England-Thims & Miller, Inc.
VISION ▪ EXPERIENCE ▪ RESULTS

ROBERT M. ANGAS ASSOCIATES, INC.
SURVEYORS · PLANNERS · CIVIL ENGINEERS

2017 Benefits and Enrollment Guide

Health | Dental | Vision | Life | Disability | FSA | EAP
Worksite Products

HYLANT

Benefits Overview

At **England, Thims and Miller, Inc. and Robert M. Angas Associates, Inc. (ETM/RMA)** we are committed to the health and wellness of our employees. As part of this dedicated effort, we offer a variety of benefits that can provide you and your family with health care coverage, financial protection and more, tailored to best fit your needs.

Our benefits program is an important part of your overall compensation and with the assistance of Hylant, we are regularly assessing the quality and cost of the benefits to ensure we offer the most competitive package possible.

This Benefits Guide provides a comprehensive overview of our benefits package for the plan year that runs from January 1, 2017 to December 31, 2017. It includes information on eligibility, election periods and costs. In addition, the guide offers descriptions and detailed explanations of each plan design. We encourage you to carefully consider all aspects of these plans, including their premiums, provider networks (where applicable), flexibility and restrictions, so that you can determine the benefits that best suit the needs of you and your family.

Our hope is to continue the trend of improving the well-being of employees at **ETM/RMA.** As always, we are happy to

Contents

This booklet is intended for illustrative and information purposes only. The plan documents, insurance certificates and policies will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern. ***ETM/RMA*** *reserves the right to change or terminate at any time, in whole or in part, the employee benefit package, with respect to all or any class of employees, former employees and retirees.*

Plan Year January 1 - December 31 Enrollment

New Employees

Health and welfare plans are available to all full time employees who work 30 or more hours a week. As a new hire, your plan eligibility date is the **first day of the month coinciding with or following two (2) months of service** with **England, Thims and Miller, Inc. and Robert M. Angas Associates, Inc.** It is your responsibility to enroll in the offered benefit plans prior to your eligibility date. If you do not enroll in the required timeframe, coverage may not be available.

Rehires

Employees rehired within 30 days of termination are eligible for benefits as of the date of rehire.

Annual Open Enrollment

This is the only opportunity you will have this year to make changes to your benefit elections. It is important that you make your choices carefully, since changes to those elections can generally only be made during the annual open enrollment period.

Exceptions will be made for **changes in family status** during the year, allowing you to make a mid-year benefit change. A family status change includes but is not limited to: Marriage, Divorce, Birth or adoption, Death of a dependent, Change in your spouse's employment or Loss of coverage by a spouse.

If you have a family status change, you must change your benefit elections within 30 days of the qualifying event, or you will need to wait until the next annual open enrollment period.

Dependents

Eligible dependents include **Legal spouse, as defined by Federal Law; and Children** as follows:

- ☑ MEDICAL - Your children up to age 26 regardless of marital status, financial dependency, residency with the Eligible Employee, student status, employment status, or eligibility for other coverage. ***Coverage ends when your dependent no longer meets the carrier's eligibility guidelines or at the end of the calendar year in which your child turns age 26.***
- ☑ Dental, Life & Vision - Your unmarried children up to age 26 regardless of financial dependency, residency with the Eligible Employee, student status, employment status, or eligibility for other coverage. ***Coverage ends when your dependent no longer meets the carrier's eligibility guidelines or at the end of the calendar year in which your child turns age 26.***
- ☑ Voluntary Accident and Voluntary CI - Your unmarried dependent children up to age 26 regardless of financial dependency, residency with the Eligible Employee, student status, employment status, or eligibility for other coverage. ***Coverage ends when your dependent no longer meets the carrier's eligibility guidelines or on your child's 26th birthday.***

It is your responsibility to provide HR with proof of your dependents' eligibility, in the form of: (a) Court Order specifying your responsibility to provide "group health care coverage" to your dependent children or (b) copy of birth certificate. **It is also your responsibility to notify HR when your dependent(s) no longer meet the eligibility criteria.**

Please note, that if your spouse is employed and eligible for coverage through his/her employer, he/she cannot be covered on the ETM/RMA Medical Plan.

COBRA Continuation Coverage

When you or any of your dependents no longer meet the eligibility requirements for health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. Our COBRA Third Party Administrator (TPA) is Meritain Health. All COBRA correspondence (when applicable) will be mailed to your home by Meritain Health.

Health Insurance Marketplace Coverage & Mandate Penalties

As a result of the Affordable Care Act (ACA), commonly referred to as "health care reform", the benefits landscape is changing. **Please carefully read the following as it contains important information regarding your healthcare plan and the Affordable Care Act.**

There is a new way to buy health insurance: the **Health Insurance Marketplace**. ***The Marketplace Open Enrollment starts in November with coverage effective January 1, 2017.*** To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace.

What is the Health Insurance Marketplace?: The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?: Yes. If you have an offer of health coverage from your employer that meets certain standards (minimum value and affordability), you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan.

Do the Plans Offered by ETM/RMA Meet the Minimum Value Standard Set by the Affordable Care Act (ACA)?: Yes, our plans meet the minimum value requirement.

Do any of the ETM/RMA plans meet the cost requirements (affordability) of the Affordable Care Act (ACA)?: Yes, the **ETM/RMA** plans meet the cost requirements for most if not all employees.

Will any ETM/RMA employees be eligible for subsidies through the Marketplace? Because at least one of our plans meets the minimum value and the cost (affordability) standards of the Affordable Care Act, **ETM/RMA** employees who are eligible for benefits are not expected to be eligible for Marketplace subsidies.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution to the employer-offered coverage. Also, this employer contribution (as well as your employee contribution to employer-offered coverage) is excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

What is the penalty for noncompliance of the individual mandate?: As of January 1, 2014, all American citizens are required to have health insurance, including their dependents. Adults who do not have health insurance will be subject to a fine. After 2016 the fine is adjusted for inflation. If you're uninsured for just part of the year, 1/12 of the yearly penalty applies to each month you're uninsured.

If you're uninsured for less than 3 months, you don't have to make a payment.

Who will be exempt from the mandate?: Individuals who have a religious exemption, those not lawfully present in the United States, and incarcerated individuals are exempt from some requirements. **You are also exempt from the penalty if you have minimum essential health coverage.** You are considered to have minimum essential coverage if you have Medicare, Medicaid, CHIP, any job-based plan (i.e. **ETM/RMA** medical plan or your Spouse's medical plan through his/her place of employment), any medical plan you bought through the Marketplace, COBRA, retiree medical coverage, Tricare, VA health coverage. If you are uninsured, you will be subject to the fee. **In order to avoid the fee, you should enroll in the company medical plan.**

If you drop our group medical plan can you get immediate coverage with a Marketplace plan?: No, dropping/ cancelling employer coverage does not qualify as a special event for the Marketplace. You would have to wait until Marketplace Open Enrollment.

If you get a Marketplace plan and then drop it, can you get back on the ETM/RMA plan?: Dropping/cancelling a Marketplace plan is not a qualifying event to elect group coverage. You would need to wait until the next Open Enrollment to elect group coverage.

How Can I Get More Information?: For more information about your coverage offered by your employer, please review this benefit guide or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

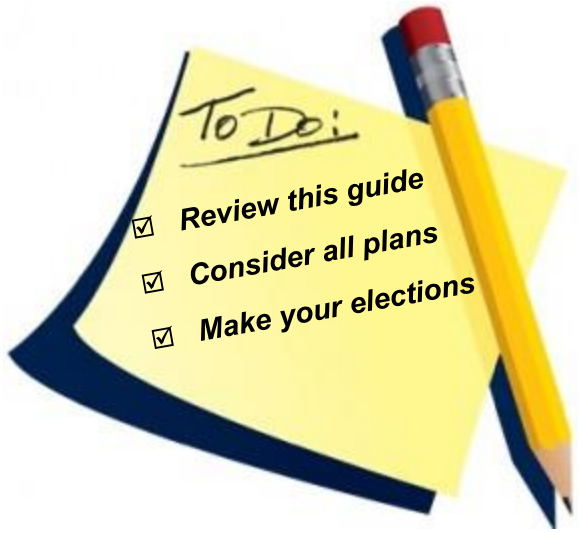
Health Care Reform information is changing almost daily. As a result, this information is subject to change at any time. For more information on Health Care Reform, please visit www.healthcare.gov or call 1-800-318-2596 for the most current information.

