PEAK TECHNICAL SERVICES

- MINIMUM ESSENTIAL COVERAGE (MEC)
- HOSPITAL INDEMNITY PLAN 1
- HOSPITAL INDEMNITY PLAN 2
- DENTAL
- SHORT TERM DISABILITY
- LIFE INSURANCE
- VISION

2017 HEALTH BENEFITS GUIDE

HEALTH PLAN OPTIONS

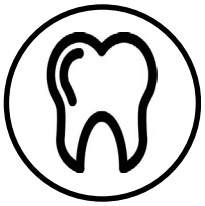
You must enroll in coverage within 30 days of your hire date.

A

MINIMUM ESSENTIAL COVERAGE (MEC)
This plan provides coverage for well care and preventive services. This plan also protects you from the tax penalty of the individual mandate of the Affordable Care Act. The 2016 tax penalty was the greater of $695 per adult and $347.50 per child (under 18) or 2.5% of your yearly household income.

B

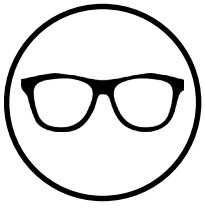
Hospital Indemnity
There are two Hospital Indemnity Plans available to choose from to help cover the cost of doctor's office visits, laboratory services and X-rays. Plan B, purchased without Plan A, does not protect you from the tax penalty. You must enroll in the Hospital Indemnity plan 1 or 2 to enroll in Dental, Short Term Disability, or Life Insurance.



Dental Insurance
You must be enrolled in the Hospital Indemnity Plan 1 or 2 to elect to purchase Dental Insurance. The dental insurance benefits are outlined on page 5.

Short Term Disability Insurance
You must be enrolled in the Hospital Indemnity Plan 1 or 2 to elect to purchase Short Term Disability Insurance. These benefits are outlined on page 5.

Life Insurance
You must be enrolled in the Hospital Indemnity Plan 1 or 2 to elect to purchase Life Insurance. These benefits are outlined on page 5.



Vision Insurance
These benefits are available without the purchase of any other benefit.
Vision Benefits are outlined on page 6.

IF YOU HAVE QUESTIONS ABOUT THE BENEFITS AVAILABLE TO YOU PLEASE CALL

866-629-5456

MONDAY-FRIDAY 8AM - 7PM EST

MEC
MINIMUM ESSENTIAL COVERAGE

100% COVERED SERVICES IN NETWORK (www.multiplan.com)

Total Weekly Cost	Employee	Employee + Spouse	Employee + Child	Family
MEC	$15.86	$27.88	$27.14	$40.65

20 PREVENTIVE SERVICES COVERED FOR ADULTS (AGES 18 AND OLDER)

1	Abdominal Aortic Aneurysm one time screening for age 65-75
2	Alcohol Misuse screening and counseling
3	Aspirin use for men ages 45 - 79 and women ages 55-79 to prevent CVD when prescribed by a physician
4	Blood Pressure screening
5	Cholesterol screening for adults
6	Colorectal Cancer screening for adults starting at age 50 limited to one every 5 years
7	Depression screening
8	Type 2 Diabetes screening
9	Diet counseling
10	Fall prevention to include physical therapy and vitamin D supplementation to prevent fall in community dwellings age 65+
12	Hepatitis C screening
13	HIV screening
14	Immunization vaccines (Hepatitis A & B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella) screening
15	Lung cancer screening for adults age 55-80 who smoke 30 packs/year
16	Obesity screening and counseling
17	Sexually Transmitted Infection (STI) prevention counseling
18	Skin cancer behavioral counseling for adults to age 24 with fair skin
19	Tobacco Use screening, counseling and cessation interventions
20	Syphilis screening

