Atlanta Habitat for Humanity®

2016-2017 Employee Benefit Plans

Build.

Thrive.

Grow.

BENEFIT QUESTIONS AND CLAIM RESOLUTION

CONTACT INFORMATION

Atlanta Habitat for Humanity - Employee Advocate

Because of HIPAA laws, Atlanta Habitat for Humanity 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:
Humana
1-800-4HUMANA
www.myhumana.com

If you have questions about your Dental benefits, call:
MetLife
1-800-942-0854
www.metlife.com

If you have questions about your Vision benefits, call:
MetLife
1-855-638-3931
www.metlife.com

If you have questions about your Basic Life, AD&D, Supplemental Life, Short and/or Long Term Disability benefits call:
Mutual of Omaha
1-800-775-8805
www.mutualofomaha.com

September 13, 2016

Atlanta Habitat Team:

I am very pleased that we are able to continue the robust and competitive benefits plans that we offered last year. As an organization we value your service and want to make sure that your benefits needs are met and that you are able to provide benefits to your family at a reasonable cost. The health care market has been very volatile and through the hard work of the team at CBIZ and our Executive Team our current plans will be extended until December of 2017.

The following benefits will be included in the 2016-2017 plans:

- Medical Plans - Atlanta Habitat will continue to fund 90% of an employee's cost and 70% of the cost for the employee plus spouse, child or family for both medical plans.
- Dental Plan – optional coverage includes orthodontist benefits for children and adults.
- Vision Plan – we will return to the MetLife vision plan and continue funding 50% of the employee's cost.
- 403(b) Retirement Plan – enrollment allows immediate vesting for new employees. Atlanta Habitat will match 50% of the employee's contribution up to 3.0%. This means employees contributing 6% to their retirement will receive a 3.0% contribution from Atlanta Habitat.
- Short Term Disability – coverage takes effect after 7 days.
- Long Term Disability – coverage in the unfortunate event of a long term disability employees will have a benefit comparable to their current pay.
- Life/AD&D – $50,000 in basic coverage provided with an option to add additional coverage.

The chart below identifies the employee costs per pay period:

	Humana Medical Plans		MetLife Plans	
	Core Plan	**Buy-Up Plan**	**Dental**	**Vision**
Employee Only	$ 23.56	$ 26.71	$ 17.38	$ 1.77
Employee + Spouse	141.38	160.27	34.66	5.31
Employee + Child(ren)	130.78	148.25	42.33	4.23
Employee + Family	201.47	228.38	64.73	8.12

For 2016-2017, you will also continue to receive many preventive services with no co-pays or deductibles such as wellness visits, standard immunizations, and routine age-appropriate screenings. Please utilize our benefits partner, CBIZ, to educate yourself about available benefits, plan changes related to health care reform, wellness programs, and to make sure you maximize the value of your coverage.

Atlanta Habitat will continue to respond to the market and do all that we can to keep benefits competitive and focus on encouraging healthy behaviors in the work place. It is remarkable that over 72% of our employees have reached Silver Status or above with Humana's Vitality wellness program, earning rewards for participating in activities that create healthy lifestyles and workplace practices. We want to reach 100% and encourage you to sign-up!

Your health and wellness are important to Atlanta Habitat because your contributions are integral to the success of our mission.

Sincerely,

Lisa Y. Gordon

Lisa Y. Gordon, CPA
President and CEO

Welcome to your 2016-17 Employee Benefits Guide

We recognize the role employee benefits plays as a critical component of your overall compensation. Atlanta Habitat continues to make every effort to choose the best quality benefit plans for our employees and their families. Our program offers a range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family. This program is designed to assist you in providing for the health, well being and financial security of you and your family.

Benefits Guide Overview

Atlanta Habitat is proud to offer a high quality assortment of benefit choices, and the freedom to select coverage that will fit your needs and your budget. This Benefits Guide, along with your Benefit Summaries, provides a full explanation of the benefits available to you and your family.

The coverage you elect during the annual open enrollment period becomes effective on October 1, 2016. If you are a new employee, your coverage will begin the first of the month following your date of hire.

This is your enrollment opportunity. At this time, you may elect to enroll in the benefit programs offered. Options selected during this enrollment period will remain in place until December 30, 2017 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 elections to the plan during their initial eligibility period or once a year at open enrollment. The following circumstances are the only reasons you may change your benefit elections during the year:

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

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 your Human Resources Department within 30 days of the event in order to make a qualified change. All other changes will be deferred to open enrollment.

WHAT'S NEW IN 2016-17?

Medical Plan – New Telemedicine Service

Employees who are enrolled in one of the Humana medical plans will have access to a new telemedicine program effective January 1st. Doctor on Demand will allow members virtual access to an in-network physician, 24/7. The cost for virtual visits will be the same as the Primary Care Physician co-pay. Please see page 10 for additional information on Doctor on Demand and instructions on how to register.

Vision Plan—Carrier Change

Beginning October 1, 2016, MetLife will be the new vision plan carrier. The plan benefits are similar to the previous vision plan, but please review the benefit summary on page 6 carefully. Atlanta Habitat is subsidizing 50% of the vision premium for employee premium portion of coverage.

