ASPIRE
HEALTH PARTNERS

BENEFITS at a GLANCE Handbook

Benefit Year: December 1, 2014 – November 30, 2015

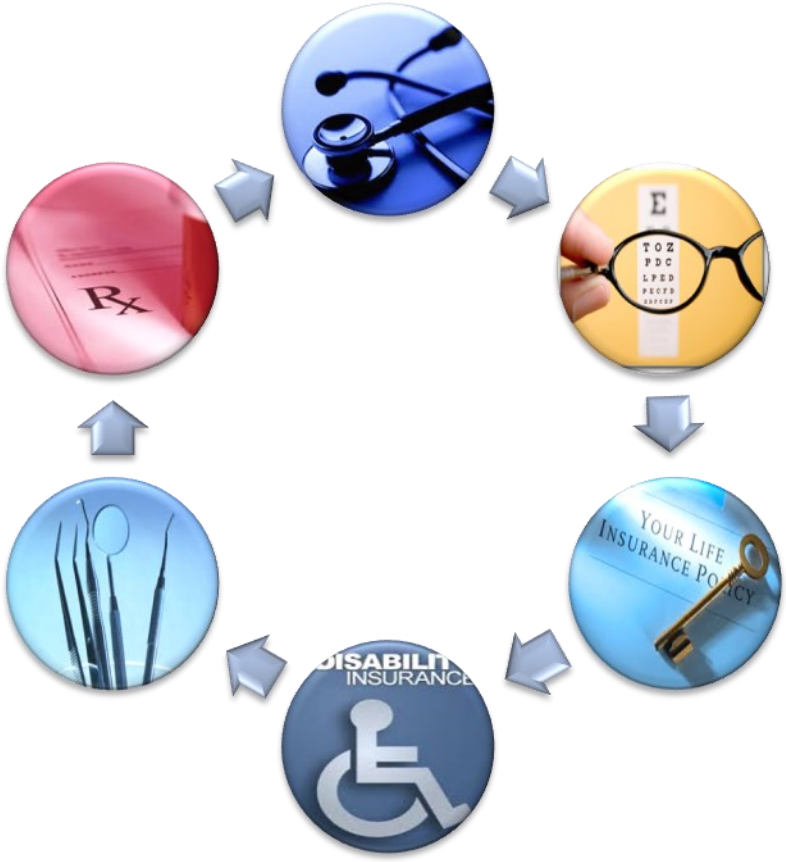

Table of Contents

IMPORTANT NOTE

The Benefits At A Glance Handbook is designed to provide select information on Employee Benefit plans and programs available during the 2014-2015 Plan Year. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs described herein. This booklet does not constitute a Summary Plan Description (SPD) or Plan Document as defined by the Employee Retirement Income Security Act. The Summary Plan Description or Plan Document is available from your Benefits Administrator.

If you are newly eligible and/or electing group life, voluntary life and/or disability coverage for the first time, you are required to be 'Actively at Work' on the day that the coverage commences. 'Actively at Work' is defined as, you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. Please note that Medical, Dental and Vision coverage is not subject to the 'Actively at Work' Provision.

Prepared By:

LassiterWare

i³Risk IDENTIFY · INNOVATE · IMPLEMENT

This is for illustrative purposes only. For a more detailed description of benefits, please refer to your Certificate of Coverage

Tobacco Free Discount

TOBACCO USE SURCHARGE
If you used tobacco products in the preceding 6 months (smoke, chew or any other manner) and are enrolled in *Aspire Health Partners'* medical plan, you will be assessed a tobacco-use surcharge.

Not only are we trying to reduce our escalating insurance costs, but we are also striving for a healthier work force. There is a proven link between smoking and the rising cost of healthcare because smokers / tobacco-users have a higher risk of cancer, stroke, heart disease and chronic obstructive pulmonary disease (COPD) than non-tobacco users. You will be required to complete a Tobacco-Use certification as part of your benefits enrollment.

Aspire Health Partners offers a reasonable opportunity for employees to avoid the smoking premium surcharge upon completion of an approved tobacco cessation program. This applies to covered employees, for whom it is unreasonably difficult because of a medical condition, or for whom it is medically inadvisable to be tobacco-free under our standard. *Aspire Health Partners* has chosen the standards that the tobacco cessation program must meet such as the timeframe, and the manner in which employees must certify their completion of the program. An approved tobacco cessation program may be a certified online program, classroom-based course, or telephonic counseling/support program.

Smoking Premium Surcharge Reasonable Alternative Information
The following information describes *Aspire Health Partners* "reasonable opportunity" for you to avoid the smoking premium surcharge. It is each employee's responsibility to pay for the cost of tobacco cessation.

Step 1: Choose an approved online, classroom-based or telephonic tobacco cessation program. Some resources available to help you locate approved tobacco cessation programs include:

Telephonic Courses: More than 30 states now run tobacco guidelines that are confidential, staffed by trained specialists and free to residents. Some of these helplines provide over-the-counter support products, such as gum or patches, at reduced prices or as part of the program. Courses must consist of at least four telephonic counseling / support sessions to be acceptable. You will have to obtain verification that you completed at least four sessions.

Online Course: Take the online American Lung Association's *Freedom From Smoking* Program (make sure to elect the Premium membership for a nominal fee so you can present a completion certificate.) Go to: www.ffsonline.org A completion certificate will be required as proof of your online course.

Classroom-Based Courses: Approved classroom-based courses are those offered through a hospital, community organizations (such as the American Cancer Society) or your state's Department of Health courses. Courses must consist of at least four classroom-based meetings to be acceptable. You will have to obtain verification that you completed at least four sessions.

The Tobacco Free Florida Website is a great place to start www.tobaccofreeflorida.com

If you do not have access to a computer, you may call 877-822-6669 for your options.

Step 2: Enroll in and complete one of the approved tobacco cessation programs listed above.

Step 3: Obtain a completion certificate from your program and submit to your Human Resources Department

Notices

NOTICE REGARDING THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF '98

Under federal law, group plans providing benefits for a mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications of mastectomy, including lymph edemas, in a manner determined in consultation between the attending physician and the patient.

PORTABILITY OF COVERAGE

The Health Insurance Portability and Accountability Act (HIPAA) of 1997 entitles you to a complete transfer of benefits (no pre-existing condition exclusions) if you change jobs or change health insurance carrier(s). In order to qualify for this transfer of benefits, your previous coverage must not have lapsed for more than 63 days prior to your new date of hire. In order to guarantee the portability of your benefits, you must provide proof of prior coverage to your new employer at the time of application or a certificate of coverage can be sent directly to United Healthcare.

THE NEWBORNS AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NMHPA)

Under Federal law, you and your newborn child are covered for a hospital stay following childbirth. The law applies both to persons enrolled in group health plans and to persons who have individual health care coverage. In general, plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

The Uniformed Services Employment and Reemployment Rights Act (USERRA) prohibits discrimination against anyone for serving in the armed forces or for taking military leave from a civilian job. This includes discrimination in hiring, promotion, reemployment, or any other benefit of employment. USERRA also prohibits retaliation against anyone who seeks to enforce their rights under USERRA or assists another in enforcing those rights.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you are eligible for health coverage but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. 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, you can contact your State Medicaid or CHIP office or dial 1-877-KIDSNOW or go to www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once the State determines that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (PPACA) requires most US Citizens to obtain health insurance beginning January 1, 2014. Individuals who do not obtain health insurance will be subject to a penalty of $95 or 1% of your gross household income (whichever is greater) for each uninsured adult for 2014. The penalty for each uninsured child is equal to half of the adult penalty, not to exceed three times the adult penalty for the calendar year. Penalties will increase in 2015 to $325 or 2% of gross household income (whichever is greater), in 2016 to $695 or 2.5% of gross household income (whichever is greater), and for each year thereafter, it will be increased by the cost-of-living adjustment. The annual penalty will not exceed the national average premium for Bronze coverage in an Exchange. If you choose not to enroll you can go to www.healthcare.gov to review and/or obtain coverage through the federal Marketplace exchange.

Enrollment Information

The guide is to help you make the benefit choices that are right for you. Think carefully about which options best suit your individual needs and budget. The choices that you make cannot be changed until December 1, 2015, unless you experience a qualifying life event that is consistent with the changes you wish to make.

ELIGIBILITY

You are eligible to participate in the benefits program if you are a full time employee and normally work 30 hours per week. Your benefits begin on the first day of the month following 60 days of continuous employment.

If you begin work as a part-time employee and become full time you may participate in the benefits program on the first of the month following 60 days from the date you became full time. If your job status changes from full time to part-time (less than 30 hours per week), your benefits will end. You will be offered an opportunity to continue your medical, vision, FSA and dental benefits at your own expense per Federal COBRA regulations. If an employee returns to their full time status within 90 days of termination, all benefits will be reinstated effective on the full time rehire date.

Dependents are eligible for coverage under the health plans if they are the employee's spouse or domestic partner, or the employee's children including adopted, foster, step-children, or children for whom legal guardianship has been court appointed.

Coverage for the dependent children on the medical, dental and vision plans continues until end of the month in which they turn age 26. Please refer to your certificate of coverage for each benefit's dependent qualification.