Online Enrollment Instructions

Log in to: https://www.benxpress.com/eBenefits

User ID: Your First Initial, Last Name, The last 4 digits of your SSN

Password: Your First Initial, Last Name, The year in which you were born (YYYY)



Example of Log In: If your name is Joe Doe, Your SS# is 111-11-1111 and your DOB is 12/31/1971, then your User ID & Password will be as follows (**all lower case**):

User ID: jdoe1111

Password: jdoe1971

Please note that all employees (including waivers and employees that are not making any changes to their current elections) must log in and make their open enrollment elections .

The system will guide you through all benefit plans and will ask you to make your elections. As you elect benefits, a calculator tracks your total cost.

To move from screen to screen please click the **Next** button in the upper right corner or **Previous** button (upper left).

Please keep in mind that for each benefit you will have to select the dependents that you would like to cover.

After you make your elections, a complete list of all elected benefits and contribution amounts will show on the Open Enrollment Preview screen. Please review your elections for accuracy. You may change your election by clicking on the name of the benefit in the list. If you do go back and make changes to any of the benefits, you can finalize your changes and view a new confirmation screen, by clicking on the **SAVE** icon in the upper right corner of the screen.

Evidence of Insurability/Medical Questionnaire Requirement

If your Voluntary Life elections require Evidence of Insurability (EOI), you will be prompted to print the EOI form at the end of the enrollment process. Please print, complete and sign the EOI form and deliver it to Human Resources.

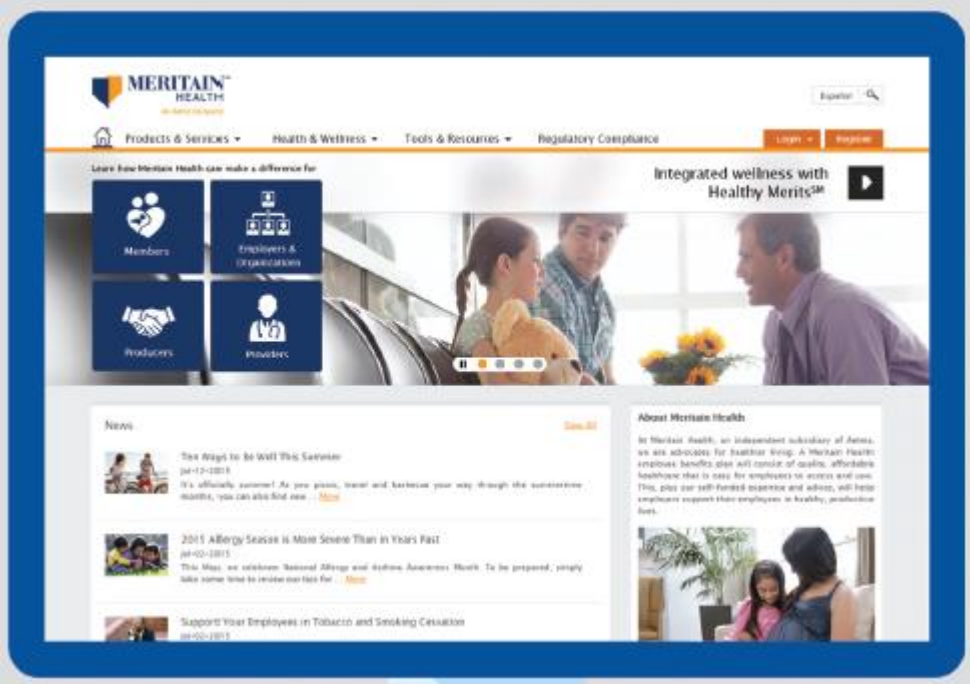
After your enrollment has been completed please click on the following icon to download and save or print a copy of your confirmation statement for your future reference. Please note that the second page of the confirmation statement will list your covered dependents and beneficiary information. Once your election has been submitted, and you have a copy of your confirmation statement, you may exit the enrollment system. **You do not need to send this to HR**.

Customer Service Hotline

In order to help you with your benefit questions, claim issues, and general inquiries, you and your dependents may contact the Hylant customer service specialists at 1-888-578-9988.

Meritain Health/Aetna Tools & Resources

https://www.meritain.com is at **your** service



- ***Check your eligibility and benefits***
- ***Find the status of claims***
- ***Locate doctors in your plan from wherever you are***
- ***View your Explanations of Benefits (EOBs)***
- ***Review your benefit plan document***
- ***Cost Information - access cost comparison tool***
- ***Wellness management - MyActiveHealth***

From any mobile device, just log into myMERITAIN

Important Plan Contacts

1-800-343-3140	**AETNA Provider Line (AETNA Choice POS II Provider Network)**
1-866-726-6529	**24-Hour access to registered nurses**
1-800-925-2272	**Meritain Health Customer Service**
1-800-242-1199	**Precertification - Meritain Health Medical Management**
1-866-475-7589	**Prescription Drug Benefit - Script World Customer Service**

Medical/Rx Benefits

Healthcare benefits are one of the most important and necessary parts of your benefit package. The following is a summary of your benefits. For a more detailed explanation of benefits, please refer to your certificate of coverage.

Carrier website: https://www.meritain.com/

Provider network: *Aetna Choice® POS II Open Access (http://www.aetna.com/docfind/custom/mymeritain/)*

	Option 1	Option 2	Option 3	Option 4
	Base HSA	**Base PPO**	**Buy-up PPO**	**Buy-up HSA**
	In-Network /What you pay	**In-Network/What you pay**	**In-Network/What you pay**	**In-Network/What you pay**
Deductible/Basis	**Calendar Year Deductible (January 1st through December 31st)**			
Individual/Family	$6,350/$12,700	$2,500/$5,000	$3,000/$6,000	$1,500/$3,000
Co-Insurance	Insurance pays100%	20% Coinsurance (Insurance pays 80%)	Insurance pays 100%	20% Coinsurance (Insurance pays 80%)
Out of Pocket Maximum	Out of Pocket Maximum Includes Deductible, Coinsurance and All Copays			
Individual/Family	$6,350/$12,700	$6,000/$12,000	$4,500/$9,000	$4,000/$8,000
Doctors Office Visits				
Primary/Specialist	Deductible Applies	$35 copay/$50 copay	$25 copay/$50 copay	Deductible + 20%
Preventive Care Services	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Urgent Care/E.R.	Deductible Applies	$75 copay/$300 copay	$75 copay/$150 copay	Deductible + 20%
Preventive Rx	$10/$30/$50 Copay Generic/Preferred/Non Preferred	$10/$35/$70 Copay Generic/Preferred/Non Preferred	$10/$30/$70 Copay Generic/Preferred/Non Preferred	$10/$30/$50 Copay Generic/Preferred/Non Preferred
Non Preventive Rx	**Deductible**	$10/$35/$70 Copay	$10/$30/$70 Copay	$10/$30/$50 **AFTER Deductible**
Mail Order (90 days)	**Deductible**	2.5 Times Retail Copay	2.5 Times Retail Copay	2.5 Times Retail Copay **AFTER Deductible**
Specialty Prescriptions*	Tier I (Generic): 20% coinsurance up to $100 maximum per script Tier II (Preferred Brand): 20% coinsurance up to $150 maximum per script Tier III (Non-Preferred Brand): 20% coinsurance up to $200 maximum per script ***Deductible applies in Option 1 and Option 4 (HSA Plans)**			
Diagnostic Labs	Deductible Applies	Covered in Full @ In-Network Lab	Covered in Full @ In-Network Lab	Deductible + 20%
X-rays	Deductible Applies	Covered in Full	Covered in Full	Deductible + 20%
Major Diagnostics	Deductible Applies	Deductible + 20%	Deductible Applies	Deductible + 20%
Hospitalization	Deductible Applies	Deductible + 20%	Deductible Applies	Deductible + 20%
Outpatient Surgery	Deductible Applies	Deductible + 20%	Deductible Applies	Deductible + 20%
Provider Services in the Hospital	Deductible Applies	Deductible + 20%	Deductible Applies	Deductible + 20%
	Out-Of-Network	**Out-Of-Network**	**Out-Of-Network**	**Out-Of-Network**
Deductible	$10,000/$20,000	$4,000/$8,000	$6,000/$12,000	$3,500/$7,000
Co-Insurance	20% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Out of Pocket Maximum	$20,000/$40,000	$12,000/$24,000	$8,000/$16,000	$4,500/$9,000

