Employee Benefits Guide

2016 - 2017

TEBARCO

TEBARCO

BENEFITS ELECTED
8/1/2016-7/31/2017

EMPLOYEE INFORMATION

Name (Last, First, Middle initial) | Social Security number | DATE Of HIRE

Date of Birth | Gender | Title

Street address | City | State | Zip Code

INSURANCE ELECTIONS

Humana - select from the following two medical plans *(choose one):*

Humana Simplicity HMO - SILVER OPTION #4		Humana Simplicity NPOS - SILVER OPTION #4	
☐ **Employee**	$38.91	☐ **Employee**	$50.77
☐ **Employee & Spouse**	$77.82	☐ **Employee & Spouse**	$101.54
☐ **Employee & Children**	$71.98	☐ **Employee & Children**	$93.93
☐ **Family**	$110.89	☐ **Family**	$144.70

☐ **Waive Medical**

Guardian Voluntary Dental	
☐ **Employee**	$8.70
☐ **Employee & Spouse**	$17.84
☐ **Employee & Children**	$21.31
☐ **Family**	$30.45

IF YES, PLEASE INDICATE:
PREFERRED/VALUE _____
NAP _____

☐ **Waive Dental**

DEPENDENT INFORMATION

List those dependents (spouse or dependent child) for whom you are selecting medical or dental coverage.

Medical	Dental	Name(Last, First)	Relationship	Social Security #	DOB	Gender
☐ Elect	☐ Elect					M F
☐ Elect	☐ Elect					M F
☐ Elect	☐ Elect					M F
☐ Elect	☐ Elect					M F
☐ Elect	☐ Elect					M F
☐ Elect	☐ Elect					M F

I certify the above is true and correct. I acknowledge that I have been given Tebarco Door & Metal Services Inc. Benefits and Services Summary and have been given the opportunity to enroll in Tebarco Door & Metal Services, Inc.benefits plans. By not enrolling in certain benefits at this time, I realize that I will be unable to enroll or make changes again until the next open enrollment unless I have a qualifying event as outlined in the Benefits and Services Summary. I hereby authorize Tebarco Door & Metal Services, Inc. to reduce my pay for the benefit plans I have selected above. I understand that my contributions will be deducted on a pre-tax basis.

Employee Signature _____ **Date** _____

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of Coverage)

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

There is an additional enrollment period if an employee or dependent loses eligibility for Children's Health Insurance Program (CHIP), Medicaid or becomes eligible for CHIP for Medicaid premium assistance. The special enrollment allows children or their parents to have 60 days, rather than 30, to request enrollment.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Complete If You Are Declining Coverage For Yourself Or Any Dependent:

If you are declining coverage for yourself or for any of your eligible dependents, you must complete the following information if you want to preserve your rights of Special Enrollment as explained above. If you decline coverage for yourself, the reason is:

☐ **I have other coverage** ☐ **Another reason**

If you decline coverage for one or more eligible dependents, please give the dependent's name below and indicate the reason coverage is declined.

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

_____ _____

Employee Name – Please Print Employee Social Security Number

_____ _____/_____/_____

Employee Signature **Date**

GUARDIAN®

□ Northeast Regional Office
P.O. Box 26050
Lehigh Valley, PA 18002-6050

□ Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012

□ Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

Beneficiary Designation/ Change Form

PLEASE TYPE or PRINT CLEARLY. *(The entire form, properly completed, signed and dated by the Insured, must be submitted or the changes cannot be processed.)*

EMPLOYER/PLANHOLDER NAME:	GROUP NUMBER
EMPLOYEE NAME (LAST, FIRST, M.)	SOCIAL SECURITY #
EMPLOYEE HOME ADDRESS (STREET, CITY, STATE, ZIP)	

I AUTHORIZE Guardian or my employer to record and consider the individuals/instructions that I have named on this form as beneficiaries for benefits under the applicable employee benefits plan.
(PLEASE COMPLETE THE APPROPRIATE SECTIONS ONLY.)