A dependent child may also remain covered on the medical plan after their 26th birthday provided the child is incapable of self-sustaining employment by reason of mental or physical handicap. Special approval must be obtained from the insurance carriers.

DOMESTIC PARTNERS

Domestic partners are eligible to be enrolled for benefits. To become covered, you must meet the following qualifications:

- Each party is at least 18 years old and competent to contract
- Neither party is married, nor a partner to another domestic partnership relationship
- Each party is the sole domestic partner of the other person
- Each party is not related to the other by blood
- Both parties consent to the domestic partnership relationship without force, duress or fraud
- Both parties agree to be jointly responsible for each others basic food, shelter, common necessities of life and welfare
- Neither party has been a member of another domestic partnership for the past year
- Each party shares his or her primary residence with the other
- Each party considers himself/herself to be a member of the immediate family of the other partner

Please take note that IRS Section 152 states that employees adding a domestic partner or the child of a domestic –partner who do not meet the IRS Section 152 definition of qualified dependents will have additional taxable income, which needs to be taxed and reported. When an employer provides health insurance coverage for the domestic partner or the dependents of the domestic partner of an employee, federal tax law considers the fair market value of that coverage, including the employee's pre-tax contributions, as "imputed income" to the employee. Additionally, employees cannot use pre-tax dollars to pay for a domestic partner's coverage, precluding them from the full benefits of a Flexible Spending Account, Health Reimbursement Account or Health Savings Account.

Miscellaneous Information

CHANGING YOUR BENEFIT CHOICES

Your benefit choices will stay in effect for a full plan year.

If you have a qualified change in family status, you may be able to change benefit elections. Qualified family status changes include, but are not limited to:

- Marriage or Divorce
- Birth, Adoption or Legal Custody of an eligible dependent
- Death of your spouse or dependent
- A covered Dependent becomes ineligible
- Change from full time to part-time status, or vice versa, by you or your spouse
- Unpaid leave of absence by you or your spouse
- Significant change in your spouse's coverage attributable to employment
- Termination or commencement of spouse's employment

If you experience a qualified family status change and wish to make changes, you must notify Human Resources within 31 days of the change. If you do not notify Human Resources within 31 days of the qualifying event, you must wait until the next annual enrollment period to make any desired changes.

Please keep in mind that documentation may be required.

BENEFIT TERMINATION & THE COBRA CONTINUATION OPTION

Your benefits will term at the end of the month in which you either elect not to participate in the plan, or you cease to be a full-time employee.

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) provides insured employees and their qualified beneficiaries the opportunity to continue health, dental, vision, and flexible spending account coverage when a "qualifying event" would normally result in the loss of coverage eligibility. Common qualifying events include resignation or termination from employment, the death of an employee, a reduction in employee's hours, an employee's divorce, and dependent child no longer meeting eligibility requirements. Under COBRA, the employee or dependent pays the full cost of coverage at the current group rates plus an administrative fee of 2%.

PAYING FOR BENEFITS WHILE ON AN APPROVED FAMILY MEDICAL LEAVE OR A MEDICAL LEAVE RELATED TO A WORKCOMP INJURY

Employees on an approved leave are still responsible for paying the same portion of premiums paid prior to the leave. You may pay your portion of premiums due before starting your leave, or you may pay monthly during your leave. Payment is due on or before the first of the month. Failure to make payments in a timely manner will result in termination of coverage, retroactive to the day your FMLA began. You should contact your Human Resources to make payment arrangements prior to your leave.

Employees on an approved leave can stop health coverage altogether and restart it when returning to work.

PRE-TAX OR AFTER-TAX?

For some benefits, you use pre-tax dollars from your pay. For others, you must use after-tax dollars. When you pay for benefits with pre-tax dollars, money is deducted from your pay before taxes are taken out. In this way, you avoid paying Federal Income and Social Security taxes on what you spend on benefits. With after-tax contributions, just the opposite is true. Premiums are deducted from your pay after Federal and Social Security taxes are calculated and deducted from your gross pay.

A NOTE ABOUT SOCIAL SECURITY

Pre-tax deductions taken from your paycheck lower your taxable income, your Social Security taxes (and, therefore, your future Social Security benefits) may be lower. How you are affected depends on your pay and the amount of pre-tax contributions you make.

The reduction in Social Security benefits, if any, for most employees will be minimal - a few dollars a month. Younger employees who use large amounts of tax-free dollars to pay for benefits over a long period (20 to 30 years) may experience a greater reduction in benefits when they retire. However, for most people, the benefit reduction has been more than offset by the tax savings. For more information, please contact your local Social Security Administration office.

MEDICARE PART D ELIGIBLE INDIVIDUALS

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. This booklet does not constitute disclosure of creditability status. Please contact Human Resources for your personalized disclosure notice regarding the credibility status of your plan.

Medical

DIRECT ACCESS BENEFITS
Referrals are not usually needed for specialist visits, including routine eye exams and gynecological/obstetrical care. However, certain laboratory procedures and X-Ray service care must be pre-certified by your physician prior to the visit

EMERGENCY CARE
Emergency services are covered anytime, anywhere in an out of network. If you need emergency care, here are some basic guidelines:

- Go to the nearest emergency room or call 911. If a delay would not be detrimental to your health, call your doctor first.
- To avoid a long wait in the emergency room, you can visit any **participating urgent care facility** in your area.
- If you're admitted to the hospital, you or a family member should notify your doctor or United Healthcare.

UNITED BEHAVIORAL HEALTH
United Behavioral Health offers confidential, comprehensive services and a wide array of treatment options from acute inpatient care to individual outpatient counseling. When you call United Behavioral Health for assistance, you will speak directly to a mental health professional who can answer questions related to the mental health and substance abuse benefits. United Behavioral Health program specializes in depression, stress & anxiety, child/adolescent issues, phobias, personality disorders, anorexia & bulimia, post traumatic syndrome, alcohol and chemical dependency.

CARE COORDINATION
United Healthcare, is able to identify, quantify and address the fragmentation of care that comprises health outcomes. Their Care Coordination[sm] approach goes beyond traditional medical coverage and preventive services and fill gaps in care. Care Coordination focuses on offering education, accelerating access to care and providing early identification and monitoring of chronic conditions. They are:

- Health education and reminder programs
- Admission counseling
- Inpatient care advocacy
- Welcome Home![sm] (readmission prevention)
- IMPACT[sm] (complex illness support)

PROVIDER DIRECTORIES
To find a participating providers prior to the effective date of your coverage, go to www.uhc.com. Once you are enrolled you can access this information at www.myuhc.com.

MYUHC.COM
MyUHC.com gives you access to tools and information so you may:

- View benefit and claim information
- Find a physician
- Print a temporary ID card
- Request a replacement ID card
- View preferred drug lists and prescription history
- Order prescription and over the counter products through home delivery service
- Set up email reminders for prescription refills

MEMBER SERVICES
Member Service representatives are trained to answer your questions concerning your health plan benefits. Call the toll-free number on your ID card to:

- Ask about your benefits
- Request another ID card

RX HOME DELIVERY
Home delivery saves time and money. Through a partnership with Optum you can have prescriptions medications and other health and beauty products sent right to your home. There is NO added shipping or handling fees for prescriptions.

The following information is provided under your pharmaceutical needs at **www.myuhc.com**:

- View personal benefit coverage information and prescription history
- Search the Preferred Drug List online
- Order Prescription and over the counter drugs for home delivery

myNurseLine[SM]
Reliable health information from registered nurses available 24 hours / 7 days a week by calling 800-846-4678. Receive immediate answers from nurses backed by medical professionals who can help you:

- Understand you current symptoms
- Decide if you should see a doctor or go to the ER
- Find a network doctor or hospital
- Explore treatment options
- Learn more about a diagnosis
- Understand you medications

Medical

GOLD

	Payroll Deductions (26 pay periods)	
Coverage Option	GOLD - Non-Tobacco	GOLD - Tobacco
Employee	$62.40	$65.90
Employee & 1	$210.00	$213.50
Employee & 2+	$240.00	$243.50

***GOLD Coverage Choice** In-Network Only*	**In-Network**	**Out-of-Network**
Lifetime Maximum	Unlimited	
Calendar Year Deductible (CYD)	$575 Individual $1,150 Family	No Coverage
Out of Pocket Maximums **(Includes deductible, coinsurance, co-pays; excludes Rx)**	$2,000 Individual $4,000 Family	No Coverage
Co-Insurance	80% / 20%	No Coverage
Well Child Care /Immunizations	100%	No Coverage
Routine Adult Physicals	100%	No Coverage
Primary Physician Office Visit	$25 Copay	No Coverage
Specialty Care Physician Office Visit	$40 Copay	No Coverage
Emergency Room (Facility)	$200 Copay	$200 Copay
Urgent Care	$50 Copay	No Coverage
In-Patient Hospitalization	CYD then 20%	No Coverage
Out-Patient Hospitalization	CYD then 20%	No Coverage
Laboratory and Radiology Services	Covered at 100%	No Coverage
Advanced Radiological Imaging **(CT Scans, PET Scans, MRI, MRA & Nuclear Medicine)**	CYD then 20%	No Coverage
Chiropractic Care	$40 Copay	No Coverage
In-Patient Mental Health and Substance Abuse (MH/SA) Treatment	CYD then 20%	No Coverage
Office visit Mental Health and Substance Abuse (MH/SA) Treatment	$25 Copay (varies depending on treatment type)	No Coverage
*Prescription Drug Co-Payments (30 day supply) Tier 1 Tier 2 Tier 3 Mail Order Prescription Drug (31-90 day supply)	 $15 Copay $25 Copay $60 Copay $30/$50/$120 Copay	No Coverage

