ABM®
Building Value

2016 Open Enrollment
Building Your ABM Benefits

Open Enrollment Is October 21 – November 4, 2015

Staff & Management

Richard Easley
Senior Director,
Benefits

Dear Colleague,

Open enrollment for 2016 benefits is from October 21 – November 4, 2015. This is an opportunity to review your benefit options and choose the coverage that best fits the needs of you and your family.

We have a diverse employee population, serving a wide variety of industries. We are pleased to offer benefits that provide choices to meet your specific needs and encourage you to consider those choices in the pages that follow.

This guide also provides information on online tools and programs that may be helpful as you manage your healthcare. You can also visit www.beneplace.com/abm which is an employee discount program where you may find savings on products and services such as health clubs, insurance and entertainment.

Benefits are an important part of your experience at ABM and we appreciate you taking the time to evaluate options.

Please review the enclosed materials carefully and enroll before the deadline. If you have questions, please contact the ABM Benefits Center at 888.351.4003.

Sincerely,

Table of Contents

ABM Benefits Center

Phone: 888.351.4003 ***VOIP: 112247***
Fax: 866.755.5398 ***Email: benefits@abm.com***

Hours are Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time

About This Guide

We understand choosing your benefits is an important decision for you and your family. Everyone's needs are unique. We offer a variety of benefits and options so you can choose what works best for you and your family. A number of these benefits are provided at no cost to you. We created this guide to help you make informed decisions. It is not a complete detailed description, nor is it a contract of employment or a guarantee of benefits. More detailed information for each benefit is contained in the relevant Summary Plan Description (SPD) or Evidence of Coverage, which are available by contacting the ABM Benefits Center.

Great care has been taken to ensure that this guide is accurate; however, oversights can occur or condensed summaries can be misinterpreted. If there is a difference between this overview and the SPD or official plan documents governing the plan, the plan documents will be followed. The company reserves the right to amend or terminate the program in whole or in part at any time.

Welcome to Open Enrollment 2016

Open enrollment for 2016 begins on Wednesday, October 21, 2015 and ends on Wednesday, November 4, 2015

Open enrollment is the time of year when you have the opportunity to review your benefit plan choices and contributions and make changes that best suit you and your family's needs.

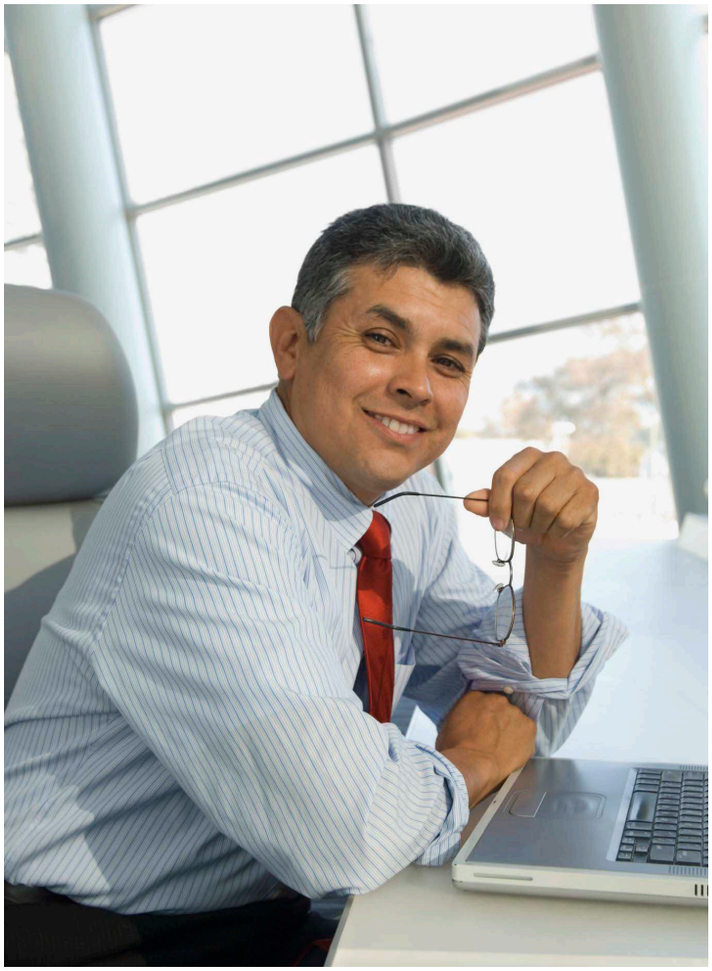
If you are currently enrolled in ABM sponsored coverage and you take no action during Open Enrollment, you will automatically have the same coverage as you had in 2015 with the exception of the Health Care Spending Account.

The Health Care Spending Account **must be selected each year in which you want to participate**.

If you are not currently enrolled in ABM sponsored coverage and you take no action, you will have no coverage in 2016.

Any changes you make during open enrollment will generally be effective January 1, 2016, and will stay in effect through December 31, 2016.

New enrollments in or increases to Voluntary Life insurance will become effective on the date your coverage is approved by MetLife, the insurance carrier.



Open Enrollment is from October 21 – November 4

What's New for 2016

United Healthcare Plans (UHC) Medical Plans

New Plan for 2016 - UHC Value Plan!

We are excited to introduce a new health care plan for 2016 - the Value plan. The Value plan is administered by UHC so you will continue to have access to the same doctors and quality care as the other UHC plans offer.

What makes the Value plan different is that it comes with an ABM-owned and funded Health Reimbursement Account (HRA) which helps you pay for covered health care services.

How Does the Value plan with the HRA Work?

Your HRA will pay first!

Your HRA will automatically pay for your share of all covered health care services first. You won't pay out of pocket as long as you have money in your HRA. That's less money you have to pay out of your pocket for covered services. And, the money you spend does not count as taxable income!

For most services under this plan, the plan pays 70% of the cost of services in-network after the deductible has been satisfied. The deductible is the amount you pay each year before the health plan begins to pay toward your covered expenses. You can use the HRA to pay a portion of your deductible.

For example, if you elect Employee Only coverage under this plan, the deductible is $2,500 in-network. If you visit an in-network doctor and your share of that visit is $120, that $120 will be paid by the HRA. In other words, you will have no out-of-pocket expense for the $120 expense you incurred. And, that $120 will count toward your deductible and calendar year out-of-pocket maximum.

If you spend all the money in the HRA, it will be your turn to pay. Once you reach the out-of-pocket calendar year maximum, you will be done paying; the plan will pay 100% of covered services for the remainder of the plan year.

You are encouraged to use in-network health care providers. When you use an in-network provider, you will usually pay less compared to seeing a provider who is out-of-network. As a reminder, preventive services received by in-network providers are covered at 100%.

Do I need to file claim forms?

No claim forms are needed if you visit in-network providers. Eligible expenses are automatically paid from the fund. If you use an out-of-network provider, you will need to file claim forms which are available at www.myuhc.com.

Will I Receive a Debit Card?

Yes. The debit card can be used for out-of-pocket in-network medical and pharmacy expenses that are covered under the plan as long as the amount you are purchasing matches your coverage. For example, if you are using the debit card for covered prescriptions you cannot use your debit card for other pharmacy items such as bandages and over-the-counter items. If a pharmacy charge is denied and you believe the prescription is covered under your plan, you may want to consider filing a claim form. Claim forms are available at myuhc.com.

The amount loaded to the debit card upon activation is the available funds for the year. As claims are paid, the amounts are deducted from the card balance. If all funds are exhausted, future card transactions will be denied for insufficient funds or no funds available.

The debit card is valid for 4 years if you continue to enroll in the HRA plan (regardless if existing funds have been exhausted). 45 days from the card expiration date, a new card with a new 4 year expiration date is automatically issued.

When can I start using the money?

The money is available to you on the first day of plan year.

Can I put money in the HRA?

No, you cannot contribute your own money to the HRA or take cash out of the HRA.

What's New for 2016 (cont'd)

If I change health plans mid-year, do I get to keep the money in the HRA?

The Value plan is the only ABM sponsored plan which has an HRA. If you move to another plan, you cannot keep the HRA money.

If I leave ABM, can I take the money with me?

No. You cannot take the HRA with you if you leave ABM. However, if you elect this plan under COBRA when you leave, your HRA will be available to you.

If there is money left in the HRA at the end of the Plan year (December 31, 2016), will I lose it?

Any unused amounts left in the account at the end of the plan year, will not be carried over into the next plan year.

If I have an HRA, can I still participate in the Flexible Spending Account (FSA)?

Yes you can. However, you cannot submit expenses to the FSA that were for covered health services paid by the HRA.

Other Plan Changes

UHC Plans - Virtual Office Visits*

Starting January 1, you will be able to take advantage of virtual office visits. A virtual office visit lets you see and talk to a doctor from your mobile device or computer without an appointment.

Doctors can write a prescription, if needed, that you can pick up at your local pharmacy. You can also schedule Virtual Visits by downloading the Health4Me app. Just download the free apps for the iPhone®, iPad®, or iPod touch®, from the App StoreSM, or for the Andriod™ from Google Play.

Doctors can diagnose and treat a wide range of non-emergency medical conditions such as bladder/urinary tract infections, colds, flu, pink eye, rashes and stomach problems. Virtual visits are not good for complex or chronic conditions, injuries requiring bandaging or sprains/broken bones.

(Apple, iPhone, iPad, and Ipad touch are trademarks of Apple, Inc., registered in the U.S. and other countries. App Store is a service mark of Apple, Inc. Android is a trademark of Google Inc.).

Log in to myuhc.com and choose from provider sites where you can register for a virtual visit. After registering and requesting a visit you will pay your portion of the service costs (according to your health plan) and then you will enter a virtual waiting room

**virtual office visits and prescription services are not available in Alaska, Arkansas and Louisiana.*

UHC Plans - Coinsurance, Deductibles, and Copays

The in-network deductible, copays and in- and out-of-network coinsurance is increasing for the UHC plans. Refer to the following medical plan charts for the specific amounts by UHC plan.

Kaiser - All regions (except Hawaii) & Group Health Cooperative (GHC)

The coinsurance, brand name drug cost and calendar year out-of-pocket maximum is increasing for the Kaiser and GHC plans. Refer to the following medical plan charts for the specific amounts by each plan.

Voluntary Life Insurance - Rate Reduction

The rates for Employee Voluntary Life have been reduced for most age brackets.

Health Care Reform - Questions & Answers

In March 2010, the Affordable Care Act (ACA) became federal law which initiated significant changes to healthcare in the United States. Countless articles appear in newspapers, magazines or are heard on the news which, at times, seem contradictory.

The Questions and Answers below are intended to provide some clarity relative to your 2016 healthcare options.

Q. What is Health Care Reform?

A. The Patient Protection and Affordable Care Act (PPACA), also known as Health Care Reform (HCR), or the Affordable Care Act (ACA), is a law that was enacted on March 23, 2010 in order to increase the number of insured Americans, lower costs, and improve health care quality.

Many HCR changes have already taken place while others are scheduled in the future.

Q. What are my healthcare options for 2016?

A. You will be able to select one of the following options for healthcare in 2016.

- Enroll in ABM's health care plan
- Enroll in your spouse's health care plan, if eligible
- If under age 26, enroll in your parent's health care plan, if eligible
- Waive ABM's coverage and enroll through the Health Insurance Marketplace
- Waive ABM's coverage and have no coverage; you may have to pay a penalty imposed by the Internal Revenue Service (IRS)

Q. What is the Health Insurance Marketplace?

A. The Health Insurance Marketplace ("Marketplace") is a new, simpler way to find, compare and enroll in health plans offered by private companies. The Marketplace will also administer Medicaid and the Children's Health Insurance Program (CHIP) and help you determine if you are eligible for financial assistance or special programs.

Some states have their own Marketplace while other states will participate in the federally-run Marketplace.

The annual open enrollment period for state and federally-run Marketplaces generally occurs in the fall.

Q. Why do I need to know about the Marketplace?

A. Most individuals are required to have health insurance or pay a penalty if they don't. The Marketplace is another avenue available to you to obtain coverage and comply with this requirement.

Q. What types of financial assistance or special programs are available?

A. Many states have increased Medicaid eligibility income limits to cover individuals under age 65 including people with disabilities.

Q. How can I save money on my health care coverage?

A. Depending on your income, you may be able to get free or low-cost coverage through Medicaid or CHIP.

Q. Can I purchase coverage on the Marketplace at any time?

A. No. You can only purchase coverage on the Marketplace during the Marketplace annual open enrollment period. For 2016, the annual open enrollment period for the Marketplace is expected to start on November 1, 2015.

However, if you experience a qualifying event, you may be eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include marriage, divorce and birth of a child.

✓ ***Contact your state-run or the federally run Marketplace (as applicable) before the end of your enrollment period to see if you qualify for a lower cost option.***

Your Benefits Open Enrollment "To Do" List

Review this booklet to help you make your benefits choices. Before you get started, you may want to review *A Refresher of Common Benefit Terms* on page 45.

If you want to change your medical plan and you or a family member is scheduled for surgery/other medical procedure, is pregnant or continuing treatment that started in 2015 and will continue into 2016, call the plan you are considering and ask how they will oversee the transition of your care.

- ☐ Review the *What's New for 2016* section of this book starting on page 3.
- ☐ Visit the carrier websites to look for a provider, hospital or to learn more about the coverage offered:
  - United Healthcare . . . . .www.welcometouhc.com
  - Kaiser . . . . . .my.kp.org/abm
  - Group Health Cooperative . . . . . www.ghc.org
  - MetLife Dental. . . . .www.metlife.com/mybenefits
  - Delta Dental . . . . . www.deltadentalins.com
  - VSP. . . . . www.vsp.com
  - WageWorks. . . . . www.wageworks.com
- ☐ Visit the Marketplace at www.healthcare.gov for other healthcare options available to you.
- ☐ Request Summary of Benefits and Coverage (SBC) from the ABM Benefits Center for other medical plans that may interest you.
- ☐ If you want to change, waive or enroll in medical, dental or vision, complete an Election Form.
- ☐ Decide if you want to enroll in the Health Care Flexible Spending Account (FSA). If you do, enroll online with WageWorks at www.wageworks.com (see page 25).
- ☐ Decide if you want to enroll in, change or waive Voluntary Life Insurance (see page 32). If you do, you must complete an Enrollment Change Form and a Statement of Health form.
- ☐ Decide if you want to enroll in, change or waive Voluntary Accidental Death & Dismemberment insurance (see page 32). If you do, you must complete an Enrollment Change Form.
- ☐ If you wish to add or remove eligible dependents from medical, dental or vision coverage, you must complete an Election Form.
- ☐ Complete a beneficiary form for Basic Life insurance.
- ☐ Return your completed and signed Election Form and any other applications or forms, **no later than November 4**, to ABM at:

ABM Benefits Center
via email or scan: benefits@abm.com
via fax: 866.755.5398
Or mail to the ABM Benefits Center address at:
8101 W. Sam Houston Parkway S.
Suite 150
Houston, TX 77072

If you mail your form(s) they must be postmarked on or before November 4, 2015.

✓ ***The PPOs are offered nationally. However, if you elect an HMO plan, double check that the plan you choose is offered in your area.***

✓ ***The Health Care FSA must be re-elected every Plan Year in which you wish to participate.***

✓ ***Choose carefully - Your elections will stay in effect through the end of the 2016 Plan Year (December 31, 2016).***

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Open Enrollment - The Basics

ABM is committed to making sure you fully understand the benefits and programs ABM offers.

We invite you to review the plan details outlined in this brochure carefully and encourage you to evaluate your choices by balancing the monthly contributions against your out-of-pocket expenses.

- The benefit elections you make now will stay in effect until the end of the 2016 Plan Year (December 31, 2016).

✓ ***Changes during the Plan Year will be permitted only if you have a qualifying event that affects your benefits coverage (see "How to Change or Cancel Coverage" on page 10) and you notify the ABM Benefits Center in a timely manner.***

- When you make your elections for medical, dental or vision coverage, you decide which eligible family members to cover under each plan.
- Your dependents may not enroll unless you are enrolled. Your dependents can only be enrolled in the benefits you enroll in yourself.

Below are things you should know about open enrollment:

- If you are not enrolled in 2015 and you do not complete an Election Form for 2016, you will have no coverage in 2016.
- The Health Care Flexible Spending Account (FSA) must be re-elected every Plan Year in which you wish to participate.

✓ ***Open enrollment Election Forms and any other applicable forms must be completed and received (or postmarked if mailed) by the ABM Benefits Center no later than November 4.***

Open Enrollment is from October 21 – November 4

Eligibility for Benefits

Who is Eligible

If you are a regular full-time Staff/Management employee of ABM or an affiliated participating company working at least 30 hours per week, you are eligible the for benefits described in this booklet. Staff/Management employees are accounting, administrative, clerical, management, professional or salaried sales employees of ABM.

