2019 Benefits Guide
Welcome to Open Enrollment!

The Avante Group's benefit program provides a full range of benefits that address your needs now and in the future.

**To Your Health**
- Medical Insurance / Prescription Drug
- Dental Insurance
- Vision Insurance
- Employee Assistance Program
- Hospital Indemnity Insurance
- Critical Illness Insurance
- Accident Insurance

**To Your Wealth**
- Flexible Spending Accounts
- Health Savings Account
- Term Life Insurance
- Short Term Disability Insurance
- Long Term Disability Insurance
- **NEW!** Whole Life Insurance

**About This Benefits Guidebook**

This Benefits Guidebook describes the highlights of the Avante Group benefit program in non-technical language. Your specific rights to benefits under this program are governed solely, and in every respect, by the official documents and not the information contained within this Benefits Guidebook.

If there is any discrepancy between the descriptions of the program elements as contained within this Benefits Guidebook or other benefits enrollment materials you receive and the official plan documents, the language of the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. Eligibility for any benefit plan is determined by applicable plan documents and policies. You should be aware that any and all elements of the Avante Group Benefits Program may be modified in the future to meet Internal Revenue Service rules or otherwise as determined by Avante.

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How to Enroll During Open Enrollment

OPEN ENROLLMENT:
DECEMBER 3 – DECEMBER 12

We’re excited to once again offer personalized enrollment support through our enrollment partner, Hodges-Mace. Their professional Benefit Counselors will be available to meet with you at your work site during the Open Enrollment window. We received positive feedback on this process last year, so we hope you will continue to enjoy the individual assistance and advice that this service provides.

Open Enrollment is your once-a-year opportunity for you to review and consider all of the benefits available to you and your family. Better yet, you will have the chance to ask specific questions, get detailed answers, and enroll in your benefits! The following are a few things you need to know about enrolling with a Benefit Counselor.

Making Your Appointment
Counselors will be onsite at your work location for certain days during the Open Enrollment window. Please see posters at your work location for instructions on making an appointment.

Be Prepared!
Before your counselor meeting, be sure to read this benefit guide, review your options, and write down any questions you may have. Please be sure to bring the following information with you to your meeting:

- If you are adding dependents, you will need their names, birth dates, and Social Security numbers.
- If you would like to change your beneficiaries, you will need their names, birth dates, addresses, and phone numbers.

Meeting with Your Benefit Counselor
During your individual enrollment session, you will:

- Review the new and existing benefit options available to you for 2019.
- Ask questions so you are able to understand the choices you are making.
- Get enrolled in your benefits.
- Receive a confirmation statement to make sure your benefits are correctly listed.
- Have the chance to provide feedback by completing a confidential survey.

ABOUT THE ENROLLMENT PERIOD

The Annual Open Enrollment Period is your opportunity to make changes to your benefits for the upcoming Plan Year:

- Enroll in, change or drop medical/prescription drug, dental and/or vision coverage;
- Enroll in Flexible Spending Accounts or Health Savings Account;
- Add, change or drop dependents;
- Enroll in supplemental term life insurance; short-term disability, long-term disability, critical illness, accident, hospital indemnity, and whole life.

Special Enrollment Opportunities
During this year’s Open Enrollment, you can get guaranteed coverage under the Voluntary Benefit Plans (accident insurance, critical illness insurance, hospital indemnity insurance, whole life insurance) and Supplemental Term Life insurance up to the guarantee issue levels without having to provide proof of good health. Learn more about these options on pages 7 and 12.
ASSOCIATE ELIGIBILITY

• All full-time associates working 30 or more hours per week are eligible to enroll in the Avante benefits program.
• Benefits are effective the 1st of the month following 60 days of full-time employment.
• Benefits are effective the 1st of the month following 30 days for part-time and PRN associates who switch to full-time status provided the new hire probationary period has been satisfied.

DEPENDENT ELIGIBILITY

Your eligible dependents may include:

• Your legal spouse (Certain Union Groups - spouses are not eligible for medical/Rx coverage)
• Your child(ren) under age 26 regardless of student status, tax dependence or marital status
• Your child(ren) over age 26 who are not able to support themselves due to a physical or mental disability

Only those dependents meeting the eligibility requirements can enroll for coverage. In order to add a spouse or a dependent child(ren) you must supply the appropriate documentation such as a marriage license and/or a birth certificate. Check with the Corporate Benefits Department for more information regarding dependent eligibility.

HOW CAN I CHANGE MY COVERAGE?

Outside of the Open Enrollment Period, you may only make changes to your benefits if you experience a qualifying life event. The IRS has strict rules that govern these types of employer-sponsored health care plans. These rules restrict the circumstances under which you are permitted to make benefit election changes mid-year to the following benefits programs: medical, dental, vision, and certain voluntary programs. You are permitted to make changes mid-year if you have a “Qualifying Life Event.” Any changes you make must be consistent with the Qualifying Life Event you experience.

