2017 - 2018

Executives Benefits Guide

Your Health, Well-Being & Security

Pacific Southwest Realty Services
Commercial Real Estate Financial Expertise ... since 1972

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Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Pacific Southwest Realty Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

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 18-19 for more details.

Your Health, Well-Being & Security.

At Pacific Southwest Realty Services, 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 Pacific Southwest Realty Services offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. 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.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or Summary Plan Descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

The benefits in this summary are effective:

September 1, 2017 - August 31, 2018

Eligibility & Enrollment

Who Is Eligible?

Pacific Southwest Realty Services defines “Full-Time Benefit Eligible” employees as those regularly scheduled to work 30 or more hours per week.

You can enroll the following family members in our medical, dental, and vision plans.

- Your spouse (as defined by CA Law)
- Your children (including your Domestic Partner’s children):
    - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - 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.

If a covered dependent reaches the plan age limit, please notify Human Resources immediately for COBRA information.

When Can I Enroll?

Employees are eligible to enroll in benefits on the First Day of the Month Following 30 days of employment.

Dependents are eligible to enroll on the employee’s eligibility date or within 30 days of experiencing a “qualifying life event.”

A new dependent may be added to your coverage during the year by completing the necessary forms within 30 days of becoming eligible. Failure to comply within the 30 day period will require you to wait until the next annual open enrollment period. The only exception in which you may add a dependent in the middle of the year is if you experience a “qualifying life event.”

What Happens If I Waive Coverage?

If an eligible employee waives coverage in any of the medical, dental, or vision benefits being offered, they will be forfeiting their eligibility, and will not be able to enroll until the next open enrollment period without a “qualifying life event” (see below).

How Do I Waive Coverage?

If an eligible employee chooses not to participate in the medical, dental, vision, or any other benefit offerings, please initial the opt out box on the Employee Benefit Payroll Deduction Form.

What Is The Cost Of Coverage?

Pacific Southwest Realty Services pays a majority of the cost for medical, dental, and vision coverage for full-time benefit eligible employees. Pacific Southwest Realty Services continues to pay 100% for the employee’s Basic Group Term Life/AD&D and Long Term Disability Insurance.

What Is A Qualifying Life Event?

As defined by the IRS, “qualifying life events” that would permit you to enroll or change coverage elections outside of the initial eligibility or open enrollment period include (but are not limited) to:

- Marriage, divorce, legal separation or annulment
- Birth, adoption, or placement for adoption of a child
- Death of a spouse, domestic partner, or child
- Change in employment status
- Reduction of hours that changes your eligibility status
- A substantial change in your benefits coverage
- A relocation that impacts network access

You must notify Human Resources within 30 days of a “qualifying life event.” The new benefit choices will then remain in force for the remainder of the plan year unless there is another “qualifying life event.”

Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

Stay Well

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

Ask Questions and Stay Informed

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

Get a Primary Care Provider

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

Going To The Doctor

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

An Apple a Day

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

Using The Emergency Room

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time.

Be Med Wise

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

Blue Shield HMO – Gold Access+ HMO 500/35

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. Pacific Southwest Realty Services gives you a choice between the two HMO plans managed by Blue Shield.

	Gold Access+ HMO 500/35 OffEx
	In-Network
Annual Deductible Individual Family	 $500 $1,000
Annual Out-of-Pocket Max Individual Family	 $5,600 $11,200
Office Visit Primary Provider Specialist	 $35 copay $55 copay
Preventive Services	No charge
Chiropractic Care	$15 copay (up to 15 visits per year)
Basic Lab **Basic X-ray** **Complex Imaging** (CT Scan, MRI, PET, etc.)	$35 copay per visit $50 copay per visit $250 copay per visit (after deductible)
Inpatient Hospitalization	20% after deductible
Outpatient Surgery Free-Standing Ambulatory Surgery Center Hospital	 20% $300 copay per surgery (after deductible)
Urgent Care	$35 copay
Emergency Room (facility fee)	$250 copay after deductible (copay waived if admitted)
Retail Pharmacy	
Tier 1	$15 copay
Tier 2	$30 copay
Tier 3	$50 copay
Tier 4[1]	20% up to a max of $250 per RX
Supply Limit	30 days
Mail Order Pharmacy	
Tier 1	$30 copay
Tier 2	$60 copay
Tier 3	$100 copay
Tier 4[1]	20% up to a max of $500 per RX
Supply Limit	90 days

[1]Specialty drugs are available from a Network Specialty Pharmacy by mail or upon member request, retail stores for pick up. Blue Shield's short cycle Specialty Drug Program allows initial Specialty Drugs to be dispensed in 15-day supply trials.

