Health, Security and Wellbeing

At Adventist Health System, we’re committed to your health, security and wellbeing. We provide access to benefits and programs that support your total wellness.

Use this guide throughout the plan year to learn about your benefit options so you can make the best coverage choices for yourself and your family. Please refer to your Benefits at a Glance document for rate information.

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Medical

You have access to competitive medical benefits that promote preventive care and provide prescription drug coverage.

Your Medical Plan Options

For the 2016 plan year, you will have two medical plans to choose from: the Health Savings Plan or the Traditional Plan.

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<thead>
<tr>
<th>How they’re the same</th>
<th>How they’re different</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both plans:</td>
<td>• Premiums</td>
</tr>
<tr>
<td>• Are administered by Florida Hospital Care Advantage (FHCA)</td>
<td>• Deductibles</td>
</tr>
<tr>
<td>• Cover the same types of services</td>
<td>• Out-of-pocket maximums</td>
</tr>
<tr>
<td>• Offer the flexibility of in- and out-of-network care</td>
<td>• The Health Savings Plan includes a Health Savings Account (HSA)</td>
</tr>
<tr>
<td>• Provide greater savings when you use a Tier 1 provider</td>
<td>• The Traditional Plan allows a Medical Flexible Spending Account (FSA)</td>
</tr>
<tr>
<td>• Include prescription drug coverage through Rx Plus Pharmacy</td>
<td></td>
</tr>
</tbody>
</table>

Eligibility

All full-time or part-time benefit eligible employees may elect coverage. Eligible dependents include your spouse, to whom you are legally married, and children up to the last day of the month in which they turn age 26. Any unmarried child with a mental or physical handicap or developmental disability who is incapable of self-support is eligible provided the condition started before they reached the age limit, they had continuous coverage, and they depend on you for support and maintenance.

Coverage Levels

You can choose from four levels of coverage:

• Employee Only
• Employee + Children
• Employee + Spouse
• Employee + Family

The Traditional Plan

The Traditional Plan is a Preferred Provider Organization (PPO) plan where you pay less when you use network providers. With this plan, you pay a copay or coinsurance whenever you obtain care, and there is a limit to how much you pay for covered medical expenses in a calendar year.

With the Traditional Plan, you can contribute up to $2,550 to a Medical Flexible Spending Account (FSA) in 2016 to cover certain out-of-pocket health care expenses you incur. However, you must use the money in the account for eligible expenses incurred in 2016, or the money will be forfeited.

FOR MORE INFORMATION
Please contact Florida Hospital Care Advantage Customer Service at 844-522-5279.

With both the Traditional Plan and the Health Savings Plan, preventive care and certain preventive prescription drugs are covered at 100%. Before either plan begins to pay other benefits, you must first meet a deductible. Once that deductible is satisfied, you share the costs of coverage, until you reach an out-of-pocket maximum. When the out-of-pocket maximum is reached in a calendar year, the plan will pay the remaining covered expenses that year in full.
The Health Savings Plan
The Health Savings Plan is what’s known as a “High Deductible Health Plan” and enables participants to set up, and contribute to, a tax-advantaged “Health Savings Account.”

You can set up a Health Savings Account (HSA) with this plan, enabling you to pay your out-of-pocket medical, dental and vision costs with tax-free dollars that have been contributed to the account. Money in your HSA is not taxed when it goes in, can grow with tax-free investment earnings while in the account, and can be withdrawn tax-free provided the funds are used for qualified health care expenses.

The IRS limits how much you can put into the account each year, but the account is always yours and can be taken with you when you leave for any reason. Also, money in the account can roll over from one year to the next.

Adventist Health System self-insures our health care plans. This means that when it comes to paying the bill, AHS pays the insurer’s share of the cost for services and every dollar spent comes out of the plan. This is why we encourage you to be an educated health care consumer. Making informed decisions about how you use health care services, and getting the right care every time, enables us all to better manage costs.

Network Tiers
Our health plans use a “Tier” approach that encourages you to use certain health plan providers, especially those affiliated with Adventist Health System. What you pay for a particular service will depend on which tier that provider is in, and using Tier 1 providers will cost you less when you receive care.

**Tier 1** (“In-Network Preferred”) are services where the care is received from a provider (doctor, clinic, hospital, etc.) who is part of the Adventist Health System or who has been placed in Tier 1 for other reasons. Care received from a Tier 1 provider costs you less.

**Tier 2** (“In-Network”) are services where the care is received from a provider who is part of the Florida Hospital Care Advantage (FHCA) network but not affiliated with Adventist Health System. Care received from a Tier 2 provider costs you more than from a Tier 1 provider but less than from a Tier 3 provider.

**Tier 3** (“Out-of-Network”) are services where the care is received from a provider who is not part of Adventist Health System or a specified provider in the FHCA network. Tier 3 services cost you the most.

Use Tier 1 Providers and Save Money
Any time you receive care, it is important that you ensure your provider, clinic or facility is in the preferred tier. As a good health care consumer, you must take this action yourself — it isn’t up to your doctor’s office to make this determination. You can find Tier 1 providers by going to [www.myFHCA.org](http://www.myFHCA.org).

Why Use a Network Provider?
Network providers have agreed to charge less for individuals in the network, so you can save money, sometimes a considerable amount of money, by using these providers, without sacrificing the quality of care you receive.

There may be some situations in which a Tier 1 provider is not available for a specific service. In these cases, use a Tier 2 provider to keep your costs as low as possible.
Your Spending Account Options

Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs) are spending accounts that allow you to reduce your income taxes by paying for qualifying expenses with pre-tax funds. With both HSAs and FSAs, you can deposit pre-tax funds and use the account to pay for qualifying medical, dental and vision expenses as they occur. Read on to learn about the key features of these spending accounts, including how they can be used, who can open an HSA or FSA, and how the accounts differ.

