Palo Alto Veterans Institute for Research

Summary of Benefits

2020

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WELCOME TO YOUR BENEFITS!

The investment in employee benefits is a very important way in which PAVIR is able to care for you and your family. We are pleased to provide a comprehensive benefits package centered around four important areas of wellness:

HEALTH CARE | **PRE-TAX BENEFITS** | **FINANCIAL SECURITY** | **WORK-LIFE BALANCE**

This document provides a high-level overview of the benefits available so that you can review your options for enrollment. Individual carrier documents provide more detail regarding coverage and benefits. These documents supersede any information provided here.

PAVIR + VITA

The Vita Concierge is here to help! PAVIR has partnered with Vita to assist you with your benefits needs. We can support you with a multitude of issues including those outlined below:

- Benefit plan enrollment
- Plan design inquiries
- ID cards and eligibility issues
- Health and pre-tax claims assistance
- Accessing pre-tax funds
- Enrollment guidance

Vita Concierge may be reached Monday – Friday 8:00 a.m. – 5:00 p.m. PT via phone, (650) 966-1492 or email, help@vitamail.com.

Making sure your request is resolved to your satisfaction is our top priority. Please be aware that Vita complies with all Federal HIPAA privacy and security regulations to ensure your information is safe.

SIGNING UP AND MAKING CHANGES

ELIGIBILITY

Full-time regular employees working 30 or more hours per week are eligible for all benefits on the first of month following or coinciding with their date of hire. For life, disability, and FSA coverages, employees must be actively working on the date coverage begins.

ELIGIBLE DEPENDENTS

You may enroll spouses/domestic partners and children up to age 26 in your medical, dental, and vision plans. If enrolling a non-registered domestic partner, you must meet the criteria outlined in the "Affidavit of Domestic Partnership". A completed affidavit must be submitted to HR prior to your enrollment being approved.

DOMESTIC PARTNERS

You will pay taxes on the employer paid premium and employee contribution for enrolled domestic partners and/or their children. State level tax exemptions may apply. Please see your tax advisor for more details.

ENROLLMENT

All enrollments are submitted online through ADP. Additional enrollment instructions are available from your Human Resources Representative. You must complete your initial enrollment within 30 days of your eligibility date.

ADDITIONAL INFORMATION AND RESOURCES

Benefit summaries, detailed plan information, plan certificates, and forms are available to view and download online. To access these documents, log into ADP.

SPECIAL ENROLLMENT PERIOD/ADDING NEW DEPENDENTS

You may only enroll or make election changes mid-year if you experience a qualified life event such as marriage, birth or adoption of a new child, divorce, or an involuntary loss of coverage from another group plan. **You must notify HR and submit the request for changes within 30 days of the life event.**

OPEN ENROLLMENT

Open Enrollment is your annual opportunity to enroll in or make changes to your benefits without a qualified life event. If you or your dependents do not enroll when you first become eligible, you will only be able to enter the plan during Open Enrollment. Open Enrollment is conducted in November each year, with the changes effective January 1st.

COVERAGE TERMINATION

Medical, dental, and vision benefits terminate on the last day of the month following employment termination. All other benefits end on your last day of employment.

COBRA CONTINUATION

You and your covered dependents have a right to continue medical, dental, vision, and Health FSA coverage for a specified period of time after you terminate your employment or for other qualified life events. You will be notified of your rights and responsibilities to continue coverage under Federal COBRA law.

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EMPLOYEE COST SHARING

MEDICAL/DENTAL/VISION PLANS

- PAVIR pays the majority of coverage costs for employees and their eligible dependents.
- Contributions are taken via pre-tax payroll deductions over 24 pay periods.

LIFE, AD&D AND DISABILITY PLANS

- PAVIR pays 100% of the premiums for eligible employees.
- Voluntary Life and AD&D plans are also available and 100% employee paid.

HEALTH SAVINGS ACCOUNT (HSA) FUNDING

- If you enroll in the HDHP, you will automatically be enrolled in an HSA.
- PAVIR will contribute to your HSA on a monthly basis.
- See the HSA section for more details.

EMPLOYEE CONTRIBUTIONS PER PAY PERIOD

	EMPLOYEE ONLY	EMPLOYEE + SPOUSE/DP	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Anthem HDHP	$25.00	$180.00	$145.00	$287.50
Anthem PPO	$47.50	$275.00	$225.00	$445.00
Anthem HMO	$40.00	$260.00	$215.00	$420.00
Kaiser	$60.00	$230.00	$205.00	$365.00
Dental	$7.50	$20.00	$35.00	$47.50
Vision	$3.50	$4.00	$4.00	$6.00
Life/Disability	No cost, paid by PAVIR			
Voluntary Life	Age banded rates			
Pre-Tax Benefits	Self-directed up to IRS maximum			
401(k)	Self-directed up to IRS maximum			

ID CARDS

You will receive an ID card for medical coverage only. Your ID card will arrive within 7-10 business days of your enrollment being processed by the insurance carrier. You can also download an electronic version of your ID card by registering directly on the carrier's website.

If you are enrolling in Kaiser and have been a Kaiser member in the past, you will use the same Medical Record Number (MRN) that you used previously. No new ID card will be issued.

Guardian Dental and MES Vision do not issue ID cards. Eligibility is verified for you and your eligible dependents using your name, date of birth, and last four digits of your social security number along with PAVIR's group numbers. Generic ID cards may be downloaded directly from the carrier's website once you have registered.

HOW TO FIND AN IN-NETWORK PROVIDER

We recommend that you contact your physicians directly to confirm participation in your network prior to seeking services. Locating the provider's name on the carrier's website does not guarantee they are part of the network, as provider participation is subject to change at any time.