24 PREVENTIVE SERVICES COVERED FOR WOMEN (INCLUDING PREGNANT WOMEN)

1	Anemia screening on a routine basis for pregnant women
2	Aspirin for pregnant women at high risk for preeclampsia
3	Bacteriuria Urinary Tract or other infection screening for pregnant women
4	BRCA counseling and genetic testing for women at higher risk
5	Breast Cancer Mammography screenings every year for women age 40 and over
6	Breast Cancer Chemo Prevention counseling as well as breast cancer testing and medications for women with increased risk of breast cancer
7	Breastfeeding comprehensive support and counseling from trained providers as well as access to breastfeeding supplies for pregnant and nursing women. Non-network services will be payable as network services.
8	Cervical Cancer screening
9	Chlamydia Infection screening
10	Contraception: Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
12	Folic acid supplements for women who may become pregnant when prescribed by a physician.
13	Gestational diabetes screening
14	Gonorrhea screening
15	Hepatitis B screening for pregnant women
16	Human Immunodeficiency Virus (HIV) screening and counseling
17	Human Papillomavirus (HPV) DNA test: HPV DNA testing every three years for women with normal cytology results who are 30 or older.
18	Osteoporosis screening over age 60
19	Routine prenatal visits for pregnant women
20	Rh Incompatibility screening for all pregnant women and follow-up testing
21	Tobacco Use screening and interventions for all women and expanded counseling for pregnant tobacco users
22	Sexually Transmitted Infections (STI) counseling
23	Syphilis screening
24	Well-woman visits to obtain recommended preventive services

29 PREVENTIVE SERVICES COVERED FOR CHILDREN

1	Alcohol and Drug Use assessments
2	Autism screening for children limited to two screenings up to 24 months
3	Behavioral assessments for children limited to five assessments up to age 17.
4	Blood Pressure Screening
5	Cervical Dysplasia screening
6	Congenital Hypothyroidism screening for newborns
7	Depression Screening for adolescents ages 12 and older
8	Developmental Screening for children under age 3 and surveillance throughout childhood
9	Dyslipidemia screening for children
10	Fluoride Chemoprevention supplements for children without fluoride in their water source when prescribed by a physician and fluoride varnish to primary teeth through age 5
11	Gonorrhea preventive medication for the eyes of all newborns
12	Hearing screening for all newborns
13	Height, weight and body mass index measurements for children
14	Hematocrit or Hemoglobin screening for children
15	Hemoglobinopathies or Sickle Cell screening for newborns
16	Hepatitis B screening for adolescents
17	HIV screening for adolescents
18	Immunization Vaccines for children from birth to age 18 - Doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Human Papillomavirus, Influenza (Flu Shot), Meningococcal, Rotavirus, Diphtheria, Tetanus, Pertussis, Hemophilus influenza type B, Inactivated Poliovirus, Measles, Mumps Rubella, Pneumococcal, Varicella
19	Iron supplements for children up to 12 months when prescribed by a physician
20	Lead screening for children
21	Medical History for all children throughout development Ages: 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years
22	Obesity screening and counseling
23	Oral Health risk assessment for young children up to age 10
24	Phenylketonuria (PKU) screening in newborns
25	Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents
26	Skin Cancer behavioral counseling for adolescents age 10 and up who have fair skin
27	Tobacco use screening, counseling and cessation interventions for children and adolescents
26	Tuberculin testing for children
29	Vision screening for all children under the age of 5

This plan provides no coverage for sickness/hospitalization/surgical benefits. Refer to Plan B for those additional benefits including surgical/hospitalization/sickness.

HOSPITAL INDEMNITY PLANS

PPO NETWORK: Multiplan

FULLY INSURED INDEMNITY BENEFITS		
	PLAN 1	PLAN 2
The amounts listed below are what the insurance company pays for each covered service.		
Daily In-Hospital Indemnity Benefit	$400 per day, 31 days max	$600 per day, 31 days max
Inpatient Surgical Indemnity Benefit Rider	$1,500 and 20% Anesthesia	$2,000 and 20% Anesthesia
Outpatient Surgical Indemnity Benefit Rider	$750 and 20% Anesthesia	$1,000 and 20% Anesthesia
Outpatient Physician Office Visit Indemnity Benefit	$80 per visit, 6 per year	$100 per visit, 6 days max
Outpatient Diagnostic Lab Indemnity Benefit	$20, 2 days maximum	$30 per day, 4 days max
Outpatient Select Diagnostic Test Indemnity Benefit Rider	$100, 2 days maximum	$150 per day, 2 days max
Outpatient Advanced Studies Diagnostic Test Indemnity Rider	$400, 1 day maximum	$600 per day, 2 days max
Outpatient Prescription Drug Benefit	$30 generic, $60 brand 12 scripts max annually	$35 generic, $70 brand 12 scripts max annually
Wellness Benefit	$100 per occurrence, 1 max	$150 per occurrence, 1 max
Emergency Room Sickness Benefit	$200 per occurrence, 2 max	$200 per occurrence, 2 max
Inpatient Daily Intensive Care Benefit	$200 per day, 30 days max	$300 per day, 30 days max
Life & AD&D*	Employee: $10,000 Benefit Spouse: $5,000 Benefit Child(ren): $2,500 Benefit	Employee: $10,000 Benefit Spouse: $5,000 Benefit Child(ren): $2,500 Benefit
PPO	Multiplan	Multiplan