Medical

SILVER

	Payroll Deductions (26 pay periods)	
Coverage Option	SILVER - Non-Tobacco	SILVER - Tobacco
Employee	$41.63	$45.13
Employee & 1	$175.00	$178.50
Employee & 2+	$210.00	$213.50

SILVER Coverage Choice *In-Network Only*	**In-Network**	**Out-of-Network**
Lifetime Maximum	Unlimited	No Coverage
Calendar Year Deductible (CYD)	$1,000 Individual $3,000 Family	No Coverage
Out of Pocket Maximums **(Includes deductible, coinsurance, co-pays; excludes Rx)**	$3,500 Individual $7,000 Family	No Coverage
Co-Insurance	80% / 20%	No Coverage
Well Child Care Exams/ Immunization	100%	No Coverage
Routine Adult Physical Exams	100%	No Coverage
Primary Physician Office Visit	$25 Copay	No Coverage
Specialty Physician Office Visit	$50 Copay	No Coverage
Emergency Room Co-Payment (Facility)	$200 Copay	$200 Copay
Urgent Care	$75 Copay	No Coverage
In-Patient Hospitalization	CYD then 20%	No Coverage
Out-Patient Hospitalization	CYD then 20%	No Coverage
Laboratory and Radiology Services Co-Payment	Covered at 100%	No Coverage
Advanced Radiological Imaging Co-Payment **(CT Scans, PET Scans, MRI, MRA & Nuclear Medicine)**	CYD then 20%	No Coverage
Chiropractic Care Co-Payment	$50 Copay	No Coverage
In-Patient Mental Health and Substance Abuse (MH/SA) Treatment	CYD then 20%	No Coverage
Office visit Mental Health and Substance Abuse (MH/SA) Treatment	$25 Copay (varies depending on treatment type)	No Coverage
*Prescription Drug Co-Payments (30 day supply) Tier 1 Tier 2 Tier 3 Mail Order Prescription Drug (31-90 day supply)	 $30 Copay $50 Copay $100 Copay $60/$100/$200 Copay	No Coverage

This is for illustrative purposes only. For a more detailed description of benefits, please refer to your Certificate of Coverage

Medical

BRONZE

	Payroll Deductions (26 pay periods)	
Coverage Option	BRONZE - Non-Tobacco	BRONZE - Tobacco
Employee	$7.88	$11.38
Employee & 1	$110.00	$113.50
Employee & 2+	$150.00	$153.50

BRONZE Choice Plus Coverage *HSA*	**In-Network**	**Out-of-Network**
Lifetime Maximum	Unlimited	
Calendar Year Deductible (CYD)	$2,000 Individual $4,000 Family*	$4,000 Individual $8,000 Family
Out of Pocket Maximums **(Includes deductible, coinsurance, co-pays; excludes Rx)**	$4,000 Individual $8,000 Family*	$9,000 Individual $18,000 Family
Co-Insurance	80% / 20%	60% / 40%
Well Child Care Exams/ Immunization	100%	No Coverage
Routine Adult Physical Exams (PCP/Specialist)	100%	No Coverage
Primary Physician Office Visit	CYD then 20%	CYD then 40% of Eligible Expenses
Specialty Care Physician Office Visit	CYD then 20%	CYD then 40% of Eligible Expenses
Emergency Room (Facility)	CYD then 20%	CYD then 20% of Eligible Expenses
Urgent Care	CYD then 20%	CYD then 20% of Eligible Expenses
In-Patient Hospitalization	CYD then 20%	CYD then 40% of Eligible Expenses
Out-Patient Hospitalization	CYD then 20%	CYD then 40% of Eligible Expenses
Laboratory and Radiology Services	Preventive Covered at 100%	CYD then 40% of Eligible Expenses
Advanced Radiological Imaging **(CT Scans, PET Scans, MRI, MRA & Nuclear Medicine)**	CYD then 20%	CYD then 40% of Eligible Expenses
Chiropractic Care	CYD then 20%	CYD then 40% of Eligible Expenses
In-Patient Mental Health and Substance Abuse (MH/SA) Treatment	CYD then 20%	CYD then 40% of Eligible Expenses
Office visit Mental Health and Substance Abuse (MH/SA) Treatment	CYD then 20%	CYD then 40% of Eligible Expenses
*Prescription Drug Co-Payments (30 day supply) Tier 1 Tier 2 Tier 3 Mail Order Prescription Drug (31-90 day supply)	*CYD then: $10 Copay $30 Copay $50 Copay $20/$60/$100 Copay	No Coverage

FAMILY DEDUCTIBLE MUST BE MET BEFORE CO-INSURANCE APPLIES

Health Savings Account (HSA)

A Health Savings Account (HSA) is a tax-preferred account that may be opened by individuals covered by a Qualified High Deductible Health Plan (HDHP). If you are enrolled in Bronze plan, and are otherwise qualified, you have the option of opening an HSA.

HOW AN HSA WORKS

Part 1: Qualifying High Deductible Health Insurance Plan

Intended to cover serious illness or injury after the deductible has been met.

Part 2: Health Savings Account (HSA)

Pays for out-of-pocket expenses incurred before the deductible is met.

1. Employee enrolls in a Qualified High Deductible Health Plan (HDHP).
2. Employee opens an HSA (encouraged, but not required) and provides account information to Human Resources.
3. Employee makes deposits to their HSA account through pre-tax payroll deductions (encouraged, but not required).
4. Employee or covered Dependent seeks medical services.
5. Medical services are covered by the HDHP, subject to a deductible and coinsurance.
6. Employee may use their HSA account to pay for qualified medical expenses, including those applied to their deductible and coinsurance.

- The Deductible is waived for Preventive care. Refer to the Benefit Summary for additional information.
- Employees may also make deposits directly to their HSA account without going through payroll.

WHY OPEN A HEALTH SAVINGS ACCOUNT

An HSA can be used to accumulate funds on a tax-free basis to pay for qualified health care expenses, as defined by the Internal Revenue Service (IRS). The account acts like a regular bank account with a debit card and/or checkbook, and accrues interest. **Depositing funds in your HSA through payroll deductions can help you be prepared for expenses that you incur before your deductible is met.** The account is owned by you and funds can accumulate over time. The account is portable among employers.

WHO CAN OPEN A HEALTH SAVINGS ACCOUNT

The IRS has established guidelines on individuals qualified to open an HSA. You must be:

- Covered by a Qualified High Deductible Health Plan, and
- Not covered by any other plan that is not a Qualified High Deductible Health Plan
- Not enrolled in Medicare or Medicaid
- Not eligible to be claimed as a dependent on another's tax return
- Not covered under an unlimited FSA or HRA

PERMISSIBLE INSURANCE WITH A HSA

Coverage under certain types of insurance policies will not affect your ability to open an HSA. Permissible insurances include:

- Workers Compensation
- Disability insurance
- Dental insurance
- Vision insurance
- Specific Disease policies (Accident, Cancer, etc.)
- Long Term Care insurance

MAXIMUM CONTRIBUTION LIMITS

The maximum amount that can be deposited, from all sources, into the HSA each calendar year is established by the IRS and whether you have employee only coverage or family coverage. HSA contributions are separate from, and in addition to, the premium you pay for your Qualified High Deductible Health Plan. HSA contributions may be made through payroll deductions on a pre-tax basis, or you can make contributions directly to your HSA. You may contribute any amount up to the maximums shown below. Individuals age 55 and older can make "Catch-Up Contributions" in addition to the maximum annual contribution limits.

	2015
Employee Only Coverage	$ 3,350
Family Coverage	$ 6,550
Catch Up Contributions	$ 1,000

HSA FREQUENTLY ASKED QUESTIONS

What is a qualified High Deductible Health Plan?
The IRS has established guidelines on the minimum in-network deductibles and out-of-pocket maximums for qualified plans. The plan must also require that the deductible apply to all services, including prescriptions. The only exception is that the plan may pay for preventive care without having to meet the deductible. The United Healthcare plans are qualified High Deductible Health Plans.

What happens to the money in my HSA at the end of the year?
The funds remain in your account, continue to earn interest, and are available to pay for qualified expenses tax free in the future.

What happens if I go over the maximum contribution?
If your deposits (including contributions from all sources) exceed the maximum contribution limit you will be required to pay income tax and penalty tax on the excess amount. This is also the case if you do not remain covered for the entire testing period and your contributions exceed the pro-rated contribution limit. Excess contributions can be withdrawn without tax penalties if the withdraw is completed prior to your tax filing deadline. Contact your HSA trustee and/or your tax advisor for assistance.