ANTHEM MEDICAL PLAN

www.anthem.com/ca

1. Click on the ***Menu*** link on the top left side of the page.
2. Under ***Care*** click on ***Find a Doctor***.
3. Under ***Search*** as a ***Guest*** click ***Continue***.
4. Under ***How do you get your insurance?*** choose appropriate option from the drop down menu.
5. Under ***What state do you want to search in?*** choose your state.
6. Under ***What type of care are you searching for?*** choose ***Medical***.
7. Under ***Select a plan/network***, choose your network.
8. Click on ***Select*** and ***Continue***.
9. Enter your search criteria and click ***Search***.

KAISER MEDICAL PLAN

www.kp.org

1. Click on ***Doctors & Locations*** at the top of the page.
2. Under ***Find doctors and location***, select ***California – Northern***.
3. Click the ***Go to My Doctor Online*** button.
4. Click on the ***Go to Search*** button under ***Search Doctors***.
5. Note your preferences then click ***Search***.

GUARDIAN DENTAL PLAN

www.guardianantytime.com

1. Click ***Find a Provider*** at the top of the screen.
2. Click on the ***Find a Dentist*** link.
3. Enter your ***City, State***, or ***Zip Code***.
4. Choose your plan and click ***Search***.

MES VISION PLAN

www.mesvision.com

1. Under ***Search for an MESVision Doctor near you***, enter your ***zip code***.
2. Click ***Submit***.
3. Click ***Continue to Search*** when box pops up.

Q: IS IT CRITICAL TO STAY IN-NETWORK?

YES

A. **Medical**. You will have significant out-of-pocket exposure if you go out-of-network for medical care, typically ranging in the four to six figure amount.

NO

A. **Dental** and **Vision**. Your dental and vision coverage may be applied to out- of-network expenses, however staying in-network reduces your out-of-pocket costs.

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HEALTH CARE

UNDERSTANDING YOUR MEDICAL PLAN

PAVIR offers employees a choice of four medical plans. Before making your medical plan election, it is important to understand the differences between each of the plans, including how to access care and what your out of pocket costs will be under each plan.

KEY DEFINITIONS

- **Network Provider:** Physician/provider who has contracted with the insurance carrier and has agreed to a negotiated rate for services.
- **Annual Deductible:** Amount a member pays each calendar year for covered services before the plan's coinsurance (cost sharing) begins. The deductible resets every January 1st.
- **Copayment:** Member's flat dollar payment or "copay" at point of service.
- **Coinsurance:** Cost sharing element of the plan expressed as a percentage. Coinsurance payments are based on negotiated rates.
- **Out of Pocket Maximum (OOP):** Maximum amount a member will pay for covered services in a calendar year. Once met, the plan pays 100% for all covered services when in-network.
- **Preferred Drug List (PDL):** A list (formulary or preferred drug list) that outlines how a particular medication is covered under the different prescription tiers. PDLs change throughout the year, and members are notified by mail when and if a change will affect them.

CONTROLLING YOUR COSTS

Save yourself time and money by knowing where to direct your care!

SYMPTOM	WHERE TO GO	COST	MORE INFORMATION
"I have a minor problem that won't require a test."	Virtual Visit	$	Anthem: www.livehealthonline.com Kaiser: www.kp.org/mydoctor/videovisits
"I have a minor problem that may require a test/exam but my doctor isn't available."	Convenience Care Clinic	$$	Find in-network facilities and providers using the How to Find a Network Provider instructions on page 4 or download the Anthem or Kaiser mobile app!
"I want routine care or have a minor, complex, or chronic problem."	Office Visit	$$	
"It's not life threatening, but I need care quickly."	Urgent Care	$$$	
"It's life threatening or very serious."	Emergency Room	$$$$	
"Help! I don't know where to go."	Call the Nurse Help Line	No Cost	See the back of your medical ID card for phone number

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UNDERSTANDING YOUR MEDICAL PLAN (CONTINUED)

KEY PLAN DESIGN DIFFERENCES

	PPO	HMO
How is Kaiser different?	Kaiser requires that you go to a Kaiser facility in your service area. Care outside of Kaiser is only covered in a life threatening emergency.	
Which health providers must I choose?	Whenever possible you should choose doctors, hospitals, and other providers that contract with the PPO network.	You must choose doctors, hospitals, and other providers that contract with the HMO network.
Do I need to have a primary care provider (PCP)?	No. You can receive care from any doctor you choose but you will pay more for out-of-network providers.	Yes. Your HMO will not provide coverage if you do not have a designated PCP or medical group.
How do I see a specialist?	You do not need a referral to see a specialist. However, some specialists will only see patients who are referred to them by a primary care doctor. Also, some PPOs require that you get a prior approval for certain expensive services, such as MRIs.	You need a referral from your PCP to see a specialist (such as a cardiologist or surgeon) except in emergency situations. Your PCP also must refer you to a specialist who is in the HMO network.
Do I have to file an insurance claim?	Not usually for in-network care. However, if you go out-of-network for services you may have to pay the provider in full and then file a claim with the health plan to get reimbursed.	No, unless in an emergency where an outside facility is used.
Can I seek care out of my service area?	Yes. Most PPOs have a nationwide network, meaning that you can find in-network providers in most states.	No. All care must be rendered within your Primary Medical Group, or pre-authorized by them.
Why do we have a High Deductible Health Plan (HDHP)?	An HDHP has a high deductible that you must meet before the insurance will start paying for your office visits, lab tests and prescriptions. The increased deductible helps control costs and therefore usually means a lower premium contribution out of your paycheck. Also, your employer may offset your expenditure by offering a Health Savings Account (HSA).	

SIDE BY SIDE MEDICAL PLAN COMPARISON

Following is a very brief side by side comparison of the key benefit features of each plan. **All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated.** As always, please refer to your carrier's Certificate of Coverage for more details.

