PLANO ORTHOPEDIC
Sports Medicine & Spine Center, P.A.

2017-2018

Employee Benefits

You're a valued member of Plano Orthopedic Sports Medicine, and your health and well-being are important to us. We are proud to provide you and your dependents with valuable and significant benefits. This guide is an overview of the benefits available to you and their impact on your hard-earned compensation. Please read it carefully in order to make the best choices for you and your family in the 2017-2018 plan year and consult your HR representative with any questions.

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See **page 20** for important information concerning Medicare Part D coverage.

In this Guide, we use the term Company to refer to Plano Orthopedic & Sports Medicine Center, P.A. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

ELIGIBILITY & ENROLLMENT

You and your family have unique needs, which is why Plano Orthopedic Sports Medicine offers a variety of benefit plans from which you may choose. If applicable, please make sure to consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Eligibility

If you are a full-time employee of Plano Orthopedic Sports Medicine who is regularly scheduled to work at least 40 hours a week (35 hours for Physical Therapists), you are eligible to participate in the medical, dental, vision, life and disability plans, and other additional benefits.

When Does Coverage Begin?

The elections you make are effective on the first of the month following date of hire. Due to IRS regulations, once you have made your choices for the 2017-2018 plan year, you won't be able change your benefits until the next enrollment period unless you experience a qualifying life event.

Eligible Dependents

Dependents eligible for coverage in the Plano Orthopedic Sports Medicine benefits plans include:

- Your legal spouse (or common-law spouse in states which recognize common-law marriages).
- Children up to age 26 (includes birth children, stepchildren, legally-adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your medical plan to continue coverage past age 26.

Verification of dependent eligibility will be required upon enrollment.

Qualifying Life Events

When one of the following events occurs, you have 31 days from the date of the event to notify Human Resources and/or request changes to your coverage.

- Change in your legal marital status (marriage, divorce or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility. NOTE: If you drop below 30 hours per week you may be able to extend your coverage due to Affordable Care Act requirements.
- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace (during a Marketplace special or open enrollment period)
- Change in your address or location that may affect the coverage for which you are eligible

Your change in coverage must be consistent with your change in status. Please direct questions regarding specific life events and your ability to request changes to Human Resources.

Preparing to Enroll

Plano Orthopedic Sports Medicine provides its employees the best coverage possible. As a committed partner in your health, Plano Orthopedic Sports Medicine will be absorbing a significant amount of the costs. Your share of the contributions for medical, dental and vision benefits is deducted on a pre-tax basis, which lessens your tax liability. Please note that employee contributions for medical, dental and vision coverage vary depending on the level of coverage you select. In general, the more coverage you have, the higher your contribution will be.

Keep in mind that you may select any combination of medical, dental and/or vision plan coverage categories. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of Plano Orthopedic Sports Medicine, must elect coverage for yourself in order to elect any dependent coverage. Be sure to have the Social Security numbers and birthdates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information.

You CANNOT change your benefit selections during the plan year unless you have a qualifying life event, such as marriage and/or the birth or adoption of a child.

OPEN ENROLLMENT CHECKLIST

You only have a small window of time to make changes that are effective for the entire plan year (unless you have a qualifying life event). To save time and money, here some things you should check off of your to-do list before Open Enrollment begins.

1. Update your personal information.

If you've experienced a qualifying life event in the last year (moving, new baby, change in marital status, etc.), you may need to change your elections. This seems like an obvious action to take, but failure to update your personal information could cost you in the long run.

2. Double-check covered and restricted medications.

If you currently take a medication that requires prior authorization, you may be prompted to try a lower-cost drug or even be limited in the amount of medication you can buy at one time. Review your available options outlined in this guide.

3. Review available plans' deductibles.

If you're planning on having a baby or major surgery this year, think carefully about your out-of-pocket medical costs and deductible. Conversely, if you don't anticipate a great need for healthcare this year, perhaps you could switch to a plan with a higher deductible and lower premiums. Read on for more information about various plan deductibles later in the guide.

MEDICAL BENEFITS

Our medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers, as well as prescription medication. Medical benefits are offered through Blue Cross Blue Shield of Texas. Choose the plan that best matches your needs and please keep in mind that the option you elect will be in place for all of the 2017-2018 plan year, unless you have a qualifying life event.

