Larson Design Group®

2017 EMPLOYEE BENEFITS

Introduction

The hard work and dedication of our talented staff means that you deserve competitive, comprehensive benefits.

Having competitive compensation, employee recognition programs, and excellent benefits ensures that everyone can take care of themselves and their families, which allows us all to focus on providing top performance for our clients. Benefit coverage for you and your family is a very important part of your health, quality of life and total compensation.

Table of Contents

Benefit Resources

Benefit Enrollment and Information Portal

https://benefits.plansource.com/

PlanSource is your resource for the following actions:

- Submit initial benefit enrollment
- Submit a life event (i.e. add or drop coverage)
- Update Life Insurance Beneficiary
- Review your current benefit elections along with costs of each benefit
- Choose benefits during annual open enrollment periods (HR will communicate timeline)
- Provide and confirm information about your dependents
- Review benefit materials and plan summaries

You may access the information in PlanSource at any time. Login information is as follows:

- Your username is the first letter of your first name, the first 6 letters of your last name, and the last 4 digits of your social security number.
- If you previously created a password you may continue to use it. Passwords do expire after a period of time so you will have to reset your password at some point.
- If this is the first time you are logging into the portal, birth date in YYYYMMDD format. March 1, 1978 would be 19780301.

HealthAdvocate™

Employees of Larson Design Group have access to a comprehensive core Health Advocacy service through Health Advocate at no cost to employees and it is also available to spouses, dependent children, parents and parents-in-law.

Health Advocate's services are provided by Personal Health Advocates, typically registered nurses, supported by a team of medical directors and benefits and claim specialists.

Below is a just small sample of what Health Advocate assist with:

- **Help resolve insurance claims** and assist with negotiating billing and payment arrangements.
- **Get to the bottom of insurance denials** and uncover billing errors.
- **Work with insurance companies** to obtain appropriate approvals for needed services.
- **Find the right doctors**, hospitals, dentists and other healthcare providers anywhere in the country.
- **Facilitate appointments with providers** including hard-to-reach specialists, and can arrange for specialized treatments and tests.
- **Answer questions** about tests, treatments and medications recommended or prescribed by your physician.
- **Assist in the transfer of medical records**, X-rays and lab results.
- **Locate and research the newest treatments** for a medical condition.

……and much more!

Easy to Reach

24/7 Support **866.695.8622**

Email: answers@HealthAdvocate.com
Web: HealthAdvocate.com/members

Eligibility

Full-Time

An employee is considered Full-Time if he or she normally works at least 30 hours per week. A Full-Time employee is eligible for benefit coverage the first of the month following their hire date. Employees hired on the first of the month are eligible for benefits on the first of the following month.

Part-Time

An employee is considered Part-Time if he or she is expected to work less than 30 hours per week. As required by the Patient Protection and Affordable Care Act, Larson Design Group will do the following for Part-Time employees:

- Starting on the date of hire, and continuing for 12 months, LDG will measure the amount of hours a Part-Time employee works (Measurement Period). At the end of that 12-month period, if the employee averaged 30 or more hours per week, then benefit eligibility has been met and a 1-month Administrative Period will occur.
- During this time, Human Resources will notify the employee of this and the employee will be asked to go through the benefit enrollment process.
- Starting after the 1-month Administrative Period, the Stability Period begins.
    - If the employee is deemed benefit eligible then the employee will remain benefit eligible for 12 months, regardless of hours worked, provided the employee maintains active employment with LDG or if deemed ineligible for benefits the employee will maintain that ineligible status for 12 months.

Dependent Eligibility

Currently, benefit eligible employees can cover eligible dependents and spouses. However if your spouse's employer provides subsidized group coverage for medical, dental and vision then your spouse must elect coverage with their employer. Subsidized is defined as the employer pays for more than 25% of the costs for the medical, dental and/or vision coverage. If your spouse's employer doesn't subsidize this coverage, then the spouse is eligible to enroll in our medical, dental and vision benefit plans. Dependents are covered to the end of the month that they turn 26. Disabled dependents are covered to the end of the month that they turn 31. See individual benefit summary plan description for more details on eligibility for each benefit.

Qualified Life Events

The IRS states that the elections you make during an enrollment period, including Flexible Spending Account elections, must stay in effect for the entire plan year (July 1 through June 30) unless you experience a Qualified Life Event.

Based on IRS regulations, if you experience a Qualified Life event and you wish to change your benefits, you must complete a Life Event via the PlanSource website and provide proof of the event to Human Resources within 30 days of the event. If the Life Event isn't completed within 30 days, coverage will remain unchanged for the remainder of the plan year.

Examples of a Qualified Life Event is:

- A change in marital status
- The death of a spouse
- The birth or adoption of a child or placement of a child for adoption
- A change in employment status of the employee, spouse or dependent affecting the employee's eligibility under the plan
- Your spouse loses coverage as a result of a layoff, termination or plan cancellation
- Spouse gains subsidized coverage with his/her employer
- An entitlement to, or loss of, Medicare or Medicaid by the employee or spouse
- A change in residence of the employee, spouse or dependent

Changes in elections must be consistent with the life event.

If you waive coverage, you may join the plan at the next open enrollment period. Evidence of Insurability may be required.

New Hires If you don't enroll when you first become eligible for benefits as a new employee, you will only be enrolled in the company-paid benefits of Life and Long-Term Disability Insurance. You will not be enrolled in any benefits that require you to make an election or employee contribution (such as medical, dental and vision coverage).

You will not be able to make changes until the next annual open enrollment period, unless you experience a Qualified Life Event.

Medical Benefits

Medical coverage is a very important part of our benefit program offered to you and your family.

Currently, our medical coverage is a self-funded plan managed by a Third Party Administrator (TPA) Meritain utilizing Aetna Choice Point of Service (POS) II Network.

There are two different plans, a plus and standard plan. Both options cover the same services, however the deductible and out-of-pocket maximum varies between the plans. We encourage employees to carefully review the information on the next few pages as well as Summary Plan Description for each of the medical options. This information can be found in the library section on the PlanSource website.

Dependents are covered to the end of the month that they turn 26.