BENEFICIARY INFORMATION: *(Complete to designate a beneficiary or change the beneficiary designation); Include full proper name, relationship and social security number of proposed beneficiary(s) - i.e. Mary A. Doe, and relationship - i.e. husband, wife, friend, son, daughter.*

Primary: 1) Name _____ Date of Birth _____ Relationship _____ Social Security # _____ % _____
Address _____

2) Name _____ Date of Birth _____ Relationship _____ Social Security # _____ % _____
Address _____

Contingent: 1) Name _____ Date of Birth _____ Relationship _____ Social Security # _____ % _____
Address _____

2) Name _____ Date of Birth _____ Relationship _____ Social Security # _____ % _____
Address _____

If more than one primary and/or contingent Beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the estate of the Insured, unless otherwise provided in the Group Plan.

SIGNATURE OF INSURED	SIGNATURE OF WITNESS (SOMEONE OTHER THAN BENEFICIARY)	DATE

ALL SIGNATURES MUST BE IN INK

CHANGE IN BENEFICIARY'S NAME *(Complete only if the name has been legally changed.)*

FROM (WAS)	TO (NOW IS)	SOCIAL SECURITY #	DATE

CHANGE IN INSURED'S NAME *(Complete only if the name has been legally changed.)*

FROM (WAS)	TO (NOW IS)	SOCIAL SECURITY #	DATE

SIGNATURE OF INSURED	DATE

ANY CHANGES IN DEPENDENT STATUS AND/OR NAME OF INSURED SHOULD BE REPORTED TO THE GROUP FIELD SUPPORT DEPARTMENT ON THE APPROPRIATE FORM

THIS SECTION TO BE COMPLETED BY GUARDIAN/or THE PLANHOLDER ONLY.

This is to certify that the following changes have been recorded in connection with the insurance for the above named insured.

☐ The BENEFICIARY has been changed ☐ The NAME of the BENEFICIARY has been changed ☐ New Employee

Recorded by _____ Date _____

GG-17 (5/07)

FORWARD FORM TO THE PLANHOLDER OR GUARDIAN LIFE INSURANCE FOR RECORDING

HumanaHMO 16

Georgia 100% Simplicity Plan
Option 4

		In-network
Office visit copay		$55 primary care $100 specialist
Deductible		Individual: $0 Family: $0
Out-of-pocket maximum	• Based on a calendar year Limit includes copays, deductibles and coinsurance	Individual: $6,850 Family: $13,700
Preventive care	• Office visit • Laboratory and radiology • Pap smear • Mammogram • Prostate screening • Immunizations • Endoscopy	100%
Other services	• Physician services	
	- Office visit	100% after office visit copay
	- Retail clinic	100% after primary care copay
	- Urgent care	100% after $125 copay
	- Emergency	100%
	- Diagnostic laboratory and radiology	100%
	- Inpatient, outpatient, and surgical	100%
	• Facility services	
	- Inpatient	100% after $2,250 copay per day for the first three days
	- Outpatient (surgical and non-surgical)	100% after $2,250 copay
	- Diagnostic laboratory and radiology	100%
	- Emergency room (copay waived if admitted)	100% after $750 copay
	• Advanced imaging	100% after $750 copay
	• Spinal manipulations and adjustments (visit limits may apply per calendar year)	100% after $100 copay

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GAHJCTUEN 9/15

PRESCRIPTION DRUGS

Rx4: Most prescription drugs are assigned to one of four levels with corresponding amounts or coinsurance.
A detailed Rx4 EHB drug list is available at **Humana.com/druglist.**

National Pharmacy Network

• Retail: 30-day supply	**Level 1:** $10 copay **Level 2:** $45 copay after $0 individual/$0 family deductible **Level 3:** $90 copay after $0 individual/$0 family deductible **Level 4:** 25% coinsurance after $0 individual/$0 family deductible
• Mail order (up to 90-day supply)	2.5 times the retail copayment
• Specialty drugs (up to 30-day supply)	35% or 25% by using a preferred specialty pharmacy like Humana Specialty Pharmacy

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Provider disclaimer:
Primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

Limitations and Exclusions:
Before applying for group coverage, please refer to the pre-enrollment disclosures for a description of plan provisions, which may exclude, limit, reduce, modify or terminate your coverage. These disclosures are available at http://www.humana.com/insurance-through-employer/enrollment-center/pre-enrollment-disclosure or through your sales representative.

Humana medical plans are offered by Humana Medical Plan, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plan of Ohio, Inc., Humana Health Plans of Puerto Rico, Inc . License # 00235-0008, Humana Wisconsin Health Organization Insurance Corporation, or Humana Health Plan of Texas, Inc. - A Health Maintenance Organization, or insured by Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, Humana Insurance of Puerto Rico, Inc. License # 00187-0009, or administered by Humana Insurance Company or Humana Health Plan, Inc.