PPO OPTIONS	MEDICAL OPTION 1 ANTHEM HDHP		MEDICAL OPTION 2 ANTHEM PPO	
Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	$2,800	$8,400	$500	$1,500
Family	$5,600	$16,800	$1,500	$4,500
Copays/Coinsurance	0%	30%	10%	30%
Office Visit	0%	30%	$20	30%
Hospital	0%	30%	10%	30%
Prescriptions	$5/$15/$40/$60	N/A	$5/$15/$30/$50	50% up to $250
Out-of-Pocket Max				
Individual	$5,000	$15,000	$3,500	$10,500
Family	$10,000	$30,000	$7,000	$21,000
Consider this Plan If…	• you have low medical and prescription utilization • you want to receive employer funding into a Health Savings Account (HSA)		• you are a moderate to heavy user of medical services and prescriptions • you want freedom of choice of providers	

HMO OPTIONS	MEDICAL OPTION 3 ANTHEM HMO	MEDICAL OPTION 4 KAISER HMO
Benefit	PCP Authorized Care	Kaiser Authorized Care
Deductible **Individual** **Family**	None	None
Copays/Coinsurance	Various	Various
Office Visit	$10	$20
Hospital	$250 per admit	$250 per admit
Prescriptions	$5 / $15 / $30 / $50	$10 / $35
Out-of-Pocket Max		
Individual	$2,000	$1,500
Family	$4,000	$3,000
Consider this Plan If…	• you prefer a specific medical group • you prefer simplified copay expenses	• you prefer a one-stop location for your medical and prescription needs • you prefer simplified copay expenses

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OPTION 1: ANTHEM HDHP

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Network	Prudent Buyer PPO	
Reimbursement Basis	Anthem's contracted rate	Anthem's allowed amount. All charges in excess of the allowed amount are the member's responsibility.
Deductible	$2,800/single; $5,600/family	$8,400/single; $16,800/family
Out-of-Pocket Maximum	$5,000/single; $10,000/family	$15,000/single; $30,000/family
Office Visit	0%	30%
Virtual Visit	0%	30%
Prescriptions (up to a 30-day supply)	$5/ $15 / $40 / $60	30% up to $250
Mail Order Prescriptions (up to a 90-day supply)	$12.50 / $37.50 / $120 / $180	Not covered
Specialty Prescriptions	30% up to $250	30% up to $250
Preventive Care	No charge	30%
Basic Lab and X-ray	0%	30%
Complex Lab and X-ray	0%	30%
Urgent Care	0%	30%
Outpatient	0%	30%
Inpatient	0%	30%
Emergency Services	0%	
Physical Therapy	0%	30%
Chiropractic Services (30 visits max/year)	0%	30%
Acupuncture (20 visits max/year)	0%	30%
Durable Medical Equipment	50%	50%
Infertility	Not Covered	Not Covered
Lifetime Maximum	Unlimited	
Plan Details	See Additional Plan Notes section	

All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated. The benefit information above outlines the key components of this medical policy. Please refer to your carrier's Certificate of Coverage for additional details on plan benefits and limitations.

OPTION 1: ANTHEM HDHP ADDITIONAL PLAN NOTES

ALL NON-PREVENTIVE EXPENSES APPLY TO THE DEDUCTIBLE

All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated. Health Savings Account (HSA) qualified plans require that all non-preventive expenses receive no reimbursement from insurance prior to the deductible being met. With that said, you will still get the benefit of negotiated discounts when using in-network providers.

GOING OUT-OF-NETWORK: "ALLOWED AMOUNT" DEFINED

The "allowed amount" is the amount that Anthem will allow for a participating provider even when the services are rendered out-of-network. Out-of-network charges can be significantly greater than the allowed amount and you will be responsible for the difference between what the out-of-network provider charges and what Anthem reimbursed. These balanced billed charges **do not** accumulate towards your out-of-network deductible or out-of-pocket maximum.

UTILIZATION REVIEW

All hospital confinements and surgeries must be preauthorized by Anthem. You or your physician must call Anthem prior to a hospital admission for non-emergency treatment. If you do not obtain this mandatory authorization, your benefits will be reduced or a penalty payment will apply. Please refer to your ID card for the utilization review phone number and required time frame for reporting.

CLAIMS

In-network providers will submit claims directly to Anthem. If you see an out-of-network provider, you may be required to submit the claim directly to Anthem for reimbursement.

BRAND NAME PRESCRIPTION DRUG BENEFIT

If you choose to receive a brand name drug when a generic equivalent is available, you will be responsible for the generic drug cost plus the difference in cost between the generic and the brand name negotiated rate.

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OPTION 2: ANTHEM PPO

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Network	Prudent Buyer PPO	
Reimbursement Basis	Anthem's contracted rate	Anthem's allowed amount. All charges in excess of the allowed amount are the member's responsibility.
Deductible	$500/individual; $1,500/family	$1,500/individual; $4,500/family
Out-of-Pocket Maximum	$3,500/individual; $7,000/family	$10,500/individual; $21,000/family
Office Visit	$20 PCP, no deductible; $40 Specialist, no deductible	30%
Virtual Visit	$10, no deductible	30%
Prescriptions (up to a 30-day supply)	$5/$15/$30/$50, no ded	50% up to $250, no ded
Mail Order Prescriptions (up to a 90-day supply)	$12.50/$37.50/$90/$150, no ded	Not covered
Specialty Prescriptions	30% up to $250, no ded	50% up to $250, no ded
Preventive Care	No charge	30%
Basic Lab and X-ray	10%	30%
Complex Lab and X-ray	10%	30%
Urgent Care	$20, no deductible	30%
Outpatient	10%	30%
Inpatient	10%	30%
Emergency Services	$150 + 10%	
Physical Therapy	10%	30%
Chiropractic Services (30 visits max/year)	$20	30%
Acupuncture (20 visits max/year)	$20	30%
Durable Medical Equipment	10%	50%
Infertility	Not Covered	Not Covered
Lifetime Maximum	Unlimited	
Plan Details	See Additional Plan Notes section	

All benefits listed refer to the member's responsibility or cost share after the deductible is met, unless otherwise indicated. The benefit information above outlines the key components of this medical policy. Please refer to your carrier's Certificate of Coverage for additional details on plan benefits and limitations.