You must notify the Corporate Benefits Department to make the change within 31 days of the event and provide documentation for the changes. The elections you make during your enrollment period will remain fixed, unless you experience one of the following Qualifying Life Events:

• Changes to legal marital status: marriage, divorce, death of a spouse, legal separation;
• Changes to number of dependents: birth, death, adoption, placement for adoption;
• Dependent ceases to satisfy eligibility requirements;
• Changes in spouse’s employment status;
• Change in residence (moving from state to state);
• Entitlement to Medicare or Medicaid;
• Significant cost or coverage changes in this plan (this does not extend to significant cost or coverage changes in any other medical plan in which you participate, such as a spouse’s plan)

WHEN CAN I CHANGE MY BENEFITS?

- Marriage
- Divorce
- Birth or Adoption of a Child
- Significant change in the plan or plan costs
- End of COBRA Continuation Coverage through another employer
- Coverage by another group health plan
Things to Know About Your Aetna Medical Benefits

You have access to comprehensive medical coverage through Aetna. In this section, you will find information on the three medical plans: the HDHP or High Deductible Health Plan, the Basic Plan, and the Premium Plan.

CHOOSING A MEDICAL OPTION

When it comes to choosing a medical plan, it’s important to consider how you use the plan and how much you can afford to pay, both out of your paycheck through payroll deductions and out of your pocket when you use the plan.

All three of our medical plans cover a wide range of services, from preventive care and routine office visits to hospitalization and surgery. Plus, they cover in-network, recommended preventive care at 100% and include coverage for prescriptions at participating pharmacies and through a mail-order program.

The medical plan chart on page 4 lets you compare side-by-side the plan features that affect what you pay – be sure to look at things like the deductible, out of pocket maximum, coinsurance percent, and cost per paycheck. You can also review a brief description of the plans below.

HDHP (High Deductible Health Plan)
The HDHP offers the lowest cost per paycheck and has a higher deductible that you must pay before your coverage begins.

If you are worried about having a higher deductible, be sure to check out the Voluntary Plans on page 7. They pay cash in the event of an injury or illness – that’s money you can use to pay down your deductible faster.

If you enroll in the HDHP, you are also eligible to enroll in a Health Savings Account (HSA) provided through Payflex. An HSA allows you to contribute pre-tax dollars through payroll deductions to an account that is specially designed to help pay for eligible medical expenses. Please see page 5 for more details on the HSA plan.

Premium Plan and Basic Plan
With the Premium and Basic plans, there is a network of providers and the amount the plan pays varies based on your use of that network. You always have the choice to go to any provider, but you’ll pay less if you use an in-network doctor or hospital.

1. Go to www.aetna.com and click “Find a Doctor”
2. Follow the steps to log on or create an Aetna Navigator account using the ID number on the back of your ID card, which you will receive after enrollment.
3. Once logged on, click the icon that says “Find Care” and search for the type of provider you need.

STAY HEALTHY WITH FREE PREVENTIVE CARE SCREENINGS

The following screenings are recommended by the CDC based on age and gender. These services are covered by the medical plans at 100%.

<table>
<thead>
<tr>
<th>Preventive Screenings</th>
<th>How Often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Physical</td>
<td>Annually</td>
</tr>
<tr>
<td>Flu Shot</td>
<td>Annually</td>
</tr>
<tr>
<td>Mammogram</td>
<td>Women—Annually</td>
</tr>
<tr>
<td>OB/GYN Exam</td>
<td>Women—Annually</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Women ages 21—65; every 3 years</td>
</tr>
<tr>
<td>Colon Cancer Screening</td>
<td>The following tests will be covered for colorectal cancer screening, ages 50 and older:</td>
</tr>
<tr>
<td></td>
<td>• Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually</td>
</tr>
<tr>
<td></td>
<td>• Flexible sigmoidoscopy every 5 years</td>
</tr>
<tr>
<td></td>
<td>• Double-contrast barium enema (DCBE) every 5 years</td>
</tr>
<tr>
<td></td>
<td>• Colonoscopy every 10 years</td>
</tr>
<tr>
<td></td>
<td>• Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years</td>
</tr>
</tbody>
</table>

Restrictions apply. Please refer to the U.S. Preventive Services Task Force website for more details.
## Medical Plan Overview

### AETNA MEDICAL PLANS

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>HDHP</th>
<th>Basic Plan</th>
<th>Premium Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>$5,000 Individual $10,000 Family</td>
<td>$2,500 Individual $5,000 Family</td>
<td>$1,500 Individual $3,000 Family</td>
</tr>
<tr>
<td>Calendar Year Out-of-Pocket Maximum</td>
<td>$6,350 Individual $12,700 Family</td>
<td>$6,350 Individual $12,700 Family</td>
<td>$6,350 Individual $12,700 Family</td>
</tr>
<tr>
<td>Coinsurance (Plan / You)</td>
<td>70% / 30%</td>
<td>70% / 30%</td>
<td>70% / 30%</td>
</tr>
</tbody>
</table>

### Office Visits

- **Preventive Care**
  - Covered 100%
  - $0 copay
  - $0 copay
- **Primary Care Physician (PCP)**
  - 30% after deductible
  - $40 copay
  - $30 copay
- **Specialty Physician**
  - 30% after deductible
  - $60 copay
  - $50 copay

