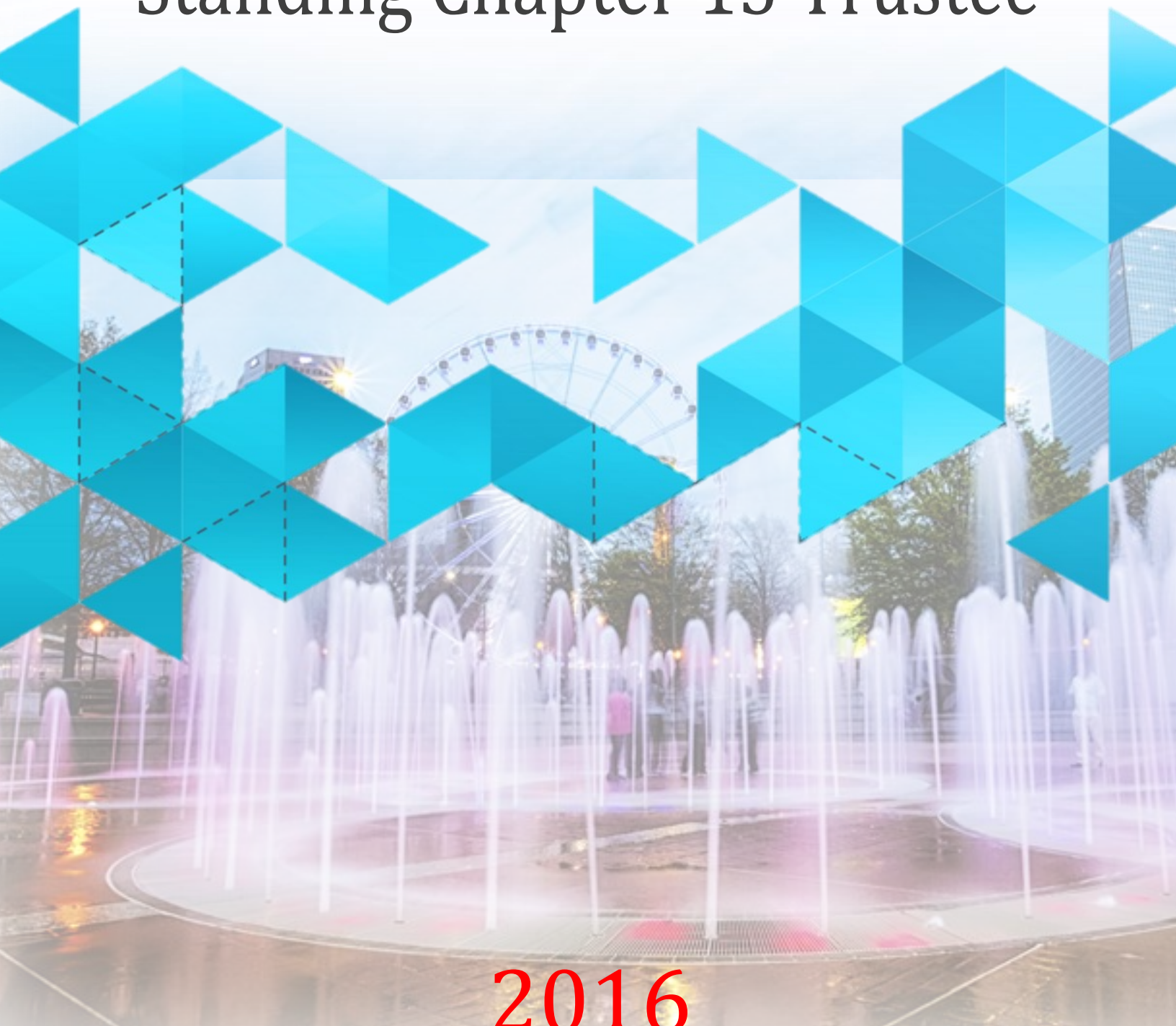
Adam M. Goodman

Standing Chapter 13 Trustee



2016

Employee Benefits Guide

Adam Goodman Standing Chapter 13 Bankruptcy Trustee

Medical Coverage

Type of Plan	NATIONAL POS
	HUMANA Group #657216
Annual Deductible	**In-Network**
Single	$2,000
Family	$4,000
Annual Out-of-Pocket Maximum	**Includes Deductible, Copays and Rx Copays**
Single	$6,500
Family	$13,000
Coinsurance	Plan pays 100% after deductible
Lifetime Maximum	Unlimited
Preventative Care (Immunizations, health examinations, annual gynecology exam, prostate screening)	Plan pays 100% (not subject to deductible)
Physician Office Visit (includes lab, radiology, office surgery)	$40 copay
Specialist Office Visit	$70 copay
Diagnostic x-ray and lab	Office covers 100%
Advanced Imaging	Subject to deductible
Urgent Care	$100 copay
Hospital Inpatient	Plan pays 100% after deductible
Hospital Outpatient	Plan pays 100% after deductible
Emergency Room Services (Life-threatening illness or serious accidental injury) *Non-emergency services are not covered	$500 copay (waived if admitted)
Chiropractic Care Maximum Annual Benefit	$70 Copay (maximum 40 visits per year)
Mental Health/Substance Abuse Services	Inpatient: Pays 100% after deductible Outpatient Services: $30 copay
Prescription Drugs	
Retail Pharmacy (30 day supply)	Tier 1: $10 copay per prescription Tier 2: $45 copay per prescription - $100 deductible Tier 3: $90 copay per prescription - $100 deductible Tier 4: 25% coinsurance - $100 deductible
Mail Order (90 day supply)	Tier 1: $25 copay per prescription Tier 2: $112.50 copay per prescription Tier 3: $225 copay per prescription Tier 4: 25% coinsurance
Specialty Drugs	**35% Coinsurance (preauthorization may be required)**
Annual Deductible	**Out of Network**
Single	$6,000
Family	$12,000
Annual Out-of-Pocket Maximum	
Single	$19,500
Family	$39,000
Coinsurance	Plan pays 70% after deductible

Adam Goodman Standing Chapter 13 Bankruptcy Trustee

Medical Coverage

Type of Plan	NATIONAL POS (Simplicity)
	HUMANA Group #657216
Annual Deductible	**In-Network**
Single	$0
Family	$0
Annual Out-of-Pocket Maximum	**Includes Copays and Rx Copays**
Single	$6,000