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Employee Contributions *(26 Payroll Deductions)*

	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Healthcare				
Option 1: Base HSA	**$0.00**	**$199.76**	**$143.64**	**$271.60**
Option 2: Base PPO	**$0.00**	**$294.77**	**$242.60**	**$462.50**
Option 3: Buy-up PPO	**$48.99**	**$406.04**	**$342.87**	**$609.21**
Option 4: Buy-up HSA	**$17.20**	**$333.96**	**$277.93**	**$514.22**

In Network Lab Facilities: We highly recommend that for lab work, you go to an In-Network standalone facility to minimize your expenses. If your doctor's office sends out labs, you run the risk of them being sent to an Out-of-Network facility. If that happens, you will be responsible for the Out-of-Network charges which can be significant! **Participating labs are Quest, Consolidated and some Independent Labs.**

The most current provider information can be found online:

Go to ***http://www.aetna.com/docfind/custom/mymeritain/*** and search for a participating facility, provider or Lab

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Health Savings Account (HSA)

HSA Account Definition	A tax-advantaged account used to pay for qualified medical expenses of the account holder, spouse, and/or dependents.
Who can open the account and contribute to it?	1. You must be covered by a Qualified High Deductible Health Plan to be eligible (Option 1 or Option 4) 2. You must not be covered under other health insurance (i.e. Spouse's employer's plan or FSA plan) 3. You must not be enrolled in Medicare; and 4. You must not be another person's dependent.
Who owns the account?	The money is yours and may earn interest until you use it. Money comes out tax free for eligible healthcare expenses. There's no "use it or lose it" rule, so you can save money for future expenses and pay for current ones. You can take the account funds with you if you change jobs, change health plans, or retire.
Is there an annual contribution limit?	You can contribute up to **$3,400 /$6,750 (single/family) for 2017** by tax-free payroll deduction or by tax-deductible lump sum deposits. Contributions can be made until April 15 of the following year. **Employees age 55 or older can contribute an additional $1,000 in "catch up" contribution per person per year.**
Are there account fees?	Yes. Depending on the type of the account and the balance in it, monthly maintenance fees and investment fees may apply.
Can my HSA be used to pay insurance premiums?	No, this would be a non-medical withdrawal, subject to taxes and penalty. There are a few exceptions: No penalty or taxes will apply if the money is withdrawn to pay premiums for Qualified long-term care insurance; or Health insurance while you are receiving federal or state unemployment compensation; or Continuation of coverage plans, like COBRA, required under any federal law; or Medicare premiums.
Can you use the account for retirement income?	Yes, after age 65, you can withdraw funds for any reason with no penalty. Although, if not used for qualified medical expenses, withdrawals will be taxed as income.
Is the account tax advantaged?	Yes, account holders and employer contributions are tax-free, any interest or investment gains are tax-free, and when used for qualified expense, your withdrawals are always tax free. Remember, HSA accounts can be audited by the IRS so be sure to keep your payment receipts for all expenditures made from your HSA.
Can the account earn interest?	Your deposits earn interest and continue to grow over time. And, you can invest a portion of your balance in mutual funds to help save for future health care expenses.
Qualifying Expenses	You can always find the most up-to-date list of qualifying expenses online, in Publication 502 on the IRS website (www.irs.gov) Below are a sampling of qualifying expenses: Services that are subject to Deductible, Coinsurance and Copays, Nursing Services, Medical doctors, Physical Therapy, Acupuncture, Psychoanalysis, Emergency Care, Chiropractic Care, Dental care including dentures, medical equipment, appliances and other personal items, Vision care including eyeglasses/lenses/eye surgery, alcoholism or drug addiction treatment, fertility treatment, hearing aides, over the counter medications (with prescription).
What Expenses Do NOT Qualify?	These expenses are just a sampling of expenses you can't pay for with your HSA. Remember, most over the counter medications are no longer eligible without a prescription: Cosmetic surgery, Diaper Services, Teeth Whitening, Electrolysis for hair removal, Maternity Clothes, supplements, over the counter vitamins, not prescribed weight loss programs, etc.

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Health Consumer Information

Emergency Room (ER) vs. Urgent Care

Urgent care centers are different from emergency rooms in many ways. While they provide many of the same services, they do not have the same pricing schedules or wait times.

While an ER could treat any of the urgent care issues, it is not recommended because emergency rooms are busier and more expensive. Also, it is important to note that urgent care centers may not be able to treat the illnesses listed for emergency rooms.

Patients should be aware that their co-pay is based on the facility they visit. It is usually much cheaper to go to urgent care centers than ERs.

The average urgent care visit costs patients $71-125 for basic care, with additional costs added for shots, x-rays, and labs. The average emergency room visit costs $1,318.

Being informed about the differences and similarities between these kinds of care is important. Whether you choose to receive care from an urgent care center or an emergency room, it is important to follow-up with additional treatments as necessary.

Comparisons for treatment for some of the most common ailments at an emergency room vs. an urgent care center

Ailments	Emergency	Urgent Care	Potential
Acute Bronchitis	$814	$122	85%
Sore Throat	$620	$93	85%
Low Back Pain	$751	$113	85%
Attention to Dressing/ Removal of Sutures	$343	$76	78%

EXAMPLES OF TIMES YOU SHOULD GO TO THE ER

- Poisoning
- Sudden, severe abdominal pain
- Coughing up or vomiting blood
- Cut or wound that won't stop bleeding
- Major Trauma or Accident
- Heart Attack or Chest Pain
- Loss of Consciousness

Urgent Care vs. Family Doctor

Neither ERs nor Urgent Care centers are equipped to deal with non-emergency, chronic conditions. Patients with chronic needs need to be seen by a primary care physician. If you are having a non-emergency condition, contact your family doctor for advice.




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Rx Coverage

Advancements in medicine are resulting in increased prescription drug use by consumers and rising costs.

This year, our pharmacy benefit will have 5 levels (tiers) of benefits. See below for additional information.

Tiers of Prescriptions:

The formulary (list of covered medications) is divided into tiers by drug type. Your cost is determined by your drug tier.

Tier 1 (**Generic):** All drugs in this category are generic. Employees pay the lowest cost (in copays or deductible) for generics, making these drugs the most cost-effective option for treatment.

Tier 2 (Preferred brand - higher copay): This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and have higher copay and higher cost toward deductibles in HSA plans.

Tier 3 (Non-Preferred brand - highest brand name copay): Medications in this category are non preferred, brand-name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have a higher copay and cost toward deductible from Tiers 1 and Tier 2 drugs.

Specialty Medications: Specialty medications are high-cost injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of the patient's therapy, and prior authorization. Preferred Specialty medications may have a lower cost generic alternative. Non-preferred specialty medications are highest cost specialty medications with no generic alternative.

Specialty drugs must be obtained through BrilovaRx. To learn more visit http://briovarx.com/ or contact their customer service team at:

1-800-850-9122

Monday through Friday, 9 a.m. to 11 p.m. EST

Saturday 8 a.m. to 12 p.m. EST

A clinician is available 24 / 7 for emergency support.

Please note that if you are enrolled in one of the HSA plans (Option 1 or Option 4), the deductible applies before the copay for all covered prescriptions except the ones on the Preventive Medication List. Please review the list in order to determine whether the deductible will apply to your prescription or not.

briovaRx™

800.850.9122 | BriovaRx.com

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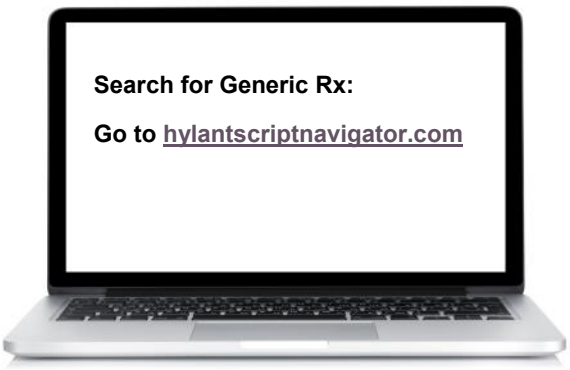
Prescription Drug Resources that can save you money

Hylant Script Navigator is the ultimate pharmacy search engine for discounted **generic** drug programs available at pharmacies throughout the USA.

http://www.hylantscriptnavigator.com

Enter the drug name, dosage and your zip code and find the best deal for your generic prescription. You can also find therapeutic alternatives, search at a specific pharmacy or suggest a pharmacy.



