2017
Benefits Enrollment Guide

CLINICAL Resources LLC

Your wellness is our focus.

WHAT'S INSIDE

HumanaNPOS 17

Georgia 100/70 Simplicity Plan
Option 6

Effective dates starting 1/1/17
(includes pediatric dental and vision)

		In-network	Out-of-network
Office visit copay		$55 primary care $110 specialist	Not applicable
Deductible		Individual: $0 Family: $0	Individual: $5,000 Family: $10,000
Out-of-pocket maximum	• Based on a calendar year Limit includes copays, deductibles and coinsurance (out-of-network limit excludes pharmacy)	Individual: $7,150 Family: $14,300	Individual: $21,450 Family: $42,900
Preventive care	• Office visit • Laboratory and radiology • Pap smear • Mammogram • Prostate screening • Immunizations • Endoscopy	100%	70% after deductible
Other services	• Physician services		
	- Office visit	100% after office visit copay	70% after deductible
	- Retail clinic	100% after primary care copay	70% after deductible
	- Urgent care	100% after $125 copay	70% after deductible
	- Emergency	100%	100%
	- Diagnostic laboratory and radiology	100%	70% after deductible
	- Inpatient, outpatient, and surgical	100%	70% after deductible
	• Facility services		
	- Inpatient	100% after $2,350 copay per day for the first three days	70% after deductible
	- Outpatient (surgical and non-surgical)	100% after $2,350 copay	70% after deductible
	- Diagnostic laboratory and radiology	100%	70% after deductible
	- Emergency room (copay waived if admitted)	100% after $850 copay	100% after $850 copay
	• Advanced imaging	100% after $850 copay	70% after deductible
	• Spinal manipulations and adjustments (visit limits may apply per calendar year)	100% after $110 copay	70% after deductible

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PRESCRIPTION DRUGS

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

In-network

• Retail: 30-day supply	**Level 1:** $10 copay **Level 2:** $50 copay after $0 individual/$0 family deductible **Level 3:** $100 copay after $0 individual/$0 family deductible **Level 4:** 25% coinsurance after $0 individual/$0 family deductible
• Mail order (up to 90-day supply)	2.5 times the retail copayment
• Specialty drugs (up to 30-day supply)	35% or 25% by using a preferred specialty pharmacy like Humana Specialty Pharmacy

Out-of-network

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

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

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

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

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

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

Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, call or write your Humana insurance agent or broker.

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HumanaNPOS 17

Effective dates starting 1/1/17
(includes pediatric dental and vision)

Georgia 80/60 HDHP Plan
Option 5

Embedded - All covered benefits apply to the individual and family deductible and maximum out-of-pocket. When any family member reaches the individual deductible amount, that family member will begin receiving coinsurance benefits - even if the family deductible has not been met.

		In-network	Out-of-network
Embedded deductible	• Based on a calendar year	Individual: $2,900 Family: $5,800	Individual: $8,700 Family: $17,400
Embedded out-of-pocket maximum	• Based on a calendar year Limit includes copays, deductibles and coinsurance (out-of-network limit excludes pharmacy)	Individual: $5,000 Family: $10,000	Individual: $15,000 Family: $30,000
Preventive care	• Office visit • Laboratory and radiology • Pap smear • Mammogram • Prostate screening • Immunizations • Endoscopy	100%	70% after deductible
Other services	• Physician services		
	- Office visit	80% after deductible	60% after deductible
	- Retail clinic	80% after deductible	60% after deductible
	- Urgent care	80% after deductible	60% after deductible
	- Emergency	80% after deductible	80% after deductible
	- Diagnostic laboratory and radiology (performed in an office)	80% after deductible	60% after deductible
	- Inpatient, outpatient, and surgical	80% after deductible	60% after deductible
	• Facility services		
	- Inpatient	80% after deductible	60% after deductible
	- Outpatient (surgical and non-surgical)	80% after deductible	60% after deductible
	- Diagnostic laboratory and radiology	80% after deductible	60% after deductible
	- Emergency room	80% after deductible	80% after deductible
	• Advanced imaging	80% after deductible	60% after deductible
	• Spinal manipulations and adjustments (visit limits may apply per calendar year)	80% after deductible	60% after deductible
Prescription drugs A detailed HDHP EHB drug list is available at **Humana.com/druglist.**	• Retail: 30-day supply • Mail order (up to 90-day supply) • Specialty drugs (up to 30-day supply)	80% after deductible	60% after deductible

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Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, call or write your Humana insurance agent or broker.

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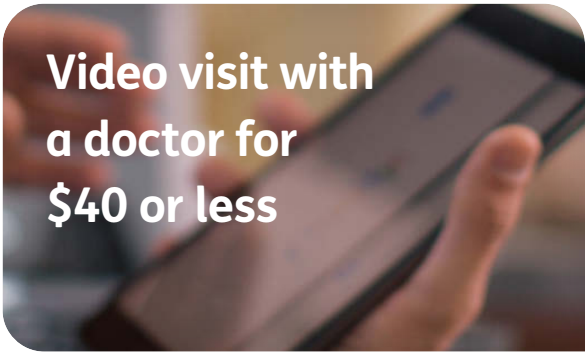
Feeling under the weather?

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 or retail clinic benefit cost may actually be less than $40.

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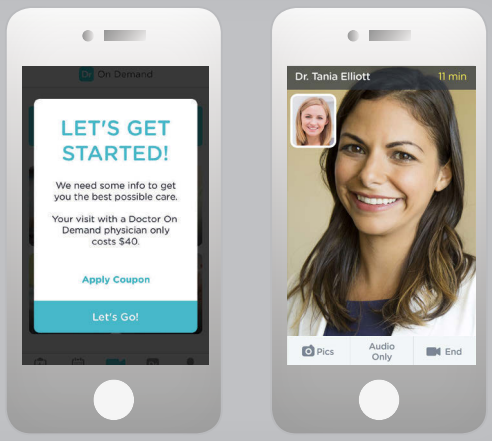
Visit the doctorondemand.com for information and promotional offers

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.

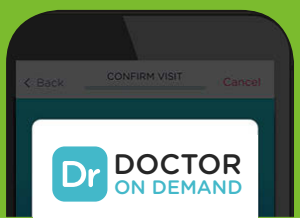
No appointments required

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.

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Ready. Set. go365™

CAPTURE LIFE REWARDS

Earn plenty of Points.

Say hello to Go365.

It's your personalized wellness and rewards program.

Getting healthier is easier – and lots more fun – with Go365™. When it comes to health and wellness, you have your own approach. One that works for you. Go365 makes it easier to get moving along your path with more ways to start, more Activities to unlock, and more ways to rack up rewards.

Unlock Activities.

Go365 is all about you. You'll receive Activities personalized to help you reach your health goals, no matter where you are on your journey to better health. Just unlock your Activities and earn Points for higher Status.

Stay inspired.

Getting healthier can be hard. Go365 makes it easier by connecting you to all the tools and resources you need to get there. Tracking your activity is a breeze – just connect your compatible apps or fitness devices and earn Points for all your healthy activities.