Eligible Dependents

If you enroll in the plan, your eligible dependents may also be enrolled for coverage. Eligible dependents include your children and your legal spouse or domestic partner, as described below.

- Your legal spouse
- Your same sex domestic partner regardless of state of residence; your opposite sex domestic partner is eligible for coverage if you reside in the State of California
- Your children who are under age 26. Eligible children may include a biological child, stepchild, legally adopted child or a child placed for adoption, or a child for whom you or your legal spouse or domestic partner are the legal guardian
- Your unmarried child(ren) age 26 or older who is disabled (see “Coverage for a Disabled Child”)
- Your child(ren) who you are required to cover pursuant to a Qualified Medical Child Support Order (QMCSO)

Eligible dependents for Voluntary Life Insurance and Voluntary AD&D are described on the page where these plans are described.

When requested, you will need to provide documentation to confirm the eligibility of your dependents as follows:

- For all dependent children – Birth certificate (hospital record accepted for newborn)
- For a legal spouse – Marriage certificate or 1040 tax filing (first page only – please delete any confidential information)
- For a domestic partner – Proof of registration with a government authority or the ABM Domestic Partner Affidavit with supporting documentation
- For an adoption/legal guardianship – Court order

Social Security Numbers

Please note that federal law (Medicare Secondary Payer Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (42.U.S.C.1395y(b)(7)&(b)(8)) requires the Company to have Social Security numbers (SSNs) on file for many individuals enrolled in an ABM-sponsored medical plan. This includes, among others, individuals aged 45 or older as well as certain categories of individuals younger than age 45. By enrolling your Eligible Dependents in ABM-sponsored health care plans, you agree to provide their SSNs. If you fail to do so, your enrolled dependent(s) may be terminated from medical coverage. If your dependent’s correct SSN is missing, please contact the ABM Benefits Center at 888-351-4003 (open weekdays from 8:00 a.m. to 5:00 p.m. Central time), and provide the SSN in order to continue medical coverage for that dependent.

Duplication of Coverage

If both you and your legal spouse or domestic partner are employees of ABM, you may each enroll as an individual or one of you can elect employee plus one coverage or employee plus family coverage. If you elect coverage separately, you cannot cover each other as dependents and your eligible children may only be covered by one of you.

Providing False Information

Employees who submit false information intended to provide health care coverage (including dental and vision) for ineligible dependents, may be subject to discipline up to and including termination of coverage. Such employees will also be held financially responsible for all claims filed and will be required to reimburse ABM for any payments made on behalf of or for the benefit of any ineligible person claimed as a dependent.

Eligibility for Benefits

Who is Eligible (cont'd)

Coverage for a Disabled Child

If an unmarried enrolled dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;

Coverage will continue, as long as the enrolled dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

This request must be made within 31 days of the date your dependent would otherwise become ineligible for coverage.

✓ ***Call the ABM Benefits Center for more information, if you have additional questions about dependent eligibility or if you need to request a Certificate of Disabled Dependent form.***

Tax Implications of Coverage for Your Registered Domestic Partner or Children of Your Registered Domestic Partner

Federal Taxes

It is important to note that the value of the health care coverage provided for a registered domestic partner or any enrolled dependent children of a registered domestic partner is treated as income to you for federal tax purposes.

An exception to these income reporting and withholding rules applies if your registered domestic partner or children of your registered domestic partner are your tax dependents under Internal Revenue Code section 152, as amended by Code section 105(b).

Note: Many registered domestic partners do not qualify as tax dependents. However, if your enrolled, registered domestic partner, or his or her enrolled children are your tax dependents and you complete a Certification of Tax Dependency form, the value of the health care benefits will not be reported as taxable income. You must complete a new certification each year. If you don't receive a Certification of Tax Dependency form for the upcoming tax year, please call the ABM Benefits Center to request a form. Forms received after the last day of the year will not be processed until the first of the following month after receipt.

You are encouraged to consult a tax professional before claiming that your registered domestic partner and/or the children of your registered domestic partner qualify as your tax dependents.

How to Change or Cancel Coverage

Generally, you can only change your benefit choices during open enrollment. Open enrollment is typically held in the fall and changes take effect January 1. You cannot change your benefits during the year unless you have a Qualifying Life Event as defined by the IRS, such as:

- A change in status such as gain or loss of benefits by your legal spouse or domestic partner.
- A reduction or increase in your hours of employment, including a switch between part-time and full-time, or commencement or return from an unpaid leave of absence.
- A change in legal marital status, including marriage, death of legal spouse, divorce, legal separation, or termination of domestic partnership.
- A judgment, decree or order resulting from a divorce, legal separation, or change in legal custody (including a Qualified Medical Child Support Order) that requires health coverage for your child.
- Eligibility for Medicare, Medicaid or CHIP.

Review the rules on page 8 to determine dependent eligibility.

If you experience a qualifying life event and want to change your benefits, you MUST contact the ABM Benefits Center within 31 days of the date of the event and provide proof of the event in addition to completing a Qualifying Event Election Request form and a new Election Form. (These forms are available from the ABM Benefits Center.)

If the qualifying event is eligibility for Medicare, Medicaid or CHIP, you have 60 days from the date of the event to make the change. You must provide proof of the event in addition to completing a new Election Form.

If you decline enrollment for yourself or your dependents (including your legal spouse or domestic partner) because of other health insurance coverage and that coverage ends, you may be able to enroll yourself or your dependents in this plan outside of open enrollment. In order to exercise this option, you must request enrollment during the first 30 days after your other coverage ends.

Any new election based upon the qualifying life events noted in the previous column must be on account of and consistent with the change in status that affects eligibility for coverage under the plan.

For example, if one of your children covered under the Plan turns age 26 and is no longer eligible for coverage, you may drop him/her from coverage but you may not add your legal spouse or other children for whom you previously declined coverage. Nor can you decline coverage for any of your other covered dependents.

Ready to quit smoking? Contact your carrier's Member Services department to learn about smoking cessation programs. You'll breathe easier.

Evaluating Your Medical Plan Options

ABM provides a range of plans and premiums so you can make choices that balance cost against other factors that are important to you. As you consider your medical plan choices, you may wish to consider whether you're getting the best value and are enrolled in the plan that is best for you and your family. Unless you experience a Qualifying Life Event, the plan you choose now will remain in effect for the entire plan year.

To make an informed choice, it is important to carefully review each medical plan for which you are eligible. Your review should include the plan provisions (e.g., deductible, copays, coinsurance, hospital benefits, prescription drug benefits) and the amount you have to pay each month. See 2016 ABM National Monthly Contributions on page 42.

✓ ***Selecting a plan with a higher deductible means that your fixed monthly costs (the contribution you make from your paycheck) may be less but you may have to pay more when you receive care.***

Medical Plan Choices

ABM offers employees different types of medical plans which are described below.

UHC Plans

With these plans, you have the flexibility, at the time of service, to seek care from an In-Network or Out-of-Network provider. If you enroll in one of the UnitedHealthcare (UHC) plans, you will pay a copayment, coinsurance and/or deductible for covered In-Network services. You can choose to see any doctor (including specialists), pharmacy or hospital in UHC's national network, you do not need referrals and you do not need to choose a Primary Care Physician (some services, however, will be subject to pre-authorization). In fact, when you see an In-Network physician, you don't even have to worry about paperwork such as claim forms. UHC will take care of it for you.

If you choose to receive care outside of UHC's network, you will be subject to the deductible and coinsurance, and in some cases a copayment, before the carrier starts paying benefits. You may be required to submit claims paperwork when you receive Out-of-Network care.

Keep in mind there is no coverage for Out-of-Network pharmacy services - ensure you always use an In-Network pharmacy.

UHC Value Plan

– This plan is another UHC plan option which is a high deductible health plan that comes with a Health Reimbursement Account (HRA) funded by ABM. If you select this plan, the HRA will automatically pay for your share of covered services first. Once you have spent all the money in the HRA, it will be your turn to pay for your share of services. And, the HRA money you spend does not count as taxable income.

Kaiser Permanente HMO

– If you select the Kaiser Permanente plan, you must use Kaiser's exclusive network of providers to receive coverage. Kaiser is only available if you live in California, Colorado, Georgia, Mid-Atlantic States (Maryland, Virginia and Washington, D.C.) or the Northwest (Oregon and parts of Southeast Washington). Under these plans, there is no coverage out-of-network unless your event is a qualifying emergency. As a Kaiser member, you also don't have to worry about the administrative burden of filing claim forms.

Group Health Cooperative (GHC)

– This plan is only available if you live in certain parts of Washington state. If you enroll in GHC, you must select a Primary Care Physician (PCP). All care, except emergency services, must be coordinated through your selected primary care physician in order to receive the benefits. You can change your PCP by calling Member Services.

Health Insurance Marketplace

– Visit your state-run or the federally-run Marketplace (as applicable) to see if you qualify for a low cost or free option for healthcare coverage.

The Marketplace is an easy to use resource where you and your family may be eligible to purchase private insurance or enroll in public programs such as Medicaid or the Children's Health Insurance Program (CHIP) which are designed to make healthcare more affordable. You will be able to compare healthcare coverage options that best fit your needs and your budget.

Even if you are not eligible for financial assistance, visit the Marketplace to see if you qualify to purchase coverage on the Marketplace and if there is a lower cost option available. Note that while your payments through ABM are made on a pre-tax basis, your payments for coverage through the Marketplace are made on an after-tax basis.

Evaluating Your Medical Plan Options (cont.)

UnitedHealthcare
www.welcometouhc.com/ABM

As you consider your medical plan choices, we suggest you visit www.welcometouhc.com/ABM to learn more about the benefits offered by UHC. On this website, you can:

Click on "Find a Doctor/Hospital" to find a network doctor or determine if your doctor is in the network.

Click on "Tools and Resources" to find out what's included with your UnitedHealthcare plan. You'll get a preview of the tools and resources you'll have available after you enroll. This includes information on what you can do on myuhc.com (your personal member website), and an overview of the wellness resources available with your plan including a Health Risk Assessment, access to myNurseline® including online nurse chat feature, personal health support tools, virtual office visits and more.

Kaiser Permanente
my.kp.org/ABM

If you live in a Kaiser Permanente service area and are interested in learning more about Kaiser Permanente, you may visit Kaiser online at my.kp.org/ABM and:

Click on "Why KP" to learn more about the tools and resources that are available to help you stay healthy including award-winning wellness programs and online health resources.

Select your region (top right) and *click on "Support", then "Locate our services"* to search for nearby facilities and find a doctor.

Click on "Plans and services" to find a description of the benefits offered in your region.

Group Health Cooperative (GHC)
www.ghc.org

If you live in the State of Washington, check and see if you live in a Group Health Cooperative (GHC) service area. If you live in a GHC service area and are interested in learning more about GHC, visit them online at www.ghc.org.

Group Health Cooperative (GHC) *(cont.)*

On GHC's website, you can:

Click on "Provider & Facility Directory" (under Find a Doctor or Medical Facility) to search for GHC locations and doctors. Once you're a GHC member, you can change your primary care physician and find a doctor that's right for you.

Click on "SEARCH HEALTH TOPICS" to learn more about the wellness programs and online health resources that are available to help you stay healthy.

Health Insurance Marketplace
www.healthcare.gov

To learn more about your options through the Health Insurance Marketplace, visit www.healthcare.gov.

Click on "Learn", then "See your plans and prices" and answer a few short questions to see the specific plans and pricing available to you. Answering the questions is optional. If you do not answer the questions, you will still have full access to all content on www.healthcare.gov.

Medicare

If you continue working at ABM beyond age 65 and are covered by an ABM medical plan as an active employee, you are not required to sign up for Medicare. Any family member covered by your plan who becomes eligible for Medicare may also defer signing up for Medicare. When you leave ABM or if you or your covered dependent lose your active employer medical coverage, you must immediately enroll in Medicare.

COBRA is not considered active employer medical coverage. If you do not enroll immediately, Medicare may require you to pay a late enrollment penalty if you later enroll.

Medicare rules are complex. If you are thinking about turning down Medicare, you should call the Center for Medicare & Medicaid Services (CMS), the Federal Agency that runs the Medicare Program at 800-Medicare (800.633.4227).

Make the Most of Your Medical Benefits

There are many simple steps you can take to care for you and your family while saving time and money.

Preventive Care - Get an annual check-up. All ABM medical plans provide certain important preventive services without having to pay copays, coinsurance or deductibles if you use an in-network provider. Examples of preventive services include diabetes and cholesterol screening, routine immunizations and vaccinations, well baby care, counseling for smoking and alcohol abuse and more.

We encourage you to take advantage of preventive examinations. Talk to your doctor about preventive screenings that may be right for you. Your doctor may be able to detect early warning signs of more serious conditions and get started on treatment early.

Ask for generic medications. If your doctor prescribes a brand-name drug, ask if there is a generic equivalent. All drugs are regulated by the Food and Drug Administration. Generic drugs contain the same active ingredients as brand name and may cost you a lot less.

Use the mail order benefit. Are there prescriptions that you or your family members take every day? These are called "maintenance medications" and you can save yourself time and money by ordering them through the mail order program if your plan offers one.

✓ ***For most plans, mail order gives you a three-month supply of medicine for only two months of copayments —that's a 33% discount—plus the medicines are delivered to your door!***

Use an in-network pharmacy. Some medical plans do not provide any benefit if you use an out-of-network pharmacy.

Always carry your medical ID card with you. Take your ID card with you every time you visit the pharmacy or doctor to ensure you are receiving the maximum benefit.

Program the Member Services' phone number in your cell phone. If you have questions about a benefit or how much you will have to pay, call Member Services before your appointment.

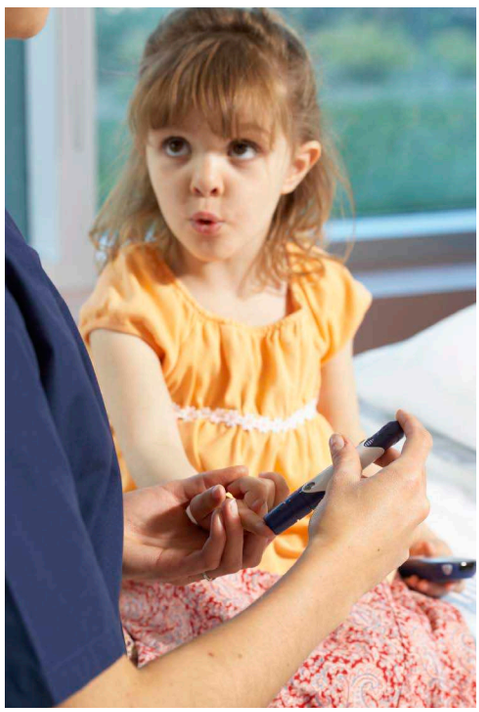
Be informed. Generally, you can estimate the cost of your treatment beforehand if you visit your carrier's website.

✓ ***Compare the cost of services. For example, based upon the Healthcare Blue Book, a colonoscopy can range anywhere from A low of $900 to a high of $4,900. That's a variance of 436%!***

Find the nearest Urgent Care center. If you need help after your doctor's office is closed, consider using Urgent Care instead of an emergency room. Urgent Care centers typically provide care on weekends and in the evenings. Using Urgent Care centers can save you time and money.

Of course, if you think you are having a medical emergency, call 911 or go to the nearest emergency room right away.

Schedule a Virtual Office Visit. If you participate in a UHC plan, you can save time by registering for a virtual visit. You can see and talk to a doctor from your mobile device or computer without an appointment. Simply log in to myuhc.com and choose from provider sites. After you register and pay your portion of the service costs, you will enter a virtual waiting room. You will be able to talk to a doctor about your symptoms and treatment options. Doctors can write a prescription, if needed, that you can pick up at your local pharmacy.



