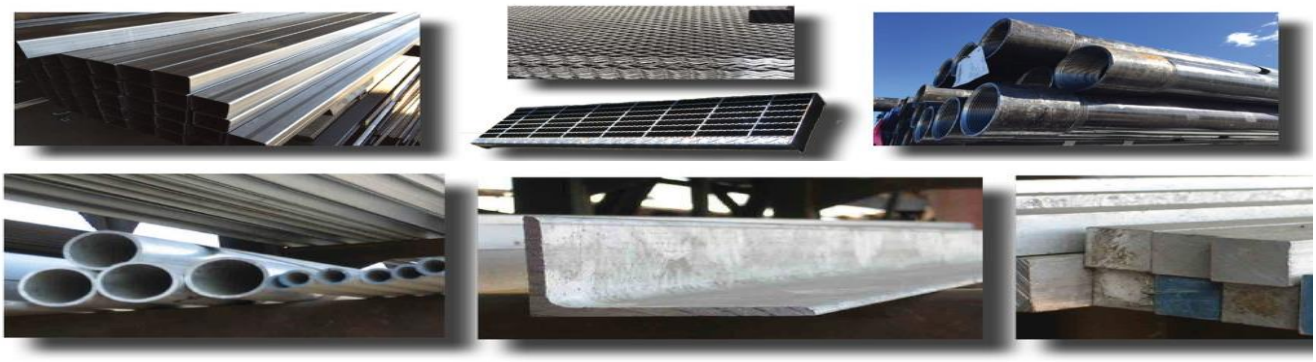
Employee Benefits Enrollment Guide

Plan Year: November 1, 2016 – October 31, 2017



Jim's Supply Company offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to review your options and choose the best coverage for you and your family.

Who is Eligible?

If you are a full time employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide, effective the 1st of the month following 30 days after your hire date. Eligible dependents include your spouse or registered domestic partner and children up to age 26.

How to Enroll

A member of your service team at The Lynn Company will coordinate a meeting with you to review your options and assist with any enrollment forms. Prior to the meeting, please review your current benefit elections in this booklet and write down any questions you may have. Please make sure to bring your questions and you and your dependents personal information to your enrollment meeting. Please note, once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

When to Enroll

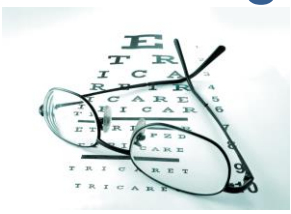
You are eligible for benefits on the first of the month following 30 days of full time employment. After your original effective date, you can enroll or make changes every year during open enrollment. Open enrollment will take place each year, during October for a November 1st effective date. The benefits you elect during open enrollment will be effective through October 31, 2017.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change of your dependent's status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status. Contact The Lynn Company service team if you qualify. Forms must be submitted within 30 days from the date of the change.

Jim's Supply Company
Benefit Package






New! Medical: Anthem

Voluntary Dental: GUARDIAN

Voluntary Vision: GUARDIAN

Voluntary Life: GUARDIAN

New! Voluntary Accident: GUARDIAN
(Off the Job Only)

Aflac: Aflac

Jim's Supply Company provides a $370.00 monthly credit towards all benefits. The rates shown in this guide reflect the total monthly cost for benefits, the employer benefit credit will be deducted from the total rates from all benefits that you select. The employee share of cost is divided into a per pay period deduction except for voluntary life or voluntary short term disability benefits which are deducted on an after-tax basis.

Medical Premiums

Anthem

	HMO California Care				PPO Prudent Buyer			
	Monthly	Bi-Monthly	Bi-Weekly	Weekly	Monthly	Bi-Monthly	Bi-Weekly	Weekly
Employee	$354.78	$177.39	$163.74	$ 81.87	$ 477.64	$238.82	$220.45	$110.22
Employee + Spouse	$780.51	$390.26	$360.24	$180.12	$1050.80	$525.40	$484.98	$242.49
Employee + Child(ren)	$638.60	$319.30	$294.74	$147.37	$ 859.74	$429.87	$396.80	$198.40
Family	$1099.81	$549.91	$507.60	$253.80	$1480.67	$740.34	$683.39	$341.69
Benefit Credit	Monthly $370.00	Bi-Monthly $185.00	Bi-Weekly $170.77	Weekly $ 85.38	Monthly $370.00	Bi-Monthly $185.00	Bi-Weekly $170.77	Weekly $ 85.38

Your summary of benefits

Anthem Blue Cross
Your Plan: Classic HMO 20/40/250 Admit /125 OP (Essential Formulary $10/$30/$50/30%)
Your Network: California Care HMO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail. Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$0	$0
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$2,000 single / $4,000 family	$0
Doctor Home and Office Services **Preventive care/screening/immunization** *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Primary care visit to treat an injury or illness	$20 copay per visit	Not covered
Specialist care visit	$40 copay per visit	Not covered
Prenatal and Post-natal Care *In network preventive prenatal and postnatal services covered at 100%.*	$20 copay per visit	Not covered
Other practitioner visits: Retail health clinic	Not covered	Not covered
On-line Visit	Not covered	Not covered
Chiropractor services *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Chiropractor visits count towards your physical and occupational therapy limit.*	$20 copay per visit	Not covered
Acupuncture	$20 copay per visit	Not covered