Blue Shield HMO – Silver Access+ HMO 1700/55

	Silver Access+ HMO 1700/55 OffEx
	In-Network
Annual Deductible Individual Family	 $1,700 $3,400
Annual Out-of-Pocket Max Individual Family	 $6,800 $13,600
Office Visit Primary Provider Specialist	 $55 copay $85 copay
Preventive Services	No charge
Chiropractic Care	$15 copay (up to 15 visits per year)
Basic Lab **Basic X-ray** **Complex Imaging** (CT Scan, MRI, PET, etc.)	$55 copay per visit $55 copay per visit $250 copay per visit (after deductible)
Inpatient Hospitalization	40% after deductible
Outpatient Surgery Free-Standing Ambulatory Surgery Center Hospital	 40% after deductible 40% after deductible
Urgent Care	$55 copay
Emergency Room (facility fee)	$275 copay (after deductible) (copay waived if admitted)
Retail Pharmacy Deductible* Individual Family	 $275 $550
Tier 1	$15 copay
Tier 2	$55 copay
Tier 3	$75 copay
Tier 4[1] (Excluding Specialty Drugs)	20% up to $250 max per Rx
Supply Limit	Up to 30 days
Mail Order Pharmacy	
Tier 1	$30 copay
Tier 2	$110 copay
Tier 3	$150 copay
Tier 4[1](Excluding Specialty Drugs)	20% up to $500 max per Rx
Supply Limit	Up to 90 days

*Pharmacy Deductible is separate from the Calendar Year Medical Deductible. Does not apply to contraceptive drugs and devices, oral anticancer medications or Tier 1 drugs. Otherwise applicable to covered drugs in Tiers 2, 3 and 4. Accrues to the calendar year out-of-pocket maximum.

[1]Specialty drugs are available from a Network Specialty Pharmacy by mail or upon member request, retail stores for pick up. Blue Shield's short cycle Specialty Drug Program allows initial Specialty Drugs to be dispensed in 15-day supply trials.

Blue Shield PPO Silver Full PPO 1300/45

In addition to two HMO plans to choose from, Pacific Southwest Realty Services gives you the option of electing a PPO Plan managed by Blue Shield.

	Blue Shield Silver Full PPO Plan 1300/45 OffEx	
	In-Network	**Out-Of-Network**
Annual Deductible Individual Family	 $1,300 $2,600	 $2,600* $5,200*
Annual Out-of-Pocket Max Individual Family	 $6,800 $13,600	 $10,000** $20,000**
Office Visit Primary Provider Specialist	 $45 copay $60 copay	 50% after deductible 50% after deductible
Preventive Services	No charge	Not covered
Chiropractic Care	50% (up to 12 visits per year)	50% (in-network limitations apply)
Basic Lab **Basic X-ray** **Complex Imaging** (CT Scan, MRI, PET, etc.)	 40% after deductible 40% after deductible $100 Copay + 40%	 50% after deductible 50% after deductible 50% after deductible[1]
Inpatient Hospitalization	40% after deductible	50% after deductible[2]
Outpatient Surgery Free-Standing Ambulatory Surgery Center Hospital	 40% after deductible 40% after deductible	 50% after deductible[1] 50% after deductible[1]
Urgent Care	$45 copay	Not covered
Emergency Room	$250 copay + 40% (copay waived if admitted)	
Prescription Drug Deductible* * Individual** Family**	 $250 $500	Not covered
Retail Pharmacy		
Tier 1	$15 copay	Not covered
Tier 2***	$55 copay	
Tier 3***	$75 copay	
Tier 4 ***	30% up to $250 max per RX	
Supply Limit	Up to 30 days	
Mail Order Pharmacy		
Tier 1	$30 copay	Not covered
Tier 2***	$110 copay	
Tier 3***	$150 copay	
Tier 4***	30% up to $500 max per RX	
Supply Limit	Up to 90 days	

*Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar year medical deductibles.
**Any calendar year medical deductible and any calendar year pharmacy deductible accrues to the calendar year out-of-pocket maximum. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar year out-of-pocket maximums.
***Applicable to all covered drugs not in Tier 1. Does not apply to contraceptive drugs and devices. Separate from the calendar year medical deductible.
1. Up to $350 max per day
2. Non-participating hospital fees up to $2,000 per da

Blue Shield Tools & Resources

Your health and wellness are very important to Pacific Southwest Realty Services and Blue Shield. Having the tools and knowledge to help educate yourself and your family can empower you to make positive changes in your lifestyle and improve your overall wellness. If you are enrolled in the Blue Shield HMO or PPO plan, you can access free tools, discounts, and resources regarding your health and wellness by going to **www.blueshieldca.com**.