Medical Premiums

Premium contributions for medical will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your biweekly contributions.

How to Find a Provider

To see a current list of Blue Cross Blue Shield of Texas network providers, visit www.bcbstx.com or call Customer Care at 800-521-2227 for assistance.

Medical Plan Summary

The chart on the next page gives a summary of the 2017-2018 medical coverage provided by Blue Cross Blue Shield of Texas. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

Health Care Cost Transparency

Tools like the Health Savings and Flexible Spending Accounts have helped put the power of health care spending in consumers' hands. This means you have control over how your health care dollars are spent. But with the cost of services varying widely, make sure you're making the best choice for your health and your wallet. Enter health care cost transparency tools. Online tools available via www.bcbstx.com allow you to compare costs for everything from prescription drugs to major surgeries. For more information, visit www.bcbstx.com.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms may look a lot like urgent care centers, but the costs and services can be drastically different. In general, consider an urgent care center as an extension of your primary care physician, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns rather than an ER could save you hundreds of dollars.

Take advantage of preventive care offered by an in-network physician. This will save you time and money in the long run!

	MM17-PPO	MM26-PPO	MMH8-HSA
BIWEEKLY CONTRIBUTIONS			
EMPLOYEE ONLY	$134.67	$94.03	$50.35
EMPLOYEE + SPOUSE	$592.10	$502.68	$406.56
EMPLOYEE + CHILD(REN)	$458.68	$383.49	$302.65
EMPLOYEE + FAMILY	$973.25	$843.19	$703.38

	MM17-PPO	MM26-PPO	MMH8-HSA
	IN-NETWORK	IN-NETWORK	IN-NETWORK
CALENDAR YEAR DEDUCTIBLE			
INDIVIDUAL	$1,500	$3,000	$4,000
FAMILY	$4,500	$9,000	$8,000
COINSURANCE (PLAN PAYS)	75%*	70%*	10%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)			
INDIVIDUAL	$6,500**	$6,600**	$4,000
FAMILY	$13,200**	$13,200**	$8,000
COPAYS/COINSURANCE			
PREVENTIVE CARE	100%	100%	100%
SPECIALIST VISIT	$30 copay	$40 copay	100%*
DIAGNOSTIC SERVICES	$30 copay	$40 copay	100%*
URGENT CARE	$55 copay	$65 copay	100%*
EMERGENCY ROOM	$100 copay then 75%		100%*

*After Deductible
**Separate Rx Out-of-Pocket Maximum of $1,000 for Individual and $3,000 for Family
Please refer to the BCBS medical benefit highlight sheets for out-of-network coverage

There are no pricing standards for healthcare so charges for medical services can vary greatly — even for the same procedure, in the same area, within the same network. Make sure to use healthcare cost transparency tools to ensure the most cost-effective choice.

PREVENTIVE CARE

Did you know that your health plans must cover a set of preventive services — such as shots and screening tests — at no cost to you? Work with your Primary Care Physician to stay up to date on preventive services — identifying and treating illnesses early will save you time and money, and promote a healthy lifestyle in the long run!

Key Things to Remember:

- Many preventive care services and tests are covered at 100%. You can find a list of covered services in your plan documents.
- Think of preventive care visits as routine check-ups. Things that may occur during a preventive visit include immunizations, blood pressure and cholesterol measurement, diabetes screening, or counseling on healthy weight.
- Diagnostic care to identify potential health risks are covered according to plan benefits, even if recommended or done during a preventive care visit.
- If your physician finds a specific health risk or new medical condition during your appointment, your doctor may bill those services as diagnostic medicine. These types of diagnostic services may result in out-of-pocket costs for you (i.e., deductibles, coinsurance, or copayments) because they are no longer considered preventive care.

Check your benefit summary to see what preventive services are available to you at no cost.

Any screening test done in order to catch a disease early is considered a preventive service. Due to the U.S. Patient Protection and Affordable Care Act (ACA), many services, screenings and supplies are paid at 100% including, but not limited to, the following:

- Wellness visits, yearly physicals and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and Type 2 diabetes
- Pediatric screenings for hearing, vision, obesity, depression, autism and developmental disorders
- Anemia screenings, breastfeeding support and breastfeeding pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

VIRTUAL MEDICINE

Pressed for time or too sick to drive to the doctor? Consider one of these modern ways of seeking medical assistance.