Many pharmacies now offer discount prescriptions—often even lower than your copay. Below are just a few of the current discounts offered:

- **Target:** over 300 generics for only $4
- **Wal-Mart:** $4 for a 30-day supply and $10 for a 90-day supply of some generic medications
- **Walgreens:** Over 300 generics for $12.99 for a 90-day supply

90-Day supply and Mail Order Rx

Mail Order Prescriptions

You can easily fill and refill prescriptions online while saving time and money. Find out more, by going to http://mycatamaranrx.com/. Please note that Catamaran is part of OptumRx.

First time users need to register - you will be asked to enter your ID number as it appears on your ID card.

DID YOU KNOW?

Generic equivalents are often up to 80% less than their name brand counterparts. It is estimated that generics account for two-thirds of all prescriptions filled in the US.

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Worksite Benefits - Voluntary Accident

The Voluntary Accident and Voluntary Critical Illness programs are offered through ***SunLife***. Benefits are paid directly to you to use as you see fit. This benefit is 100% employee paid and the payroll deductions will be taken on after tax basis.

Accident	
Benefit	**Benefits are paid for multiple <u>OFF THE JOB</u> injuries related to a single accident. Benefit helps pay for:** ▪ **Direct costs associated with an accident**: deductibles, coinsurance, ER copay, drugs, bandages, appliances, follow up visits ▪ **Indirect costs associated with an accident:** lost wages, property damages (auto deductible), transportation and misc. costs **A wide range of covered benefits:** Benefits for injuries are payable once for each covered accident (unless stated otherwise in the certificate), and benefits for hospital stays and related care are payable up to a specific number of days or visits for each covered accident. **Categories of coverage:** – **For injuries:** Insureds will receive a payment for covered dislocations, fractures, lacerations, burns and other injuries. – **For diagnosis and services:** Insureds will receive a payment for related covered medical services (ranging from X-rays to office visits), hospital services (including emergency room admissions and ambulance rides), surgeries, and emergency dental (crown and extraction). – **For loss:** The plan includes accidental death and dismemberment coverage and pays benefits for loss of hearing and for loss of sight occurring as a result of a covered accident.
Guarantee Issue	Coverage is Guarantee Issue
Portability	Employees who terminate employment and who meet other eligibility criteria may apply to continue accident insurance.
Sample Benefits	▪ Ambulance ($200), Air Ambulance ($1,000) ▪ Emergency Room ($100), Hospital admission ($1,000), Hospital Confinement ($200/day up to 365 days) ▪ Fractures—hip or thigh ($2,000 to 4,000), leg ($1,000 to $2,000) ▪ Fractures—scull depressed ($3,000 to $6,000) ▪ Dislocation—ankle, collarbone, foot ($400 to $3,000) ▪ Laceration ($300-$600) ▪ Coma ($10,000) ▪ Accidental Death ($25,000), Common Disaster enhanced death benefit (2 x benefit amount) ▪ Catastrophic Loss ($50,000) *The above is only a sample of the benefits provided. Please refer to the Summary of Benefits for further details.*

Employee Cost (26 Payroll Deductions)

	Employee	*EE + Spouse*	*EE + Children*	*EE + Family*
Accident				
SunLife	**$6.63**	**$10.45**	**$11.84**	**$18.50**

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Worksite Benefits - Voluntary Critical Illness

Our Critical illness insurance pays a lump-sum benefit upon diagnosis (*as defined by SunLife's policy/certificate*) of a covered critical illness or condition. This benefit is 100% employee paid and the payroll deductions will be taken on after tax basis.

Critical illness insurance could be a strong supplement to your health insurance. A critical illness insurance payout helps you avoid the financial strain a major illness can create so you can focus on your recovery. It helps give you the freedom to get the treatment you want. **If you did not elect this coverage during your initial enrollment opportunity and choose to enroll now, you must complete an Evidence of Insurability form and be approved by SunLife.**

	Critical Illness Benefit Summary		
Benefit Amount	$5,000 or $10,000 or $15,000 or $20,000		
Conditions	**Percentage of Lump Sum**		
		Benefit	**Waiting Period**
	▪ Cancer	100%	30 days
	▪ Cancer (Non-life threatening)	25%	30 days
	▪ Heart Attack/Stroke	100%	none
	▪ Major Organ Failure	100%	none
	▪ Severe burns, paralysis	100%	none
	▪ Coma	100%	none
	▪ Coronary Artery disease	25%	none
Spouse Benefit	$5,000 or $7,500 or $10,000		
Child(ren) Benefit	Flat $5,000		
Recurrence Benefit Rider	12-month waiting period between diagnoses and there has been no evidence of cancer for 12 months		
Guarantee Issue (GI)	$20,000 for employees, $10,000 for spouses and $5,000 for children. **Guarantee Issue Amount means the maximum amount of coverage available to new hires during the initial enrollment period with no medical information required.**		
Continuation	Included		
Pre-Existing Condition Limitation	In addition to the limitations stated in the Covered Conditions section of the Certificate, Critical Illness that is diagnosed in the first 12 months following the effective date of any Insured's insurance and results from a Pre-Existing Condition will not be covered. **Pre-Existing Condition** means during the 6 months prior to the person's effective date of insurance, any condition for which he/she sought medical treatment, consultation, advice, care or services, including diagnostic measures for the condition, regardless of whether the condition was diagnosed or suspected at that time, took prescribed drugs or medicines for the condition; or had symptoms for which a prudent person would have consulted a health care provider for Diagnosis, care or Treatment.		
Wellness Benefit	Wellness benefit of $50 for employee and $50 for spouse		
Benefit Waiting Period	30 days benefit waiting period applies for some conditions		

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Dental

Our dental coverage will change to **Guardian**. You have the option of visiting any provider; however, by choosing network providers you'll receive the highest level of benefit and save on out of pocket costs.

When utilizing ***out-of-network providers*** remember that benefits will be reimbursed based on the approved usual and customary fee **(90th percentile U&C)** and balance billing may occur.

Carrier website: https://www.guardianantytime.com

GUARDIAN	Dental PPO	
	In-Network	**Out-Of-Network**
Preventive Services: Cleanings, Fluoride Treatments (to age 19), Sealants (to age 16), X-Rays, Periodontal Maintenance	Covered in Full	Covered in Full (Based on U&C)
Basic Services: Simple Extractions, Amalgam Restorations, Crown Build-ups, Resin based Composite Restoration (anterior and posterior teeth), Endodontics, Periodontics & Surgical Periodontics, Oral Surgery, General Anesthesia	Covered in Full after Deductible	Insurance Pays 80%, you pay 20% after Deductible (Based on U&C)
Major Services: Inlays, Onlays, Crowns, Bridges, Dentures, Implants	Insurance Pays 60%, you pay 40% after Deductible	Insurance Pays 50%, you pay 50% after Deductible (Based on U&C)
Orthodontia - Children Only (up to age 19)	Insurance Pays 50%, you pay 50%	Insurance Pays 50%, you pay 50% (Based on U&C)
Deductible (Calendar Year)	Waived for Preventive Services	
Individual/Family	$50/$150	$50/$150
Maximum Annual Benefit (with Maximum Rollover)	$2,000 per person	
Orthodontics Lifetime Max	Lifetime maximum: $1,500 per person	
Waiting Periods	None	

The Guardian dental plan with **Annual Benefit Maximum Rollover** allows for a portion of each member's unused annual maximum to carry over to next year's maximum benefit amount. To qualify, you must have had a dental service performed within the Calendar year and used less than the maximum threshold ($800). If qualification is met, $400 ($600 if network dentist is used) is carried over to next year's maximum benefit. You can accumulate an additional $1,500 per person.

***When utilizing *out-of-network providers* remember that benefits will be reimbursed based on the approved usual and customary fee for a given area and balance billing** may occur.

While employees retain complete freedom of choice, they benefit by using an *In-network* dentist because of significant contracted discounts result in less out-of-pocket expenses; enabling the employee to receive more services during the year than if he or she visited an *Out-of-network* dentist.