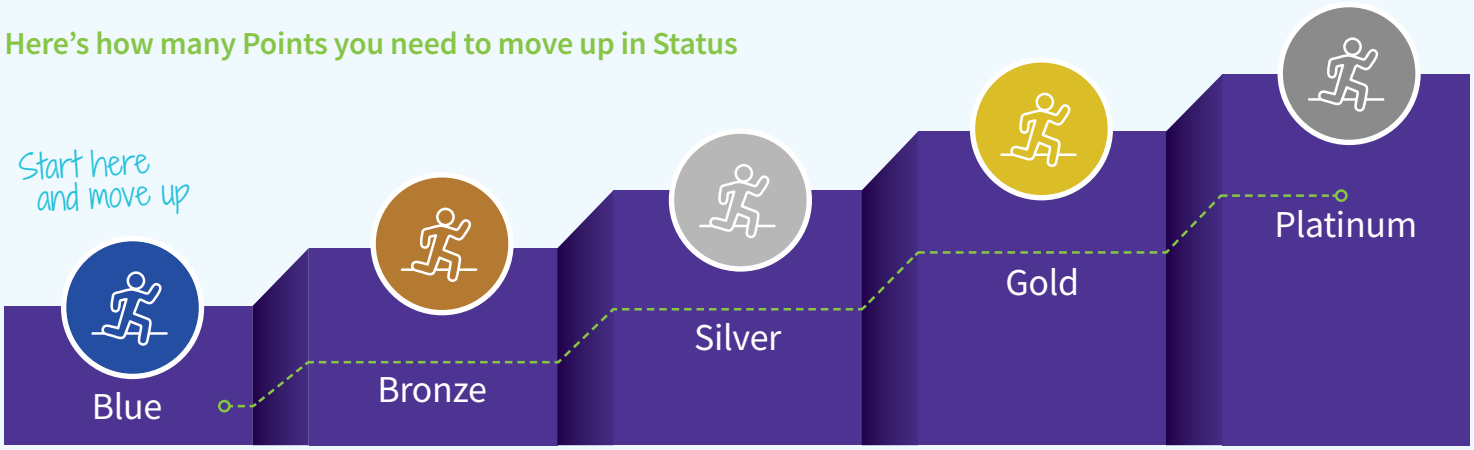
Earn rewards.

Making healthier choices is a lot more fun with Go365. The more you move up in Status, the more Bucks you can earn and spend on great items in the Go365 Mall. Plus, Bonus Bucks, surprise rewards, and monthly Jackpot drawings make getting healthy more fun!

More Points. Higher Status.

Earning Points pays off big with higher Status levels. Get your spouse and kids involved too and see how fast you can move up in Status.

Here's how many Points you need to move up in Status



3 ways to get to Bronze

1. Complete at least one Health Assessment section online or on the Go365 App
2. Get a Biometric Screening
3. Log a verified workout

Blue	Bronze	Silver	Gold	Platinum
5,000 One adult per policy	8,000 One adult per policy	10,000 One adult per policy		
8,000 **combined** two adults per policy	12,000 **combined** two adults per policy	15,000 **combined** two adults per policy		
+3,000 for each member 18 years and older per policy	+4,000 for each member 18 years and older per policy	+5,000 for each member 18 years and older per policy		

Adult children can only move a family to Bronze Status by completing a verified workout.

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Stay connected with Go365.

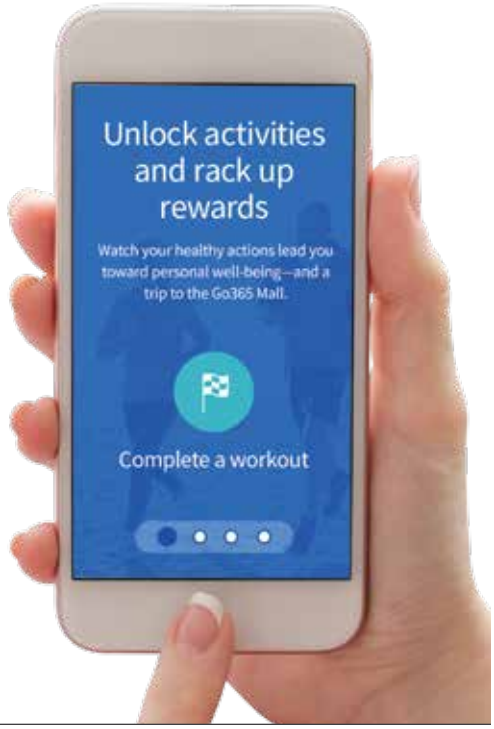
Participate when, where, and how you want.

Whether you go online or are on the go, Go365 goes right along with you. Engage and track your wellness journey through a best-in-class digital experience that was designed just for you.

Go365 puts you in the driver's seat. There are lots of ways to get started and start earning Points. Sign-in online or with the App to unlock recommended Activities that are personalized just for you.

Then track your Points and watch your Bucks build up. Go365 connects to dozens of the most popular activity tracking apps, more than 70 fitness devices and over 40,000 participating fitness facilities, so you can earn rewards for healthy Activities you're already doing. Plus, the App makes it even easier to track your Activities – just snap and send a picture.

Make the connection so you don't miss out on rewards!



Get it done. Online or on the go.

- View personalized dashboard
- Take your Health Assessment
- Connect your compatible fitness devices or tracking apps
- Unlock Activities
- Track Points
- Submit a picture
- Contact a Health Coach
- Reach out to the Go365 Community
- Join a Challenge

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Unlock Activities.

Watch your success lead to your wellbeing.

Go365 is for anyone, at any stage… no matter what shape you're in or how hard you work out. Go365 knows what it takes to motivate and reward you to make healthier choices for life.

Activities	These are simple things you can do every day to get healthier. Tracking your steps, getting a flu shot, going for a bike ride – these are easy ways to keep moving forward with Go365.
Recommended Activities	Once you complete your Health Assessment, you'll get personalized Activities based on your responses. Because Recommended Activities are created just for you, they can have a big impact on your overall health. Plus, you earn more Points for each one you complete.
Go365 Kids*	Kids can earn Points when they do "kid" things, like playing on a soccer or baseball team. When you do things that are good for their health, like keeping up with their immunizations and getting a dental check-up, your kids earn more Points.
Challenges	Earn Points by going head-to-head against your friends and co-workers and compete for the most steps taken or pounds lost.

Have some healthy fun.

Getting healthier is a lot more fun with Go365. Earn Bucks you can use in the Go365 Mall for e-giftcards from Amazon.com, Target, Lowes and Spafinder, the latest activity trackers from Garmin and Fitbit, and more. Plus, you could win a prize in our monthly Jackpot drawings or get a surprise reward.

The merchants represented are not sponsors of Go365 or otherwise affiliated with Go365. The logos and other identifying marks attached are trademarks of and owned by each represented company and/or its affiliates. Please visit each company's website for additional terms and conditions.
*Go365 Kids is not available to all Go365 programs. Check with your Employer or Benefits Administrator to check your eligibility.

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Earn Points for your everyday activities – everyday!