Telemedicine

Telemedicine through MDLive is an additional benefit available to employees and their dependents. With MDLive, you have on-demand access to board-certified doctors and pediatricians by online video, phone or secure email. You can be treated for various general health and general pediatric care issues without leaving the comfort of your home. This service can be utilized for after-hours non-emergency care, when your primary care physician is not available, to make requests for prescriptions or refills, or if you are traveling and need general medical care. Examples of items that can be treated include allergies, asthma, headache, pink eye, respiratory infections, ear infections and much more. Please note that some states do not allow physicians to prescribe medications via telemedicine. For more information, visit www.mdlive.com/bcbstx.

MDLive doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems

MDLive doctors can also share information with your primary care physician with your consent.

PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through Blue Cross Blue Shield of Texas.

That means you will only have one ID card for both medical care and prescriptions. You may find information on your benefits coverage and search for network pharmacies by logging on to www.bcbstx.com or by calling the Customer Care number on your ID Card.

Your cost is determined by the tier assigned to the prescription drug product. All products on the list are assigned as generic, preferred or non-preferred as designated on the BCBSTX "Preferred Drug List 2."

	MM17-PPO	MM26-PPO	MMH8-HSA
	IN-NETWORK	IN-NETWORK	IN-NETWORK
RETAIL RX (30-DAY SUPPLY)			
GENERIC	$20**	$20**	100% of allowable*
PREFERRED	$40**	$40**	100% of allowable*
NON-PREFERRED	$60**	$60**	100% of allowable*
MAIL ORDER RX (90-DAY SUPPLY)			
GENERIC	$60**	$60**	100% of allowable*
PREFERRED	$120**	$120**	100% of allowable*
NON-PREFERRED	$180**	$180**	100% of allowable*

*After Deductible
**Separate Rx Out-of-Pocket Maximum of $1,000 for Individual and $3,000 for Family
Please refer to the BCBS medical benefit highlight sheets for out-of-network coverage

Q & A: GENERIC DRUGS

What is a generic drug?

Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety and strength as the original drug. In other words, their pharmacological effects are exactly the same as those of their brand-name counterparts.

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

What standards do generic drugs have to meet?

Health professionals and consumers can be assured that FDA approved generic drugs have met the same rigid standards as the innovator drug. To gain FDA approval, a generic drug must:

- Contain the same active ingredients as the innovator drug (inactive ingredients may vary)
- Be identical in strength, dosage form, and route of administration
- Have the same use indications
- Be bioequivalent
- Meet the same batch requirements for identity, strength, purity, and quality
- Be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products

Are generic drugs that much cheaper than brand-name medications?

Yes. On average, the cost of a generic drug is 80% to 85% lower than the brand-name equivalent.

Is there a generic equivalent for my brand-name drug?

To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov to view a catalog of FDA-approved drug products, as well as drug labeling information.

DENTAL BENEFITS

Regular dental checkups do more for your well-being than just preserve a healthy smile. Plano Orthopedic Sports Medicine's dental coverage will provide you and your family affordable options for overall health. Coverage is available from Blue Cross Blue Shield of Texas.

Network Dentists

If you choose to use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Blue Cross Blue Shield of Texas at www.bcbstx.com.

Dental Premiums

Premium contributions for dental will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your biweekly premium.

Dental Plan Summary

Dental plan benefits are available to you on a voluntary basis. The chart below gives a summary of the 2017-2018 dental coverage provided by Blue Cross Blue Shield of Texas. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

DENTAL PPO

	BIWEEKLY CONTRIBUTIONS
EMPLOYEE ONLY	$18.33
EMPLOYEE + SPOUSE	$36.66
EMPLOYEE + CHILD(REN)	$49.30
EMPLOYEE + FAMILY	$74.76
	IN-NETWORK
	CALENDAR YEAR DEDUCTIBLE
INDIVIDUAL	$50
FAMILY	$150
	CALENDAR YEAR MAXIMUM
PER PERSON	$1,500
	COVERED SERVICES
PREVENTIVE SERVICES	100%
BASIC SERVICES	80%*
MAJOR SERVICES	50%*
ORTHODONTICS	50%
ORTHODONTIC LIFETIME MAXIMUM	$1,500

*After Deductible

As many as 120 systemic diseases can be visible in your mouth. Regular checkups can reveal the signs of diseases before they even cross your mind.