### Hospital / Emergencies

- **Inpatient Hospital Services**
  - 30% after deductible
  - $600 copay plus 30% after deductible
  - $500 copay plus 30% after deductible
- **Emergency Room**
  - 30% after deductible
  - $500 copay plus 30% (deductible waived)
  - $500 copay plus 30% (deductible waived)
- **Urgent Care**
  - 30% after deductible
  - $50 copay plus 30% (deductible waived)
  - $50 copay plus 30% (deductible waived)

### RETAIL PHARMACY - 30 DAY SUPPLY

- **Preferred Generic**
  - $15 copay*
  - $15 copay
  - $15 copay
- **Preferred Brand**
  - $35 copay*
  - $35 copay
  - $35 copay
- **Non-Preferred Brand**
  - $60 copay*
  - $60 copay
  - $60 copay
- **Preferred Specialty Drugs**
  - 20%, $100 max.*
  - 20%, $100 max.
  - 20%, $100 max.

### MAIL ORDER PHARMACY - 90 DAY SUPPLY

- **Preferred Generic**
  - $37.50 copay*
  - $37.50 copay
  - $37.50 copay
- **Preferred Brand**
  - $87.50 copay*
  - $87.50 copay
  - $87.50 copay
- **Non-Preferred Brand**
  - $150 copay*
  - $150 copay
  - $150 copay
- **Specialty Drugs**
  - 20%, $100 max.*
  - N/A
  - N/A

### Bi-Weekly Medical Plan Rates (26 deductions per year)

<table>
<thead>
<tr>
<th></th>
<th>HDHP</th>
<th>Basic Plan</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate</td>
<td>$30.00</td>
<td>$65.00</td>
<td>$154.39</td>
</tr>
<tr>
<td>Associate + Spouse</td>
<td>$263.88</td>
<td>$281.25</td>
<td>$444.85</td>
</tr>
<tr>
<td>Associate + Child(ren)</td>
<td>$185.07</td>
<td>$200.22</td>
<td>$347.91</td>
</tr>
<tr>
<td>Family</td>
<td>$361.59</td>
<td>$387.67</td>
<td>$624.72</td>
</tr>
</tbody>
</table>

*Subject to the plan's calendar year deductible, excluding drugs on the Aetna preventive medication list (found online).
Learn About the HSA Plan!

Take charge of your health care spending with a Health Savings Account (HSA) alongside our HDHP (High Deductible Health Plan). Contribute however much you choose, up to the federal maximum limits each year. Your HSA contributions are tax-free, and the money remains in the account for you to spend on eligible expenses either now or in the future – even if you are no longer employed with the company.

SAVE MONEY FOR HEALTH CARE COSTS NOW AND IN THE FUTURE

Want to reduce your taxable income and increase your take-home pay? By enrolling in the HSA you can start saving money for eligible health care expenses for you, your spouse and your dependents.

HSA Funding and Limits

The 2019 maximum contributions are:
- **Individual** - $3,500
- **Family** - $7,000

What do people love about the HSA?

- You can contribute pretax and post-tax dollars.
- Unused funds roll over from year to year.
- Your HSA stays with you, even if you switch employers, change health plans or retire.
- If you have an HSA somewhere else, you can transfer the balance to your new HSA.
- Your money can earn interest — plus, you can enjoy investment options.

Some common eligible expenses may include:
- Deductibles, copays and coinsurance
- Eligible prescriptions
- Vision care, including LASIK laser eye surgery
- Dental care, including orthodontia

Take care of your HSA, and it may grow

Once you have a minimum balance (typically $1,000) in your HSA, you can open an investment account. There are a variety of mutual funds to choose from. There’s also no transfer or trading fees and no minimum investment amount for a trade request.

Are you eligible for an HSA?

To enroll in an HSA, you must be enrolled in a qualified high-deductible health plan (HDHP). In addition:

- You can’t have other health coverage that pays for out-of-pocket health care expenses before you meet your plan deductible.
- You or your spouse can’t have a general-purpose health care flexible spending account (FSA) or health reimbursement arrangement (HRA) in the same year.
- You can’t have Medicare, TRICARE or have received Veterans Administration (VA) health benefits in the previous three months.
- You can’t be claimed as a dependent by someone else.

PAY THE PAYFLEX WAY

Once funds are available in your HSA, PayFlex makes it easy to pay for your eligible expenses.

- **Use the PayFlex Card HSA debit card.** It’s a convenient way to pay for eligible expenses. Expenses are paid automatically, as long as funds are available, and there’s no paperwork to file.
- **Pay yourself back:** Pay for eligible expenses with cash, check or your personal credit card. Then withdraw funds from your HSA to pay yourself back. You can even have your payment deposited directly into your checking or savings account.
- **Pay your provider:** Use PayFlex’s online feature to pay your provider directly from your account.