Standard Plan	In-Network	Out-of-Network
Deductible	$1250/Individual $2500/ Family	$10,000
Out-of-Pocket Maximum	$4,000 per Covered Person $8,000 per Family Unit	$15,000
Copayments	$20 Primary Care Physician Visit $40 Specialist Visit $40 Urgent Care Visit $125 Emergency Room (waived if admitted)	40% of usual and customary after deductible $125 Emergency Room (waived if admitted)
	$40 after deductible for Home Health Care, Chiropractic, Physical, Speech and Occupational Therapy (please see SPD for Plan Year maximums)	40% of usual and customary after deductible
Primary Care Physician Office Visit (Includes Family practice, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner)	100% after copayment *Percentage listed is what plan pays	60% of usual and customary after deductible *Percentage listed is what plan pays
Specialist Office Visit	100% after copayment	60% of usual and customary after deductible
Preventive Care (Includes Well Adult, Women's Preventive Care Services and Well Child Care. Must be coded as wellness)	100% $0 copayment	60% of usual and customary after deductible
Emergency Room	100% after copayment	100% after copayment
Hospital Services	90% after deductible	60% of usual and customary after deductible
Surgery (Outpatient)	100% after deductible	60% of usual and customary after deductible
Urgent Care Services	100% after copayment	60% of usual and customary after deductible
Diagnostic Testing (X-Ray and Lab)	Diagnostic - No Copay Basic - $20 Copay Complex - $100 Copay	60% of usual and customary after deductible
Radiology (CT, PET, MRI, MRA, SPECT)	Diagnostic - No Copay Basic - $20 Copay Complex - $100 Copay	60% of usual and customary after deductible
Durable Medical Equipment	100% after deductible	60% of usual and customary after deductible

Please note this list is not all inclusive. Please see Summary Plan Description for more information

Plus Plan	In-Network	Out-of-Network
Deductible	$750/Individual $1500/ Family	$5,000
Out-of-Pocket Maximum	$3,000 per Covered Person $6,000 per Family Unit	$10,000
Copayments	$20 Primary Care Physician Visit $40 Specialist Visit $40 Urgent Care Visit $125 Emergency Room (waived if admitted)	30% of usual and customary after deductible $125 Emergency Room (waived if admitted)
	$40 after deductible for Home Health Care, Chiropractic, Physical, Speech and Occupational Therapy (please see SPD for Plan Year maximums)	30% of usual and customary after deductible
Primary Care Physician Office Visit (Includes Family practice, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner)	100% after copayment *Percentage listed is what plan pays	70% of usual and customary after deductible *Percentage listed is what plan pays
Specialist Office Visit	100% after copayment	70% of usual and customary after deductible
Preventive Care (Includes Well Adult, Women's Preventive Care Services and Well Child Care. Must be coded as wellness)	100% $0 copayment	70% of usual and customary after deductible
Emergency Room	100% after copayment	100% after copayment
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Durable Medical Equipment	100% after deductible	70% of usual and customary after deductible

Please note this list is not all inclusive. Please see Summary Plan Description for more information

TELADOC™

Save time and money by avoiding crowded waiting rooms in the doctor's office, urgent care clinic or Emergency Room. Talk to a doctor from the comfort of your home or office without an appointment and best of all there is no co-pay for the visit!

Teladoc doctors diagnose non-emergency medical problems, recommend treatment, and can even call in a prescription to your pharmacy of choice, when necessary. Common medical issues treated are colds, flu, poison ivy, respiratory infections, bronchitis, pink eye, sinus problems, allergies, urinary tract infections and ear infections.

Please note this benefit is available to employees and their dependents who are enrolled in the Company's health insurance plan.

TELADOC DOCTORS ARE:

U.S. board-certified in internal medicine, family practice, or pediatrics • State-licensed • U.S. residents who average 20 years of experience.

Talk with a Teladoc doctor 24/7/365

FOR FREE

Connect to Your Benefits Plan Information

Meritain Connect for Members

Logging into Meritain Connect

Meritain Connect gives you the information you need to understand and manage your employee healthcare benefits. Plus, you can access wellness tools and resources, too.

How to log in

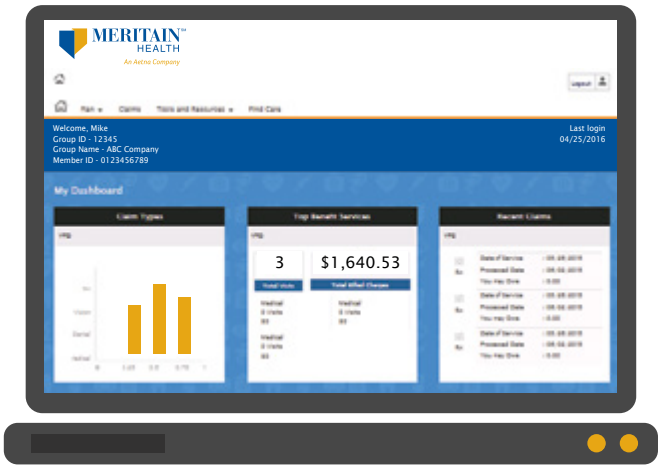
If you have accessed a Meritain Health website in the past, you can simply visit **https://www.meritain.com** and click *Login* in the upper right-hand corner. Then, enter your previous username and password, and click *Login*. Please note, if the system prompts you to re-register, follow the below steps for new users.

For new users or to re-register:

- On the login page (**https://www.meritain.com**), just click *Register*.
- Click on the *Member* tab.
- Enter your Group ID (which you can find on your member ID Card) and click *Next*.
- Enter your personal information, as prompted, then click *Next*. (The *Middle initial* and *Suffix* fields are optional.)
- Review your information. You can click *Cancel* to start over, or *Previous* to make changes. You can confirm your information by clicking *Yes, I am*. Then, just click *Next*.
- Create a username and password. If you are re-registering, you will not be able to reuse your current username, and will need to choose a new one. For security purposes, we recommend NOT using your Social Security number as your username.
- Your password must be at least ten characters long and contain at least one of the following:
  - An uppercase letter
  - A lowercase letter
  - A number
  - One of the following symbols: (# $! % ^ @ & *) = + -
- Choose your security question and answer.
- Review the terms and conditions, and click *I agree to terms and conditions* and *Next*, or click *Cancel*.

Once you log in, you'll have access to a webguide with additional information about how to use Meritain Connect.

If you have any questions, we can help. Simply call Meritain Health Customer Service using the phone number on your member ID Card.