Statements in languages other than English contained in the advertisement do not necessarily reflect the exact contents of the policy written in English, because of possible linguistic differences. In the event of a dispute, the policy as written in English is considered the controlling authority.

Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance or Summary Plan Description) for more information on the company providing your benefits.

Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, contact your employer.

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HumanaNational POS 16

Georgia 100/70 Simplicity Plan
Option 4

		In-network	Out-of-network
Office visit copay		$55 primary care $100 specialist	Not applicable
Deductible		Individual: $0 Family: $0	Individual: $5,000 Family: $10,000
Out-of-pocket maximum	• Based on a calendar year Limit includes copays, deductibles and coinsurance (out-of-network limit excludes pharmacy)	Individual: $6,850 Family: $13,700	Individual: $20,550 Family: $41,100
Preventive care	• Office visit • Laboratory and radiology • Pap smear • Mammogram • Prostate screening • Immunizations • Endoscopy	100%	70% after deductible*
Other services	• Physician services		
	- Office visit	100% after office visit copay	70% after deductible
	- Retail clinic	100% after primary care copay	70% after deductible
	- Urgent care	100% after $125 copay	70% after deductible
	- Emergency	100%	100%
	- Diagnostic laboratory and radiology	100%	70% after deductible
	- Inpatient, outpatient, and surgical	100%	70% after deductible
	• Facility services		
	- Inpatient	100% after $2,250 copay per day for the first three days	70% after deductible
	- Outpatient (surgical and non-surgical)	100% after $2,250 copay	70% after deductible
	- Diagnostic laboratory and radiology	100%	70% after deductible
	- Emergency room (copay waived if admitted)	100% after $750 copay	100% after $750 copay
	• Advanced imaging	100% after $750 copay	70% after deductible
	• Spinal manipulations and adjustments (visit limits may apply per calendar year)	100% after $100 copay	70% after deductible

*Deductible may not apply to certain services.

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• Mail order (up to 90-day supply)	2.5 times the retail copayment
• Specialty drugs (up to 30-day supply)	35% or 25% by using a preferred specialty pharmacy like Humana Specialty Pharmacy

Out-of-network

- Deductible: Individual: $0/Family: $0
- If a non-participating pharmacy is used, the claim will be covered at 100% after applicable cost share
- Specialty drugs are covered at 65% if a non-participating pharmacy is used

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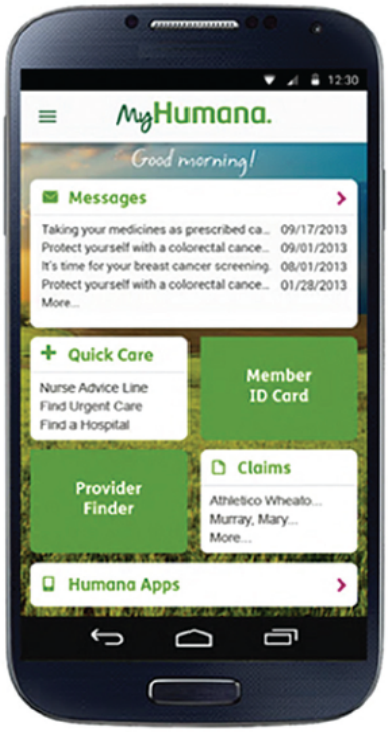
MyHumana Mobile app
"Now we go where you go"



Access your health information anytime, anywhere

Whether you prefer downloading a mobile application, using your mobile device or receiving text messages, you have the ability to manage your healthcare needs virtually anywhere, anytime.

Use the MyHumana Mobile app and website to:

- View medical, dental, vision and pharmacy claims
- View and fax medical, dental and pharmacy ID cards
- View your plans and coverage details
- View your HumanaVitality® Dashboard†
- Receive medication reminders
- Research drug prices
- Locate providers in your network
- Refill your Humana Pharmacy™ prescriptions

Download the Mobile App:

Download the MyHumana Mobile app from your app store. Search "MyHumana" in the Google Play or App Store.

Download on the App Store

ANDROID APP ON Google play

From your mobile device's browser:

You can visit MyHumana from your mobile device's browser. To get started, go to **Humana.com** and sign in.