It’s a simple tap with the PayFlex mobile app

Managing your account has never been easier. Use to app to:

- Check your balance
- Make payments, withdrawals and deposits
- View PayFlex debit card transactions
- View common eligible expense items, and more

Like most bank accounts, the HSA has a $5.00 monthly maintenance fee. This fee is waived as long as you are enrolled in the Avante HDHP medical option.
Added Benefits for Aetna Medical Plan Members

**AETNA NAVIGATOR**

Once you are enrolled in an Aetna medical plan and have received your ID number, you can easily manage your plan online with your Aetna Navigator website. All of your health benefits and insurance plan information and cost-savings tools are in one place!

Aetna Navigator’s tools can help you:

- Find plan details, like your out-of-pocket costs and what’s covered.
- Compare drug costs.
- Get medicine mailed straight to your door.

Once you’re a member, register for Aetna Navigator at www.aetna.com.

**Compare costs, find pharmacies and more!**

- **Find a nearby pharmacy.** It’s easy to find one in your neighborhood or while traveling.
- **Get help using medicine safely.** You can learn what a drug is used for and how it should be taken. Or help prevent harmful drug interactions.
- **Get an ID card.** It’s easy to print one out in seconds or pull up a copy on your mobile device.
- **Chat with your virtual assistant, Ann.** She can help you find a doctor, estimate the cost of services, answer questions about claims, ID cards and more. She never sleeps, so you can chat with her anytime.
- **Plus — estimate drug costs with the Price-A-Drug tool.** You can find out how much a drug may cost through your local pharmacy or mail order. Or compare the costs of generic and brand-name drugs to see how much you can save.

**MEDICINE BY MAIL, PLUS EXTRA SUPPORT AND SAVINGS**

Mail order is quick and private. Your medicine is sent right to your mailbox, or wherever you choose. And you get free standard shipping, too.

**Aetna Rx Home Delivery**

Use this option if you take medicine on a regular basis for conditions like arthritis, asthma or diabetes.

- You can get up to a 90-day supply, or the most allowed by your plan.
- You may pay less for that larger supply, depending on your plan.

**Aetna Specialty Pharmacy Support**

Use this option if you take specialty medicine for conditions like multiple sclerosis, rheumatoid arthritis or cancer.

- Get this unique medicine packed safely and securely.
- Get tips and training on how to self-inject your medicine or cope with side effects or other issues.

**TELADOC**

All Aetna medical plan members have access to Teladoc, which provides access to U.S. board-certified doctors and pediatricians via phone or online video consultations 24/7/365. You can use Teladoc for a variety of non-emergency medical issues rather than taking expensive and time-consuming trips to the ER and urgent care.

If you’re having trouble getting in to see your doctor, Teladoc doctors can diagnose, recommend treatment, and prescribe medication for many basic medical issues, including:

- Cold and flu symptoms
- Bronchitis
- Allergies
- Poison ivy
- Pink eye
- Urinary tract infection
- Respiratory infection
- Sinus problems
- Ear infection

**Travel frequently?** Whether on vacation, traveling for work, or traveling internationally, Teladoc is there for you 24/7 wherever you may be.

**FIND WHAT YOU NEED — WHEREVER, WHENEVER — WITH THE AETNA MOBILE APP.**

The Aetna Mobile app puts our most popular online features at your fingertips. It’s available for iPhone and Android mobile devices.

*Scan this code or visit www.aetna.com/mobile to download the app.*
The Aetna medical plans provide great coverage for you and your family’s general health care needs. Still, everyone’s needs are slightly different. That’s where the Unum voluntary Accident and Critical Illness options come in! These benefits are designed to protect your family’s finances in case of an unforeseen injury or illness.

**HOSPITAL CONFINEMENT INDEMNITY INSURANCE**

We all know that an unexpected, or even planned stay in the hospital, can be expensive as you meet your deductible and out-of-pocket obligations under the medical plan.

The Unum Hospital Indemnity insurance plan is designed to provide financial protection by paying you a direct benefit due to a hospitalization. You can use the benefit to meet out-of-pocket expenses and extra bills that can occur.

Lump sum benefits are paid directly to you based on the type of facility and number of days of confinement listed below, regardless of the actual cost of treatment.

<table>
<thead>
<tr>
<th>HOSPITAL INDEMNITY BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Features</strong></td>
</tr>
<tr>
<td>Hospital Admission</td>
</tr>
<tr>
<td>Daily Hospital Confinement</td>
</tr>
<tr>
<td>Portability</td>
</tr>
<tr>
<td>Guarantee Issue</td>
</tr>
</tbody>
</table>

**VOLUNTARY ACCIDENT INSURANCE**

The voluntary Accident Plan is designed to help cover the expenses associated with an accidental injury and provides direct cash benefits for emergency treatment, hospitalizations, specific injury treatments, accidental death, etc., regardless of any other insurance you may have. Coverage is available for you, your spouse and/or child(ren). Your coverage is portable, which means you can take your policy with you if you leave the company.