3 UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact Humana
1-800-4HUMANA or www.myhumana.com

Humana National Point of Service (POS) - Core Plan		
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, as well as any Copayments and/or applicable coinsurance.	
Annual Deductible	**In-Network**	**Out-of-Network**
Single	$3,000	$9,000
Family	$6,000	$18,000
Annual Out-of-Pocket Maximum	*Excludes Deductible*	
Single	None	$9,000
Family	None	$18,000
Coinsurance	Plan pays 100% after Deductible	Plan pays 70% after Deductible Member pays 30% after Deductible
The following do not apply to out-of-pocket maximum: Deductibles, copayment amounts, and non-covered items. Out-of-pocket maximums accumulated separately for in-network and out-of-network services.		
Lifetime Maximum	Unlimited	
Primary Care Physician's Office Visits	$35 Copay	Plan pays 70% after Deductible
Specialist Office Visits	$75 Copay	Plan pays 70% after Deductible
Preventive Care Services	Plan pays 100%, not subject to Deductible or Copays	Plan pays 70% after Deductible
Maternity Care	Plan pays 100% after Deductible	Plan pays 70% after Deductible
Hospital Inpatient/Expenses *(Facility Charges)*	Plan pays 100% after Deductible	Plan pays 70% after Deductible
Hospital Outpatient/Expenses *(Facility Charges)*	Plan pays 100% after Deductible	Plan pays 70% after Deductible
Emergency Room	$250 Copay (waived if admitted)	$250 Copay (waived if admitted)
Urgent Care	Concentra Facility: $35 Copay Non Concentra Facility: $100 Copay	Plan pays 70% after Deductible
Outpatient Therapy / Chiropractic Care *(ex: physical, speech and occupational)* *Maximum Annual Benefit*	$75 Copay 30-visit calendar year maximum	Plan pays 70% after Deductible 10-visit calendar year maximum
Allergy Care	Injection - $5 Copay Serum - Plan pays 100% after Deductible	Plan pays 70% after Deductible
Mental Health/Behavioral Treatment Services ***(Pre-authorization required)***	Inpatient: Plan pays 100% after Deductible 10 day Calendar Year Max Outpatient: $75 Copay 15 visit Calendar Year Max	Inpatient: Plan pays 70% after Deductible 10 day Calendar Year Max Outpatient: Plan pays 70% after Deductible 15 visit Calendar Year Max
Alcohol/Drug Abuse Treatment Services ***(Pre-authorization required)***	Inpatient: Plan pays 100% after Deductible 10 day Calendar Year Max Outpatient: $75 Copay 15 visit Calendar Year Max	Inpatient: Plan pays 70% after Deductible 10 day Calendar Year Max Outpatient: Plan pays 70% after Deductible 15 visit Calendar Year Max
Prescription Drugs		
Retail Pharmacy (30-Day Supply)	$10 for Tier 1 drugs $40 for Tier 2 drugs $65 for Tier 3 drugs 25% for Tier 4 drugs	$10 for Tier 1 drugs $40 for Tier 2 drugs $65 for Tier 3 drugs 25% for Tier 4 drugs
Mail Order Pharmacy (90-Day Supply)	$15 for Tier 1 drugs $100 for Tier 2 drugs $195 for Tier 3 drugs 25% for Tier 4 drugs	Not covered
Bi-Weekly Contribution	**Atlanta Habitat reserves the right to amend or modify plan design or employer contribution prior to December 1, 2015 should the insurance carrier adjust premiums or rates.**	
Employee Only	$23.56	
Employee + Spouse	$141.38	
Employee + Child(ren)	$130.78	
Employee + Family	$201.47	
Eligibility Date	First of the month following your date of hire	

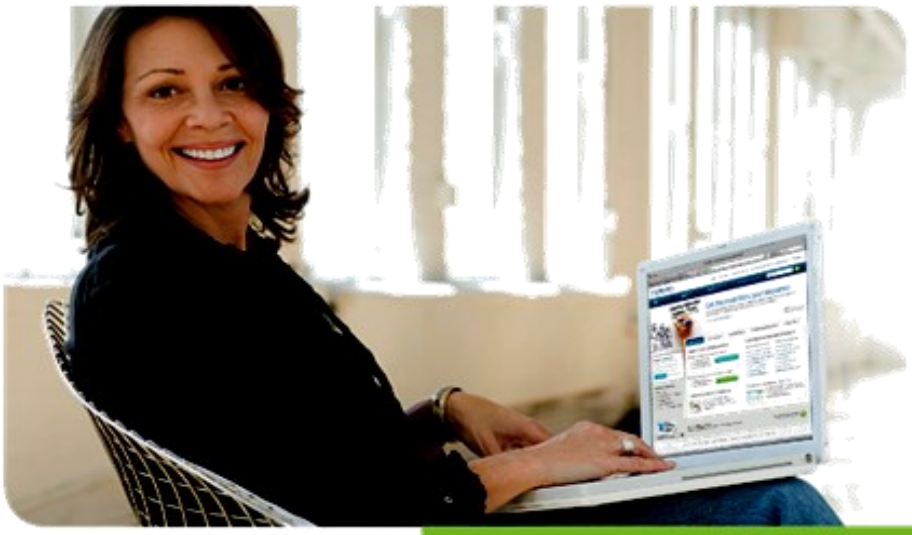
UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact Humana
1-800-4HUMANA or www.myhumana.com

