FRYER, SHUSTER & LESTER, P.C.

Practical · Professional · Thorough · Dedicated

2017 Guide to Employee Benefits

Your wellness is our focus.

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Benefit Guide Table of Contents

Medical Coverage Options - Aetna - Traditional POS Plans			
Type of Plan	**GA Silver OAMC 2500 100/70 Choice**	**GA Silver OAMC 3000 100/70 Choice**	**GA Silver HNOption 5000 100/50 Choice**
In-Network Calendar Year Deductible			
Single	$2,500	$3,000	$5,000
Family	$5,000	$6,000	$10,000
In-Network Calendar Year Out of Pocket Maximum			
Single	$6,850	$6,500	$5,750
Family	$13,700	$13,000	$11,500
Lifetime Maximum	Unlimited *(Some benefits may have limitations)*	Unlimited *(Some benefits may have limitations)*	Unlimited *(Some benefits may have limitations)*
In-Network Coinsurance	Plan Pays 100% after Deductible and Copays	Plan pays 100% after Deductible and Copays	Plan Pays 100% after Deductible
In-Network Physician and Hospital Services			
Primary Care	$25 Copay	$30 Copay	$30 Copay
Specialty Care	$50 Copay, after Deductible	$60 Copay, after Deductible	$60 Copay, after Deductible
Walk-in Clinics	$25 Copay, Deductible waived	$30 Copay, Deductible waived	$30 Copay, Deductible waived
Urgent Care	$75 Copay, after Deductible	$75 Copay, after Deductible	$75 Copay, after Deductible
Emergency Room	$500 Copay, after Deductible	$500 Copay, after Deductible	$500 Copay, after Deductible
Non-Emergency Room care	Not Covered	Not Covered	Not Covered
Preventive Care Services	Plan pays 100%	Plan pays 100%	Plan pays 100%
Advanced Imaging	$250 Copay, after Deductible	$250 Copay, after Deductible	$250 Copay, after Deductible
Physical Therapy *(limited to 40 visits)*	$50 Copay, after Deductible	$60 Copay, after Deductible	$60 Copay, after Deductible
Hospital Inpatient Expenses *(Preauthorization Required)*	Plan Pays 100% after Deductible and $250 Admit Copay	Plan Pays 100% after Deductible and $250 Admit Copay	Plan Pays 100% after Deductible and $250 Admit Copay
Hospital/Outpatient Facility Expenses *(Preauthorization Required)*	Plan Pays 100% after Deductible and $250 Copay	Plan Pays 100% after Deductible and $250 Copay	Plan Pays 100% after Deductible and $250 Copay
In-Network Mental Health and Alcohol/Drug Abuse Services			
Inpatient Mental Health	Plan Pays 100% after Deductible and $250 Admit Copay	Plan Pays 100% after Deductible and $250 Admit Copay	Plan Pays 100% after Deductible and $250 Admit Copay
Outpatient Mental Health	$50 Copay, after Deductible	$60 Copay, after Deductible	$60 Copay, after Deductible
Prescription Drugs - Retail Pharmacy (30 day supply) ***Mail Order Available.***			
Level 1	$5 A/$15 Copay	$3 A/$15 Copay	$3 A/$15 Copay
Level 2	$50 Copay, after Deductible	$45 Copay, after Deductible	$45 Copay, after Deductible
Level 3	$75 Copay, after Deductible	$75 Copay, after Deductible	$75 Copay, after Deductible
Level 4	30% Coinsurance, after Deductible, $250 Max	30% Coinsurance, after Deductible, $250 Max	30% Coinsurance, after Deductible, $250 Max
Level 5	40% Coinsurance, after Deductible, $500 Max	40% Coinsurance, after Deductible, $500 Max	50% Coinsurance, after Deductible, $500 Max
Out of Network Benefits	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Eligibility Date	Effective on the 1st of the month following 30 days of full-time employment		
Contact Information	888-802-3862 www.aetna.com		