**VOLUNTARY CRITICAL ILLNESS**

The voluntary Critical Illness Coverage is designed to pay cash in the event that you or your covered family member is diagnosed with a critical illness, such as heart attack, coma, end-stage renal failure, stroke, paralysis, invasive cancer or major human organ transplant. Critical illness insurance helps protect your income and personal assets when your out-of-pocket expenses increase as a result of specified critical illness. Coverage is available for you, your spouse and/or child(ren).

*During Open Enrollment, you are guaranteed coverage in these plans. Don’t miss this opportunity to enroll!*
### AETNA DENTAL PLANS

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>DHMO Plan</th>
<th>PPO Plan</th>
<th>PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>$50 per person</td>
<td>$50 per person</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>None</td>
<td>$1,500</td>
<td>$1,250</td>
</tr>
<tr>
<td>Class I - Preventive Care Cleanings, X-rays</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Class II - Basic Restorative Fillings, Root Canals</td>
<td>See Patient Charge Schedule</td>
<td>90% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Class III - Major Restorative* Crowns, Dentures, Bridges</td>
<td>See Patient Charge Schedule</td>
<td>60% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Orthodontia Coverage (Children up to Age 19)</td>
<td>Covered 50% up to a $1,000 lifetime maximum per child</td>
<td>Covered 50%</td>
<td></td>
</tr>
</tbody>
</table>

*12 month waiting period applies to Major Restorative Care (Class III) and Orthodontia (Class IV).

<table>
<thead>
<tr>
<th>Bi-Weekly Dental Plan Rates (26 deductions per year)</th>
<th>DHMO Plan</th>
<th>PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate</td>
<td>$7.41</td>
<td>Associate</td>
</tr>
<tr>
<td>Associate + Spouse</td>
<td>$14.16</td>
<td>Associate + Spouse</td>
</tr>
<tr>
<td>Associate + Child(ren)</td>
<td>$16.68</td>
<td>Associate + Child(ren)</td>
</tr>
<tr>
<td>Family</td>
<td>$23.49</td>
<td>Family</td>
</tr>
</tbody>
</table>

### What does a balance bill amount look like?

**Dr. Jones charges $750 for a crown.**

**The Aetna Dental Plans will only cover $600.**

**Since Dr. Jones isn’t in the network, he has the right to bill you for the $150 difference - plus the coinsurance you still have to pay.**

**On the other hand, if you visit an in-network dentist, he or she has already agreed to charge the $600 that the plan covers for crowns, so there is no balance left over.**
# AETNA VISION PLAN

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Aetna Vision Network</th>
<th>Out-of-Network Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Eye Exam</td>
<td>Covered in full after $10 exam copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Lenses (per pair)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Single</td>
<td>Covered in full after $10 exam copay</td>
<td>Up to $25</td>
</tr>
<tr>
<td>• Bifocal</td>
<td>Covered in full after $10 exam copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>• Trifocal</td>
<td>Covered in full after $10 exam copay</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Contacts (in lieu of lenses and frames)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Elective</td>
<td>Up to $100 Covered in full</td>
<td>Up to $80</td>
</tr>
<tr>
<td>• Medically Necessary</td>
<td>Covered in full</td>
<td>Up to $200</td>
</tr>
<tr>
<td>• Fit &amp; Follow-up</td>
<td>Covered in full</td>
<td>Up to $40</td>
</tr>
<tr>
<td>• Premium Fit &amp; Follow-up</td>
<td>Covered in full</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Frames</td>
<td>$130 allowance Up to $65 allowance</td>
<td>Up to $65</td>
</tr>
<tr>
<td>Frequency (Exams/Lenses/Frames)</td>
<td>Every 12 months</td>
<td></td>
</tr>
</tbody>
</table>

## Bi-Weekly Vision Plan Rates (26 deductions per year)

<table>
<thead>
<tr>
<th></th>
<th>Bi-Weekly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate</td>
<td>$3.60</td>
</tr>
<tr>
<td>Associate + 1</td>
<td>$6.42</td>
</tr>
<tr>
<td>Family</td>
<td>$8.34</td>
</tr>
</tbody>
</table>

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## 5 Tips for Healthy Eyes

1. **Schedule Eye Exams** for your whole family.
2. **Wear Sunglasses** to protect your eyes from the sun’s UV rays.
3. **If you smoke, quit!** Smoking increases your risk of cataracts.
4. **Rest your Eyes** once every 20 minutes for 20 seconds while working at a computer.
5. **Be Active.** Regular exercise can delay the onset of age-related permanent vision loss.
Flexible Spending Accounts (FSAs) are another way to help you save money on health or dependent care expenses throughout the year on a pre-tax basis. An FSA plan is a type of benefit plan under Section 125 of the IRS code that allows you to set aside money on a pre-tax basis to pay for certain medical and/or dependent care expenses that you and your eligible dependents incur. These expenses are usually not covered at all or are only partially covered by insurance.

**HEALTH CARE FSA**

This FSA is for health care expenses not paid by insurance, including deductibles, copayments (medical and prescription drug), coinsurance payments, and non-reimbursed dental and vision expenses.

**DEPENDENT CARE FSA**

This FSA is for dependent care expenses you incur to care for your eligible dependents, including daycare, afterschool care or elder care.