Employee Contributions (26 Payroll Deductions)

	Employee	*EE + Spouse*	EE + Children	*EE + Family*
Dental				
	$0.00	**$21.73**	**$25.50**	**$44.94**

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Guardian Tuition Benefit Program

College Tuition Benefit Self-Registration

GUARDIAN

Welcome to the College Tuition Benefits Rewards program! You can now create your Rewards account and start accumulating your Tuition Rewards that can be used to pay up to one year's tuition at SAGE Scholar Consortium colleges.

How does it work?
You can use your College Tuition Benefits Rewards at over 330 private colleges and universities across the nation. 80% of SAGE colleges have received an "America's Best" ranking by US News and World Reports.

- Each Tuition Reward point equals a $1 tuition reduction
- You will receive rewards each year you have Guardian Dental Plan benefits
- Tuition Rewards can be given to your relatives including children, nephews, nieces, and grandchildren.
- See how quickly your account can grow!

Policy Year	Subscriber Reward*	Subscriber's Reward Balance (Balance does not accrue interest)
Initial Registration Subscriber and Student Rewards		2,500 (2,000 + 500)
2	2,000	4,500
3	2,000	6,500
4	**4,500 (Bonus Year)**	11,000
5	2,000	13,000
6	2,000	15,000
7	2,000	17,000

*After initial registration, future points credited 30 days after plan anniversary.

To learn more about the program and how to get started, go to: www.Guardian.CollegeTuitionBenefit.com to set up your account. If you have any questions, please feel free to visit the website or contact College Tuition Benefit directly at 215-839-0119.

Guardian's Group Dental Insurance is underwritten by The Guardian Life Insurance Company of America (Guardian) or its subsidiaries. The Tuition Rewards program is provided by College Tuition Benefit. The Guardian Life Insurance Company of America (Guardian) does not provide any services related to this program. College Tuition Benefit is not a subsidiary or an affiliate of Guardian.
#2014-15077 Exp. 12/16.

Register Today!
(Print and cut out ID Card)

College Tuition Benefits Rewards – ID Card

Register @
www.Guardian.CollegeTuitionBenefit.com

User ID: Type in your Guardian Dental Plan Number. (Your 'Plan Number' can be found on your Dental ID Card)

Password: Guardian

fold

COLLEGE TUITION BENEFIT.com

The College Tuition Benefit
150 E. Swedesford Road, Suite 100
Wayne, PA 19087
Phone: (215) 839-0119
Fax: (215) 392-3255

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Vision

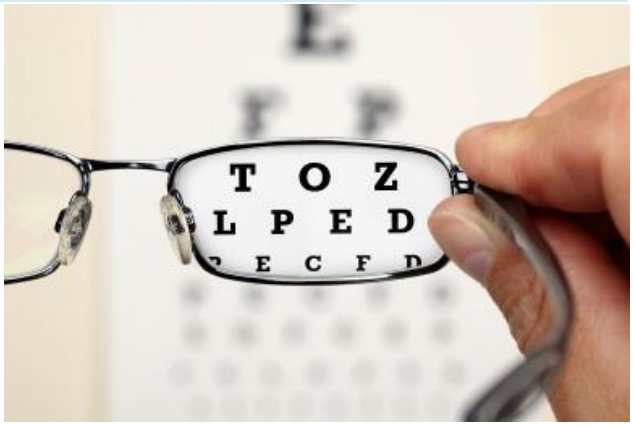
The vision coverage is provided by Superior Vision using the Superior National Network which consists of private practicing optometrists, ophthalmologists, opticians and optical retailers.

You have the option of visiting any provider; however, by choosing a Superior contracted provider you'll receive the highest level of benefit and save on out-of-pocket costs.

Carrier website: https://www.superiorvision.com/

Provider network: Superior National Network

SuperiorVision.com
Customer Service
800.507.3800



	In-Network Benefits	Out-of-Network Allowance
Exam (Optometrist)	$10 Copay then covered in full	Up to $33 retail
Exam (Opthamologist)		Up to $28 retail
Every 12 Months from last date of service		
Frames Every 24 months from date of last service	$25 Copay then $130 retail allowance	Up to $60 retail
Contact Lens Fitting (standard)	$30 Copay then covered in Full	Not covered
Contact Lens Fitting (specialty) Every 12 Months from last date of service	$30 Copay then $50 Retail Allowance	Not covered
Lenses (standard) per pair		
Single Vision / Bifocal / Trifocal/ Progressives (Standard)	$25 Copay then Covered in Full	Up to $28 / $40 / $53 / $40 retail
Contact Lenses Every 12 Months from last date of service	$130 retail allowance	Up to $100 retail
Discount Features: Look for providers who accept discounts, as some do not, please verify their services and discounts (range from 10% to 30%) prior to service as they vary. Superior has a nationwide network of refractive surgeons and leading LASIK networks who offer members from 15% to 50% discount.		

Vision Employee Contributions (26 Payroll Deductions)

	Employee	EE + Spouse	EE + Child(ren)	EE + Family
Vision				
Superior Vision	**$0.00**	**$2.15**	**$2.25**	**$5.38**

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Superior Vision Online Tools & Online Contact Lens Orders

SUPERIOR VISION
See yourself healthy.

https://www.superiorvision.com/

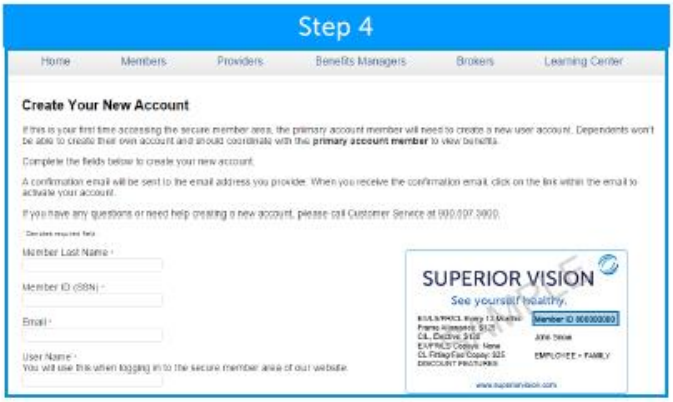
- Locate a provider
- View your benefits
- Print and/or order an ID card
- Download forms
- Order contacts

SuperiorVision.com gives you quick access to your vision benefits information. Member account information is shared by all covered family dependents—family members may log in as the primary member.

Logging In

From the home page of our website, select the "Members" link.

From the member home page, click the "Member Login" button.



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Group Life and Accidental Death & Dismemberment

Group Life and Accidental Death & Dismemberment (AD&D) Insurance is provided by **Guardian at no cost to the employees.** Life Insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at **ETM/RMA.**

AD&D Insurance is equal to your Life Insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances. It is important to keep your beneficiary information up-to-date.

Group Life/AD&D Benefit Summary	
Life Insurance	Flat $50,000
Accidental Death and Dismemberment	Benefit up to 100% of the Life amount due to certain injuries or death from an accident.
Benefit Reduction Schedule	Benefit reduces 35% at age 70, an additional 55% at age 75
Proof Of Good Health	Proof of good health is NOT required.
Plan Features	**Waiver of Premium:** If disabled, insurance will continue until age 65 or no longer disabled with no premium due. **Portability or Conversion:** Coverage may be ported or converted upon termination of active employment. You must contact Guardian within 30 days of termination to verify eligibility to port or convert your plan. **Accelerated Death Benefit**: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan. **AD&D coverage includes:** seat belt benefit, Air Bag benefit, catastrophic loss, day care expense, child education benefit, repatriation benefit, education & retraining

Life insurance policies require that you name a beneficiary. Here are some thoughts to consider:

- It is important to review insurance beneficiary designations in the event of marriage, new dependent children or divorce.
- It is advisable to name a "contingent" or secondary beneficiary in the event a primary beneficiary has predeceased you.
- Naming minor children as beneficiaries may cause unforeseen problems. Generally, insurance companies will not pay death benefits to minors. The benefits would likely be held until they could be made to a court-approved guardian and/or trustee of a children's trust. A guardian, trust, or trustee should be named beneficiary to help ensure competent management of the proceeds for the children.

Guardian WillPrep Services

WillPrep services offer support and guidance to help you properly prepare the documents necessary to preserve your family's financial security. WillPrep can assist with estate taxes, financial power of attorney, wills and living wills, and more. For more information, go to www.ibhwillprep.com (Username WillPrep; Password GLIC09) or call 1-877-433-6789.