Stay on top of your benefits

Meritain Connect is your all-in-one tool for managing your benefits. When you visit Meritain Connect, you'll find:

- Your benefits information—all in one place.
- Time-saving features at home or on-the-go.
- A sleek new streamlined design.

www.meritain.com

MERITAIN HEALTH℠
An Aetna Company

LDG Larson Design Group®

Meritain Connect

Stay on top of your benefits

Meritain Connect is your all-in-one tool for managing your plan. When you visit Meritain Connect, you'll find:

Your information—all in one place

Meritain Connect is an overall tool for:

- Claims history.
- Explanations of Benefits (EOBs).
- Plan documents.
- Eligibility details.
- Wellness resources.
- Updating your contact information.
- ID Cards (view, print or request new cards).

Time-saving features at home or on-the-go

You'll always know where to go next. Thanks to our new Quick Links, the pages you need are often one click away. Plus, you can access Meritain Connect by computer, tablet or smart phone.

Meritain Connect is available when—and where—**you** need it.

A sleek new streamlined design

With our new look and feel, Meritain Connect organizes your plan in an easy-to-follow layout.

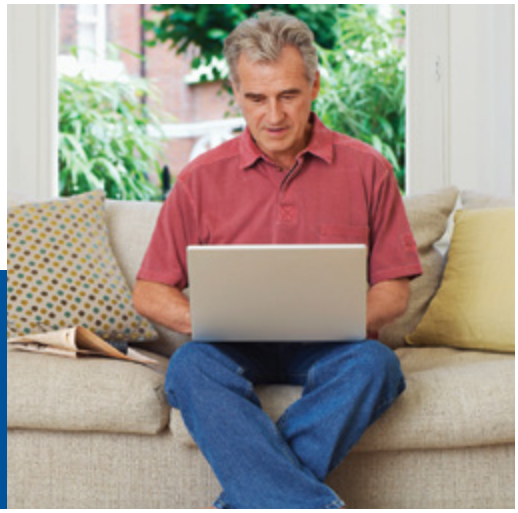
We make your online healthcare experience more user-friendly than ever before.

MERITAIN℠ HEALTH

An Aetna Company

MERITAIN™ HEALTH

An Aetna Company



Save on Healthcare Costs

And Earn Valuable Incentives

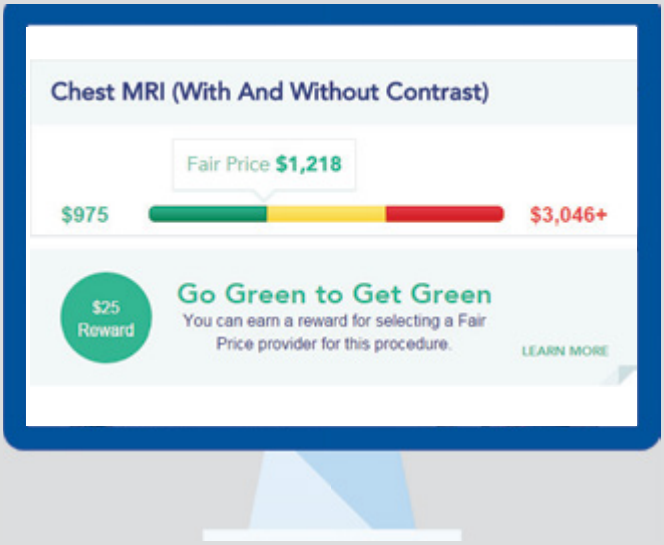
How Healthcare Bluebook™ can help

Want to save money on healthcare services for you and your family, as well as find providers that offer a Fair Price™ in your area? Healthcare Bluebook and your employer are working hard to help you spend less on your healthcare! You can earn cash incentives as part of the Go Green to Get Green™ program.

"Go Green to Get Green" and earn cash incentives

Healthcare Bluebook is an online tool that can help you better understand what you should pay for healthcare procedures, as well as find providers offering fair prices in your area. Healthcare Bluebook is a free service, and is easy to find through your member website, **www.meritain.com**.

Within the Healthcare Bluebook tool, providers are listed as **green**, **yellow** or **red**. Your employer offers incentives for certain healthcare services when you visit a "green" provider. That's because "green" providers offer high-value services, at or below the Fair Price, providing you the most value for your healthcare dollar.



When you visit "green" providers for the following healthcare services, you'll earn a cash incentive:

Procedure	Incentive	Procedure	Incentive
Most CT scans	$25	Lithotripsy	$50
Most MRIs	$25	Removal of adenoids	$50
Transthoracic Echocardiogram (TTE)	$25	Sleep study	$50
TTE with doppler	$25	Tonsillectomy	$50
Cataract surgery	$50	Colonoscopies	$100
Cholecystectomy (laparoscopic)	$50	Knee arthroscopy	$100
Ear tube placement (tympanostomy)	$50	Shoulder arthroscopy	$100
Heart perfusion imaging	$50	Upper gastrointestinal endoscopies	$100

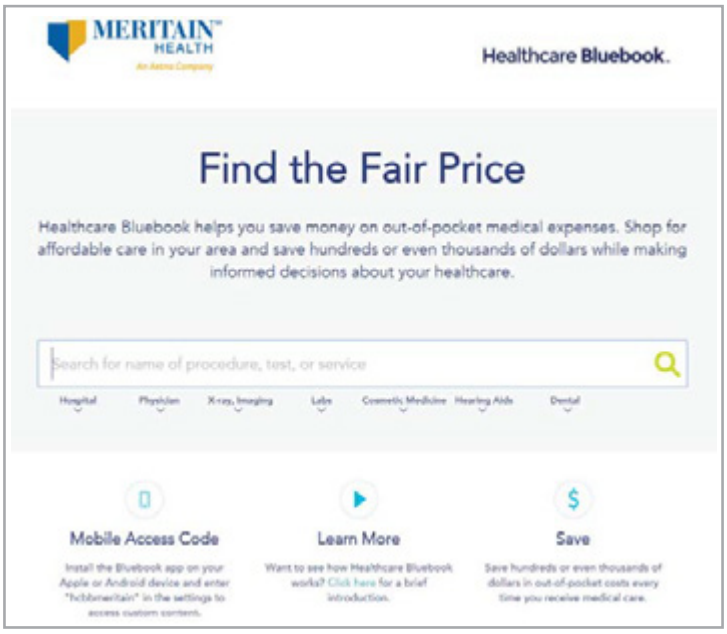
How to locate providers using Healthcare Bluebook:

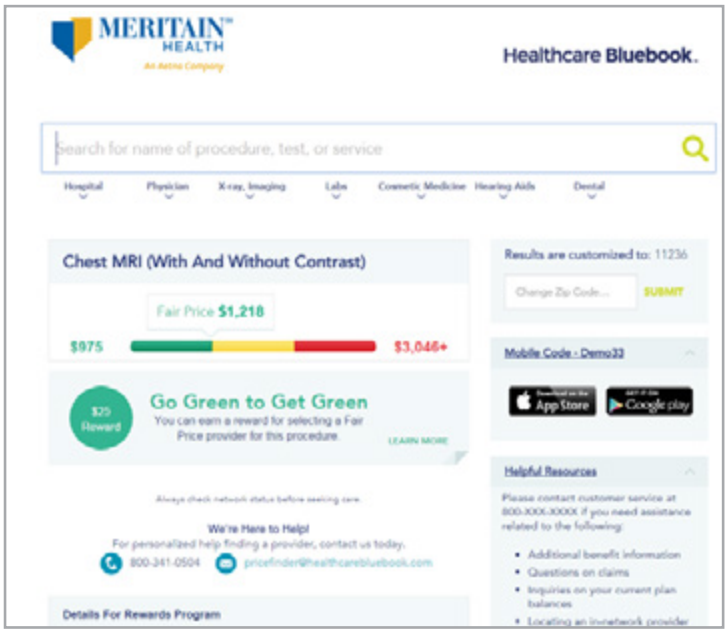
1. First, just log in to your member website at **www.meritain.com**. If you don't have an account, you can create one by following the prompts.

2. Then, choose *Healthcare Bluebook* from the *Compare Cost Information* section on your homepage.

3. On the next screen, click *Access Healthcare Bluebook*. This will take you to the Healthcare Bluebook website.

4. To search for specific healthcare services, simply use the drop-down menu or enter text into the search box. Healthcare Bluebook will then display pricing and provider information, including green, yellow and red provider rankings.





If you have questions or need help finding fair-priced facilities, just call Healthcare Bluebook's PriceFinder support team at 1.800.341.0504 or email them at pricefinder@healthcarebluebook.com. You can also call Meritain Health Customer Service using the phone number located on your member ID Card.

MERITAIN HEALTH
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www.meritain.com

Becoming a Wise Healthcare Consumer

As health care costs continue to increase, employees are encouraged to become a better healthcare consumer. By becoming aware of how health care dollars are spent and how to be proactive with your own health, both time and money can be saved for you. Below are a few tips on how we can all become a better health consumer.

1. Establish a relationship with a doctor. Do not wait until you're sick to try to find a primary care doctor. Become an established patient by scheduling an initial exam. The doctor will then have your health history, which is an important tool in good medical care.
2. Get regular physical exams. The single best way to keep medical costs down is to detect health issues early—when they are generally less complicated to treat.
3. Use network providers. When you utilize network providers, your share of the cost is significantly less than if you went to a non-network provider.
4. Visit an Urgent Care or Walk-In Clinic. Instead of going to the ER for a common illness, consider the less expensive urgent care center. (Find one by searching on aetna.com)
5. Use generic drugs. Generic drugs typically contain the same active ingredients as the brand name, but cost less.
6. Review your bills. Medical billing is complicated and mistakes can easily happen. Review your explanation of benefits (EOB) or bills to be sure the correct services appear.

Searching for Providers

To take advantage of lower costs for in-network providers please visit the Aetna website to search for in-network providers. Also, please call the medical provider to confirm that they are an in-network provider with the Aetna Choice Point of Service (POS) II network.

www.aetna.com/docfind/custom/mymeritain/

Prescription Drug Benefits

There are four tiers of covered prescription drugs with four different copayments: Generic Drugs, Preferred Brand, Non-Preferred Brand and Tier O. Below are brief descriptions for each of those categories.

1. **Generic Drugs** Generics are equivalent to their brand-name counterparts and are ensured by the FDA to be as safe as effective. On average, generic drugs cost 30 to 70 percent less than brand-name drugs.
2. **Preferred Brand Name Drugs** Prescriptions in this category do not have a generic equivalent available. They have been in the market for a time and are widely accepted.
3. **Non-Preferred Brand Name** These drugs have the highest copayment. Generally these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available.
4. **Tier 0** is a fourth tier of drugs in our multi-tiered prescription drug program. There are approximately 65 generic drugs with a cost of $0—that's right, no copayment, no cost to you! Many of these generic drugs are used to treat chronic, high-cost conditions like diabetes, high blood pressure and heart disease. The idea behind this is to ensure chronic health conditions are managed and to prevent high claim costs down the road. For more information on this benefit contact CVS Caremark or view the list of applicable drugs via the library in PlanSource.

To find out more information on the drugs currently on the "Preferred Drug List" please login to your account via the CVS Caremark website for the most current list. If you are visiting this website for the first time, you will need to register to access this information.

Prescription Drug Purchasing Options

1. **Retail Pharmacy** To find a Participating Pharmacy please login to your account via the CVS Caremark website.
2. **Mail Order Pharmacy** Home delivery of monthly medications with NO shipping or handling fees for standard delivery is required. You may receive up to a 90 day supply of most medications delivered right to your door before you are out of medication. You also have the option to pick up a 90 day supply of monthly maintenace drugs at either a CVS or Target Pharmacy. For more information on this program please visit the CVS Caremark website **www.caremark.com**

Drug Category	Pharmacy Option (30 Day Supply) Co-pay	Pharmacy and Mail Order Options Co-pay (90 Day Supply)
Tier O Drugs	No Charge	No Charge
Generic Drugs	$10	$20
Preferred Brand Name (no generic available)	$35	$87.50
Non-Preferred Brand Name	$60	$180

Dental Benefits

A visit to a dentist can help you keep a great smile and prevent many health issues. But dental care can be costly and you can be faced with unforeseen expenses. The dental benefits offered are designed to provide high quality dental care while controlling the costs of the care. Current dental benefits are offered through Guardian. Below is a brief description of the plan.

1. **Preferred Provider Organization (PPO)** Dental Guard Preferred Networks or Dental Guard Preferred for Texas employees.

The PPO plan is designed to provide high quality dental care while controlling the cost of such care. To do this, the plan encourages a covered person to seek dental care from providers that are under contract with Guardian's PPOs. Use of the dental PPO is voluntary but using a PPO dentist will mean a lower cost to you.

If you choose to use a PPO dentist, the plan will pay a higher level of benefits for covered treatments furnished by a preferred provider. However if treatment is sought from a non-preferred provider the plan will pay "Usual and Customary" for the billed services. Any remaining balance above the Usual and Customary will be billed to the patient.

Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300 or more, the dentist should submit a treatment plan to Guardian before treatment begins. For orthodontia, a treatment plan should always be sent to Guardian before orthodontic treatment starts.

