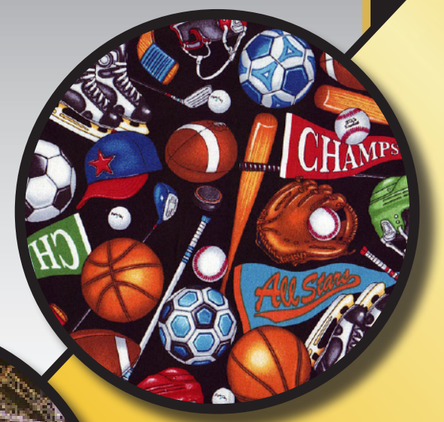
1401 South Grand Avenue
Santa Ana, California 92705

Save Time, Enjoy The Experience!



Human Resources Benefits 2016 -2017

Vision Plan

If you are applying for VSP Vision Care Insurance you are covered with all the features listed below. If you are covered every month you will be deducted the certain amount of money that the insurance didn't cover from your paycheck. If you do not have vision insurance and need vision care you will have to pay the whole amount of money by yourself.

Preferred Provider Network	**Choice**
Employer-paid Plan Option	Minimum of 10 enrolled employees
Choice of Copays	YES
Well Vision Exam	Covered in Full
Basic Lenses	Covered in Full
Discounts on Additional Pairs of Glasses	20% off
Contact Lens Exam **(Fitting and evaluation)**	Standard and premium fit: covered in full after copay (15% off contact lens exam services; copay will never exceed $60)
Prescription Contact Lenses	Materials covered in full up to $130. Exclusive mail-in rebate savings on eligible
(In lieu of glasses)	Bausch+Lomb and ACUVUE contact lenses
VSP Laser VisionCare Program Discounts on LASIK, custom LASIK, and PRK, plus patient education.	Average 15% off or 5% off promotional offer.
Low vision For people with extremely limited vision, not fully Correctable by glasses or contacts	Exam and allowance for low vision aids two years.

Employee	Employee and Spouse	Employee and Children	Employee and Family
$9.39	$15.02	$15.33	$24.72

Please select the plan you would like:

- Employee Only
- Employee and Spouse
- Employee and Children
- Employee, Spouse, and Children

By signing this document I agree and accept the term for VSP Vision Care Insurance and will like to have their services for vision insurance.

Name (Print):_____

Signature:_____ **Date:**_____

Table Of Contents

Empire's *Benefits*

Eligibility for Benefits

You are eligible to participate in our benefits program if you are an active employee on a contract part-time. Employees must also be a U.S Citzen to recieve the company benefits. The benefits package includes all benefits provided by an employer. These benefits include child care, health insurance, paid vacation leave, and personal leave. Health insurance provides assistance with medical cost. Determined on the company policy, employees can pay fee.

When Coverage Begins

As a new employee, your benefits will become effective two weeks after the following day of hire or the date you transfer.

Dependant Eligibility

The following dependants are eligible for benefits:

- Your legal spouse
- Your domestic partner that has properly filed a Declaration of Domestic Partnership with the California Secretary of State. **Note: California stae registration is limited to same sex domestic parnters and only those opposite sex parnters where one parnter is at least 62 and eligible for Social Security based on age.**
- Your natural children, stepchildren, and/or adopted children of which the employee is the legal guardian, children legally placed with the employee, spouse or eligible domestic parnter (including a qualified medical child support order). In addition, such children must be less than 26 years age. (Student or marital status no longer affects eligibility.)
- Dependent children over age 19 who are mentally or physically handicapped and incapable of sel-sustaining employment. Verification of handicapped status will be required before the 19th

Dental Monthly Plan

Dental Plan: Delta Dental

Service	Plan Pays	Limitations
Exam	100%	Twice in a calendar year
Bitewing X- rays	100%	Twice in a calendar for a children through age 18, or more In a calendar year for adults 19 and over
other x- rays	80%	Full-mouth X-rays, single X-rays, and panographic X-rays once in any 5 year period
Prophylaxis	100%	Twice in a calendar year
Fluoride Treatments	100%	only for children up to age 19, twice in a calendar year
palliative care	80%	Usual, Customary, and reasonable
Denture Relines	80%	Twice in a calendar year
Space Maintainers	100%	Usual, customary and Reasonable
Fillings	80%	Usual, Customary and reasonable
Stainless steel crowns	80%	Primary teeth only
Oral Surgery	80%	Usual, Customary
Crowns and Cast Restorations	not covered	Includes replacements in 5 years
Prosthodontics	not covered	Standard removable prosthetic appliances
Orthodontics	not covered	For eligible dependent children, $1,500 lifetime maximum per insured
Deductible	$25	Per person, per calendar year, up to a family maximum of $25
Maximum	$1,000	Per person, per calendar year