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Voluntary Life Insurance/AD&D

You can purchase Supplemental Life insurance for yourself and your dependents through Guardian. Employees are responsible for 100% of the cost.

Benefit	
Employee Life Insurance	You may purchase benefits in increments of $10,000 Minimum $20,000 to a maximum of $300,000 **Employees must buy coverage for themselves in order to buy coverage for their dependents.**
Spouse Life Insurance	You may purchase benefits in $5,000 increments, minimum of $10,000 and maximum of $150,000 (up to 50% of Employee's Voluntary Life Amount). Spouse coverage terminates at age 70.
Dependent Child(ren)	$10,000
Benefit Reduction	35% benefit reduction at age 70, 55% reduction at age 75
Guarantee Issue (GI)	$150,000 For Employees under age 65; $50,000 for Spouses under age 65 $50,000 for Employees between age 65 and 70; $10,000 for Spouses between age 65 and 70 Guarantee Issue for Employees age 70+ is $10,000; $0 for spouses over age 70 **Guarantee Issue Amount means the maximum amount of coverage available to new hires during the initial enrollment period with no medical information required.**
Additional Features	Conversion/Portability, Waiver of Premium & Accelerated Death Benefit. Coverage for dependents who are hospital-confined due to illness or injury will be effective on the date they are no longer hospital-confined. Hospital-confined does not apply to a newborn child.

Voluntary Life Enrollment Options	
Employees that Previously Waived Voluntary Life	You can enroll in Voluntary Life during open enrollment up to the Guarantee Issue amounts shown above. All elections over GI are subject to Evidence Of Insurability (EOI).
Employees currently enrolled in Voluntary Life	You can Keep, Reduce or Cancel Current Voluntary Life insurance coverage. You can increase Voluntary Life Amount up to the GI amounts with no Evidence Of Insurability (EOI).
New Hires	You can elect up to the Guarantee Issue amount with no medical questions asked. **If you waive voluntary life coverage when you are initially eligible you will be required to provide Evidence of Insurability when enrolling at a later date.**
If you are submitting Evidence Of Insurability (EOI), please allow 4 to 6 weeks for underwriting approval. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results.	

Plan Features	
Coverage During Disability	For employees with an approved disability prior to age 60, premium is waived until age 65 if conditions are met.
Accelerated Death Benefit	If you are terminally ill you can receive up to 75% of your benefit amount in a lump sum if you are diagnosed with a terminal illness. If you use the accelerated benefit, your death benefit is reduced by the accelerated benefit payment. There are possible tax consequences to receiving an accelerated benefit payment. You should contact your tax advisor for details. Receipt of accelerated benefits could also affect eligibility for public assistance. The charge for this benefit is included in your premium.
Portability	Coverage may be ported upon termination of active employment.

Short Term Disability (STD)

Statistics show that nearly *one-third* of Americans between the ages of 35 and 65 will suffer a serious disability at one point in their life. Short Term Disability (STD) insurance is designed to provide you with a periodic income in the event you cannot work due to a disabling illness or accident that is not work-related. It generally covers those illnesses and injuries that are temporary, or short in duration (some common causes of Short Term Disability claims are: pregnancy, non-work related injuries, back injuries, digestive problems & intestinal problems).

Our Short Term Disability Insurance is provided by **Guardian at no cost to employees**. The plan provides financial protection by paying a portion of your income while you are disabled. The benefit you receive is based on your pre-disability earnings - the amount you earned before your disability began. The coverage starts after it has been medically determined that you meet the plan's definition of disability.

Short Term Disability Benefit Summary	
Benefit Amount	70% of your weekly salary
Benefit Maximum	$2,000 per week
Benefit Duration	You would receive STD benefits for **up to 15 weeks** or until you are no longer disabled, whichever happens first.
Elimination Period	In the event you become disabled while covered under the STD plan, weekly STD benefits would start on the **15th day of sickness, and 15th day of accidental injury.**
Pre-Existing Condition Limitation	None

Long Term Disability

Long Term Disability Insurance is provided by **Guardian at no cost to the employees**. Long Term Disability Insurance provides income protection in the event you become disabled and are unable to work for an extended period of time.

Long Term Disability Benefit Summary	
Benefit Amount	60% of Basic Monthly Earnings up to a benefit maximum based on your job classification. Please refer to the Guardian Certificate of Coverage.
Benefit Duration	For as long as you remain disabled, or until you reach your Social Security Normal Retirement Age (as stated in the 1983 revision of the US Social security act), whichever is sooner. You are considered disabled during the entire benefit period if you are unable to perform the material duties of your own occupation. Please note that your age at the time disability occurs determines the length of time you are eligible to receive disability benefits. Please refer to the detailed benefit summary posted on our benefits portal.
Elimination Period	Benefits will start on the 121st Day of Disability (subject to carrier's approval)
Pre-Existing Condition Limitation	If the pre-existing condition exists within 3 months prior to your effective date of coverage, no benefits are payable for any disability related to the pre-existing condition unless the elimination period for the disability starts after you have been an active employee under the plan for 12 months.

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Employee Assistance Program (EAP)

There are times in our lives when we need a little help. Personal issues, planning for life events or simply managing daily life can affect your work, health and family. Our Guardian EAP program is called WorkLifeMatters, and it provides support, resources and information for personal and work-life issues. WorkLifeMatters is company-sponsored, confidential and provided at no charge to you and your dependents.

For more information visit

www.ibhworklife.com

User ID: Matters; Password: wlm70101

or talk with a specialist at 1-800-386-7055

Education	▪ Admissions testing & procedures ▪ Adult re-entry programs ▪ College planning ▪ Financial aid resources
Lifestyle & Fitness Management	▪ Anxiety & Depression ▪ Divorce & separation ▪ Drugs & alcohol
Dependent Care & Care Giving	▪ Adoption Assistance ▪ Before/after school programs ▪ Day care/elder care ▪ In home services
Working Smarter	▪ Career development ▪ Effective managing ▪ Relocation
Legal and Financial Assistance	▪ Basic tax planning ▪ Credit & collections ▪ Debt counseling ▪ Home buying ▪ Immigration

Flexible Spending Accounts (FSA)

All eligible employees will have the opportunity to participate in a Flexible Spending Account (FSA) program administered through BASIC.

What is a Flexible Spending Account?

A Flexible Spending Account allows participants to set aside pre-tax dollars to be used to pay for various out of pocket medical, dental or vision expenses, and dependent care expenses.

What are the types of FSAs?

We offer Medical Care and Dependent Care Flexible Spending Accounts. You can use the Medical Care account to pay for medical, dental or vision expenses that you or your dependents incur even if they are not enrolled in the company sponsored insurance plans. You also have a Dependent Care flexible spending account. This account is for DAYCARE expenses ONLY & cannot be used for medical expenses.

How Does an FSA work?

First, you must estimate the amount of out-of-pocket expenses you feel you may incur in the upcoming year. This amount will be your election amount. Your election amount is divided by the number of pay periods during the year. This amount is then deducted from your paycheck each pay period on a pre-tax basis. When you incur expenses during the plan year, submit your claim to our FSA administrator for reimbursement.

What is the Plan year?

January 1st through December 31st

The Use It or Lose It Rule

Section 125 Plans are governed by the "use it or lose it" rule, whereby, any amounts remaining at the end of the year are forfeited due to IRS regulations. **All claims must be submitted no later than 90 days after the end of the plan year.**

If you have not spent all the amounts in your Health Flexible Spending Account or Dependent Care Flexible Spending Account by the end of the Plan Year, you may continue to incur claims for expenses during the **"Grace Period."** The "Grace Period" extends 2 1/2 months after the end of the Plan Year, during which time you can continue to incur claims and use up all amounts remaining in your account(s).

	Without Flex Plan	With Flex Plan
Salary	$700	$700
FSA Election	$0	$25
Taxable Income	$700	$675
Income Tax	$105	$101
State Tax	$56	$54
Social Security Tax	$53	$51
Income After Taxes	$486	$469
Medical Premium	$10	
Medical Expenses	$5	
Dependent Care	$10	$0
Take Home Pay	$461	$469
Net Increase		$8
Pay Periods		x 52
Annual Increase		$416

How Much Can I Contribute to the FSA Plan?