Searching for Providers

To search for providers included in the PPO Network, please visit the Guardian website for more information.
https://www.guardiananytime.com/fpapp/FPWeb/dentalSearch.process

Your Dental Plan	**PPO**	
Your Network is	DentalGuard Preferred	
Calendar year deductible	*In-Network*	*Out-of-Network*
Individual	$50	$50
Family limit	3 per family	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*
Preventive Care	100%	100%
Basic Care	80%	80%
Major Care	50%	50%
Orthodontia	50%	50%
Annual Maximum Benefit	$1000	$1000
Maximum Rollover	Yes	
Rollover Threshold	$500	
Rollover Amount	$250	
Rollover In-network Amount	$350	
Rollover Account Limit	$1000	

****Percentage of Usual & Customary****

Vision Benefits

Eye care is a vital component of a healthy lifestyle. This plan is designed to provide a high quality vision care benefit while controlling the cost of such care. To do this, the plan encourages covered persons to seek vision care from doctors and vision care facilities that belong to the Davis Vision's Preferred Provider Organization Network (PPO). Use of the PPO is voluntary. A covered person may receive vision care from either a preferred or non-preferred provider. However this plan usually pays more in benefits for covered services furnished by a preferred provider. If a covered person chooses a non-preferred provider the plan will usually pay less for covered services which could mean more money out-of-pocket for the member.

	In-Network Provider	Out-of-Network Provider
Exam Co-Pay	$25	Up to $50 Reimbursement
Materials Co-Pay	$25	$25
Plan Pays the Following:		
Lenses	Co-pay applies, plan pays rest of cost	Plan will pay between $48-$126 of the cost of lenses. Reimbursement is based on the type of lenses. Remaining balance is patient responsibility.
Contact Lenses Conventional and Disposable	Up to $120 allowance	Up to $105 Reimbursement
Frames	Up to $120 allowance	$30 Remaining balance is patient responsibility.
Medically Necessary Contact Lenses	Covered in full with Prior Approval. Co-pay doesn't apply.	$225 Remaining balance is patient responsibility.

How often can I obtain vision Services?

Exams ---------- Once every 12 months
Lenses ---------- Once every 24 months
Frames ---------- Once every 24 months
Materials ---------- Once every 24 months

Searching for Providers

To search for providers included in the Davis Vision PPO Network please visit the Guardian website for more information.
https://www.guardiananytime.com/fpapp/FPWeb/visionSearch.process

Wellness Program

The daily demands of life and work can make it hard to live a healthy lifestyle. Larson Design Group appreciates our employees and wants to provide the tools and support for them to be healthy and well. Larson Design Group has partnered with Viverae, a leading health management services provider, to bring the latest health and wellness content, educational programs, and an online community to keep employees motivated.

The Larson Design Group Wellness Program is a vital part of our overall benefits program and aims to improve the health of our employees through health behavioral changes which can lead to the improvement of employee health, increase in productivity, reduction in Larson Design Group's healthcare cost, Workers Compensation and disability claim costs.

Another great thing about this is that employees who participate and complete the Larson Design Group Wellness Program can qualify for a discount on their health insurance premium.

How is the discount earned?

Each year on June 1, Human Resources will release the new wellness program outlining the activities and points that need to be achieved to qualify for the discount. When the wellness program activities and points are achieved, the employee will qualify for the discounted health insurance rate. This would be effective the beginning of the next plan year which begins each year on July 1.

New LDG Employees

If you were hired **prior** to June 1 you will automatically receive the "wellness rate" when you first become eligible for benefits and also for the new health plan year that begins July 1. However to receive further wellness program discounts for future plan years, new employees would need to start participating in this wellness program that begins June 1.

If you were hired after June 1, you will automatically receive the "wellness rate" for the remaining portion of the plan year and also for the plan year that begins July 1. However to receive further wellness program discounts for future plan years, new employees would need to start participating in this wellness program that begins June 1.

Viverae

How to get started?

To view your personal wellness portal please follow the instructions below.

Step 1

»» Visit https://connect.viverae.com

»» Click New User Registration

»» Enter your last name and date of birth (DOB)

»» Enter your identifier: Four digit employee number (use a leading 0 if only three digits)

»» Enter the registration code: larson

Step 2

»» Create a user name (5 – 25 characters)

»» Create a password (8 – 12 characters) using letters (upper and/or lowercase), numerals and/or special characters (such as @$%&#)

»» Select a security question and answer, then click Save

Health, Dental and Vision Costs

All rates are based on a bi-weekly pay schedule

Health Standard "Wellness"	Per Pay Cost
Employee Only	$ 79.00
Employee + Spouse	$ 176.00
Employee + Child	$ 128.00
Employee + Children	$ 128.00
Employee + Family	$ 243.00

Health Standard "Non-Wellness"	Per Pay Cost
Employee Only	$ 108.00
Employee + Spouse	$ 239.00
Employee + Child	$ 191.00
Employee + Children	$ 191.00
Employee + Family	$ 307.00

Health Plus "Wellness"	Per Pay Cost
Employee Only	$ 106.00
Employee + Spouse	$ 235.00
Employee + Child	$ 166.00
Employee + Children	$ 169.00
Employee + Family	$ 323.00

Health Plus "Non-Wellness"	Per Pay Cost
Employee Only	$ 169.00
Employee + Spouse	$ 298.00
Employee + Child	$ 229.00
Employee + Children	$ 232.00
Employee + Family	$ 386.00

Dental	Per Pay Cost
Employee Only	$ 3.00
Employee + Spouse	$ 6.50
Employee + Child(ren)	$ 6.50
Employee + Family	$ 8.00

Vision	Per Pay Cost
Employee Only	$ 0.52
Employee + Spouse	$ 0.98
Employee + Child(ren)	$ 0.98
Employee + Family	$ 1.15

Disability Benefits

You probably have insurance for your car or home, but what about the source of income that pays for it? Disability insurance can help replace lost income and make a difficult time a little easier. There are currently two types of disability coverages offered to employees through Guardian Life.

1. **Long-Term Disability** This plan is mandatory for all benefit eligible employees. Currently the Company pays 50% of the premium for this benefit with the employee paying the remaining 50%. Premiums for this benefit can be found during the enrollment process in PlanSource.

   This benefit would begin on the 91st day of a disability and would pay benefits for the first two years of the disability if the employee is unable to work in their own occupation. After two years, the employee can continue to receive benefits if they cannot work in any occupation based on training, experience and education.