Other services in an office:		
Allergy testing	$20 copay per visit	Not covered
Chemo/radiation therapy	$40 copay per visit	Not covered
Hemodialysis	$40 copay per visit	Not covered
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	30% coinsurance up to $150 per visit	Not covered
Diagnostic Services		
Lab:		
Office	No charge	Not covered
Freestanding Lab	No charge	Not covered
Outpatient Hospital	No charge	Not covered
X-ray:		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Costs may vary by site of service.*	$100 copay per test	Not covered
Freestanding Radiology Center *Costs may vary by site of service.*	$100 copay per test	Not covered
Outpatient Hospital *Costs may vary by site of service.*	$100 copay per test	Not covered
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.*	$100 copay per visit	Covered as In-Network
Emergency room doctor and other services	No charge	Covered as In-Network
Ambulance (air and ground)	$100 copay per trip for ground and air	Covered as In-Network
Urgent Care (office setting) *Copay waived if admitted. Costs may vary by site of service.*	$20 copay per visit	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$20 copay per visit	Not covered
Facility visit:		
Facility fees	No charge	Not covered
Outpatient Surgery		
Facility fees:		

Hospital	$125 copay per admission	Not covered
Freestanding Surgical Center	$125 copay per admission	Not covered
Doctor and other services	No charge	Not covered
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	$250 copay per admission	Not covered
Doctor and other services	No charge	Not covered
Recovery & Rehabilitation		
Home health care	$20 copay per visit	Not covered
Coverage for In-Network Provider is limited to 100 visit limit per benefit period.		
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service. Chiropractor visits count towards your physical and occupational therapy limit.*	$20 copay per visit	Not covered
Outpatient hospital *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service.*	$40 copay per visit	Not covered
Habilitation services *Habilitation visits count towards your rehabilitation limit.*	$40 copay per visit	Not covered
Cardiac rehabilitation		
Office *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service.*	$20 copay per visit	Not covered
Outpatient hospital *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service.*	$40 copay per visit	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider is limited to 100 day limit per benefit period.*	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment	20% coinsurance	Not covered
Prosthetic Devices	No charge	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$0	$0
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage		
Preventive Pharmacy Preventive Immunization Female oral contraceptive *Generic and Single Source brand*	$0 copay (retail only) $0 copay (retail only)	50% coinsurance (retail only) 50% coinsurance (retail only)
Tier1 - Typically Generic *Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)*	$10 copay per prescription (retail only) and $25 copay per prescription (home delivery only)	50% coinsurance (retail only)
Tier2 - Typically Preferred / Brand *Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) No coverage for non-formulary drugs.*	$30 copay per prescription (retail only) and $90 copay per prescription (home delivery only)	50% coinsurance (retail only)
Tier3 - Typically Non-Preferred / Specialty Drugs *Certain drugs require preauthorization approval to obtain coverage. Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) No coverage for non-formulary drugs.*	$50 copay per prescription (retail only) and $150 copay per prescription (home delivery only)	50% coinsurance (retail only)
Tier4 - Typically Specialty Drugs *Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy and home delivery program) No coverage for non-formulary drugs.*	30% coinsurance up to $250 per prescription (retail and home delivery)	50% coinsurance (retail only)

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- Your plan requires a selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV

testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.

- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 visits per lifetime.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Infertility services are not included in the out of pocket amount.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage

Your summary of benefits

Anthem Blue Cross

Your Plan: Classic PPO 500/30/20 (RX $10/$30/$50/30%)

Your Network: Prudent Buyer PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$500 single / $1,500 family	$750 single / $2,250 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$3,500 single / $7,000 family	$7,000 single / $14,000 family
Doctor Home and Office Services **Preventive care/screening/immunization** *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	40% coinsurance
Primary care visit to treat an injury or illness *Deductible does not apply to In-Network providers.*	$30 copay per visit	40% coinsurance
Specialist care visit *Deductible does not apply to In-Network providers.*	$30 copay per visit	40% coinsurance
Prenatal and Post-natal Care *Deductible does not apply to In-Network providers. In network preventive prenatal and postnatal services covered at 100%.*	$30 copay per visit	40% coinsurance
Other practitioner visits: Retail health clinic *Deductible does not apply to In-Network providers.*	$30 copay per visit	40% coinsurance
On-line Visit *Deductible does not apply to In-Network providers.*	$30 copay per visit	40% coinsurance

Chiropractor services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visit limit per benefit period. Deductible does not apply to In- Network providers.*	$30 copay per visit	40% coinsurance
Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visit limit per benefit period. Deductible does not apply to In- Network providers.*	$30 copay per visit	40% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	40% coinsurance
Chemo/radiation therapy	20% coinsurance	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	20% coinsurance	40% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	40% coinsurance
Freestanding Lab	20% coinsurance	40% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% coinsurance
X-ray:		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	20% coinsurance	40% coinsurance
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	20% coinsurance	40% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	20% coinsurance	40% coinsurance
Emergency and Urgent Care		
Emergency room facility services *Copay waived if admitted. This is for the hospital/facility charge only. The ER physician charge may be separate.*	$150 copay per admission and then 20% coinsurance	Covered as In-Network
Emergency room doctor and other services	20% coinsurance	