What happens to the money in my HSA if I decide next year to go back to a non-qualified plan?
The money is yours to keep. You can no longer deposit additional money into the account if you are not HSA eligible, but you can continue to use the funds tax-free to pay for qualified expenses or you can let the funds stay there and accumulate interest.

What happens to the money in my HSA if I leave my current employer?
The money in the HSA is yours to keep. If you remain HSA eligible, you can continue to make contributions directly to your HSA. If you do not remain HSA eligible, you can no longer deposit additional money into the account, but you can continue to use the funds tax-free to pay for qualified expenses or you can let the funds stay there and accumulate interest.

Can my spouse have an HSA?
Yes, provided he/she is covered under a qualified High Deductible Health Plan. If both spouses have HSA's, the maximum family contribution as defined by the IRS each year is divided equally between them unless both spouses agree on a different division. If both spouses are 55 or over, they can both make "Catch-Up Contributions" in addition to the family maximum.

Can I use my HSA to pay for my family's qualified expenses if they are not covered under my health plan?
Yes, as long as the expense is not reimbursed by another health plan, you may use your HSA to pay for qualified expenses incurred by you, your spouse, and your dependent children., even if they are not covered on the qualified health plan.

What happens if I don't have enough money in my HSA to cover the charge?
You will need to pay the provider from another source. You can later reimburse yourself when the funds are available in your HSA, if you choose to do so. Remember to keep all receipts to show that the funds were withdrawn for a qualified expense.

If I use all the money in my HSA early in the year can I put more in?
You can not exceed the maximum contribution limits for the calendar year, even if some of that money was taken out to pay for qualified expenses. You will be able to deposit additional funds in the next calendar year, if you remain HSA eligible.

Can I use my HSA to pay for my dental and expenses?
Yes, as long as the expense was not reimbursed by another plan. However, dental expenses will not help you meet the deductible on your health plan.

Why should I choose an HSA?
1. Cost Savings
   - Reduction in medical plan premium (payroll deduction)
   - Tax benefits
     - HSA contributions are excluded from federal income tax
     - Withdrawals for eligible expenses are exempt from federal income tax
   - Unused money is held in an interest-bearing account
2. Long-term financial benefits
   - Save for future medical expenses
   - Unused funds roll over year to year
   - This is your account, you take it with you
3. Choice
   - You control and manage your health care expenses.
   - You choose whether to use your HSA dollars to pay your health care expenses or to save them for future use.

Dental

Coverage Option	Payroll Deduction (26 pay periods) Dental PPO Plan	DMO Plan
Employee	$13.72	$6.93
Employee & 1	$26.85	$12.15
Employee & 2+	$45.37	$18.02

Benefit Description	PPO		DMO (Co-Payment Schedules)
	In-Network	Out-of Network	In-Network Only
	YOU PAY	YOU PAY	YOU PAY
Preventive Services • Cleanings, oral exams	0% Deductible Waived	0% Deductible Waived	See schedule of benefits (see next page)
Basic Services • Oral Surgery-Simple extractions, fillings • Periodontics	Deductible then 20%	Deductible then 20% of eligible expenses	See schedule of benefits (see next page)
Major Services • Crowns, Dentures, Bridges	Deductible then 50%	Deductible then 50% of eligible expenses	See schedule of benefits (see next page)
Orthodontic Services	50% **Child to Age 19 Only** $1,000 Lifetime Maximum	50%	See schedule of benefits, Adult and Child Ortho is covered
Calendar Year Maximum	$1,500 Per Person		No Annual Maximum
Calendar Year Deductible • Per Person • Per Family	$50 $150	$50 $150	No Deductible

WWW.MYUHCDENTAL.COM
You can access your dental plan 24 hours a day, 7 days a week at www.myuhcdental.com. Once registered you can search for a participating dentist, review your claims, view your remaining Calendar Year Benefit, and much more!

LATE ENTRANT PENALTIES
If you decline this coverage now, and choose to enroll later, you may be subject to late entrant penalties. Late Entrant penalties may be waived during Open Enrollment.

PRE-DETERMINATION REVIEW
When the expected cost of a proposed course of treatment is $200 or more, United Healthcare will review the treatment plan and let your dentist know what benefits could be payable. Simply ask your dentist to fax your treatment plan to United Healthcare and request a Pre-Determination Review prior to receiving care.

SPECIAL LIMITATION
Teeth lost or missing before a covered person becomes insured by this plan. The plan won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan.

Dental

(DMO Sample Fee Schedule)

APPOINTMENTS

Periodic oral evaluation, established patient	No charge
Limited oral evaluation - problem focused	No charge
Comprehensive oral evaluation - new or established patient	No charge
Detailed and extensive oral evaluation - problem focused	No charge
Re-evaluation - limited, problem focused	No charge
Comprehensive periodontal evaluation - new or established patient	No charge
Palliative (emergency) treatment of dental pain	No charge
Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	25.00
Office visit for observation/OSHA	No charge
Office visit - after regularly scheduled hours	25.00

PREVENTIVE DENTISTRY

Routine prophylaxis-adult (once every 6 months)	No charge
Additional routine prophylaxis - adult	15.00
Routine prophylaxis - children under the age of 16 (once every 6 months)	No charge
Additional routine prophylaxis - children under the age of 16)	15.00
Topical application of fluoride (excluding prophylaxis) children under the age of 16	No charge
Topical application of fluoride (excluding prophylaxis) adult	5.00
Nutritional counseling for control of dental disease	No charge
Tobacco counseling for the control & prevention of oral disease	No charge
Oral hygiene instructions	No charge
Application of sealant per tooth - children under the age of 16	No charge

ORTHODONTIA

Pre-orthodontic treatment visit	35.00
Orthodontic treatment plan & records	250.00
Limited orthodontic treatment of the transitional dentition (up to 24 months)	1,000.00
Limited orthodontic treatment of the adolescent dentition (up to 24 months)	1,000.00
Limited orthodontic treatment of the adult dentition (up to 24 months)	1,350.00
Comprehensive orthodontic treatment of the transitional dentition (full treatment case up to 24 months - including fixed/removable appliances)	1,800.00
Comprehensive orthodontic treatment of the adolescent dentition (full treatment case up to 24 months - including fixed/removable appliances)	1,850.00
Comprehensive orthodontic treatment of the adult dentition (full treatment case up to 24 months - including fixed/removable appliances)	1,950.00
Orthodontic retention (removal of appliances, construction and placement of retainer(s) - includes fee for fixed/removable retainers and monthly visits)	300.00

RADIOGRAPHY / DIAGNOSTIC DENTISTRY

*X-Ray - intraoral - complete series (including bitewings)	No charge
X-Ray - intraoral - periapical first film	4.00
X-Ray - intraoral - periapical each additional film	2.00
X-Ray - intraoral - occlusal film	No charge
X-Ray - extraoral - first film	No charge
X-Ray - extraoral - each additional film	No charge
*X-Ray - bitewing - single film	No charge
*X-Ray - bitewing - two films	No charge
*X-Ray - bitewing - four films	No charge
*Vertical bitewings - 7 to 8 films	20.00

Not to be taken if D0274 was done within prior six months. Copies of X-rays can be obtained for $2.00 per periapical film up to a maximum of $30.00. Panoramic X-rays can be obtained for a $15.00 fee.

Posterior-anterior or lateral skull and facial bone survey	150.00
Sialography	150.00
TMJ, including injection	250.00

ORAL SURGERY

Coronal remnants - deciduous tooth	45.00
Extraction of erupted tooth or exposed root	10.00
Surgical removal of erupted tooth	25.00
Removal of impacted tooth - soft tissue	40.00
Removal of impacted tooth - partially bony	55.00
Removal of impacted tooth - completely bony	63.00
Removal of impacted tooth - completely bony, with unusual surgical complications	100.00
Surgical removal of residual tooth roots	25.00

MISCELLANEOUS SERVICES

Local anesthesia	No charge
General anesthesia - first 30 minutes	125.00
General anesthesia - each additional 15 minutes	15.00
Analgesia nitrous oxide - per 1/2 hour	20.00
Intravenous sedation/analgesia - first 30 minutes	125.00
Intravenous conscious sedation/analgesia - each additional 15 minutes	55.00
Oral irrigation/other drugs/medicament - per quad	15.00
Application of desensitizing medicament	20.00
Occlusal guard	250.00
Occlusal analysis - mounted case	75.00
Occlusal adjustment - limited	25.00
Occlusal adjustment - complete	75.00
External bleaching - per arch	150.00
External bleaching - both arches (excluding bleaching material for home use)	275.00

Vision

Payroll Deduction (26 pay periods)	
Coverage Option	
Employee	$2.63
Employee & 1	$4.79
Employee & 2+	$8.30

SUMMARY OF BENEFITS

Eye Examination	In-Network	Out-of-Network
Co-Payment	$10	No Coverage
Frequency	Every 12 months	No Coverage
Frames	In-Network	Out-of-Network
Coverage	$25 Co-Payment $130 retail allowance	$61 retail allowance
Frequency	Every 24 months	Every 24 months
Lenses	In-Network	Out-of-Network
Coverage	$25 Co-Payment then Covered in Full – plastic or glass lenses	Allowance $40 Single Lens $60 Bifocal Lens $80 Trifocal Lens $80 Lenticular Lens
Frequency	Every 12 months	Every 12 months
Contacts	In-Network	Out-of-Network
Coverage	$25 Co-Payment $125 retail allowance if Elective Covered in Full if Therapeutic	$125 retail allowance if Elective $210 retail allowance if Therapeutic
Frequency	Every 12 Months in lieu of glasses	Every 12 Months in lieu of glasses

Vision Coverage is available through United Healthcare. Please register at myuhcvision.com to print your Vision ID card.