How the Medical Plans and Spending Accounts Work Together

The Health Savings Plan offers the same comprehensive coverage and network of providers as the Traditional Plan. The big difference is cost: how much you pay for coverage and how you and the plan share the cost of care.

Think of your medical plan as a house, where preventive care serves as the foundation:

1. The plan provides preventive care, such as annual physicals and screenings, at no cost to you when you use a Tier 1 primary care physician.
2. You pay the full cost of covered services up to the deductible. You can use money in your HSA or FSA to satisfy the deductible.
3. Once you meet the annual deductible, you share in the cost of services by paying coinsurance. You can use money from your HSA or FSA to pay these amounts.
4. The out-of-pocket maximum provides important financial protection for you. If you ever reach this maximum in a year, the plan pays 100% of your remaining covered medical expenses for the rest of that year.

HSA and Medical FSA: Know the Rules

IRS rules prohibit those with other reimbursement arrangements (such as Medical Flexible Spending Accounts) from participating in Health Savings Accounts at the same time.
Get to Know the HSA

A Health Savings Account (HSA) is a valuable way to save pre-tax dollars and pay for eligible health care expenses. When you enroll in the Health Savings Plan, you may open an HSA if you meet IRS rules of eligibility. You can contribute your own money to your HSA. The HSA offers many advantages:

- You don't pay taxes on your contributions.
- You don't pay taxes when you use funds for eligible healthcare expenses.
- You can invest your funds once you reach a minimum balance of $1,000, and any growth is tax-free.
- The funds roll over year after year, and they’re always yours to keep, even if you leave AHS.

ConnectYourCare administers the HSA. When you enroll in the Health Savings Plan, you’ll receive an HSA debit card in the mail which you can use to cover the costs of eligible expenses. You also have the option to pay out-of-pocket and reimburse yourself from your HSA at a later point. Watch for any mail from ConnectYourCare as there may be some forms to fill out in order to open your account.

How the HSA Helps You Save

The HSA is a useful savings vehicle, in both the short term and the long term.

1. **Short-term:** It helps you plan ahead and set aside money each paycheck to cover deductibles and other out-of-pocket health care expenses during the year.

2. **Long-term:** The funds roll over year after year. Once the account exceeds $1,000, you can invest your funds, and they grow tax-free. So if you start saving early and you’re smart with your spending, you can reap the rewards as your account builds in the future.
Health

Coverage for preventive services includes:
• Screenings
• Physical exams
• Immunizations
• Counseling services

Note: These services are not preventive if you get them as part of a visit to diagnose, monitor or treat an illness or injury. In such cases, copays, coinsurance and deductibles may apply.

HSA Rules to Remember
To be eligible for the Health Savings Account (HSA), you must be enrolled in an IRS-qualified high deductible health plan (HDHP) like the Health Savings Plan. You must also meet the following requirements:

☐ You (and your spouse, if you have family coverage) do not have any other health coverage that is not an HDHP.
☐ You are not enrolled in Medicare.
☐ You are not claimed as a dependent on someone else’s tax return.

There also are limits to how much you can contribute annually to an HSA. For the 2016 plan year, the limits are:
• $3,350 for employee only coverage
• $6,750 for employee + spouse, employee + children or family coverage

If you are or will be age 55 or older in 2016, you can also make an additional $1,000 annual catch-up contribution.
Flexible Spending Accounts (FSAs) are a great way to save money by paying for certain health care and dependent care expenses tax-free. You can contribute to a Medical FSA, a Dependent Care FSA or both.

The money you contribute is deducted from your paycheck before taxes, which lowers your taxable income and means lower taxes for you.

<table>
<thead>
<tr>
<th>Medical FSA</th>
<th>Dependent Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Can be used with the Traditional Plan, but per the IRS, cannot be combined with a high deductible health plan (HDHP) like the Health Savings Plan</td>
<td>• Can be used regardless of health plan enrollment</td>
</tr>
<tr>
<td>• You can contribute up to $2,550 each year, and you can use the money in the account to cover many expenses that aren’t covered by your medical, dental or vision plans.</td>
<td>• You can contribute up to $5,000 per married couple each year (up to $2,500 per year if you and your spouse file separate tax returns).</td>
</tr>
<tr>
<td>Eligible expenses include:</td>
<td>You can use this FSA to pay for day care or elder care for eligible dependents while you and your spouse (if you’re married) are at work. Eligible dependents include children up to age 13 or dependent adults. Eligible expenses include:</td>
</tr>
<tr>
<td>- Copays, deductibles, and coinsurance</td>
<td>- Babysitters (provided they’re not your child under age 19 or someone you claim as a dependent on your tax return)</td>
</tr>
<tr>
<td>- Vision care or services not covered by your plan, including contact lens solution and LASIK surgery</td>
<td>- Care at licensed nursery schools, day camps, and day care centers</td>
</tr>
<tr>
<td>- Hearing exams and hearing aids</td>
<td>- Household services for the care of an elderly or disabled adult who lives with you</td>
</tr>
<tr>
<td>- Certain over-the-counter medications as prescribed by a physician</td>
<td></td>
</tr>
</tbody>
</table>

For a complete list of eligible FSA expenses and guidelines, visit the IRS website at [www.irs.gov](http://www.irs.gov). Publication 502 includes eligible Medical FSA expenses; Publication 503 includes eligible Dependent Care FSA expenses.