Ambulance (air and ground)	20% coinsurance	Covered as In-Network
Urgent Care (office setting) *Costs may vary by site of service. Deductible does not apply to In-Network providers.*	$30 copay per visit	40% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit *Deductible does not apply to In-Network providers.*	$30 copay per visit	40% coinsurance
Facility visit:		
Facility fees	20% coinsurance	40% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% coinsurance
Freestanding Surgical Center *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Co-pay $500 if you do not receive preauthorization. Coverage is limited to $1,000 maximum per day. Apply to Out-of-Network Provider. Apply to non-emergency admission.*	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visit limit per year.*	20% coinsurance	40% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Costs may vary by site of service.*	20% coinsurance	40% coinsurance
Outpatient hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% coinsurance
Habilitation services	20% coinsurance	40% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	40% coinsurance

Outpatient hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% coinsurance
Skilled nursing care (in a facility) *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 day limit per year.*	20% coinsurance	40% coinsurance
Hospice	No charge	40% coinsurance
Durable Medical Equipment	20% coinsurance	40% coinsurance
Prosthetic Devices	20% coinsurance	40% coinsurance
Pharmacy Deductible	$0	$0
Pharmacy Out of Pocket	$0	$0
Prescription Drug Coverage		
Preventive Pharmacy Preventive Immunization Female oral contraceptive Generic & Single Source Brand	$0 copay (retail only) $0 copay (retail only)	50% coinsurance (retail only) 50% coinsurance (retail only)
Tier1 - Typically Generic *Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)*	$10 copay per prescription (retail only) and $25 copay per prescription (home delivery only)	50% coinsurance (retail only)
Tier2 - Typically Preferred / Brand *Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)*	$30 copay per prescription (retail only) and $90 copay per prescription (home delivery only)	50% coinsurance (retail only)
Tier3 - Typically Non-Preferred / Specialty Drugs *Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)*	$50 copay per prescription (retail only) and $150 copay per prescription (home delivery only)	50% coinsurance (retail only)
Tier4 - Typically Specialty Drugs *Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy and home delivery program)*	30% coinsurance up to $250 per prescription (retail and home delivery)	50% coinsurance (retail only)

This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- In network and out of network deductible and out of pocket maximum are exclusive of each other.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out of network benefit and you use a non-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 visits per lifetime.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Preferred Generic Program: If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense

as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.

- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

Voluntary Dental & Vision Premium

GUARDIAN℠

	Dental Low Option				Dental High Option			
	Monthly	Bi-Monthly	Bi-Weekly	Weekly	Monthly	Bi-Monthly	Bi-Weekly	Weekly
Employee	$20.04	$10.02	$ 9.25	$ 4.62	$ 40.55	$20.28	$18.72	$ 9.36
Employee + Spouse	$43.09	$21.55	$19.89	$ 9.94	$ 87.17	$43.59	$40.23	$20.12
Employee + Child(ren)	$40.08	$20.04	$18.50	$ 9.25	$ 81.09	$40.55	$37.43	$18.71
Family	$62.13	$31.07	$28.68	$14.28	$125.69	$62.85	$58.01	$29.01

GUARDIAN℠

	Vision			
	Monthly	Bi-Monthly	Bi-Weekly	Weekly
Employee	$ 7.00	$3.50	$3.23	$1.62
2 Party	$14.00	$7.00	$6.46	$3.23
Family	$19.00	$9.50	$8.77	$4.38

Guardian Contact Information

Website - **www.GuardianAnytime.com**

Helpline (888) 600-1600

GUARDIAN®

Jim's Supply Company Inc

Dental Benefit Summary

Group Number: 00504685

About Your Benefits:

A visit to your dentist can help you keep a great smile and prevent many health issues. But dental care can be costly and you can be faced with unforeseen expenses. Did you know, a crown can cost as much as $1,400[1]? Guardian dental insurance will help you pay for it. With access to one of the largest network of dental providers in the country, who agreed to charge negotiated fees for their services of up to 30% less than average charges in the same community, you will benefit from lower out-of-pocket costs, quality care from screened and reviewed dentist, no claim forms to file, and excellent customer service. Enroll today and smile next time you see your dentist!

[1] http://health.costhelper.com/dental-crown.html.

Option 1: With your **Low** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are limited to our PPO fee schedule.

Option 2: With your **High** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

Your Dental Plan	**Option 1: Low**		**Option 2: High**	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Calendar year deductible	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Individual	$50	$50	$0	$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Not applicable	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Preventive Care	100%	100%	100%	100%
Basic Care	80%	80%	90%	80%
Major Care	50%	50%	60%	50%
Orthodontia	Not Covered		Not Covered	
Annual Maximum Benefit	$1000	$1000	$1500	$1500
Maximum Rollover	Yes		Yes	
Rollover Threshold	$500		$700	
Rollover Amount	$250		$350	
Rollover In-network Amount	$350		$500	
Rollover Account Limit	$1000		$1250	
Lifetime Orthodontia Maximum	Not Applicable		Not Applicable	
Dependent Age Limits	26		26	

A Sample of Services Covered by Your Plan:

		Option 1: Low *Plan pays (on average)*		**Option 2: High** *Plan pays (on average)*	
		In-network	*Out-of-network*	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 14		Under Age 14	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	80%	80%	90%	80%
	Fillings‡	80%	80%	90%	80%
	Simple Extractions	80%	80%	90%	80%
	Surgical Extractions	80%	80%	90%	80%
Major Care	Bridges and Dentures	50%	50%	60%	50%
	Inlays, Onlays, Veneers**	50%	50%	60%	50%
	Perio Surgery	50%	50%	60%	50%
	Periodontal Maintenance	50%	50%	60%	50%
	Frequency:	Once Every 6 Months (Standard)		Once Every 6 Months (Standard)	
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	50%	60%	50%
	Root Canal	50%	50%	60%	50%
	Scaling & Root Planing (per quadrant)	50%	50%	60%	50%
	Single Crowns	50%	50%	60%	50%

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

This is a temporary card to use for the first 30 days of your plan. After 30 days you may log into GuardianAnytime.com to register, obtain your permanent card and get an overview of your plan benefits.

Step 1: Determine if you or your provider should call the Employee Benefits Hotline.

- Do you need help completing enrollment forms?
- Do you or your primary care dentist have questions within 30 days of the plan effective date about the benefits or eligibility under the plan my employer is offering?

Step 2: Prepare yourself and/or your provider to call the Employee Benefits Hotline with the following information:

- Name of the company you work for: **Jim's Supply Company Inc.**
- Your company's plan number: **504685.**
- Your ID number, which is your Social Security Number.

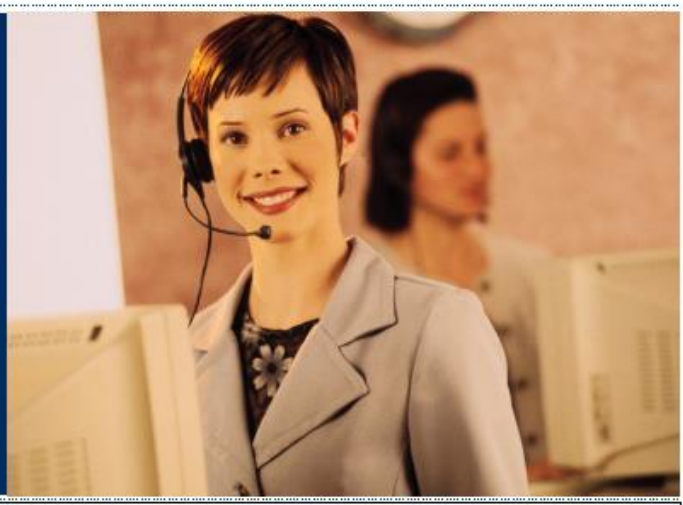
Step 3: Call 888-600-1600 to get answers!

- Press #1 if you are an employee or dependent, Press #2 if you are a provider
- At the next prompt: Press #1 if your questions relate to Dental Benefits
  Press #0 for all other questions
- Enter your 9 digit ID number, which is your Social Security Number.
- If asked, enter your 6 digit plan number, which is **504685.**

Employee Benefits Hotline

Benefit specialists are available to answer questions as you sign up for your Guardian benefits.

TOLL-FREE PHONE	
1-888-600-1600 Monday – Friday	8:00 a.m. - 8:30 p.m. EST 7:00 a.m. - 7:30 p.m. CST 6:00 a.m. - 6:30 p.m. MST 5:00 a.m. - 5:30 p.m. PST



IMPORTANT NOTE: The Employee Benefits Hotline provides pre-enrollment support in over 50 languages! Once you are enrolled in a plan, you will receive additional information and new toll-free phone numbers. If you are looking for a dentist who participates in your plan, go to www.GuardianAnytime.com

DENTALGUARD

GUARDIAN

The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004 2013-xxxxx

GUARDIAN®

Jim's Supply Company Inc

Vision Benefit Summary

Group Number: 00504685

About Your Benefits:

Eye care is a vital component of a healthy lifestyle. With vision insurance, having regular exams and purchasing contacts or glasses is simple and affordable. The coverage is inexpensive, yet the benefits can be significant! Guardian provides rich, flexible plans that allow you to safeguard your health while saving you money. Review your plan options and see why vision insurance may be a great benefit for you.

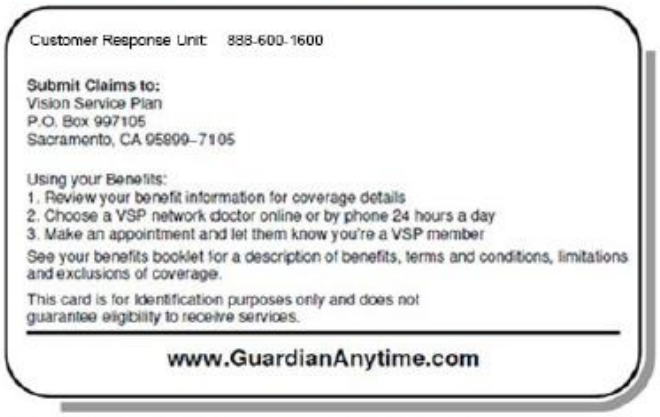
Visit any doctor with your **Full Feature** plan, but save by visiting any of the 50,000+ locations in the nation's largest vision network.