UnitedHealthcare Plans - At a Glance

	High Flexible Choice Plan		Comprehensive Value Plan		Thrifty Plan		Value Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Provisions								
Maximum lifetime benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Calendar year deductible (individual/family)	$550/$1,100	$1,000/$2,000	$1,250/$2,500	$2,500/$5,000	$1,750/$3,500	$3,000/$6,000	$2,500/$5,000	$6,250/$12,500
Calendar year out-of-pocket maximum – Medical (individual/family)	$2,850/$5,700	$10,000/$20,000	$4,000/$8,000	$12,500/$25,000	$4,600/$9,200	$15,000/$30,000	$6,500/$13,000	$16,250/$32,500
Calendar year out-of-pocket maximum – Prescription Drugs (individual/family)	$2,000/$4,000	Not Covered	$2,000/$4,000	Not Covered	$2,000/$4,000	Not Covered	N/A	N/A
Funding	N/A	N/A	N/A	N/A	N/A	N/A	$500/$1,000	$500/$1,000
Outpatient Services Copays	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay		
Office visit	$25, deductible does not apply	50%, after deductible	$30, deductible does not apply	50%, after deductible	$25 copay, deductible does not apply	50%, after deductible	30%, after deductible	50%, after deductible
Specialist	$45, deductible does not apply	50%, after deductible	$60, deductible does not apply	50%, after deductible	$45 copay, deductible does not apply	50%, after deductible	30%, after deductible	50%, after deductible
Routine physical – adults	No charge	50%, after deductible	No charge	50%, after deductible	No charge	50%, after deductible	30%, after deductible	50%, after deductible
Well baby visits/routine physicals – children	No charge	50%, after deductible	No charge	50%, after deductible	No charge	50%, after deductible	30%, after deductible	50%, after deductible
Office-based Diagnostic lab and X-rays (excludes MRI/ PET/CAT SCANS)	No charge	50%, after deductible	No charge	50%, after deductible	No charge	50%, after deductible	30%, after deductible	50%, after deductible
Outpatient surgery	$200 plus 20%, after deductible	$500 plus 50% after deductible	$200 plus 20%, after deductible	$500 plus 50%, after deductible	$200 plus 25%, after deductible	$500 plus 50%, after deductible	$200 plus 30%, after deductible	$500 plus 50%, after deductible
Urgent care	$25, deductible does not apply	50%, after deductible	$30, deductible does not apply	50%, after deductible	$25 copay, deductible does not apply	50%, after deductible	30%, after deductible	50%, after deductible
Hospital Services	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay		
Emergency room (waived if admitted)	$200 plus 20%, after deductible	$200 plus 20%, after deductible	$200 plus 20%, after deductible	$200 plus 20%, after deductible	$200 plus 25%, after deductible	$200 plus 25%, after deductible	$200 plus 30%, after deductible	$200 plus 30%, after deductible
Inpatient hospital	$250 minimum / $500 maximum per visit plus 20% after deductible	50%, after deductible	$250 minimum / $500 maximum per visit plus 20% after deductible	50%, after deductible	$250 minimum / $500 maximum per visit plus 25% after deductible	50%, after deductible	$250 minimum / $500 maximum per visit plus 30% after deductible	50%, after deductible
Mental Health and Substance Abuse	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay		
Outpatient services	$25 copay, deductible does not apply	50%, after deductible	$30 copay, deductible does not apply	50%, after deductible	$25 copay, deductible does not apply	50%, after deductible	30%, after deductible	50%, after deductible
Inpatient hospital	$250 minimum / $500 maximum per visit plus 20% after deductible	50%, after deductible	$250 minimum / $500 maximum per visit plus 20% after deductible	50%, after deductible	$250 minimum / $500 maximum per visit plus 25% after deductible	50%, after deductible	$250 minimum / $500 maximum per visit plus 30% after deductible	50%, after deductible
Prescription Drugs	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay		
Retail – up to a 30 day supply	Generic - $15 Brand Formulary - 40% coinsurance, $45 minimum/$90 maximum Brand Non-Formulary - 50% coinsurance, $70 minimum/$140 maximum Deductible does not apply	Not covered	Generic - $15 Brand Formulary - 40% coinsurance, $45 minimum/$90 maximum Brand Non-Formulary - 50% coinsurance, $70 minimum/$140 maximum Deductible does not apply	Not covered	Generic - $15 Brand Formulary - 40% coinsurance, $45 minimum/$90 maximum Brand Non-Formulary - 50% coinsurance, $70 minimum/$140 maximum Deductible does not apply	Not covered	Generic - $15 Brand Formulary - 40% coinsurance, $45 minimum/$90 maximum Brand Non-Formulary - 50% coinsurance, $70 minimum/$140 maximum Deductible does not apply	Not covered
Home Delivery – up to a 90 day supply	Generic - $30 Brand Formulary - 40% coinsurance, $90 minimum/$180 maximum Brand Non-Formulary - 50% coinsurance, $140 minimum/$280 maximum Deductible does not apply	Not covered	Generic - $30 Brand Formulary - 40% coinsurance, $90 minimum/$180 maximum Brand Non-Formulary - 50% coinsurance, $140 minimum/$280 maximum Deductible does not apply	Not covered	Generic - $30 Brand Formulary - 40% coinsurance, $90 minimum/$180 maximum Brand Non-Formulary - 50% coinsurance, $140 minimum/$280 maximum Deductible does not apply	Not covered	Generic - $30 Brand Formulary - 40% coinsurance, $90 minimum/$180 maximum Brand Non-Formulary - 50% coinsurance, $140 minimum/$280 maximum Deductible does not apply	Not covered

UHC High Flexible Choice Plan — Summary

Not available in Hawaii

If you choose this plan, you may see any provider you wish. Before UHC starts paying for services, you must pay the deductible unless otherwise noted. After you satisfy the deductible, you have to pay a percentage of the cost for hospitalization or other services, until you reach the calendar year out-of-pocket maximum. Some covered services require a copay in addition to a percentage of the cost of services.

	In-Network	Out-of-Network
General Plan Provisions		
Maximum lifetime benefit	Unlimited	Unlimited
Calendar year deductible (individual/family)	$550/$1,100	$1,000/$2,000
Calendar year out-of-pocket maximum – Medical (individual/family)	$2,850/$5,700	$10,000/$20,000
Calendar year out-of-pocket maximum – Prescription Drugs (individual/family)	$2,000/$4,000	Not Covered
Funding	Not Applicable	Not Applicable
Outpatient Services Copays	You Pay	You Pay
Office visit	$25, deductible does not apply	50%, after deductible
Specialist	$45, deductible does not apply	50%, after deductible
Routine physical – adults	No charge	50%, after deductible
Well baby visits/routine physicals – children	No charge	50%, after deductible
Office-based diagnostic lab and X-rays (excludes MRI/PET/CAT scans)	No charge	50%, after deductible
Outpatient surgery	$200 plus 20%, after deductible	$500 plus 50%, after deductible
Urgent care	$25, deductible does not apply	50%, after deductible
Hospital Services	You Pay	You Pay
Emergency room (waived if admitted)	$200 plus 20%, after deductible	$200 plus 20%, after deductible
Inpatient hospital	$250 minimum / $500 maximum per visit plus 20% after deductible	50%, after deductible
Mental Health and Substance Abuse	You Pay	You Pay
Outpatient services copays	$25, deductible does not apply	50%, after deductible
Inpatient hospital	$250 minimum / $500 maximum per visit plus 20% after deductible	50%, after deductible
Prescription Drugs	You Pay	You Pay
Retail – up to a 30 day supply	Generic - $15 Brand Formulary - 40% coinsurance, $45 minimum/$90 maximum Brand Non-Formulary - 50% coinsurance, $70 minimum/$140 maximum Deductible does not apply	Not covered
Home Delivery – up to a 90 day supply	Generic - $30 Brand Formulary - 40% coinsurance, $90 minimum/$180 maximum Brand Non-Formulary - 50% coinsurance, $140 minimum/$280 maximum Deductible does not apply	Not covered

For more information about this plan, call UHC Member Services at 855.ABM.3456 or, if enrolled, visit myuhc.com.

UHC Comprehensive Value Plan — Summary

Not available in Hawaii

If you choose this plan, you may see any provider you wish. Before UHC starts paying for services, you must pay the deductible unless otherwise noted. After you satisfy the deductible, you have to pay a percentage of the cost for hospitalization or other services, until you reach the calendar year out-of-pocket maximum. Some covered services require a copay in addition to a percentage of the cost of services.

	In-Network	Out-of-Network
General Plan Provisions		
Maximum lifetime benefit	Unlimited	Unlimited
Calendar year deductible (individual/family)	$1,250/$2,500	$2,500/$5,000
Calendar year out-of-pocket maximum – Medical (individual/family)	$4,000/$8,000	$12,500/$25,000
Calendar year out-of-pocket maximum – Prescription Drugs (individual/family)	$2,000/$4,000	Not Covered
Funding	Not Applicable	Not Applicable
Outpatient Services Copays	You Pay	You Pay
Office visit	$30, deductible does not apply	50%, after deductible
Specialist	$60, deductible does not apply	50%, after deductible
Routine physical – adults	No charge	50%, after deductible
Well baby visits/routine physicals – children	No charge	50%, after deductible
Office-based diagnostic lab and X-rays (excludes MRI/PET/CAT scans)	No charge	50%, after deductible
Outpatient surgery	$200 plus 20%, after deductible	$500 plus 50%, after deductible
Urgent care	$30, deductible does not apply	50%, after deductible
Hospital Services	You Pay	You Pay
Emergency room (waived if admitted)	$200 plus 20%, after deductible	$200 plus 20%, after deductible
Inpatient hospital	$250 minimum / $500 maximum per visit plus 20% after deductible	50%, after deductible
Mental Health and Substance Abuse	You Pay	You Pay
Outpatient services copays	$30, deductible does not apply	50%, after deductible
Inpatient hospital	$250 minimum / $500 maximum per visit plus 20% after deductible	50%, after deductible
Prescription Drugs	You Pay	You Pay
Retail – up to a 30 day supply	Generic - $15 Brand Formulary - 40% coinsurance, $45 minimum/$90 maximum Brand Non-Formulary - 50% coinsurance, $70 minimum/$140 maximum Deductible does not apply	Not covered
Home Delivery – up to a 90 day supply	Generic - $30 Brand Formulary - 40% coinsurance, $90 minimum/$180 maximum Brand Non-Formulary - 50% coinsurance, $140 minimum/$280 maximum Deductible does not apply	Not covered

For more information about this plan, call UHC Member Services at 855.ABM.3456 or, if enrolled, visit myuhc.com.

UHC Thrifty Plan — Summary

Not available in Hawaii

If you choose this plan, you may see any provider you wish. Before UHC starts paying for services, you must pay the deductible unless otherwise noted. After you satisfy the deductible, you have to pay a percentage of the cost for hospitalization or other services, until you reach the calendar year out-of-pocket maximum. Some covered services require a copay in addition to a percentage of the cost of services.

	In-Network	Out-of-Network
General Plan Provisions		
Maximum lifetime benefit	Unlimited	Unlimited
Calendar year deductible (individual/family)	$1,750/$3,500	$3,000/$6,000
Calendar year out-of-pocket maximum – Medical (individual/family)	$4,600/$9,200	$15,000/$30,000
Calendar year out-of-pocket maximum – Prescription Drugs (individual/family)	$2,000/$4,000	Not Covered
Funding	Not Applicable	Not Applicable
Outpatient Services Copays	You Pay	You Pay
Office visit	$25; deductible does not apply	50%, after deductible
Specialist	$45; deductible does not apply	50%, after deductible
Routine physical – adults	No charge	50%, after deductible
Well baby visits/routine physicals – children	No charge	50%, after deductible
Office-based diagnostic lab and X-rays (excludes MRI/PET/CAT scans)	No charge	50%, after deductible
Outpatient surgery	$200 plus 25%, after deductible	$500 plus 50%, after deductible
Urgent care	$25; deductible does not apply	50%, after deductible
Hospital Services	You Pay	You Pay
Emergency room (waived if admitted)	$200 plus 25%, after deductible	$200 plus 25%, after deductible
Inpatient hospital	$250 minimum / $500 maximum per visit plus 25% after deductible	50%, after deductible
Mental Health and Substance Abuse	You Pay	You Pay
Outpatient services copays	$25; deductible does not apply	50%, after deductible
Inpatient hospital	$250 minimum / $500 maximum per visit plus 25% after deductible	50%, after deductible
Prescription Drugs	You Pay	You Pay
Retail – up to a 30 day supply	Generic - $15 Brand Formulary - 40% coinsurance, $45 minimum/$90 maximum Brand Non-Formulary - 50% coinsurance, $70 minimum/$140 maximum Deductible does not apply	Not covered
Home Delivery – up to a 90 day supply	Generic - $30 Brand Formulary - 40% coinsurance, $90 minimum/$180 maximum Brand Non-Formulary - 50% coinsurance, $140 minimum/$280 maximum Deductible does not apply	Not covered

For more information about this plan, call UHC Member Services at 855.ABM.3456 or, if enrolled, visit myuhc.com.

UHC Value Plan

Not available in Hawaii

If you choose this plan, you may see any provider you wish. Since this plan comes with a Health Reimbursement Account (HRA), your HRA will pay for covered services first. You won't pay out-of-pocket for in-network covered services as long as you have money in your HRA. If you have spent all the money in your HRA, you must pay the remainder of your deductible (unless otherwise noted) before UHC starts paying for services. After you satisfy the deductible, you have to pay a percentage of the cost for hospitalization or other services, until you reach the calendar year out-of-pocket maximum. Some covered services require a copay in addition to a percentage of the cost of services.

	In-Network	Out-of-Network
General Plan Provisions		
Maximum lifetime benefit	Unlimited	Unlimited
Calendar year deductible (individual/family)	$2,500/$5,000	$6,250/$2,500
Calendar year out-of-pocket maximum – Medical (individual/family)	$6,500/$13,000	$16,250/$32,500
Funding	$500/$1,000	$500/$1,000
Outpatient Services Copays	You Pay	You Pay
Office visit	30%, after deductible	50%, after deductible
Specialist	30%, after deductible	50%, after deductible
Routine physical – adults	No charge	50%, after deductible
Well baby visits/routine physicals – children	No charge	50%, after deductible
Office-based diagnostic lab and X-rays (excludes MRI/PET/CAT scans)	No charge	50%, after deductible
Outpatient surgery	$200 plus 30%, after deductible	$500 plus 50%, after deductible
Urgent care	30%, after deductible	50%, after deductible
Hospital Services	You Pay	You Pay
Emergency room (waived if admitted)	$200 plus 30%, after deductible	$200 plus 30%, after deductible
Inpatient hospital	$250 minimum / $500 maximum per visit plus 30% after deductible	50%, after deductible
Mental Health and Substance Abuse	You Pay	You Pay
Outpatient services	30%, after deductible	50%, after deductible
Inpatient hospital	$250 minimum / $500 maximum per visit plus 30% after deductible	50%, after deductible
Prescription Drugs	You Pay	You Pay
Retail – up to a 30 day supply	Generic - $15 Brand Formulary - 40% coinsurance, $45 minimum/$90 maximum Brand Non-Formulary - 50% coinsurance, $70 minimum/$140 maximum Deductible does not apply	Not covered
Home Delivery – up to a 90 day supply	Generic - $30 Brand Formulary - 40% coinsurance, $90 minimum/$180 maximum Brand Non-Formulary - 50% coinsurance, $140 minimum/$280 maximum Deductible does not apply	Not covered

For more information about this plan, call UHC Member Services at 855.ABM.3456 or, if enrolled, visit myuhc.com.

Kaiser Permanente HMO Plans — Summary

For California and Colorado

If you select a Kaiser Permanente plan, you must use Kaiser Permanente Network providers to receive coverage. Under these plans, you will pay the full cost if you go to a non-Kaiser provider; there is no out-of-network coverage unless your event is a qualifying emergency.

	California	Colorado
General Plan Provisions		
Maximum lifetime benefit	Unlimited	Unlimited
Calendar year deductible (individual/family)	$100/$200	$100/$200
Calendar year out-of-pocket maximum (individual/family)	$4,000/$8,000	$4,000/$8,000
Funding	Not Applicable	Not Applicable
Outpatient Services Copays	You Pay	You Pay
Office visit	$25	$25
Specialist	$50	$50
Routine physical – adults	No charge	No charge
Well baby visits/routine physicals – children	No charge	No charge
Diagnostic lab and X-rays	No charge (includes MRI/PET/Cat Scans)	No charge (excludes MRI/PET/Cat Scans)
Outpatient surgery	20%, after deductible	20%, after deductible
Urgent care	$25	$50
Hospital Services	You Pay	You Pay
Emergency room	20%, after deductible	20%, after deductible
Inpatient hospital	20%, after deductible	20%, after deductible
Mental Health and Substance Abuse	You Pay	You Pay
Outpatient services copays	$25 for private sessions $12 for group mental health sessions $5 for group substance abuse sessions	$25 for private sessions $12 for group sessions
Inpatient hospital	20%, after deductible	20%, after deductible
Prescription Drugs	You Pay	You Pay
Retail	Up to a 30-day supply Generic - $10 Brand - $30	Up to a 30-day supply Generic - $10 Brand - $30
Mail order	Up to a 100-day supply Generic - $20 Brand - $60	Up to a 90-day supply Generic - $20 Brand - $60

For more information about these plans, call Kaiser Permanente Member Services:
800.464.4000 for California
303.338.3800 for Denver/Boulder or 888.681.7878 for Colorado Springs
Or, my.kp.org/ABM

Kaiser Permanente HMO Plans — Summary

For Georgia and Mid-Atlantic States (Maryland, Virginia & Washington, DC)

If you select a Kaiser Permanente plan, you must use Kaiser Permanente Network providers to receive coverage. Under these plans, you will pay the full cost if you go to a non-Kaiser provider; there is no out-of-network coverage unless your event is a qualifying emergency.