OPTION 2: ANTHEM PPO ADDITIONAL PLAN NOTES

GOING OUT-OF-NETWORK: "ALLOWED AMOUNT" DEFINED

The "allowed amount" is the amount that Anthem will allow for a participating provider even when the services are rendered out-of-network. Out-of-network charges can be significantly greater than the allowed amount and you will be responsible for the difference between what the out-of-network provider charges and what Anthem reimbursed. These balanced billed charges **do not** accumulate towards your out-of-network deductible or out-of-pocket maximum.

UTILIZATION REVIEW

All hospital confinements and surgeries must be preauthorized by Anthem. You or your physician must call Anthem prior to a hospital admission for non-emergency treatment. If you do not obtain this mandatory authorization, your benefits will be reduced or a penalty payment will apply. Please refer to your ID card for the utilization review phone number and required time frame for reporting.

CLAIMS

In-network providers will submit claims directly to Anthem. If you see an out-of-network provider, you may be required to submit the claim directly to Anthem for reimbursement.

BRAND NAME PRESCRIPTION DRUG BENEFIT

If you choose to receive a brand name drug when a generic equivalent is available, you will be responsible for the generic drug cost plus the difference in cost between the generic and the brand name negotiated rate.

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OPTION 3: ANTHEM HMO

BENEFIT	IN-NETWORK
Network	California Care HMO
Reimbursement Basis	All care must be rendered or authorized by your Primary Care Physician (PCP)
Deductible	None
Out-of-Pocket Maximum	$2,000/individual; $4,000/family
Office Visit	$20 PCP; $40 Specialist
Virtual Visit	$10
Prescriptions (up to a 30-day supply)	$5 / $15 / $30 / $50
Mail Order Prescriptions (up to a 90-day supply)	$12.50 / $37.50 / $90 / $150
Specialty Prescriptions	30% up to $250
Preventive Care	No charge
Basic Lab and X-ray	No charge
Complex Lab and X-ray	$100
Urgent Care	$20
Outpatient	$125
Inpatient	$250
Emergency Services	$100
Physical Therapy	$20
Chiropractic Services	$20
Acupuncture	$20
Durable Medical Equipment	20%
Infertility	Not Covered
Lifetime Maximum	Unlimited
Plan Details	See Additional Plan Notes section

The benefit information above outlines the key components of this medical policy. Please refer to your carrier's Certificate of Coverage for additional details on plan benefits and limitations.

OPTION 3: ANTHEM HMO ADDITIONAL PLAN NOTES

REFERRALS

All medical treatment must be coordinated by your selected Primary Care Physician (PCP) in order to be covered by the plan. Your PCP will make any referrals to specialists, if needed. No referral is required when:

- Accessing care from an OB/GYN provider within your Primary Medical Group (PMG) for an annual well women's exam

You may go to a satellite office of your PMG as long as your PCP authorizes your visit to that facility. Always call your PCP prior to any treatment

NON-AUTHORIZED TREATMENT

If you go to an Anthem facility other than your selected PMG, to another Anthem doctor, to a private doctor, or to a hospital without your PCP's authorization and it is not an acute, life threatening emergency, you will be responsible for all medical expenses you incur.

EMERGENCY TREATMENT

Anthem defines an emergency as those services required for the alleviation of severe pain or immediate diagnosis and treatment of an unforeseen medical condition which, if not treated, would jeopardize or impair your health.

In the case of a life-threatening emergency, obtain care immediately. After care is obtained, you must contact your PCP within 24 to 48 hours after the onset of the emergency. A family member, co-worker, etc. may make this call on your behalf. In the case of a non-life-threatening emergency, regardless of where you are, call your PCP prior to receiving care. If your PCP is not available, there should be another physician on call 24 hours who can assist you. If you do not consult a physician at your PMG first, you will be responsible for all charges for non-life threatening, but acute emergency services.

BRAND NAME PRESCRIPTION DRUG BENEFIT

If you choose to receive a brand name drug when a generic equivalent is available, you will be responsible for the generic drug cost plus the difference in cost between the generic and the brand name negotiated rate.

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OPTION 4: KAISER HMO

BENEFIT	IN-NETWORK
Network	Kaiser Northern California
Reimbursement Basis	All care must be rendered or authorized by a Kaiser Permanente facility
Deductible	None
Out-of-Pocket Maximum	$1,500/individual; $3,000/family
Office Visit	$20 PCP; $35 Specialist
Virtual Visit	No charge
Prescriptions (up to a 30-day supply)	$10 / $35
Mail Order Prescriptions (up to a 90-day supply)	$20 / $70
Specialty Prescriptions	$35
Preventive Care	No charge
Basic Lab and X-ray	No charge
Complex Lab and X-ray	No charge
Urgent Care	$20
Outpatient	$35 per procedure
Inpatient	$250 per admit
Emergency Services	$100
Physical Therapy	$20
Chiropractic Services (20 visits max/year)	$15
Acupuncture	$20 - $35 (need referral)
Durable Medical Equipment	20%
Infertility	50% Coinsurance (ART services are not covered)
Lifetime Maximum	Unlimited
Plan Details	See Additional Plan Notes section

The benefit information above outlines the key components of this medical policy. Please refer to your carrier's Certificate of Coverage for additional details on plan benefits and limitations.

OPTION 4: KAISER HMO ADDITIONAL PLAN NOTES

REFERRALS

All medical care must be coordinated by your Kaiser clinic. You cannot make a self-referral. Always call Kaiser prior to any treatment.