Life Insurance

BASIC LIFE COVERAGE
Aspire Health Partners provides all full time employees (**at no cost to you)** with basic life insurance coverage equal to one times your annual salary up to $300,000. Lincoln Financial is the carrier for your basic life benefit.

VOLUNTARY LIFE
Full time employees may purchase additional voluntary life insurance for themselves and their dependents.

AGE REDUCTION
(Applies to Basic & Voluntary Life)
At age 70, the benefit amount will be reduced by 40% and at age 75 the benefit amount will be reduced by an additional 10%. Benefits will terminate upon retirement.

CONVERSION POLICY
(Applies to Basic & Voluntary Life)
Allows a covered person whose life insurance coverage ends to obtain an individual policy at his/her expense, without providing evidence of insurability. A covered person may convert all or part of the coverage. The premiums will be based on the amount of coverage and the covered person's age and class of risk at the time of conversion (Subject to state requirements).

PORTABILITY COVERAGE
(*Applies to Voluntary Life ONLY)*
This feature allows a covered employee, whose optional life coverage ceases, the right to continue all or a portion of his/her optional life benefit. A covered employee may make a written request to continue his or her benefits during the Request Period, which is 31 days after coverage ceases.

GUARANTEE ISSUE
If you are enrolling during your initial eligibility period Medical Underwriting is required for amounts over the guarantee issue.
- Employee: $250,000 under age 70
- Spouse: $30,000 for your spouse.
- Children: $10,000 from 6 months to age 19
    - Dependent children up to age 25 if unmarried and a full time student

You must complete an Evidence of Insurability form for submission to be approved in the following circumstances:
A) If you are electing coverage for yourself or your spouse over the guarantee issue amounts.

PLEASE NOTE THAT YOU MUST BE APPROVED FOR COVERAGE BEFORE YOUR PAYROLL DEDUCTIONS WILL BEGIN. You can obtain an Evidence of Insurability Form by contacting Human Resources.

COVERAGE CHOICES

	Employee	Spouse	Child (ren)
Increments	1, 2, 3, 4, 5x Salary	$1,000	$10,000
Minimum Amount	$10,000	$5,000	$10,000
Maximum Amount	5x annual salary (rounded to the nearest $1,000) or $500,000, whichever is lower	50% of Employee amount (rounded down to the nearest $1,000) or $100,000, whichever is lower	$10,000
Guarantee Issue Amount	$250,000 under age 70	$30,000 under age 60	$10,000

To Calculate Payroll Deduction:
1) Determine if you want to elect 1, 2, 3, 4 or 5 x your salary
2) Round up to the next $1,000
3) Divide the amount you elect by 1,000
4) Multiply the amount in # 2 times the corresponding rate in the table

Example: John is 42, his salary is $40,000. He elects the amount of $80,000:
1) $80,000
2) $80,000 / 1,000 = 80
3) 80 x 0.069 = $5.52 = *payroll deduction*

Age Spouse Rate is determined by using Employee's Age	Payroll Deduction Rates Per $1,000 of Coverage
Under 30	0.028
30-34	0.028
35-39	0.042
40-44	0.069
45-49	0.106
50-54	0.203
55-59	0.318
60-64	0.346
65-69	0.637
70+	1.306
All Children (over 6 months of age to age 19 or 25 if full time student)	0.92/ $10,000

Short-Term Disability

Disability coverage is designed to replace a portion of your income should you become unable to work due to a non-work related accident or illness. Please refer to your summaries for additional details, including limitations and exclusions.

ELIMINATION PERIOD:
Benefits begin on the 8th day after a non work related injury or illness.

INCOME BENEFIT:
66.67% of your income to a maximum of $1,000 per week if you are unable to work due to an injury or illness.

DURATION:
You may receive benefits for up to 13 week if you continue to be disabled and are unable to work.

PRE-EXISTING CONDITIONS:
If you have been treated for a condition in the 3 months prior to the effective date, **that** condition will not be covered for the first 6 months of coverage.

EVIDENCE OF GOOD HEALTH
If you are enrolling during an annual open enrollment period and previously waived this coverage you must first complete an Evidence of Insurability Form prior to benefits being approved. Coverage and/or Payroll Deductions will not begin until this approval process is complete.

HOW TO CALCULATE YOUR PAYROLL DEDUCTION
The cost for the voluntary short term disability plan is based upon your weekly benefit. If you would like to calculate your payroll deduction, please follow the formula outlined below. The amount is based on your weekly rate excluding overtime compensation.

APPROXIMATE BIWEEKLY PAYROLL DEDUCTION COSTS FOR VOLUNTARY SHORT TERM DISABILITY
(Use this chart to determine the approximate payroll deductions)

Weekly Earnings	STD Weekly Benefit	Rate $0.83
$200	$133	$5.11
$250	$167	$6.38
$300	$200	$7.66
$350	$233	$8.94
$400	$267	$10.22
$450	$300	$11.49
$500	$333	$12.77
$550	$367	$14.05
$600	$400	$15.32
$650	$433	$16.60
$700	$467	$17.88
$750	$500	$19.15
$800	$533	$20.43
$850	$567	$21.71
$900	$600	$22.99
$950	$633	$24.26
$1,000	$667	$25.54
$1,050	$700	$26.82
$1,100	$733	$28.09
$1,200	$800	$30.65
$1,250	$833	$31.92
$1,300	$867	$33.20
$1,350	$900	$34.48
$1,400	$933	$35.76

HOW TO CALCULATE VOLUNTARY STD PAYROLL DEDUCTIONS

Base Annual Income	Weekly Income	STD Weekly Benefit	Per $10 Increment	Multiply by Rate	Payroll Deduction
$24,000	(÷) Divide by 52 $461.54	(x) Multiply by 0.6667 $307.71	(÷) Divide by $10 $30.77	(x) Multiply by 0.83 $25.54	(x) Multiply by 12 and divide by 26 $11.79

Long-Term Disability

Disability coverage is designed to replace a portion of your income should you become unable to work due to a non-work related accident or illness. Please refer to your summaries for additional details, including limitations and exclusions.

ELIMINATION PERIOD:
Benefits begin on the 91st day after a non work related injury or illness.

INCOME BENEFIT:
60% of your income to a maximum of $6,000 per month if you are unable to work due to injury or illness.

DURATION:
Benefits are payable to your normal social security retirement age if you continue to be disabled and unable to work.

PRE-EXISTING CONDITIONS:
If you have been treated for a condition in the 3 months prior to the effective date, **that** condition will not be covered for the first 6 months of coverage.

EVIDENCE OF GOOD HEALTH
If you are enrolling during an annual open enrollment period and previously waived this coverage you must first complete an Evidence of Insurability Form prior to benefits being approved. Coverage and/or Payroll Deductions will not begin until this approval process is complete.

EVIDENCE OF GOOD HEALTH
If you are enrolling for the first time and still within your initial eligibility period, you will not be required to complete an Evidence of Insurability Form. If you are enrolling during an annual open enrollment period and previously waived this coverage you must first complete an Evidence of Insurability Form prior to benefits being approved. Coverage and/or Payroll Deductions will not begin until this approval process is complete.

Please note that you do not have to enroll in both Short Term Disability and Long Term Disability. You may choose both plans or just one of the plans.

HOW TO CALCULATE LTD PAYROLL DEDUCTIONS
(determine the approximate payroll deductions)

Annual Income	Monthly Income	Per $100 Increment	Multiply by Rate 0.93	Convert monthly deduction to 26 Pay Periods
$24,000	(÷) Divide by 12 $2,000	(÷) Divide by $100 $20.00	(x) Multiply by 0.93 $18.60	(x) Multiply by 12 months and (÷) divide by the 26 pay periods $8.58

Flexible Spending Account

FLEX SPENDING ACCOUNTS
JANUARY 1, 2015 TO DECEMBER 31, 2015

Employees have a choice of two FSA plans, which create an opportunity to save on taxes. Money is deducted from you pay and contributed to the accounts on a pre-tax basis so that taxes aren't paid on eligible expenses.

HEALTHCARE ACCOUNT
Allows you to reimburse yourself with pre-tax dollars, from a minimum of $300 up to $2,500 in eligible expenses not reimbursed under any healthcare plan.