	Georgia	Mid-Atlantic States
General Plan Provisions		
Maximum lifetime benefit	Unlimited	Unlimited
Calendar year deductible (individual/family)	$100/$200	$100/$200
Calendar year out-of-pocket maximum (individual/family)	$4,000/$8,000	$4,000/$8,000
Funding	Not Applicable	Not Applicable
Outpatient Services Copays	You Pay	You Pay
Office visit	$25	$25
Specialist	$50	$50
Routine physical – adults	No charge	No charge
Well baby visits/routine physicals – children	No charge	No charge
Diagnostic lab and X-rays (excludes MRI/PET/CAT scans)	No charge	No charge
Outpatient surgery	20%, after deductible	20%, after deductible
Urgent care	$50	$50
Hospital Services	You Pay	You Pay
Emergency room	20%, after deductible	20%, after deductible
Inpatient hospital	20%, after deductible	20%, after deductible
Mental Health and Substance Abuse	You Pay	You Pay
Outpatient services copays	$25 for private sessions and group substance abuse sessions $12 for group mental health sessions	$25 for private sessions $12 for group sessions
Inpatient hospital	20%, after deductible	20%, after deductible
Prescription Drugs	You Pay	You Pay
Retail – up to a 30-day supply	Kaiser Pharmacy Generic - $10 Brand - $30	Kaiser Pharmacy Generic - $10 Brand - $30
Mail order – up to a 90-day supply	Kaiser Pharmacy Generic - $20 Brand - $60	Kaiser Pharmacy Generic - you pay $20 Brand - you pay $60

For more information about these plans, call Kaiser Permanente Member Services:
404.261.2590 for the Atlanta metro area; 800.611.1811 for outside the Atlanta metro area
301.468.6000 for the DC metro area; 800.777.7902 for outside the DC metro area
800.777.7902 for other Mid-Atlantic state areas
Or visit my.kp.org/ABM

Kaiser Permanente HMO Plans — Summary

For Northwest (Oregon, parts of southeast Washington)

If you select a Kaiser Permanente plan, you must use Kaiser Permanente Network providers to receive coverage. Under these plans, you will pay the full cost if you go to a non-Kaiser provider; there is no out-of-network coverage unless your event is a qualifying emergency.

	Northwest (Oregon & parts of southeast Washington)
General Plan Provisions	
Maximum lifetime benefit	Unlimited
Calendar year deductible (individual/family)	$100/$200
Calendar year out-of-pocket maximum (individual/family)	$4,000/$8,000
Funding	Not Applicable
Outpatient Services Copays	**You Pay**
Office visit	$25
Specialist	$50
Routine physical – adults	No charge
Well baby visits/routine physicals – children	No charge
Diagnostic lab and X-rays (excludes MRI/PET/CAT scans)	No charge
Outpatient surgery	20%, after deductible
Urgent care	$50
Hospital Services	**You Pay**
Emergency room	20%, after deductible
Inpatient hospital	20%, after deductible
Mental Health and Substance Abuse	**You Pay**
Outpatient services copays	$25 for private sessions $12 for group sessions
Inpatient hospital	20%, after deductible
Prescription Drugs	**You Pay**
Retail	Up to a 30-day supply Generic - $10 Brand - $30
Mail order	Up to a 90-day supply Generic - $20 Brand - $60

For more information about these plans, call Kaiser Permanente Member Services:
503.813.2000 for Portland, OR
800.813.2000 for other Northwest areas
Or visit my.kp.org/ABM

Group Health Cooperative HMO Plan (GHC or Group Health) — Summary

For Washington

If you choose Group Health, you must use a provider in the Group Health network to receive benefits. You will pay the full cost if you do not go to a Group Health provider; there is no out-of-network coverage (unless the situation is a qualifying emergency).

	Group Health Cooperative
General Plan Provisions	
Maximum lifetime benefit	Unlimited
Calendar year deductible (individual/family)	$100/$200
Calendar year out-of-pocket maximum (individual/family)	$4,000/$8,000
Funding	Not Applicable
Outpatient Services Copays	**You Pay**
Office visit	$25
Specialist	$25
Routine physical – adults	No charge
Well baby visits/routine physicals – children	No charge
Diagnostic lab and X-rays	20% after deductible
Outpatient surgery	$25 copay, then 20% coinsurance after deductible
Urgent care	$25
Hospital Services	**You Pay**
Emergency room (waived if admitted)	$150 copay, then 20% after deductible
Inpatient hospital	20% after deductible
Mental Health and Substance Abuse	**You Pay**
Outpatient services copays	$25
Inpatient hospital	20% after deductible
Prescription Drugs	**You Pay**
Retail – up to a 30-day supply	Generic - $10 Brand - $30
Mail order – up to a 90-day supply	Generic - $20 Brand - $60

For more information about this plan, call Group Health Cooperative Member Services at 888.901.4636.

Dental Plans

ABM offers employees three dental plans, depending on where you live.

You can find out how a dental procedure will be covered in advance. Ask your provider for a pre-determination of benefits to find out how the procedure will be covered and how much it will cost you.

MetLife Dental PPO Plan

With the MetLife plan you can receive care from any provider; however, you will receive a higher level of benefit if you stay in-network. Even though the reimbursement percentages are the same for in and out-of-network services, out-of-network providers do not agree to discounted fees which can make out-of-network usage more expensive. Out-of-network charges are subject to Reasonable and Customary charges (see *A Refresher of Common Benefit Terms* on page 45). Download the free apps from the App Store℠ (or Google Play for Android™) by searching MetLife.

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Routine dental exams and regular cleanings may help prevent your need for more serious and higher cost dental treatments in the future.

A visit to your dentist for a routine cleaning can also identify larger health issues such as heart disease, diabetes and lung disease.

MetLife and DeltaCare provide ID cards; however, you do not need a dental ID card to receive services. When you call to make an appointment, simply tell your dental provider the name of your dental plan and the ABM group number (see *Contacting Your Carriers* on page 40).

Delta Dental DeltaCare USA

Generally, you will pay less if you enroll in this HMO dental plan. However, you and your family members must select a participating contracted Dental Provider or Dental Office. The network of HMO dentists in your area may be limited. Call your dental provider to make sure she/he is part of the DeltaCare USA DHMO network before you enroll. You may change your dentist to another participating contracted dentist by calling Member Services at 800.422.4234.

The DeltaCare HMO is available in:

- Arizona
- California
- Florida
- Georgia
- Illinois
- Maryland
- Nevada
- New York
- Ohio
- Pennsylvania
- Texas
- Utah
- Washington, D.C.

Plan Design	MetLife Premium PPO	MetLife PPO	DeltaCare HMO
General Plan Provisions			
Calendar year dental maximum	$3,000 per person	$2,000 per person	No annual maximum
Calendar year deductible (individual/family)	$25/$75	$50/$150	No annual deductible
Covered Services	**You Pay**	**You Pay**	**You Pay**
Preventive Includes: exams, teeth cleaning and x-rays	No charge for 2 cleanings; deductible does not apply Out-of-Network: Subject to Reasonable & Customary	No charge for 2 cleanings; deductible does not apply Out-of-Network: Subject to Reasonable & Customary	No charge
Basic Includes: fillings, extractions, endodontics, periodontics, oral surgery	30% of contracted rate after deductible	30% of contracted rate after deductible	You pay approximately 20%
Major Includes: crowns, inlays, onlays, bridges, dentures, and restorations	50% of contracted rate after deductible	50% of contracted rate after deductible	You pay approximately 40%
Orthodontia Available to children and adults	50% of contracted rate after deductible	50% of contracted rate after deductible	Set copays apply; refer to DeltaCare's Schedule of Benefits
Lifetime orthodontia maximum*	$2,500	$1,500	No lifetime MetLife maximum

*The Orthodontia lifetime benefit maximum is based on enrollment at time of appliance banding; only one benefit is payable for both plans (MetLife Premium PPO and MetLife PPO).

Vision Plan

Vision Service Plan (VSP) provides ABM's vision benefit. You may see any doctor you wish. However your out-of-pocket costs will be lower if you use an In-Network provider in the VSP Choice Network.

✓ ***You will not receive an ID card from VSP. Your vision provider will use your social security number to verify eligibility for you and your dependents.***

In addition to the benefits described below, you have access to a number of discounts through VSP including:

- 20-25% savings on lens coatings
- If you buy frames that cost more than the maximum $200 frame allowance, you will receive 20% off the additional cost
- 20% off additional prescription glasses or prescription sunglasses if purchased within the same calendar year as your regular glasses
- Savings on laser vision correction
- If you have had laser vision surgery, you can use your $200 frame allowance to buy non-prescription sunglasses from a VSP provider

Plan Design	Vision Service Plan (VSP)	
	In-Network	Out-of-Network*
Copay for eye exam (one exam every calendar year)		
	$25 copay	$45 maximum benefit
Copay for prescription glasses (one copay every calendar year)		
	$25 copay	See below
Eyeglass Lenses (one pair every calendar year)		
Single vision	Covered in full	$30 maximum benefit
Lined bifocal	Covered in full	$50 maximum benefit
Lined trifocal	Covered in full	$65 maximum benefit
Progressive	Covered in full	$50 maximum benefit
Eyeglass Frames (one pair every other calendar year)		
	$200 maximum benefit Copay included in prescription glasses copay (above);	$70 maximum benefit
Contact Lenses (in lieu of glasses) (one order every calendar year)		
Medically Necessary	$25 copay	$210 maximum benefit
Elective	$150 allowance for contacts	$105 maximum benefit
Contact Lens Fitting and Evaluation	Up to $60	No benefit

*Plan pays maximum Out-of-Network benefits after deduction of copay, if applicable, from total charges.

Routine eye exams can identify serious medical problems, like constricted arteries, much earlier than medical exams. Even if you think your vision is fine, take advantage of the annual eye exam benefit.

Health Care Flexible Spending Account

Flexible Spending Accounts (FSA) allow you to pay for health care goods and services you use with money deducted from your paycheck before it is taxed. This can reduce your eligible health care expenses by as much as 30%. This plan is administered by WageWorks.

Expenses incurred by domestic partners and their children do not qualify as eligible expenses under the Health Care FSA.

ABM's FSA benefit includes a 10-week grace period. Including the grace period, you can use your 2016 contributions to reimburse expenses made between your eligibility date and March 15, 2017.

$2,550 Annual Limit*

You are allowed to pay for qualifying out-of-pocket health care expenses for you and your dependents. The amount you choose to contribute will be deducted from your pay in equal installments throughout the year. You cannot change your annual contribution amount unless you have a Qualifying Life Event.

You must make an election for each year in which you wish to participate in the FSA. The minimum/maximum you can contribute is:

- Minimum annual contribution: $300
- Maximum annual contribution: $2,550

Plan carefully when determining how much to contribute. The IRS has imposed a "use it or lose it" rule.

Eligible expenses for services rendered during the plan year and grace period (your eligibility date - March 15, 2017) must be submitted for reimbursement by June 15, 2017. Any amount remaining in your health care account at the end of that period will be forfeited, as required by law.

Using Your Debit Card**

For your convenience, WageWorks, our FSA administrator, provides debit cards that can be used to purchase eligible health care goods and services.

If you use your debit card at a health care provider or at a pharmacy that does not have an IRS approved inventory system, WageWorks will likely require that you submit a receipt or your explanation of benefits (EOB) to verify that the transaction was for eligible health care goods or services.

You have 90 days from the date of the transaction to take care of any outstanding, unverified purchases. If you do not take action within 90 days:

1. The amount of the outstanding unverified card transactions may be deducted from your next claim submission.
2. Your card may be suspended. If your card is suspended, it will be reactivated 48 to 72 hours after approved receipts or repayments have been processed for the unverified card transactions.

Eligible Over-the-Counter (OTC) Items

Many OTC drugs and medicines are not eligible for reimbursement through the FSA unless accompanied by a doctor's prescription. This limitation is on drugs and medicines only, and does not apply to items such as bandages and contact lens solution, which are still eligible without a doctor's prescription.

For those expenses that do not require a doctor's prescription, your card transaction will, most likely, be automatically verified at checkout, which means you will not have to submit a receipt to WageWorks after the transaction. You are, however, required to keep each receipt for tax purposes in the event it is needed for verification.

**As of the printing of this booklet, the Federal government had yet to release the maximum allowable pre-tax benefit for 2016. Once this information is released, it will be available on the WageWorks website or you can call the ABM Benefits Center at 888.351.4003,*

***The FSA account and debit card are regulated by the IRS and certain rules apply.*

Enroll online at: www.wageworks.com or call 877.WAGEWORKS (877.924.3967).

Employee Assistance Program
Staff & Management Employees

Life can be challenging and pull you in many directions. Your overall well-being and happiness depend on balancing your life at home and your life at work. Successfully managing these challenges is important to your overall health and wellness.

ABM encourages you and your family to ease the stress of challenging situations by contacting the Employee Assistance Program (EAP).

The EAP can help you address a wide range of work and personal issues. You and your covered dependents have unlimited phone access to EAP counselors and up to three face-to-face sessions per issue per year. Discounted rates are available if additional sessions are necessary.

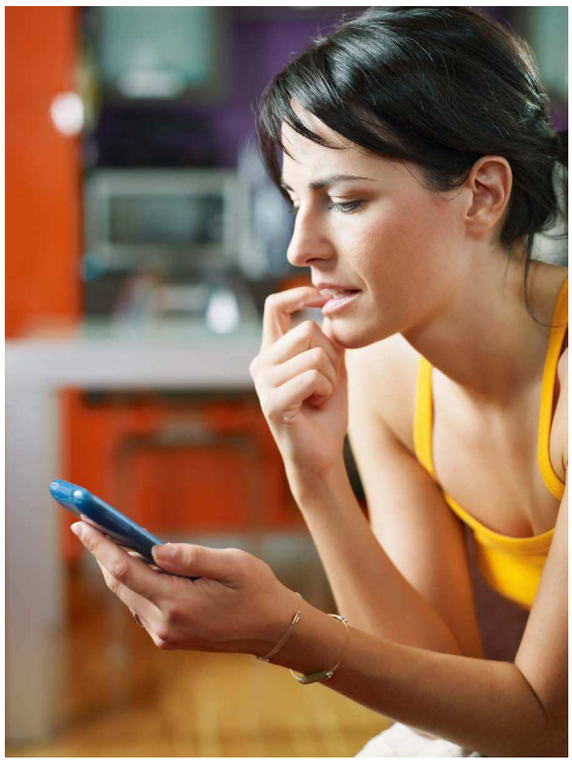
You don't need to enroll to use the EAP — you are automatically enrolled. Use of the EAP is 100% confidential and voluntary.

The EAP can help with many of life's issues including:

- Marriage, family and relationship issues
- Addiction and recovery
- Emotional, personal and stress-related concerns
- Grief counseling
- Legal matters
- Financial and credit problems
- Worksite issues
- Child care or elder care concerns
- Pre-retirement planning

✓ ***Call Bensinger, Dupont and Associates, our EAP administrator, at 800.272.2727, anytime day or night, every day of the year, to speak with an EAP counselor.***

You can also log in to the EAP website at www.bdaeap.com (password: abmeap).



Building Better Health in 2016
UnitedHealthcare Wellness Resources

Learn how to live healthier by visiting UnitedHealthcare's website at www.myuhc.com. As a member, you can use the fun and free online tools to start a health program for your unique needs or learn about health topics, take a health quiz, get healthy recipes and more. You may also take a Health Risk Assessment and receive personalized/customized programs to help improve your health. Call UHC Member Services to learn more: 855.ABM.3456 (855.226.3456).

Why Would UHC Call Me?

ABM has asked UHC to call employees who have been identified as someone who could benefit from a telephone conversation with a nurse. This is not a sales call; no one will try to sell you anything. When you pick up the phone, it will be a nurse employed by UHC who may suggest you participate in a clinical management program, or who is checking to be sure you're receiving timely care for your needs. You can expect a call if:

- You or a family member has a chronic medical condition
- You or a family member was recently hospitalized.
- You are pregnant.