Text message alerts*

On the MyHumana Mobile app:

1. Register or sign in (have your Humana ID or Social Security number available)
2. Click on the "Menu" icon
3. Select "Text Alerts"
4. Register and verify your mobile #
5. Select the alerts you want to receive

On Humana.com:

1. Register or sign in (have your Humana ID or Social Security number available)
2. Click on "Account settings & preferences"
3. Select "Edit your preferences"
4. Select "Mobile" from the tab
5. Register and verify your mobile #
6. Select the alerts you want to receive

†Available to HumanaVitality members only.
*Message and data rates may apply.

Humana.com

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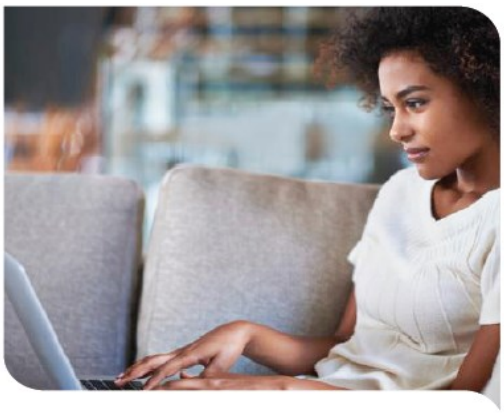
Telemedicine is a virtual, on-demand 24-hour service to access care from in-network physicians:

- Choose from Doctor on Demand's list of U.S. board certified doctors in-network
- Immediately see a doctor 24 hours a day, 7 days a week from any location
- Have the option for your primary care doctor to have access to your telemedicine visit
- If medically necessary, the telemedicine doctor can send a prescription to a preferred pharmacy



Approximately 70% of ER visits are non-emergent and could be avoided [1]

Average family practice wait time is **18.5 days** and counting [2]

Four out of five smartphone users are interested in mobile health technologies that allow them to interact with a healthcare provider [3]

Source 1. "Avoidable Emergency Department Usage Analysis." Truven Health Analytics. (April 25, 2013), 2. "Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates." Merritt Hawkins 2014 Survey, 3. "Most smartphone users want mHealth interactions" FierceMobileHealthcare (June 29, 2014)

No appointments required. Connect online at www.doctorondemand.com or download the Doctor on Demand app today!

Download on the App Store

ANDROID APP ON Google play

What can be treated by telemedicine

Telemedicine should be considered when a PCP is unavailable, after hours or on holidays for non-emergent needs. Many urgent care ailments can be treated with telemedicine, such as:

- Upper respiratory infections
- Colds, sore throat, and flu symptoms
- Allergies and sinus infections
- Ear and eye problems
- Skin conditions

Telemedicine is not for emergency situations such as chest pain, abdominal pain or shortness of breath.

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Humana.com

GCHJGLSEN/ 1015

Get healthy on your terms with HumanaVitality®

HumanaVitality is a wellness and rewards program- no matter your age or health status. It will put you on the path to healthier living whether you're a fitness buff, just working on losing a few pounds, looking to lower your blood pressure, or wanting to learn healthy eating habits.

- All Humana medical members have access to HumanaVitality.
- Members can earn Vitality points through verified workouts, athletic events, preventative care, and education.
- Members can cash in their points for rewards such as Amazon gift cards, Apple Products, movie tickets, hotel stay & more!

The Mobile App is fast, convenient and personalized. It provides new ways to engage in HumanaVitality - download it today to learn more.

Download the HumanaVitality Mobile App

Download on the App Store

ANDROID APP ON Google play

How do I get started?

- **Register on Humana.com**
- **Take your Health Assessment**
- **Set your goals**
- **Complete your Vitality Check**

Number of Vitality Points needed to move up to each Vitality Status level:

Platinum Vitality Status	**10,000** One adult per policy	**15,000 combined** Two adults* per policy	**5,000 additional** for each member 18 years and older per policy
Gold Vitality Status	**8,000** One adult per policy	**12,000 combined** Two adults* per policy	**4,000 additional** for each member 18 years and older per policy
Silver Vitality Status	**5,000** One adult per policy	**8,000 combined** Two adults* per policy	**3,000 additional** for each member 18 years and older per policy
Bronze Vitality Status	You immediately move up from Blue Vitality Status after completing the Health Assessment		
START HERE AND MOVE UP → **Blue** Vitality Status	You start at Blue Vitality Status with 0 Vitality Points		

*If applicable, the number of Vitality Points that is required to achieve each Vitality Status.