Medical Flexible Spending:

- **$2,600 Maximum**.

Dependent Care Flexible Spending:

- **$5,000 married couple filing jointly**

  OR

- **$2,500 per person if filing separate returns**

Limited FSA (LFSA) - for employees that enroll in the HSA

Please note that if you have a Health Savings Account you may not enroll in the Medical FSA, but you may enroll in a Limited Purpose Health FSA. Only Dental and Vision expenses incurred by you and your dependents are eligible for reimbursement under the Limited Purpose Health FSA.

Medical FSA Overview

There are at least two significant ways to benefit from a Flexible Spending Account. The first is by taking advantage of the tax savings. By reducing your gross income, you pay less in taxes, take home more pay, and have the freedom to choose how your money is used.

The second benefit is the "cash flow" increase built into the medical FSA (not the dependent day care FSA). Your entire annual election is available to you on January 1st. This means that no matter how much money you have contributed to the plan at any given point, you can still be reimbursed up to your entire annual election. So a major medical expense at the beginning of the plan year can be reimbursed even though few, if any, deposits have been made into the account at that time. This applies to the medical FSA only.

In 2017, the maximum annual contribution amount will increase to $2,600.

Sample Medical Eligible Expenses

The following is a partial list of expenses that are reimbursable tax-free with a Medical Expense FSA. For a complete list, visit the IRS's website at www.irs.gov and search for Section 213 expenses.

Acupuncture (if medically necessary)
Ambulance service
Chiropractic care
Contact lenses (corrective)*
Diagnostic tests
Doctor's fees
Drugs (prescription only**)
Experimental medical treatment (only if referred by a physician)
Eyeglasses
Hearing aids & exams
Injections and vaccinations
Optometrist fees
Orthodontic treatment*
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Transportation for local medical care
Wheelchairs
X rays

**To be eligible for reimbursement, some treatments, prescription drugs, or services deemed cosmetic in nature require written proof of medical necessity from your health care provider.*

***Not all drugs requiring a prescription are approved by the IRS as eligible for reimbursement.*

Over-the-Counter items:
Letter of Medical Necessity required from a physician (LOMN). Items marked (Rx) require a doctor's prescription.

- Adhesive or elastic bandages
- Blood pressure meter
- Cold or hot compresses
- Eye drops (Rx)
- Foot spa (LOMN)
- Gauze and tape (LOMN)
- Gloves and masks (LOMN)
- Herbs (Rx)
- Leg or arm braces
- Massagers (LOMN)

- Minerals (Rx) & Multivitamins (Rx)
- Saline nose drops (Rx)
- Special supplements (Rx)
- Special teeth cleaning system (Rx)
- Thermometers
- Vitamins (Rx)

Over-the-counter items that DO NOT qualify for reimbursement under an FSA plan:

- Aromatherapy, Cosmetics, Facial Care
- Baby bottles and cups, Baby oil, Baby wipes
- Blistex® / Chapstick®
- Breast enhancement system
- Cotton swabs
- Dental floss, toothbrushes
- Deodorants
- Feminine care fragrances
- Hair regrowth
- Insoles
- Low "carb" foods & Low calorie foods
- Oral care
- Petroleum jelly
- Shampoo and conditioner, Skin care, Spa salts
- Sun tanning products
- Over-the-Counter items, drugs or medications that are not medically necessary, or are not prescribed by your physician or health practitioner

Dependent Care FSA Eligible Expenses

Below is a list of expenses that qualify for reimbursement from the Dependent Care Account. Generally, eligible expenses include the cost of childcare for dependents under age 13 or care for a disabled spouse or dependent that allows you – or you and your spouse – to work. You'll also find examples of expenses that do not qualify for reimbursement because they are not considered legitimate deductions for federal income tax purposes. To make sure your situation and the type of care being provided meet IRS requirements, refer to IRS Publication 503.

Eligible Expenses

- Fees paid to a child care center or day care camp that complies with all applicable state and local regulations if providing care for more than six children
- Full amount paid to a nursery school, even though the cost may include lunch and education services
- Fees paid to a babysitter in or outside your home
- Fees paid to a relative who provides dependent care services, other than your spouse, your child under age 19 or a dependent you claim for federal income tax purposes
- Fees paid to a housekeeper or cook who also is responsible for providing care for an eligible dependent
- Fees paid to a nurse or home health care agency for care for your spouse or legal dependent who is physically or mentally incapable of self-care
- Legally mandated amounts paid on behalf of the provider – Social Security (FICA), federal (FUTA) and state (SUTA) unemployment taxes

Ineligible Expenses

- Food, clothing and education
- Transportation to and from the place where dependent care services are provided
- Fees paid for a child care center that provides care for more than six children but does not comply with all applicable laws
- Expenses for which a federal child care tax credit is taken or which are claimed under the Health Care Account
- Search fees for a dependent care provider

Section 125 Cafeteria Plan

The Section 125 - Cafeteria Plan allows you to contribute "before-tax" dollars to pay for your coverage under a portion of the Company's Benefit Plans (e.g. medical, dental and vision coverage). By paying your premiums with "before-tax" dollars, you generally may reduce the amount of income and social security taxes that you otherwise would be required to pay. The elections you make during the Cafeteria Plan enrollment period are effective for the entire 12-month Plan Year. You generally cannot change your elections during the year unless you experience a change in status event (refer to your benefits booklet for the definition of a "change in status"). The circumstances that permit a change of election vary from one benefit to another. If you believe you have experienced a change in status event and you wish to change your elections, notify Human Resources within 30 days of the change.

Important Disclosures

NOTE TO ALL EMPLOYEES:

Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

England Thims & Miller, Inc.
Robert M. Angas Associates
Human Resources
14775 Old Saint Augustine Road
Jacksonville, FL 32258
Phone: 904.642.8990

FORM 1095-C

The Affordable Care Act (ACA) continues to impact the health insurance industry. At **ETM/RMA**, we value our employees and are committed to providing you and your family with affordable, substantial health benefits that meet the requirements of "minimum essential coverage" under the ACA. You will be receiving the form listed below in late January of 2017, similar to how you receive your W-2 each year. The purpose of this form is to report to the IRS that you were offered minimum essential health coverage during 2016.

Form 1095-C is being provided to you by **ETM/RMA** as proof of the health coverage we offer you and your family. It contains information about who provides the health insurance, as well as information about the health coverage that was offered to you. It also lists the lowest monthly premium that you could have elected for the self-only health benefits we offered to you.

What Do I Do With The Form? You can use Form 1095-C to help you report your insurance coverage when filing your tax return. Only one form is provided for all the individuals listed on your policy, you may need to provide copies to your spouse or dependents, as necessary.

WHERE TO FIND FULL BENEFIT SUMMARIES AND SUMMARY PLAN DESCRIPTIONS (SPD):

This document is intended to give you a brief outline of the benefits available to you as an employee of **ETM/RMA.** There may be additional limitations and exclusions. All employees are encouraged to review the full benefit summaries, Summary of Benefits and Coverage (SBC) and Summary Plan Descriptions (SPDs) that are available on our enrollment website BenXpress. A printed copy of these documents can also be requested from the Human Resources Department.

While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual Plan documents, the actual Plan documents will prevail.

Summary of Material Modifications (SMM):

When distributed in conjunction with open enrollment, this document is intended to serve as the Summary of Material Modifications (SMM) for Plan Number **501** as required by ERISA.

SPECIAL ENROLLMENT RIGHTS Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan, except as otherwise provided below.

Loss of Other Coverage

If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Medical Program within **30 days** of the loss of that coverage. Your enrollment will become effective on the date you enroll in the Medical Program. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

Important Disclosures

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that coverage.

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days** after the marriage, birth, or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within **60 days** of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

Other Circumstances

You may enroll an Eligible Dependent child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (as defined under ERISA Section 609). This enrollment of an Eligible Dependent will become effective as of the Plan Administrator's qualification and acceptance of the Qualified Medical Child Support Order.

You are eligible to enroll yourself and your Eligible Dependents in the Plan under any other special circumstances permit ted under the applicable Benefits Guide (and subject to the Cafeteria Plan rules outlined in Section 125 of the Internal Revenue Code).