VISION BENEFITS

Even those with perfect eyesight should have their vision checked on a regular basis. To ensure that you and your family have access to quality vision care, Plano Orthopedic Sports Medicine offers a comprehensive vision benefit provided by EyeMed.

Vision Premiums & Plan Summary

Premium contributions for vision will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your biweekly premium. The chart below gives a summary of the 2017-2018 vision coverage provided by EyeMed. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	VSP	
BIWEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$3.01	
EMPLOYEE + SPOUSE	$5.73	
EMPLOYEE + CHILD(REN)	$6.03	
EMPLOYEE + FAMILY	$8.86	
	IN-NETWORK	**OUT-OF-NETWORK**
COVERED MATERIALS		
LENSES		
SINGLE VISION LENSES	Copay then 100%	$30 reimbursement
BIFOCAL LENSES	Copay then 100%	$50 reimbursement
TRIFOCAL LENSES	Copay then 100%	$70 reimbursement
FRAMES		
RETAIL FRAME EQUIVALENT	$130 allowance*	$91 reimbursement
CONTACT LENSES		
NECESSARY	Copay then 100%	$210 reimbursement
ELECTIVE	$130 allowance**	$130 reimbursement
COPAYS		
EXAMINATION	$10	$40 reimbursement
MATERIALS	$25	See fee schedule
BENEFIT FREQUENCY		
EXAMINATION	Every 12 months	
LENSES	Every 12 months	
FRAMES	Every 24 months	
CONTACTS (in lieu of Lenses and Frames)	Every 12 months	

*Additional 20% off remaining balance over $130
**Additional 15% off remaining balance over $130 (does not apply for Disposable Contacts)

Eye doctors are often the first health care professionals to detect chronic systemic diseases such as high blood pressure and diabetes.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax payroll deductions to pay for various out-of-pocket expenses.

Health Care Flexible Spending Account

You can contribute up to $2,650 for qualified medical expenses (deductibles, copays and coinsurance, for example) with pre-tax dollars, which will reduce the amount of your taxable income and increase your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them, so you don't have to wait for reimbursement.

Please note: Over-the-counter (OTC) drugs are not eligible for reimbursement through an FSA without a doctor's prescription.

Dependent Care Flexible Spending Account

In addition to the Health Care FSA, you may opt to participate in the Dependent Care FSA as well — whether or not you elect any other benefits. The Dependent Care FSA allows you to set aside pre-tax funds to help pay for expenses associated with caring for elder or child dependents. Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you are allowed to set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children younger than the age of 13 and dependents of any age who are incapable of caring for themselves.
- Expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes.
- In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

Eligible Dependent Care Flexible Spending Account Expenses

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. The dependent must be a child younger than the age of 13 and claimed as a dependent on your federal income tax return or a disabled dependent who spends at least eight hours a day in your home.

Examples of eligible dependent care expenses include:

- In-Home Baby-Sitting Services (not by an individual you claim as a dependent)
- Care of a Preschool Child by a Licensed Nursery or Day Care Provider
- Before- and After-School Care
- Day Camp
- In-House Dependent Day Care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the Flexible Spending Account programs. Please check with your tax advisor to determine if any exceptions apply to you.

Your FSA money can cover the cost of going to a chiropractor or acupuncturist, if your insurance doesn't already cover it.

How to Use the Account

You can use your FSA debit card at locations such as doctor and dentist offices, pharmacies, and vision service providers. The card cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The swipe transaction will be denied if you attempt to use the card at an ineligible location.

Once you incur an eligible expense, submit a claim form along with the required documentation. If you have a question about a reimbursement, contact Dearborn National. Should you need to submit a receipt, you will receive an email or be mailed a receipt notification from Dearborn National. You should always retain a receipt for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. This means that you must always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. If you don't provide proof that an expense was valid can result in your card being turned off and your expense being deemed taxable.