Your Vision Plan	**Full Feature**	
Your Network is	VSP Choice Network	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 10	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $39
Single Vision Lenses	$0	Amount over $23
Lined Bifocal Lenses	$0	Amount over $37
Lined Trifocal Lenses	$0	Amount over $49
Lenticular Lenses	$0	Amount over $64
Frames	80% of amount over $130	Amount over $46
Contact Lenses *(Elective)*	Amount over $130	Amount over $100
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts
Cosmetic Extras	Avg. 20-25% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price**	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	
Frames	Every two calendar years‡‡‡	
Network discounts *(cosmetic extras, glasses and contact lens professional service)*	Limitless within 12 months of exam.	
Dependent Age Limits	26	

‡‡Benefit includes coverage for glasses or contact lenses, not both.

‡‡‡The VSP system considers contact lenses to be the equivalent of a full pair of eyeglasses (lenses and frames) so while the member can obtain contact lenses one year and standard eyeglass lenses the next year, the frames benefit would not be available until 24 months or two calendar years, depending on the plan design, after the date the member obtained the contact lenses.

This is a temporary card to use for the first 30 days of your plan. After 30 days you may log into GuardianAnytime.com to register and obtain your permanent card or log into VSP.com to get an overview of your plan benefits and check claim status.



Step 1: Determine if you or your provider should call the Employee Benefits Hotline.

- Do you need help completing enrollment forms?
- Do you need to make a vision appointment within 30 days after the plan's effective date? *(If so, it's suggested you contact the hotline at least 72 hours prior to your visit so you can ensure your vision provider has your coverage information. Coverage begins on your plan's effective date.)*

Step 2: Prepare yourself and/or your provider to call the Employee Benefits Hotline with the following information:

- Name of the company you work for: **Jim's Supply Company Inc.**
- Your company's plan number: **504685.**
- Your ID number, which is your Social Security Number.

Step 3: Call 888-600-1600 to get answers!

- Press #1 if you are an employee or dependent, Press #2 if you are a provider
- At the next prompt: Press #2 for all other questions

Employee Benefits Hotline

Benefit specialists are available to answer questions as you sign up for your Guardian benefits.

TOLL-FREE PHONE	
1-888-600-1600 Monday – Friday	8:00 a.m. - 8:30 p.m. EST 7:00 a.m. - 7:30 p.m. CST 6:00 a.m. - 6:30 p.m. MST 5:00 a.m. - 5:30 p.m. PST

IMPORTANT NOTE: The Employee Benefits Hotline provides pre-enrollment support in over 50 languages! Once you are enrolled in a plan, you will receive additional information and new toll-free phone numbers. If you are looking for a vision provider who participates in your plan, go to www.GuardianAnytime.com

VSP

GUARDIAN

The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004

GUARDIAN®

Jim's Supply Company Inc

Life Benefit Summary

Group Number: 00504685

About Your Benefits:

Your family depends on you in many ways and you've worked hard to ensure their financial security. But if something happened to you, will your family be protected? Will your loved ones be able to stay in their home, pay bills, and prepare for the future. Life insurance provides a financial benefit that your family can depend on. And getting it at work is easier, more convenient and more affordable than doing it on your own. If you have financial dependents- a spouse, children or aging parents, having life insurance is a responsible and a smart decision. Enroll today to secure their future!

What Your Benefits Cover:

	VOLUNTARY TERM LIFE
Employee Benefit	$10,000 increments to a maximum of $250,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Enhanced employee coverage. Maximum 1 times life amount.
Spouse ‡ Benefit	$5,000 increments to a maximum of $100,000. See Cost Illustration page for details.
Child Benefit	Your dependent children age birth† to 26 years. $2,500 increments to a maximum of $10,000. Subject to state limits. See Cost Illustration page for details.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	We Guarantee Issue coverage up to $100,000 per employee and $20,000 for a spouse
Premiums	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take your coverage with you if you terminate employment.	Yes, with age and other restrictions
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	50% at age 65

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style. To help you assess your needs, you can also go to Guardian Anytime and use our Life Insurance Explorer Tool.

Weekly premiums displayed. Cost of AD&D is included.