EDUCATION

Activity	Points	
Health Assessment Take your full Go365 Health Assessment online or on the App and earn Points for completing it for the first time each program year.	500	
OR **Health Assessment sections** Earn 50 Points for each section you complete online or on the App: >> Get Active >> Eat Better >> Reduce Stress >> Be Well >> Stay Healthy >> Know Me *Bonus Points when you complete all six sections*	50	
Adult children are not eligible to earn Points for Health Assessment completion.		
First Step Health Assessment Bonus Once-in-a-lifetime reward for your first-time Health Assessment completion.	500	
90 Day Health Assessment Bonus Earn Bonus Points when you complete your Heath Assessment within 90 days of your Go365 program effective date or program renewal date.	250	
Weekly log* Log your activity in any of these areas: food, weight, Blood Pressure and Blood Glucose.	10	weekly
Sleep Diary* Sleep 7+ hours 5+ days per week (Mon-Sun) and log your progress.	25	weekly
Daily Health Quiz* Log in to the Health IQ app or website and complete a quiz on a variety of health topics. Connect your Go365 App to Health IQ to automatically earn your Points.	2	daily
Health Coaching* Get matched with a certified well-being coach who can give you expert guidance, support and attention in these areas: weight management, quitting tobacco, managing stress, healthy eating and more.		
Enrolling (first time enrollees only)	200	once/lifetime
Three phone interactions or three online chats (individually or combined)	50	up to 600/per program year
Six email interactions or six progress note entries (individually or combined)	50	up to 600/per program year
Calculators These online tools measure aspects of your health, like “Are you at risk for a heart attack?” They can help you take steps to lead a healthier life. There are many different Calculators, and adult members can earn Points for each Calculator you use.	75	up to 300/ program year
CPR certification	125	
First aid certification	125	
An adult member must send the completed CPR Form or First Aid Form, available online, to Go365 with the copy of certification within 90 days of completing the event. The form can be submitted while your certification is still valid, if you completed your certification before your Go365 effective date. Proof of CPR and first aid certification may also be submitted on the App.		

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Go365.com

(cont. from previous page)

EDUCATION

Activity	Points	
Update/confirm your contact information Verify your information once a year and earn Points.	50	
Monthly Go365.com visit or Go365 App sign in	10	up to 120/ program year
First time Go365 App sign in	50	once/lifetime
Accept online statements Once per lifetime. Not available for all Go365 members.	50	

Maximum of 500 Points for Health Assessment completion per program year. Health Assessment Points are awarded the same online and on the App.
*Activities will award Points under Personalized Activities on your Go365 Statement.

Make it count with Go365.

Earn Points for your everyday activities – everyday!

FITNESS

Activity	Points	
Daily Points **Earn Points for activities you do every day.**		up to 50/day maximum
Steps	1	per 1,000 steps
Heart Rate	15	for every 15 minutes above 60% of maximum heart rate
Calories	5	per 100 calories if burn rate exceeds 200 calories/hr.
Participating Fitness Facility	10	once/day
Earn Bonus Points:		
Exceed 50 weekly workout Points	50	only one bonus awarded per week
Exceed 100 weekly workout Points	100	
Fitness Habit*	25	monthly maximum
Start a new fitness habit and submit photo proof to earn your Points. Fitness habits include: walking breaks, take the stairs, park further away, stretching, visit a park, walk your dog.		
First verified lifetime workout	500	once/lifetime
First verified workout each new program year	750	once/year
Sports league	350	up to 3,000/program year
You must be an active team member in a qualified, organized sports league, such as baseball or basketball. The minimum number of games or matches that must be played is eight. Members must complete a League Participation Form, available online and submit within 90 days of league completion to Go365 or claim Points on the App by sending a photo of the official schedule, award or certificate from your phone.		
Challenges*		up to 100/month maximum
Create a Challenge – community	50	
Join a Challenge – community or sponsored	50	
Join a team – sponsored	50	
Sponsored Challenges are setup by employers. Community Challenges are setup by members.		
Athletic events		up to 1,400/program year
You must register for and complete a fitness event or race approved by a fitness, athletic, or sporting organization recognized by Go365. Members must complete the Athletic Event Form, available online, and submit it within 90 days of the event completion to Go365 or claim Points on the App by sending a picture of your race bib or results from your phone.		
Level 1 Example: 1.9 mi/3K – 5.1 mi/9K running, walking, or cross-country skiing	250	
Level 2 Example: Sprint triathlon	350	
Level 3 Example: Olympic, ITU, half or full triathlon	500	

How Go365 Points are calculated: Each day, Go365 will look at Points earned across all workout types and award the highest value for that day. Points are awarded for one workout type per day. A week is defined as Sunday – Saturday. We are committed to helping you achieve your best health. Rewards for participating in Go365 are available to all members. If you think you might be unable to meet a standard for a Go365 reward, you might qualify for an opportunity to earn the same reward by different means. Sign in to your Go365.com account and visit the Communication center to send us a secure message and we will work with you (and, if you wish, with your healthcare practitioner) to develop another way to qualify for the reward.
*Activities will award Points under Personalized Activities on your Go365 Statement.

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Earn Points for your everyday activities – everyday!

PREVENTION

Activity	Points	
Health screenings Earn Points by getting screenings such as a Pap smear, mammogram, prostate exam or colorectal screening. Age restrictions apply. See Go365.com for details.	400	up to 400/program year per screening
Dental exam Visit your dentist and earn Points for preventive dental exams, up to two times per program year.	200	up to 400/program year
Vision exam Earn Points for a preventive vision exam, once per program year.	200	
Flu shot Get your annual flu shot and submit the Prevention Activity Form, available online, within 90 days to earn Points. Use the App to snap and submit a photo of the date and location where you received your flu shot.	200	
Nicotine test After receiving a cotinine (nicotine) test, submit a Nicotine Test Form, available online, within 90 days of completing the test with your healthcare provider.	400	
Biometric Screening Earn Points by getting your Biometric Screening at an approved healthcare provider or from your physician. The Biometric Screening measures your:		
Body mass index (BMI)	800	
Blood pressure	400	
Blood glucose	400	
Total cholesterol	400	
Adult dependents are not eligible to earn Points for Biometric Screening Completion.		

We are committed to helping you achieve your best health. Rewards for participating in Go365 are available to all members. If you think you might be unable to meet a standard for a Go365 reward, you might qualify for an opportunity to earn the same reward by different means. Sign in to your Go365.com account and visit the Communication center to send us a secure message and we will work with you (and, if you wish, with your healthcare practitioner) to develop another way to qualify for the reward.

Reach Silver Status Completing your Health Assessment and getting your Biometric Screening gives you a great start toward earning 5,000 Points toward Silver Status. Here's an example of how you can earn 5,000 Points:

Health Assessment	500
First Step Health Assessment	500
Biometric Screening	2,000
Basketball league	350
Blood donation (x3)	150
Flu shot	200
Daily step (10,000 per day for 30 days)	300
First verified workout of program year	750
Calculator (x4)	300
CPR certification	125

5,000
Points total
(individual plan)

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Earn Points for your everyday activities – everyday!

HEALTHY LIVING

Activity	Points	
Blood donation	50	up to 300/program year

Donate blood up to six times a year. Earn Points when you submit a Blood Donation Form, available online, within 90 days of the donation date or use the App to send a photo of your donation card, signed document from agency or signed work release by phone.

Nicotine test healthy in-range results	400

After you receive a cotinine (nicotine) test, submit a Nicotine Test Form, available online, within 90 days of completing the test with your healthcare practitioner. You can earn Points if the results fall within a healthy range.

Biometric Screenings in-range results

Double your Points if these results are within a healthy range. Sign in to Go365.com to find healthy in-range results.

Body mass index (BMI) ≥ 18.5 and < 25, or BMI > 25 and < 30, with a waist circumference < 40" for males and < 35" for females	800
Blood pressure < 130/85 mm Hg	400
Blood glucose < 100 mg/dL or A1c < 6.5%	400
Total cholesterol < 200 mg/dL or an HDL ≥ 40 mg/dL for males and ≥ 50/mg/dL for females	400

Adult dependents are not eligible to earn Points for Biometric Screening Completion or healthy range values.