**Reminder:** Save your receipts! ConnectYourCare may request that you provide receipts to substantiate eligible purchases.
About FSAs

- In general, you may only set your pre-tax contribution in an FSA during open enrollment or when you first become eligible based on your employer’s plan.
- Estimate your FSA contribution carefully. Unused funds will be forfeited after the last day of the plan year.
- In the event you resign, or your employment is terminated, your medical spending account will be frozen the day following your last active day of work. Claims incurred following this date will not be eligible for reimbursement through the plan.
- You may file claims for any expenses incurred through your final day of employment as allowed by Federal guidelines.
- For information about eligible expenses, go to www.connectyourcare.com.

Important Note on the Medical FSA

According to IRS regulations, if you enroll in the Health Savings Plan (HDHP), you are not permitted to open a Medical FSA (but you can open a Dependent Care FSA).

ConnectYourCare will administer our HSA and FSA as of January 1, 2016. For questions related to accounts held under our previous administrator, PayFlex, call 888-678-8242.

FOR MORE INFORMATION
Please contact ConnectYourCare at 844-680-5661 or visit www.connectyourcare.com.

HSA/Medical FSA — A Quick Comparison

<table>
<thead>
<tr>
<th></th>
<th>HSA</th>
<th>Medical FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who’s eligible</td>
<td>Health Savings Plan participants</td>
<td>Traditional Plan participants</td>
</tr>
<tr>
<td>Tax-free dollars</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tax-free withdrawals</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical expenses</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dental expenses</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Vision expenses</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Unused funds roll over</td>
<td>Yes</td>
<td>No, unused funds will be forfeited if you don’t use them by December 31, 2016 for 2016 claims</td>
</tr>
<tr>
<td>Portable</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Withdrawals for</td>
<td>Yes, the penalty for using HSA funds for nonqualified medical</td>
<td>No</td>
</tr>
<tr>
<td>nonqualified health</td>
<td>expenses is 20%</td>
<td></td>
</tr>
<tr>
<td>care expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual contribution</td>
<td>• $3,350 (employee only coverage)</td>
<td>$2,550</td>
</tr>
<tr>
<td>limits</td>
<td>• $6,750 (employee + spouse, employee + children or family coverage)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Additional $1,000 catch-up contribution for those who are or will be age 55 or older in 2016</td>
<td></td>
</tr>
</tbody>
</table>
Prescription Drug Coverage

Prescription drug coverage is included under the medical plan and administered through Rx Plus Pharmacy with assistance from MedImpact. With this coverage, you can obtain short-term prescriptions through your local pharmacy but will need to use the Rx Plus mail order program for maintenance medications. Note: Prescription benefit information is listed on the back of your medical card.

Using the Mail-Order Pharmacy

To fill a 90-day supply through mail order, call 866-943-4535 or register online at www.myahsrx.com. If you have a prescription being filled through a local retail pharmacy, Rx Plus can transfer that prescription.

To order a refill from Rx Plus Pharmacy, you can either call an automated refill line at 866-943-4535 when you have at least a 14 to 30 day supply remaining, or sign up for the internet refill service available at www.myahsrx.com. Rx Plus Pharmacy does not automatically refill maintenance medications.

Your Formulary

Certain “preferred” brand-name drugs are in what’s called a “formulary,” a list of brand-name drugs that are preferred over other brand-name drugs that may be prescribed for the same condition. You pay less for formulary drugs than non-formulary drugs. Certain “High Cost Generics” are priced at the formulary brand tier due to the availability of a less expensive generic alternative.

A list of these drugs can be found online at myahsrx.com and may change from time to time. Your specific prescription benefit inclusions, exclusions, copayments, or lack of coverage are not reflected in the formulary.

Specialty Rx Program

Patients with complex, chronic medical conditions need the necessary care management to monitor their condition. The Rx Pharmacy Specialty Rx Program provides that attention, working one-on-one with the patient and managing their treatment.

FOR MORE INFORMATION

Please contact Rx Plus at 866-943-4535.

Getting Help with Prescription Costs

If you are having trouble with your out-of-pocket costs for medications, please refer to the following links and see if patient assistance is available. In many cases, there are assistance cards available specific to the medication being prescribed.

www.needymeds.org
This website provides a comprehensive list of both brand and specialty medications and any assistance that may be available. Qualification guidelines and contact information is also available.

Below are prescription drug resources that may offer additional support.

American Kidney Foundation
800-638-8299
www.kidneyfund.org

Caring Voice Coalition
888-267-1440
www.caringvoice.org

Chronic Disease Fund
972-608-7141
www.cdfund.org

Healthwell Foundation
800-675-8416
www.healthwellfoundation.org

Patient Access Network
866-316-7263
www.panfoundation.org

Patient Advocate Foundation
866-512-3861
www.copays.org

Patient Services Incorporated
800-366-7741
www.patientservicesinc.org
Dental

To promote good dental health, you can choose from three dental plan options to best meet your needs.

Eligibility

All full-time or part-time benefit eligible employees may elect coverage. Eligible dependents include your spouse, to whom you are legally married, and children up to the last day of the month in which they turn age 26. Any unmarried child with a mental or physical handicap or developmental disability who is incapable of self-support is eligible provided the condition started before they reached the age limit, they had continuous coverage, and they depend on you for support and maintenance.

Coverage Levels

You may cover yourself, your spouse, and your dependent children. Dependent children can be covered up to the end of the month of their 26th birthday.