NON-KAISER TREATMENT

If you go to any facility other than Kaiser and it is not based on a referral from a Kaiser physician or an acute life threating emergency, then you will be responsible for all medical expenses you incur.

EMERGENCY TREATMENT

Kaiser defines an emergency as those services required for the alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical condition which, if not treated, would jeopardize or impair your health.

In the case of a life-threatening emergency, obtain care immediately. After care is obtained, you must contact Kaiser within 24 to 48 hours after the onset of the emergency. A family member, co-worker, etc. may make this call on your behalf. In the case of a non-life-threatening emergency, regardless of where you are, call Kaiser prior to receiving care. If you do not consult a physician at Kaiser first, you will be responsible for all charges for non-life threatening, but acute emergency services.

SELECTING A CLINIC

You may visit any of the Kaiser Permanente clinics or hospitals in the Northern California (for employees residing in Northern California) service area. You are encouraged, but not required, to select a PCP for yourself and each dependent. Only care provided by Kaiser physicians and hospitals are covered under the plan.

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DENTAL BENEFITS: GUARDIAN

OVERVIEW

The Guardian dental plan includes a network of preferred dentists. If you receive treatment from a preferred dentist, you will receive enhanced benefits. However, you do have the option of receiving treatment from the dentist of your choice, even if the dentist is not within the preferred network. Benefits for treatment from non-preferred dentists will be paid at a lower reimbursement level and may be subject to benefit limitations.

BENEFIT	PREFERRED DENTISTS	NON-PREFERRED DENTISTS
Deductible • Waived for preventive care	$100 per member; 3 per family	$100 per member; 3 per family
Maximum Annual Benefit	$1,500 per covered member	
Preventive Care • Includes routine exams, teeth cleanings, x-rays, etc. • Cleanings covered once every 6 months	0% (covered at 100%)	0% (covered at 100% of UCR)
Basic Care • Includes fillings, endodontics, periodontics, extractions, etc.	30% (covered at 70%)	30% (covered at 70% of UCR)
Major Care • Includes crowns, bridges, dentures, onlays, etc.	50% (covered at 50%)	50% (covered at 50% of UCR)
Orthodontia • Covers children to age 19 and adults • Separate lifetime maximum of $1,500 per member	50% (covered at 50%)	50% (covered at 50% of UCR)

USUAL, CUSTOMARY, AND REASONABLE (UCR) DEFINED

Non-preferred benefits are based on the member's geographic location. Guardian pays non-preferred dentists based on the 90th percentile, or what nine out of ten dentists charge for a procedure in a given geographic location. If you receive services from a non-preferred dentist, you are responsible for any charges that exceed the recognized UCR amounts.

MAXIMUM ROLLOVER ACCOUNT (MRA)

Your dental plan has a Maximum Rollover Account (MRA) feature. Guardian will automatically rollover a portion of each covered member's unused annual maximum benefit into their own MRA. The MRA will be used in future years if a member ever reaches the annual plan maximum. To qualify, you must incur at least one claim during the calendar year and you cannot exceed the claims threshold, illustrated below.

ANNUAL PLAN MAXIMUM	CLAIMS THRESHOLD	ROLLOVER AMOUNT	ROLLOVER AMOUNT (PREFERRED DENTISTS ONLY)	MRA LIMIT
$1,500	$700	$350	$500	$1,250

VISION BENEFITS: MESVISION

OVERVIEW

The MES vision plan includes a network of optometrists and ophthalmologists. If you receive treatment from an in-network optometrist/ophthalmologist, you will receive enhanced benefits. While you do have the option of receiving treatment from out-of-network optometrists or ophthalmologists, you will only receive a limited reimbursement.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Network	MESVision	
Vision Exam	One exam covered every 12 months	
	$10 copay	Up to $40
Prescription Glasses: Lenses	One new set of prescription lenses covered every 12 months	
	$25 materials copay (lenses and frames) for single vision, lined bifocal, and lined trifocal lenses	Single vision: up to $30 Lined bifocal: up to $50 Lined trifocal: up to $65
Prescription Glasses: Frames	One new set of frames covered every 12 months	
	$150 allowance	Up to $75
Contact Lenses	You may choose to purchase contact lenses in lieu of glasses every 12 months (same as glasses lens schedule)	
	Contact Lens Fitting: Deducted from Contact Lens benefit allowance $150 allowance	Up to $150
Laser Vision Correction	Substantial discounts are available through LasikPlus and QualSight Lasik.	
Buy-Up Options	MES may offer additional allowances or discounts for lens options such as: • Blended lenses • Progressive lenses • Photochromatic or tinted lenses other than Pink 1 or 2 • Coated or laminated lenses	
Exclusions	The following services and supplies are not covered: • Orthoptics or vision training • Nonprescription lenses • Medical or surgical treatment of the eyes • Two pairs of glasses in lieu of bifocals • Lost or broken glasses will not be replaced except at the normal intervals	

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PRE-TAX BENEFITS

HEALTH SAVINGS ACCOUNT (HSA) FACT SHEET

OVERVIEW

Participation in the combination of a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA) allows you to save premium dollars and create a personally owned, tax advantaged savings account for your future medical expenses.

Your HSA balance rolls over year to year. If you terminate employment with PAVIR, this account is yours to take with you. If, at a later date, you are no longer qualified to make contributions into the HSA, you can still use HSA funds for the reimbursement of medical expenses.

ELIGIBILITY RESTRICTIONS

In order to be eligible to make contributions into an HSA, you must meet all of the following criteria:

- Covered by a qualified High Deductible Health Plan (HDHP)
- Not covered by any other health coverage, including a regular Flexible Spending Account (FSA)
- Cannot be claimed as a dependent on another person's tax return
- Not entitled to benefits under Medicare, including Medicare Part A

LIMITED PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT (HEALTH FSA)

If you participate in the HDHP and HSA and elect a Health FSA, your Health FSA is a Limited Purpose account. This means that eligible expenses for the health care FSA include dental and vision expenses but cannot be used for medical expenses until you've met a portion of the plan deductible. Once you've met $1,400 of the deductible (individual coverage) or $2,800 of the family deductible, your FSA account can then be used for medical expenses such as additional deductibles or coinsurance.

