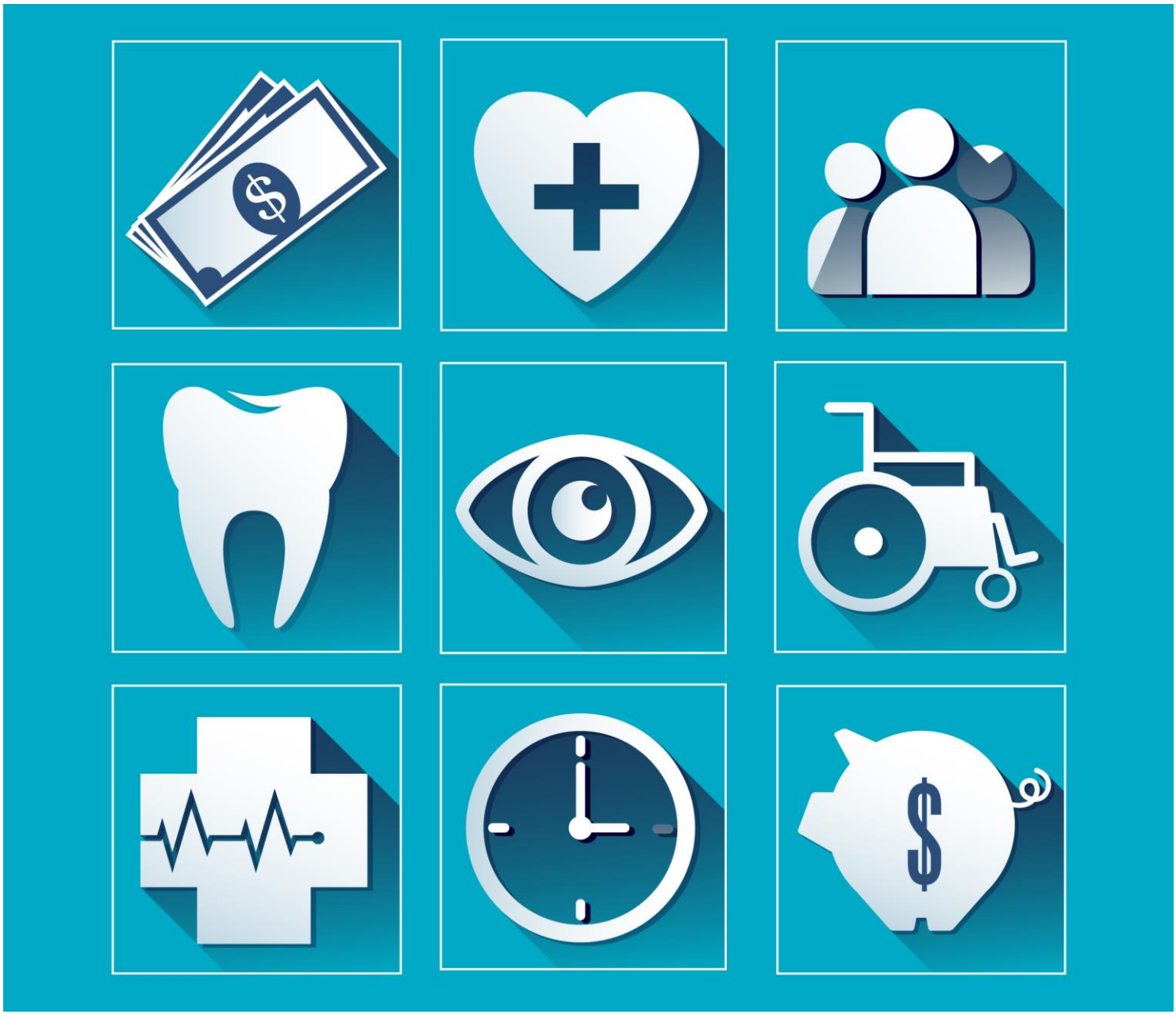
RP MANAGEMENT INC.

Employee Benefits Enrollment Guide

Plan Year: 2017



RP Management offers you and your eligible family members a valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

The information in this Benefit Guide is presented for illustrative purposes. The text contained in this Guide was taken from various summary plan descriptions and benefit materials. While every effort was made to accurately report your benefits, discrepancies or errors are always possible. In case of a discrepancy between this Guide and the actual plan documents, the plan documents will prevail.

Contents

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see Page 18 for more details.

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. The following family members are eligible for medical, dental and vision coverage: your legal spouse and dependent children up to age 26.