Family	$12,000
Coinsurance	Plan pays 100%
Lifetime Maximum	Unlimited
Preventative Care (Immunizations, health examinations, annual gynecology exam, prostate screening)	Plan pays 100%
Physician Office Visit (includes lab, radiology, office surgery)	$40 copay
Specialist Office Visit	$80 copay
Diagnostic x-ray and lab	100%
Advanced Imaging	$400 copay
Urgent Care	$100 copay
Hospital Inpatient	$1,250 copay per day for the first 3 days
Hospital Outpatient	$1,250 copay
Emergency Room Services (Life-threatening illness or serious accidental injury) *Non-emergency services are not covered	$400 copay (waived if admitted)
Chiropractic Care Maximum Annual Benefit	$80 Copay (maximum 40 visits per year)
Mental Health/Substance Abuse Services	Inpatient: $1,250 / day for the first 3 days Outpatient Services: $40 copay
Prescription Drugs	
Retail Pharmacy (30 day supply)	Tier 1: $10 copay per prescription Tier 2: $30 copay per prescription Tier 3: $55 copay per prescription Tier 4: 25% coinsurance
Mail Order (90 day supply)	Tier 1: $25 copay per prescription Tier 2: $75 copay per prescription Tier 3: $137.50 copay per prescription Tier 4: 25% coinsurance
Specialty Drugs	**35% Coinsurance (preauthorization may be required)**
Annual Deductible	**Out of Network**
Single	$5,000
Family	$10,000
Annual Out-of-Pocket Maximum	
Single	$18,000
Family	$36,000
Coinsurance	Plan pays 70% after deductible

Feeling under the weather?

See a doctor from the comfort of home

If you or a covered family member is not feeling well and doesn't require emergency care, telemedicine, delivered by Doctor On Demand, lets you video visit with a U.S. board-certified physician in minutes using a smartphone, tablet, or computer.

With Doctor On Demand, you can:

- Video visit with a physician from one of Doctor On Demand's U.S. board-certified doctors
- Immediately video visit with a doctor 24 hours a day, 7 days a week from any location
- Your primary care physician can access your telemedicine visit at your request
- If medically necessary, a Doctor On Demand can send a prescription to a preferred pharmacy

Based on your Humana medical plan, your copayment may actually be less than $40.