Humana National Point of Service (POS) - Buy Up Plan		
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, as well as any Copayments and/or applicable coinsurance.	
Annual Deductible	**In-Network**	**Out-of-Network**
Single	$1,500	$4,500
Family	$3,000	$9,000
Annual Out-of-Pocket Maximum	*Excludes Deductible*	
Single	None	$9,000
Family	None	$18,000
Coinsurance	Plan pays 100% after Deductible	Plan pays 70% after Deductible Member pays 30% after Deductible
The following do not apply to out-of-pocket maximum: Deductibles, copayment amounts, and non-covered items. Out-of-pocket maximums accumulated separately for in-network and out-of-network services.		
Lifetime Maximum Benefit	Unlimited	
Primary Care Physician Office Visits	$35 Copay	Plan pays 70% after Deductible
Specialist Office Visits	$75 Copay	Plan pays 70% after Deductible
Preventive Care Services	Plan pays100%, not subject to Deductible or Copays	Plan pays 70% after Deductible
Maternity Care	Plan pays 100% after Deductible	Plan pays 70% after Deductible
Hospital Inpatient/Expenses *(Facility Charges)*	Plan pays 100% after Deductible	Plan pays 70% after Deductible
Hospital Outpatient/Expenses *(Facility Charges)*	Plan pays 100% after Deductible	Plan pays 70% after Deductible
Emergency Room	$250 Copay (waived if admitted)	$250 Copay (waived if admitted)
Urgent Care	Concentra Facility: $35 Copay Non Concentra Facility: $100 Copay	Plan pays 70% after Deductible
Outpatient Therapy / Chiropractic Care *(ex: physical, speech and occupational)* *Maximum Annual Benefit*	$75 Copay 30-visit calendar year maximum	Plan pays 70% after Deductible 10-visit calendar year maximum
Allergy Care	Injection - $5 Copay Serum - Plan pays 100% after Deductible	Plan pays 70% after Deductible
Mental Health/Behavioral Treatment Services ***(Pre-authorization required)***	Inpatient: Plan pays 100% after Deductible 10 day Calendar Year Max Outpatient: $75 Copay 15 visit Calendar Year Max	Inpatient: Plan pays 70% after Deductible 10 day Calendar Year Max Outpatient: Plan pays 70% after Deductible 15 visit Calendar Year Max
Alcohol/Drug Abuse Treatment Services ***(Pre-authorization required)***	Inpatient: Plan pays 100% after Deductible 10 day Calendar Year Max Outpatient: $75 Copay 15 visit Calendar Year Max	Inpatient: Plan pays 70% after Deductible 10 day Calendar Year Max Outpatient: Plan pays 70% after Deductible 15 visit Calendar Year Max
Prescription Drugs		
Retail Pharmacy (30-Day Supply)	$10 for Tier 1 drugs $40 for Tier 2 drugs $65 for Tier 3 drugs 25% for Tier 4 drugs	$10 for Tier 1 drugs $40 for Tier 2 drugs $65 for Tier 3 drugs 25% for Tier 4 drugs
Mail Order Pharmacy (90-Day Supply)	$15 for Tier 1 drugs $100 for Tier 2 drugs $195 for Tier 3 drugs 25% for Tier 4 drugs	Not covered
Bi-Weekly Contribution	**Atlanta Habitat reserves the right to amend or modify plan design or employer contribution prior to December 1, 2015 should the insurance carrier adjust premiums or rates.**	
Employee Only	$26.71	
Employee + Spouse	$160.27	
Employee + Child(ren)	$148.25	
Employee + Family	$228.38	
Eligibility Date	First of the month following your date of hire	

5 UNDERSTANDING YOUR MEDICAL PLAN

Humana will remain the medical carrier for 2016-17 and Atlanta Habitat for Humanity will continue to offer two plan options—a core plan and buy up plan. There are no changes to the benefits under either the core or the buy up plan option, but please review the medical coverage section of this guide for benefit details and payroll deduction information. All employees must complete the medical portion of the 2016-17 election form, even if you are waiving medical coverage.



Manage your plan at Humana.com

*My*Humana is your secure Website on **Humana.com**. *My*Humana gives you access to many tools and resources to support you.

As a registered user of *My*Humana, you can:

- View information specific to your plan and the medical services you receive
- Find a participating doctor, pharmacy, or hospital
- Review prescription benefits, prescription claims, drug pricing, and find alternatives to brand-name prescription drugs
- Research medical conditions
- Access health and wellness programs offered by Humana
- View claims and estimated costs
- Keep track of immunizations, medications, and family medical histories
- Get estimated costs of common medical services, procedures, and prescriptions

Registration is simple

Have your Humana identification card ready and go to **Humana.com**. Click "Register for *My*Humana" and follow the steps.

We're here to help

To speak to a Humana Customer Care specialist, call 1-866-4-ASSIST (1-866-427-7478).

HUMANA.

GN67523SB 1010

Proudly produced with 100% renewable energy using environmentally friendly vegetable-based inks.