We are committed to helping you achieve your best health. Rewards for participating in Go365 are available to all members. If you think you might be unable to meet a standard for a Go365 reward, you might qualify for an opportunity to earn the same reward by different means. Sign in to your Go365.com account and visit the Communication center to send us a secure message and we will work with you (and, if you wish, with your healthcare practitioner) to develop another way to qualify for the reward.

About Biometric Screening results

Go365 automatically awards in-range biometric screening results for two years (current and your next program year in the prevention and healthy living categories) for Blood Pressure, Blood Glucose and Total Cholesterol. Only your BMI needs to be rechecked every program year. Some employers may require a full biometric screening completed each year. Check with your employer or Benefits Administrator.

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Earn Points for your everyday activities –everyday!

Go365 KIDS™

Activity	Points	
Health Assessment The Kids Health Assessment covers a child's physical activity, nutrition, lifestyle, and wellbeing. You get a better understanding of your children's current health and the areas that need improvement. No Points are awarded for Kids Health Assessment completion.		
Dental exam Take your kids to the dentist and earn Points for preventive dental exams, up to two times per program year.	100	up to 200/program year
Vision exam Earn Points for a preventive vision exam, once per program year.	100	
Preventive care visit A pediatrician can check on the health of your children and you can ask any questions you may have about their health.	200	
Immunizations At designated ages, your children will receive immunization shots to help protect them from various illnesses.	100	
Fitness Children (up to 18 years old) in a Go365 program can earn Points for two qualifying sports league activities and four athletic events, like baseball or swimming, per program year. Each sport season qualifies as a single sports league. Minimum number of games or matches is eight.		
Sports league	100	up to 200/program year
Athletic events	50	up to 200/program year
Fitness category maximum	400	Points per child

1,000 maximum total Points may be earned per program year per child. Up to 500 maximum preventive Activity Points may be earned per program year per child. Preventive Activities include: dental exam, vision exam, preventive care visit and immunizations.

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Go365 Kids is not available to all Go365 programs. Check with your Employer or Benefits Administrator to check your eligibility.

Athletic Events

If your children participate in events like running, walking, cycling or swimming, they can earn Points that contribute to your family's overall Point total and Status.

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Go365 Activities Summary.

Complete Point detail for each Activity including annual maximums and limits on pages 5-10.

Education

Activity	Points	
Health Assessment full completion	500	per program year
OR Earn 50 Points for each section you complete. Bonus Points when you complete all six sections.		
First Step Health Assessment Bonus	500	once/lifetime
90 Day Health Assessment Bonus	250	for completion within the first 90 days of program year
Weekly Log	10	
Sleep Diary	25	
Daily Health Quiz	2	
Health Coaching		
Enrolling	200	once/lifetime
Three phone interactions or three online chats	50	up to 600/program year
Six email interactions or six progress note entries	50	up to 600/program year
Calculator(s)	75	up to 300/program year
CPR certification	125	
First aid certification	125	
Update/confirm your contact information	50	
Monthly Go365.com visit or Go365 App sign in	10	up to 120/program year
First time Go365 App sign in	50	
Accept online statements	50	

Fitness

Activity	Points	
Daily Points		up to 50/day maximum
Steps	1	per 1,000 steps
Heart Rate	15	for every 15 minutes above 60% of maximum heart rate
Calories	5	per 100 calories if burn rate exceeds 200 calories/hr.
Participating Fitness Facility	10	once/day
Fitness Habit	25	monthly
First verified lifetime workout	500	once/lifetime
First verified workout each new program year	750	once/program year
Sports league	350	
Challenges		up to 100/month maximum
Create a Challenge	50	
Join a Challenge	50	
Join a team	50	
Athletic events		up to 1,400/program year
Level 1	250	
Level 2	350	
Level 3	500	
Kids sports league	100	
Kids athletic events	50	

Prevention

Activity	Points	
Health screening*	400	per eligible screening
Dental exam	200	up to 400/program year
Vision exam	200	
Flu shot	200	
Nicotine test	400	
Kids preventive care visit	200	
Kids dental exam	100	up to 200/program year
Kids vision exam	100	
Kids immunizations	100	
Kids flu shot	100	

Biometric Screening completion:	
Body mass index (BMI)	800
Blood pressure	400
Blood glucose	400
Total cholesterol	400

* Subject to certain requirements and will appear on your Points statement if they are applicable to you.

Healthy Living

Activity	Points	
Blood donation	400	up to 300/program year
Nicotine test healthy in-range results	400	

If your Biometric Screening is in healthy range, you double your Points.

2x Biometric Screening in-healthy range Points:	
Body mass index (BMI)	800
Blood pressure	400
Blood glucose	400
Total cholesterol	400

See page 9 for Biometric Screening healthy ranges.

We are committed to helping you achieve your best health. Rewards for participating in Go365 are available to all members. If you think you might be unable to meet a standard for a Go365 reward, you might qualify for an opportunity to earn the same reward by different means. Sign in to your Go365.com account and visit the Communication center to send us a secure message and we will work with you (and, if you wish, with your healthcare practitioner) to develop another way to qualify for the reward. Online statements not available for all Go365 members. Go365 Kids is not available to all Go365 programs. Check with your Employer or Benefits Administrator to check your eligibility. Adult children are not eligible to earn Points for Health Assessment, Biometric Screening completion or for having in healthy range results.

Plan your next Status move.

Sign in to Go365.com or download the Go365 App.

Then use this worksheet to map out the number of Points you need to move up to the next Go365 Status level. Include standard Activities, as well as Recommended Activities based on your Health Assessment responses.

(Check the next Status level based on your current Status)

Status goal: ◯ Bronze ◯ Silver ◯ Gold ◯ Platinum

Points required: _____

Sign in to Go365.com to verify your actual Points required or reference page 2 of this document for required Points for each Status level.

EXAMPLE:

✓ Get a flu shot _____ 200 PTS

Recommended Activities:

Once you complete your Health Assessment, you'll get personalized Activities based on your responses. Because Recommended Activities are created just for you, they can have a big impact on your overall health. Plus, you earn more Points for each one you complete.

◯ _____ _____ PTS

◯ _____ _____ PTS

◯ _____ _____ PTS

◯ _____ _____ PTS

Activities:

These simple things you can do every day to get healthier. Tracking your steps, getting a flu shot, going for a bike ride – these are easy ways to keep moving forward with Go365.

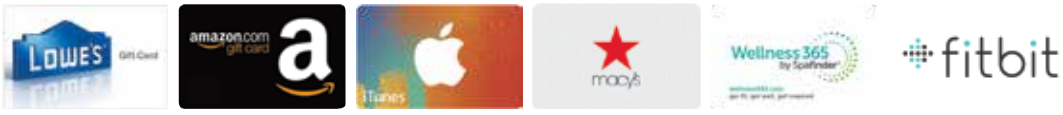
◯ _____ _____ PTS

◯ _____ _____ PTS

◯ _____ _____ PTS

◯ _____ _____ PTS

Go shopping: the Go365 Mall has a wide selection of rewards to choose from:



ANDROID APP ON Google play

Download on the App Store

Go365.com

It's simple to get started with Go365™. Here's how to get rewarded for your healthy behaviors.

1. Register now

Download the Go365 App or visit **Go365.com** to access your secure, password- protected Go365 account and program.