HOW IT WORKS

- During the enrollment period, you decide how much you want to contribute to each account.
- Each pay period, the appropriate amount is deducted (before taxes) and contributed to your account.
- When incurring an eligible expense you may either pay for the services at that time and then submit the expense for reimbursement **or** use the debit MasterCard.
- If you do not use your debit card, you must submit a claim form to in order to be reimbursed. You must attach either a copy of your Explanation of Benefits or a paid receipt.

You have three months after the end of the plan year to submit claims incurred during the previous year. Claims incurred during one plan year cannot be submitted for reimbursement from contributions made to your account during any other plan year.

CARRYOVER PROVISION
Amounts allocated to the Health FSA that are unused at the end of the Plan Year (determined as of the last day of the Run -Out Period for that Plan Year) up to a maximum of $500 may be used to reimburse Eligible Medical Expenses incurred in the current Plan Year.

ELIGIBLE HEALTHCARE EXPENSES
The general rule is that any medical expense that is deductible on your federal income tax return may be reimbursed through the healthcare flex spending account.

HOW THE FLEX ACCOUNT WORKS WITH THE HSA ACCOUNT (Limited Flex Account)
You may continue to use your debit MasterCard to pay for unreimbursed expenses on anything other than medical expenses. You must use the funds in your HSA account to cover any out of pocket expenses you incur as a result of obtaining medical care. Out of pocket expenses for things like dental work and eyeglasses would still be covered under the debt MasterCard.

EXAMPLES OF ELIGIBLE EXPENSES		
• Alcoholism treatment • Artificial limbs • Car control for the handicapped • Chiropractor fees • Christian Science practitioner fees • Contact Lenses • Crutches • Dental fees • Doctor fees • Eyeglasses • Guide Dog	• Hearing Aids • Hospital Services • In vitro fertilization • Lab fees • Learning disability tuition, if referred by a physician • Nursing services • Optometrist fees • Orthopedics shoes • Oxygen • Orthodontics	• Psychoanalysis • Special school for the handicapped • Sterilization • Surgery • Telephones for the deaf • Therapy (medical) • Transplants of organs • Transportation for medical care • Wheelchairs • X-rays
EXAMPLES OF INELIGIBLE HEALTHCARE EXPENSES		
• Health Clubs, spas, and non prescribed weight loss program • Expenses covered by another plan	• Smoking cessation education materials and programs • Hair transplants • Over the counter medications	• Electrolysis • Teeth Whitening • Cosmetic Surgery unless medically necessary

You are responsible to provide receipts, if requested for all transactions processed by the Debit Card.

FSA (cont.) & Direct Deposit

DEPENDENT CARE ACCOUNT
Allows you to reimburse yourself with pre-tax dollars for day-care expenses for your children under age 13 and other qualified dependents. You may contribute from a minimum of $300 up to $5,000 a year.

MONEY LEFT IN THE ACCOUNT AFTER TERMINATION OF EMPLOYMENT
If you have unused money in your account and you terminate your employment, you must elect to continue the plan through the COBRA program in order to have access to the unused healthcare account funds.

EASY BALANCE ACCESS
An automated voice response system designed to provide parti cipants of the Flexible Spending Account (FSA) and Dependent Care Assistance (DCAP) easy access to their account balance. You may call Medcom's regular number 800-523-7542 and continue to "press 1" until you enter the Easy Balance System which is available around the clock 24/7. Participants only need to enter their MasterCard debit number, type of plan (FSA or DCAP), and zip code for primary card holder.

Eligible Day Care Expenses	
• Childcare/Adult Care by a licensed childcare facility for children under age 13 who qualify as dependents on your federal income tax return • Childcare/Adult Care for children or adult of any age who are physically or mentally unable to care for themselves and who qualify as dependents.	
Ineligible Day Care Expenses	
• Child support payments • Food, clothing and entertainment • Educational supplies and activity fees	• Cleaning and cooking services not provided by the day care provider • Overnight camp

DIRECT DEPOST & PAY CARDS
Aspire requires direct deposit, which means the electronic deposit of your paycheck to a bank account or other account. For employees with or without existing bank accounts, a paycard is an alternative to using a bank account. Aspire has teamed with two banks to offer a safe and convenient alternative to paper payroll checks.

FAQs
How does the Paycard VISA work?
Your net pay is automatically deposited to your paycard every payday. You no longer have to come in person to Human Resources to pick up a paper check. The paycard is a Visa prepaid card that will allow you to withdraw your money from the bank, or use it for purchases at grocery stores, restaurants, online, and other places you find the Visa logo.

When you pick up your first paycard, you will also get instructions for using the card and a schedule of fees. You will need to call and activate your card before using it for the first time. You will be asked to confirm personal information to ensure you are truly the cardholder. If you do not activate the card, you will not be able to use it.

How does the paycard benefit me?
Having a paycard means no check-cashing fees, no more worry about how you will pick up your paycheck in the rain or if you are on vacation, and you have instant access to your money on payday instead of waiting for a paper check to be deposited to your account! All of your pay stub information can be viewed on the employee portal.

How much does it cost?
Your paycard is free for most transactions. There are no monthly charges and you are only charged a fee if you exceed the free transaction limits. The schedule of fees will be provided when you receive your paycard.

More information on Direct Deposit and Paycards can be obtained from your HR or PR office.

Retirement Plan

403(b) RETIREMENT PLAN

Providing a retirement plan that lets you save for the future is important to us. To better serve all of our Aspire employees and offer the best possible services and benefits we have teamed up with Transamerica Retirement Solutions.

WHAT YOU NEED TO DO:

Step 1: Review the highlights of the Aspire Health Partners Retirement Plan. You can find them along with other valuable information in the enrollment book located under the plan information tab at aspire2retire.trsretire.com.

Step 2: Join the plan by visiting aspire2retire.trsretire.com and selecting "New user? Get started now." Establish a customer ID and password.

Step 3: You may choose to make pretax contributions up to the maximum allowed by law. Transamerica Retirement Solution's free auto-increase service allows you to raise your plan contribution rate once a year by an amount you choose. You can sign up for the auto-increase service online at aspire2retire.trsretire.com.

You may designate your contributions as traditional pretax contributions, after-tax Roth contributions, or a combination of both.

You should evaluate your ability to continue the auto-increase service in the event of a prolonged market decline, unexpected expenses, or an unforeseeable emergency.

Step 4: Contribute enough to take full advantage of your employer's total contribution.

Aspire Health Partners provides a plan contribution of 2% of compensation. You will receive the 2% plan contribution regardless of whether you elect to defer into the plan or not. You will begin receiving this contribution once you have completed one year and 1,000 hours of service.

After one year and 1,000 hours of service, you are also eligible to take advantage of your employer's matching contribution which is based on your level of contribution:

- **4% Employee Contribution (payroll deduction)**
  2% (50% match on Employee's 4%)
  \+ 2% Employer Contribution
  4% total Employer Contribution

- **8% Employee Contribution (payroll deduction)**
  4% (50% match on Employee's 8%)
  \+ 2% Employer Contribution
  6% total Employer Contribution

Employer contributions will begin on either January 1 or July 1 -whichever date occurs first after you meet eligibility. You will be 100% vested (all employer contributions belong to you) once you have completed three years of service with any Aspire Health Partners affiliate.

Matching contributions are subject to plan vesting requirements.

Step 5: Decide how your contributions will be invested among the available investment options.

Designating a beneficiary: Designate at least one beneficiary for your retirement account, so that your assets can be distributed according to your wishes upon your death. You can find the Beneficiary Designation form under the plan information tab at aspire2retire.trsretire.com.

.

Paid Time Off

WHAT IS PAID TIME OFF?

To reward employees for loyal and continuous service, Aspire Health Partners provides a pre-determined number of paid days off to observe such occasions as vacations, illness, medical appointments, personal business or leave of absence.

The Paid Time Off (PTO) program gives you flexibility in taking paid time off from work. Time away from work will make you more productive when you are working. Under the PTO program, you decide, with your supervisor's approval at least two weeks in advance, when and how you will use your PTO hours.

HERE'S HOW IT WORKS

Time off for vacation, personal business, or personal and family illness is taken utilizing PTO hours. You need to schedule your time off at least two weeks in advance to allow more efficient staffing throughout Aspire Health Partners.

ELIGIBILITY

If you are classified as a Full-Time (30+ hours) employee you are eligible to accrue PTO based upon length of service to the organization. A staff member is not eligible to use PTO hours for the first 90 days of employment. You may schedule time off based on your available hours. Under no circumstances will you be able to borrow against PTO hours to be earned in the future, or paid in advance of the regular payday for PTO hours.

PAYMENT METHOD

PTO hours are paid at your base hourly rate of pay in effect at the time you use the hours.

PERIOD OF ACCRUAL

You accrue hours each pay period to a maximum amount of 320. When your accrued hours fall below 320, you will start accruing again. The CSD (normally your date of hire) will change if your status changes from a regular to a non-benefit eligible position or vice versa.

ACCRUAL AMOUNTS

The chart at the bottom of the page details the maximum number of hours you accrue in the PTO plan. The maximums are based on a 80 hours per pay period.