PLAN B HOSPITAL INDEMNITY WEEKLY PREMIUMS				
	Employee	Employee + Spouse	Employee + Child(ren)	Family
PLAN 1	$30.08	$61.42	$51.57	$75.58
PLAN 2	$38.30	$79.86	$66.38	$98.33

COMBINED MEC PLAN A + HOSPITAL INDEMNITY PLAN B WEEKLY PREMIUMS				
	Employee	Employee + Spouse	Employee + Child(ren)	Family
PLAN 1	$45.94	$89.30	$78.71	$116.23
PLAN 2	$54.16	$107.74	$93.52	$138.98

On all plan B hospital indemnity benefits, missed premium is not required to be made up. If you miss **5 consecutive weeks** of payroll deductions your plan B benefits will terminate back to the last paid date. These rules do not apply to the MEC plan A benefits.

SHORT TERM DISABILITY
DENTAL & LIFE INSURANCE

THE BENEFITS LISTED BELOW ARE ONLY AVAILABLE IF YOU ARE ENROLLED IN THE HOSPITAL INDEMITY PLANS 1 OR 2

SHORT-TERM DISABILITY INCOME INSURANCE - WEEKLY COST

You must enroll in Plan B Hospital Indemnity plan 1 or 2 to purchase disability insurance.

Elimination Period for Accident and Sickness	**14 days**	**Employee Only $4.95**
Maximum Disability Period	**6 months**	
Maximum Benefit Per Month	**$800**	

DENTAL INSURANCE

You must enroll in Plan B Hospital Indemnity plan 1 or 2 to purchase dental insurance.

Maximum Available Allowance	$1,000
Coinsurance	Diagnostic and Preventive Services: 80% Basic Restorative Services: 50% Major Restorative Services: 50%
Deductible	$50 Waived for Diagnostic and Preventive Services. No Family Maximum
Waiting Period	No waiting period for Diagnostic and Preventive and Basic Restorative Services; 12 months for Major Restorative Services.

DENTAL WEEKLY COST

Employee	$4.51
Employee + Spouse	$8.76
Employee + Child(ren)	$9.52
Family	$14.69

$10,000 GROUP TERM LIFE WITH AD&D

You must enroll in Plan B Hospital Indemnity plan 1 or 2 to purchase group term life insurance.

Employee Only Weekly Cost	**$1.06**

VISION INSURANCE

There is **no** gap coverage with the Vision Plan. If you miss one week's premium your coverage will be terminated.

VISION INSURANCE

Benefits	In-Network	Out of Network
Contribution	Voluntary	
Product Type	Exam with Materials	
Network Type	Full Network	
Benefits	**Participating Provider**	**Non-Participating Provider***
Examination (Once Every 12 months)	100%	Up to $40
Single/Bifocal/Trifocal Lens (Standard Plastic) (Once Every 12 months)	100%	Up to $40/$60/$80
Lenticular Lenses	100%	Up to $80
Retail Frame Allowance (Once Every 24 months)	Up to $130	Up to $45
Discount on Frame Overage at Participating Providers	30%	N/A
Covered Selection Contacts	Up to 4 boxes	Up to $105
Non-Selection Contacts	Up to $105	Up to $105
Necessary Contact Lenses	100%	Up to $210
Covered-in-full-Lens Options	Standard Scratch-Resistant Coating	N/A
Non-Covered Lens Options	Price Protection available for non-covered lens options ranging from 20-60% off retail pricing at participating providers.	
Laser Vision Discount	United Healthcare is proud to add value to your vision care program by offering access to discounted laser vision correction procedures through Laser Vision Network of America (LVNA). Members receive a discount of 15% off standard prices or 5% off promotional prices with any in-network surgeon	

Vision Weekly Cost	
Employee	$2.29
Employee + Spouse	$3.75
Employee + Child (ren)	$4.12
Family	$5.62
	WEEKLY

IF YOU HAVE QUESTIONS ABOUT THE BENEFITS AVAILABLE TO YOU, PLEASE CALL

866-629-5456

MONDAY-FRIDAY 8AM - 7PM EST

Every field of this form must be complete to be processed for benefits.