How to Enroll

Enrollments are completed in the Benefits Administration module in Paychex. The same login used to clock in also allows you to access this information; just click on the Benefits Administration link. Once your elections are made, you will not be able to change them until open enrollment for a January 1st effective date unless you have a qualified change in status.

When to Enroll

Benefits begin on the 1st of the month following 60 days from your date of hire or the date you became eligible for benefits. You must complete your enrollment at least 7 days prior to the effective date.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include, for example: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in employment status or change in coverage under another employer-sponsored plan. You have 30 days to communicate any qualified change in status to Candice Allen in Human Resources.

Medical and Prescription Drugs

Three PPO plan options are offered through Highmark. All three plans are open access – you do not need to designate a primary care physician or obtain a referral to see a specialist.

You have nationwide access to in-network physicians and hospitals when utilizing the National Blue Cross Blue Card Network.

	PPO HSA 3500		PPO HSA 2000		PPO 2000	
In Network Benefits	**In Network**					
Deductible (Single/Family)	$3,500/$7,000[1]		$2,000/$4,000[1]		$2,000/$4,000	
Out of Pocket Maximum[1]	$6,350/$12,700		$5,000/$10,000		$6,350/$12,700	
Preventive Care	Covered in full, no deductible		Covered in full, no deductible		Covered in full, no deductible	
Routine Office Visit	0% after deductible		0% after deductible		$25 copay	
Specialist Office Visit	0% after deductible		0% after deductible		$50 copay	
Telemedicine	0% after deductible		0% after deductible		$20 copay	
Emergency Room	0% after deductible		0% after deductible		$125 copay; waived if admitted	
Outpatient Surgery	0% after deductible		0% after deductible		0% after deductible	
Inpatient Hospital	0% after deductible		0% after deductible		0% after deductible	
Outpatient Lab	0% after deductible		0% after deductible		0% after deductible	
Outpatient Radiology	0% after deductible		0% after deductible		0% after deductible	
Durable Medical Equipment	0% after deductible		0% after deductible		0% after deductible	
Out of Network Benefits	**Out of Network**					
Deductible[1]	$3,500/$7,000		$2,000/$4,000		$2,000/$4,000	
Coinsurance	20%/50%		20%/50%		50%	
Out of Pocket Maximum[1]	$6,350/$12,700		$5,000/$10,000		$6,350/$12,700	
Prescription Benefits	**Prescription**					
	Generic Preferred/Non Preferred	Brand Preferred/Non Preferred	Generic Preferred/Non Preferred	Brand Preferred/Non Preferred	Generic Preferred/Non Preferred	Brand Preferred/Non Preferred
Retail (30 day supply)	100% after deductible[2]	100% after deductible[2]	100% after deductible[2]	100% after deductible[2]	$4/$15	$45/$70
Mail Order (90 day supply)					$10/$38	$113/$175
Specialty Rx (30 day supply)					$10/$38	$113/$175

[1]Any enrollment greater than Single requires the Family deductible be met prior to the plan paying. Deductible and Out of Pocket Maximum are combined between in network and out of network services.
[2]During the deductible phase, you will be responsible for the full cost of your prescription. Once the deductible has been met, your prescriptions will be covered 100%.

Your Cost

EMPLOYEE BI-WEEKLY DEDUCTIONS				
	Employee Only	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
PPO HSA 3500	$110.00	$290.00	$255.00	$445.00
PPO HSA 2000	$140.00	$362.50	$327.50	$517.50
PPO 2000	$170.00	$422.50	$387.50	$577.50

Health Reimbursement Arrangement (HRA)

RP Management provides an HRA to help offset out of pocket medical costs. All employees who are enrolled in the medical plan will receive $90.00 per month deposited in their HRA account. As long as you are still employed by RP Management and enrolled in the medical plan, unused balances will roll over each year.

The HRA reimburses participants, on a tax-free basis, for a number of eligible expenses such as copays and deductibles for:

- Medical expenses
- Dental expenses
- Vision expenses
- Over the counter (OTC) items
    - Note: OTC medications require a doctor's prescription

You can use your HRA funds for expenses incurred by your spouse and children as long as they are also enrolled on your medical benefits.

Debit Card

You will have convenient and immediate access to your available HRA funds via a Visa debit card.

The card may be used at:

- Health Care Provider
    - i.e. doctor, dentist, hospital, etc.
- Pharmacy
- Discount Retailers and Grocery Stores

You may need to provide substantiation when you use your card at a health care provider. Accepted forms of documentation are an itemized receipt or carrier Explanation of Benefits. A credit card receipt is not a proper form of documentation.