Healthy Weight Program

Learn how UHC can help you lose weight.

There are real advantages to losing weight. Being overweight can lead to diseases such as heart disease, diabetes, high blood pressure and high cholesterol. UHC's online health coaches will guide you through a staged approach to learning about proper nutrition and how to plan healthy meals.

- Learn different ways to lose weight
- Plan more nutritious meals
- Manage your exercise and track your progress
- Avoid food temptations

myNurseline®

With myNurseLine® services, you can call a registered nurse at any time, day or night. They can help answer questions like "Can you help me find a network doctor?", "Does my medication have side effects?" and "What are my treatment options?" They can direct you to network doctors and even schedule appointments.

- Get health tips from a registered nurse by phone
- Prepare yourself with questions before you see a doctor
- Listen to recorded messages on thousands of health topics
- Participate in live, one-on-one nurse chats on www.myuhc.com

Healthy Back Program

When you enroll in the Healthy Back program, you will be paired with your own personalized health coach. Your health coach specializes in low back pain and will be your one-stop shop for information, advice and encouragement. They will help you understand your treatment options, make sure you have access to the right kind of care, and give you tips and advice on how to limit or stop low back pain. And, they will be there for you in the future if you ever have problems.

Building Better Health in 2016 (cont.)
UnitedHealthcare Wellness Resources

Wellness Coaching

Connect with a Health and Wellness Coach for help identifying your risks, setting goals and developing a personalized strategy for positive lifestyle changes. A wellness coach can help you with the following lifestyle concerns:

- Tobacco cessation
- Diabetes lifestyle
- Heart health lifestyle
- Weight management
- Stress management
- Nutrition management
- Exercise management

Maternity Support Program

If you are pregnant or thinking about having a baby, this program can help you through every stage - having a healthy pregnancy, preparing for a safe delivery, and caring for your newborn through the first few months of your baby's life. You will receive:

- Access to your own personal maternity nurse who will keep in touch throughout your pregnancy and after giving birth.
- Information and facts to help you identify risks and special needs.
- Customized maternity education materials to support your needs.

Enroll by calling UHC at 877.201.5328, 8:00 a.m. to 8:00 p.m. Central Time. It is best to enroll during the first trimester of your pregnancy.

Building Better Health in 2016
Kaiser Permanente Wellness Resources

Kaiser Permanente offers numerous programs which contribute to your overall health and well being. Some of the programs that are offered nationally are described below. Log onto my.kp.org/ABM to learn about additional programs as well as other programs which may be specific to your region.

Microsite

Get more resources to help you stay engaged with your health. Go to my.kp.org/abm, a Kaiser Permanente site dedicated for ABM employees. Find healthy resources as well as information about the plans and services available to you.

CARE® for Diabetes

One in 10 American adults has diabetes, and the disease is spreading — 7 million new cases worldwide every year. But the epidemic can be managed a case at a time, starting with you.

HealthMedia® CARE® for Diabetes puts you in charge of your condition so you can live life on your terms. Kaiser Permanente will cover how to improve eating, manage medications, and get more from your health care team.

This program offers strategies for day-to-day management of diabetes, including lifestyle changes and in-depth education, which can mean improved A1c levels and better health.

Maximize your Health

Need a personalized plan to tackle issues like losing weight, increasing your physical activity, reducing stress, quitting smoking and more? Call a Kaiser Permanente wellness coach or try a personalized online program.

To make an appointment, wellness coaches can be reached at 1-866-862-4295, Monday through Friday, from 6 a.m. to 7 p.m. Pacific time.

Balance®

Two-thirds of us wrestle with our weight, and it's not easy to master the mix of exercise and food. Kaiser will teach you how to reach that ideal balance. This comprehensive weight management program includes helpful tools and a personalized plan to help you coordinate mind, food, and body. The benefits will be obvious, and can be significant if you stick with it permanently. With simple changes to how you eat, move, and think about how you eat and move, Balance® can help you reach your weight goal and maximize your health and performance.

Breathe®

Every year more than one million people quit smoking. Even if you've tried quitting before, it's important to keep at it. Most people who try to stop smoking eventually succeed!

Kaiser's award-winning program can help you quit smoking for good. If you use tobacco in any form (cigarettes, pipes, cigars, or smokeless products), then Kaiser's resources can help you break the habit as well as overcome cravings and withdrawal once you stop. Participants create a personalized quitting plan that includes proven strategies for decreasing dependency and cravings.

If you're a smoker who's thinking about quitting, a concerned family member or friend of a smoker, or a former smoker looking for support, Kaiser Permanente has a program for you.

Enroll in a Health Class

Take a local health education class in your area. Visit kp.org/classes or the Health Education Department of your local Kaiser Permanente Medical Center. With many health classes offered at Kaiser Permanente facilities, there's something for everyone. Try a yoga class or classes on eating well, baby care, specific health conditions, and much more. Classes vary by location; some classes may require a fee.

Building Better Health in 2016 (cont.)
Kaiser Permanente Wellness Resources

OVERCOMING™ Insomnia

As much as a third of the adult U.S. population sleeps poorly. HealthMedia® OVERCOMING™ Insomnia offers a range of solutions to help improve your sleep without medication.

This program offers evidence-based techniques to help participants sleep.

CARE® for Your Back

Whether it's cervical, thoracic, lumbar, or all three, a bad back is bad news. Anybody who's suffered from back pain understands how it can turn something as simple as tying your shoes into a major ordeal. HealthMedia® CARE® for Your Back takes a scientific, multi-step approach that combines exercise and small, smart lifestyle changes to help put back pain behind you.

This program gives participants living with chronic back pain techniques and approaches to better manage their condition. HealthMedia® CARE® for Your Back unfolds a personal roadmap to help reduce pain and regain control of your daily life.

OVERCOMING™ Depression

Sometimes depression sneaks up. Other times, it seems we'll never escape it. Maybe we know we need help, but are afraid to ask. One in 5 Americans have grappled with depression. In this program you can learn how to cope with symptoms, change negative thinking, and help prevent relapses. Your plan will help you get the most from treatments, doctors, and life.

This program offers focused coping strategies, ideas to build motivation to change, as well as relapse prevention strategies.

NOURISH®

HealthMedia® NOURISH® will show you how to balance portions and how small adjustments will fuel you the right way. Nourish helps you create a custom-made nutrition plan and offers personalized strategies for making smart, satisfying food choices to improve health and well-being. HealthMedia® NOURISH® offers easy-to-understand, one-on-one nutritional counseling to help improve your eating habits — for life!

Good Health on the Go

Kaiser Permanente mobile apps make it easy to manage your health no matter where you are—at home, at work, and when you're on the go. Email your doctor's office, schedule or cancel appointments, get lab results and more, straight from your smartphone or mobile device.

You can also find the motivation to stay fit in your community with the free Every Body Walk! mobile app for your smartphone or mobile device. It's a fun, interactive tool to help you create and maintain a daily walking routine.

Just download the free apps for the iPhone®, iPad®, or iPod touch®, from the App StoreSM, or for the Android™ from Google Play.

Protecting Your Income

Basic Life Insurance & Accidental Death & Dismemberment (AD&D) Insurance

ABM is committed to helping you protect your financial security. As part of that commitment, ABM offers Staff & Management employees Basic Life Insurance and Basic AD&D insurance at no cost to you!

Life Insurance provides some financial security to your beneficiaries in the event of your death or terminal illness. MetLife insures these benefits.

Your Basic Life Insurance Benefit

Two times your annual base salary to a maximum of $750,000.

Your Basic AD&D Benefit

Two times your annual base salary to a maximum benefit of $750,000 for loss of life which occurs as the result of a qualifying accident.

If you have a qualifying accident which results in the loss of limb(s) or eyesight, you will receive a percentage of the AD&D amount.

✓ ***It is your responsibility to ensure that your beneficiary information is correct. If you experience a qualifying event, like marriage or divorce, contact the ABM Benefits Center to update your beneficiary.***

Accelerated Benefit

If you are terminally ill, you can receive up to 80% of your Basic Life insurance benefit to a maximum of $500,000 in a lump sum if your life expectancy is less than 12 months. Your death benefit will be reduced by any accelerated payment made.

Imputed Income

IRS regulations allow employers to provide up to $50,000 of life insurance to employees on a tax-free basis. The premium paid on behalf of employees for coverage amounts in excess of $50,000 will be added to the employee's gross income for tax purposes. This is referred to as "imputed income".

If you are subject to imputed income, it will appear in the earnings section of your paycheck as GTLEXCESS.

✓ ***Free will preparation - employees eligible for Life Insurance coverage through ABM's plan can benefit from a Will Preparation service. You have access to Hyatt Legal Plans' network of 13,000+ participating attorneys for preparing or updating a will at no additional cost to you. Call 800.821.6400 for more information or to get started.***

It's important to name a beneficiary. Your beneficiary is the person (or people) who will receive this benefit when you die. Contact the ABM Benefits Center to update your beneficiary following a life event such as marriage or divorce.

Protecting Your Income (cont.)

Voluntary Life & AD&D Insurance

While the Basic Life insurance benefit was designed to provide a foundation for you and your beneficiaries, we recognize the potential need to increase your beneficiaries protection. ABM offers you access to Voluntary Life and AD&D insurance which allows you to purchase additional amounts of insurance at favorable group rates. Refer to page 43 for rate information. These benefits are insured by MetLife.

Eligible Dependents

- Spouse means your lawful spouse.
- Domestic Partner means each of two people who are the same or opposite sex, one who is an eligible employee and who
  represent themselves publicy as each other's Domestic Partner and have registered as domestic partners with a government agency or office where such registration is available or submitted an Affidavit of Domestic Partnership to ABM.
- Child means your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption) or stepchild (including the child of a Domestic Partnership) who is under the age of 26, unmarried and supported by you.
- Eligible Dependents for Voluntary Life and/or Voluntary AD&D do not include any person who is on active duty in the military of any country or international authority (active duty does not include weekend or summer training for the reserve forces of the United States, including the National Guard), or is insured under this plan as an employee.

✓ ***To apply for, change or waive your Voluntary Life and/or AD&D insurance, complete a Life Insurance Enrollment Change Form and return it to the ABM Benefits Center. If you apply for or increase your Voluntary Life, you will also need to complete a Statement of Health form which will be sent to you from the ABM Benefits Center.***

Voluntary Life

- You may purchase coverage of 1, 2, 3, 4, or 5 times your annual base salary rounded up to the next thousand (subject to a maximum of $1,000,000 when combined with the Basic Life insurance benefit provided by ABM).
- If you elect Voluntary Life for yourself, you may purchase Voluntary Life insurance for your legal spouse/domestic partner and/or dependent child(ren). For your legal spouse/domestic partner, you may purchase Voluntary Life insurance in multiples of $10,000, up to 50% of your (the employee's) Voluntary Life benefit not to exceed $250,000. For dependent child(ren), Voluntary Life may be purchased in the amount of $2,000, $5,000 or $10,000.

Statement of Health (Legal Evidence of Insurability)

If you elect Voluntary Life insurance or request to increase your coverage during open enrollment, you must complete a Statement of Health (SOH), sometimes called Evidence of Insurability. If Voluntary Life insurance is elected or you request an increase for your legal spouse/domestic partner during open enrollment, your legal spouse/domestic partner must complete an SOH. The SOH collects personal health information. MetLife must review and approve the SOH before coverage will begin; coverage will be effective on the first of the month following the date your coverage is approved by MetLife.

Voluntary Accidental Death & Dismemberment (AD&D)

You may elect between $25,000 and $500,000 to a maximum of 10 times your annual base salary in Voluntary AD&D.You may also elect Voluntary AD&D for your family. If elected, your legal spouse/domestic partner's benefit will be 50% of your benefit amount or 60% if you have no dependent children. Each child's amount is 10% of yours or 15% if you are a single parent.

✓ ***Don't forget you have access to a will preparation service and it's free. Call Hyatt Legal Plans at 800.821.6400 for more information or to get started.***

Protecting Your Income (cont.)

Disability Benefits - Staff and Management Employees

Disability insurance replaces a percentage of your income during extended periods of illness or injury that prevent you from performing your regular work. ABM pays for the cost of these benefits; there is no cost to you. These benefits will coordinate with any State Disability benefits for which you are eligible.

Short Term Disability

Waiting Period

You must be employed by ABM for one year before you are eligible for this benefit. Rehired employees must wait one year after being rehired to be eligible.

Your Benefit

The benefit is based on how long you have worked at ABM.

- Less than one year – no benefit
- 1 year but less than 5 – 50% of basic weekly earnings to a maximum of $2,071/week
- More than 5 years – 100% of basic weekly earnings to a maximum of $4,142/week

How Do I Report a Disability Claim?

If you are absent from work due to sickness or pregnancy, you must notify your supervisor on the first day you are absent. If you will be absent from work for more than 7 consecutive days, you need to report your absence to the MetLife Claims Center at 800.858.6515 to initiate your disability benefit.

Benefit Period

You will receive benefits as long as you qualify as disabled, for up to 83 days.

When Benefits Begin

Benefits begin on the 8th day of disability or illness.

Definition of Disability - Short Term Disability

Generally, you are qualified if you are unable to work due to illness or injury as determined by a physician in writing.

Disability Benefits - Staff and Management Employees

Disability insurance replaces a percentage of your income during extended periods of illness or injury that prevent you from performing your regular work. ABM pays for the cost of these benefits; there is no cost to you. These benefits will coordinate with any State Disability or Social Security Disability benefits for which you are eligible.

Long Term Disability

Waiting Period

You are eligible for this benefit on the first of the month following 60 days from your date of hire.

Your Benefit

66.67% of your monthly pre-disability earnings, up to a maximum of $18,000 per month.

When Benefits Begin

Benefits begin after 90 days of disability.

Benefit Period

If you become disabled prior to age 60, benefits will continue to age 65 if you continue to qualify as disabled. If you become disabled after age 60, the period of payment will vary based on the age you were when the disability began.

Definition of Disability - Long Term Disability

For the first 24 months of disability, you are qualified if you are receiving appropriate care and treatment and are unable to earn more than 80% of your pre-disability earnings performing your normal occupation from any employer in your local economy. After 24 months, you qualify if you cannot earn more than 80% of your pre-disability earnings performing any work in your local economy for which you are reasonably qualified to perform based on your background, education and training.

Pre-Existing Conditions for LTD

If you had symptoms, or received treatment or medication for any condition during the three months prior to your effective date of coverage, you will not be eligible for LTD payments if you become disabled *for that condition* during the first 12 months after your LTD coverage is effective.

Saving for Retirement

Did you know that the average person needs to replace 60% to 80% of their final income in order to afford retirement? When it comes to retirement planning, it is never too soon to start!

ABM 401(k) Employee Savings Plan

The ABM 401(k) Employee Savings Plan offers you an excellent opportunity to save for your retirement by deferring a percentage of your pay on a pre-tax basis.

Eligibility

Eligible employees can participate in the plan on the first of the month following completion of one year of qualifying service AND a minimum of 1,000 hours worked within that one year period. This plan is not available in Puerto Rico.

If you are a rehired employee who previously qualified for the ABM 401(k) Employee Savings Plan, you will qualify immediately upon your rehire.

Company Match

ABM will match 100% of the first 3% and 50% of the next 2% of your eligible compensation that you contribute. To receive the maximum company match of 4% you need to contribute 5% of your eligible compensation.

Maximum Contribution Amount

You may defer (contribute) up to 50% of your eligible earnings once you are eligible for the plan, pre-tax, up to the annual IRS Limit. For 2015, the limit was $18,000*.

Your participation can begin on the first of the month following one year of service, or the first of any subsequent month as soon as administratively practicable.

Vesting

Your contributions and match are immediately vested. This means you have a non-forfeitable right to all money in your account.

Investment Options

Through Merrill Lynch, you have access to a variety of investment options. If you are not sure how to invest the money in your account, a Merrill Lynch representative can offer guidance. To see the investment options available, log in to www.benefits.ml.com.

Catch up Contributions

If you will reach age 50 in 2016 or are older than 50, you can defer additional amounts called “Catch Up Contributions”. The catch up amount is determined by the IRS. For 2015, the catch up amount was $6,000*.