Employee	Employee + One	Employee + 2 or more
$12.83	$21.48	$38.56

Please select the plan you would like:

- Employee only
- Employee + one
- Employee + two or more

By signing this document i agree and accept the term for Delta Dental Insurance and will like to have their services for dental insurance.

Name (Print): _____ **Signature:** _____ **Date:**_____

HMO Monthly Plan

HMO (Kaiser Permanente) Monthly Plan

	HMO Deductible Plan
Features	**$40/$4,000 Plan Member pays**
Calendar - Year Deductible Individual/ Family	$200/$400
Pharmacy Calendar Year Deductible	N/A
Annual out-of-pocket Maximum Individual/Family	$4,500/$9,000
In the Medical Office Office Visits Preventive Exams Maternity/Prenatal Care Well-child preventive visits Vaccines (Immunizations) Allergy Injections Infertility services Occupational, physical, and speech therapy Most labs and Imaging MRI/CT/PET Outpatient Surgery	 $40 $40 $0 $0 $0 $5 (after deductible) Not covered $40 (after deductible) $10 (after deductible) $50 (after deductible) 30% (after deductible)
Emergency Services Emergency Department visits (waived if admitted directly to hospital) Ambulance	 30% (after deductible) $100 (after deductible)
Prescriptions Generic Brand-name	(up to 30-day supply) $10 $35
Hospital Care Physicians' services, room and board, test, medications, supplies, therapies Skilled nursing facility care (up to 60 days per benefit period)	 30% per admission (after deductible) 30% per admission (after deductible)
Mental Health Services In the medical office (up to 20 visits per calendar year) In the hospital (up to 30 days per calendar year)	 $40 (for individual therapy) $20 (for group therapy) 30% per admission (after deductible)

Employee Only	Employee and Spouse	Employee and Children	Employee, Spouse, and Children
$61 per month	$255 per month	$202 per month	$317 per month

Please select the plan you would like:

- Employee Only
- Employee and Spouse
- Employee and Children
- Employee, Spouse, and Children

Name (Print): _____

Signature:_____ **Date:**_____

PPO Monthl Plan

PPO (Anthem Blue Cross) Monthly Plan

Anthem Blue Cross	Deductible 500 PPO
Yours choices	• Affordable office visit copay • Comprehensive health benefits • Generic Premium drug benefits
Annual Deductible	$500 per member; Two-member maximum
Annual Out-Of-Pocket Maximum Includes deductible	$7,000 per member; Two-Member maximum
Office Visits	$49 copay (not subject to deductible)
Professional Services Including maternity, diagnostic lab and X-rays	20% after deductible
Hospital Inpatient	20% after deductible
Prescription Drugs Amount shown are for a 30-day retail supply. Home-Delivery Program is available	**Generic Premium Prescription Drug Formulary** **Tier 1 $10 copay** **Tier 2 $35 copay** **Tier 3** 30% of prescription drug maximum allowed amount up to a maximum $200 per $3500 Tier 3 prescription drug annual out-of-pocket maximum per member $500 annual pharmacy deductible per member (waived for Tier 1 drugs)
Preventive Care This includes physical exams, preventive screenings and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration	**No copay** (not subject to deductible
Physical Therapy, Occupational Therapy and Chiropractic Services (limited to 24 visit/calendar year)	40% after deductible

Employee Only	Employee and Spouse	Employee and Children	Employee, Spouse, and children
$276 per month	$927 per month	$708 per month	$1,083 per month

Please select the plan you would like:

- Employee Only
- Employee and Spouse
- Employee and Children
- Employee, Spouse, and Children

☐ Yes, I agree to enroll with this PPO (Anthem Blue Cross) Plan.
By signing this form I accept this plan and understand it. Empire will contribute $50 of each employee benefit but the employee is responsible for the extra cost of their own medical plan

Name(Print) _____ **Signature:**_____ **Date:**_____