Humana®

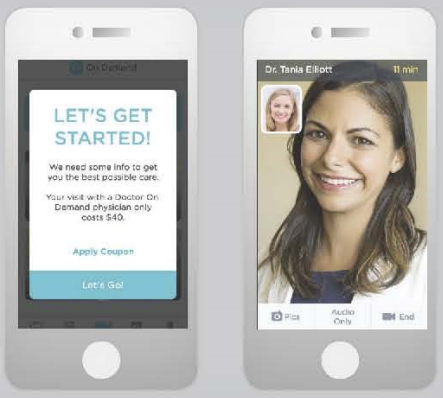
GCHJHCLEN 1115

Visit the doctorondemand.com/humana

See a doctor in three minutes – get started now:

1. Download the Doctor On Demand app
2. Enter your medical plan information
3. Enter your payment method
   (credit card or HSA)

NOTE: Select "none" when asked how you were referred



What can be treated by telemedicine

Telemedicine should be considered when your primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Doctor On Demand physicians can treat ailments, such as:

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

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

No appointments required

There are many ways to sign up and start seeing a doctor:

- Visit **www.doctorondemand.com/humana**
- Download the Doctor On Demand mobile app, available on the App Store and Google Play

ANDROID APP ON Google play

Download on the App Store

To provide you the best possible experience, this service can only be accessed by using Google's Chrome web browser.

Humana.

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MyHumana Mobile app

Manage your healthcare — wherever you are

Access your health information anytime, anywhere

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

Use the MyHumana Mobile app to:

- View your plans and coverage details
- View medical, dental and pharmacy claims
- View, fax or save medical, dental and pharmacy ID cards
- View vision coverage information or ID cards
- Find a doctor, pharmacy, dentist, hospital, urgent care center or retail clinic in your network
- Research drug prices

Additional tools available on **Humana.com** include:

- View your HumanaVitality® Dashboard†
- Refill your Humana Pharmacy® prescriptions‡

Download on the App Store

ANDROID APP ON Google play

Download the Mobile app:

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

From your mobile device's browser:

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

Sign up for text message alerts* on **Humana.com**

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

†Available to HumanaVitality members only.
‡Available to members who use Humana Pharmacy only.
*Message and data rates may apply.

Humana®

Humana.com

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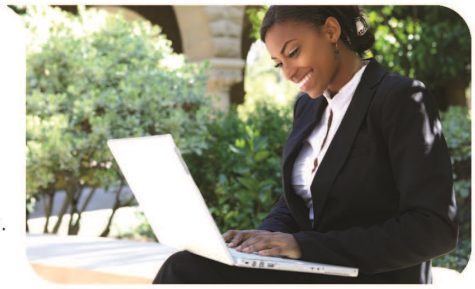
MyHumana

Register now at **Humana.com**



Find your personalized health and benefits information in one place – MyHumana

As a Humana member, you have a secure website on **Humana.com** called MyHumana. With MyHumana, you have fast, easy access to your personalized benefits information, planning tools and wellness resources.

Some of what you can do on MyHumana:

- Claims – Check if a claim has been paid along with your estimated cost, if any
- ID cards – View, print and email up-to-date medical and dental Humana member ID cards
- Coverage details – Review deductibles, coverage levels and limits
- Provider search – Use "Find a doctor" to find in-network providers near you
- Humana's cost comparison tool - compare providers and services, choose wisely and estimate costs
- Drug pricing – Look up coverage, estimated prices and possible alternatives
- Rx calculator – Plan for out-of-pocket drug costs
- Health and condition centers – Access health information specific to your conditions and life stage
- Year-to-date summary – See an at-a-glance view of your financial information – including balances in your health savings account, flexible spending account or personal care account and amounts applied to deductibles
- Manage access – Give other adults on your policy permission to access your health information
- Update your communications preferences – Select which communications you want to receive from Humana and how you want to receive them – via paper or email

Registering is easy

- Have your Humana member ID or Social Security number available
- Go to **Humana.com**
- Select "Register" at the top of the page
- Choose "Member all other plan types"
- Fill in some basic information – like your Humana member ID number or Social Security number, date of birth, ZIP code, and email and click "next"
- Create a username, password and security prompt and click "next" to finish

Now, how easy was that? You're all set – jump in and start exploring!

You don't have to wait for health and benefits guidance – you can get it right away with MyHumana.
Please note, all features may not be available to all members.

Humana.

Humana.com

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Dental Coverage - HUMANA #657216		
Type of Plan	**PPO**	
	In-Network	**Out-of-Network** *(Subject to Usual, Reasonable and Customary)*
Deductible	Single: $50	
	Family: $150	
Annual Maximum Benefit	$2,500	
Preventive Services *(oral exam, cleaning, x-rays)*	100%	100%
Basic Services	80% after Deductible	80% after Deductible
Major Services *(crowns, dentures)*	50% after Deductible	50% after Deductible
Orthodontia *(children up to age 19)*	50% (Deductible Waived)	50% (Deductible Waived)
Orthodontia Lifetime Maximum Benefit	$1,000	
Added Benefit beginning August 1, 2014	**Implant Coverage Rider** **Composite Filling Rider**	**Covered under Major Maximum $1500** **Covered under Basic**