Policy Election Amount	Policy Election Cost Per Age Bracket								
Employee	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$10,000	$.21	$.22	$.27	$.38	$.58	$.84	$1.35	$2.20	$3.40
$20,000	$.42	$.43	$.54	$.77	$1.15	$1.68	$2.71	$4.41	$6.79
$30,000	$.63	$.65	$.81	$1.15	$1.73	$2.51	$4.06	$6.61	$10.18
$40,000	$.84	$.87	$1.08	$1.53	$2.31	$3.35	$5.41	$8.82	$13.58
$50,000	$1.05	$1.09	$1.35	$1.92	$2.89	$4.19	$6.76	$11.02	$16.97
$60,000	$1.26	$1.30	$1.62	$2.30	$3.46	$5.03	$8.11	$13.22	$20.37
$70,000	$1.47	$1.52	$1.89	$2.68	$4.04	$5.86	$9.47	$15.43	$23.76
$80,000	$1.68	$1.74	$2.16	$3.07	$4.62	$6.70	$10.82	$17.63	$27.16
$90,000	$1.89	$1.95	$2.43	$3.45	$5.19	$7.54	$12.17	$19.84	$30.55
$100,000	$2.10	$2.17	$2.70	$3.83	$5.77	$8.38	$13.52	$22.04	$33.95
$110,000	$2.31	$2.39	$2.97	$4.21	$6.35	$9.22	$14.88	$24.24	$37.34
$120,000	$2.52	$2.60	$3.24	$4.60	$6.92	$10.05	$16.23	$26.45	$40.74
$130,000	$2.73	$2.82	$3.51	$4.98	$7.50	$10.89	$17.58	$28.65	$44.13
$140,000	$2.94	$3.04	$3.78	$5.36	$8.08	$11.73	$18.93	$30.85	$47.53
$150,000	$3.15	$3.25	$4.05	$5.75	$8.65	$12.57	$20.29	$33.06	$50.92
$160,000	$3.36	$3.47	$4.32	$6.13	$9.23	$13.40	$21.64	$35.26	$54.31
$170,000	$3.57	$3.69	$4.59	$6.51	$9.81	$14.24	$22.99	$37.47	$57.71
$180,000	$3.78	$3.91	$4.86	$6.90	$10.39	$15.08	$24.34	$39.67	$61.10
$190,000	$3.99	$4.12	$5.13	$7.28	$10.96	$15.92	$25.69	$41.87	$64.50
$200,000	$4.20	$4.34	$5.40	$7.66	$11.54	$16.75	$27.05	$44.08	$67.89
$210,000	$4.41	$4.56	$5.67	$8.05	$12.12	$17.59	$28.40	$46.28	$71.29
$220,000	$4.62	$4.77	$5.94	$8.43	$12.69	$18.43	$29.75	$48.49	$74.68
$230,000	$4.83	$4.99	$6.21	$8.81	$13.27	$19.27	$31.10	$50.69	$78.08
$240,000	$5.04	$5.21	$6.48	$9.19	$13.85	$20.11	$32.46	$52.89	$81.47
$250,000	$5.25	$5.42	$6.75	$9.58	$14.42	$20.94	$33.81	$55.10	$84.87
Policy Election Amount									
Spouse									
$5,000	$.08	$.08	$.11	$.16	$.26	$.39	$.65	$1.07	$1.67
$10,000	$.15	$.16	$.21	$.33	$.52	$.78	$1.30	$2.15	$3.34
$15,000	$.23	$.24	$.32	$.49	$.78	$1.17	$1.94	$3.22	$5.01
$20,000	$.31	$.32	$.43	$.65	$1.04	$1.56	$2.59	$4.29	$6.67

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$25,000	$.38	$.40	$.53	$.81	$1.30	$1.95	$3.24	$5.37	$8.34
$30,000	$.46	$.48	$.64	$.98	$1.56	$2.34	$3.88	$6.44	$10.01
$35,000	$.53	$.56	$.74	$1.14	$1.82	$2.73	$4.53	$7.51	$11.68
$40,000	$.61	$.64	$.85	$1.30	$2.08	$3.12	$5.18	$8.59	$13.35
$45,000	$.69	$.72	$.96	$1.46	$2.34	$3.51	$5.83	$9.66	$15.02
$50,000	$.76	$.80	$1.06	$1.63	$2.60	$3.90	$6.47	$10.73	$16.69
$55,000	$.84	$.88	$1.17	$1.79	$2.86	$4.29	$7.12	$11.80	$18.35
$60,000	$.91	$.96	$1.27	$1.95	$3.12	$4.68	$7.77	$12.88	$20.02
$65,000	$.99	$1.04	$1.38	$2.12	$3.38	$5.07	$8.42	$13.95	$21.69
$70,000	$1.07	$1.12	$1.49	$2.28	$3.64	$5.46	$9.06	$15.02	$23.36
$75,000	$1.14	$1.19	$1.59	$2.44	$3.89	$5.85	$9.71	$16.10	$25.03
$80,000	$1.22	$1.27	$1.70	$2.60	$4.15	$6.24	$10.36	$17.17	$26.70
$85,000	$1.30	$1.35	$1.81	$2.77	$4.41	$6.63	$11.00	$18.24	$28.36
$90,000	$1.37	$1.43	$1.91	$2.93	$4.67	$7.02	$11.65	$19.32	$30.03
$95,000	$1.45	$1.51	$2.02	$3.09	$4.93	$7.41	$12.30	$20.39	$31.70
$100,000	$1.52	$1.59	$2.12	$3.25	$5.19	$7.80	$12.95	$21.46	$33.37
Policy Election Amount									
Child(ren)									
$2,500	$0.10	$0.10	$0.10	$0.10	$0.10	$0.10	$0.10	$0.10	$0.10
$5,000	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19
$7,500	$0.29	$0.29	$0.29	$0.29	$0.29	$0.29	$0.29	$0.29	$0.29
$10,000	$0.39	$0.39	$0.39	$0.39	$0.39	$0.39	$0.39	$0.39	$0.39

GUARDIAN

Accident Premier Plan (Off Job)