Online / Mobile Resources

Many resources tools are available to help you manage your health. Make sure to login to your Blue Shield account to get started.

Blue Shield's website and mobile app allow you to:

- View your ID Card
- View your Claims
- Find a Provider/Facility
- AND MUCH MORE!

NurseHelp 24/7

Call 877-304-0504 toll free and talk with a registered nurse anytime you have health-related questions. Experienced nurses can help you figure out how you can care for yourself, evaluate treatment options, and help you determine whether to see a doctor.

Wellvolution

It's the next generation in wellness programs, and it's an easy and fun way to incorporate health activities into even the busiest lifestyles. To find interactive tools such as daily challenges and wellbeing assessment, visit: **mywellvolution.com**

Wellness Discount Programs

To help save money while working on your health, Blue Shield offers member discounts on popular weight loss, health, wellness, and vision programs. The discounts are available to all members who have enrolled in the Blue Shield medical plans.

- Discounts on Gym Memberships
- Discount on Weight Watchers
- Alternative Care Discount Program

How to Find a Blue Shield Provider

- Log on to **www.blueshieldca.com** and click on the "Members" tab
- Click on "Find a Provider"
- Click on "Select A Plan" and select your "Medical Plan and Network"
  - **FOR HMO:** select "2017 Small Business Access+"
  - **FOR PPO:** select "2017 Small Business PPO Full"
- Under "Select Sub Plan"
  - **FOR HMO choose either:**
    - Silver Access+ HMO 1700/55 OffEx, or
    - Gold Access+ HMO 500/35 OffEx
  - **FOR PPO choose:**
    - Silver Full PPO 1300/45 OffEx
- Click on the "Set Plan" button
- Now you can move to Step 2 to select additional criteria to narrow down your search
- Click on "Find now" and your search results will be displayed
- If you are enrolling in an HMO, you will need to enter the doctor's PIN number on your enrollment form

Teladoc – Talk to a doctor 24/7/365

Teladoc allows you to see a board-certified doctor to resolve many of your non-emergency medical issues through the phone or video. This feature eliminates the need to go to an Urgent Care or Emergency facility and wait hours for common care that is non-emergency. This plan works with both Blue Shield HMO and PPO plans with a **$5 copay** per consult. Teladoc doctors can treat many medical conditions including: Cold and Flu symptoms

- Allergies
- Bronchitis
- Urinary Tract Infections
- Respiratory Infection
- Sinus Problems

Log on to **teladoc.com/bsc** and set up your account or call 800-835-2362.

Kaiser HMO

Pacific Southwest Realty Services also gives you the choice of enrolling in an HMO Plan managed by Kaiser Permanente.

	Kaiser Gold 80 HMO w ChildDental Plan
	In-Network
Annual Deductible	None
Annual Out-of-Pocket Max Individual Family	 $6,750 $13,500
Office Visit Primary Provider Specialist	 $30 copay $55 copay
Preventive Services	No charge
Chiropractic Care	Not covered
Acupuncture	$30 copay (physician referral required)
Basic Lab **Basic X-ray** **Complex Imaging** (MRI, CT Scan, PET Scan, Etc.)	$35 copay $55 copay $275 copay
Inpatient Hospitalization	$655 copay per day (up to 5 days per admission)
Outpatient Surgery	$655 copay per procedure
Urgent Care	$30 copay
Emergency Room	$325 copay (copay waived if admitted)
Retail Pharmacy	
Tier 1	$15 copay
Tier 2	$55 copay
Tier 3	$55 copay (when approved through exception process)
Tier 4 (only available in a max. 30 day supply)	20% up to $250 max per RX
Supply Limit	Up to 30 days
Mail Order Pharmacy	
Tier 1	$30 copay
Tier 2	$110 copay
Tier 3	$110 copay (when approved through exception process)
Tier 4	N/A
Supply Limit	Up to 100 days

Kaiser Tools & Resources

Your health and wellness are very important to Pacific Southwest Realty Services and Kaiser Permanente. Having the tools and knowledge to help educate yourself and your family can empower you to make positive changes in your lifestyle and improve your overall wellness. If you are enrolled in the Kaiser HMO plan, you can access free tools, discounts, and resources to manage your health and wellness by going to **kp.org**.

