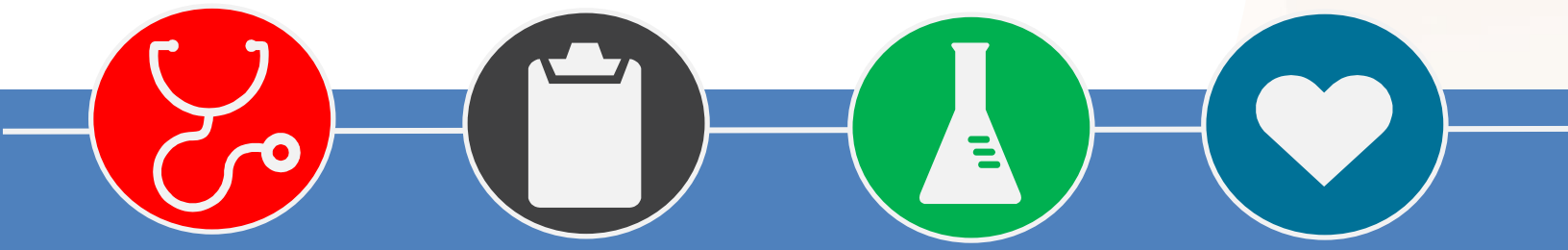
2017

BENEFITS OVERVIEW GUIDE

Profisee®
Connect anything. Master everything.



Your wellness is our focus.

BENEFIT QUESTIONS AND CLAIM RESOLUTION

CONTACT INFORMATION

Employee Advocate

Because of HIPAA laws, Profisee Group Incorporated staff cannot answer any questions specific to medical conditions or procedures. If you need assistance with your Medical, Dental, Vision, Life and/or Long Term Disability benefits or have questions regarding an Explanation of Benefits, a bill you received or any benefit or coverage issues and concerns, please call your **Employee Advocate, Traci Blake, at 1-888-517-3659 or email** TBlake@CBIZ.com@CBIZ.com for personalized service.

Direct Inquiries

If you have questions about your Medical benefits, call:

United Healthcare

1-800-241-4675

www.myuhc.com

If you have questions about your Dental benefits, call:

Principal

1-800-247-4695

www.principal.com

If you have questions about your Vision benefits, call:

United Healthcare

1-800-638-3120

www.myuhcvision.com

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Your 2017 Employee Benefits Guide

We recognize the important role employee benefits plays as a critical component of your overall compensation. Profisee Group Incorporated continues to make every effort to target the best quality benefit plans for our employees and their families. We know that your benefits are important to you and your family, and this program is designed to assist you in providing for the health, well being, and financial security of you and your covered dependents. Helping you understand the benefits Profisee Group Incorporated offers is important to us and that is why we have created this Employee Benefits Guide.

Benefits Guide Overview

This Guide, along with your Benefit Summaries, provides a full explanation of the benefits available to you and your family. At this time, all full time employees who work at least 30 hours per week are eligible for benefits and you may elect to enroll in the benefit programs offered. Options selected during this enrollment period will remain in place until 2017 Open Enrollment unless you or your dependents experience a qualified life event (see box below).

Changing Benefits During the Year

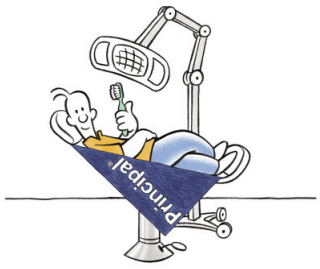
The IRS states that eligible employees may only make plan elections during their initial eligibility period or once a year at open enrollment. The initial eligibility period for Profisee Group Incorporated is the first of the month after date of hire . The following circumstances are the only reasons you may change your benefit elections during the year:

Marriage	**Death of a Dependent**
Divorce	**Dependent/Spouse Loss of Coverage**
Birth or Adoption	**Loss of Dependent Eligibility**
Change in Employment Status, Addition of a New Benefits Package, and Open Enrollment for a Spouse	

These special circumstances, often referred to as life event changes, allow you to make plan changes at any time during the year when they occur. You must inform Human Resources within 30 days of the event in order to make a qualified change. All other changes will be