Visit Merrill Lynch (the Plan’s recordkeeper and trustee) at www.benefits.ml.com or call the Merrill Lynch Retirement Center at 888-221-9867 to:

- ***Enroll***
- ***Change your contributions***
- ***Change your investment elections***
- ***Designate a beneficiary***

Rollovers

Rolllovers from another tax-qualified retirement plan, of pre-tax contributions from a 403(b) tax-deferred arrangement, or of pre-tax contributions from a government 457 plan may be accepted by the Plan. But after-tax contributions are not eligible to be rolled over into the Plan. Be sure to consider the advantages and disadvantages of a rollover before initiating one.

*As of the printing of this booklet, the Federal government had yet to release the maximum allowable pre-tax benefit for 2016. Once this information is released, it will be available on the Merrill Lynch website or you can call the ABM Benefits Center at 888.351.4003.

Employee Stock Purchase Plan (ESPP)

The ESPP provides all employees of ABM, including hourly, union, and part-time employees, a convenient way to become owners of the Company through the purchase of ABM common stock directly from the Company. Once enrolled, you can purchase ABM common stock each month through payroll deduction.

There is no waiting period to enroll in this Plan.

The Company will provide a 5% discount on the stock price to employees. The price per share of stock will be 95% of the market price on the last trading day of any calendar month. Additionally, you save money because there is no commission charge to purchase the stock.

Design features of the Plan include:

- Employee Discount: 5%
- Payroll Deduction: Minimum 1% of your pay
- Offering Period: Monthly
- Stock Purchased: Monthly (no minimum)
- Stock Hold Period: Six months from purchase date

Details of the Plan are explained in the ABM Employee Stock Purchase Plan Prospectus. The ESPP Enrollment form and the ESPP Prospectus are available from the ABM Benefits Center. You should read the Prospectus carefully before you decide to participate in the offering.

If you decide to participate, you will need to submit a completed Employee Stock Purchase Plan Enrollment form on or before any Offering Dates. Contact the ABM Benefits Center to request an enrollment form.

This plan is administered by Computershare.

Commuter Transit & Parking Benefits

ABM provides a Transit benefit, through WageWorks, that allows you to save money on commuter and parking related expenses. With this benefit, you can use pre-tax dollars to pay for bus/subway/ferry tickets, passes, and tokens; vanpool fares, commercial parking; and commuter parking costs.

Eligibility for this benefit begins on the day you are hired; you may enroll as soon as administratively practicable.

For 2015*, you were able to set aside:

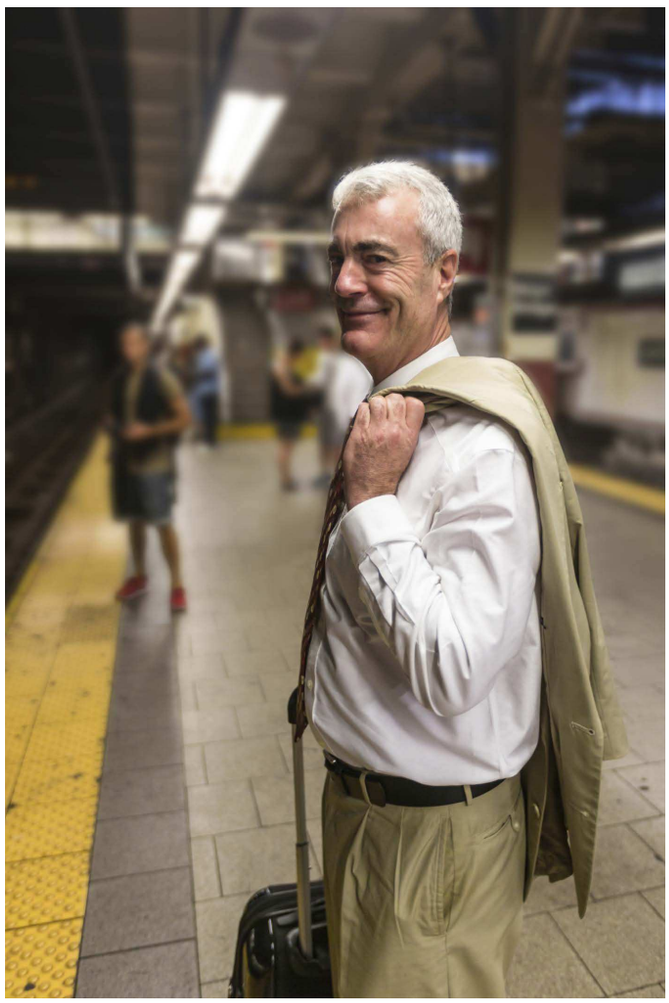
- Up to $130 per month for mass transit/public transportation (for example, bus tickets)
- Up to $250 per month for parking expenses

The amount you contribute will be deducted from your paycheck pre-tax. To sign up for the benefit, change your contribution or update your account, visit www.wageworks.com or call 877.WAGEWORKS (877.924.3967).

Enrolling is easy. If you would like to participate, you must enroll in the program by the 4th day of the month immediately before the commuter period in which you wish to use the benefit.

For example, if you wish to use this benefit to purchase transit passes, you must enroll by May 4 for a transit pass effective June 1. You will receive your first order of transit passes by mail for the beginning of that period.

*As of the printing of this booklet, the Federal government had yet to release the maximum allowable pre-tax benefit for 2016. Once this information is released, it will be available on the WageWorks website or you can call the ABM Benefits Center at 888.351.4003.



Frequently Asked Benefit Questions

Q. Can I change my elections during the Plan Year?

A. IRS regulations require you to keep your elections through the end of the Plan Year (December 31, 2016) unless you experience a Qualifying Life Event. If you experience a Qualifying Life Event, changes to coverage must be requested within 31 days of the date of the event.

If your qualifying event is entitlement to Medicare/ Medicaid/CHIP, you have 60 days from the date of the event to make requested changes.

Q. I was recently married. How do I add my legal spouse to my medical coverage?

A. You should contact the ABM Benefits Center to obtain an Election Form and Qualifying Life Event Request form to add your new legal spouse to coverage.

You will need to provide a copy of your marriage certificate. You have 31 days from the date of marriage to add your legal spouse to your health coverage. Coverage will be effective on the first of the month following the date of your marriage. If you miss this 31 day period, the next opportunity you will have to add your legal spouse will be during the next annual open enrollment period or if you experience another qualifying event consistent with that election. Your contributions to the plan will increase, consistent with the addition of your legal spouse, unless you are already enrolled under Family coverage.

Q. I participate in an HMO and my dependent child was accepted at an out of state college. Since the HMO is not offered in the state where he/she now resides, can I change to another Plan option?

A. Yes. Coverage under the HMO will not be available to your dependent child except for life threatening situations. You may want to consider enrolling in the High Flexible Choice Plan, the Comprehensive Value Plan, the Thrifty Plan, or the Value Plan which are available nationwide.

You have 31 days from the date your child starts residing in the new area to make this change and will be required to provide proof of this change.

Q. What is a Health Care Flexible Spending Account?

A. A Health Care Flexible Spending Account allows you to put aside pre-tax dollars to pay for predictable health care expenses.

Q. What is the difference between a Health Reimbursement Account (HRA) and FSA?

A. While both accounts can be used to pay for eligible health care expenses there are a couple of key differences. The first difference is that the HRA is funded by ABM and the FSA is funded by you through payroll deductions. The second difference is that the FSA can be used for health care expenses not covered by the HRA such as vision and dental.

Q. Can I change or cancel my contributions to the Health Care Flexible Spending Account?

A. You cannot increase, decrease or cancel your contributions during the plan year unless you experience a Qualifying Life Event. Since the FSA has a “use it or lose it” provision, it is very important to plan your contribution carefully.

When was the last time you had your blood pressure checked? Adopting a healthy lifestyle is critical for the prevention of high blood pressure and an indispensable part of managing it.

Taking Time Off

ABM provides competitive paid time off policies including paid holidays, sick leave and vacation. These policies may vary by location and local business needs.

Generally, ABM offers 8 paid holidays, however, the specific holidays and number of days may vary by location.

You should check with your local Human Resources representative regarding the specific paid time off applicable to your circumstances.

Discount Programs

Marketplace Mall

This program is designed exclusively for ABM employees. You can take advantage of special pricing on popular, innovative products and services to help you better manage your day-to-day personal needs. You will find discounts on health clubs, weight management programs such as Weight Watchers and Nutrisystem, and more.

Visit the Mall at www.beneplace.com/ABM

This site is for the exclusive use by, and is currently available to, ABM employees located in the continental United States, Hawaii, and Alaska. ABM does not endorse or attest to the quality or reliability of any item or service advertised on this website. ABM does not guarantee the offerings on this website represent the best value for the products, services or practices promoted on this website.

Other Benefits - *No Cost to You*

Business Travel Accident

ABM provides you Business Travel Accident (BTA) insurance when traveling on Company business. The cost for BTA is paid completely by ABM. There is no charge to you.

There is no waiting period to participate in the plan; coverage begins on your hire date.

All eligible employees working full-time (30 or more hours a week) are covered during ABM's business hours. Executives are covered 24 hours a day.

A benefit is paid for certain injuries or death, where eligible. The maximum benefit is $150,000.

For a detailed description of the Plan, please contact the ABM Benefits Center.

Travel Assistance

If you are eligible for the MetLife Accidental Death & Dismemberment benefit, you are eligible for Travel Assistance. You do not need to enroll. This valuable benefit is provided and administered by AXA Assistance USA, Inc. through an arrangement with MetLife. This service offers you and your dependents medical, travel, legal and financial assistance services, 24 hours a day, 365 days a year, while traveling internationally or domestically more than 100 miles from home. With one quick toll-free phone call to the alarm center, you will receive assistance in obtaining the help you need through more than 600,000 pre-qualified providers in more than 238 countries.

If you have questions about this benefit, please call Travel Assistance at 800.454.3679 or 312.935.3783.

Planning a vacation to somewhere exotic? Make sure you and your family are up to date on your routine immunizations. Call your carrier's Member Services Department to learn if there are any recommended or required immunizations or vaccinations for your destination.

Contacting Your Carriers

	Type/Location	Group Number	Member Services	Website
UnitedHealthcare	**Medical Benefit Provider**			
	High Flexible Choice Plan	743018	855.ABM.3456 (855.226.3456)	www.myuhc.com
	Comprehensive Value Plan	743018	855.ABM.3456 (855.226.3456)	www.myuhc.com
	Thrifty Plan	743018	855.ABM.3456 (855.226.3456)	www.myuhc.com
	Value Plan	743018	855.ABM.3456 (855.226.3456)	www.myuhc.com
KAISER PERMANENTE	**Medical Benefit Provider**			
	HMO/Northern CA	9038	800.464.4000	my.kp.org/ABM
	HMO/Southern CA	102205	800.464.4000 Spanish: 800.788.0616 Mandarin/Cantonese: 800.757.7585	my.kp.org/ABM
	Colorado	26937	Denver metro area: 303.338.3800 Colorado Springs: 888.681.7878	my.kp.org/ABM
	Georgia	9334	metro Atlanta: 404.261.2590 outside metro Atlanta: 800.611.1811	my.kp.org/ABM
	MD, VA, Wash DC	18284	metro Wash DC: 301.468.6000 outside Wash DC Metro: 800.777.7902 MD, VA: 800.777.7902	my.kp.org/ABM
	Northwest (Oregon)	14332	Portland area: 503.813.2000 all other areas: 800.813.2000	my.kp.org/ABM
GroupHealth.	**Medical Benefit Provider**			
	GHC (West Wash)	9796	888.901.4636	www.ghc.org
	GHC (East Wash)	49796	888.901.4636	www.ghc.org
VSP	**Vision Provider**			
	Vision - National	12225508	800.877.7195	www.vsp.com
MetLife				www.metlife.com/mybenefits
	Dental PPO Provider	305807	800.942.0854	
	Short Term Disability	123288	800.858.6515	
	Long Term Disability	123288		
	Life and AD&D Insurance	123288	Contact the ABM Benefits Center	benefits@abm.com
	Travel Assistance - USA	123288	800.454.3679, in the USA	
			312.935.3783, when abroad*	

*Call Travel Assistance collect when traveling abroad

Contacting Your Carriers (cont.)

	Type/Location	Group Number	Member Services	Website
ACE insured.	Business Travel Accident	01AH585	800.243.6124 (inside US) 202.659.7803 (outside US, call collect) ops@europassistance-usa.com	
WageWorks	Health Care FSA Commuter & Transit Benefits		877.WAGEWORKS (877.924.3967)	www.wageworks.com
Hyatt Legal Plans A MetLife Company	Will Preparation Service		800.821.6400	
DELTA DENTAL	**Dental HMO**		800.422.4234	www.deltadentalins.com
	Arizona	00072-4130 AZ		
	California	00072-4102 CA		
	Washington, D.C.	00072-4003 DC		
	Florida	00072-4104 FL		
	Georgia	00072-4105 GA		
	Illinois	00072-4150 IL		
	Maryland	00072-4108 MD		
	Nevada	00072-4109 NV		
	New York	00072-4110 NY		
	Ohio	00072-4218 OH		
	Pennsylvania	00072-4001 PA		
	Texas	00072-4107 TX		
	Utah	00072-4002 UT		
bda	Employee Assistance Program (EAP)		800.272.2727	www.bdaeap.com passcode: abmeap
Merrill Lynch Wealth Management	ABM 401(k) Employee Savings Plan		800.228.4015	www.benefits.ml.com
Computershare	Employee Stock Purchase Plan (ESPP)		800.325.1542	www.computershare.com
Beneplace	Discounts (movie tickets, theme park tickets, home insurance, and more)			www.beneplace.com/abm

2016 ABM National Monthly Contributions

This chart tells you how much you will have to pay for benefits each month.

	Employee only	Employee + 1	Employee + Family
UnitedHealthcare Medical Plan Options			
High Flexible Choice Plan	$440.32	$904.36	$1,303.64
Comprehensive Value Plan	$298.92	$634.56	$875.20
Thrifty Plan*	$158.64	$346.40	$513.68
Value Plan	$158.64	$346.40	$513.68
Kaiser Permanente Medical Plan Options			
Kaiser – California	$249.28	$510.44	$767.28
Kaiser – Colorado, Georgia, Virginia, Maryland, Washington DC	$228.80	$464.04	$720.88
Kaiser – Oregon	$252.16	$545.00	$834.20
Other Medical Plan Options			
Group Health Cooperative (GHC)	$210.24	$421.96	$619.44
Dental PPO Options			
MetLife Premium PPO	$31.20	$62.44	$88.92
MetLife PPO	$24.28	$48.52	$69.16
DeltaCare HMO Options			
The DeltaCare USA HMO plan is available in Arizona, California, Florida, Georgia, Illinois, Maryland, Nevada, New York, Ohio, Pennsylvania, Texas, Utah and Washington, DC.			
DeltaCare USA HMO – California	$12.48	$25.00	$34.36
DeltaCare USA HMO – Illinois & Ohio	$16.64	$29.16	$41.64
DeltaCare USA HMO – Other States	$8.32	$16.64	$22.88
Vision Plan			
Vision Service Plan (VSP)	$5.60	$10.20	$16.96
Other Benefits			
Basic Life Insurance Basic AD&D Insurance Short Term and Long Term Disability Employee Assistance Program Business Travel Accident Employee Stock Purchase Plan	Provided at no cost to you.		

The medical plans above meet or exceed the Health Care Reform Minimum Value Requirements.

*The Thrifty Plan contribution rate for Employee Only coverage is subject to change based on the affordability rules under Health Care Reform and will be the lesser of 9.5% of monthly salary or the amount shown above, whichever is less.

About Your Contributions

Any contributions you make for you and your IRS dependents' medical, dental or vision plan coverage are automatically deducted from your paycheck on a pre-tax basis per IRS guidelines under Section 125. This decreases your taxable earnings and can increase your take-home pay. When you enroll in this program, your deductions will be taken on a pre-tax basis. You must notify the ABM Benefits Center in writing if you would like your contributions to be taken post-tax.

The health plan reserves the right to change employee contributions at any time during the year.

2016 Voluntary Life Insurance Rates

Voluntary Life Insurance		
Age on December 31, 2016	Employee Only Rate	Spouse Rate
Age less than 25	$0.05/$1,000	$0.06/$1,000
25 to 29	$0.06/$1,000	$0.06/$1,000
30 to 34	$0.08/$1,000	$0.08/$1,000
35 to 39	$0.09/$1,000	$0.10/$1,000
40 to 44	$0.10/$1,000	$0.11/$1,000
45 to 49	$0.20/$1,000	$0.16/$1,000
50 to 54	$0.34/$1,000	$0.28/$1,000
55 to 59	$0.60/$1,000	$0.51/$1,000
60 to 64	$0.90/$1,000	$0.84/$1,000
65 to 69	$1.32/$1,000	$1.27/$1,000
70 to 74	$2.06/$1,000	$2.06/$1,000
75+	$3.34/$1,000	$2.06/$1,000
Child	NA	$0.104/$1,000

Calculating Your Costs

To calculate the annual cost, follow this example.