Manual Claims

If you are unable to use your debit card, you can submit a manual claim to Eflex, a TASC division, via the employee portal, fax, or mail. If you sign up for direct deposit, you will receive your money faster.

The deadline to submit manual claims incurred in 2017 is January 31, 2018.

If you waive medical benefits in the future or terminate employment you will have 90 days to spend down your HRA account balance at no additional cost.

Vision

If you are enrolled in one of the medical plans you also receive vision benefits through Highmark at no additional cost.

	In Network Member Cost	Out of Network Reimbursement
Eye Exam (once every 12 months)	$0	Up to $32.00
Lenses[1] (once every 12 months) Single Vision Bifocal Trifocal	$0	 Up to $24.00 Up to $36.00 Up to $46.00
Frames (once every 12 months) Davis Vision Frame Collection – Fashion Level - Designer Level - Premier Level Non-Collection Allowance	 $0 $20 copay $40 copay Up to $60	 Up to $30
Contact Lenses (once every 12 months) Benefit in lieu of eyeglasses Evaluation & Fitting Elective Lenses Medically Necessary Lenses	 $0 $0 standard daily wear $0	 Up to $20 Up to $50 Up to $150

[1] Additional costs apply for specialty lenses and coatings (i.e. tinting, scratch protection, progressive lenses, etc.)

Virtual Medicine

All three medical plans include access to virtual medicine.

With this benefit you and your covered dependents have access – 24/7 – to licensed, board certified doctors via a computer, tablet, or smartphone. These doctors can diagnose and treat most non-emergency illnesses. They can even prescribe medications when appropriate.

Virtual doctors can treat many common illnesses, such as sinus infection, upper respiratory infection, bronchitis, flu, conjunctivitis, cough and sore throat. Eighteen of the top 20 reasons people visit urgent care centers can be treated through a virtual medicine visit.

Register and Download the App to Get Started

Visit www.amwell.com or www.doctorondemand.com and follow the instructions to register and download their mobile apps.
You can use either or both of these services, depending on the availability of virtual doctors in your area.

Save Time and Money

Virtual Medicine provides around the clock access.

Participants enrolled in the PPO HSA 3500 or PPO HSA 2000 will pay a $40 consultation fee which will apply towards the plan deductible. A $20 copay will apply for those enrolled in the PPO 2000.

Dental

There are two dental plan options offered through Aetna on a voluntary basis – a DMO and PPO.

The DMO requires you to select a primary care dentist and obtain a referral for specialty care. You also have access to in network providers only. There is no deductible or annual maximum benefit.

The PPO allows you to see any licensed dentist. You will save money by seeking care within the Aetna network.

	Aetna DMO	Aetna PPO
	In network only	In and Out of Network*
Preventive & Diagnostic Services Exams & Cleanings X-Rays Sealants	100%	100%
Basic Services Fillings, Stainless Crowns Scaling Root Canal (Anterior & Bicuspid teeth) Simple Extractions	100%	80%
Major Services Crowns, Inlays, Onlays Bridges Dentures	60%	50%
Office Visit Co-Pay	$5	N/A
Orthodontia (children up to age 19)	$2,300 copay	50% to $1,000 lifetime maximum
Deductible	None	$50/$150
Annual Maximum	None	$1,500
***When utilizing out of network providers, Aetna will pay a percentage of the usual, customary, and reasonable charge (UCR) and you may be subject to balance billing. Balance billing is the difference between the dentist's charge and what Aetna pays.**		

Your Cost

EMPLOYEE BI-WEEKLY DEDUCTIONS				
	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
DMO	$9.10	$17.85	$25.20	$33.95
PPO	$15.05	$29.85	$41.15	$55.95

Basic Life Insurance

RP Management provides full-time employees with $10,000 in group life and accidental death and dismemberment (AD&D) insurance, and pays the full cost of this benefit.

The benefit reduces at the following ages:

- To 65% ($6,500) at age 65
- To 50% ($5,000) at age 70

Contact Human Resources to update your beneficiary designation.

If you leave employment there are two options to continue your benefit.

- Portability allows you to keep the same term life coverage at a discounted group rate.
- Conversion allows you to convert your coverage to an individual whole life policy.

You must apply for coverage under either of these options within 30 days of when your benefit ends.

Long Term Disability Income Benefits

RP Management provides full-time employees with long-term disability income benefits, and pays the full cost of this coverage. In the event you become disabled for an extended period of time, long term disability income benefits are provided as a source of income.