Your Dental Plan Options

You have three dental plan options:
- The $50 Deductible Plan (PPO)
- The $75 Deductible Plan (PPO)
- DeltaCare USA Managed Care (DMO)

Delta Dental PPO

With these plans, you may use any dentist; however, you will pay less when you use a dentist in the Delta PPO network.

The $50 Deductible Plan
- $50 deductible per person, $150 per family per plan year
- $1,500 per person maximum benefit paid per calendar year

The $75 Deductible Plan
- $75 deductible per person, $225 per family per plan year
- $1,000 per person maximum benefit paid per calendar year

Both Plans Feature:
- Diagnostic and Preventive (D&P) Maximum Waiver Benefit, which allows you to obtain such services without those costs applying to the plan year maximum
- Annual maximum is waived for D&P services such as x-rays and cleanings

To find a Delta Dental PPO Preferred provider:
Call the dental office and verify that the dentist is in the Delta network. For a list of dentists in your area, go to www.deltadentalins.com.

DeltaCare USA Managed Care

With this plan you must use a network provider. For specific information about your plan coverage, contact DeltaCare USA Managed Care directly. Plan features include:
- Total enrollee costs included in copayments; no hidden fees
- Primary dentist coordinates care
- No deductibles or maximum benefits
- No claim forms to complete
- No copayments for routine cleanings (two per year) with additional cleanings at a modest copayment
- Copayments for basic, major and orthodontia
- Extractions covered for orthodontia
- External bleaching
- Intravenous conscious sedation/analgesia coverage

Verify there is a DMO provider near you before electing this coverage
DeltaCare USA Managed Care providers are available in certain areas only. For a list of dentists in your area who are part of the DeltaCare USA Managed Care network, go to www.deltadentalins.com.
### How the Dental Plans Work

<table>
<thead>
<tr>
<th></th>
<th>Delta Dental PPO 50</th>
<th>Delta Dental PPO 75</th>
<th>DeltaCare USA DMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$50/person</td>
<td>$75/person</td>
<td>No deductibles</td>
</tr>
<tr>
<td>Deductible does not apply to diagnostic and preventive services</td>
<td></td>
<td></td>
<td>Copays apply</td>
</tr>
<tr>
<td>$150/family</td>
<td>$225/family</td>
<td>No deductibles</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Maximum Benefit</strong></td>
<td>$1,500</td>
<td>$1,000</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Diagnostic and preventive services do not count towards Annual Maximum</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Delta Dental PPO Dentists*</th>
<th>Non-Delta Dental PPO Dentists*</th>
<th>Delta Dental PPO Dentists*</th>
<th>Non-Delta Dental PPO Dentists*</th>
<th>DeltaCare USA Network Providers ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic and Preventive Care</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>Up to $50 copay</td>
</tr>
<tr>
<td>(Exams, cleanings, x-rays, fluoride treatment, space maintainers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic and Restorative Care</strong></td>
<td>80%</td>
<td>80%</td>
<td>60%</td>
<td>60%</td>
<td>Restorative: Up to $50 copay Peridontics: $35 to $240** copay Endodontics: Up to $335 copay Oral Surgery: Up to $115 copay</td>
</tr>
<tr>
<td>(Fillings, simple tooth extractions, denture repairs, endodontics [root canals], periodontics [gum treatment] oral surgery and sealants)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Major Care</strong></td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>$145 to $355 copay</td>
</tr>
<tr>
<td>(Crowns, inlays, onlays and cast restorations)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontic Lifetime Deductible</strong></td>
<td>$50</td>
<td>$50</td>
<td>$75</td>
<td>$75</td>
<td>No deductibles Copays apply</td>
</tr>
<tr>
<td>(Adults and children)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontic Lifetime Maximum</strong></td>
<td>$1,500</td>
<td>$1,500</td>
<td>$1,000</td>
<td>$1,000</td>
<td>No maximum Copays apply</td>
</tr>
<tr>
<td>(Adults and children)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontic Care</strong> (Adults and children)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>Pre- and post-treatment records copay: $270 Limited Orthodontic copay: child $1,150; adult $1,350 Interceptive copay: $1,150 Comprehensive copay: child $1,900; adult $2,100</td>
</tr>
</tbody>
</table>

*Reimbursement is based on PPO contracted fees for PPO dentists; Delta Dental Premier® contracted fees for Premier dentists; Dental dentists and Premier contracted fees for non-Delta.

**Periodontics may be based on number of teeth and/or copay per quadrant.
Vision

With the Vision plan, administered by Vision Service Plan (VSP), you can go to any eye-care professional you choose, but if you use a VSP network provider, you’ll pay less.

Eligibility

All full-time or part-time benefit eligible employees may elect coverage. Eligible dependents include your spouse, to whom you are legally married, and children up to the last day of the month in which they turn age 26. Any unmarried child with a mental or physical handicap or developmental disability who is incapable of self-support is eligible provided the condition started before they reached the age limit, they had continuous coverage, and they depend on you for support and maintenance.

Using Your VSP Benefit

• Register at www.vsp.com
• To find a VSP provider, visit www.vsp.com or call 800-877-7195
• At your appointment, tell them you have VSP. There’s no ID card necessary. If you’d like a card as a reference, you can print one at www.vsp.com

That’s it! VSP will handle the rest. There are no claim forms to complete when you see a VSP provider.

TruHearing Benefit from VSP

VSP members receive a special benefit from TruHearing. You can save up to $2,400 on a pair of hearing aids with TruHearing pricing.