Monthly Volume	60% of monthly earnings
Maximum Amount	$8,000 per month
Benefits begin on	Accident: Day 91 Illness: Day 91
Maximum Payment Period	Latter of Age 65 or Social Security Normal Retirement Age

2. **Short-Term Disability** This voluntary benefit is available to all benefit eligible employees. Employees who choose to enroll in this benefit will pay 100% of the benefit premium on a post-tax basis. Premiums for this benefit can be found during the enrollment process in PlanSource. Evidence of Insurability is required on all late enrollees but not for a new hire electing at the initial enrollment period. Please refer to certificate of coverage for full plan description.

   For Short-Term Disability, an employee is considered disabled if unable to perform major job duties on a full-time basis. This would include pregnancy. An employee is not considered disabled if they are able to perform any work for wage or profit.

Weekly Volume	60% of weekly earnings
Maximum Amount	$1500 per week
Benefits begin on	Accident: Day 1 Illness: Day 8
Maximum Payment Period	13 weeks

Basic Life Insurance and Accident Death and Dismemberment (AD&D) Insurance

Life and Accidental Death and Dismemberment (AD&D) insurance provides you and your family with financial protection should you die or become permanently disabled. This benefit is company paid and provides a benefit equal to 200% of annual earnings up to $250,000.

Your group life insurance will terminate if your employment ends, or if you stop being a member of an eligible class of employees. If either happens, you can convert all or part of your group life insurance to an individual life insurance policy. The process of continuing your life insurance coverage is called Conversion. Please refer to the certificate of benefits located on the PlanSource website for more information on this option.

Don't forget to designate a beneficiary when enrolling in the life insurance plan.

You can change your beneficiary at any time by updating the information via the PlanSource website.

Supplemental Term Life Insurance (Employee, Spouse and Children)

Voluntary Term Life Insurance can be purchased to supplement the paid life insurance. Employees can also purchase coverage for a spouse and children. Premiums for these supplemental benefits can be found during the enrollment process or in the library on the PlanSource website.

This supplemental benefit has a Portability option if you would terminate employment. Portability allows for coverage to continue after employment is terminated. Please refer to the certificate of benefits located on the PlanSource website for more information on this option.

Employee Volume Amount	Increments of $10,000 to a Maximum of $500,000
Spouse Volume Amount	Minimum Amount of $5,000 and Increments of $5,000 to a maximum of $250,000. Spouse volume can be no more than 50% of Employee Option Life Insurance.
Child Volume Amount	Ages 14 Days to 23 Years Flat $10,000
Member Guaranteed Issue	Ages 15-64 $150,000 Ages 65-69 $10,000 Ages 70 and up, evidence of insurability is required for all amounts.
Spouse Guaranteed Issue	Spouse's Age 15-64 $25,000 Spouse's Age 65 and up $5,000
Child Guaranteed Issue	There is no guaranteed issue. All amounts are approved.
Age-defined Benefit Reductions	35% at age 65 60% at age 70 75% at age 75 85% at age 80

Additional Information about Voluntary Benefits:

Guaranteed Issue (Voluntary Term Life)

Guarantee Issue means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.

If you decide to purchase more than the Guaranteed Issue amount or enroll after you first become eligible, you must complete an Evidence of Insurability which contains medical questions that will assess your insurability. Answering "yes" to any of the questions will not necessarily prevent you from obtaining coverage.

Evidence of Insurability (EOI)

An EOI will be required under the following circumstances when applying for voluntary benefits:

- At hire if you wish to elect more than the Guaranteed Issue amount of voluntary life insurance for yourself and a spouse.
- You wish to elect wish to elect voluntary life insurance and/or short term disability coverage after your initial eligibility period.
- You wish to increase your current elected level of coverage for the voluntary life insurance.

Flexible Spending Accounts

There are two types of Flexible Spending Accounts (FSAs) available to employees—Health Care Spending Account and Dependent Care Spending Account. These accounts reimburse you for certain health care and child care expenses before Federal, Social Security and (in most areas) State and Local Income taxes are withheld. Our FSA plans are administered by our TPA Meritain.

How FSAs Work

At hire, or during Open Enrollment, employees can set aside money for the plan year for health and/or dependent expenses. Your contributions are deducted from your paycheck on a pre-tax basis in equal installments during the plan year. These are separate accounts in which an employee can choose to participate in. Please note that you cannot use money from the Health Care Spending Account to cover expenses eligible under the Dependent Care Spending Account, or vice versa.

Be sure to estimate your expenses carefully as any money remaining in the account (s) at the end of the grace period is forfeited and according to IRS rules cannot be refunded to an employee and funds will be applied towards administrative costs. Furthermore, the amount contributed can't be changed or stopped, unless there is a Qualified Life Event.

Participating in the Health Care Spending Account

You can use your Health Care Spending Account to pay for many of the health care expenses that the IRS considers deductible on your income tax return and aren't reimbursed from any other source. This includes health care expenses for anyone you can claim as a dependent on your tax return, regardless of whether or not the dependent is covered under the medical plan.

You may contribute up to $2,500 to the Health Care Spending Account. Expenses must be incurred between July 1 (or date of hire, if later) and August 15 of the following year. Expenses are considered incurred when the service is provided, not when you are billed or pay for the services. You may submit claims at any time throughout the year (a form can be found in the library on the PlanSource website). In addition, an employee will have until August 31 to submit eligible expenses for reimbursement.

Tax Considerations

Flexible Spending Accounts (both Health Care and Dependent Care) are governed by Section 125 of the Internal Revenue Code. This section of the tax law imposes certain restrictions on spending accounts. Expenses paid through the Health Care and Dependent Care Spending Accounts may not be taken as itemized deductions on your income tax return or applied toward the federal or state tax credit on your income tax return.

Please Note: *Consult your tax advisor for more information about Flexible Spending Accounts and tax laws.*

How to Access Funds

There are two options for accessing funds in the health care spending account.

1. If you enroll in the Health Care spending account you will automatically receive a “Benny Card.” This Debit card will contain your annual election amount and can be used at locations that accept Visa and would be used to pay for qualified expenses not covered by insurance.
2. If you pay for qualified expenses out-of-pocket, in order to be reimbursed for the expenses, you would need to complete and submit the required documentation to Meritain. This form can be found in the library on the PlanSource website. The deadline to submit claims for reimbursement is August 31.