Medical Coverage Options - Aetna - High Deductible Health Plans (POS)		
Type of Plan	**GA Silver OAMC 4000 100/70 HSA Emb**	**GA Bronze OAMC 6450 100/70 HSA Emb**
In-Network Calendar Year Deductible		
Single	$4,000	$6,450
Family	$8,000	$12,900
In-Network Calendar Year Out of Pocket Maximum		
Single	$4,000	$6,450
Family	$8,000	$12,900
Lifetime Maximum	Unlimited *(Some benefits may have limitations)*	Unlimited *(Some benefits may have limitations)*
In-Network Coinsurance	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
In-Network Physician and Hospital Services		
Primary Care	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Specialty Care	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Walk-in Clinics	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Urgent Care	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Emergency Room	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Non-Emergency Room care	Not Covered	Not Covered
Preventive Care Services	Plan pays 100%, Not subject to Deductible	Plan pays 100%, Not subject to Deductible
Advanced Imaging	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Physical Therapy *(limited to 40 visits)*	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Hospital Inpatient Expenses *(Preauthorization Required)*	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Hospital/Outpatient Facility Expenses *(Preauthorization Required)*	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
In-Network Mental Health and Alcohol/Drug Abuse Services		
Inpatient Mental Health	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Outpatient Mental Health	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Prescription Drugs - Retail Pharmacy (30 day supply) ***Mail Order Available.***		
Level 1	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Level 2	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Level 3	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Level 4	Plan Pays 100% after Deductible	Plan Pays 100% after Deductible
Out of Network Benefits	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Eligibility Date	Effective on the 1st of the month following 30 days of full-time employment	
Contact Information	888-802-3862 www.aetna.com	

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Summary of Benefits

Plan Name: **Plus 24M** Frequency: Exam & Lens every 12 rolling months. Frames every 24 rolling months Group# 9884016134 (AVP Standard - Series 9)	**In Network**	**Out of Network***
Exam	**Aetna Vision Network**	
Use your Exam coverage once every 12 rolling months		
Routine/Comprehensive Eye Exam	**$10 Copay**	$25 Reimbursement
Standard Contact Lens Fit/Follow-up	**Member pays discounted fee of $40**	Not Covered
Premium Contact Lens Fit/Follow-up	**Member pays 90% of retail**	Not Covered
Eyeglass Lenses /Lens options		
Use your Lens coverage once every 12 rolling months to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses		
Single vision lenses	**$25 Copay**	$10 Reimbursement
Bifocal vision lenses	**$25 Copay**	$25 Reimbursement
Trifocal vision lenses	**$25 Copay**	$55 Reimbursement
Lenticular vision lenses	**$25 Copay**	$55 Reimbursement
Standard Progressive vision lenses	**$90 Copay**	$25 Reimbursement
Premium Progressive vision lenses[1]	**20% Discount off retail minus $120 plan allowance plus $90 Copay = member out-of-pocket**	$25 Reimbursement
UV treatment	**Member pays discounted fee of $15**	Not Covered
Tint (Solid and Gradient)	**Member pays discounted fee of $15**	Not Covered
Standard plastic scratch coating	**$0 Copay**	$15 Reimbursement
Standard polycarbonate lenses - Adult	**Member pays discounted fee of $40**	Not Covered
Standard polycarbonate lenses - Children to age 19	**$0 Copay**	$35 Reimbursement
Standard anti-reflective coating	**Member pays discounted fee of $45**	Not Covered
Polarized	**Member pays 80% of retail**	Not Covered
Contact Lenses		
Use your Lens coverage once every 12 rolling months to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses		
Conventional contact lenses	**$130 Allowance** additional 15% off balance over allowance**	$90 Reimbursement
Disposable contact lenses	**$130 Allowance**	$90 Reimbursement
Medically necessary contact lenses	**$0 Copay**	$200 Reimbursement
Frames		
Use your Frame coverage once every 24 rolling months		
Any Frame available, including frames for prescription sunglasses	**$130 allowance additional 20% off balance over allowance**	$65 Reimbursement
Discounts		
Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands.		
Additional pairs of eyeglasses or prescription sunglasses. Discount applies to purchases made after the plan allowances have been exhausted.	**Up to a 40% Discount**	No Discount
Non-covered items such as cleaning cloths and contact lens solution[2]	**20% Discount**	No Discount
Lasik Laser vision correction or PRK from U.S. Laser Network[3] only. Call 1-800-422-6600	**15% discount off retail or 5% discount off the promotional price**	No Discount
Retinal Imaging[4]	**Member pays a discounted fee up to $39**	No Discount
Replacement contact lenses	**Receive significant savings after your lens benefit has been exhausted on replacement contacts by ordering online. Visit www.aetnavision.com for details**	No Discount