Manage Your Care Online

As a Kaiser Permanente member, **kp.org** is your online gateway to great health. Register so that you can securely access many time-saving tools for managing your care. Visit **kp.org** anytime, from anywhere to:

- View most lab results
- Refill most prescriptions
- Email your doctor's office
- Schedule and cancel routine appointments

Wellness Programs

Take advantage of Kaiser's wide range of convenient tools to help you stay well, such as:

- A Total Health Assessment
- Healthy Lifestyle Programs
- Wellness Coaching

Get Answers to Your Health Questions & More

Information and inspiration are just a click away. Whether you're looking up a specific topic or browsing for ideas, Kaiser's reference guides and online tools give you many ways to connect to your health.

Member Discounts

Kaiser members get reduced rates on a variety of products and services through ChooseHealthy at **kp.org/choosehealthy**. You'll find reduced rates on:

- Acupuncture
- Massage therapy services
- Gym memberships

On the website, you'll also get complimentary access to:

- Wellness programs
- Trackers
- Health and wellness library

How to Find a Kaiser Provider

- Logon to **kp.org**
- Click on "Find doctors & locations" in the upper right hand corner of the webpage
- Choose an area for your search, enter your zip code and distance OR city
- Narrow your search by entering a physician or facility
- Click on "Search" and your results will be displayed

Choose your doctor – and change anytime

Connecting you with a doctor to meet your health needs is very important. Kaiser provides you the option to have your family under one or many doctors for Primary Care Services. Visit: **KP.org/searchdoctors** and you will be able to locate providers, change providers and research more information about your current providers.

You can choose the following:

- Adult Medicine/ internal medicine
- Family Medicine
- Pediatrics/ family medicine (for children up to 18)

TravelCare

Sickness can be unplanned, however; Kaiser Permanente provides you coverage while you are on the go! If you are traveling and and need care, you can call the Away from Home Travel Line at 951-268-3900 or visit **kp.org/travel**.

Finding convenient locations

Kaiser is continuously expanding their facilities and clinics. Choosing the right location for you is very important to seek care! You can locate facilities now through your Kaiser Permanente app or online by visiting **kp.org/kpfacilities.**

Kaiser Permanente HMO Medical Plan Child Dental Plan (Children Only)

When you and your dependents enroll within the Kaiser HMO medical plan, children will also be enrolled within a child dental program administered by Kaiser and Delta Dental of California.

	Child Dental Plan GOLD 80 HMO 3/30*+ CHILD DENTAL (Only available for children enrolled in the Kaiser HMO Plan) In-Network
Calendar Year Deductible	None
Annual Plan Maximum	
Child	$350
Multichild	$750
Diagnostic and Preventive Services Includes: Oral Evaluations, Bitewing X-rays, Prophylaxis Cleaning, Fluoride treatments, Space Maintainers, Sealant Repair	Plan pays 100%
Periodontics	
Maintenance	$30
Scaling and Root Planning	$30
Surgery – Osseous	$265
Restorative	
Fillings	$25
Composite crowns – resin based	$30
Crown - Porcelain	$300
Endodontics	
Therapeutic pulpotomy	$40
Root Canal- Anterior or Molar	$195 - $300
Prosthodontics	$300
Complete Denture	$60
Reline Maxillary Denture "partial"	$90
Oral Maxillofacial Surgery	
Extraction – erupted tooth/ exposed root	$65
Surgical removal of erupted tooth	$120
Orthodontics* (medically necessary only)	$350*

*Orthodontics includes medically necessary orthodontia only

Helpful Tips:

- Don't forget your dental cleanings!
- Make sure to see an in-network provider
- Once you receive a welcome kit, you can schedule an appointment
- You can change your selected network dentist at anytime by phone
- If you require specialty care, your Delta Dental dentist will coordinate it for you

To find a dentist, please call Delta Dental at

800-422-4234

Standard 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.