**Qualifying Dependents**
- A child under age 13 who can be claimed as your dependent on your federal income tax return; or
- Your spouse, if he or she is physically or mentally incapable of caring for himself or herself and has the same principal residence as you for more than one-half of the year; or
- Any other person who can be claimed as a dependent on your federal income tax return (without regard to the gross income limitation), if he or she is physically or mentally incapable of caring for himself or herself and has the same principal residence as you for more than one-half of the year.

**HOW DOES AN FSA PLAN WORK?**

- When you incur expenses, you submit for reimbursement to receive your funds or use the debit card at the point of purchase.
- If you use the debit card, you must be able to substantiate the claim with written proof (receipts) of the expense. So save your paperwork in case it’s needed later. If you do not use the debit card, you must initiate the reimbursement process by collecting receipts and completing reimbursement request forms.
- If you submitted a claim for reimbursement, you will receive your reimbursement check directly in the mail from our FSA plan administrator. Sign-up for direct deposit after enrolling to get your money faster!
- You will only be reimbursed for qualified expenses incurred during the 2019 calendar year.
- Expenses are incurred only after the service has been provided. You will not be reimbursed in advance for services not yet rendered.
- For the Health Care FSA, you can use your full annual election as early as January 1, 2019. For the Dependent Care FSA, you can only be reimbursed up to the amounts you’ve deposited into your Dependent Care FSA.

**NOTE:** Once you make an FSA election, you cannot change it until open enrollment, except in special circumstances known as “Qualifying Life Events” (described on page 2).

**FSA DETAILS**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Annual Limit</th>
<th>Examples of Covered Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Flexible Spending Account</td>
<td>$2,650</td>
<td>Copays, coinsurance, deductibles, orthodontia, etc.*</td>
</tr>
<tr>
<td>Dependent Care Flexible Spending Account</td>
<td>$5,000</td>
<td>Day care, nursery school, elder care expenses, etc.*</td>
</tr>
</tbody>
</table>

($2,500 if married and filing separate tax returns)

*See IRS Publication 502 and 503 for a complete list of covered expenses.

**USE IT OR LOSE IT!** Remember to calculate your expenses conservatively when making your FSA elections. IRS regulations require that you forfeit any money left in your account after the claims submission deadline. You may not carry over unused funds from one plan year to another.
Your family depends on your income for a comfortable lifestyle and for the resources necessary to make their dreams – such as a college education – a reality. Like anyone, you don’t like to think of the scenario where you’re no longer there for your family. However, you do need to ensure their lives and dreams can continue if the worst does happen.

Avante knows how difficult it can be to provide this peace of mind on your own, which is why we have made it a priority to give you the ability to assemble a complete life insurance portfolio using the options listed on this page and the page following.

**BASIC TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE**

Avante provides eligible associates with basic term life and accidental death and dismemberment coverage at no cost to you and enrollment is automatic.

- **Basic Term Life**: Avante is providing eligible full-time associates with a $10,000 Life Benefit.
- **Accidental Death and Dismemberment**: If you are seriously injured or lose your life in an accident, you will be eligible for a benefit equal to your basic term life coverage.

**Company-Provided Life Insurance**

If you are eligible for basic life insurance through Unum, you also get life planning support (financial and legal resources) at no cost. This personalized financial counseling service provides expert, objective financial counseling to survivors and terminally ill employees. This service is also extended to employees upon the death or terminal illness of their covered spouse. The financial consultants are Master’s-level consultants. They will help develop strategies needed to protect resources, preserve current lifestyles, and build future security.

**EMPLOYEE ASSISTANCE PROGRAM**

All employees have access to the Employee Assistance Program (EAP). This professional service offers counseling, information and support for a variety of issues and problems. It is available 24 hours a day, 7 days a week just by calling the toll-free number 800-854-1446 or online at www.unum.com/lifebalance (no password required).

Experienced Behavioral Health staff can provide comprehensive assessment of personal issues, as well as coordinate subsequent services and referrals. The program includes the following features:

- Up to three face-to-face visits with a consultant for help with a short-term problem.
- Unlimited access to Master’s-level consultants by telephone.
- Medical Bill Saver™ service that can help negotiate out-of-pocket medical and dental expenses over $400.
- Locate child care and elder care services and obtain matches to the appropriate provider based on your or your family’s preferences and criteria. The consultant will even confirm space availability.
- Speak with financial experts by phone regarding issues such as budgeting, controlling debt, teaching children to manage money, investing for college, and preparing for retirement.
- Work through complex, sensitive issues such as personal or work relationships, depression or grief, or issues surrounding substance abuse.
- Referral to a local attorney for a free, 30-minute in person or telephonic legal consultation.
- Access to an attorney for state-specific legal information and services.
- If you decide to retain the attorney, you may be eligible to receive a 25% discount on additional services.
SUPPLEMENTAL LIFE INSURANCE

In addition to the company-paid life insurance benefit described on the previous page, you may also choose to purchase supplemental life insurance coverage. You pay the total cost of this benefit through convenient payroll deduction.