LensCrafters · Pearle Vision · Sears Optical · Target Optical · jcp optical · Private Practitioners

Partial list of Exclusions and Limitations

Vision insurance plans contain exclusions and limitations. Not all vision services are covered. See your plan booklet for details.
*You can choose to receive care outside the network. Simply pay for the services up front and then submit a claim form to receive an amount up to the out of network reimbursement amounts listed above. Reimbursement will not exceed the providers actual charge. Claim forms can be found at www.aetnavision.com or by calling customer service Mon-Sun @ 877-9-SEE-AETNA. Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111.

**Allowances are one-time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.

[1]Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information.

[2]Non covered discounts may not be available in all states.

[3]Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

[4]Retinal Imaging available at participating locations. Contact your eyecare provider to verify if available.

Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.

Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed. Aetna does not provide medical/vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice.

This material is for information only, and is not an offer or invitation to contract.

Extraterritorial state requirements may apply to members residing in specific States. If your plan covers members in other states, impacts to your plan of benefits and rates adjustments (if any) will be evaluated and communicated to you at the point of sale.

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Features of Aetna Mobile

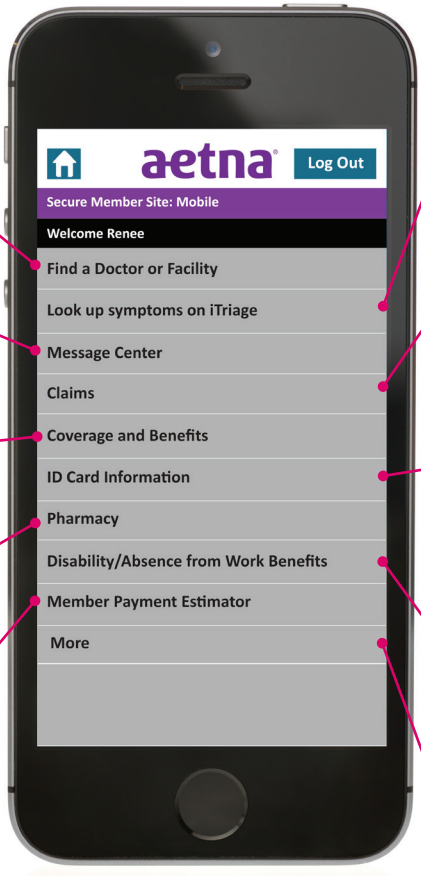
Find a doctor — it's easy to search for doctors, dentists and specialists in your area.

Message center — one location for all Aetna email correspondence from Member Services.

Check benefits and coverage information — just clear, accurate details when you click.

Pharmacy — find a pharmacy, get drug costs or refill a prescription on the go.

Member Payment Estimator — real-time estimates for out-of-pocket medical expenses based on your health plan.



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Group Benefits from The Hartford

Basic Life and AD&D Insurance

Benefit Highlights

Fryer, Shuster & Lester, P.C.