	Standard Dental PPO	
	In-Network	Out-Of-Network
Calendar Year Deductible	$50 $150	$50 * $150 *
Annual Plan Maximum	$1,500	$1,500 *
Diagnostic and Preventive Services Includes: Exam, Bitewing X-rays, 2 cleanings per year, sealants, space maintainers, etc.	Plan pays 100%	Plan pays 100%
Basic Services Includes: Fillings, Root Canals, Amalgams, Composites, Endodontics, Periodontics, Denture Repair, Simple Extractions	90% after deductible	90% after deductible
Major Services Includes: Onlays, Crowns, Crown Repairs, Prosthodontics, Complex Extractions, Anesthesia	60% after deductible	60% after deductible
Orthodontic Services	Not covered	Not covered

* Combined with in-network.

Helpful Tips:

- Don't forget your dental cleanings!
- Make sure to see an in-network provider to get the most out of your dental plan benefits.
- Need major dental work performed? Contact your carrier for a "pre-treatment estimate." This way you know your share of cost ahead of time.

Find a Dental Provider:

- Go to: **www.standard.com/employer/insurance/group-dental**
- Click on find a dentist
- Enter your City, State, Zip Code, and the type of provider you are looking for
- Select "Classic (PPO)" in the "Select a Network" drop down list
- Select the type of Provider you are searching for from the "Choose Specialties" drop down list
- Click on "Search Now" and your results will be displayed

Standard Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

	The Standard Vision Network: EyeMed Access Network	
	In-Network	**Out-Of-Network**
Deductibles Exam Annual Eye Exam	 $10 Exam $25 Eye Glass Lenses	 No Deductible Up to $35
Annual Eye Exam		
Lenses (Per Pair)		
Single	Covered in full	Up to $25
Bifocal	Covered in full	Up to $40
Trifocal	Covered in full	Up to $55
Lenticular	20% discount	No Benefit
Progressive	See lens options	N/A
Contacts		
Fit & Follow Up Exam		
Standard	Up to $55	No benefit
Premium (Allowance)	10% off of retail	No benefit
Elective	Up to $115	Up to $100
Medically Necessary	Covered in full	Up to $200
Frames	$110	Up to $45
Frequencies (months)		
Exam	Every 12 Months	
Lens	Every 12 Months	
Frame	Every 24 Months	
Lens Options (Participant Cost)		
Progressive Lenses		
Standard	$65 + Lens deductible	
Premium	Lens cost – 20% discount - $120 allowance + Standard Progressive Cost	
Std. Polycarbonate	$40	
Tint (solid and gradient)	$15	
Scratch Resistant Coating	$15	No benefit
Anti-Reflective Coating	$45	
Ultraviolet Coating	$15	
Lasik or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers	

Take care of your eyes!

Get an eye exam if you experience:

- Sudden blurry vision or problems focusing
- Red, dry, itchy eyes
- You see spots, flashes of light, or floaters
- You get motion sick, dizzy or have headaches
- Eye pain or eye fatigue/strain
- Squinting or sensitivity to light

Life / AD&D Insurance

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

Basic 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, or hearing, or if you die in an accident. The cost of coverage is paid in full by Pacific Southwest Realty Services and is provided by The Standard.

Eligibility	All Presidents, Vice Presidents and other Members earning $40,000 or more annually working at least 30 or more hours per week.
Basic Life Amount	$105,000
Benefit Maximum	$105,000
Guaranteed Issue	$105,000
Benefits Will Reduce To	65% at age 65, 40% at age 70; and 25% at age 75. Benefits terminate at retirement.
Basic AD&D Amount	Same As Life Benefit Amount

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.

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.

Your Basic Life plan includes:

- Accelerated Death Benefit
- Portability of Insurance Provision
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Waiver of Premium

Your Basic Accidental Death and Dismemberment (AD&D) plan includes:

- Air Bag Benefit
- Family Benefits package
- Seat Belt Benefit

The Life Services Toolkit

The Standard values your life and provides additional support to help you. The Standard helps you with your Health and Wellness, Identity Theft, Estate Planning, Financial Planning and Funeral Arrangements. If you need to use the Accelerated Benefit your Beneficiaries have Grief Support, Legal Services, Financial Assistance, Support Services and Online Resources available to them at no cost.

For more information, visit **www.standard.com/mytoolkit** (**USER ID**: Support) or call 800-378-5742.

Disability Insurance

If you become disabled and are unable to work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

Long-Term Disability

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

If you qualify, long-term disability benefits begin after short-term disability benefits end. Coverage is provided by The Standard.