RATES

	Monthly	Bi-Monthly	Bi-Weekly	Weekly
Employee	$18.60	$ 9.30	$ 8.58	$ 4.29
Employee & Spouse	$30.32	$15.16	$13.99	$ 7.00
Employee & Child	$29.99	$15.00	$13.84	$ 6.92
Family	$41.71	$20.86	$19.25	$ 9.63

Portability	Included without evidence of insurability
Child(ren) Age Limits	Birth to 26 yrs (26 if full-time student), subject to state limitations

BENEFITS

	Premier Plan
Accident Coverage	Off Job
Accidental Death and Dismemberment	Employee: $50,000 Spouse: $25,000 Child: $5,000
Catastrophic Loss	Quadriplegia: 100% of AD&D Loss of speech and hearing (both ears): 100% of AD&D Loss of cognitive function: 100% of AD&D Hemiplegia: 50% of AD&D Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D
Common Disaster	200%of Spouse AD&D benefit
Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D
Seatbelts and Airbags	Seatbelts: $10,000 Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500
Accident Emergency Treatment	$200
Accident Follow-Up Visit - Doctor	$75 up to 6 treatments
Air Ambulance	$1,500
Ambulance	$200
Appliance	$125
Blood/Plasma/Platelets	$300
Burns (2nd Degree/3rd Degree)	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
Burn – Skin Graft	50% of burn benefit
Child Organized Sport	20% increase to child benefits
Chiropractic Visits	$50 per visit up to 6 visits
Coma	$12,500
Concussions	$100
Dislocations	Schedule up to $4,800
Diagnostic Exam (Major)	$200
Emergency Dental Work	$400/Crown $100/Extraction
Epidural pain management	$100, 2 times per accident
Eye Injury	$300
Family Care	$20/day up to 30 days
Fracture	Schedule up to $6,000

Hospital Admission			$1,250
Hospital Confinement			$250/day, up to 1 yr
Hospital ICU Admission			$2,500
Hospital ICU Confinement			$500/day – up to 15 days
Initial Physician's office/Urgent Care			$100
Knee Cartilage			$750
Joint Replacement			$3,500/$1,750/$1,750
Laceration			Schedule up to $500
Lodging			$150/day, up to 30 days for companion hotel stay
Occupational or Physical			$35/day up to 10 days
Prosthetic Device/Artificial			1: $750 2 or more: $1,500
Rehabilitation Unit			$150/day up to 15 days
Ruptured Disc with Surgical Repair			$750
Surgery (Cranial, Open Abdominal,			$1,500 Hernia: $200
Surgery – Exploratory or			$350
Tendon/Ligament/Rotator Cuff			1: $750 2 or more: $1,500
Transportation			$600, 3 times per accident
X-Ray			$40

The benefits listed are payable if the service, treatment or procedure is due to injuries incurred in a covered accident.
Appliance – Benefit is paid if a wheelchair, leg or back brace, crutches, walker, walking boot that extends above the ankle or brace for the neck is prescribed by a physician as necessary due to an injury sustained as the result of a covered accident.
Child Organized Sport – Benefit is paid if the covered accident occurred while your covered child is participating in an organized sport that is governed by an organization and requires formal registration to participate. This benefit is only payable if child coverage is included on the plan.
Family Care – Benefit is payable for each child attending a Child Care center while the insured is confined to the hospital, ICU or Alternate Care or Rehabilitative facility due to injuries sustained in a covered accident.
Lodging – Benefit is paid for a companion's hotel stay while the insured is confined to the hospital as the result of a covered accident. The hospital must be more than 50 miles from the insured's residence.
Transportation – Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.

Employee must be legally working in the United States in order to be eligible for coverage.
This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.
This plan will not pay benefits for any injury caused by or related to:
Declared or undeclared war, act of war, or armed aggression; taking part in a riot or civil disorder; or commission of, or attempt to commit a felony, intentionally self inflicted injury, while sane or insane; suicide or attempted suicide, while sane or insane.
The covered person being legally intoxicated
Treatment rendered or hospital confinement outside the United States or Canada.
Travel or flight in any kind of aircraft, including any aircraft owned by or for the employer except as a fare-paying passenger on a common carrier.
Participation in any kind of sporting activity for compensation or profit, including coaching or officiating.
Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
Participation in hang gliding, bungee jumping, sail gliding, parasailing, parakiting, ballooning, parachuting, and/or skydiving.
Job related or on the job injuries
Injuries to a dependent child received during the birth.
An accident that occurred before the covered person is covered by this plan.
Sickness, disease, mental infirmity or medical or surgical treatment.
Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Aflac
We've got you under our wing.™

For AFLAC benefits please contact Cheryl O'Brien at 633-6029 or e-mail cherylkobrien@msn.com

Questions & Answers

What forms MUST be completed to enroll?
Each carrier has a form that MUST be completed if you wish to enroll for any benefit.
If you are waiving coverage, please provide a copy of your ID card and you MUST sign a waiver

What changes can be made at open enrollment effective November 1st?
Enroll or terminate individual and/or dependent coverage or change plans for medical, dental, and vision benefits. There is no open enrollment for voluntary life insurance.