What is basic life and AD&D insurance?	Your employer provides, at no cost to you, basic life and AD&D insurance in an amount equal to $15,000. Life insurance pays your beneficiary (please see below) a benefit if you die while you are covered. This highlight sheet is an overview of your basic life and AD&D insurance. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.
Am I eligible?	You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.
When can I enroll?	As an eligible employee, you are automatically covered by basic life and AD&D insurance; you do not have to enroll. If you have not already done so, you must designate a beneficiary as described below.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. You must be actively at work with your employer on the day your coverage takes effect.
Benefit Reductions	Benefit reduces by 35% at age 65 and 50% of the original amount at age 70. All coverage cancels at retirement.
What is a beneficiary?	Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.

AD&D Coverage	AD&D provides benefits due to certain injuries or death from an accident. The covered injuries or death can occur up to 365 days after that accident. The insurance pays • 100% of the amount of coverage you purchase in the event of accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia. • 75% for paraplegia or triplegia (paralysis of three limbs). • One-half (50%) for accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia. • One-quarter (25%) for accidental loss of thumb and index finger of the same hand or uniplegia. Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage you purchase.
Can I keep my life coverage if I leave my employer?	Yes, subject to the contract, you have the option of: • Converting your group life coverage to your own individual policy (policies).
What is the Living Benefits Option?	If you are diagnosed as terminally ill with a 12 month life expectancy, you may be eligible to receive payment of a portion of your life insurance. The remaining amount of your life insurance would be paid to your beneficiary when you die.

Important Details
As is standard with most term life insurance, this insurance coverage includes certain limitations and exclusions:
• the amount of your coverage may be reduced when you reach certain ages.

AD&D insurance does not cover losses caused by or contributed by:

- sickness; disease; or any treatment for either;
- any infection, except certain ones caused by an accidental cut or wound;
- intentionally self-inflicted injury, suicide or suicide attempt;
- war or act of war, whether declared or not;
- injury sustained while in the armed forces of any country or international authority;
- taking prescription or illegal drugs unless prescribed for or administered by a licensed physician;
- injury sustained while committing or attempting to commit a felony;
- the injured person's intoxication.

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

This benefit highlights sheet is an overview of the insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the benefit highlights sheet and the insurance policy, the terms of the insurance policy apply.

GUARDIAN

Summary of Benefits

Long Term Disability Benefit Summary

Group ID:	00424686	**Member Coverage Type:**	Non Contributory
Group Name:	FRYER, SHUSTER & LESTER, P.C.	**Class:**	ALL ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 30 day(s)	**As of Date:**	03/08/2017

Coverage Information

Monthly Volume	60% of monthly earnings
Guaranteed Issue	There is no guaranteed issue. All amounts are approved.
Maximum Amount	$5,000
Waiting Periods (Benefits begin on ...)	Accident: Day 91 Illness: Day 91
Maximum Payment Period	Social Security Normal Retirement Age

Plan Information

When is my policy effective?	Coverage is effective after you satisfy any waiting period required by your employer. Coverage will not begin until Guardian has approved any amount subject to medical underwriting.
Can I take the policy with me if I leave the company?	Yes, you can convert this coverage to an group conversion trust if you terminate employment with the company. (Some restrictions apply; see certificate of benefits).
Do I have to answer medical questions as part of purchasing insurance?	No.
How are my earnings defined?	Earnings means your monthly earnings excluding bonuses, commissions, expense accounts, and any other extra compensation.
Can I return to work part time while I'm disabled	Yes, you may return to work part time and still be considered disabled. Some restrictions apply.

Long Term Disability General Limitations and Exclusions

We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces); committing a felony or taking part in any riot or other civil disorder; or intentionally injuring themselves or attempting suicide while sane or insane, and for the voluntary inhalation or ingestion of poison, gas, solvent, chemical, or other substance not intended for internal consumption.

We do not pay benefits due solely to the risk of relapse, during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee who is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability. Contract #

GP-1-LTD-15-1.0 et al.