Medical Coverage - UHC

Type of Plan	Choice Plus	
Overview	You may use both In-Network and Out-of-Network providers Use In-Network providers and receive the In-Network level of benefits. Use Non-Network providers and members are responsible for any difference between the allowed amount and actual charges.	
Annual Deductible	**In-Network**	**Out-of-Network**
Individual	$2,500	$5,000
Family	$7,500	$15,000
Annual Out-of-Pocket Maximum	*Includes Deductible*	
Individual	$2,500	$10,000
Family	$7,500	$20,000
Coinsurance	N/A	Plan pays 80% after Deductible Member pays 20% after Deductible
Deductibles apply to Out-of-Pocket maximums. Out-of-pocket maximums accumulate separately for In-Network and Out-of-Network services.		
Lifetime Maximum	Unlimited	
Primary Care Physician Office Visits	$35 Copay	Plan pays 80% after Deductible
Specialist Office Visits	$65 Copay	Plan pays 80% after Deductible
Preventive Care	Covered at 100%, not subject to Copay or Deductible	Plan pays 80% after Deductible
Maternity Physician Services	Covered at 100%, not subject to Copay or Deductible	Plan pays 80% after Deductible
Hospital Inpatient Expenses *(Facility and Physician Charges)*	Plan pays 100% after Deductible	Plan pays 80% after Deductible
Hospital Outpatient Expenses *(Facility and Physician Charges)*	Plan pays 100% after Deductible	Plan pays 80% after Deductible
Emergency Room	$300 Copay (waived if admitted)	Plan pays 80% after Deductible
Urgent Care	$75 Copay	Plan pays 80% after Deductible
Outpatient Therapies *(ex: physical, chiropractic and occupational)* *Maximum Annual Benefit*	$35 Copay per visit Limits based on type of therapy (20-36 visits)	Plan pays 80% after Deductible 10-visit calendar year maximum
Mental Health, Drug and Alcohol Abuse Treatment Services *(Prior Authorization Required)*	Inpatient: Plan pays 100% after Deductible Outpatient: $65 Copay per visit	Inpatient: Plan pays 80% after Deductible Outpatient: Plan pays 80% after Deductible
Prescription Drugs		
Retail Pharmacy (30 day supply)	$15 for Tier 1 drugs $45 for Tier 2 drugs $85 for Tier 3 drugs $125 for Tier 4 drugs	$15 for Tier 1 drugs $45 for Tier 2 drugs $85 for Tier 3 drugs $125 for Tier 4 drugs
Mail Order Maintenance Drug (90 day supply)	$45 Copay for Tier 1 drugs $135 Copay for Tier 2 drugs $255.00 Copay for Tier 3 drugs $375 Copay for Tier 4 drugs	$45 Copay for Tier 1 drugs $135 Copay for Tier 2 drugs $255.00 Copay for Tier 3 drugs $375 Copay for Tier 4 drugs



Policyholder: PROFISEE GROUP

Dental PPO Benefit Summary

Predetermination of Benefits: Before treatment begins for inlays, onlays, single crowns, prosthetics, periodontics and oral surgery, you may file a dental treatment plan with Principal Life Insurance Company before treatment begins. Principal Life will provide a written response indicating benefits that may be payable for the proposed treatment.

This chart provides you a brief summary of the key benefits of the dental coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your dental coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	ALL MEMBERS

Benefits Payable				
Network	Dental Preferred Provider Organization (PPO)			
	Calendar Year Deductible		Coinsurance (Policy Pays)	
	In-Network	Non-Network	In-Network	Non-Network
Unit 1 – Preventive	$0	$0	100%	100%
Unit 2 – Basic	$50	$50	80%	80%
Unit 3 – Major	$50	$50	50%	50%
Family Deductible Maximum	3 times the per person deductible amount			
Combined Deductible	In-network deductibles for basic and major procedures are combined. Non-network deductibles for basic and major procedures are combined.			
Combined Maximums	Maximums for preventive, basic, and major procedures are combined. In-network calendar year maximums are $2,000 per person. Non-network Calendar year maximums are $2,000 per person.			

How Are Dental Procedures Covered?

The list of common procedures shows what unit the procedure is included in and how often they are covered.