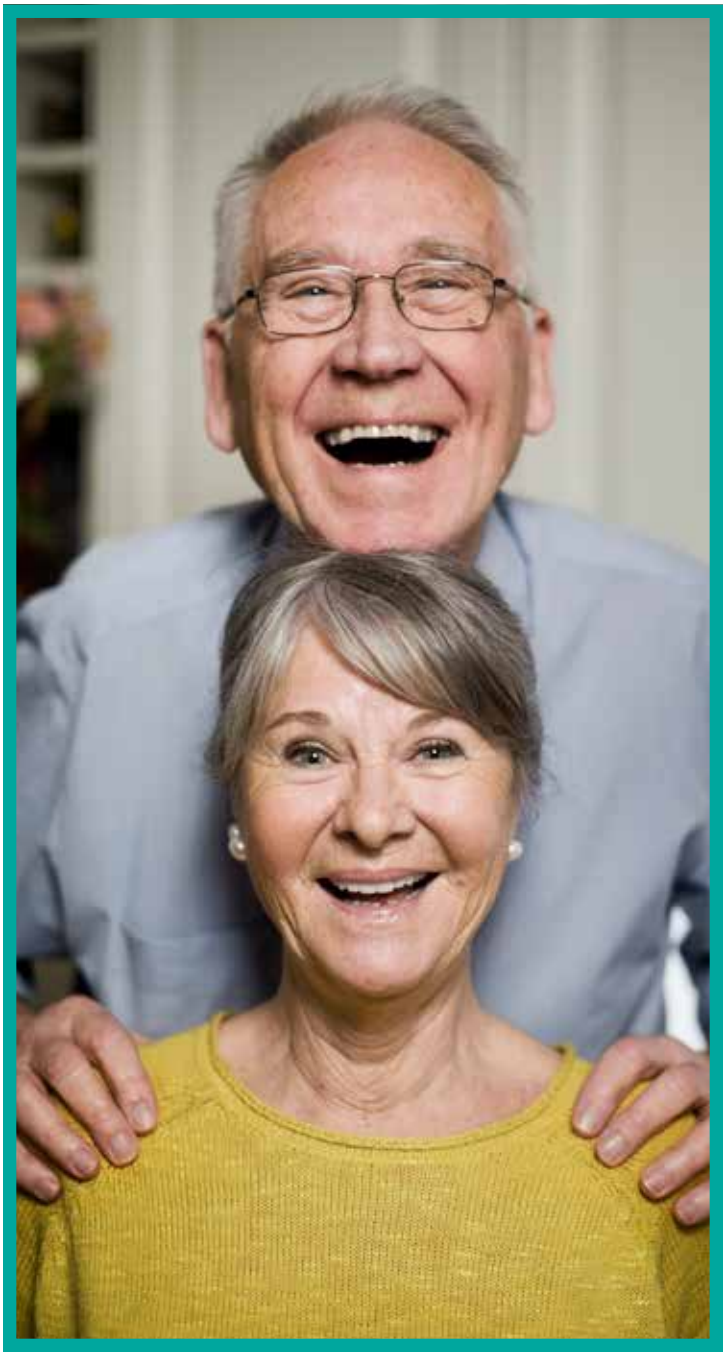
General Rules and Restrictions

In exchange for the tax advantages that FSAs offer, the IRS has imposed the following rules and restrictions for both Health Care and Dependent Care FSAs:

- Your expenses must be incurred during the 2017-2018 plan year.
- Your dollars cannot be transferred from one FSA to another.
- You cannot participate in Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it"— any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year unless you experience a qualifying life event like marriage, divorce or birth of a child.

Grace Period

- FSA participants have an additional 2½-month grace period of time to incur expenses after the plan year ends November 30, 2018.
- If an expense is incurred between November 30, 2018 and February 15, 2019 AND submitted for reimbursement by February 28, 2019, any remaining balance in the previous plan year that ended November 30, 2018, will be paid out from the claim, even though the service was provided in the NEW plan year.
- The grace period applies to both the Dependent Care and Health Care FSAs.



SURVIVOR BENEFITS

It's not always easy to talk with your family about how they'll be provided for if you weren't around, but it's an important conversation to have. Survivor benefits provide financial assistance in an absence, and can help you plan for the unexpected. If you secure Life insurance now, chances are you can take comfort in knowing that those who depend on you will be provided for.

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

Life and AD&D benefits are essential to your family's financial security. As such, it is important to understand how your plan works and what benefits you will receive. Basic Life and AD&D benefits are provided to you as a part of your basic coverage. Plano Orthopedic Sports Medicine provides employees with Basic Life and AD&D insurance through Dearborn National, which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after death.