The Standard's Definition of Disability states that you are eligible for this benefit as a result of physical disease, injury, pregnancy or mental disorder. Also, you are not considered disabled because your right to perform your occupation is restricted, this includes a restriction or loss of license. For more information about the LTD plan, please refer to your plan summary for more information.

Eligibility	All Eligible Executives, President, CEO, and Vice Presidents working at least 30 or more hours per week.
Monthly Benefit Amount	Plan pays 66.67% of the first $15,000 monthly predisability earnings.
Maximum Monthly Benefit	$10,000
Elimination Period	90 days
Maximum Payment Period*	Age 65 or SSNRA

*The age at which the disability begins may affect the duration of the benefits

Your Long Term Disability (LTD) plan includes

- Reasonable Accommodation Expense Benefit
- 24 hour coverage, including coverage for work-related disabilities
- Rehabilitation Incentive Benefit
- Rehabilitation Plan Provision
- Return to work Incentive
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while LTD benefits are payable

Travel Assistance

When you are away from home, unexpected things can happen. When traveling, it is easy to lose your identification, passport and even your wallet. Travel Assistance is provided by The Standard and administered by United HealthCare (UHC) to provide you peace of mind while away on vacation. If you have medical, financial or logistical problems, UHC will be able to help you.

- Travel Requirements
- Emergency tickets, credit cards, passport replacements, fund transfers
- Help with missing baggage
- Registered Nurse phone line for help with medication information, symptom decision support, and understanding treatment options
- Emergency evacuation information
- Connect you to medical providers, translation services, legal support, consular office or bail bond services
- Return Travel Companion
- Logistical arrangements for ground transportation, housing, evacuation due to instability, complex situations

Travel Assistance can be reached in the following ways:
800-527-0218
(USA, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda)
1-410-453-6330
(Everywhere Else)
www.standard.com/travel

assistance@uhcglobal.com

Employee Assistance Program (EAP)

Life can present some complex challenges and that is why Pacific Southwest Realty Services is providing you with an Employee Assistance Program through The Standard that can provide the assistance you may need. This service includes up to 3-face-to-face emotional or work-life counseling sessions as well as unlimited telephonic consultations for benefit eligible employees covered under the Long Term Disability plan. The Employee Assistance Program can offer assistance in the following areas:

- Job pressures
- Stress, anxiety and depression
- Relationship / marital conflicts
- Life improvements
- Emotional well-being
- Financial and legal concerns
- Grief and loss
- Identity theft and fraud resolution

Accessing help is easy!

Call:

888-293-6948

OR GO TO:

www.eapbda.com
Log in: standard

Password: eap4u

Ben IQ

Meet Ben-IQ

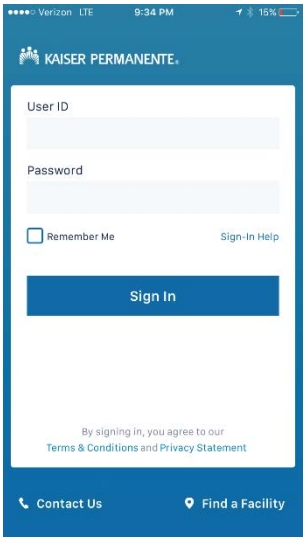
Ben-IQ is a free app that includes much of the information that's included in this overview, but in a place that's always at your fingertips – your smartphone. Ben-IQ is available for Android and iPhone.

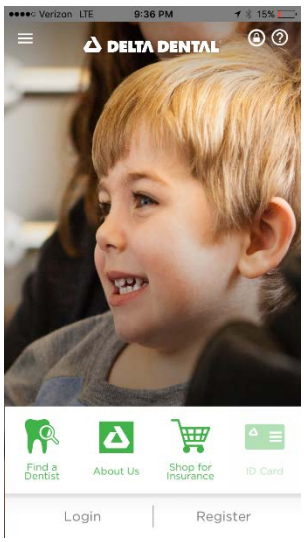
Getting Started With Ben-IQ

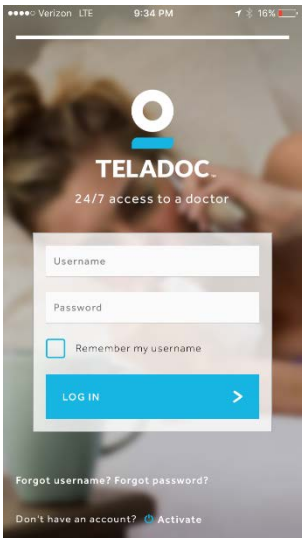
1. Download and launch the app
2. Enter your assigned username: **PSRS**
3. Read and agree to the Terms and Conditions

Take a tour of Ben-IQ and review plan summaries, and important contacts like our nurse line and EAP. Store and organize ID cards using your phone's camera, and much more! Be sure to share Ben-IQ with your covered family members too.