PEAK TECHNICAL	ID#	Effective Date	Employee ID

PERSONAL INFORMATION

Member (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of Birth
Street Address and Apt #			
City, State	Zip Code	Home Phone	
Email Address		Date of Hire	

SPOUSE AND CHILD/DEPENDENT INFORMATION

Spouse (Last, First, M.I.)	Date of Marriage	☐ Male ☐ Female	Social Security No.	Date of Birth
Child Name	☐ FT Student ☐ Non-Student	☐ Male ☐ Female	Social Security No.	Date of Birth
Child Name	☐ FT Student ☐ Non-Student	☐ Male ☐ Female	Social Security No.	Date of Birth
Child Name	☐ FT Student ☐ Non-Student	☐ Male ☐ Female	Social Security No.	Date of Birth
Child Name	☐ FT Student ☐ Non-Student	☐ Male ☐ Female	Social Security No.	Date of Birth

BENEFIT OPTIONS - Questions 1-3 pertain to Medical Benefits ONLY

1. Is anyone proposed for coverage covered by any Title XIIX program (e.g. Medicaid)?	☐ Yes ☐ No
If "Yes," please list name(s), who will be excluded from coverage:	
2. Are you actively at work on a full-time basis and able to perform the regular duties of your occupation?	☐ Yes ☐ No
If "No," you and your dependents are not eligible for coverage	
3. If applying for spouse and/or child(ren) coverage, is/are any of the proposed insured currently disabled?	☐ Yes ☐ No
If "Yes," list name(s), who will be excluded from coverage.	

DECLINE ALL COVERAGE. If you choose **not** to enroll in coverage, please sign below. I decline coverage at this time.

Signed in (City/State) _____ **Date** _____

Employee's signature_____

WEEKLY PREMIUMS	MEC PLAN A	HOSPITAL INDEMNITY PLAN 1	HOSPITAL INDEMNITY PLAN 2	VISION	DENTAL YOU MUST ELECT HOSPITAL INDEMNITY PLAN 1 OR 2 FOR THIS COVERAGE	SHORT TERM DISABILITY YOU MUST ELECT HOSPITAL INDEMNITY PLAN 1 OR 2
Employee Only	☐ $15.86	☐ $30.08	☐ $38.30	☐ $2.29	☐ $4.51	☐ $4.95
Employee + Spouse	☐ $27.88	☐ $61.42	☐ $79.86	☐ $3.75	☐ $8.76	
Employee + Child(ren)	☐ $27.14	☐ $51.57	☐ $66.38	☐ $4.12	☐ $9.52	
Family	☐ $40.65	☐ $75.58	☐ $98.33	☐ $5.62	☐ $14.69	

BUY-UP LIFE You must enroll in the hospital indemnity policy to purchase this coverage.	☐ $1.06 / week (Employee Only)

Primary Beneficiary (Last, First, M.I.)	Relationship
Contingent Beneficiary (Last, First, M.I.)	Relationship

Spouse's Signature (if applicable) _____

EMPLOYEE'S STATEMENTS AND AGREEMENTS:

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I also understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class of employees; b) I must have satisfied the employer waiting period; c) the employer group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work, and for my dependents, they must not be disabled, on the effective date (according to the insurer's rules); and f) the first months premium must have been received by the underwriting company at its administration office. Lastly, I understand that completion of this enrollment form in no way implies that I will be accepted for coverage.

Signed in (City/State) _____ Date_____

Employee's signature_____

I agree that typing my full legal name and last four digits of my social security number shall be the electronic representation of my signature for all purposes, with the exception of the cancellation of any coverage, when I {or my Agent} use them on documents, including legally binding contracts, to include all Employee Benefits applications and Section 125 forms, just the same as a pen and paper signature.

Full Legal Name _____ Last Four Digits of Social _____

Licensed Representative's Name _____ Licensed Representative's Signature _____Agent #_____

PEAK TECHNICAL SERVICES BENEFITS GUIDE

HAVE QUESTIONS ABOUT THESE BENEFITS? WANT TO ENROLL IN BENEFITS?
PLEASE CALL OUR SERVICE CENTER AND TALK WITH A LICENSED BENEFIT COUNSELOR TODAY OR COMPLETE THE ENROLLMENT FORM THAT IS ATTACHED.

- MINIMUM ESSENTIAL COVERAGE (MEC)
- HOSPITAL INDEMNITY PLAN 1
- HOSPITAL INDEMNITY PLAN 2
- DENTAL
- SHORT TERM DISABILITY
- LIFE INSURANCE
- VISION

2017 HEALTH BENEFITS FOR THE EMPLOYEES OF PEAK TECHNICAL SERVICES

TO ENROLL IN BENEFITS CALL :

866-629-5456 Monday-Friday 8AM-7PM