John wants to purchase additional life insurance in the amount of 2 times his annual base salary. He is 42 and earns $39,850 per year. He calculates his cost as follows:

1. Total amount of voluntary insurance:
   2 x $39,850 = $79,700

2. Round up to the next $1,000.
   = $80,000

3. Divide the total amount by $1,000:
   $80,000 / $1,000 = 80

4. Multiply the answer (80) by the monthly rate per thousand to determine John's monthly cost:
   80 x $0.10 = $8.00 per month

   (John's rate is $0.10 since he is in the age 40 to 44 bracket)

5. Multiply the monthly cost by 12 to determine John's annual cost:
   $8.00 x 12 months = $80.00

2016 Voluntary AD&D Insurance Rates

Voluntary AD&D Insurance		
Benefit Amount	Monthly Rate for Employee Only	Monthly Rate for Family Coverage
$25,000	$0.50	$0.75
$50,000	$1.00	$1.50
$75,000	$1.50	$2.25
$100,000	$2.00	$3.00
$150,000	$3.00	$4.50
$200,000	$4.00	$6.00
$250,000	$5.00	$7.50
$300,000	$6.00	$9.00
$350,000	$7.00	$10.50
$400,000	$8.00	$12.00
$500,000	$10.00	$15.00

Continuing Your Benefits

What Happens to My Benefits If I...

- **Take a leave of absence under the Family Medical Leave Act (FMLA), including the Military Family Leave Provisions of the FMLA (Active Duty Qualifying Exigency Leave and/or Service Member Military Caregiver Leave)**
  Your ABM benefits including the Health Care Spending Account will continue while you are on a FMLA as long as you continue to pay the employee contribution. If paid leave is substituted for unpaid FMLA, deductions for benefits coverage will be deducted by payroll deduction. If the leave is unpaid or there is not sufficient pay to take payroll deductions for benefits coverage, contact the ABM Benefits Center to make arrangements for payment and additional information.
- **Take an unpaid leave of absence**
  If you do not qualify for FMLA or if you want to continue benefits after your FMLA leave, you can continue your Medical, Dental, Vision and Health Care Flexible Spending Account (if you have a remaining balance) under a federal law called COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986). Federal law does not provide for COBRA continuation coverage for domestic partners and their dependents and, accordingly, continuation coverage will not be offered to domestic partners and their dependents under the Plan.

  Your Basic Life & AD&D insurance, Voluntary Life, Voluntary Dependent Life, Voluntary AD&D and disability benefits will end at the end of your FMLA or on the date preceding the beginning of an unpaid leave of absence.

  Contributions and loan repayments to the ABM 401(k) Employee Savings Plan will be suspended while you are on an unpaid leave.
- **Military Leave – Uniformed Services Employment and Reemployment Rights Act (USERRA)**
  Benefits will continue while you are on a Military Leave if your absence is 31 calendar days or less. If your absence is longer than 31 days, your health benefits will end at the end of the month in which you where actively employed. Your life insurance and AD&D will end as of your last day of employment before your Military Leave begins. If you want to continue benefits during your Military Leave, you can continue your Medical, Dental, Vision, and Health Care Flexible Spending Account (if you have a remaining balance) under a federal law called COBRA.

  A Military Leave under USERRA is complex. You should contact your Human Resources Representative for information concerning Military Leaves.

Contact the ABM Benefits Center at 888.351.4003 for information on continuing your benefits or loan repayments while on either an unpaid leave or a FMLA leave.

A Refresher of Common Benefits Terms

You may want to review some commonly used benefit terms.

Balance Billing – The practice of billing a member for the difference between what an out-of-network physician or dentist charges and what the insurance carrier has agreed to pay providers for specific services (see: Reasonable and Customary).

Beneficiary – The person you designate to receive your life and AD&D insurance proceeds in the event of your death. You, the employee, are always the beneficiary for optional dependent life and optional dependent AD&D.

Calendar Year Out-of-Pocket Maximum – Generally, the maximum amount of money a member will have to pay each year.

Coinsurance – The member and insurance company share the cost of covered procedures in a specific ratio (e.g., member pays 20% and the insurance company pays 80%). Generally, coinsurance does not apply until the member has paid the deductible.

Coordination of Benefits – When one person is covered by more than one insurance plan, the two plans "coordinate" coverage to determine which insurance carrier pays first and which pays second.

Copay – A fixed dollar amount you pay for a given expense when receiving services or prescriptions.

Deductible – The amount you pay each year before most services are covered. The deductible is generally waived for services that are subject to a copay.

Employee Contribution – The per pay period and/or monthly cost of a benefit paid by the employee.

Formulary – A list of preferred medications identified by the medical carrier. These medications are generally brand-name drugs. Generally these medications are covered by the benefit provider at a higher rate than the rate for non-formulary medications. You can obtain a list of formulary medications by visiting the carrier websites located on page 40, *Contacting Your Carriers*.

Health Reimbursement Arrangement (HRA) – Commonly referred to as a Health Reimbursement Account are solely employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. The employer funds and owns the account.

Health Risk Assessment – A health risk assessment (HRA) is a health questionnaire that asks questions about your health and lifestyle. An HRA is used to provide individuals with an evaluation of their health risks with an emphasis on education and behavior changes.

In-Network Expense – A charge for services from a doctor, hospital, lab or other health care professional who joins a health care company's network and agrees to pre-negotiated fees. The plan pays a higher level of benefits for in-network use.

Mail Order/Home Delivery – A benefit that allows you to order certain maintenance drugs at a reduced cost. You receive multiple months' worth of medication by mail.

Non-Formulary – Any brand-name medication that is not included on the formulary list.

Out-of-Network Expense – A charge for services from a doctor, hospital lab or other health care professional who is not a member of a health care company's network and has not agreed to pre-negotiated fees. Benefits are lower for out-of-network care and are limited to what are known as "reasonable and customary" (R&C) charges. You also pay 100% of the charges above R&C.

PCP – Primary Care Physician. A doctor who is your first point of contact and who must coordinate your care and refer you to specialists. Primarily required by medical or dental HMO plans.

Pre-Tax – Money used to pay for certain benefits that is deducted from your pay before it is taxed. Pre-tax benefits can increase your take-home pay.

Post-Tax – Money used to pay for certain benefits that is deducted from your pay after it is taxed.

Qualifying Life Event – A significant life change, as defined on page 10, that allows you to make changes to your benefit choices outside of open enrollment.

Reasonable and Customary – The range of usual fees for comparable services charged by the medical or dental professionals in a geographic area. If your provider charges more than the reasonable and customary fee, you may be responsible for paying the difference (see: Balance Billing).

Statement of Health – Also known as Evidence of Insurability (EOI), this is a questionnaire that insurance companies use to ask about the health of a participant. Depending on the responses, this may lead to the requirement of a physical exam. These forms are often used if you apply for voluntary life insurance benefits outside of your initial eligibility period.

Inquiries about plan coverage and wellness are best directed to your carrier. Contact information for Member Services may be found on pages 40 and 41.

If you have inquires regarding eligibility, beneficiary designation questions or have other routine benefit questions, please contact the ABM Benefits Center.

Call volumes are high during open enrollment; your patience is appreciated.

ABM Benefits Center

Phone: 888.351.4003 ***VOIP: 112247***
Fax: 866.755.5398 ***Email: benefits@abm.com***

Hours are Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time

Open Enrollment Election Form – 2016

Questions? Call us M-F 8am-5pm CT at 1.888.351.4003 (VOIP 112247)

ABM Benefits Center
Submit completed form via:
Email: Benefits@ABM.com or
Fax: 1.866.755.5398

1. Employee Information (Please Print Clearly)

Employee's Last Name	Employee's First Name & M.I.	Social Security Number	Date of Birth
		- -	

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partnership	Work Phone	Home or Cell Phone	Email Address

Home Address	City	State	Zip

2. Election of Coverage

For Medical, I elect:	☐ **Employee Only**	☐ **Employee + 1**	☐ **Employee + Family**	**OR**	☐ **I decline Medical coverage**
For Dental, I elect:	☐ **Employee Only**	☐ **Employee + 1**	☐ **Employee + Family**	**OR**	☐ **I decline Dental coverage**
For Vision, I elect:	☐ **Employee Only**	☐ **Employee + 1**	☐ **Employee + Family**	**OR**	☐ **I decline Vision coverage**

Medical (select a plan, if applicable)	☐ **High Plan Flexible Choice** ☐ **Comprehensive Value Plan**	☐ **Thrifty Plan** ☐ **Value Plan with HRA**	☐ **Kaiser Permanente HMO** Available only in California, Colorado, Georgia, Maryland, Oregon (Northwest), Virginia, State of Washington (GHC provides this coverage in the State of Washington) and Washington, D.C.
Dental (select a plan, if applicable)	☐ **MetLife Dental Premium Plan** (All states) ☐ **MetLife Dental PPO Plan** (All states)		☐ **DeltaCare HMO** Available only in Arizona, California, Florida, Georgia, Illinois, Maryland, Nevada, Ohio, New York, Pennsylvania, Texas, Utah and Washington D.C.

3. Dependent Information (Please Print Clearly)

(If electing an HMO, contact the HMO after enrollment to select your provider, if applicable)

Relationship	Last Name	First Name	Medical	Dental	Vision
☐ Spouse OR ☐ Domestic Partner			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	Date of Birth	Social Security Number (required) - -		Gender ☐ M ☐ F	
☐ Child ☐ Disabled Dependent			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	Date of Birth	Social Security Number (required) - -		Gender ☐ M ☐ F	
☐ Child ☐ Disabled Dependent			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	Date of Birth	Social Security Number (required) - -		Gender ☐ M ☐ F	
☐ Child ☐ Disabled Dependent			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	Date of Birth	Social Security Number (required) - -		Gender ☐ M ☐ F	

If you wish to cover more than three children, please attach additional information to this form. Refer to *Building Your ABM Benefits – 2016 Open Enrollment* for dependent eligibility.

4. Employee Signature

I hereby certify that all the information I have provided on this Election Form is true and correct to the best of my knowledge under penalty of perjury. I further certify that all enrolled dependent(s) are eligible for coverage based on the definitions and rules specified in ABM's publication, *Building Your ABM Benefits – 2016 Open Enrollment*. Further, I understand that if I enroll family members, ABM and/or the carrier(s) may require proof of eligibility. Marriage or birth certificates, domestic partner certification, adoption papers, tax records and other similar forms of dependent verification may be requested, and I agree to produce such documentation upon request.

I understand the choices I make on this Election Form will be effective through December 31, 2016 unless I notify the ABM Benefits Center within thirty-one (31) days of any qualifying changes in my family status. I understand it is my responsibility to report any changes in my eligibility or that of my dependent(s) within thirty-one (31) days of the qualifying event or I will lose my right to change my election until the following annual open enrollment period. Further, I understand that the ABM Benefits Center must be informed within thirty-one (31) days of a change of status that affects benefit eligibility and that failure to notify ABM could result in my selected medical, dental and/or vision plan(s) denying coverage with the costs of services being my sole responsibility.

I agree to authorize pre-tax payroll deductions in the form of salary reduction or post-tax deductions, where appropriate, to pay for the required contribution or premium deductions of the benefits that I have elected above for me and my eligible family members, if applicable. If, for any reason, my share of the contribution or premium for health and welfare benefits is missed or cannot be fully paid with salary reduction contributions or post-tax deductions, where appropriate, I understand that ABM has the right to recover the payment deficiency from subsequent paychecks or any other means available to ABM. If I take unpaid leave, I agree to pay any required contributions according to the terms and conditions of the ABM Leave of Absence Policy in effect at the time of my approved leave of absence.

I understand that making false statements or providing misleading information or failing to notify ABM of loss of eligibility within thirty-one (31) days of such loss, or failing to provide documentation when requested may lead to my de-enrollment and the de-enrollment of my affected family member(s) and possible legal action by the Plan. In addition, I understand I may be responsible for any employer contributions to and benefits paid by the plans for the ineligible coverage. I further understand that the Plan has the right to recover any premium payments or benefits paid based on such information.

By signing below, I understand and agree that if I have misrepresented or falsified any information on this Election Form, the Plan will take corrective action, up to and including termination of coverage.

Signature of Employee: ______________________________ **Date:** ____________________

5. Kaiser Permanente Authorization: If enrolling in a Kaiser Permanente HMO Plan in California or Colorado, this form must be signed and dated below or Kaiser will not accept your coverage election.

The following Arbitration Agreement is required by the Kaiser Foundation Health Plan, Inc. (KFHP) for coverage in California and Colorado. If you have not enrolled in a Kaiser Permanente HMO Plan in California or Colorado, please disregard this section.

Kaiser Foundation Health Plan Arbitration Agreement

For California Kaiser Permanente HMO Plan Enrollees only: I understand that, (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any claims that cannot be subject to binding arbitration under governing law), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage.*

For Colorado Kaiser Permanente HMO Plan Enrollments only: I have read and agree to the terms and conditions on this enrollment form. Except for Small Claims Court cases, claims arising under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA), claims covered under Colorado Health Care Availability Act, Section 13.64-403, claims reviewed through independent external review as set out in CRS 10-16-113-5, and claims subject to Medicare appeals procedures, any dispute between Members, their heirs, or other associated parties on the one hand and Kaiser Permanente parties on the other hand, for alleged violation of any duty arising from your membership in the KFHP, must be decided through binding arbitration. This includes claims for premises liability, or relating to the coverage for, or delivery of, services or items regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration. This provision shall not limit an individual's access to procedures for review of utilization management determination as set out in Colorado Revised Statutes and Division of Insurance Regulation.

I hereby apply for Kaiser Permanente membership for myself and eligible family dependents listed on this form. I understand that if I/we, are accepted for membership, my/our benefits will be in accordance with the master contract applicable to the type of plan for which I/we are enrolled.

Your signature below indicates you have read and agree to the Kaiser Foundation Health Plan Arbitration Agreement.

Signature of Employee: _____ **Date:** _____

Name of Employee (please print clearly): _____ _____
Last Name **First Name**

Basic Life Insurance
Basic AD&D Insurance
Voluntary Life & Voluntary AD&D
Insurance Enrollment Application

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
ABM Industries Incorporated	**123288**	**123288**		
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)		Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life. I understand that contributions are required for the benefits I select below.

► If you are enrolling during the initial enrollment period, you must complete a Statement of Health form:
- If you are enrolling for more than 3x your Basic Annual Earnings (BAE) of Supplemental/Optional Life Insurance
- If you are enrolling for more than $40,000 of Dependent Spouse Life Insurance

► If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

Term Life Insurance

☐ Supplemental/Optional Life [1]
☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x Basic Annual Earnings up to a maximum of $1,000,000

☐ Dependent Spouse Life [1,2]
Enter a multiple of $10,000 up to a maximum of $250,000 not to exceed 50% of your Supplemental/Optional Life. $_____

☐ Dependent Child Life [2]
☐ $2,000 ☐ $5,000 ☐ $10,000

Waive/Cancel ☐ Employee Voluntary Life ☐ Voluntary Spousal Life ☐ Voluntary Dependent Child Life

Accidental Death & Dismemberment (AD&D) Insurance

☐ Voluntary AD&D
VAD&D Coverage Options: ☐ Employee Only ☐ Employee + Dependent(s)

Then select your level of coverage
☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $350,000 ☐ $400,000 ☐ $500,000

Waive/Cancel ☐ Employee Voluntary AD&D ☐ Employee + Dependent(s) Voluntary AD&D

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance.
[2] Amounts will be subject to state limits, if applicable.