Humana Vitality

GUARDIAN

Summary of Benefits

Dental Benefit Summary

Group ID:	00428639	**Coverage Type:**	Voluntary
Group Name:	TEBARCO DOOR & METAL SERVICES, INC.	**Class:**	0001 ALL ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 60 day(s)	**As of Date:**	08/23/2016

Plan Information

Dental - DentalGuard Pref NAP - Atlanta and Dental - DentalGuard Pref - Atlanta

Coverage Information

	Dental - DentalGuard Pref NAP - Atlanta		**Dental - DentalGuard Pref - Atlanta**	
What's the most cost-effective way to use dental insurance?	You may go to any dentist, however those who belong to the **Dental - DentalGuard Pref NAP - Atlanta** network will be most cost effective.		You may go to any dentist, however those who belong to the **Dental - DentalGuard Pref - Atlanta** network will be most cost effective.	
	In Network	Out of Network	In Network	Out of Network
Calendar year deductible	Out of Network is a combined deductible for in and out of network services.	$50, Once the annual deductible is met by each of three family members, no further deductibles apply.	$50, Once the annual deductible is met by each of three family members, no further deductibles apply.	$50, Once the annual deductible is met by each of three family members, no further deductibles apply.
Preventive		Waived	Waived	Waived
Basic		Not Waived	Not Waived	Not Waived
Major		Not Waived	Not Waived	Not Waived
Calendar Year Maximum Benefit	The amount shown in the out of network field is your combined Calendar Year maximum for both in and out of network services.	$1,000	The amount shown in the out of network field is your combined Calendar Year maximum for both in and out of network services.	$1,000
Maximum rollover	Yes	Yes	Yes	Yes
Monthly Switch	Not Available	Not Available	Not Available	Not Available
	How much does the plan pay?	How much does the plan pay?(as a	How much does the plan pay?	How much does the plan pay?(as a

	Dental - DentalGuard Pref NAP - Atlanta		Dental - DentalGuard Pref - Atlanta	
What's the most cost-effective way to use dental insurance?	You may go to any dentist, however those who belong to the **Dental - DentalGuard Pref NAP - Atlanta** network will be most cost effective.		You may go to any dentist, however those who belong to the **Dental - DentalGuard Pref - Atlanta** network will be most cost effective.	
	In Network	Out of Network	In Network	Out of Network
		percentage of reasonable and customary.)		percentage of fee schedule.)
Office Visit Co-pay (one office visit may cover multiple services)	None	None	None	None
Preventive Care:	100%	100%	100%	100%
Bitewing X-Rays	100%	100%	100%	100%
Full Mouth X-Rays	100%	100%	100%	100%
Cleaning	100%	100%	100%	100%
Oral Exams	100%	100%	100%	100%
Sealants (per tooth)	100%	100%	100%	100%
Basic Care:	80%	80%	100%	100%
Fillings (one surface)	80%	80%	100%	100%
General Anesthesia[1]	80%	80%	100%	100%
Simple Extractions	80%	80%	100%	100%
Major Care:	50%	50%	60%	60%
Scaling & Root Planing (per quadrant)	50%	50%	60%	60%
Dentures	50%	50%	60%	60%
Single Crowns	50%	50%	60%	60%
Orthodontia	Not Available	Not Available	Not Available	Not Available

General Exclusions

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans:

This policy provides dental insurance only. Coverage is limited to charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury.

Deductibles apply.

The plan does not pay for:

- Oral hygiene services (except as covered under preventive services),
- Orthodontia (unless expressly provided for),
- Cosmetic or experimental treatments (unless they are expressly provided for).
- Any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment.

The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.

Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

1 Restrictions apply and may be subject to medical necessity.

This Benefit Summary is for illustrative purposes. Your benefits booklet will show exactly what is covered and/or excluded under your plan. If there is a discrepancy between this Benefit Summary and your benefit booklet, the benefit booklet prevails.

Definitions shown on this site are in summary form and are for general informational purposes. The terms of the insurance contract prevails.