Hearing aid benefits include:
1. Three provider visits for fitting, adjustments, and cleanings
2. 45-day money back guarantee
3. Three-year manufacturer’s warranty for repairs, one-time loss and damage issues
4. 48 free batteries per hearing aid

Visit www.vsp.truhearing.com or call 877-396-7194 to learn more.
### How the Vision Plan Works

You pay less when you receive care from a VSP doctor or participating retail chain.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Copay</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your Coverage with a VSP Provider</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WellVision Exam</strong></td>
<td>Focuses on your eyes and overall wellness</td>
<td>$10</td>
<td>Every 12 months</td>
</tr>
<tr>
<td><strong>Prescription Glasses</strong></td>
<td></td>
<td>$15</td>
<td>See frame and lenses</td>
</tr>
<tr>
<td><strong>Frame</strong></td>
<td>• $160 allowance for a wide selection of frames</td>
<td>Included in Prescription Glasses</td>
<td>Every 12 months</td>
</tr>
<tr>
<td></td>
<td>• 20% savings on the amount over your allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Or $90 allowance at Costco® Optical, Walmart or Sam’s Club</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• $180 allowance for featured frame brands</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td>Single vision, lined bifocal, and lined trifocal lenses</td>
<td>Included in Prescription Glasses</td>
<td>Every 12 months</td>
</tr>
<tr>
<td></td>
<td>Polycarbonate lenses for dependent children</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lens Enhancements</strong></td>
<td>Scratch-resistant coating</td>
<td>$0</td>
<td>Every 12 months</td>
</tr>
<tr>
<td></td>
<td>Standard progressive lenses</td>
<td>$55</td>
<td></td>
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<tr>
<td></td>
<td>Premium progressive lenses</td>
<td>$95 - $105</td>
<td></td>
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<tr>
<td></td>
<td>Custom progressive lenses</td>
<td>$150 - $175</td>
<td></td>
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<tr>
<td></td>
<td>Average savings of 20-25% on other lens enhancements</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contacts</strong> (instead of glasses)</td>
<td>$160 allowance for contacts; copay does not apply</td>
<td>Up to $50</td>
<td>Every 12 months</td>
</tr>
<tr>
<td></td>
<td>Contact lens exam (fitting and evaluation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetic Eyecare Plus Program</strong></td>
<td>Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD)</td>
<td>$20</td>
<td>As needed</td>
</tr>
<tr>
<td></td>
<td>Retinal screening for eligible members with diabetes</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.</td>
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</tr>
<tr>
<td><strong>Extra Savings</strong></td>
<td>Glasses and Sunglasses</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.</td>
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<tr>
<td></td>
<td>20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</td>
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</tr>
<tr>
<td><strong>Laser Vision Correction</strong></td>
<td>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Your Coverage with Out-of-Network Providers</strong></td>
<td>Visit vsp.com or call 800-877-7195 if you plan to see a provider other than a VSP network provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exam: up to $50</strong></td>
<td>Single Vision Lenses up to $30</td>
<td>Lined Trifocal Lenses up to $65</td>
<td>Contacts up to $105</td>
</tr>
<tr>
<td><strong>Frame: up to $70</strong></td>
<td>Lined Bifocal Lenses up to $50</td>
<td>Progressive Lenses up to $50</td>
<td></td>
</tr>
</tbody>
</table>
Short-Term Disability

If you’re unable to work due to illness or injury, short-term disability can help you replace your income so you can pay your bills and protect your savings.

Eligibility

All active benefit-eligible employees working 32 or more hours per pay period (16 or more hours per week) who have completed the required waiting period as defined by your facility are eligible for coverage with Adventist Health System. Coverage for the current plan year is effective on your benefit eligible date. Coverage selected during annual enrollment is effective the following January 1.

How the Plan Works

• Benefits begin on the first day after an accident, or the 15th day of an illness*.
• The benefit amount is 60% of your current weekly base income to a maximum of $5,000 per week.
• You must be actively at work on the effective date.
• Benefits are payable for up to 26 weeks.
• If you are disabled, premiums are waived after 90 consecutive days of a covered total disability for the remainder of the benefit period, as long as total disability continues.

*See the plan document for the complete definition of “accident” and “illness.”

Total Disability

You are totally disabled when Aetna determines that you are unable, due to illness or injury, to perform all the material and substantial duties of your regular occupation and you are not working in any occupation.

Partial Disability

You will continue to be paid a disability benefit after you have received benefits under this plan if you are partially disabled and your disability earnings are less than 80% of pre-disability earnings.

Pre-Existing Conditions

No benefits will be paid if you are disabled during the first 12 months for a condition which commenced prior to the effective date and for which you consulted a physician or took prescription drugs within the three consecutive months immediately preceding the effective date; this includes pregnancy.

FOR MORE INFORMATION

To start a disability claim, or for general claim questions, call Aetna at 866-326-1380. To submit a claim online, visit www.aetnadisability.com.
Long-Term Disability

Long-term disability coverage is available if you’re unable to return to work after the short-term disability coverage period.

Eligibility
This plan is available to all currently active, benefit-eligible full-time employees. You must be actively at work on the date the coverage takes effect.

How the Plan Works
- Benefits begin after 180 days of disability (the elimination period).
- The benefit amount is 60% of your monthly earnings, with a maximum monthly benefit of $6,000*.
- If disability occurs prior to age 60, benefits are payable until age 65.
- If disability occurs after age 60, benefits are paid for the maximum benefit period listed in the schedule of benefits.
- Premium payments for a disabled employee are waived during any period for which total or partial disability benefits are payable.
- If you are covered for a year and leave, coverage can continue for up to one year at the same rate in effect at the time you left, provided you are not disabled, on a leave of absence, or retired when you leave.

*Physicians and other higher-earning individuals are enrolled for another plan with higher average limits.