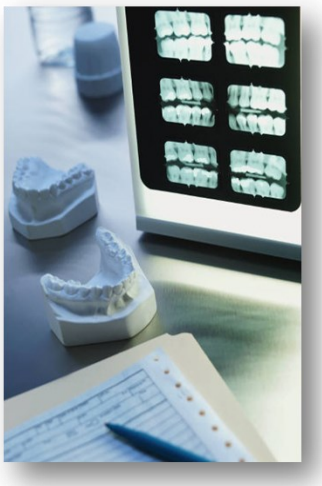
UNDERSTANDING YOUR DENTAL PLAN

Dental Questions? Need to Locate a Provider?
Contact MetLife
1-800-942-0854 or www.metlife.com

Atlanta Habitat dental benefits are insured by MetLife. The dental plan utilizes the MetLife PDP plus dental network. Although you can visit any dentist you would like, in or out of network, staying in network excludes any possible balance billing. Visiting a MetLife PPO dentist will ensure that you receive the greatest discount of service and maximize your calendar year benefit.

To search for a dentist in the network, go to www.metlife.com. On the right side of the page, click on the link to "Find a Dentist". Enter your zip code and select the "PDP" network from the drop down menu.

MetLife - Voluntary PPO		
	In-Network	**Out-of-Network** *(*Subject to 90th Percentile of Reasonable and Customary)*
Deductible	Single: $50 Family: $150	Single: $50 Family: $150
Annual Maximum Benefit	$1,500	
Preventive Services *(oral exam, cleaning, bitewing x-rays)*	100%	100%*
Basic Services *(fillings, simple extractions, other x-rays)*	80% after Deductible	80% after Deductible*
Major Services *(crowns, dentures, oral surgery, root canals)*	50% after Deductible	50% after Deductible*
Orthodontia *(adults and children to age 19)*	50% to a $1,500 Lifetime Maximum	50% to a $1,500 Lifetime Maximum
Bi-weekly Contribution		
Employee Only	$17.38	
Employee + Spouse	$34.66	
Employee + Child(ren)	$42.33	
Employee + Family	$64.73	



7 UNDERSTANDING YOUR VISION PLAN

Vision Questions? Need to Locate a Provider?
Contact MetLife
1-855-638-3931 or www.metlife.com/mybenefits

Metlife Vision offers complete, high quality vision care to Atlanta Habitat employees through their vision network. The plan includes benefits for eye exams, frames, eyeglasses and contact lenses. In addition, members receive discounts for Lasik surgery and preferred pricing for frames.

Choose from a large network of ophthalmologist, optometrists, and opticians from private practices to retailers like Costco Optical and Vision Works. To search for a provider, go to www.metlife.com/mybenefits.

MetLife Vision Care		
	In-Network	**Out-Of-Network**
Examination	Once per 12 months	
	$10 Copay	Reimbursed up to $45
Eyeglass Lenses	Once per 12 months	
Single Vision	$10 Copay	Reimbursed up to $30
Bifocal	$10 Copay	Reimbursed up to $50
Trifocal	$10 Copay	Reimbursed up to $65
Frames	Once per 24 months	
Standard	$150 allowance after $10 eyewear copay. Costco: $85 allowance after $10 eyewear copay. 20% savings on amounts over allowance $150	Reimbursed up to $70
Contact Lenses (in lieu of frames or glasses)	Once per 12 months	
Elective	$150 Allowance	Reimbursed up to $105
Necessary Lenses	Covered in full after eyewear copay	
Fitting and Evaluation Fee	Covered in full with a maximum copay of $60 applied to contact lens allowance	
Additional Discounts	20% discount on additional pair of glasses or frames. Discounts averaging 15% on LASIK	
Bi-weekly Contribution		
Employee Only	$1.77	
Employee + Spouse	$5.31	
Employee + Child(ren)	$4.23	
Employee + Family	$8.12	

UNDERSTANDING YOUR ANCILLARY PLANS

Questions?
Contact Mutual of Omaha
1-800-775-8805
www.mutualofomaha.com

Life and Disability benefits are insured through Mutual of Omaha and Atlanta Habitat pays the cost of the Basic Life, AD&D, Short Term Disability and Long Term Disability. Employees can elect Supplemental Life for themselves and any dependents. Employees who previously elected life can increase their elections by $10,000 at renewal without completing Evidence of Insurability as long as they are not electing coverage greater than the Guaranteed Issue amount.

Employer Paid Basic Life Coverage	
Employee Basic Life	Flat $50,000
Employee Basic AD&D	Flat $50,000
Contribution	*Your employer provides this coverage on your behalf.*

Employer Paid Short Term Disability (STD)	
Amount of Benefit	60% of weekly earnings with a maximum benefit of $1,000 per week
When Benefits Begin	On the 8th day of disability due to injury or illness as approved by Mutual of Omaha
Definition of Disability	The inability to perform the material and substantial duties of your regular occupation
Benefit Duration	13 Weeks
Limitations	None
Monthly Contribution	*Your employer provides this coverage on your behalf.*

Employer Paid Long Term Disability (LTD)	
Amount of Benefit	60% of monthly earnings with a maximum benefit of $2,500 or $10,000 per month (dependent upon salary)
When Benefits Begin	90 days following the date of disability as determined by Mutual of Omaha
Definition of Disability	The inability to perform the material and substantial duties of your regular occupation for 24 months and any occupation thereafter
Benefit Duration	Social Security Normal Retirement Age
Limitations	Pre-existing conditions: 3 months prior/12 months insured Mental Health and Substance Abuse: 24 Months Lifetime Maximum
Monthly Contribution	*Your employer provides this coverage on your behalf.*