Members Save on Eyewear Enhancements through Davis Network Discounts

Service	Patient Price	Average Discount
Routine Eye Examination	15% off provider's Usual and Customary	15%
Frames*		
Priced up to $70 Retail	$40	40%
Priced above $70 Retail	$40 plus 10% off the amount over $70	28%
Lenses (Uncoated Plastic)*		
Single Vision	$35	30%
Bifocal	$55	27%
Trifocal	$65	28%
Lenticular	$110	31%
Lens Options (Add to Lens Prices Above)*		
Polarized Lenses	$75	20%
High Index Lenses	$55	40%
Glass Lenses	$18	40%
Polycarbonate Lenses	$30	50%
Blended Invisible Bifocals	$20	60%
Intermediate Vision Lenses	$30	80%
Scratch Resistant Coating	$20	33%-66%
Standard Anti-Reflective Coating	$45	20%
Ultraviolet Coating	$15	25%
Solid Tint	$10	30%
Gradient Tint	$12	20%
Photogrey	$35	20%-45%
Plastic Photosensitive	$65	35%-55%
Contact Lenses		
Conventional	20% off Usual and Customary	20%
Disposable/Planned Replacement	10% off Usual and Customary	20%
Membership in Lens 1-2-3® mail order replacement contact lens program	Free	Up to 50%
Other Products		
Laser Vision Correction**	Up to 25% off Usual and Customary	Up to 25%

Applies to Vision Access Plan. Prices subject to change

Visit www.GuardianAnytime.com **or contact member services at 877-393-7363 for more information**

Additional discounts not applicable at Walmart and Sam's Club locations.
For standard eyeglass lenses, you will receive the lower of the Davis Vision discounted charge or Wal-Mart's everyday low price.
*Special lens designs, materials, powers, and frames may require additional cost.
** Or receive an additional 5% discount on any advertised specials – whichever is lowest

Summary of Benefits

Basic Life Benefit Summary

Group ID:	00428639	**Member Coverage Type:**	Non Contributory
Group Name:	TEBARCO DOOR & METAL SERVICES, INC.	**Class:**	0001 ALL ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 60 day(s)	**As of Date:**	08/23/2016

Coverage Information

Employee Volume Amount	Flat $15,000
Maximum Amount	$15,000
Cutbacks	35% at age 65 60% at age 70 75% at age 75 85% at age 80

Plan Information

When is my policy effective?	Coverage is effective after you satisfy any waiting period required by your employer. Coverage will not begin until Guardian has approved any amount subject to medical underwriting.
Do I have to answer medical questions as part of purchasing insurance?	No
Can I take the policy with me if I leave the company?	You may be able to port this coverage to a group trust plan. You must answer some medical questions to help us assess your insurability for the ported coverage. Yes, you can convert this coverage to an individual policy if you terminate employment with the company or the policy ends. (Some restrictions apply; see certificate of benefits for more information.)

Basic Life and General Exclusions

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.

Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a

Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to policy booklet for full plan description.

The group policy or individual certificate cannot be contested after it, or any rider or amendment subsequently added to it, has been in force for a period of two years.

If the age or any other relevant factor of the insured has been misstated, Guardian or its subsidiaries will use the true fact in determining whether insurance is in force under the terms of the certificate and in what amounts.

Dependent coverage will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex (may vary by state).

This Benefit Summary is for illustrative purposes. Your benefits booklet will show exactly what is covered and/or excluded under your plan. If there is a discrepancy between this Benefit Summary and your benefit booklet, the benefit booklet prevails.

Definitions shown on this site are in summary form and are for general informational purposes. The terms of the insurance contract prevails.

Summary of Benefits

Accidental Death and Dismemberment Benefit Summary

Group ID:	00428639	**Member Coverage Type:**	Non Contributory
Group Name:	TEBARCO DOOR & METAL SERVICES, INC.	**Class:**	0001 ALL ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 60 day(s)	**As of Date:**	08/23/2016

Coverage Information

Volume Amount	Flat $15,000
Guaranteed Issue	Your Accidental Death and Dismemberment coverage is guaranteed based on your Basic Life coverage.
Maximum Amount	$15,000
Cutbacks	35% at age 65 60% at age 70 75% at age 75 85% at age 80

Plan Information

When is my policy effective?	Coverage is effective after you satisfy any waiting period required by your employer. Coverage will not begin until Guardian has approved any amount subject to medical underwriting.
Do I have to answer medical questions as part of purchasing insurance?	No
Can I take the policy with me if I leave the company?	No

Accidental Death and Dismemberment and General Exclusions

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
Dependent coverage will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex (may vary by state).