Total and Partial Disability Benefits
Benefits are paid if you are unable to perform all the main duties of your occupation on a full-time basis and earn less than 85% of your pre-disability earnings due to injury or sickness.

Benefit Offset
If you are receiving Social Security and/or Workers’ Compensation payments, the plan will offset those payments up to your benefit maximum.

Mental Disorders/Substance Abuse
The plan provides a 24-month maximum benefit unless you are confined to the hospital. The monthly benefit will not be paid beyond the maximum benefit period.

Pre-existing Conditions
Pre-existing conditions for first time eligible employees are not covered until they have been insured for 12 months.

A pre-existing condition is an illness or injury for which one consulted a physician or took prescription drugs within the three consecutive months immediately before the effective date of coverage.

FOR MORE INFORMATION
Please contact Aetna at 866-326-1380.
Life and AD&D Insurance

You automatically receive life insurance coverage upon meeting eligibility requirements, and you have the option of electing supplemental Life and AD&D insurance.

Eligibility
This plan is available to all benefit eligible full-time and part-time employees as defined by your facility.

Term Life Insurance
This is a term life insurance and therefore has no cash value buildup.

Full Time Employees
You are automatically covered by your employer for Basic Group Life and Accidental Death & Dismemberment (AD&D) insurance in the amount of your base annual salary, subject to a maximum of $300,000. AD&D pays an additional amount equal to your base annual salary if death occurs due to an accident.

Death benefits are payable under the Basic Life plan if you die of any cause other than suicide. Benefits are payable under the AD&D portion of the plan if your death or dismemberment is the result of an accident.

Part Time Employees
Your employer pays a portion of the cost for Basic Group Life and AD&D insurance for coverage equal to your annual salary. AD&D pays an additional amount equal to your annual salary if death occurs due to an accident. Annual salary is determined by computing your hourly rate x scheduled hours x 26 pay periods.

Supplemental Life and AD&D
You may purchase more coverage under the Supplemental Life and AD&D plan. Coverage is available in amounts equal to 1, 2, 3, or 4 times your annual rate of basic earnings, subject to a maximum of $1,000,000 with Evidence of Good Health.

Benefits under this plan are paid just as they are under the Basic Life Plan. Death benefits are payable if you die of any cause. AD&D benefits are paid if your death or dismemberment is the result of an accident. Your life insurance amount will be decreased by:

- 60% at age 65
- 65% at age 75
- 75% at age 80

A Personal Health Application (PHA) will be required:

Initial Hire
- If electing the four times coverage level
- If electing an amount over $750,000

Late Entrant
- Enrolling in coverage if, at the time of hire or when first eligible, you did not elect to take it
- Requesting an increase of two or more times coverage level on yourself
- If electing four times coverage level
- If electing an amount over $750,000

If you are requesting any of the above or electing coverage after the initial offering, you will need to complete a PHA. Upon approval, your premium deductions will begin through payroll deductions.

Premiums for this coverage must be paid from after-tax dollars which are withheld every pay period. Federal tax laws require you to pay taxes on the value of life insurance over $50,000 which is provided by your employer. The value of this extra amount will be added to each of your paychecks and your W-2 statement at the end of the year as “imputed income” for income tax purposes.

Update Your Beneficiary
You will receive your ID and password from an Aetna mailing after you enroll. Once you have enrolled and obtained your ID and password, visit www.aetnadisability.com to review your coverages and designate or add a new beneficiary.
Dependent Life Insurance
In addition to the Basic Group and Supplemental Life insurance for yourself, you may purchase life insurance for your spouse and/or children. (Accidental Death & Dismemberment benefits are not included.)

Spouse Option
Life coverage for a spouse is available up to 50% of the employee’s current amount of group life insurance to a maximum of $25,000 at the initial offering without a PHA and $250,000 with a PHA. After the initial offering, a PHA is required for any increased amount selected. Upon approval from Aetna, your contributions will begin through payroll deductions. You may not elect coverage for your spouse if your spouse is covered as an employee under this policy.

Cancer and Specified Diseases
This optional coverage can help you pay for medical costs associated with illness or general living expenses.

Eligibility
This supplemental plan is available for employees and their dependents who are eligible for medical coverage. Children are covered until the last day of the month in which they turn age 26, but coverage does not end for incapacitated children.

How the Plan Works
This plan works with your medical coverage to provide financial protection from costs associated with cancer or other specified diseases.

This plan:
• Pays directly to you, unless you assign benefits
• Pays in addition to other coverage
• Provides in and out of hospital benefits
• Provides transportation and lodging allowances
• Pays an initial diagnosis benefit
• Pays an annual wellness benefit for routine screening exams

FOR MORE INFORMATION
Please contact Aetna at 800-523-5065.
## What is Covered?