Supplemental Life Coverage		
Employee	Increments of $10,000 up to $50,000 without Evidence of Insurability (Guaranteed Issue available at initial eligibility only, subject to terms of plan), up to 5 times Basic Annual Earnings with Evidence of Insurability, not to exceed $250,000.	
Spouse	Increments of $5,000 up to $25,000 without Evidence of Insurability (Guaranteed Issue available at initial eligibility only, subject to terms of plan), not to exceed $50,000 or 50% of employee election, whichever is less.	
Dependent Life	Increments of $1,000 up to $10,000	
Employee and Spouse Rates Monthly contribution based on employee's age and coverage	**Age**	**Cost Per $1,000**
	<25	$0.08
	25-29	$0.08
	30-34	$0.09
	35-39	$0.10
	40-44	$0.19
	45-49	$0.32
	50-54	$0.55
	55-59	$0.90
	60-64	$1.40
	65-69	$2.50
	70-74	$4.49
	75-79	$7.40
Eligible Child(ren)	14 days - 21 years of age: $10,000	Monthly contribution: $.15 per $1,000
Eligibility Date	First of the month following your date of hire	

Life/AD&D	MUTUAL OF OMAHA
BENEFIT	$50,000 In the event of death, the benefit paid will equal the benefit amount after any age reductions less any living benefits previously paid under the Policy.
REDUCTIONS	Your original Life Insurance Benefit will reduce to: · 65% at age 65 (reducing to $32,500) · 50% at age 70 (reducing to $25,000) Life Insurance Benefits end on the date of Your retirement
MINIMUM WORK HOURS REQUIRED	30 or more hours each week

9 UNDERSTANDING YOUR VITALITY PLAN

Questions?
Contact Humana Vitality
www.humanavitality.com

HumanaVitality® Getting Started

Ready.

Have you ever been someplace new and felt lost? Chances are, all you needed was some basic information and you'd be good to go.

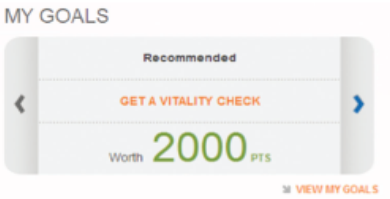
Figuring out the basics of HumanaVitality is no different. That's why we created this simple guide to get you started on the path to better health.

Set.

1. To get to your personal HumanaVitality website, go to **HumanaVitality.com**.
2. Register or log in to enter the secure website.
3. Take the HumanaVitality Health Assessment to begin earning Vitality Points™. This takes about 10-15 minutes.
4. Review your Health Results to receive your Vitality Age™ and find out more about your health status.
5. Set your personal goals, including scheduling a Vitality Check® and other healthy activities to earn more Vitality Points.
6. Review other opportunities to earn Vitality Points in categories like Healthy Living, Fitness, Prevention, and Education on your browser bar. Build Vitality Points to raise your Vitality Status℠ level and get bigger discounts.
7. Each Vitality Point you earn is worth one Vitality Buck.® Redeem your Vitality Bucks for rewards inside the HumanaVitality Mall.

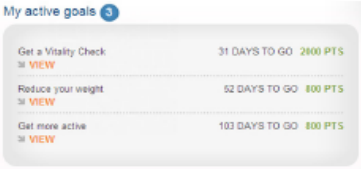
Go. Setting goals.

1. **From the HumanaVitality home page, click View My Goals under the My Goals section on your dashboard page.**



2. **For each recommended goal, click View to find out more about how the goal will help you. You also can access the Set Goal feature here.**

3. **Once you set a goal, it will appear in the My Active Goals section. Repeat the steps above to add more goals. Once you complete a goal within the specified time frame it will be saved. If the goal is not achieved it will reappear in your Recommended Goals section to be selected again.**



Humana Vitality®

UNDERSTANDING YOUR VITALITY PLAN

Questions?
Contact Humana Vitality
www.humanavitality.com

Vitality Status℠

The more you do to stay healthy, the more Vitality Points you can earn, and when you have other members of your household enrolled in HumanaVitality, their healthy activities can count toward Vitality Points too. The more Vitality Points you earn, the higher your Vitality Status, giving you more Vitality Bucks® to spend at the HumanaVitality Mall as well as opportunities for discounts up to 40 percent on your purchases.

Below is a breakdown of the number of Vitality Points needed to reach each Vitality Status.