SUBMISSION INSTRUCTIONS
After completion, make a copy for your records and return the original to your Employer.
ABM Industries Incorporated

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
Name(s) of your Child(ren) (First, Middle, Last)	**Date of Birth (MM/DD/YYYY)**	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Basic Life Insurance
Basic AD&D Insurance
Voluntary Life & Voluntary AD&D
Insurance Enrollment Application

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

Note: Dependent insurance is payable to the Employee.
If you have previously designated a beneficiary under this Group Customer's plan, such beneficiary designation will remain in effect. Any MetLife payment upon your death will be paid in accordance with the records of the recordkeeper for such insurance unless you designate a beneficiary below.
I designate the following person(s) as primary beneficiary(ies) for any MetLife payment upon my death.
I understand I have the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Primary Beneficiary(ies).			**TOTAL:**	**100%**

If all of the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Contingent Beneficiary(ies).			**TOTAL:**	**100%**

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I understand that if I do not sign the payment authorization below, coverage for which contributions are required will not take effect until I have provided such authorization.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Employee | Print Name | Date Signed (MM/DD/YYYY)

PAYMENT AUTHORIZATION

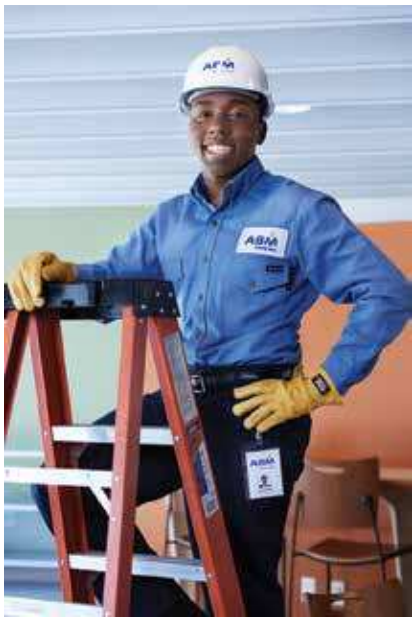
By signing below, I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.

Sign Here

Signature of Employee | Print Name | Date Signed (MM/DD/YYYY)

ABM
Building Value

2016 Important Benefits Notices



IMPORTANT BENEFIT NOTICES FOR PARTICIPANTS IN ABM HEALTH PLANS

The following notices are provided for your information and as required by law. These notices reflect the requirements as of July 2015. In the event that additional disclosures are required after that time, the additional disclosures will be provided to you separately.

Newborns' and Mothers' Rights

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

WHCRA

The Women's Health and Cancer Rights Act requires employer-sponsored group health plans to provide an annual notification of the provisions of the Act. All of the medical plan options provide coverage for medically necessary mastectomies, including related reconstructive surgery. This includes both reconstruction of the breast on which the surgery was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage is also provided for breast prosthetics and for any 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 under the Plan.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that requires a group health benefit plan to provide parity between mental health and substance abuse benefits and medical/surgical benefits offered under a plan. This means, in general, that requirements that apply to mental health and substance abuse benefits cannot be more restrictive than those that apply to medical and surgical benefits. Your benefits under the medical plan options are intended to comply with MHPAEA and any applicable regulations and official guidance. In compliance with the MHPAEA, eligible mental health and substance abuse benefits will generally be covered at the same level as any other covered medical expense, to the extent required under the MHPAEA.

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 the notices starting on page 7 for more details.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your Domestic Partner) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself or your dependents in group health benefits provided under the Plan if you or your dependents lose eligibility for that other coverage (or the employer stops contributing towards the other coverage). However, you must request enrollment within 30 days of the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 31 days of the marriage, birth, adoption, or placement for adoption.

Additionally, you may be entitled to special enrollment rights pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) if your or your dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility or if you or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP. You may change your election consistent with such special enrollment rights within 60 days of the event.

Primary Care Provider Designation

It is important that you know your rights to (1) choose a primary care provider or a pediatrician when a plan requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. If the plan requires or allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If you are planning on enrolling or are enrolled in a plan that requires a primary care provider, please refer to the plan's Evidence of Coverage (EOC). Generally, Health Maintenance Organizations (HMOs) require or allow for the designation of a primary care provider.

For a copy of the plan's EOC, a list of participating primary health care providers or health care professionals who specialize in obstetrics or gynecology or additional information, visit the carrier's website or contact the plan's Member Services Department.

CHIP Notice

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you or your children are eligible for Medicaid or CHIP and you are 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 of CHIP Programs. If you or your children are not eligible for Medicaid or CHIP, you will not 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, you can 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, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or visit www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the 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 are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 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 July 31, 2015. Contact your State for more information on eligibility.

ALABAMA — Medicaid
Website: http://myalhipp.com
Phone: 1-855-692-5447

ALASKA — Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

COLORADO — Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA — Medicaid
Website: http://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA — Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA — Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA — Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS — Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY — Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA — Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE — Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TYY: 1-800-977-6741

MASSACHUSETTS — Medicaid and CHIP
Medicaid & CHIP Website: http://www.mass.gov/MassHealth
Medicaid & CHIP Phone: 1-800-462-1120

MINNESOTA — Medicaid
Website: http://www.dhs.state.mn.us/id_006254
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3739

MISSOURI — Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA — Medicaid
Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEBRASKA — Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA — Medicaid
Medicaid Website: http://www.dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE — Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY — Medicaid and CHIP
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

NEW YORK — Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA — Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA — Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA — Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON — Medicaid
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA — Medicaid
Website: http://dhs.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND — Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA — Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA — Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS — Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH — Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414

VERMONT — Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA — Medicaid and CHIP
Medicaid Website:
http://www.covera.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

WASHINGTON — Medicaid
Website: http://www.hca.wa.gov/medicaid.premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA — Medicaid
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN — Medicaid and CHIP
Website: http://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING — Medicaid
Website: http://www.wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, you can 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

MEDICARE PART D – Creditable Coverage Information

Important Notice from ABM 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 ABM 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. ABM has determined that the prescription drug coverage offered by the ABM medical plans listed in the next column 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.

- United HealthCare High Flexible Choice Plan
- United HealthCare Comprehensive Value Plan
- United HealthCare Thrifty Plan
- Kaiser Permanente - All Regions
- Group Health Cooperative (GHC)
- Hawaii Medical Service Association (HMSA)
- Total Plan Services-Companion Life
- Medica Elect
- Medica Essential
- Medica Choice Passport

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 ABM coverage will not be affected. You may keep your ABM coverage (under the listed plans) if you elect Part D and these plans will coordinate with Part D coverage according to Medicare Secondary Payer Rules.

If you do decide to join a Medicare drug plan and drop your current ABM medical coverage, be aware that you and your dependents will 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 ABM (under the listed plans) 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 or call the ABM Benefits Center at 888.351.4003. 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 ABM 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: September 30, 2015
Name of Entity/Sender: ABM Industries Incorporated
Contact--Position/Office: ABM Benefits Center
Address: 8101 West Sam Houston Parkway South, Suite 150
Houston, TX 77072
Phone Number: 888.351.4003

COBRA Notice

General Notice of COBRA Continuation Coverage Rights

Introduction

This notice applies to you if you are covered under a group health plan offered by ABM under the ABM Employee Benefits Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the qualifying event when the qualifying event is the end of employment or reduction of hours of employment, death of the employee, if the Plan provides retiree health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both) if coverage is terminated under the Plan due to entitlement.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce, or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

ABM Industries Incorporated
ABM Benefits Center
8101 West Sam Houston Parkway South, Suite 150
Houston, TX 77072
888.351.4003
866.755.5398 Secure Fax
benefits@abm.com

If you fail to notify the Plan Administrator within this time frame, you will lose your right to elect COBRA continuation coverage and this right will not be reinstated.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's coverage under the Plan is terminated based on the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total maximum of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his/her employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

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

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your dependents who are qualified beneficiaries experience another qualifying event while receiving 18 months of COBRA continuation coverage, your dependents who are qualified beneficiaries can get up to 18 additional months of COBRA continuation coverage, for a total maximum of 36 months, if notice of the second qualifying event is properly given to the Plan before the end of the initial 18-month period. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, loses benefits as a result of becoming entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

To protect your rights to federal continuation coverage, keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

For further information, contact:

ABM Industries Incorporated
ABM Benefits Center
8101 West Sam Houston Parkway South, Suite 150
Houston, TX 77072
888.351.4003

866.755.5398 Secure Fax
benefits@abm.com

Cal-COBRA Notice

Kaiser Permanente of California COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the person's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than three years from the date the qualifying event has occurred which originally entitled the person to continue group coverage under this Plan.

Notification Requirements

Kaiser Permanente of California is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA enrollee should contact Kaiser Permanente of California for more information about continuing coverage. If the enrollee elects to apply for continuation of coverage under Cal-COBRA, the enrollee must notify Kaiser Permanente of California at least 30 days before COBRA termination.

Payment of COBRA Premium

Premiums for the person continuing coverage are 102 percent of the applicable group premium rate if the person is a COBRA enrollee, or 110 percent of the applicable group premium rate if the person is a Cal-COBRA enrollee, except for the person who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the premiums for months 19 through 29 are 150 percent of the applicable group premium rate.

HIPAA Notice

Group Health Plans - Notice of Privacy Practices

Summary

ABM is the plan sponsor of group health plans ("Plans") that are subject to a Federal law called the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The Plans are required by law to provide you with a copy of the following Notice of Privacy Practices ("Notice").The Notice describes how medical information about you may be used and disclosed by the Plans – and how you can get access to your information. Please review the Notice carefully.

Note:
Receipt of the Notice does not mean you are either eligible for or covered by any of the Plans. Eligibility and coverage are determined solely by the Plans' provisions and your elections.

How the Plans Will Use Your Information

The Plans may use, share, or disclose personal health information they create, receive, or maintain about you – this is called "protected health information" or PHI – for the following reasons: (i) Payment of your medical benefits; (ii) Plan administrative operations; or (iii) Treatment by a health care provider. The Plans may use or disclose your information in other special circumstances described in the Notice. For any other purpose, the Plans will not use or disclose your PHI without your written consent.

Your Rights

You have the right to inspect and copy your PHI, request a change of the information, request restrictions on the use and disclosure of the information, request that communications be made to you through alternate means or at an alternate location, and obtain an accounting of the information that the Plans have disclosed (with certain exceptions such as: disclosures for treatment, payment, or health care operations and disclosures to you or that you authorize). There are certain limitations on these rights as explained in the Notice.

Questions and Complaints

If you have any questions about the Plans' privacy practices or a complaint about how the Plans are treating your PHI, you may contact:

ABM Industries Incorporated
ABM Benefits Center
Office of Privacy
8101 West Sam Houston Parkway South, Suite 150
Houston, TX 77072
Attention: HIPAA Compliance
Telephone: 888.351.4003

NOTICE OF PRIVACY PRACTICES

Your Information | Your Rights | Our Responsibilities

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of ABM's self-insured ERISA covered group health plans (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH" Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment or health care operations, or for any other purposes that are permitted or required by law and how you can get access to this information.

We are required to provide this Notice to you pursuant to HIPAA. Please review it carefully.

Your Rights	
When it comes to your health information, you have certain rights. This section explains your rights with respect to your protected health information and some of our responsibilities in order to assist you.	
Get a copy of your health and claims records	• You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. Ask us how to do this. We may deny your request to inspect and copy protected health information in certain limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the ABM Office of Privacy at the address shown on page 18. • We will provide a copy or summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct or amend health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your request must be made in writing and submitted to the ABM Office of Privacy at the address shown on page 18. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. • With limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan. If the employee's spouse or other person covered under the Plan has requested that we communicate with them in a certain way, that request will be considered. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Your Rights (cont'd)	
Ask us to limit what we use or share	• You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared health information	• You can ask for a list (accounting) of certain disclosures of your protected health information. Your request must state the time period you want the accounting to cover, which may not be longer than the six years before the date of the request. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). The first list you request within a 12 month period will be provided free of charge. For additional accounting requests, within that same 12 month period, we may charge you for the cost associated with providing the list.
Get a copy of this privacy Notice	• You have the right to a paper copy of this Notice. You may ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• We will disclose your protected health information to individuals authorized by you, or to an individual designated as your medical power of attorney, personal representative or legal guardian so long as you provide us with a written notice/authorization and any supporting documentation (i.e., power of attorney). If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights have been violated	• If you have any questions about this Notice or a complaint relative to how your protected health information is handled or if you feel we have violated your rights, contact the ABM Office of Privacy at the address shown on page 18. All complaints must be submitted in writing. • You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. • We will not retaliate against you for filing a complaint.

Your Choices		
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we'll follow your instructions.		
In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care; or • Share information in a disaster relief situation; or • Contact you for fundraising efforts. If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.	
In these cases, we *never* share your information unless you give us written permission	• Marketing purposes; or • Sale of your information. Most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of protected health information require an authorization.	
Our Uses and Disclosures		
How do we typically use or share your health information? Under the law we may use and disclose your protected health information under certain circumstances without your permission. We typically use or share your health information in the following ways.		
Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	*Example:* A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services, or send you information about treatment alternatives or other health related benefits and services that might be of interest to you.

Our Uses and Disclosures (cont'd)		
Run the plan	• We can use and disclose your information to run the Plan and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.	*Example:* We may use health information in connection with conducting quality assessment and improvement activities; underwriting premium rating and other activities relating to Plan coverage; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative services. We may also share your protected health information with business associates who perform various functions on our behalf or provide certain types of services but only after the business associate enters into a business associate contract with us.
Pay for your health services	• We can use and disclose your protected health information to facilitate payment for the treatment and services you receive.	*Example:* We may share information about you with another entity or health plan to assist with the adjudication of health claims or to another health plan to coordinate benefit payments.
How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. Visit www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html for more information.		
Help with public health and safety issues	• We can share health information about you for certain situations, such as: ○ Preventing disease ○ Helping with product recalls ○ Reporting adverse reactions to medications ○ Reporting suspected abuse, neglect, or domestic violence ○ Preventing or reducing a serious threat to anyone's health or safety	
Conduct research	• We can use or share your protected health information for health research.	
Comply with the law	• We will share information about you if state, local or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.	

Our Uses and Disclosures (cont'd)	
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share protected health information about you with organ procurement organizations, as necessary, to facilitate organ or tissue donation and transplantation. • We can share protected health information with a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release protected health information to funeral directors, as necessary, to carry out their duties.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: ○ For workers' compensation or similar programs, but only as authorized by law, and to the extent necessary to comply with laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illnesses. ○ For law enforcement purposes or with a law enforcement official, for example, in response to a court order, subpoena, warrant, summons or similar process; about criminal conduct; and, about a death we believe may be the result of criminal conduct. ○ With health oversight agencies for activities authorized by law including oversight activities such as audits, investigations, inspections and licensure. ○ If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information, if necessary.
Respond to lawsuits and legal actions	• We can share protected health information about you in response to a court or administrative order. We may also disclose your protected health information in response to a discovery request, or other lawful process by someone involved in a legal dispute.

Our Responsibilities

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

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

State Privacy Laws

To the extent that state or local law is not preempted by HIPAA or other federal law, any state or local law that requires greater privacy protections will prevail.

Changes to the Terms of this Notice

We reserve the right to change the terms of this Notice and make new provisions regarding your protected health information that we maintain, as allowed or required by law. Changes will apply to all information we have about you. If we make any material change to this Notice, we will provide you with a copy of our revised Notice by U.S. mail to your last known address on file.

Effective Date of this Notice
The effective date of this notice is September 30, 2014.
Exercising Your Rights
If you have any questions about this Notice or a complaint relative to how your Protected Health Information is handled, please contact us at: ABM Industries Incorporated ABM Benefits Center Office of Privacy 8101 West Sam Houston Parkway South, Suite 150 Houston, TX 77072 ATTENTION: HIPAA Compliance Telephone: 888-351-4003 Benefits@abm.com You can contact the Secretary of Health and Human Services at: U.S. Department of Health and Human Services Office of Civil Rights 200 Independence Avenue S.W. Washington, D.C. 20201 Toll Free Phone: 877-696-6775 www.hhs.gov/ocr/privacy/hipaa/complaints

Leave of Absence—Health Care Premium Payments

To ensure that health and welfare costs remain as low as possible and that you remain enrolled in your selected plans, ABM will auto-deduct your portion of pre- and post-tax benefit contributions from the paycheck immediately following any pay period in which you do not work. In other words, if you are on a three-week unpaid leave, benefit contributions due for any pay cycle in which you receive no income will be deducted from your paycheck following your return to work. In cases where you are out for an extended period of time, arrangements may be made to collect personal checks from you for your benefit contributions or contributions may be deducted over several pay cycles following your return.

If you have any questions about this process, please contact the ABM Benefits Center at 888-351-4003.

Insufficient Premium Payments

When you enroll in ABM benefits, you agree to authorize payroll deductions for your portion of the required benefit contributions for your selected benefits. If, for any reason, your portion of contributions for health and welfare benefits cannot be fully paid with salary reduction contributions (both pre- and post-tax), the remainder of the premium expenses for such coverage must be paid by check no later than thirty one (31) days after the date on which such amount was due. You agree to make up the benefit contribution and ABM's contribution on your behalf will be deemed a catch-up payment. ABM has the right to recover your benefit contribution deficit (both pre- and post-tax) through payroll deduction from subsequent paycheck(s) or any other means available to ABM. By participating in ABM health and welfare benefit plan(s), you agree to comply with the terms and conditions of the plan, including those that relate to benefit contribution deficit.

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