This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department. If the plan is new (not transferred):

Non-NY states: If the plan is new (not transferred): During the exclusion period, this disability plan does not pay charges relating to a pre-existing condition. A pre-existing condition includes any condition for which an employee, in a specified period of time prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. Please refer to the plan details for specific time periods. State variations may apply.

Please refer to plan documents for specific time periods.

Contract #'s GP-1-LTD94-A,B,C-1.0 et al.; GP-1-STD94-1.0 et al; GP-1-LTD2K-1.0 et al, GP-1-STD2K-1.0 et al; GP-1-LTD07-1.0 et al, Contract # GP-1-LTD-15-1.0 et al.

Acts of war etc.

Disability benefits do not cover any disability caused by

1. war or any act of war, including service in the armed forces;
2. committing a crime or taking part in a riot or civil disorder;
3. intentionally injuring yourself or attempting suicide while sane or insane;
4. confined to a correctional facility, or
5. receiving treatment outside US.

Disability benefits are not paid for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces); committing a felony or taking part in any riot or other civil disorder; or intentionally injuring themselves or attempting suicide while sane or insane, and for the voluntary inhalation or ingestion of poison, gas, solvent, chemical, or other substance not intended for internal consumption.

Disability benefits are not paid due solely to the risk of relapse, during any period in which you are in confined to a correctional facility, you are not under the care of a doctor, you are not receiving treatment outside of the US or Canada, and or your loss of earnings is not due solely to disability.

You will receive a certificate of coverage after you enroll which contains a complete list of exclusions. If there is a difference between this booklet and the certificate of coverage, the certificate of coverage prevails.

Other

Where applicable, this coverage will be integrated with Social Security and with Workers Compensation. Refer to your booklet for additional details.

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

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

2017 Annual Health Plan Notices

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

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

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

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

Who needs protection from genetic discrimination?

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

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

Why was the law needed?

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

- **Newborn's Act Disclosure**

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

- **HIPAA Notice of Privacy Practices**

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

- **Michelle's Law**

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

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

The Plan currently permits an employee to continue a child's coverage if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

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

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

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

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

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

- **Patient Protection Model Disclosure**

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Michael Shuster.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Fryer, Shuster & Lester, P.C.	58-1573954
5. Employer address	**6. Employer phone number**
1050 Crown Pointe Pkwy., Suite 410	

7. City	8. State	9. ZIP code
Atlanta	GA	30338

10. Who can we contact about employee health coverage at this job?
Deborah Rosser/Administrator

11. Phone number (if different from above)	12. Email address
	drosser@galegal.com

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

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

[x] All employees. Eligible employees are:

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

[ ] Some employees. Eligible employees are:

- With respect to dependents:

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

*Legal spouses

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

[ ] We do not offer coverage.

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

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

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

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

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

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

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

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

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

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

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

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

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

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

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

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

Paperwork Reduction Act Statement

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

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

Important Notice from FRYER, SHUSTER & LESTER P.C. 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 FRYER, SHUSTER & LESTER P.C. **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. FRYER, SHUSTER & LESTER P.C. **has determined that the prescription drug coverage offered by the Group Health Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

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

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

If you decide to join a Medicare drug plan, your current FRYER, SHUSTER & LESTER P.C. coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current FRYER, SHUSTER & LESTER P.C. coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through FRYER, SHUSTER & LESTER P.C. 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:	2017
Name of Entity/Sender:	Fryer, Shuster & Lester P.C.
Contact--Position/Office:	Deborah Rosser/Administrator
Address:	1050 Crown Pointe Pkwy Ste 410, Atlanta, GA 30338
Phone Number:	770-668-9300

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

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

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

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

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

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

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

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

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

_____ _____

Employee Name – Please Print Employee Social Security Number

_____ _____/_____/_____

Employee Signature **Date**

FRYER, SHUSTER & LESTER, P.C.

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