Vitality Status	Number of Vitality Points required for one adult	For each additional adult age 18+ the following number of additional Vitality Points are required*
Blue	Starting Vitality Status	
Bronze	Any adult member Health Assessment completion	
Silver	5,000	3,000
Gold	8,000	4,000
Platinum	10,000	5,000

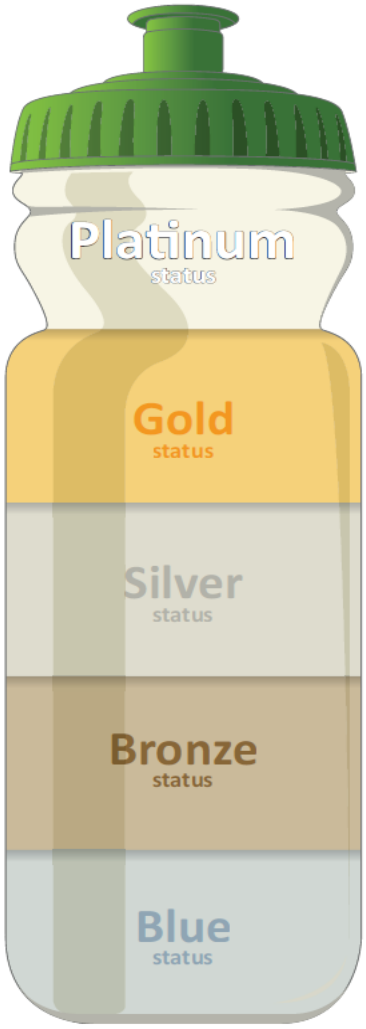
*Applies to additional dependents on your plan, such as your spouse and/or children who are age 18+

A suggested path to Silver Status. While you can choose any qualified activity, we've provided some of the most popular to help you improve your status.

Individual

Activity During Year	Points Earned
Health Assessment (HA)	500
Bonus - HA completed within the first 90 days	250
First Step HA*	500
Vitality Check® completion	2,000
Vitality Check® in-range results	
BMI (Body Mass Index)	800
Blood pressure	400
Blood glucose level	400
Cholesterol level	400
Silver Points level (5,000 points)	**5,250**

* 500-point limit for First Step HA over the life of membership



Family

(two adults, one child. Assumes both adults complete Health Assessment)

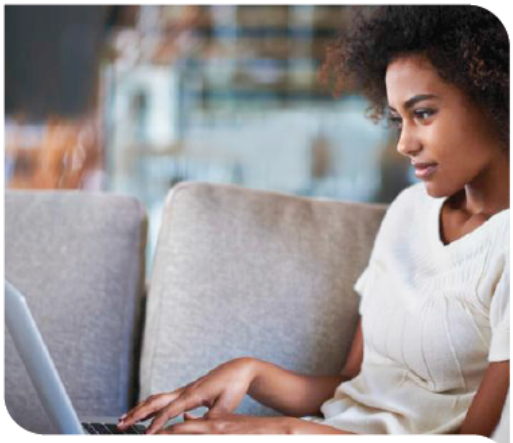
Activity During Year	Points Earned
Health Assessment (x2)	1,000
Bonus - HA completed within the first 90 days (x2)	500
First Step HA* (x2)	1,000
Vitality Check® completion (x1)	2,000
Vitality Check® in-range results (x1)	
BMI (Body Mass Index)	800
Blood pressure	400
Blood glucose level	400
Cholesterol level	400
Complete 5K run/walk	250
Two workouts per week for 12 weeks (15pts*24)	360
Bonus - 15 pts for 1st workout of week	180
Kids Health Assessment	200
Kids preventive care visit	200
Kids flu shot	100
Kids Sports league	100
CPR certification	125
Silver Points level (8,000 points)	**8,015**

11 UNDERSTANDING YOUR DOCTOR ON DEMAND

Questions?
Contact Humana Doctor on Demand
www.doctorondemand.com

Telemedicine is a virtual, on-demand 24-hour service to access care from in-network physicians:

- Choose from Doctor on Demand's list of U.S. board certified doctors in-network
- Immediately see a doctor 24 hours a day, 7 days a week from any location
- Have the option for your primary care doctor to have access to your telemedicine visit
- If medically necessary, the telemedicine doctor can send a prescription to a preferred pharmacy



Approximately 70% of ER visits are non-emergent and could be avoided [1]

Average family practice wait time is **18.5 days** and counting [2]

Four out of five smartphone users are interested in mobile health technologies that allow them to interact with a healthcare provider [3]

Source 1. "Avoidable Emergency Department Usage Analysis." Truven Health Analytics. (April 25, 2013), 2. "Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates." Merritt Hawkins 2014 Survey, 3. "Most smartphone users want mHealth interactions" FierceMobileHealthcare (June 29, 2014)

No appointments required. Connect online at www.doctorondemand.com or download the Doctor on Demand app today!

Download on the App Store

ANDROID APP ON Google play

What can be treated by telemedicine

Telemedicine should be considered when a PCP is unavailable, after hours or on holidays for non-emergent needs. Many urgent care ailments can be treated with telemedicine, such as:

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

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

* Women's Health and Cancer Rights Act of 1998

Your medical 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. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

* The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The law prevents discrimination from health insurers and employers.

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.

Important Notice from Atlanta Habitat for Humanity 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 Atlanta Habitat for Humanity 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. **Atlanta Habitat for Humanity has determined that the prescription drug coverage offered by Humana is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

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 Atlanta Habitat for Humanity coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Atlanta Habitat for Humanity 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 Atlanta Habitat for Humanity 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 Atlanta Habitat for Humanity 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:	July 18, 2016
Name of Entity/Sender:	Atlanta Habitat for Humanity
Contact--Position/Office:	Financial Operations Manager
Address:	519 Memorial Drive Atlanta, GA 30312
Phone Number:	404-223-5180

Georgia Consumer Choice Option

What is Consumer Choice?