MAXIMUM CONTRIBUTIONS

Contribution maximum limits are determined each year by the IRS and are inclusive of both employer and employee funding. The 2020 HSA contribution limits are as follows:

- **Single**: $3,550
- **Family**: $7,100

If you are age 55 or turn age 55 during the calendar year, you may make an additional $1,000 "catch-up" contribution.

If you enroll in an HSA qualified HDHP plan after January 1 and contribute to the HSA, you may only contribute up to the IRS maximum if you will be covered by the plan for at least 13 consecutive months. If you will not be enrolled in an HSA qualified HDHP plan for at least 13 consecutive months, your maximum election must be prorated. When considering the contributions you will make, the maximum election would be 1/12 of the annual election multiplied by the number of months you are covered by the HDHP. You may wish to consult a tax professional for additional guidance.

ADDITIONAL INFORMATION

For detailed information, rules, and restrictions on Health Savings Accounts, see IRS Publication 969 (https://www.irs.gov/pub/irs-pdf/p969.pdf), or contact Vita.

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HEALTH SAVINGS ACCOUNT (HSA) ADMINISTRATION

ADMINISTRATOR

VitaFlex HSA

ELIGIBILITY

If you and your eligible dependents choose to participate in the High Deductible Health Plan (HDHP) *and* are not covered by other disqualifying coverage, you are eligible to establish an HSA through PAVIR.

EFFECTIVE DATE

Your VitaFlex HSA becomes active as of the effective date of your enrollment into the HDHP plan offered by PAVIR. You are eligible to incur qualified health-related expenses any time on or after this date.

EMPLOYER FUNDING

PAVIR will make a monthly contribution to your VitaFlex HSA on your behalf. Each employee's HSA is personally owned by the employee. Deposits made by PAVIR into the account are tax-free under federal law. Once deposited into your HSA, these funds may be used at any time to fund eligible medical expenses on a tax preferred basis. Deposit amounts are as follows and are determined by PAVIR each January 1.

HSA COVERAGE TIER	MONTHLY CONTRIBUTION FROM PAVIR
Employee Only	$100.00
Employee + Spouse	$100.00
Employee + Child(ren)	$100.00
Employee + Family	$100.00

EMPLOYEE CONTRIBUTIONS

You have the option to fund your VitaFlex HSA through pre-tax payroll contributions. The pre-tax deductions will begin on the next available payroll date. Your HSA contribution may be changed at any time.

ACCESSING FUNDS

There are three ways to access funds from your VitaFlex HSA to pay for eligible expenses. Expenses must be incurred on or after the effective date of the account.

- **Debit Card**: Use at time of service or to pay bills
- **Online**: Submit a claim for reimbursement online at www.vitaflex.net
- **Mobile App**: Upload claims for reimbursement through the VitaFlex mobile app

FLEXIBLE SPENDING ACCOUNTS (FSA): VITAFLEX

OVERVIEW

A Flexible Spending Account (FSA) enables tax-free reimbursement of health-related or dependent care expenses. You decide how much you want to set aside for the year and a portion of that amount is deducted from your paycheck before taxes. When you or your dependents incur an eligible expense, you may be reimbursed for that expense with the money that you have put aside.

EFFECTIVE DATE

Your election becomes effective on either the date that you become benefits eligible or the date that you complete your enrollment, whichever is later.

ANNUAL ELECTION

The election that you make is irrevocable for the Plan Year (January 1 – December 31). This means that, in general, you cannot adjust or stop your contributions once the Plan Year has begun. It is important to note that elections do not carry forward year-to-year. You must actively make a new election during each Open Enrollment period, or your account will be made inactive.

PAYCHECK DEDUCTIONS

Your election is made as an annual election for the Plan year. Your annual election is then divided by the total number of paychecks during the Plan Year or by the number of remaining paychecks in the Plan Year if you are hired mid-year.

MID-YEAR CHANGES

You may only change your election mid-year in certain limited circumstances, and even then, changes are subject to restrictions. In order to change your election mid-year, you must experience a qualified status change (birth, marriage, etc.) or other approved exception. All change requests must be made within 30 days of the status change date.

TERMINATION

Medical expenses are only eligible to the extent that they are incurred prior to or on your date of termination. The exception to this rule is that if you elect COBRA coverage for your Health FSA and continue to make contributions to your FSA (on a post-tax basis), claims may be incurred as long as the COBRA coverage is active. Dependent care expenses may be reimbursed after your termination date without electing COBRA, as long as the expense occurred in the current Plan Year.

USE IT OR LOSE IT

Under IRS guidelines, FSAs are subject to a "use it or lose it" provision. If your eligible expenses are not sufficient to exhaust your full FSA election, any unused funds are forfeited. In order to protect yourself against this, carefully consider your medical and dependent care expenses prior to making your election.

Your employer's plan includes a rollover feature. This feature allows up to $500 of unused funds (those left over after the claims submission deadline) to roll over into the new Plan Year as of March 31 of the following year (e.g. 3/31/2020). If your Health FSA balance is greater than $500 as of the deadline, any amount in excess of that figure is forfeited under the "use it or lose it" rule. Note that there is no rollover provision for the Dependent Care FSA.

LIMITED PURPOSE HEALTH FSA

If you participate in the HDHP and HSA and elect a Health FSA, your Health FSA will be deemed a Limited Purpose account. See Health Savings Account (HSA) Fact Sheet for more information.