- **Associate:** You may elect coverage for yourself up to $500,000 in $10,000 increments (not to exceed 5x your base annual salary). No medical evidence is required for amounts elected up to $250,000 when initially eligible. Coverage ends at retirement.

- **Spouse:** Your spouse is eligible for coverage up to $150,000 in $5,000 increments (limited to 50% of your supplemental life amount). No medical evidence is required for amounts elected up to $50,000 when initially eligible. Spouse coverage ends at age 70 or your retirement, whichever comes first. You must be enrolled in order for your spouse to elect coverage.

- **Children:** May be enrolled in $10,000 of coverage (up to age 26 if unmarried and financially dependent upon you; children less than 6 months limited to $1,000 in coverage). You must be enrolled in order for you to elect coverage for your children.

<table>
<thead>
<tr>
<th>Age</th>
<th>Employee</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>$0.07</td>
<td>$0.07</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.07</td>
<td>$0.07</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.08</td>
<td>$0.08</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.11</td>
<td>$0.11</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.18</td>
<td>$0.18</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.29</td>
<td>$0.29</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.43</td>
<td>$0.43</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.65</td>
<td>$0.65</td>
</tr>
<tr>
<td>60-64</td>
<td>$1.07</td>
<td>$1.07</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.93</td>
<td>$1.93</td>
</tr>
<tr>
<td>70-74</td>
<td>$2.73</td>
<td>$2.73</td>
</tr>
<tr>
<td>75+</td>
<td>$5.89</td>
<td>$5.89</td>
</tr>
</tbody>
</table>

Child Rate $0.10 per $1,000

**Rate Calculation Example**

<table>
<thead>
<tr>
<th>Age</th>
<th>Amount</th>
<th>Unit</th>
<th>Rate</th>
<th>Cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>30 @ $100,000 / 1,000 X $0.080 = $8.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>30 @ $20,000 / 1,000 X $0.080 = $1.60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td>$10,000 / 1,000 X $0.100 = $1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: To determine the biweekly cost, first multiply cost by 12, then divide by 26.

NEW! WHOLE LIFE INSURANCE

Whole Life insurance provides financial support for families after the death of a loved one. Coverage is available for your dependents, even if you don’t elect coverage for yourself. This coverage provides protection for a lifetime, with guaranteed renewal year after year.

Rates will not go up as you age, and coverage is portable, so you can keep it even if you leave Avante, as long as you continue making payments to Unum.

**Benefit Amounts**

- **Associate:** $2,000 - $200,000 in increments of $5,000
- **Spouse:** $2,000 - $50,000 in increments of $5,000
- **Child/grandchild:** $5,000 - $50,000 in increments of $5,000

Talk with a Benefit Counselor to see if this option is right for you. Since rates vary by age and how much coverage you elect, they will be able to provide specific rates for you.

During Open Enrollment, you are guaranteed coverage in the Supplemental Life and Whole Life plans. Don’t miss this special opportunity to enroll!
A disabling injury or illness that keeps you out of work could have a devastating impact on your income, jeopardizing your ability to cover normal household expenses. Nearly 50% of all mortgage foreclosures are the result of a disability. The federal government estimates that 3 out of every 10 American workers will be disabled before reaching retirement age. With the right disability insurance, your income is protected, relieving you of the anxiety of depleting your savings to pay your bills.

**SHORT TERM DISABILITY INSURANCE**

Short term disability insurance replaces a portion of your income if an injury or illness forces you out of work for an extended period of time. Avante offers a voluntary short term disability plan which you can pay for through payroll deductions. After you are out of work for 14 days and declared disabled, you will receive 60% of your base earnings to a maximum of $1,000 for up to 24 weeks.

**Monthly Premium Calculation**
The cost for STD coverage is based on your age and weekly base earnings. See below for an example of the monthly STD cost for an associate age 25 earning $25,000 annually.

<table>
<thead>
<tr>
<th>Calculate 60% of weekly base earnings</th>
<th>Multiply by age-based rate per $10 of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000 ÷ 52 weeks x .60 = $288.46</td>
<td>$288.46 ÷ $10 x .825 = $23.80 per month*</td>
</tr>
</tbody>
</table>

**LONG TERM DISABILITY INSURANCE**

Avante also provides long term disability insurance to protect your finances when your disability continues beyond the period covered by the short term disability plan. This benefit is an optional benefit and you can pay for this benefit through convenient payroll deductions. If you elect long term disability benefits, you are eligible for 60% of your gross monthly income (after 180 consecutive days of disability) to a maximum of $5,000 for up to 5 years if you are disabled prior to age 65 (duration limits apply for disabilities incurred starting at age 65).

**Monthly Premium Calculation**
The cost for LTD coverage is based on your age and monthly gross income. See below for an example of the monthly LTD cost for an associate age 35 earning $36,000 annually.

<table>
<thead>
<tr>
<th>Calculate gross monthly income</th>
<th>Multiply by age-based rate per $100 of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$36,000 ÷ 12 months = $3,000</td>
<td>$3,000 ÷ $100 x .56 = $16.80 per month</td>
</tr>
</tbody>
</table>

*Note: To determine the biweekly cost, first multiply cost by 12, then divide by 26.