SCHEDULED TIME OFF

Earned PTO hours will be used for personal business any time during the year, provided such time off has management's approval. Jury duty and bereavement times are covered under separate policies and do not come from the PTO bank. Requests for PTO hours must be submitted on the appropriate form with management authorization obtained in advance. Approvals are made by the employee's manager based on periods convenient to the operations of the department. Preferences for PTO hours will be granted whenever possible. The approval of request for PTO hours is based on departmental needs.

OBSERVED HOLIDAYS

Aspire Health Partners observes the following seven holidays: New Year's Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving Day, Christmas Day and "Floating Holiday".

PTO HARDSHIP CASH-OUT PROVISIONS

A PTO hardship is defined as an unexpected expense which would cause an interruption in the course of everyday living such as a foreclosure or repossession of property, major repair for living quarters or transportation. In order to be eligible to cash out PTO hours due to a hardship case, the employee must complete a PTO Hardship Request Form and have it approved by Human Resources. The employee needs to have been employed for over one year and leave a minimum balance of 80 hours after the cash out of PTO for hardship. Details explaining the hardship will be required when completing the PTO Hardship Request Form. Please note a PTO hardship is paid at 75% of the gross amount. A Hardship is not defined as:

- Needing to lower the balance of PTO to prevent stoppage of accrual
- Payments for recurring expenses
- Purchase of personal merchandise such as a car or furniture

Years of Service	Hours per pay period	ANNUAL		
		Hour	Days	Weeks
0-1.99	3.85	100	12.50	2.5
2-4.99	6.15	160	20.00	4.0
5-8.99	7.08	184	23.00	4.6
9-13.99	8.00	208	26.00	5.2
14+	9.24	240	30.00	6

Critical Illness

AFLAC
Voluntary Products

CRITICAL ILLNESS

A critical illness plan helps prepare you for the added costs of battling a specific critical illness. The good news is that many people with a specified critical illness survive these life-threatening battles. Unfortunately, as the recovery process begins, people become aware of the unexpected bills that have piled up. Your recovery doesn't have to be spoiled by unexpected bills. With this plan, our goal is to help you and your family cope with and recover from the financial stress of surviving a specified critical illness. Listed below is a brief summary of the benefits.

Benefits	With Cancer Benefit
Heart Attack	100% **Percentage of Principal Sum**
Stroke	100% **Percentage of Principal Sum**
Major Organ Transplant	100% **Percentage of Principal Sum**
End-Stage Kidney Failure	100% **Percentage of Principal Sum**
Coronary Artery Bypass Graft Surgery	25% **Percentage of Principal Sum**
Diagnosis of Cancer - Invasive	100% **Percentage of Principal Sum**
Diagnosis of Cancer In Situ	25% **Percentage of Principal Sum**
Subsequent Diagnosis of *Different Illness*	Original Percentage of face amount
Time separation for recurrence	90 Days between different illnesses
Available Coverage	
Employee	20,000
Spouse	10,000
Child	$5,000 at no charge
Guarantee Issue	
Employee	$20,000
Spouse	$10,000
Child (to age 26)	None
Health Assessment Benefit (Wellness)	$50 subject to 30 day waiting period
Pre-Existng Conditional Limitations	6/12
Benefit Reduction	None
Limit on Number / Amount of Claims	Each claim category will be paid once
Waiting Period	**30 Days**

AFLAC Critical Illness Bi-Weekly Payroll Deductions

EMPLOYEE $20,000			SPOUSE $10,000	
ISSUE AGE	BI WEEKLY		ISSUE AGE	BI WEEKLY
18-29	10.67		18-29	5.60
30-39	10.67		30-39	5.60
40-49	20.83		40-49	10.67
50-54	31.94		50-54	16.34
55-59	43.11		55-59	21.92
60-64	69.42		60-64	35.08
65-69	75.60		65-69	38.17

Accident

AFLAC
Voluntary Products

ACCIDENT

An accident insurance plan provides benefits to help cover the costs associated with unexpected bills. You don't budget for accidents if you're like most people. When a Covered Accident occurs, the last thing on your mind is the charges that may be accumulating while you're at the emergency room. These costs add up—fast. You hope they never happen, but at some point you may take a trip to your local emergency room. If that time comes, wouldn't it be nice to have an insurance plan that pays benefits regardless of any other insurance you have? This group accident plan does just that. Listed below is a brief summary of the Accident Policy.

Emergency Care	
Ambulance	$450
Emergency Room	$300
Treatment Care	
Hospital Admission	$1,000
Hospital Confinement Daily Benefit	$300 / Day up to 365 Days
Intensive Care Unit Daily Benefit	$500 / Day up to 30 Days
Specific Injuries or Treatments	
Blood	$250
Joint Dislocation	$400-$4,500 Closed / $600-$6,750 ***Spouse & Children paid at 50% of Employee Amount***
Dental Crown	$250
Laceration	$50 - $400
Ruptured Disc	$100 - $400
Fractures (Per Fracture)	
Leg (knee to ankle)	$3,600 / $5,400
Ankle, arm, bones of face, collarbone, elbow, foot, hand, jaw, kneecap, shoulder blade, wrist	$1,800-$3,000 / $2,700-$4,500
Accidental Death & Dismemberment	
Accidental Death of Employee	$75,000
Accidental Death of Spouse	$37,500
Accidental Death of Child	$10,000
Loss of or loss of use of one: hand, foot , arm, leg or eye	$18,750 EE / $9,375 SP / $2,500 CH
Catastrophic loss	$37,500 EE / $18,750 SP / $10,000
Health Assessment Benefit (Wellness)	$60 Subject to 12 month wait period
Pre-Existing Condition Limitations	6/12
Limit on Number / Amount of Claims	Limited to 150% for multiple fractures or dislocations
	Off Job Coverage
	Payroll Deductions
Employee Only	**$5.84**
Employee & Spouse	**$7.61**
One Parent Family	**$10.75**
Employee & Family (children to age 26)	**$12.52**

Employee Assistance Plan

Lincoln Financial Group®

EmployeeConnect Services

There are times when we all need a little help. No matter what the issue, *EAP Plus* counseling services are available 24 hours a day, seven days a week with confidential support, guidance, and resources.

- Assistance for you or an immediate household family member.
- Six in-person counseling sessions per person per issue per year.
- 24 x 7 x 365 telephone and Web access.
- Unlimited phone access to legal counsel.
- 25% discount for in-person legal services.
- Work/life services for assistance with:
  - √ Parenting and Childcare
  - √ Eldercare
  - √ Relationships
  - √ Work and career
  - √ Financial

To learn more about the Lincoln Financial *EmployeeConect* program visit:

www.Lincoln4Benefits.com or
www.GuidanceResources.com

(User name=LFGsupport; password=LFGsupport1)
or talk with a specialist at 1-888-628-4824.

LifeKeys Services

When you choose life insurance, you're planning for your family's future assuring their comfort and securing their plans. With Lincoln Term Life Insurance, you can also access services that make a real difference now as well as in the future. *LifeKeys* services, included at no additional cost with all Lincoln Term Life and Accidental Death and Dismemberment Insurance policies, provide assistance to you, your family and your beneficiaries.

- EstateGuidance® Will Preparation
- GuidanceResources® Online
- Identity Theft
- Legal Support
- Other support services

To utilize LifeKeys services, please contact 1-855-891-3684 or visit GuidanceResources.com or www.lincoln4benefits.com (WebID= LifeKeys)

TravelConnect

Traveling just got easier.

An employee benefit that includes travel, medical, and safety related services while traveling. Lincoln Financial has partnered with MEDEX Assistance Corporation, a worldwide leader in travel assistance, to make this valuable benefit available to you and your immediate family members.

Business or leisure travel – it's covered.

The *TravelConnect* benefit is provided at no cost to you and includes a wealth of services when traveling just 100 miles or more from home. These services are provided regardless if you're traveling for business or leisure. Whether you simply want the weather forecast for your travel destination or you need emergency medical assistance halfway around the world, MEDEX has the professional staff and resources to provide support, 24 hours a day, seven days a week.

Comprehensive coverage.

Just a sampling of the services includes:

- Destination info – weather, currency, etc.
- Emergency travel arrangements and funds transfer.
- Lost or stolen travel documents assistance.
- Language translation services.
- Emergency medical evacuation and transportation.
- Dependent child transportation if left unattended.
- Medical and dental referrals.
- Assistance with corrective lenses or medical device replacement.
- Treatment monitoring of a medical situation.
- Arrange delivery of medications, vaccines, or blood.
- Updates to family, employer, and/or home physician.
- Repatriation of a deceased traveler.
- Security and political evacuation assistance.

Travel assistance services are subject to specific terms, conditions and limitations. A program description is available at www.lincoln4benefits.com. To use *TravelConnect* services, call MEDEX at (800) 527-0218 or (410) 453-6330.