Mobile Apps







Important Plan Notices and Documents

COBRA Initial Notice

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to selected insurance carrier.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Women's Health and Cancer Rights Annual Notice

The Women's Health and Cancer Rights Act ("WHCRA") requires us to notify participants and beneficiaries of the Group Health Plans (the "Plans"), of their rights to mastectomy benefits under the Plans. 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 these Plans. For further details, please refer to the Plan's Summary Plan Description.

For more information on WHCRA benefits, contact your Plan Administrator.

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, contact your Plan Administrator.

HIPAA Notice of Special Enrollment Rights

Notice of Special Enrollment Rights for Medical/Health Plan Coverage

If you decline enrollment in the health plans for you or 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 our health plans 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 the health plans if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for health plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Notice of Choice Providers

An HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the health plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Plan Administrator.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact your Plan Administrator.

Michelle's Law Notice

The health plans may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, please contact your plan administrator as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Medicare Part D Notice

Important Notice 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 Pegasus School and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. It has been determined that the prescription drug coverage offered by the health 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, your current coverage will not 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 under the health plans is creditable (e.g., as good as Medicare coverage), 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 your current 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 and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below 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 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 **medicare.gov**
• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
• Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **socialsecurity.gov**, or call them at 800-772-1213 (TTY 800-325-0778).

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

Date:	September 1, 2017
Name of Entity/Sender:	Pacific Southwest Realty Services
Contact-Position/Office:	Human Resources
Address:	8840 Complex Drive, Suite 101 San Diego, CA 92123

Paperwork Reduction Act Statement

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

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

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

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 **https://www.healthcare.gov/**.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **http://www.insurekidsnow.gov/** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

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

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711

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

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

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: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003 TTY: Maine relay 711

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

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

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

NEBRASKA – Medicaid
Website:
http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

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

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

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
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 Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
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
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website:
http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

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

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

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

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

Notes

For Assistance

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

Plan Type	Carrier	Member Services	Website & Email
MEDICAL			
HMO	Blue Shield	1-800-424-6521	www.blueshieldca.com
PPO	Blue Shield	1-800-200-3242	www.blueshieldca.com
HMO	Kaiser Permanente	1-800-278-3296	kp.org
DENTAL			
PPO	The Standard	1-800-547-9515	www.standard.com
VISION			
PPO	The Standard	1-866-289- 0614	www.standard.com
ANCILLARY			
BASIC LIFE / AD&D	The Standard	1-800-628-8600	www.standard.com
LONG TERM DISABILITY	The Standard	1-800-368-1135	www.standard.com
EAP			
EMPLOYEE ASSISTANCE PROGRAM	The Standard	1-888-293-6948 TDD: 1-800-327-1833	www.eapbda.com LOG IN: Standard PASSWORD: EAP
TRAVEL ASSISTANCE			
TRAVEL ASSISTANCE	The Standard through UnitedHealthcare	1-800-527-0218 1-410-453-6330	www.standard.com/travel
LIFE SERVICES TOOLKIT			
LIFE SERVICES TOOLKIT	The Standard	1-800-378-5742	www.standard.com/mytoolkit USER NAME: Support

HUMAN RESOURCES – PACIFIC SOUTHWEST REALTY SERVICES			
Sharon Hering	Human Resources & Office Manager	858-522-1410	shering@psrs.com
BROKER – ALLIANT INSURANCE SERVICES			
Debby Miller	Account Executive	619-849-3778	debby.miller@alliant.com
Cecilia Iñiguez	Account Associate	619-849-3979	cecilia.iniguez@alliant.com
Rachelle Engel	Account Associate	619-849-3930	rachelle.engel@alliant.com

The information in this brochure is a general outline of the benefits offered under the Pacific Southwest Realty Services' benefits program. This brochure may not include all relevant limitations and conditions. Specific details and limitations are provided in the plan documents, which may include a Summary Plan Description (SPD), Evidence of Coverage (EOC), and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this brochure differs from the plan documents, the plan documents will prevail.