Georgia law requires insurers to offer a "Consumer Choice" option to members enrolling in an insured HMO, POS or PPO plan. This Consumer Choice option allows members to receive services from a non-network provider (physician, hospital or other provider) while still being covered at an in-network level.

Although members may "nominate" any non-network provider, the nominated doctor or hospital must first agree to the following in order for the member's services to be covered at the in-network rate:

- Accept the insurer's reimbursement as payment in full (in addition to the member's usual copayments, deductibles and/or coinsurance)
- Comply with the insurer's utilization management programs

Is there a charge to elect the Consumer Choice Option?

Yes. The law allows insurers to increase the monthly premium rate for members who elect this offering. The amount of the monthly premium increase is 17.5% for Consumer Choice Option HMO and POS benefit plans, and 10% for Consumer Choice Option PPO plans.

How do I choose the Consumer Choice Option?

Selecting the Consumer Choice Option is just like selecting any other benefit option. You must do so either at open enrollment, if you are a new hire, or when your employer's eligibility rules allow you to do so. To select the Consumer Choice Option:

Newly applying members must complete the insurer's Member Enrollment Application and select the Consumer Choice Option plan desired. (Members must still select a network Primary Care Physician for each person enrolled if a HMO or POS Consumer Choice Option is selected.)
Currently enrolled members must complete a Member Change Form and select the Consumer Choice Option plan desired.

How is the Consumer Choice Option different from a PPO or POS plan?
A PPO or POS plan allows members access to out-of-network providers at an out-of-network benefit level. When a member utilizes the services of an out-of-network provider, the member usually pays more in the form of increased copayments, deductibles and/or coinsurance.

Under the Consumer Choice Option, members may utilize the services of an out-of-network provider at in-network benefit levels only when that provider has:

Been nominated by the member:
Signed a form accepting the insurer's conditions; and
Been approved by the insurer.

After a provider has been approved, the member's benefits are paid as though the provider were part of the insurer's network.

Once I elect the Consumer Choice Option, can I go to any doctor and get benefits paid at in-network levels?

First, you must complete a Provider Nomination Form and receive notification from the insurer that the nomination has been accepted before out-of-network providers can be reimbursed at in-network benefit levels.

For any nomination to be approved, the provider must sign the nomination form agreeing to the insurer's terms and conditions before that provider's services will be covered at in-network levels. The provider has absolute discretion regarding whether he or she wishes to participate in the Consumer Choice Option.

How do I nominate my physician?

Call the insurer's customer service department to request a Consumer Choice Physician Nomination Form. Members must complete the provider nomination form, which is a two-step process:

- The provider must sign the nomination form and request details about the insurer's reimbursement rates for the services he or she intends to provide.
- The provider must sign the form again to indicate his or her acceptance of the rates and other terms and conditions, once he or she has reviewed them.

After you have completed these steps, please return the completed nomination form to the insurer for approval.

How long will it take to get approval of a nominated provider?

Once the insurer has received a completed nomination form – completed and signed by both the provider and the member – they will respond by mail or fax within three business days.

What if I select the Consumer Choice Option and then decide I want to return to a non-Consumer Choice Option plan?

Under most employers' rules, you may make a plan election only once during each year. If your employer's rules allow you to switch plans other than during your open enrollment period, you may move from the Consumer Choice Option plan you elected back to the non-Consumer Choice version of that plan within 31 days of enrolling. Please check with your employer for details. Your employer must submit any such requests in writing to the insurer.

What if my doctor doesn't want to accept reimbursement terms or comply with utilization management guidelines required by the insurer?

The law does not obligate a provider to accept the terms and conditions or reimbursement rates. If a provider elects not to sign the Consumer Choice Option Provider Nomination Form, he or she is under no obligation to do so.

If you are seeking services from a specific provider, check with that provider BEFORE completing the Consumer Choice Option application and making a final plan election. Once you have selected a Consumer Choice Option plan, you cannot switch plans until the following open enrollment, except within 31-day grace period described above.

Once a doctor has agreed to your terms, can I receive services from that doctor or hospital for the remainder of the time I'm enrolled in the health plan?

Once the provider has signed the form agreeing to the reimbursement and other terms and conditions, you may utilize the services of the provider until your plan's anniversary the following year. You will need to repeat the nomination/approval process each year for the out-of-network provider's services to be covered at in-network benefit levels.

Will prescriptions written by a non-network doctor be covered?

If you nominate a provider and that provider is ultimately approved under the Consumer Choice Option, he or she may write prescriptions that will be covered at in-network benefit levels. Remember, if your plan restricts you to having prescriptions filled at network pharmacies, you must either use only network pharmacies or have a completed and approved Provider Nomination Form for any non-network pharmacy. (Note: This requirement does not apply to PPO plans.)

If my doctor admits me to a non-network hospital, will the hospital charges be covered?

Any services must be provided by either a network hospital or a hospital for which a Provider Nomination Form has been completed and approved. This form must also be completed and approved for any other providers rendering services – for example, radiology, anesthesia services, physical therapy or lab work. To be eligible for in-network benefit levels, all services must be provided by either in-network providers or providers approved under the Consumer Choice Option.

For additional information about the Consumer Choice Option, please call the insurer's Customer Service Department.