2. Take the next step

Three easy ways to start earning Points and get to Bronze Status:

- Complete at least one section of your Health Assessment
- Log a verified workout
- Get your biometric screening

3. Enjoy the rewards

Keep earning Points by completing healthy activities. The more Points you earn, the more Bucks you will have to spend in the Go365 Mall. Reward yourself with brands including:

amazon.com TARGET Spafinder Wellness 365 fitbit

Join the Go365 support community
community.go365.com

Register or sign in at **Go365.com** or on the App

Go365 is not an insurance product. Not available with all Humana health plans.

Adult children can only move a family into Bronze Status by completing a verified workout.

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INDIVIDUAL

GETTING TO **SILVER STATUS**

You're off to a great start. Now it's time to earn Points so you can move up to Silver Status. Earn Points in Go365™ by completing activities online or using the Go365 App.

Here are all the ways you can earn Points in Go365:

- **Activities** - Things you can do every day to get healthier
- **Recommended Activities** - Created just for you based on your Heath Assessment responses
- **Go365 Kids** - Points for activities that are good for kids' health
- **Challenges** - Compete against friends and co-workers

While you can choose any qualified activity, here are popular activities you may complete to reach Silver Status in the first 12 weeks of your Go365 program year.

Individual (5,000 Points)

Activity	Point Value
Health Assessment (all sections)	**500**
Bonus - Health Assessment 90-day completion (all sections)	**250**
Bonus - First step Health Assessment (once per lifetime) (all sections)	**500**
Biometric screening completion	**2,000**
In healthy range biometric screening results:	
Blood pressure	**400**
Blood glucose	**400**
Dental exam	**200**
Flu shot	**200**
Daily fitness Points (over 12 weeks):	
Two fitness facility workouts per week (10 Points x 24 workouts)	**240**
Complete an organized 5K walk or run	**250**
Calculators (x1)	**75**
Total Points	**5,015**

Bonus Bucks! Earn 500 Bonus Bucks when you reach Silver Status. Earn 1,000 Double Bonus Bucks when you reach Silver Status for the first time or if your prior year highest Status was Silver.

Go365 is not an insurance product. Not available with all Humana health plans.

FAMILY

GETTING TO **SILVER STATUS**

Give the whole family a boost! Get to Silver Status together by earning Points through activities, Challenges and even Go365 Kids.

Family; 2 adults + child (8,000 Points)

5,000 Points for primary Go365 member + 3,000 Points for additional adult family member

Activity	Point Value
Health Assessment (2 adults; 500 Points x 2)	**1,000**
Bonus - Health Assessment 90-day bonus (2 adults; 250 Points x 2)	**500**
Bonus - First step Health Assessment (2 adults; 500 Points x 2)	**1,000**
Biometric screening completion (2 adults; 2,000 Points x 2)	**4,000**
In healthy range biometric screening results (1 adult):	
BMI	**800**
Calculators (1 adult; 75 Points x 4)	**300**
Blood donation (1 adult; 50 Points x 2)	**100**
Sports league participation (1 adult)	**350**
Monthly **Go365.com** visit (1 adult; 10 Points x 12 months)	**120**
Daily fitness Points (1 adult; over 12 weeks):	
8,000 steps per day achieved 5 days per week (8 Points x 60 days)	**480**
First lifetime verified workout (1 adult)	**500**
First verified workout of the new program year (1 adult)	**750**
Kids sports league (100 Points x 2)	**200**
Kids preventive care visit	**200**
Kids dental exam	**100**
Total Points	**8,400**

Adult children are not eligible to earn Points or Bucks for Health Assessment, biometric screening completion or for having in healthy range results.

Bonus Bucks! Earn 500 Bonus Bucks when you reach Silver Status. Earn 1,000 Double Bonus Bucks when you reach Silver Status for the first time or if your prior year highest Status was Silver.

We'll award your adult family members, too! Each adult family member will receive 250 Bonus Bucks for reaching Silver Status. Adult family members will earn 500 Double Bonus Bucks when you reach Silver Status for the first time or if your prior year highest Status was Silver. That's a lot of buying power!

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We are committed to helping you achieve your best health. Rewards for participating in Go365 are available to all members. If you think you might be unable to meet a standard for a Go365 reward, you might qualify for an opportunity to earn the same reward by different means. Sign in to your Go365.com account and visit the Communication center to send us a secure message and we will work with you (and, if you wish, with your health care practitioner) to develop another way to qualify for the reward.
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INDIVIDUAL

GETTING TO **GOLD STATUS**

You've made it this far. Take the next step. Earn more Points so you can move up to Gold Status. Earn Points in Go365™ by completing activities online or using the Go365 App.

Here are all the ways you can earn Points in Go365:

- **Activities** - Things you can do every day to get healthier
- **Recommended Activities** - Created just for you based on your Heath Assessment responses
- **Go365 Kids** - Points for activities that are good for kids' health
- **Challenges** - Compete against friends and co-workers

While you can choose any qualified activity, here are popular activities you may complete to reach Gold Status in the first 12 weeks of your Go365 program year.

Individual (8,000 Points)

Activity	Point Value
Health Assessment (all sections)	**500**
Bonus - Health Assessment 90-day completion (all sections)	**250**
Bonus - First step Health Assessment (one per lifetime)	**500**
Biometric screening completion	**2,000**
In healthy range biometric screening results:	
Blood pressure	**400**
Blood glucose	**400**
Total cholesterol	**400**
CPR certification	**125**
Join a Challenge (x2)	
50 Points to join Challenge + 50 Points to join challenge team	**200**
Fitness habit Milestone (25 Points x 2)	**50**
Dental exam	**200**
Flu shot	**200**
First lifetime verified workout	**500**
First verified workout of the new program year	**750**
Daily fitness Points (over 12 weeks):	
Three fitness facility workouts per week (10 Points x 36 workouts)	**360**
10,000 steps per day (achieved 1 day per week) (10 Points x 12 days)	**120**
8,000 steps per day (achieved 3 days per week) (8 Points x 36 days) Only one type of daily workout Points awarded per day.	**288**
Bonus - exceeded 50 weekly workout Points (50 Points x 12 weeks)	**600**
Complete a 10K run	**350**
Calculators (75 Points x2)	**150**
Total Points	**8,343**

Bonus Bucks! Earn 1,500 Bonus Bucks when you reach Gold Status. Earn 3,000 Double Bonus Bucks when you reach Gold Status if your prior year highest Status was Gold.

Go365 is not an insurance product. Not available with all Humana health plans.

FAMILY

GETTING TO **GOLD STATUS**

The whole family can go for the Gold Status together by earning Points through activities, Challenges and even Go365 Kids.

Family; 2 adults + child (12,000 Points)

8,000 Points for Primary Go365 member + 4,000 Points for additional adult family member

Activity	Point Value
Health Assessment (2 adults; 500 Points x 2)	**1,000**
Bonus - Health Assessment 90-day bonus (2 adults; 250 Points x 2)	**500**
Bonus - First step Health Assessment (2 adults; 500 Points x 2)	**1,000**
Biometric screening completion (2 adults; 2,000 Points x 2)	**4,000**
In healthy range biometric screening results (1 adult):	
BMI	**800**
Total cholesterol	**400**
Calculators (1 adult; 75 Points x 4)	**300**
Blood donation (1 adult; 50 Points x 2)	**100**
Sports league participation (1 adult)	**350**
Monthly **Go365.com** visit (2 adult; 10 Points x 12 months)	**240**
First lifetime verified workout (1 adult)	**500**
First verified workout of the new program year (1 adult)	**750**
Daily fitness Points (1 adult; over 12 weeks):	
Two fitness facility workouts per week for 12 weeks (10 Points x 24 workouts)	**240**
12,000 steps per day (achieved 1 day per week) (12 Points x 12 days)	**144**
7,500 steps per day (achieved 2 days per week) (7 Points x 24 days) Only one type of daily workout Points awarded per day.	**168**
Vision exam (1 adult)	**200**
Flu shot (2 adults; 200 Points x 2)	**400**
Dental exam (1 adult; 200 Points x 2)	**400**
Daily health quiz Milestone (1 adult; 2 Points x 30 days)	**60**
Kids sports league (100 Points x 2)	**200**
Kids preventive care visit	**200**
Kids dental exam	**100**
Total Points	**12,052**

Adult children are not eligible to earn Points or Bucks for Health Assessment, biometric screening completion or for having in healthy range results.