Can I make changes outside of my initial eligibility date or outside of open enrollment?
You may not make a change unless you experience a qualifying event such as

- Loss of other coverage
- Access to other coverage
- Marriage or Divorce
- Newborn or Adoption
- Court order to enroll dependents
- Death of a dependent

There is a 30 day window to submit enrollment forms due to a change family status as listed above.

Where do I find enrollment and change forms?
When you are first eligible for benefits, the enrollment forms will be in your benefit packet
During open enrollment forms will be available at the onsite meetings with The Lynn Company.
If you cannot attend the meetings, please contact The Lynn Company for assistance.

Please contact your Human Resources Department for the Notice of Exchange and Summary of Benefits and Coverage (SBC) for each medical plan.

Who do I contact with questions?

The Lynn Company

3761 Bernard St, Bakersfield, CA. 93306

Telephone: 661-873-2200 / 800-326-5966

Fax: 661-873-2242

http://www.lynncompany.com

Cheryl Nieuwkoop, Agent
Telephone: 661-430-6295
E-mail: cheryl@lynncompany.com

Marty Nino, Customer Service Representative (se habla español)
Telephone 661-873-2200 ext 216
E-mail: rnarty@lynncompany.com

Kacey Mendoza, Enrollment Support Representative (se habla español)
Telephone 661-873-2200 ext 265
E-mail: kacey@lynncompany.com

IMPORTANT CONSIDERATIONS FOR EMPLOYEES BEFORE DECIDING TO WAIVE COVERAGE

The Affordable Care Act (ACA) requires each individual to have qualifying health care coverage (known as minimum essential coverage) for each month, qualify for an exemption, or pay a penalty when filing his or her federal income tax return. Each year the amount of the ACA individual mandate penalty increases as shown in the chart below:

ACA Individual Mandate Penalties*	
2016	**2017**
$695 per individual Maximum $2,085 per family -or- 2.5% of household income over the filing threshold	$695** per individual Maximum $2,085** per family -or- 2.5% of household income over the filing threshold

*Your payment amount is capped at the cost of the national average premium for a bronze level health plan available through the Marketplace. ** For 2017 and beyond, flat amounts will be based on 2016 amounts plus an adjustment for inflation.

If you are considering waiving your employer-sponsored coverage because of concerns you cannot afford it please keep these penalties in mind. Unless you have an exemption from the requirement to have coverage, you could end up with an expensive payment when you file your federal income tax return. ***Why not put that money toward employer-sponsored coverage to keep you healthy rather than pay a penalty and receive no benefit in return?***

If you want to learn more about the ACA Individual Mandate, including who is eligible for an exemption, here is a link to the section of the IRS website with frequently asked questions on this important topic: http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

If you currently have coverage, or plan to apply for coverage, through Covered California Exchange/Marketplace and are receiving/will receive a Premium Tax Credit (PTC) which reduces the amount you pay per month for this coverage, please keep in mind that if the coverage your employer offers meets one of the following ACA Affordability Safe Harbors, you are not eligible for a Premium Tax Credit (PTC) and may be required to pay back a significant portion of the money Covered California advanced to your selected health plan each month to reduce the portion you had to pay.

Affordability Safe Harbor Options for Employers	
2016	**2017**
• **9.66%** of Federal Poverty Level • **9.66%** of W-2 Box 1 income • **9.66%** of Rate of Pay	• **9.69%** of Federal Poverty Level • **9.69%** of W-2 Box 1 income • **9.69%** of Rate of Pay

**ACA Affordability is based on the employee contribution for employee-only coverage on the lowest cost plan offered by the employer that meets the ACA minimum value requirement (60%). The cost of dependent coverage is not part of the Affordability calculation.*

The coverage offered by Jim's Supply Company meets the ACA Affordability Safe Harbor

WAIVER OF HEALTH INSURANCE COVERAGE

Jim's Supply Company, Inc.

PLAN YEAR: 11/01/2016 through 10/31/2017

I understand that I am eligible for benefits, effective _____. I am signing this form to decline the medical insurance offered by my employer. This declination is void upon my submission of completed enrollment forms within 30 days from date of hire or during open enrollment.

- I cannot revoke or change this election during the plan year unless I have a qualifying change in family and/or job status and that change is consistent with my change in election. I may then revoke my prior election and sign a new agreement if such change occurs. I understand that I have a 30 day window to enroll on the benefit plan if I experience a qualifying change in status.

- I understand that under PPACA (Patient Protection Affordable Care Act) an employee who is offered group coverage that is affordable and meets the minimum value standard, is not eligible for a subsidy through the Covered California Marketplace.

- If I have Medicare, Medi-Cal, or group coverage through my parents or my spouse's employer, I do not need to enroll at this time. If I experience a status change or loss of coverage, there is a 30 day window to enroll for the group medical plan through Jim's Supply Company.

- Due to Health Care Reform there is an individual mandate and IRS penalties that apply per year for not being insured. The penalty is the higher of the following:

Year	Per adult	Per child	Family Maximum	% of taxable income above the tax filing threshold	
2016	**$695**	**$347.50**	**$2085**	**Or**	**2.5%**
2017	**$695**	**$347.50**	**$2085**	**Or**	**2.5%**

If you are waiving medical coverage, please sign this waiver of coverage form and return it to your Human Resources Department.

Signed: _____ Date: _____

Print Name: _____