Dental Benefits

Vision Coverage - HUMANA #657216

	In-Network	Out-of-Network
Comprehensive Eye	Once per 12 months	
Examination	$10 Copay	$40 Allowance
Eyeglass Lenses	Once per 12 months	
Single Vision	$15 Copay	$33 Allowance
Bifocal	$15 Copay	$50 Allowance
Trifocal	$15 Copay	$65 Allowance
Frames	Once per 12 months	
Standard	Wholesale Frame Allowance $50	$57 Allowance
Contact Lenses (in lieu of lenses and frames)	Once per 12 months	
Conventional	$150 Allowance	

Humana and Standard Insurance

Employee Basic Life & AD&D

All Full time Employees	$50,000 with Humana plus $20,000 with Standard Insurance
Contribution	*Your employer provides this coverage on your behalf.*

Short Term Disability (STD) - Standard Insurance

Amount of Benefit	60% of weekly earnings to a maximum of $1,000 per week for 13 weeks
When Benefits Begin	8th day for disability due to an accident; 8th day due to a sickness
Contribution	*Your employer provides this coverage on your behalf.*

Long Term Disability (LTD) - Standard Insurance

Amount of Benefit	60% of monthly earnings with a maximum benefit of $6,381per month
When Benefits Begin	On the 90th day of disability caused by the same or a related Sickness or Injury
Contribution	*Your employer provides this coverage on your behalf.*

Voluntary Life and AD&D Coverage - Humana

Employee	Increments of $1,000 up to $75,000 without Evidence of Insurability (Guaranteed Issue available a initial eligibility only, subject to terms of plan) Not to exceed $100,000		
Spouse	Increments of $1,000 up to $35,000 without Evidence of Insurability (Guaranteed Issue available a initial eligibility only, subject to terms of plan), not to exceed $50,000 Spouse coverage cannot exceed 50% of the employee selected coverage amount.		
Dependent Child Life	Flat $10,000 per child		
Employee Rates **Monthly contribution based on employee's age and coverage**	**Age**	**Employee Cost Per $1,000**	**Spouse Rate per $1,000**
	<25	$0.09	$0.10
	25-29	$0.09	$0.10
	30-34	$0.10	$0.11
	35-39	$0.12	$0.14
	40-44	$0.16	$0.19
	45-49	$0.23	$0.28
	50-54	$0.35	$0.43
	55-59	$0.54	$0.66
	60-64	$0.75	$0.92
	65-69	$1.21	$1.49
	70-74	$2.33	$2.88
	75-79	$4.47	$5.53
Eligible Child(ren)	6 months - 19 years of age: $10,000	$2.00	
Annual Enrollment	You may increase your life insurance amount with evidence of insurability.		

2016 Annual Health Plan Notices

Women's Health and Cancer Rights Act of 1998

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

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a new 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 Department.

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.

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, 2014. Contact your State for more information on eligibility –

GEORGIA – Medicaid
Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

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

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

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

Important Notice from Adam Goodman Standing Chapter 13 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 Adam Goodman Standing Chapter 13 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. **Adam Goodman Standing Chapter 13 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 Adam Goodman Standing Chapter 13 coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Adam Goodman Standing Chapter 13 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 Adam Goodman Standing Chapter 13 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 Adam Goodman Standing Chapter 13 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:	08/01/2016
Name of Entity/Sender:	Adam Goodman Standing Chapter 13
Contact--Position/Office:	Julie Cowan
Address:	260 Peachtree Street, NW Suite 200 Atlanta, GA 30303
Phone Number:	678-510-1444

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, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

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

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

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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.

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)
Adam Goodman Standing Chapter 13	043720880
5. Employer address	6. Employer phone number
260 Peachtree Street, NW, Suite 200	678-510-1444

7. City	8. State	9. ZIP code
Atlanta	GA	30303

10. Who can we contact about employee health coverage at this job?
Julie Cowan

11. Phone number (if different from above)	12. Email address
	jcowan@13trusteeatlanta.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:

All full-time employees working 30 hours or more per week

[ ] Some employees. Eligible employees are:

- With respect to dependents:

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

Legal spouses and children up to age 26 and domestic partners

[ ] 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)

Notice of Special Enrollment Rights

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

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

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

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

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

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

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

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

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

_____ _____

Employee Name – Please Print Employee Social Security Number

_____ _____/_____/_____

Employee Signature **Date**

Adam M. Goodman
Standing Chapter 13 Trustee

260 Peachtree St N.W.
Suite 200
Atlanta, GA 30303

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

CBIZ Benefits & Insurance Services