Model General Notice Of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

MANDATED NOTICES

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

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

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred

Are there other coverage options besides COBRA Continuation Coverage?

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

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

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you **send to the Plan Administrator.**

Plan Contact Information
Habitat for Humanity in Atlanta Business Manager, 824 Memorial Drive SE, Atlanta, GA 30316. Phone: 404-223 -5180

MANDATED NOTICES

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

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: Nary Dam 404-223-5180 x 125.

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 Habitat for Humanity in Atlanta		4. Employer Identification Number (EIN) 58-1535414
5. Employer address 519 Memorial Drive SE		6. Employer phone number 404-223-5180
7. City Atlanta	8. State GA	9. ZIP code 30312
10. Who can we contact about employee health coverage at this job? Nary Dam		
11. Phone number (if different from above)	12. Email address narydam@atlantahabitat.org	

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

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - X Some employees. Eligible employees are:
    Full Time Employees who work at least 30 hours per week.

- 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.

MANDATED NOTICES

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility –

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

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

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

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

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

Notice of Privacy Practices

For your personal health and financial information

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

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare. We protect this information in all formats including electronic, written and oral information.

How do we protect your information?

In keeping with federal and state laws and our own policy, we have a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

How do we use and disclose your information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission or your plan sponsor has certified they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you if you have not opted out as described below
- To your family and friends if you are unavailable to communicate, such as in an emergency
- To your family and friends or any other person you identify, provided the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill our obligations under any workers' compensation law or contract

Notice of Privacy Practices
(continued)

- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

Will we use your information for purposes not described in this notice?

In all situations other than described in this notice, we will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission. The following uses and disclosures will require an authorization:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of protected health information

What do we do with your information when you are no longer a member or you do not obtain coverage through us?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

The following are your rights with respect to your information. We are committed to responding to your rights request in a timely manner.

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Adverse Underwriting Decision – You have the right to be provided a reason for denial or adverse underwriting decision if your application for insurance is declined. *
- Alternate Communications – You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life threatening situation. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure – You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for a period of six years at your request. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice – You have the right to receive a written copy of this notice any time you request.
- Restriction – You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

What types of communications can I opt out of that are made to me?

- Appointment reminders
- Treatment alternatives or other health-related benefits or services

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at Humana.com and going to the Privacy Practices link

* This right applies only to our Massachusetts residents in accordance with state regulations.

Notice of Privacy Practices
(continued)

- E-mailing us at privacyoffice@humana.com
  Send completed request form to:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with us by calling us at 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

What will happen if my private information is used or disclosed inappropriately?

You have a right to receive a notice that a breach has resulted in your unsecured private information being inappropriately used or disclosed. We will notify you in a timely manner if such a breach occurs.

PRIVACY NOTICE CONCERNING FINANCIAL INFORMATION

We and our affiliates understand that the privacy of your personal information is important to you. We take your privacy seriously and your trust in our ability to protect your private information is very important to us. This notice describes our policy regarding the confidentiality and disclosure of personal financial information.

How do we collect information about you?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information do we receive about you?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our Website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

Where will we disclose your information?

We may share your information with affiliated companies and non-affiliated third parties, as permitted by law. We may also provide your information to other financial institutions with which we have joint marketing agreements in order to provide you with offers for products and services you may find of value or which are health-related.

What can I prevent with an opt-out disclosure?

You can prevent the disclosures to non-affiliated third parties that provide products and services not offered by us or where the non-affiliated company provides services related to your plan by requesting to opt-out of such disclosures. Your opt-out request will apply to all members or individuals covered under your identification number or member account.

Your opt-out request will continue to apply until you revoke your request or terminate your membership.

How do I request an opt-out?

At any time you can tell us not to share any of your personal information with affiliated companies that provide offers other than our products or services. If you wish to exercise your opt-out option, or to revoke a previous opt out request, you need to provide the following information to process your request: your name, date of birth, and your member identification number. You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-866-861-2762
- E-mail us at privacyoffice@humana.com.
- Send your opt-out request to us in writing:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

We follow all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws,

Notice of Privacy Practices
(continued)

rules, and regulations conflict, we follow the law, rule, or regulation which provides greater protection.

The following affiliates and subsidiaries also adhere to our privacy policies and procedures:

American Dental Plan of North Carolina, Inc.
American Dental Providers of Arkansas, Inc.
Arcadian Health Plan, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
Cariten Insurance Company
CHA HMO, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth, Inc. dba LifeSynch
CorpHealth Provider Link, Inc.
DentiCare, Inc.
Emphesys, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Company of New York, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana MarketPOINT, Inc.
Humana MarketPOINT of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Medical Plan of Michigan, Inc.
Humana Medical Plan of Pennsylvania, Inc.
Humana Medical Plan of Utah, Inc.
Humana Pharmacy, Inc.
Humana Regional Health Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, Inc.
Preferred Health Partnership, Inc.*
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

* These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

Notes

Notes

Disclaimer: This Benefit Guide provides a brief summary of the benefits available under the Atlanta Habitat Benefit Program. In the event of any discrepancy(ies) between this summary and any Document, Insurance Contract or Certificate, the Insurance Document(s) will prevail. Atlanta Habitat retains the right to modify or eliminate these benefits at any time and for any reason.