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FLEXIBLE SPENDING ACCOUNTS (CONTINUED)

	HEALTH FSA	DEPENDENT CARE FSA
Plan Year	January 1st through December 31st	
Minimum Election	$100/year	$100/year
Maximum Election	$2,750/year (per employee)	$5,000/year (per household)
Claims Incurred Deadline	December 31 or your employment termination date	December 31
Claims Submission Deadline	March 31st after Plan Year ends	
Rollover	Yes, up to $500	No
Eligible Dependents	• Yourself • Your spouse • Your children under age 26 (or who have not attained age 27 as of the end of the tax year)	• Children under age 13 • A spouse or dependent (age 13 or older) who is physically or mentally incapable of caring for himself/herself
Filing Claims	Full annual election available immediately • Debit Card (save your receipts!) • Online: www.vitaflex.net • Mobile App • Email: claims@vitamail.com (claim form required) • Fax: (650) 964-3539 (claim form required)	Funds available as contributed • Online: www.vitaflex.net • Mobile App • Email: claims@vitamail.com (claim form required) • Fax: (650) 964-3539 (claim form required)
Common Eligible Expenses	• Medical and prescription copays and coinsurance • Over-the-counter items (may need prescription) • Dental expenses including orthodontia • Vision copays, prescription glasses and contacts • Chiropractor, acupuncture and physical therapy	• Licensed day care provider • Pre-school • In-home day care • Nanny care • After-school care custodial/recreational • Summer day camps custodial/recreational • Mental health with medical diagnosis
Common Ineligible Expenses	• Vitamins/herbal supplements • Toiletries • Massage therapy for general health (without diagnosis) • Cosmetic dentistry	• Tutoring/language programs • Lessons for piano, gymnastics, etc. • Sports classes or leagues • Overnight camps

COMMUTER BENEFITS: VITACOMMUTE

OVERVIEW

Set aside pre-tax payroll deductions to pay for eligible commuting expenses. You will receive a debit card that will be loaded with funds each pay period for your elected transit and/or parking amounts. Elections may be modified at any time throughout the year and elections made before the end of a pay period will be effective the pay date following the date of the election change.

PLAN PROVISIONS

	TRANSIT	PARKING
Monthly Pre-Tax Maximum	$270	$270
	You may elect above the pre-tax maximum as an after-tax expense	
Eligible Expenses	• Train and subway • Bus • Ferry • Eligible Vanpool	• Parking near office • Parking near mass transit for commute to work
Accessing Funds	Debit card only	Debit card or submit expenses for reimbursement online at www.vitaflex.net within 60 days of the expense date

Attention Caltrain and BART riders: Due to Federal regulations, your debit card will not work at Caltrain and BART terminals. You will need to use your debit card to fund your Clipper card via www.clippercard.com.

Please note: If you've elected a Flexible Spending Account (FSA) and/or a Health Savings Account (HSA), the same debit card will be used for your pre-tax Commute elections. Funds will be pulled from the applicable account based on where the debit card is used and what is being purchased. If you haven't elected an FSA and/or HSA, you will receive a new debit card in the mail following your first election.

MAKING AN ELECTION

Elections are made in the ADP system. Your election will be a monthly recurring order unless you actively choose to log back into the system to change your election to $0. Elections submitted by the last day of the pay period will be available on the next pay date (e.g. elections made by the 15th would be available around the 22nd).

TERMINATION

Upon termination, your debit card will be deactivated and you will no longer have access to any unused transit funds. If you are submitting parking expenses for reimbursement, you have up to 60 days from your date of termination to submit expenses incurred prior to your date of termination.

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FINANCIAL SECURITY

GROUP LIFE AND AD&D BENEFITS: GUARDIAN

BENEFIT

Each employee is covered for term Life and AD&D insurance equal to a flat $100,000 benefit. No medical examination or health history disclosure is required for timely applicants.

AGE REDUCTIONS

At age 70, benefits will reduce by 50% of the original amount.

BENEFICIARIES

A personal beneficiary of your choosing must be named for the proceeds of your life insurance, however, it is not recommended to list a minor as your beneficiary. You may change your beneficiaries at any time in ADP.

NOTE ON TAXATION

The value of up to $50,000 of employer paid group term life insurance is tax exempt. However, the value of any coverage in excess of $50,000 is taxable to the employee per the IRS guidelines. This is called Table I Taxation. The following schedule is used to calculate the taxable benefit of the group term life insurance in excess of $50,000. For more questions about this, please contact Vita.

AGE BRACKET	COST PER $1,000 PER MONTH
Under 25	$0.05
25-29	$0.06
30-34	$0.08
35-39	$0.09
40-44	$0.10
45-49	$0.15
50-54	$0.23
55-59	$0.43
60-64	$0.66
65-69	$1.27
70+	$2.06

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VOLUNTARY LIFE AND AD&D BENEFITS: GUARDIAN

BENEFIT

Each employee can choose to purchase the following:

Employee: You may elect coverage in $25,000 increments up to $200,000.

Spouse: You may elect coverage up to $100,000, not to exceed 50% of the employee's election.

Child(ren): You may elect coverage up to $10,000 for your child(ren), not to exceed 10% of the employee's election. Children are covered from 14 days to age 26.

You may not elect coverage for your dependent(s) without electing coverage for yourself.

MONTHLY RATES

AGE BRACKET	EMPLOYEE * RATE PER $1,000	SPOUSE RATE PER $1,000
Under 25	$0.09	$0.09
25-29	$0.09	$0.09
30-34	$0.10	$0.10
35-39	$0.13	$0.13
40-44	$0.19	$0.19
45-49	$0.29	$0.29
50-54	$0.42	$0.42
55-59	$0.68	$0.68
60-64	$1.07	$1.07
65-69	$1.68	$1.68
70-74	$2.77	$2.77
Child	$0.19 per $1,000	

AGE REDUCTIONS

Benefits will be reduced by 35% of the pre-age 65 amount at age 65, 60% of that amount at age 70, 75% at age 75 and 85% of that amount at age 80.