With this plan, coverage includes a variety of benefits such as wellness, radiation, chemotherapy, non-local transportation and lodging for patient and family member. See below for additional detail.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Basic Coverage</th>
<th>Enhanced Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Confinement</strong></td>
<td>$100</td>
<td>$300</td>
</tr>
<tr>
<td>Payable daily for continuous hospital confinement up to 70 days.</td>
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</tr>
<tr>
<td><strong>Cancer Screening/Wellness</strong></td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Payable for a test performed once per calendar year for each covered person.</td>
<td></td>
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</tr>
<tr>
<td><strong>Radiation, Chemotherapy and Related Benefits</strong></td>
<td>$5,000 maximum per calendar year</td>
<td>$10,000 maximum per calendar year</td>
</tr>
<tr>
<td>Benefits payable per 12-month period for covered person when radiation and chemotherapy is received. Benefit is limited to the amount shown per 12-month period beginning with the first day of benefit under this provision.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Local Transportation and Lodging</strong></td>
<td>$50 per day lodging Coach fare or $.40 cents per mile for personal vehicle travel</td>
<td>$50 per day lodging Coach fare or $.40 cents per mile for personal vehicle travel</td>
</tr>
<tr>
<td>Travel and lodging covered if the insured requires treatment at a hospital or any other specialized freestanding treatment center that is not available locally. Covers the cost of round trip coach fare on a common carrier or up to 700 miles for a round trip in personal vehicle.</td>
<td></td>
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</tr>
<tr>
<td><strong>Companion Lodging and Transportation</strong></td>
<td>$50 per day lodging Coach fare or $.40 cents per mile for personal vehicle travel</td>
<td>$50 per day lodging Coach fare or $.40 cents per mile for personal vehicle travel</td>
</tr>
<tr>
<td>Benefit for one companion to accompany any covered person receiving treatment. Benefit is limited to 60 days for each period of continuous hospital confinement.</td>
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</tr>
</tbody>
</table>

This plan also covers the following specified diseases:

<table>
<thead>
<tr>
<th>Other Covered Specified Diseases</th>
<th>Polioymelits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addison's Disease</td>
<td>Poliomyelits</td>
</tr>
<tr>
<td>Brucellosis</td>
<td>Primary Biliary Cirrhosis</td>
</tr>
<tr>
<td>Cerebrospinal Meningitis (bacterial)</td>
<td>Primary Sclerosing Cholangitis</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>Rabies</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>Reye's Syndrome</td>
</tr>
<tr>
<td>Encephalitis</td>
<td>Rocky Mountain Spotted Fever</td>
</tr>
<tr>
<td>Hansen's Disease</td>
<td>Scarlet Fever</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>Sickle Cell Anemia</td>
</tr>
<tr>
<td>Legionnaire's Disease</td>
<td>Systemic Lupus Erythematosus</td>
</tr>
<tr>
<td>Lou Gehrig's Disease</td>
<td>Tetanus</td>
</tr>
<tr>
<td>Lyme Disease</td>
<td>Thalassemia</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Muscular Dystrophy</td>
<td>Tularemia</td>
</tr>
<tr>
<td>Myasthenia Gravis</td>
<td>Typhoid Fever</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td></td>
</tr>
</tbody>
</table>

FOR MORE INFORMATION

This plan is administered by Benefits Technologies, LLC for Allstate Benefits. Please contact Benefits Technologies at 407-599-5001 or 888-357-0504, or visit the Group Cancer information page at [www.bentecllc.com/adventist/](http://www.bentecllc.com/adventist/).
Retirement Plan

Adventist Health System (AHS) maintains an excellent retirement plan called the Adventist Healthcare Retirement Plan. This plan is designed to help you prepare for retirement.

Eligibility
This plan is available to all currently active, benefit eligible full-time employees. You must be actively at work on the date the coverage takes effect.

How the Plan Works
With the Adventist Healthcare Retirement Plan (AHRP), AHS makes cash contributions to an account in your name. Your employer also matches a portion of the funds that you voluntarily contribute to your AHRP account.

There are two types of contributions to your AHRP account: basic contributions and matching contributions.

Basic Contributions
Following the end of each calendar year, your employer will contribute a basic retirement benefit to your AHRP account, determined by using the following formula:
• 2.6% of wages (up to a maximum of $255,000*)
• An additional 1.5% of wages in excess of Social Security Taxable Wage Limit ($113,700*)

* or any higher amount permitted under the Social Security Taxable Wage Limit for the current year

Matching Contributions
Your employer will match 50% of the first 4% of wages you contribute to the Plan. This can add as much as an additional 2% of wages to your account.

Vesting
Although Basic and Matching retirement benefits are deposited into your retirement account, these funds do not belong to you until you complete five years of vesting service. To be granted a year of vesting service, you must be compensated for at least 1,000 hours, including paid leave, in a payroll year. Full time employment is 2,080 hours per year. If you complete five years of vesting service, you will be vested in your account, at which point you will own all of the funds in your AHRP account.

If your employment with AHS ceases before meeting the vesting requirement, employer contributions along with related earnings, will be taken from your AHRP account and returned to AHS. You are always vested in the contributions you make.

Roth 403(b)
A Roth 403(b) plan is available on an after-tax savings option through the AHRP-TSA Plan (a traditional 403(b) plan).

FOR MORE INFORMATION
Please call the AHRP Retirement Center at 800-730-2477 or visit www.ahrp.com. For a complete description of the plan provisions including any limitations and exclusions, contact your Benefits Department for a current copy of the Certificate of Insurance.
Paid Days Off

Eligibility
Eligible employees include:
- Full-time benefit-eligible employees
- Part-time benefit-eligible employees
- Certain other part-time employees working regularly scheduled hours in positions defined by facility policy as PDO-eligible

How the Plan Works
Employees may use Paid Days Off (PDO) to receive paid time off for any supervisor-approved reason, including illness, holidays and vacations.

Participation in the PDO plan begins when contributions are made by your employer to your PDO account. These contributions, referred to as your PDO accrual, are made each pay period and placed into your PDO bank for use when needed.

The actual amount contributed to your PDO account depends on a number of factors, including your pay rate, hours worked (to a maximum of 40 each week), and length of employment. Your paycheck earnings statements show these employer contributions as they accumulate each pay period. You will be paid from these contributions when you take time off. PDO accrual begins on your first day of employment but cannot be used until your entry period is completed.