Your Basic Life and AD&D insurance benefit is:

- 1 times base annual salary, up to $300,000
- If you are a full-time employee, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

Beneficiary Designation

A beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by Plano Orthopedic Sports Medicine. You receive the benefit payment for a dependent's death under the Dearborn National insurance.

Make sure your beneficiary designation is clear so there is no question as to your intentions, and remember to name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. If the beneficiary is not legally related, insert the words "Not Related" in the relationship field.

Please note that in most states, benefit payments cannot be made to a minor younger than 18. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name, and will earn interest until the minor reaches majority age at 18.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in percentages. If you need assistance, contact Human Resources or your own legal counsel.

Voluntary Benefits

Voluntary Life and AD&D insurance for your and/or your dependents is available through Dearborn National. Contact Human Resources for more information about these Voluntary Life and AD&D benefits.

Your beneficiary doesn't have to be a person. A trust, or a legal agreement that lets you place property under the control of a trust manager, can be named the beneficiary. The beneficiary can also be a charity or simply your estate.

INCOME PROTECTION

Plano Orthopedic Sports Medicine offers disability coverage to protect you against any debilitating injury. This insurance protects a portion of your income until you can return to work, or until you reach retirement age.

Long Term Disability (LTD) Insurance

LTD insurance replaces 60% of your income if you become partially or totally disabled for an extended period of time. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your plan documents for details or contact Human Resources for specific benefits.

MONTHLY MAXIMUM BENEFIT	$15,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

RETIREMENT PLANNING

It's never too early — or too late — to start planning for your retirement. Making contributions to a 401(k) account is the first step toward achieving financial security later in life. The Plano Orthopedic Sports Medicine 401(k) plan provides you with the tools and flexibility you need to retire comfortably and securely.

Eligible employees can invest for retirement while receiving certain tax advantages. Deferred contributions are based on a flat dollar amount not to exceed Plan limits set by the IRS. The limit for 2016-2017 is $18,000. Administrative and record-keeping services for this plan are provided by Great-West Retirement Services.

Eligibility

You may start making pre-tax contributions into the plan on the first day of the next quarter after completing one year of service and 1,000 hours. You must also be at least 21 years of age to be eligible.

Contributing to the Plan

Deferred contributions are based on a flat dollar amount not to exceed plan limits set by the IRS. The limit for 2017 is $18,000 and for 2018 is $18,500.

Catch-up Contributions

If you are or will be age 50 or older during this calendar year and you already contribute the maximum allowed to your 401(k) account, you may also make a "catch-up contribution." This additional deposit of funds accelerates your progress toward your retirement goals. The maximum catch-up contribution is $6,000 for 2017 and for 2018. See your plan administrator for more details.

Changing or Stopping Your Contributions

You may change the amount of your contributions any time. All changes will become effective as soon as administratively feasible and will remain in effect until you modify them. You may also discontinue your contributions any time. If you stop making contributions, you may start again at any time.

Consolidating Your Retirement Savings

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer or roll over that account into the plan any time. To initiate a rollover into your plan, contact Great-West Retirement Services at 800-338-4015 for details.

Investing in the Plan

You decide how to invest the assets in your account. The Plano Orthopedic Sports Medicine 401(k) plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, refer to your 401(k) Enrollment Guide.

If you dip into your 401(k) account before age 59 1/2, you will pay a 10% early withdrawal penalty— in addition to income tax—on the amount.

GLOSSARY

Coinsurance – Your share of the cost of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible. For instance, if your plan's allowed amount for an office visit is $100 and you've met your deductible (but haven't yet met your out-of-pocket maximum), your coinsurance payment of 20% would be $20. Your plan sponsor or employer would pay the rest of the allowed amount.

Consumer-Driven Health Plan (CDHP) – A plan option that provides choice, flexibility and control when it comes to spending money on health care. Preventive care is covered at 100% with in network providers, and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

Copay – The fixed amount, as determined by your insurance plan, you pay for health care services received.

Deductible – The amount you owe for health care services before your health insurance or plan sponsor (employer) begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've met your $1,000 deductible for covered health care services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket health care costs. This means you'll save an amount equal to the taxes you would have paid on the money you set aside.