APPLICATION PROCESS

Any amounts that you apply for up to $200,000 are guaranteed issue (no health questions or exams required) at your initial eligibility period. Amounts over $200,000 for you or amounts over $25,000 for your spouse, or any amount applied for after your initial eligibility period will be subject to medical underwriting. Coverage will only be effective if approved by Guardian. For more information on the application process, please contact Vita.

BENEFICIARIES

A personal beneficiary of your choosing must be named for the proceeds of your life insurance, however, it is not recommended to list a minor as your beneficiary. You may change your beneficiaries at any time in ADP.

DISABILITY BENEFITS: GUARDIAN

BENEFIT

These plans provide partial income replacement should you be unable to work due to an illness or injury. The plans integrate with other social sources (State Disability Insurance, Workers Compensation, Social Security, etc.) to provide a combined benefit of 60% of your base annual earnings.

	SHORT –TERM DISABILITY	LONG-TERM DISABILITY
Elimination Period	7 days	91 days
Maximum Benefit	The maximum payable benefit from all sources combined will not exceed $2,309 per week.	The maximum payable benefit from all sources combined will not exceed $10,000 per month.
Duration of Benefits	Benefits are payable for a maximum of 12 weeks.	Benefits are payable to age 65, Standard ADEA
Pre-Existing Conditions	None	Conditions that existed or are treated during the 3 months immediately preceding coverage effective date are not covered if disability occurs in the first 12 months.
Special Limitations	None	There is a 24-month lifetime benefit maximum for disabilities resulting from mental/nervous conditions and alcohol or substance abuse.

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401(K) PLAN: THE STANDARD

OVERVIEW

Eligible employees may participate in PAVIR's qualified 401(k) retirement savings plan. You may make tax-deferred contributions into a variety of investment options. PAVIR provides a company match up to 6% of deferrals, and eligible employees can also receive 3% profit sharing contribution on the first of the month following one (1) year of service.

COLLEGE TUITION REWARDS BENEFITS: THE GUARDIAN

OVERVIEW

Guardian offers the SAGE College Tuition Rewards benefit, where an employee can earn an annual Tuition Reward that can be used to pay for schooling at SAGE participating colleges. Please visit the following link for a list of participating colleges: www.guardian.collegetuitionbenefit.com. Reach out to Vita for additional details.

WORK-LIFE BALANCE

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EMPLOYEE ASSISTANCE PROGRAM (EAP): GUARDIAN

OVERVIEW

Everyone faces difficult periods in his or her life. Personal problems are part of what it means to be human, and effectively dealing with them makes us better prepared to overcome future ones. When a personal problem is making life difficult for you, it can also affect your job performance. The purpose of the Employee Assistance Program (EAP) is to help you deal with life's rough spots. When you seek help with a personal problem, your home life improves, work goes better and everyone benefits.

Your EAP is a free, professional, ***confidential*** consultation service provided by WorkLifeMatters. All counselors and consultants are experienced, licensed professionals who have specialized training in employee assistance consultation. *Everything discussed in consultation is kept completely confidential.*

TYPES OF PROBLEMS

- Marriage and family problems
- Work-related problems
- Stress, anxiety, depression and other emotional problems
- Difficulty with relationships
- Loss and death
- Alcohol or drug problems affecting you or your family
- Difficulty adjusting to a new culture or environment
- Any other personal concern which may benefit from a professional consultation

BENEFITS

You may call **(800) 386-7055** to seek assistance 24 hours a day. Counselors can assist with any type of personal situation. You are entitled to up to three (3) face-to-face counseling sessions per issue. If you choose to pursue additional outpatient consultation, additional benefits may be payable by your medical plan.

PET INSURANCE: FIGO PET INSURANCE

OVERVIEW

You may receive a 10% corporate discount on pet insurance when purchased through Figo.

PRICING AND BILLING

Pricing is based on zip code, age, breed of your cat or dog, and level of coverage selected. You will be billed directly by Figo for the cost of your pet insurance.

ENROLLMENT

You may enroll any time at http://go.pardot.com/l/173192/2017-09-14/l5b9s.

DISCOUNT PROGRAMS: ADP/LIFEMART

OVERVIEW

PAVIR employees and dependents can take advantage of our employee discount program where you can save on events and online shopping. You can register via the ADP portal by logging onto ADP, clicking "Myself", "Benefits", and finally "Employee Discounts – LifeMart". The link will push you to the LifeMart page, where you can register using your PAVIR email address.

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QUESTIONS AND HELP

Following is a listing of the current contact information for each insurance company/vendor. Many of the websites listed below contain useful information on general health topics as well as information on how the plans operate.

CARRIER/VENDOR	CONTACT INFORMATION
Anthem Medical Plan ***Group #TBD***	(800) 888-8288 www.anthem.com/ca
Kaiser Medical Plan ***Group #604633***	(800) 464-4000 www.kp.org
Guardian Dental Plan ***Group #506364***	(800) 541-7846 www.guardiananytime.com
MES Vision Plan ***Group #32920***	(800) 877-3672 www.mesvision.com
WorkLifeMatters EAP ***Username: Matters | Password: wlm70101***	(800) 386-7055 www.ibhworklife.com
Figo Pet Insurance	(844) 738-3446 www.figopetinsurance.com
The Vita Companies ***For questions regarding your healthcare benefits, FSA, HSA, 401(k) or Commuter benefits***	(650) 966-1492 help@vitamail.com

NOTES

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NOTE: The initial plan description is intended for general information purposes only; it is NOT to be considered a Summary Plan Description nor is it a contract. It provides only a very brief summary of benefits and does not replace or supersede the actual plan provisions as defined in the master plan documents. It is not all-inclusive and it is not a contract. Every attempt has been made to ensure the accuracy of this summary, but in the event of a discrepancy between this summary and the plan contract, benefits will be governed solely by the respective plan contracts.