Your PDO Bank
You may choose to build your PDO account to a maximum dollar amount equivalent to 480 hours at your current pay rate. If your balance reaches the equivalent of 480 hours, you will stop accruing more PDO until your balance is reduced below 480 hours through either use of PDO as time off or by cashing out some of your account balance.

Cashing Out PDO
After you have completed one year of service, you will be able to receive cash for PDO you have not taken, and can receive this cash any time during the year. These cash payouts will be equivalent to 75% of the value of the PDO if it were taken as time off.

There are two requirements regarding cash out:
- You must always keep at least 40 hours in your PDO bank. In other words, you can cash out only down to 40 hours. This will ensure that you have some PDO in your account to cover for emergencies or upcoming holidays.
- You cannot cash out more than 80 hours of PDO in a calendar year.

FOR MORE INFORMATION
Please see the PDO Policy or contact your Human Resources representative.
Bereavement Program

Eligibility
All actively working employees are eligible for benefits under this policy. Employees on any type of leave (medical-related, personal, educational, military, etc.) are not eligible for this benefit.

How the Plan Works
Employees are allowed up to three consecutive days off from regularly scheduled duty at their base rate of pay for the death of an immediate family member, which includes the employee’s spouse, child, father, mother, sibling, and step or in-law equivalents of the above. Days are also available for the death of grandparents and grandchildren of the employee.

The employee must provide appropriate documentation (obituary, death certificate, etc.) to their supervisor as soon as practical.

These days are available separate from any PDO benefit the employee may have. An employee may use any available PDO as necessary to supplement the bereavement leave, subject to unusual business needs or staffing requirements.

Paid bereavement leave is only provided for consecutive days on which the employee was scheduled to work.

Employee Assistance Program

Eligibility
All employees and their family members are eligible to participate in the Resources for Living Employee Assistance Program (EAP). The program is available to any household member you are legally and financially responsible for.

How the Plan Works
The EAP offers unlimited short-term counseling sessions by phone or up to five face-to-face visits with licensed professionals per issue. Features include:

- Automatic Enrollment, no ID required
- Confidentiality
- Free evaluation
- 24-hour counseling
- Online resources and webinars
- Online legal library
- Referral for on-going assistance

Services include, but are not limited to:
- Addictive behaviors
- Anger management
- Anxiety
- Child counseling
- Coping with life change
- Depression
- Divorce counseling
- Emotional/psychological concerns
- Family counseling
- Legal or financial stress (including identity theft)
- Loss and grieving
- Marital or relationship difficulties
- Stress management
- Substance abuse

FOR MORE INFORMATION
Resources for Living is available 24 hours a day, 365 days a year at 888-802-5821 or online at www.mylifevalues.com

Log in with:
username: AHS password: AHS
## Resources for More Information

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Administrator</th>
<th>Phone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td></td>
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<tr>
<td>The Health Savings Plan</td>
<td>Florida Hospital Care Advantage (FHCA)</td>
<td>844-522-5279</td>
<td><a href="http://www.myFHCA.org">www.myFHCA.org</a></td>
</tr>
<tr>
<td>The Traditional Plan</td>
<td>Florida Hospital Care Advantage (FHCA)</td>
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<tr>
<td>Prescription Drug</td>
<td>Rx Plus</td>
<td>866-943-4535</td>
<td><a href="http://www.myahsrx.com">www.myahsrx.com</a></td>
</tr>
<tr>
<td><strong>Savings Accounts</strong></td>
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<tr>
<td>Health Savings Account (HSA)</td>
<td>ConnectYourCare</td>
<td>844-680-5661</td>
<td><a href="http://www.connectyourcare.com">www.connectyourcare.com</a></td>
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<tr>
<td>Flexible Spending Account (FSA)</td>
<td>ConnectYourCare</td>
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<td><strong>Dental</strong></td>
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<tr>
<td>Delta Dental 50 (PPO)</td>
<td>Delta Dental</td>
<td>800-521-2651</td>
<td><a href="http://www.deltadentalins.com">www.deltadentalins.com</a></td>
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<tr>
<td>Delta Dental 75 (PPO)</td>
<td>Delta Dental</td>
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<tr>
<td>DeltaCare USA Managed Care Plan (DMO)</td>
<td>DeltaCare USA</td>
<td>800-422-4234</td>
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<tr>
<td><strong>Vision</strong></td>
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<tr>
<td>VSP Vision Plan</td>
<td>Vision Service Plan (VSP)</td>
<td>800-877-7195</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
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<tr>
<td><strong>Disability</strong></td>
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<tr>
<td>Short-Term Disability</td>
<td>Aetna</td>
<td>866-326-1380</td>
<td><a href="http://www.aetnadisability.com">www.aetnadisability.com</a></td>
</tr>
<tr>
<td>Long-Term Disability</td>
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<tr>
<td><strong>Life</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Life Insurance</td>
<td>Aetna</td>
<td>800-523-5065</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
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<tr>
<td><strong>Retirement Plan</strong></td>
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<tr>
<td>Retirement Plan</td>
<td>AHRP</td>
<td>800-730-2477</td>
<td><a href="http://www.ahrp.com">www.ahrp.com</a></td>
</tr>
<tr>
<td><strong>Employee Assistance Program</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Password: AHS</td>
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</table>
This document is presented as a matter of information, and is not intended to constitute a promise or contractual commitment by the company. The company reserves the right to change or terminate any or all of the programs discussed herein, as well as all of its benefit plans and programs, at any time and without prior notice. In the event of any inconsistency between a statement contained in this document and the relevant plan document or summary plan description, the plan document or summary plan description will control over this document.