Bonus Bucks! Earn 1,500 Bonus Bucks when you reach Gold Status. Earn 3,000 Double Bonus Bucks when you reach Gold Status if your prior year highest Status was Gold.

We'll award your adult family members, too! Each adult family member will receive 750 Bonus Bucks for reaching Gold Status, and 1,500 Double Bonus Bucks if your prior year hightest Status was Gold. That's a lot of buying power!

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We are committed to helping you achieve your best health. Rewards for participating in Go365 are available to all members. If you think you might be unable to meet a standard for a Go365 reward, you might qualify for an opportunity to earn the same reward by different means. Sign in to your Go365.com account and visit the Communication center to send us a secure message and we will work with you (and, if you wish, with your health care practitioner) to develop another way to qualify for the reward.

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Summary of Benefits

Dental Benefit Summary

Group ID:	00479777	**Coverage Type:**	Voluntary
Group Name:	CLINICAL RESOURCES, LLC	**Class:**	0002 ALL OTHER ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 60 day(s)	**As of Date:**	10/11/2016

Plan Information

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

Coverage Information

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

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

General Exclusions

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

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

Deductibles apply.

The plan does not pay for:

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

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

Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't

pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

1 Restrictions apply and may be subject to medical necessity.

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

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

GUARDIAN®

Choose the dental plan that's right for you and switch each year at enrollment time if your needs change!

	Value Plan	Network Access Plan
In-network:	Benefits are based on a negotiated contracted fee schedule (an average discount of 30%). No additional fees to the dentist!	
Out-of-network:	• Benefits are based on the discounted fee schedules agreed upon by our network dentists. • Any amount that is charged over the fee schedule is the responsibility of the patient	• Benefits are based on usual, customary and reasonable (UCR) charges that dentists in your area charge for each procedure.
Co-insurance	• Preventive services are covered 100% • Co-insurance (benefits) for other services are higher than the Network Access Plan	• Preventive services are covered 100% • Co-insurance (benefits) for other services are lower than the Value Plan
Save money by using network providers	• **If you always use network providers, consider the Value Plan.** • **With higher co-insurance levels, your out-of-pocket costs are reduced for in-network dentists.**	• **If you want freedom to choose between in-network and out-of-network providers, consider the Network Access Plan.** • **Coverage out-of-network is not limited to the discounted fees our in-network dentists charge.**

- Premiums are the same for either plan
- Switch plans each year at annual enrollment time
- Save an average of 30% over what dentists usually charge by using network providers

Summary of Benefits

Vision Benefit Summary

Group ID:	00479777	**Coverage Type:**	Voluntary
Group Name:	CLINICAL RESOURCES, LLC	**Class:**	0002 ALL OTHER ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 60 day(s)	**As of Date:**	10/11/2016

Plan Information

Your network is the VSP - Signature Full Feature

Coverage Information

	VSP - Signature Full Feature	
What's the most cost-effective way to use vision benefits?	You may go to any eye doctor however, if you go to a VSP network provider you will usually pay less.	
	In-Network	**Out-Of-Network**
Co-Pay		
First service provided	Not applicable	
Exams	Exams $10.00	
Materials	waived for conventional and planned replacement contact lenses $20.00	
How often can I obtain service?	**Exams:** Once a year. **Lenses:** Once a year. **Frames:** Once every other year. **Materials:** Once a year.	
	In-Network	**Out-Of-Network**
Eye exams	Copay applies	Amount over: $50.00
Lenses		
Single vision lenses	Copay applies	Amount over: $48.00
Lined bifocal lenses	Copay applies	Amount over: $67.00
Lined trifocal lenses	Copay applies	Amount over: $86.00
Lenticular lenses	Copay applies	Amount over:

	VSP - Signature Full Feature	
What's the most cost-effective way to use vision benefits?	You may go to any eye doctor however, if you go to a VSP network provider you will usually pay less.	
	In-Network	**Out-Of-Network**
		$126.00
Contact Lenses		
Conventional	Amount over: $130.00	Amount over: $130.00
Planned replacement and disposable	Amount over $130.00	Amount over: $130.00
Medically necessary	Copay Applies	Amount over: $210.00
Evaluation and fitting	15% off professional fee	Not Covered
Frames	$130.00, 20% discount on amount over $130.00.	Amount over: $48.00
Lens & Frame Allowance	No discounts	No discounts
Cosmetic Extras	Discounted at an average of 30%.	No discounts
Laser correction surgery	Average 15% discount off usual price or 5% off promotional price.	No discounts

Vision and General Exclusions

Important information

This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for:

- Orthoptics or vision training and any associated supplemental testing;
- Medical or surgical treatment of the eye;
- Eye examination or corrective eyewear required by an employer as a condition of employment;
- Replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists).

The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-VSN-96-VIS et al.

Laser Correction Surgery

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

30% discount off of additional pairs of prescription glasses as well as non-prescription sunglasses purchased the same day as the member's eye exam from the same VSP doctor who provided the exam. (Members will continue to receive 20% off unlimited additional pairs of glasses valid through any VSP doctor within 12 months of the last covered exam.)

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.

Summary of Benefits

Basic Life Benefit Summary

Group ID:	00479777	**Member Coverage Type:**	Non Contributory
Group Name:	CLINICAL RESOURCES, LLC	**Class:**	0002 ALL OTHER ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 60 day(s)	**As of Date:**	06/02/2015

Coverage Information

Employee Volume Amount	Flat $25,000
Maximum Amount	$25,000
Cutbacks	35% at age 65 60% at age 70 75% at age 75 85% at age 80

Plan Information

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

Basic Life and General Exclusions

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

Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to policy booklet

for full plan description.

A person is ADL-disabled if he or she is (a) physically unable to perform two or more ADLs without continuous physical assistance; or (b) cognitively impaired, and requires verbal cueing to protect himself/herself or others. ADLs are bathing, dressing, toileting, transferring, continence, and eating. This proposal is hedged subject to satisfactory financial evaluation. This coverage will not be effective until approved by a Guardian underwriter. Please refer to policy booklet for full plan description.