Participating in the Dependent Care Spending Account

The Dependent Care Spending Account is designed to pay for dependent care expenses on a before-tax basis so that you and your spouse (if married) can work. You can use the Dependent Care Spending Account only if your spouse is employed, is a Full-Time student or is disabled. You and your spouse may contribute up to the IRS limit of $5,000 per calendar year to a Dependent Care Spending Account.

Not all expenses qualify as dependent care. Only expenses that are excludable from income under federal tax may qualify as dependent care. Some examples of expenses that qualify are:

1. Before and after school programs
2. Care in your home or someone else’s home (as long as the care giver is not your spouse or dependent and is age 19 or older).
3. Licensed child care center
4. Nursery school or pre-school
5. Summer day care (not overnight)

Expenses for this account must be incurred between July 1 (or date of hire, if later) and August 15 of the following year. Claims forms can be found in the library on the PlanSource website. Employees will have until August 31 to submit eligible expenses for reimbursement.

Eligible Dependents

A dependent for the Dependent Care Spending Account is defined as a child under age 13, or anyone 13 or older who is physically or mentally disabled and who relies on you for financial support.

Time-Off Benefits

Full-Time Employees (30+ hours a week)

Vacation

Hours are accrued every pay period. Vacation benefits vary by job title. Please refer to the HR standards for additional details. Up to 120 hours can be carried over to the following calendar year. Employees who are eligible for vacation time can borrow up to 40 vacation hours.

Sick Time

Employees accrue two hours of sick leave every pay period. Up to 520 hours of sick leave can be carried over to the following calendar year.

Personal Day

Employees receive one personal day a year. Personal day is pro-rated for new hires.

Holidays

Employees receive nine paid holidays each year. They are as follows:

- New Year's Day
- Easter (Friday before or Monday after Easter)
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving: 2 days
- Christmas: 2 days (or Ramadan, Yule, Hanukkah or Kwanzaa)

Work & Life Resources and Employee Assistance Program

Do you need help finding a day care for your newborn or elder care for an aging parent? Need information on home buying? Do you have a loved one with a substance abuse or mental health problem?

WorkLife Matters is a Confidential Employee Assistance Program that provides guidance for employees and their dependents for personal issues that they might be facing and information about other concerns that affect your life, whether it's a life event or on a day-to-day basis.

Services Included:

- Unlimited free telephonic consultation with an EAP counselor available 24/7 at ***800-386-7055***
- Referrals to local counselors — up to three sessions free of charge. When you call ***800-386-7055***, the counselor will arrange a professional who is part of the IBH network of providers.
- State-of-the-art website featuring over 3,400 helpful articles on topics like wellness, training courses, and a legal and financial center.
- For legal and financial topics, employees receive a free initial 30 minute office or telephone consultation with an attorney or seasoned financial professional or CPA. Local referrals are available for more complex legal or financial planning issues. If the attorney is retained to provide legal services, the employee can apply a 25% discount off the attorney's normal hourly fee rate.

WorkLife Matters can offer help with:		
Education • Admissions testing & procedures • Adult re-entry programs • College Planning • Financial aid resources • Finding a pre-school **Lifestyle & Fitness Management** • Anxiety & depression • Divorce & Separation • Drugs & alcohol	**Dependent Care & Care Giving** • Adoption Assistance • Before/after school programs • Day Care/Elder Care • Elder care • In-home services **Working Smarter** • Career development • Effective managing • Relocation	**Legal and Financial** • Basic tax planning • Credit & collections • Debt Counseling • Home buying • Immigration

For more information about WorkLifeMatters and to access a vast library of resources on the above topics go to **www.ibhworklife.com.**

User name: Matters
Password: wlm70101

Retirement Plans

Two very important benefits for Larson Design Group employees are the 401(K) Savings Plan and the Employee Stock Ownership Plan (ESOP). Both benefits are an integral part of an employee's Total Compensation package and are designed with a long-term approach to retirement savings.

401(K) Savings Plan

Eligibility

Larson Design Group's 401(K) Plan is managed by Fidelity Investments. Employees are eligible for the 401(K) Plan the first of the month following their date of hire.

The Plan has an automatic enrollment feature which means employees will be automatically enrolled at 6% of earnings when they are first eligible. If an employee wishes to increase or decrease the automatic deferral contribution they can do so by contacting the Fidelity Benefits Line at 1-800-294-4015 or access the NetBenefits® web site at http://www.netbenefits.com. An enrollment packet will be sent to employees approximately 10 days after their hire date. that will contain information on the Plan.

In addition to the automatic enrollment feature, Larson Design Group has established an Annual Increase Plan (AIP). With the AIP, the contribution percentage will be automatically increased 1% annually until the AIP cap of 10% is reached. This can also be increased or decreased by contacting Fidelity.

Contribution Amounts

Employees may contribute between 1% and 75% of their eligible income up to the annual IRS dollar limit. In addition, if you are age 50 or older and have reached the IRS dollar limit for the year, you may make additional salary deferral contributions to the Plan up to the IRS Catch-up Limit. For more information on the yearly limits please visit https://www.irs.gov/.

Furthermore, employees can increase or decrease their deferral contribution at any time by contacting Fidelity Investments. Changes are effective the beginning of each pay period.

Employer Match for 401(K)

The Company currently provides a 30% match on the first 3% of the employee's deferral contributions to the Plan and 10% on all employee contributions to the Plan above 3%. For example if an employee defers 8%, the Company match would be 1.4%. The Company decided to adopt a generous & aggressive matching program that is uncapped (up to IRS limits). The more you save the more the Company matches.

Rollover

A rollover into the Plan from another Qualified Deferred Compensation Plan may be completed upon date of hire. To complete a rollover in the Plan the follow these steps:

1. Contact your prior Plan provider to request a rollover distribution.
2. The rollover check issued must be made payable to Fidelity Management Trust Company as the trustee for the benefit of (FBO) the employee and sent to the employee.
3. Complete the Fidelity Advisor Rollover contributions form provided by Fidelity.
4. Return both the Fidelity Advisor Rollover contribution form and the check from your prior Plan to Fidelity so they may authorize the contribution.

For more detailed information on the 401(K) Savings Plan please refer to the Summary Plan Description in the HR Public Folder.

Employee Stock Ownership Plan (ESOP)

Employees become a participant in the Employee Stock Ownership Plan (ESOP) on the January 1 or July 1 after the date they meet the following requirements:

- Complete one year of service and 1,000 hours of service and
- Attain age 21

Each year, the Company makes a contribution to the ESOP. This contribution will be based upon business considerations and will be made in employer stock, cash or a combination of both. This allocation will be held in the employee ESOP Account and is subject to the vesting schedule listed below. For more information on this benefit please refer to the ESOP Summary Plan Description in the HR Public Folder.