	Long-term Disability
Benefits Begin	After 180 days of being disabled
Benefits Payable	Up to your Social Security Normal Retirement Age (SSNRA)
Percentage of Income Replaced	50% of your monthly salary
Maximum Benefit	$5,000 maximum/month

Health Advocate

All employees have access to Health Advocate ™, an important benefit, available to our employees and their families. Health Advocate is designed to help handle healthcare and insurance related issues by cutting through the red tape and barriers that so often create frustrations and problems.

With Health Advocate, you will have your own Personal Health Advocate, a registered nurse, supported by a team of medical doctors and administrative experts. You will have the confidence in knowing that the entire Health Advocate team is working on your behalf to help you with your needs.

Below are a few of the many services available to you with Health Advocate:

- Help finding the best doctors and hospitals
- Help scheduling timely appointments, especially with specialist physicians
- Help when faced with a serious illness or injury
- Help with insurance claims and billing issues
- And lots more

To use your Health Advocate Benefits, simply call 866-695-8622 and identify yourself as an RP Management employee. Your spouse, dependent children, parents, and parents-in-law can also access this benefit by calling the same number. No enrollment forms are needed.

Additional Benefit Offerings

401(k)

Employees age 21 and over are eligible to participate in the 401(k) Plan after completing one year of service.

Contact Information

Below are important phone numbers and websites for your reference.

Coverage/Type	Carrier Name	Website	Telephone
Medical	Highmark	www.highmarkblueshield.com	800-345-3806
Dental	Aetna	www.aetna.com	877-238-6200
Health Reimbursement Arrangement (HRA)	eFlex (TASC)	www.eflexgroup.com	877-933-3539
Vision	Highmark	www.highmarkblueshield.com	800-345-3806
Life & Disability	AIG	www.aig.com	877-672-1648
Health Advocate	Health Advocate	www.healthadvocate.com	866-695-8622

Federally Required Notices Related to Your Benefits Program

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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
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	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself and/or your eligible dependent(s) because of other health/dental insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because you have other health/dental coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

Non-Medical

If you are voluntarily declining non-medical coverage provided by your employer, you may choose to enroll at a later date depending upon the coverage now being waived. With the late enrollment your cost may be higher, a health questionnaire may be required and the effective date of your coverage may be delayed or denied. If coverage is non-contributory (employer pays entire cost) waivers are not permitted.

Note: Under Section 125, you may make changes to your pre-tax benefit plans only if you experience a qualified event. The change you request must be consistent with the event. The following are the IRS minimum Qualified Events:

1. Marriage, divorce, or legal separation;
2. Birth or adoption of a child;
3. Death of a spouse or child;
4. Change in residence or work location that affects benefits eligibility for you or your covered dependent(s);
5. Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes);
6. You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job);
7. Loss or eligibility for Medicaid or SCHIP.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, all your plan administrator at 484-708-5100.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers 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 vaginal delivery or less than 96 hours following a cesarean section.
However, federal law generally does not prohibit the mother's or the 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 insurers 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/96 hours.

Rights under COBRA

As an RP Management employee, you are eligible for COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985 as amended). This gives employees and their qualified beneficiaries the opportunity to continue health insurance coverage for specified periods of time under the Company's health plan when a "qualifying event" occurs. Some common qualifying events are resignation, termination of employment (other than for gross misconduct), or death of an employee; a reduction in an employee's hours or a leave of absence; an employee's divorce or legal separation; and a dependent child no longer meeting eligibility requirements. Under COBRA, the employee or beneficiary pays the full cost of coverage at the employer's group rates plus an administration fee.

Family and Medical Leave Act – FMLA

The Family and Medical Leave Act of 1993 ("FMLA") requires RP Management to provide eligible employees with up to 12 weeks per year of leave in a 12-month period for:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for the employee's spouse, child, or parent who has a serious health condition;
- a serious health condition that makes the employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or

Twenty-six work weeks of leave during a single 12-month period is permitted to care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

An eligible employee is one who:

- Works for a covered employer;
- Has worked for the employer for at least 12 months;
- Has at least 1,250 hours of service for the employer during the 12 month period immediately preceding the leave*; and
- Works at a location where the employer has at least 50 employees within 75 miles.

Source: http://www.dol.gov/whd/fmla/
Please contact Human Resources if have any questions or need to request leave.

Important Notice from R.P. MANAGEMENT, INC. About your Prescription Drug Coverage and 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 R.P. Management, Inc. 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. R.P. Management, Inc. has determined that the prescription drug coverage offered is, 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. Because 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 to 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 R.P. Management, Inc. coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current R.P. Management, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back.

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 R.P. Management, Inc. 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 November 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 R.P. Management, Inc. 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" 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).

Date:	March 22, 2017
Name of Entity/Sender:	R.P. Management, Inc.
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