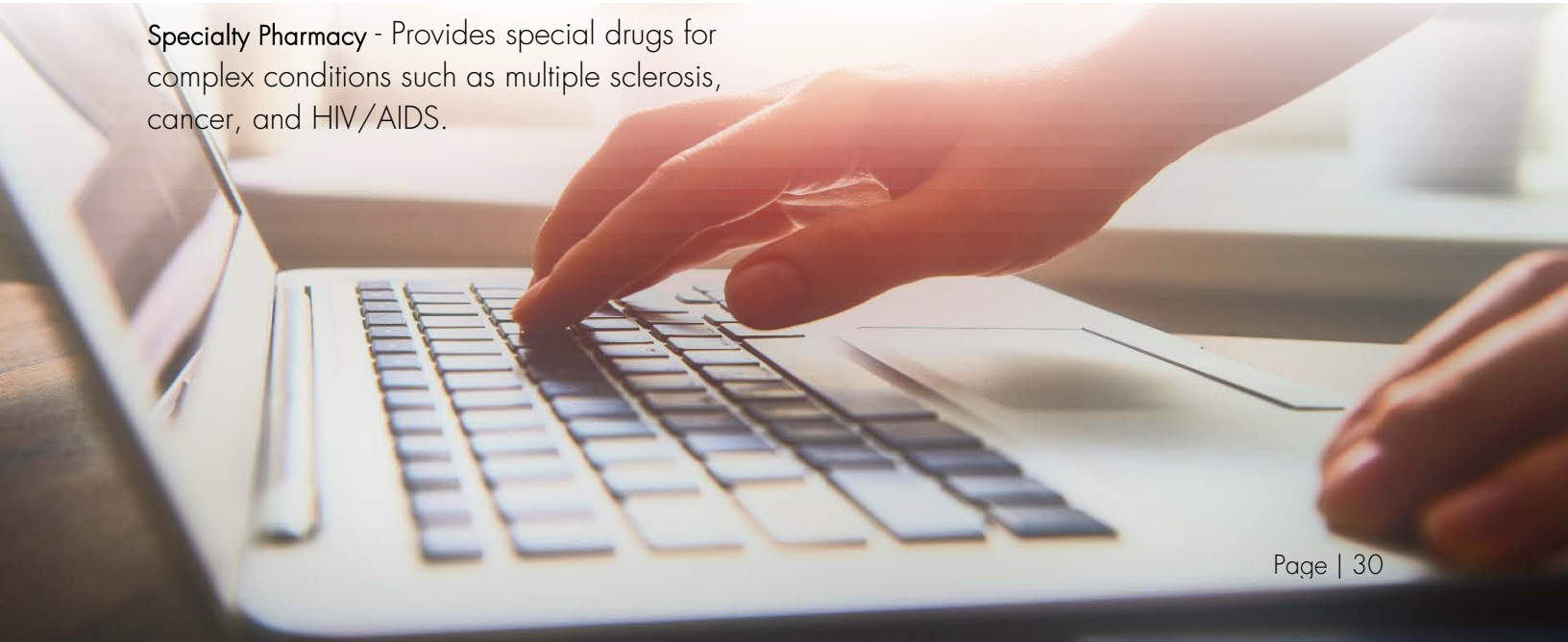
Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment. Pre-treatments are done before you get care, so that you will know early if it is covered by your dental plan.



REQUIRED FEDERAL NOTICES

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

The Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we periodically remind you of your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting Human Resources.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in one of our health plans for your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in HydraFacial health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in HydraFacial's medical plan if your dependent becomes eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights to coverage to be provided in a manner determined in consultation with the attending Physician 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 are subject to the same deductible and co-payments applicable to other medical and surgical benefits provided under this plan. You can contact your health plan's Member Services for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally 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 a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or 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 issuers 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 (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

REQUIRED FEDERAL NOTICES, CONTINUED

AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by The HydraFacial Company represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The HydraFacial Company offers a variety of benefit plans to eligible employees. The federal healthcare reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by THE HydraFacial COMPANY are available by calling Benefits Advocate at (866) 761-3116.

MEDICARE PART D

Important Creditable Coverage Notice from The HydraFacial Company 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 The HydraFacial Company 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 three 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. The HydraFacial Company has determined that the prescription drug coverage offered by Blue Shield of California plans are, 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, The HydraFacial Company coverage could be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage with Blue Shield of California plans are creditable (e.g. as good as Medicare coverage),

REQUIRED FEDERAL NOTICES, CONTINUED

MEDICARE PART D, CONTINUED

you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the office 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 THE HydraFacial Company 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).

Date:	October 1, 2017
Name of Entity:	The HydraFacial Company
Address:	2277 Redondo Avenue, Signal Hill, CA 90755
Phone:	(800) 603-4996

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).

REQUIRED FEDERAL NOTICES, CONTINUED

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 (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 (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 July 31, 2016. Contact your State for more information.

ALABAMA – Medicaid
Website: http://www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
Website:
http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-866-251-4861
Phone (Anchorage): 907-269-6529

ARKANSAS - Medicaid
Website: http://myarhipp.com/
Phone: 1-855-692-7447

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Phone: 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-404-656-4507

INDIANA – Medicaid
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0864

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

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

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

REQUIRED FEDERAL NOTICES, CONTINUED

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), CONTINUED

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

MAINE – Medicaid
Website:
http://www.maine.gov/dhhs/ofi/publicassistance/index.html
Phone: 1-800-442-6003
TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid
Website:
http://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: 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

Website: http://mn.gov/dhs/ma/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3739

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

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/montanahealthcareprograms/HIPP
Phone: 1-800-694-3084

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: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
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

REQUIRED FEDERAL NOTICES, CONTINUED

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), CONTINUED

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
Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

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

VIRGINIA – Medicaid and CHIP
Medicaid and CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website:
http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
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
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: http://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
(877) 267-2323, Menu Option 4 Ext. 61565
OMB Control Number 1210-0137 (expires 10/31/2016

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While we've made every effort to make sure this benefits overview is comprehensive, it cannot provide a complete description of all benefit provisions. For detailed information, please refer to your plan benefit booklets, or Summary Plan Descriptions (SPDs). The HydraFacial Company is required by law, ERISA (Employee Retirement Income Security Act), to make available to you Summary Plan Descriptions (SPDs) for HydraFacial's medical plans, dental plans, voluntary life insurance plans, voluntary disability plans, and flexible spending accounts. These documents summarize each insurance plan and provide valuable information on plan coverage, services and legal rights.

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