Key Contacts

COMPANY	*CONTACT INFORMATION*	*WEBSITE/ EMAIL*
UNITED HEALTHCARE		
Customer Service	866-844-4864 Gold and Silver 866-734-7970 Bronze Claims: PO Box 740835 Atlanta, GA 30374	www.myuhc.com. United Behavioral Mental Health: 800-582-8220 or 800-557-5745
UNITED HEALTHCARE		
Dental	800-445-9090	www.myuhcdental.com
Vision	800-638-3120	www.myuhcvision.com
OPTUM BANK		
Health Savings Account	866-234-8913	www.optumbank.com
LINCOLN FINANCIAL		
Life Claims & Customer Service Short-Term & Long-Term Disability	800-423-2765	www.lfg.com
LINCOLN FINANCIAL		
Employee Assistance Program	EmployeeConnect Services 877-757-7587 LifeKeys Services 855-891-3684 TravelConnect 800-527-0218	www.lincoln4benefits.com
FLEXIBLE SPENDING ACCOUNT		
Medcom	Customer Service 800-523-7542 Email claims to: Medcomreceipts@emedcom.net	Check your debit card: www.mywealthcareonline.com/medcom
LASSITER-WARE INSURANCE		
Employee Customer Service	800-845-8437 ext. 605 Fax 888-883-8680	marcyr@lassiter-ware.com
AFLAC VOLUNTARY PRODUCTS PORTFOLIO		
AFLAC	800-443-3036	WebSite: www.aflac.com Email: A_Becerra@US.Aflac.com
TRANSAMERICA RETIREMENT SOLUTIONS		
Transamerica	800 755-5801	aspire2retire.trsretire.com
ASPIRE HEALTH PARTNERS		
Human Resources Department	Jannette Mulero 407-875-3700 x6025 Linda Lovett 407-875-3700 x3222	Janenette.mulero@aspirehp.org Linda.lovett@aspirehp.org

NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is provided as required by the Federal Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and its regulations issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). It is for participants and beneficiaries in the (referred to as the "Plan").

You are entitled to receive a notice of our procedures for protecting the privacy of your health information. "Protected Health Information" is information that identifies you and is related to your medical history for health care you receive or the payment for that care. We must follow the terms of the notice currently in effect. This notice describes how we may use or disclose your Protected Health Information and your rights regarding the use and disclosure of that information.

You may also receive privacy notices from others, such as other health care plans, insurers (including HMOs) and providers about their use and disclosure of your health information.

HOW THE PLAN MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Plan may use and disclose your Protected Health Information for different purposes. The examples below illustrate the types of uses and disclosures we may make without your authorization for treatment, payment and health care operations.

- **Treatment**. The Plan may disclose your Protected Health Information to assist your health care providers (doctors, pharmacies, hospitals and others) in your diagnosis and treatment. For example, The Plan may disclose to one treating physician the name of another treating physician so that he or she can obtain records or other information needed for diagnosis or treatment.

- **Payment.** The Plan may use and disclose your Protected Health Information in order to pay for your covered health expenses. For example, we may use your Protected Health Information to enroll you for coverage or to determine if a claim for benefits is covered under the Plan (e.g., if treatment is medically necessary).

- **Health Care Operations.** The Plan may use and disclose your Protected Health Information in order to perform Plan activities, such as quality assessment and improvement activities, reviewing competence or qualifications of health care providers, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. Other activities include disease management, case management, conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, The Plan may use information about your claims to refer you to a disease management program.

- **Plan Sponsor.** The Plan discloses your medical information to , which sponsors the Plan, for Plan administration purposes that are described in the document that governs the specific Plan. The Plan Sponsor will be required to certify to us that it will use your medical information in accordance with the Privacy Regulations.

- **Enrolled Dependents and Family Members.** The Plan will mail explanation of benefits forms and other mailings containing Protected Health Information to the address we have on record for the employee who is enrolled in the health plan.

OTHER PERMITTED OR REQUIRED DISCLOSURES

- **To Your Family Member, Other Relative or Close Personal Friend.** The Plan may disclose Protected Health Information to a family member, other relative or close personal friend provided that information is directly relevant to that person's involvement in your health care or to notify them of your location, general condition or death. The Plan will not make any such disclosure unless you are given a reasonable opportunity under the circumstances to object and did, in fact, object.

- **As Required by Law.** The Plan must disclose Protected Health Information about you when we are required to do so by law.

- **Public Health Activities.** The Plan may disclose Protected Health Information to public health agencies for reasons such as preventing or controlling disease, injury or disability. This includes disclosures necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Protected Health Information may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

- **Victims of Abuse, Neglect or Domestic Violence.** The Plan may disclose Protected Health Information to government agencies about abuse, neglect or domestic violence if there is a reasonable belief that you may be a victim of abuse, neglect to domestic violence. In that case, The Plan will promptly inform you that a disclosure has been or will be made unless that notice would cause a risk of serious harm. For purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's Protected Health Information.

- **Health Oversight Activities.** The Plan may disclose Protected Health Information to government oversight agencies (e.g., U.S. Department of Labor) for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs.

- **Judicial and Administrative Proceedings.** The Plan may disclose Protected Health Information in response to a court or administrative order. The Plan may also disclose Protected Health Information about you in certain cases in response to a subpoena, discovery request or other lawful process. In such case, The Plan will require satisfactory assurances that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised, or if any were raised, that they were resolved in favor of disclosure by the court or tribunal.

- **Law Enforcement.** The Plan may disclose Protected Health Information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect or witness; or to provide information about the victim of a crime. Such disclosures include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. The law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by us in our sole discretion.

- **Coroners, Funeral Directors, Organ Donation.** The Plan may release Protected Health Information to coroners or funeral directors as necessary to allow them to carry out their duties. The Plan may also disclose Protected Health Information in connection with organ or tissue donation.

- **Plan Information and Programs.** The Plan may contact you to provide information about alternative treatment programs or other health-related benefits and services that may be of interest to you.

- **Research.** Under certain circumstances, the Plan may disclose Protected Health Information about you for research purposes, provided certain measures have been taken to protect your privacy.

- **To Business Associates.** We may disclose Protected Health Information to a "business associate", provided that person or entity enters into an agreement as described in the Privacy Regulations. A "business associate" is a vendor that provides certain services (typically Plan administration services) to or on behalf of the Plan.

- **To Limited Data Recipients.** The Plan may disclose Protected Health Information to a "limited data recipient", provided that person or entity enters into an agreement as described in the Privacy Regulations. A "limited date recipient" is a person or entity that receives Protected Health Information that is partially de-identified in accordance with the Privacy Regulations and used for purposes of research, public health or health care operations.

NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY RIGHTS continued…..

- **Marketing.** The Plan may use Protected Health Information for purposes of marketing where it is face-to-face and involves a matter of nominal value.

- **To Avert a Serious Threat to Health or Safety.** The Plan may disclose your Protected Health Information, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Special Government Functions.** The Plan may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

- **Workers' Compensation.** The Plan may disclose Protected Health Information to the extent necessary to comply with state law for workers' compensation programs or similar programs established by law.

- **Incidental to Another Permitted Use.** The Plan may disclose Protected Health Information as permitted by the Privacy Regulations to be incidental to another permitted use.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding Protected Health Information that the Plan maintains about you.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your Protected Health Information from a "designated record set" with some limited exceptions. A designated record set includes the medical and billing records about you that a covered health care provider maintains. It includes enrollment, billing, claims payment and case or medical management records maintained by us or for the Plan. Your request to review and/or obtain a copy of Protected Health Information in your designated record set must be made in writing. The Plan may charge a fee for the costs of producing, copying and mailing your requested information, but the Plan will tell you the cost in advance.

  If access is denied, you will be provided with a written denial explaining the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

- **Right To Amend Your Protected Health Information.** If you believe that Protected Health Information about you in a designated record set (maintained by the Plan) is incorrect or incomplete, you may request that the Plan amend the information. Your request must be made in writing and must include the reason you are requesting a change. Your request may be denied, for example, you ask the Plan to amend information that was not created by the Plan or that is already accurate and complete. If the request is denied, you must be provided with a written denial that explains the basis for the denial. You may then submit a written statement of disagreement.

- **Right to an Accounting of Disclosures by the Plan.** You have the right to request a list of certain disclosures the Plan has made of your Protected Health Information. The request must be in writing. If you request an accounting for the same time period more than once within a 12-month period, the Plan may charge a reasonable fee.

- **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that the Plan restrict the way it uses or discloses your Protected Health Information for treatment, payment or health care operations. ***The Plan may not agree to your request.*** Your request for a restriction must be made in writing. In your request you must tell the Plan (1) what information you want to limit; (2) whether you want to limit how the Plan uses or discloses your information, or both; and (3) to whom you want the restrictions to apply.

- **Right To Receive Confidential Communications.** You have the right to request that the Plan use a certain method to communicate with you or that information be sent to a certain location. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from the Plan could endanger you. The Plan will accommodate all reasonable requests.

- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy. To request a paper copy of this Notice, you must contact the Privacy and Complaint Officer identified at the end of this Notice.

- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting your companies Privacy and Complaint Officer.

PERSONAL REPRESENTATIVES

Your personal representative may exercise your rights. The representative must produce evidence of his/her authority to act on your behalf before that person will be given access to your Protected Health Information. Proof of such authority may be in one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- the parent of a minor child.

The Plan may deny access to your Protected Health Information to a personal representative in order to protect certain individuals who depend on others to exercise their rights under the Privacy Regulations and who may be subject to abuse or neglect, including minors.