**DISABILITY PLAN LIMITATIONS**

**Pre-Existing Conditions**

Please be aware that short term disability has a three month look back and a six month look forward; long term disability has a three month look back and a twelve month look forward.

A pre-existing condition is any sickness or injury for which you or a “prudent person” would have received medical treatment, consultation, care or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to the coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date.

**Benefit Exclusions**

You will not receive benefits in the following circumstances (Additional exclusions may apply. See certificate for details):  
- Your disability is the result of a self-inflicted injury.  
- You are not under the regular care of a doctor when requesting disability benefits.  
- You were involved in a felony, commission or act of war, or participation in a riot.  
- Your disability is covered under a worker’s compensation plan and/or is due to a job-related sickness or injury.  
- You are receiving payment under a salary continuance or retirement plan sponsored by the group policyholder.

*Note: Disability insurance through Unum will end on the date your employment with Avante terminates. Please refer to your certificate of coverage for further details.*

13
Important Notices From Avante

IMPORTANT NOTICE FROM AVANTE GROUP 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 Avante Group and about your options under Medicare’s prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Avante Group has determined that the prescription drug coverage offered by the Avante Group Employee Health Care Plan (“Plan”) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered “creditable” prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began.

For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D’s annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go 63 continuous days or longer without “creditable” prescription drug coverage (that is, prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are “special enrollment periods” that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes “creditable” prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Avante Group Plan’s summary plan description for a summary of the Plan’s prescription drug coverage. If you don’t have a copy, you can get one by contacting us at the telephone number or address listed below.
Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Avante Group Plan due to your employment (or someone else’s employment, such as a spouse or parent), your coverage under the Avante Group Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan’s summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Avante Group prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan’s eligibility and enrollment rules. You should review the Plan’s summary plan description to determine if and when you are allowed to add coverage.

For more information about this notice or your current prescription drug coverage...

Contact the person listed below for further information, or call 215-282-8601. 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 Avante Group changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

• Visit www.medicare.gov.
• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help,
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

AVANTE GROUP IMPORTANT NOTICE

COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

This notice is provided to you on behalf of:
• Avante Group Medical Plan
• Avante Group Dental Plan
• Avante Group Vision Plan
• Avante Group Life & Disability Plan

The Plan’s Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered “Protected Health Information” (“PHI”). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan’s Privacy Official, described below), and will be posted on any website maintained by Avante Group that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan’s uses and disclosures of your PHI.
**Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**

- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it’s important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

- **Payment:** Of course, the Plan’s most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse’s plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Health care Operations:** The Plan may use and disclose your PHI in the course of its “health care operations.” For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

**Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Avante Group) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan’s provision of benefits.

- **To the Plan’s Service Providers:** The Plan may disclose PHI to its service providers (“business associates”) who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.

- **Required by Law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.

- **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.

- **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

- **Relating to Decedents:** The Plan may disclose PHI relating to an individual’s death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
• **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

• **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

• **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

**Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

**Uses and Disclosures Requiring You to have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

**THE AVANTE GROUP IMPORTANT NOTICE. COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES (CONT.)**

**Your Rights Regarding Your Protected Health Information.**

You have the following rights relating to your protected health information:

• **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

• **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

• **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

• **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan’s or vendor’s records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

• **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.
• **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan’s or vendor’s records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

• **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

**How to Complain about the Plan’s Privacy Practices.**
If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

**Notification of a Privacy Breach**
Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.
If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

**Contact Person for Information, or to Submit a Complaint.**
If you have questions about this notice please contact the Plan’s Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan’s privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

**Privacy Official**
The Plan’s Privacy Official, the person responsible for ensuring compliance with this notice, is:
Privacy Officer
Avante Group
Human Resources Department
954-987-7180

**Effective Date.**
The effective date of this notice is: January 1, 2019.
NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan’s eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children’s Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent’s(s’) other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Avante Group Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If your plan designates a primary care provider automatically, until you make this designation, the plan designates one for you. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Avante Group Employee Health Care 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.

WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998 ANNUAL NOTICE

Avante Group Employee Health Care Plan is required by law to provide you with the following notice:

The Women’s Health and Cancer Rights Act of 1998 (“WHCRA”) provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Avante Group Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.
PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. 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

- **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: 1-800-257-8563

- **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

- **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: 1-800-862-4840

- **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://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

Nevada - Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1.800.992.0900

New Hampshire: Medicaid
Website: https://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

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

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: 855-697-4347

South Carolina - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

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

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

West Virginia - Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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 July 31, 2018, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1.877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)
DON’T FORGET! YOU MUST ENROLL WITH A BENEFIT COUNSELOR BY DECEMBER 12

NOTE: This booklet is intended to summarize the benefits you receive from Avante Group. The actual determination of your benefits is based solely on the plan documents provided by the carrier of each plan. This summary is not legally binding, is not a contract, and does not alter any original plan documents. For additional information, please contact the Human Resources department.