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

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

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

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

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

Summary of Benefits

Accidental Death and Dismemberment Benefit Summary

Group ID:	00479777	**Member Coverage Type:**	Non Contributory
Group Name:	CLINICAL RESOURCES, LLC	**Class:**	0002 ALL OTHER ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 60 day(s)	**As of Date:**	06/02/2015

Coverage Information

Volume Amount	Flat $25,000
Guaranteed Issue	Your Accidental Death and Dismemberment coverage is guaranteed based on your Basic Life coverage.
Maximum Amount	$25,000
Cutbacks	35% at age 65 60% at age 70 75% at age 75 85% at age 80

Plan Information

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

Accidental Death and Dismemberment and General Exclusions

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

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

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

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

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

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Summary of Benefits

Short Term Disability Benefit Summary

Group ID:	00479777	**Member Coverage Type:**	Non Contributory
Group Name:	CLINICAL RESOURCES, LLC	**Class:**	0002 ALL OTHER ELIGIBLE EMPLOYEES
Waiting Period:	90 day(s)	**As of Date:**	04/11/2013

Coverage Information

Weekly Volume	60% of weekly earnings
Guaranteed Issue	There is no guaranteed issue. All amounts are approved.
Maximum Amount	$1,000
Waiting Periods (Benefits begin on ...)	Accident: Day 1 Illness: Day 8
Maximum Payment Period	13 weeks

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.
How are my earnings defined?	Earnings means your weekly earnings excluding expense accounts, and any other extra compensation. Earnings include the average of your bonuses & commissions for the previous 24 months. If you are a partner, earnings means your partnership earnings that are reported on your IRS Form 1040 Schedule E for the prior calendar or tax year.
Can I take the policy with me if I leave the company?	No.
Do I have to answer medical questions as part of purchasing insurance?	No.
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.

Short Term Disability General Limitations and Exclusions

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.

We do not pay benefits for any job-related or on-the-job injury, or conditions for which Workers' Compensation benefits are payable.

We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We do not pay benefits 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 is receiving treatment outside of the US or Canada, and the employee's loss or earnings is not solely due to disability. This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", "medical" insurance as defined by the New York State Insurance Department. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment:

a. exceeding one year; or
b. in an area under travel warning by the US Department of State, subject to state specific variations.

If the plan is new (not transferred): This STD plan limits benefits for a disability relating to a pre-existing condition. A pre-existing condition includes any condition for which an employee, in the three month period prior to coverage under this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan details for specific time periods.

Contract #'s GP-1-STD2K-1.0 et al., GP-1-STD07-1.0 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. due to intoxication;
5. cofined to a correctional facility, or
6. receiving treatment outside US.

Disability benefits are not paid for any period in which you are in a correctional facility, you are not under the care of a doctor, 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

When applicable, this coverage will integrate with any mandated state disability plans.

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Summary of Benefits

Long Term Disability Benefit Summary

Group ID:	00479777	**Member Coverage Type:**	Non Contributory
Group Name:	CLINICAL RESOURCES, LLC	**Class:**	0002 ALL OTHER ELIGIBLE EMPLOYEES
Waiting Period:	90 day(s)	**As of Date:**	04/11/2013

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?	No.
Do I have to answer medical questions as part of purchasing insurance?	No.
How are my earnings defined?	Earnings means your monthly earnings excluding expense accounts, and any other extra compensation. Earnings include the average of your bonuses & commissions for the previous 24 months. If you are a partner, earnings means your partnership earnings that are reported on your IRS Form 1040 Schedule E for the prior calendar or tax year.
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. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, and 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. 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.

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.

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. due to intoxication;
5. confined to a correctional facility, or
6. receiving treatment outside US.

Disability benefits are not paid for any period in which you are in a correctional facility, you are not under the care of a doctor, 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.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.groupcertificate.humana.com or by calling 1-866-4ASSIST (427-7478). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $0 Individual / $0 family; Non-Network: $5,000 Individual / $10,000 family Doesn't apply to prescription drugs and network preventive services. Coinsurance and copayments don't count toward the deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Network Providers: Not Applicable. Non-Network Providers: Yes. Emergency Room Care and Prescription Drugs.	This plan does not have a network deductible. This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $7,150 individual / $14,300 family; For non-network providers $21,450 individual / $42,900 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Balance-billing charges, Health care this plan doesn't cover, Penalties, Non-network transplant, non-network prescription drugs, non-network specialty drugs	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Will you pay less if you use a network provider?	Yes. See www.humana.com/directories or call 1-866-4ASSIST (427-7478) for a list of network providers For Prescription Drugs: National Rx Network	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$55 copay/office visit; deductible does not apply	30% coinsurance	None
	Specialist visit	$110 copay/visit; deductible does not apply	30% coinsurance	None
	Preventive care / screening / immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	30% coinsurance	Diagnostic Test: Cost share may vary based on where service is performed Imaging: Cost share may vary based on where service is performed Preauthorization may be required - if not obtained, penalty will be 40%
	Imaging (CT/PET scans, MRIs)	$850 copay; deductible does not apply	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com/2017-Rx4-EHB	Level 1 - Lowest cost generic and brand-name drugs	$10 copay (Retail); deductible does not apply $25 copay (Mail Order); deductible does not apply	30% coinsurance, after network copay (Retail); deductible does not apply 30% coinsurance, after network copay (Mail Order); deductible does not apply	30 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Retail) 90 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Mail Order) Non-network cost sharing does not count toward the out-of-pocket limit.
	Level 2 - Higher cost generic and brand-name drugs	$50 copay (Retail); deductible does not apply $125 copay (Mail Order); deductible does not apply	30% coinsurance, after network copay (Retail); deductible does not apply 30% coinsurance, after network copay (Mail Order); deductible does not apply	
	Level 3 - Generic and brand-name drugs with higher cost than Level 2	$100 copay (Retail); deductible does not apply $250 copay (Mail Order); deductible does not apply	30% coinsurance, after network copay (Retail); deductible does not apply 30% coinsurance, after network copay (Mail Order); deductible does not apply	
	Level 4 - Highest cost drugs	25% coinsurance (Retail); deductible does not apply 25% coinsurance (Mail Order); deductible does not apply	30% coinsurance, after network copay (Retail); deductible does not apply 30% coinsurance, after network copay (Mail Order); deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Specialty Drugs	35% coinsurance; deductible does not apply	35% coinsurance; deductible does not apply	25% coinsurance when filled via a preferred network specialty pharmacy Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$2350 copay/visit; deductible does not apply	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	No charge; deductible does not apply	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$850 copay/visit; deductible does not apply	$850 copay/visit; deductible does not apply	Emergency room care: Copayment waived if admitted
	Emergency medical transportation	$850 copay/transport; deductible does not apply	$850 copay/transport; deductible does not apply	
	Urgent care	$125 copay/visit; deductible does not apply	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$2350 copay/day; deductible does not apply	30% coinsurance	3 days for copay per day Preauthorization may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	No charge; deductible does not apply	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$55 copay/visit; deductible does not apply	30% coinsurance	Inpatient services: 3 days for copay per day Preauthorization may be required - if not obtained, penalty will be 40%
	Inpatient services	$2350 copay/day; deductible does not apply	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge; deductible does not apply	30% coinsurance	Office visits: Cost sharing does not apply for preventive services. Childbirth/delivery professional services: Depending on the type of services, a deductible may apply. Childbirth/delivery facility services: Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) 3 days for copay per day Preauthorization may be required - if not obtained, penalty will be 40%
	Childbirth/delivery professional services	No charge; deductible does not apply	30% coinsurance	
	Childbirth/delivery facility services.	$2350 copay/day; deductible does not apply	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$110 copay/visit; deductible does not apply	30% coinsurance	120 visits per year Preauthorization may be required - if not obtained, penalty will be 40%