The group policy or individual certificate cannot be contested after it, or any rider or amendment subsequently added to

it, has been in force for a period of two years.

If the age or any other relevant factor of the insured has been misstated, Guardian or its subsidiaries will use the true fact in determining whether insurance is in force under the terms of the certificate and in what amounts.

Dependent coverage will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex (may vary by state).

This Benefit Summary is for illustrative purposes. Your benefits booklet will show exactly what is covered and/or excluded under your plan. If there is a discrepancy between this Benefit Summary and your benefit booklet, the benefit booklet prevails.

Definitions shown on this site are in summary form and are for general informational purposes. The terms of the insurance contract prevails.

2016 Annual Health Plan Notices

- **Women's Health and Cancer Rights Act of 1998**

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema). Please call your plan administrator for more information.

- **The Genetic Information Nondiscrimination Act (GINA) of 2008**

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The new law prevents discrimination from health insurers and employers. The President signed the act into federal law on May 21, 2008. The parts of the law relating to health insurers will take effect by May 2009, and those relating to employers will take effect by November 2009.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

- **Newborn's Act Disclosure**

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

- **HIPAA Notice of Privacy Practices**

This rule required health plans to send participants an initial notice of privacy practices and then reminders must be given once every three years. This memo is a reminder that if you would like to see or obtain another copy of the health plan's HIPAA Privacy Notice, please contact your HR Administrator.

- **Michelle's Law**

NOTICE OF EXTENDED COVERAGE TO PARTICIPANTS COVERED UNDER A GROUP HEALTH PLAN

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.
The Plan currently permits an employee to continue a child's coverage if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.
There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child* means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- *Medically necessary leave of absence* means a leave of absence or any other change in enrollment:
    - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury
    - which is medically necessary
    - and which causes the dependent child to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).
If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence

- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student)

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

- **Patient Protection Model Disclosure**

Medical plans generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept new members. For children, a pediatrician can be selected as the primary care provider.

Important Notice from TEBARCO DOOR AND METAL SERVICES, 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 TEBARCO DOOR AND METAL SERVICES, 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. TEBARCO DOOR AND METAL SERVICES, INC. **has determined that the prescription drug coverage offered by the Group Health Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. 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 through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current TEBARCO DOOR AND METAL SERVICES, INC. coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current TEBARCO DOOR AND METAL SERVICES, 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 TEBARCO DOOR AND METAL SERVICES, 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 October to join.

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through TEBARCO DOOR AND METAL SERVICES, 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:	August 1, 2016
Name of Entity/Sender:	Tebarco Door and Metal Services, Inc.
Contact--Position/Office:	Deborah Harder/Office Manager
Address:	1905 Grassland Pkwy Alpharetta, GA 30004
Phone Number:	770-740-8500

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, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx 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**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: 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

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Deborah Harder/Office Manager.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Tebarco Door & Metal Services, Inc.		4. Employer Identification Number (EIN) 58-1768249
5. Employer address 1905 Grassland Pkwy		6. Employer phone number 770-740-8500
7. City Alpharetta	8. State GA	9. ZIP code 30004
10. Who can we contact about employee health coverage at this job? Deborah Harder/Office Manager		
11. Phone number (if different from above)	12. Email address debharder@tebarcodoor.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

[x] All employees. Eligible employees are:

Full-time employees who work a minimum of 30 hours per week

[ ] Some employees. Eligible employees are:

- With respect to dependents:

[x] We do offer coverage. Eligible dependents are:

*Legal spouses

*Children up to age 26 to include: natural born children, step children, legally adopted children; grandchildren if employee has court ordered power of attorney. Handicapped dependent children are also eligible beyond age 26

[ ] We do not offer coverage.

[x] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

TEBARCO

CBIZ Benefits & Insurance Services

Disclaimer: This benefit summary highlights key features of Tebarco Door & Metal Services, Inc. benefits program and does not include all plan rules and details. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this summary and the legal plan documents, the plan documents are the final authority. Tebarco Door & Metal Services, Inc. reserves the right to change or discontinue its benefit plans at any time without prior advance notice.