NOTE: You will not be allowed to enroll yourself and/or Eligible Dependents for coverage in the Plan for a Plan Year unless you timely and affirmatively complete the enrollment process by the deadlines set forth above (i.e. within 30 days for loss of coverage or new dependents; within 60 days for Medicaid or CHIP circumstances; within 30 days of receipt of this notice for a dependent under the age of 26; or within the deadline established by the Plan Administrator for Open Enrollment Period).

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number listed at the beginning of this document.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE (JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. Under the Women's Health and Cancer Rights Act, group health plans and insurers offering mastectomy coverage must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and copayments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company's health and welfare plan has been designed to comply with this law. This notification is a requirement of the act.

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Services Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

Important Disclosures

MICHELLE'S LAW NOTICE

On October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans. The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

FAMILY MEDICAL LEAVE ACT/MILITARY FAMILY LEAVE

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA). The details of this law are provided in your Summary Plan Description (SPD). If you would like more information regarding FMLA, contact your plan administrator at the address and phone number listed at the beginning of this document.

Summary of Benefits & Coverage (SBC)

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group health care sponsors to provide this document to plan participants. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan.

The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

The SBCs are available electronically on BenXpress. A paper copy is also available, free of charge, by calling Human Resources.

Important Disclosures

MEDICARE NOTICE

You must notify **ETM/RMA** when you or your dependents become Medicare eligible. **ETM/RMA** is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian.

The toll free number to Medicare Coordination of Benefits is 1-800-999-1118. *If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Coverage Notice in this guide.* Should you have any questions regarding this information or require additional details please contact the Plan Administrator at the address or phone listed at the beginning of this document.

IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare and enrolled in Aetna/Meritain Options 2, 3 and 4 (See next page for notice of non-creditable coverage for Option 1). Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

If you are covered by Medicare, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **ETM/RMA** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

2) **ETM/RMA** has determined that the prescription drug coverage offered by the PPO Plans and Buy-Up HSA Plan are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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

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

Important Disclosures

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

Contact your HR Representative. You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

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

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

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

England Thims & Miller, Inc./Robert M. Angas Associates
Human Resources
14775 Old Saint Augustine Road, Jacksonville, FL 32258
Phone: 904.642.8990

Important Notice from ETM/RMA About Your Prescription Drug Coverage and Medicare
Please note that the following notice only applies to individuals who are eligible for Medicare** and **enrolled in Aetna/Meritain Option 1 (Base HSA).

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons:

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. ETM/RMA has determined that the prescription drug coverage offered by the ETM/RMA Base HSA Benefits Plan is, on average for all plan participants, **NOT** expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **NON Creditable Coverage**. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the ETM/RMA plan. This is also important because it may mean that you may pay a higher premium (penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep you current coverage from ETM/RMA. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare you current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully-it explains your options.

Important Disclosures

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current ETM/RMA coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the ETM/RMA Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the ETM/RMA Health plan due to your eligibility for Medicare. If you decide to waive coverage under the ETM/RMA Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the ETM/RMA plan during the next open enrollment period.

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

You should also know that if you drop or lose your current coverage with ETM/RMA and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ETM/RMA. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

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

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

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

NOTICE OF RESCISSION OF COVERAGE

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30 day advance notice will be provided before coverage can be rescinded.

HOW TO REQUEST A CERTIFICATION OF CREDITABLE COVERAGE FROM THIS PLAN: HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage. To request a HIPAA Certificate of Creditable Coverage, please contact the insurance company customer service department by calling the phone number on your healthcare identification card. If you are unable to obtain the certificate of coverage through the carrier, or have other questions regarding Pre-existing Conditions, please contact the Plan Administrator for assistance at the address below.

Important Disclosures

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment;
Death of the employee;
Commencement of a proceeding in bankruptcy with respect to the employer; or
The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to:

England Thims & Miller, Inc./Robert M. Angas Associates
Human Resources
14775 Old Saint Augustine Road, Jacksonville, FL 32258
Phone: 904.642.8990

Notification should be in writing and include official documentation of qualifying event (i.e. divorce decree, marriage certificate, birth certificate).

Important Disclosures

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please provide Social Security disability determination confirmation to:

England Thims & Miller, Inc./Robert M. Angas Associates
Human Resources
14775 Old Saint Augustine Road, Jacksonville, FL 32258
Phone: 904.642.8990

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

England Thims & Miller, Inc./Robert M. Angas Associates
Human Resources
14775 Old Saint Augustine Road, Jacksonville, FL 32258
Phone: 904.642.8990

Important Disclosures

NOTICE REGARDING PATIENT PROTECTION RIGHTS The **ETM/RMA** group health plan **does not** require members to designate a Primary Care Physician. The following paragraphs outline certain protections under the PPACA and only apply when the Plan requires the designation of a Primary Care Physician. One of the provisions in the PPACA of 2010 is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights beginning on the first day of the first plan year on or after September 23, 2010. You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions.

HIPAA Privacy Notice: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

Important Disclosures

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	We can use and disclose your information to run our organization and contact you when necessary. **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Important Disclosures

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	We can share health information about you for certain situations such as: ■ Preventing disease ■ Helping with product recalls ■ Reporting adverse reactions to medications ■ Reporting suspected abuse, neglect, or domestic violence ■ Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: ■ For workers' compensation claims ■ For law enforcement purposes or with a law enforcement official ■ With health oversight agencies for activities authorized by law ■ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Important Disclosures

U.S. Equal Employment Opportunity Commission

NOTICE REGARDING WELLNESS PROGRAM

The England, Thims and Miller wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for LDL cholesterol, glucose and triglycerides. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Additional incentives may be available for employees who participate in certain health related activities. If you are unable to participate in any of the health related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Jeff Krueger at kruegerj@etminc.com or 904-642-8990.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program at England, Thims and Miller may use aggregate information it collects to design a program based on identified health risks in the workplace, the England, Thims and Miller wellness program will never disclose any of your personal information either publicly or to England, Thims and Miller, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law.

Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a registered nurse, a doctor," or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Jeff Krueger at kruegerj@etminc.com or 904-642-8990.

Important Disclosures

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392; CHIP Phone: 1-800-701-0710 CHIP Website: http://www.njfamilycare.org/index.html
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740, TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100

Important Disclosures

MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/ programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/ programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ in-dex.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website - Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137

ETM/RMA Benefit Contact Information

Contact	Phone Number	Website/E-mail
Hylant (Benefits Consultant)	1-888-578-9988 1-904-854-8200	http://www.hylant.com
Meritain Health (COBRA Administrator)	1-800-925-2272	**https://www.meritain.com/**
BenXpress Enrollment Website	**https://www.benxpress.com/eBenefits** ***ID:*** *Your First Initial, Last Name, The last 4 digits of your SSN* ***PW:*** *First Initial, Last Name, Year of birth (YYYY)*	

When contacting any of the companies below it is important to have the Insurance card or I.D. number of the subscriber for the coverage you are calling about as well as any appropriate paperwork, i.e. Explanation of Benefits, denial letter, receipts, etc.

Insurance Carriers			
Line of Coverage	**Carrier Name**	**Phone Number**	**Website/E-mail**
Health Care	**Aetna/Meritain Health** **24 Hour Nurse Line** **Aetna Provider Search** **Mail Order Rx** **Specialty Rx**	1-800-925-2272 1-866-726-6529 1-800-343-3140 1-800-850-9122	**https://www.meritain.com/** **http://www.aetna.com/docfind/custom/mymeritain/** **https://mycatamaranrx.com** **https://briovarx.com/index.html**
Vision	**Superior Vision**	1-800-507-3800	**https://www.superiorvision.com/** **contuctus@superiorvision.com**
Dental	**Guardian**	1-800-541-7846	**www.guardiananytime.com**
Life & Disability	**Guardian**	1-800-268-2525	**www.guardiananytime.com**
Worksite Benefits **Accident & Critical Illness**	**SunLife**	1-800-247-6875	**http://www.sunlife.com/us/** **Group_eCommerce@sunlife.com**
Employee Assistance Plan	**Guardian WorkLifeMatters**	1-800-386-7055	**www.ibhworklife.com** **Username: Matters; Password:wlm70101**
Travel Assistance	**ID: 01-AA-SUL-100101**	1-800-872-1414 (US) 1-609-986-1234 (outside the US)	
Identity Theft	**ID: 01-AA-SUL-100101**	1-877-409-9597	
FSA & DCAP	**BASIC**	1-800-FSA-FLEX 1-800-372-3539	https://www.basiconline.com/ https://claims.basiconline.com/