Vesting Schedule: ESOP & 401(K) Savings Plan

The Employer Matching Contributions and earnings are vested in accordance with the following schedule. Additionally the ESOP account allocations are also subject to the below vesting schedule.

Years of Service	Vesting Percentage
Less than 2 Years	0%
2 Years	20%
3 Years	40%
4 Years	60%
5 Years	80%
6 or More Years	100%

Voluntary Benefits

College Tuition Benefit Rewards

Earn free Tuition Rewards for participation in the Guardian Dental Plan

http://www.guardian.collegetuitionbenefit.com/

Important Information:

- The welcome email is notification that an online account is established. Subscribers can log in to see the points posted to their account, and add additional students as they wish. If you do not log in to your account in the first 6 months, your Tuition Reward may be reduced.
- Eligible students include children, grandchildren, nieces, and nephews.
- The maximum rewards you can use, per registered student, cannot exceed one year's tuition at a participating school.
- Families do not select a college ahead of time.
- Each Tuesday, registered employees receive Market Cap and Gown, an e-newsletter that details events and topics related to college financing, and notifies employees of new colleges in the network.

Deadline dates:

- To use Tuition Rewards, a child must be registered by August 24th of the year they enter 11th grade.
- The Scholarship credits are held in the subscriber's account until they are pledged to a registered child. When a Subscriber has a student in 11th grade, they will be emailed and asked if they want to pledge some or all of their Tuition Rewards to the Registered Student. If they want to use their Tuition Rewards, they must go online before August 24th of the year the student enters 12th grade and transfer Tuition Rewards to that student's account.

What you can expect from the College Tuition Benefit?

- 2,000 Tuition Rewards® are given to each dental plan subscriber when they register an eligible student or students. Subscriber Tuition Rewards® can be allocated to any registered child.
- 500 Tuition Rewards are given to each child registered. Student Tuition Rewards® can only be used by the specific student.
- 2,000 additional Tuition Rewards® are given to the subscriber, annually in the month following the Dental Plan's renewal.
- 2,500 bonus Tuition Rewards® are given to the subscriber the month following the Dental Plan's third renewal (4th year), for a total reward of 4,500 for that year.

Other Voluntary Benefits

Employees of Larson Design Group are eligible to become members of The Pennsylvania State Employees Credit Union (PSECU). PSECU offers many banking benefits and have over 1,000 ATM's located statewide, including many located at convenience stores such as Sheetz, Rutter's, Wawa and participating 7-Elevens.

Follow these simple steps to join online:

- Visit psecu.com
- Click "Join PSECU" under "Membership"
- Click "Open an Account"
- Enter eligibility and complete application process
- Use Promo Code **MICHELLE** to waive entrance fee and establish eligibility for promotions.

For more information, contact your PSECU Representative:
MICHELLE JAMES
800.237.7328, extension 2111 or mjames@psecu.com

PSECU

verizonwireless

Larson Design Group employees are eligible for an 18% discount on their monthly phone bill. Please refer to TARM as the employer as our LDG discount is under that name.

Liberty Mutual. INSURANCE

Home & Auto Insurance

If you are interested in more information or a quote on Home or Auto insurance available through Liberty Mutual please contact:

James J. Dinsmore
999 N. Loyalsock Avenue - Suite C
Montoursville, PA 17754
(570) 337-4247
james.dinsmore@libertymutual.com
Client # 118623

Supplemental Long Term Disability

This benefit is designed to supplement the employee's long term disability plan by allowing the employee to purchase income protection in the event of an illness or injury. If you are interested in learning more about this benefit please contact:

Crockett Financial Services
1421 East Third Street, Suite 200
Williamsport, PA 17701
Phone: 570-322-1313

Important Federal Laws

Newborn and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Health Insurance Portability and Accountability Act (HIPAA)

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to 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). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Marriage, Birth or Adoption

If you have a new dependent as a result of a 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 or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

For More Information or Assistance

To request special enrollment or obtain more information, please contact any member of the Human Resources Department.

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 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)**.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). 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
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call our plan administrator (Meritain) at **800-925-2272.**

Patient Protection-Patient Access to Obstetrical and Gynecological Care

Members do not need prior authorization from the Larson Design Group health plan or from any other person (including the primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network of the member's plan who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care providers who specialize in obstetrics or gynecology please contact our plan administrator (Meritain) at **800-925-2272** or by searching for providers through the Aetna website **www.aetna.com/docfind/custom/mymeritain/.**

Important Phone Numbers and Contact Information

Provider	Description	Phone Number	Website/Email	Group #
HealthAdvocate	General benefit questions and claim advocacy help line	866-695-8622	answers@HealthAdvocate.com https://members.healthadvocate.com/	N/A
Meritain (Third Party Admin of LDG Self-Funded Health Plan)	Medical Benefits	800-925-2272	To find Aetna Providers: www.aetna.com/docfind/custom/mymeritain/ To view claims and other plan info www.meritain.com	15763
Teladoc	Non-emergency medical care option (for Health plan enrollees and their dependents)	800-835-2362	https://www.teladoc.com/	N/A
CVS/Caremark	Retail Pharmacy/Mail Order Pharmacy	877-460-7766	www.caremark.com	15763
PlanSource	Online benefit portal and resource center for benefit plans	N/A	https://benefits.plansource.com/ (User name is first letter of your first name, the first 6 letters of your last name, and the last 4 digits of your social security number)	N/A
Guardian	Dental, Life Insurance, Long Term Disability and Short Term Disability	800-541-7846	www.guardiananytime.com	00295412
Davis Vision	Vision Benefits	877-393-7363	http://www.davisvision.com/	00295412
Worklife Matters	Work and Life and Employee Assistance Program	800-386-7055	www.ibhworklife.com Username: Matters Password: wlm70101	N/A
Debra Schneider Wells Fargo Advisors	401K Plan Advisor	570-322-7788	debra.schneider@wellsfargoadvisors.com	N/A
Fidelity	401K Plan	800-294-4015	www.netbenefits.com	70371
Viverae	Wellness Program	888-848-3723	https://connect.viverae.com	N/A
Meritain	Flexible Spending Accounts	800-566-9305	To view balances visit www.meritain.com	15763

LDG Larson Design Group®

www.larsondesigngroup.com