- **Health Care FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code. Please note that over-the-counter medications are not eligible for reimbursement without a doctor's prescription with the Health Care FSA.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before- or after-school programs, and child or elder daycare. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Flexible Spending Accounts are "use it or lose it," meaning that funds not used by the end of the plan year will be lost. Although, some Heath Savings Accounts allow for a grace period or a rollover into the next plan year.

Health Care Cost Transparency – Also known as Market Transparency or Medical Transparency. Healthcare provider costs can vary widely, even within the same geographic area. To make it easier for you to get the most cost-effective healthcare products and services, online cost transparency tools, which are typically available through health insurance carriers, allow you to search an extensive national database to compare costs for everything from prescription drugs and office visits to MRIs and major surgeries.

Health Reimbursement Account (HRA) – A personal health care account funded by your employer that you could use to pay for qualified medical expenses when enrolled in a CDHP

Health Savings Account (HSA) – A personal health care bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a CDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, meaning if you change jobs your account goes with you.

Network – A group of physicians, hospitals, and other health care providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** In-network providers are doctors, hospitals and other providers that contract with your insurance company to provide healthcare services at discounted rates.
- **Out-of-Network –** Out-of-network providers are doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance company.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance or plan begins to pay 100% of the allowed amount. This limit does not include your premium, charges beyond the Reasonable & Customary, or health care your plan doesn't cover. Check with your health insurance carrier to confirm what payments apply to the out-of-pocket maximum.

Over-the-Counter (OTC) Medications –
Medications made available without a prescription.

Prescription Medications – Medications prescribed to you by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred or non-preferred.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. The color or flavor of a generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) –
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Summary of Benefits and Coverage (SBC) –
Mandated by health care reform, your insurance carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

Required Notices

Important Notice from Plano Orthopedic & Sports Medicine Center, P.A. About Your Prescription Drug Coverage and Medicare under the Blue Cross Blue Shield of Texas Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Plano Orthopedic & Sports Medicine Center, P.A. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. Plano Orthopedic & Sports Medicine Center, P.A. has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Texas plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plano Orthopedic & Sports Medicine Center, P.A. coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current Plano Orthopedic & Sports Medicine Center, P.A. coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Plano Orthopedic & Sports Medicine Center, P.A. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Plano Orthopedic & Sports Medicine Center, P.A. changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	December 1, 2017
Name of Entity/Sender:	Plano Orthopedic & Sports Medicine Center, P.A.
Contact—Position/Office:	Human Resources
Address:	5228 W. Plano Parkway Plano, Texas 75093
Phone Number:	972-250-5700

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources at 972-250-5700.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. The Notice of Privacy Practices has been recently updated. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 972-250-5700.

HIPAA Special Enrollment Rights

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

Loss of eligibility includes but is not limited to:

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

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 972-250-5700.

IMPORTANT CONTACTS

COVERAGE	CONTACT
MEDICAL	Blue Cross Blue Shield of Texas 800-521-2227 www.bcbstx.com
DENTAL	Blue Cross Blue Shield of Texas 800-521-2227 www.bcbstx.com
VISION	EyeMed 866-299-1358 www.eyemed.com
FLEXIBLE SPENDING ACCOUNTS	Dearborn National 800-348-4512 www.dearbornnational.com
LIFE AND AD&D	Dearborn National 800-348-4512
DISABILITY	Dearborn National 800-348-4512 www.dearbornnational.com
RETIREMENT	Great-West Retirement Services 800-338-4015 www.gwrs.com
TELEMEDICINE	MDLive 888-680-8646 www.mdlive.com/bcbstx
PLANO ORTHOPEDIC SPORTS MEDICINE HUMAN RESOURCES	5228 W. Plano Parkway Plano, Texas 75093 972-250-5700

GO MOBILE!

Directly access Plano Orthopedic Sports Medicine's benefits information on the go with the **Lockton BenefitLink Mobile App**. You'll find benefits contact information, Open Enrollment push notifications, Lockton's digital Lifestyle Benefits newsletter and more!

Lockton BenefitLink
Username: posmc
Password: benefits

Download on the App Store

GET IT ON Google play

NOTES

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Sports Medicine & Spine Center, P.A.