Unit 1 – Preventive Procedures	• Routine exams (two per calendar year) • Emergency exams (subject to Routine exam frequency limit) • Teeth cleaning (two per calendar year) • Fluoride treatments (one every calendar year for dependent children under age 14) • Bitewing x-rays (one set every calendar year) • Full mouth/Panoramic x-rays (one every 60 months) • Sealants (on 1st and 2nd permanent molars, once every 36 months for dependent children under age 16)
Unit 2 – Basic Procedures	• Simple Oral Surgery • Complex Oral Surgery (includes extraction of impacted teeth) • Endodontics (root canal therapy) • Fillings • Periodontal prophy (Covered if 3 months following active periodontal treatment. Subject to teeth cleaning frequency limit.) • Non-surgical Periodontics, including scaling and root planing (once every 24 months per quadrant) • Surgical Periodontics (once every 36 months per quadrant)
Unit 3 – Major Procedures	• Inlays, onlays, and crowns, including replacement (once per tooth every 60 months) • Full and partial dentures, including replacement (covered only if at least 60 months have elapsed since last placement) • Bridgework, including replacement (covered once per 60 months)

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

UnitedHealthcare

Vision Benefit Summary
www.myuhcvision.com
Customer Service: (800) 638-3120
Provider Locator: (800) 839-3242

Plan V1006

	NETWORK	NON-NETWORK
Comprehensive Vision Exam	$10 Copay	Up to $40
Materials - Eyeglass Lenses/Eyeglass Frames or Contact Lenses	$25 Copay[1]	See below
Frequencies - Based on last date of service	Exam Once every 12 months Lenses Once every 12 months Frames Once every 12 months	

COVERED SERVICES	NETWORK	NON-NETWORK
Pair of Lenses (for Eyewear)		
• Standard single vision lenses • Standard lined bifocal lenses • Standard lined trifocal lenses • Standard lenticular lenses Lens options such as progressive lenses, tints, UV, and anti-reflective coating may be available at a discount at participating providers.	Covered in full after applicable copay[1] Includes standard scratch-resistant coating	Up to $40 Up to $60 Up to $80 Up to $80
Frames		
You will receive a retail frame allowance toward the purchase of any frame at a network provider. For frames that exceed your allowance, you may receive an additional 30% discount on the overage (available only at participating providers and may exclude certain frame manufacturers).	$130 Retail Frame Allowance (after applicable copay [1])	Up to $45
Contact Lenses[2]		
• Covered contact lens selection It is important to note the covered contact lens selection may vary by provider but does include the most popular brands on the market today.[3] A complete list can be found by visiting our website www.myuhcvision.com.	Up to 4 boxes of contact lenses plus the fitting/evaluation fees and up to two follow-up visits are covered-in-full (after applicable copay [1])	Up to $105
• Non-selection contacts You receive an allowance which is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered contact lens selection.	Up to $105 (material copay is waived)	Up to $105
• Necessary contact lenses[4]	Covered in full after applicable copay[1]	Up to $210

[1] The material copayment will apply once if frames and lenses, or contact lenses in lieu of eyewear, are purchased at the same time at a network provider.

[2] Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames.

[3] Coverage for Covered Contact Lens Selection does not apply at Walmart or Sam's Club locations. The allowance for non-selection contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

[4] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or eyeglass frames; with certain conditions of anisometropia, keratoconus, irregular corneals/astigmatism, aphakia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare concerning the reimbursement that UnitedHealthcare will make before you purchase such contacts.

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.

Important Notice from PROFISEE GROUP 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 PROFISEE GROUP 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. PROFISEE GROUP 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 PROFISEE GROUP INC. coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current PROFISEE GROUP 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 PROFISEE GROUP 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 PROFISEE GROUP 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:	January 7, 2016
Name of Entity/Sender:	Profisee Group Inc.
Contact--Position/Office:	Judy Hight
Address:	3655 Brookside Parkway, Alpharetta, GA 30022
Phone Number:	678-202-8911

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. Contact your State for more information on eligibility –

<table>
<tr><td>ALABAMA – Medicaid</td><td rowspan="3">COLORADO – Medicaid

Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td><td></td></tr>
<tr><td>ARIZONA – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid

Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
<tr><td>IDAHO – Medicaid</td><td>MONTANA – Medicaid</td></tr>
<tr><td>Medicaid Website:
http://healthandwelfare.idaho.gov/Medical/Medicaid/Premiu</td><td>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</td></tr>
</table>

mAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	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
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

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

OMB Control Number 1210-0137 (expires 10/31/2017)

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 Judy Hight /Office Manager.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Profisee Group Inc.	26-0823346
5. Employer address	**6. Employer phone number**
3655 Brookside Parkway	678 202-8911

7. City	8. State	9. ZIP code
Alpharetta	GA	30022

10. Who can we contact about employee health coverage at this job?	
Judy Hight/Office Manager	
11. Phone number (if different from above)	**12. Email address**
	judy.hight@profisee.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)

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**

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