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Rehabilitation services	$110 copay/visit; deductible does not apply to Manipulations, Occupational Therapy, Speech Therapy, Audiology Therapy, Cognitive Therapy, and Physical Therapy	30% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 40% Manipulations and Therapies: 40 Visits per year combined with Physical Therapy/ Occupational Therapy/ Speech Therapy/ Audiology Therapy include Adjus & Manip, exclude Cognitive Therapy 40 visits per year combined with Physical Therapy/ Occupational Therapy/ Audiology Therapy/ Speech Therapy/ Cognitive Therapy include Adjus & Manip For non-network, 10 Visits per year combined with Physical Therapy/ Occupational Therapy/ Speech Therapy/ Audiology Therapy include Adjus & Manip, exclude Cognitive Therapy For non-network, 10 visits per year combined with Physical Therapy/ Occupational Therapy/ Audiology Therapy/ Speech Therapy/ Cognitive Therapy include Adjus & Manip
	Habilitation services	$110 copay/visit; deductible does not apply to Manipulations, Occupational Therapy, Speech Therapy, Audiology Therapy, Cognitive Therapy, and Physical Therapy	30% coinsurance	
	Skilled nursing care	$110 copay/day; deductible does not apply	30% coinsurance	60 day limit per year Preauthorization may be required - if not obtained, penalty will be 40%

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Durable medical equipment	No charge; deductible does not apply	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40% for durable medical equipment $750 and over Excludes vehicle and home modifications,exercise and bathroom equipment
	Hospice services	No charge; deductible does not apply	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$10 copay/visit; deductible does not apply	50% coinsurance	Plan coverage limited to 1 exam per year until the end of the month child turns 19
	Children's glasses	40% coinsurance; deductible does not apply	40% coinsurance	Plan coverage limited to 1 pair of frames per year until end of month child turns 19 1 pair of lenses per year until end of month child turns 19
	Children's dental check-up	40% coinsurance; deductible does not apply	40% coinsurance	2 exams per year until end of the month child turns 19

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-Emergency Care, when traveling outside of the U.S
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your **plan** document.)

Limitations may apply to these services as permitted by applicable law. These limitations are listed in your plan document.

- Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Humana, Inc.: www.humana.com or 1-866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
- Georgia Office of Insurance and Safety Fire Commissioner, Two Martin Luther King Jr. Drive, West Tower, Suite 704, Atlanta, GA 30334, Phone: 404-656-2056 or 800-656-2298 (toll free)

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of **in-network** pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$110**
Hospital (facility) copayment	**$2350**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,400**

Managing Joe's type 2 Diabetes
(a year of routine **in-network** care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$110**
Hospital (facility) copayment	**$2350**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

Mia's Simple Fracture
(**in-network** emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$110**
Hospital (facility) copayment	**$2350**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$1,740**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.groupcertificate.humana.com or by calling 1-866-4ASSIST (427-7478). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $2,900 Individual / $5,800 family; Non-Network: $8,700 Individual / $17,400 family Doesn't apply to network preventive services. Coinsurance and copayments don't count toward the deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Network Providers: Yes. Preventive. Non-Network Providers: No.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $5,000 individual / $10,000 family; For non-network providers $15,000 individual / $30,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Balance-billing charges, Health care this plan doesn't cover, Penalties, Non-network transplant, non-network prescription drugs, non-network specialty drugs	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Will you pay less if you use a network provider?	Yes. See www.humana.com/directories or call 1-866-4ASSIST (427-7478) for a list of network providers For Prescription Drugs: National Rx Network	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care / screening / immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Imaging: Cost share may vary based on where service is performed Preauthorization may be required - if not obtained, penalty will be 40%
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.humana.com/2017-HDHP-EHB	Generic and brand-name drugs	20% coinsurance (Retail) 20% coinsurance (Mail Order)	20% coinsurance (Retail) 20% coinsurance (Mail Order)	30 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Retail) 90 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Mail Order) Non-network cost sharing does not count toward the out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Inpatient services: Preauthorization may be required - if not obtained, penalty will be 40%
	Inpatient services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge; deductible does not apply	30% coinsurance	Office visits: Cost sharing does not apply for preventive services. Childbirth/delivery professional services: Depending on the type of services, a coinsurance or deductible may apply. Childbirth/delivery facility services: Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) Preauthorization may be required - if not obtained, penalty will be 40%
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services.	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visits per year Preauthorization may be required - if not obtained, penalty will be 40%

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Rehabilitation services	20% coinsurance	40% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 40% Manipulations and Therapies: 40 Visits per year combined with Physical Therapy/ Occupational Therapy/ Speech Therapy/ Audiology Therapy include Adjus & Manip, exclude Cognitive Therapy 40 Visits per year combined with Physical Therapy/ Occupational Therapy/ Speech Therapy/ Audiology Therapy/ Cognitive Therapy include Adjus & Manip For non-network, 10 Visits per year combined with Physical Therapy/ Occupational Therapy/ Speech Therapy/ Audiology Therapy include Adjus & Manip, exclude Cognitive Therapy For non-network, 10 isits per year combined with Physical Therapy/ Occupational Therapy/ Speech Therapy/ Audiology Therapy/ Cognitive Therapy include Adjus & Manip
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	60 days per year Preauthorization may be required - if not obtained, penalty will be 40%
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40% for durable medical equipment $ 750 and over Excludes vehicle and home modifications,exercise and bathroom equipment
	Hospice services	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$10 copay/visit	30% coinsurance	Plan coverage limited to 1 exam per year until the end of the month child turns 19
	Children's glasses	40% coinsurance	40% coinsurance	Plan coverage limited to 1 pair of frames per year until end of month child turns 19 1 pair of lenses per year until end of month child turns 19
	Children's dental check-up	40% coinsurance	40% coinsurance	2 exams per year until end of the month child turns 19

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-Emergency Care, when traveling outside of the U.S
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your **plan** document.)

Limitations may apply to these services as permitted by applicable law. These limitations are listed in your plan document.

- Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Humana, Inc.: www.humana.com or 1-866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

- Georgia Office of Insurance and Safety Fire Commissioner, Two Martin Luther King Jr. Drive, West Tower, Suite 704, Atlanta, GA 30334, Phone: 404-656-2056 or 800-656-2298 (toll free)

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of **in-network** pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,900**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,900
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,900**

Managing Joe's type 2 Diabetes
(a year of routine **in-network** care of a well-controlled condition)

The plan's overall deductible	**$2,900**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,900
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,820**

Mia's Simple Fracture
(**in-network** emergency room visit and follow up care)

The plan's overall deductible	**$2,900**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$1,940**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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**

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 Sadie Kulla
.

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)
Clinical Resources, LLC.	26-3208548
5. Employer address	**6. Employer phone number**
3338 Peachtree Road NE Ste 102	404-343-7227

7. City	8. State	9. ZIP code
Atlanta	GA	30326

10. Who can we contact about employee health coverage at this job?	
Sadie Kulla	
11. Phone number (if different from above)	**12. Email address**
	sadie@clinicalresources.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)

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.

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

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

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

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

Important Notice from CLINICAL RESOURCES, INC. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CLINICAL RESOURCES, INC. **and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current CLINICAL RESOURCES, INC. coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current CLINICAL RESOURCES, INC. coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through CLINICAL RESOURCES, INC. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	2017
Name of Entity/Sender:	CLINICAL RESOURCES, INC.
Contact--Position/Office:	Sadie Kulla/VP of Operational Finance
Address:	3338 Peachtree Road NE Ste 102, Atlanta, GA 30326
Phone Number:	404-343-7227

Disclaimer: This Benefit Guide provides only the briefest of summaries of the benefits available under Clinical Resources, LLC. In the event of any discrepancy between this summary and any Plan Document, the Plan Document will prevail. Clinical Resources, LLC retains the right to modify or eliminate these or any benefits at any time and for any reason.

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