ENROLLMENT – LARGE GROUP - RETURN BY NOVEMBER 3, 2017

Medical Plans – Group, Office (small group) and Individual

We recognize your health care needs are unique. What you and your family need in a health plan may not be the same as the family next door; therefore, for 2017, we continue to offer you a choice of medical plans.

The Large Group is offered by BCBS/GA - Anthem (Blue Cross/Blue Shield of Georgia) and Anthem under a national plan. The Small Group and Individual carriers will be selected by you.

Medical ID Cards

If you elect medical coverage, you will be receiving a new medical identification card prior to January 1. Keep the new card with you at all times so that you will have it available when you need medical services. The card identifies your medical plan and gives instructions for providers on where to send claim information.

LARGE GROUP PLAN	BCBS HSAOAP3 5.5K/0 5.5K	
Medical Plan Comparison	***What you Pay:***	
	In-Network	**Out-of-Network**
Calendar Year Deductible		
Individual	$5,500	$16,500
Family	$11,000	$33,000
Out-of-Pocket Expense Max		
Individual	$5,500	$19,650
Family	$11,000	39,300
Lifetime Maximum	**unlimited**	
Coverage Levels		
Preventive Care Office Visits	plan pays 100%	50% after Ded.
Physician Office Visits	0% after ded	50% after Ded.
Specialist Office Visits	0% after ded	50% after Ded.
Inpatient Hospital Care (Daily room, board and general nursing care at semi-private room rate)	0% after ded	50% after Ded.
Inpatient Physician Care (surgeon, anesthesiologist, radiologist, pathologist, etc.)	0% after ded	50% after Ded.
Outpatient Facility/hospital charges	0% after ded	50% after Ded.
Pharmacy		
Retail (31-day supply)		
Preferred Generic	Plan pays 100% after ded	
Preferred Brand	Plan pays 100% after ded	
Non-Preferred Brand	Plan pays 100% after ded	
Specialty Drug	Plan pays 100% after ded	
Mail Order (Maintenance Only, 90-day supply)	$15/$70/$180/20% coin after Deductible	
Cost/mo	*Monthly Premium*	
Member Only	$2,041.98	
Member + Spouse	$4,288.19	
Member + Child	$3,981.87	
Member + Family	$6,228.06	

For Small Group and Individual plans, you will need to complete the enrollment form and we will communicate the recommendations to you directly.

Women's Health and Cancer Rights Act - -Notice of Rights

The Women's Health and Cancer Rights Act of 1998 was enacted on October 21, 1998. It provides certain protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

Specifically, the Act requires that health plans cover post-mastectomy reconstructive breast surgery if they provide medical and surgical coverage for mastectomies. Coverage must be provided for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The benefits required under the Women's Health and Cancer Rights Act must be provided in a manner determined in consultation with the attending physician and the patient.

These benefits are subject to the health plan's regular co-payments and deductibles.

Medicare Part D

Important Notice from the Financial Network Benefits Plan 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 The Financial Network Benefit Plan 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:

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.

The Financial Network Benefit Plan has determined that the prescription drug coverage offered by the Basic PPO and Security PPO 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 November 25th through December 31st.

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 Financial Network Benefit Plan coverage will be affected. You can retain your existing coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as primary.

If you do decide to join a Medicare drug plan and drop your current Financial Network Benefit Plan coverage, be aware that you and your dependents will not be able to get this coverage back until open enrollment or due to a change in family status.

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 The Financial Network Benefit Plan 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 November 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 The Financial Network Benefit Plan 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 notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	October 26, 2017
Name of Entity/Sender:	Financial Network Group Health Plan
Contact--Position/Office:	Amy Ahrens /Nikki Hale
Address:	3226 Citation Ave NW Kennesaw, GA 30144
Phone Number:	770-966-9247

New Health Insurance Marketplace Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

Options and Your Health Coverage

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 _____
.

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)
Financial Advisors Network LTD	46-6604828
5. Employer address	6. Employer phone number
3226 Citation Ave	770-966-9246

7. City	8. State	9. ZIP code
Kennesaw	GA	30144

10. Who can we contact about employee health coverage at this job?	
Amy M. Ahrens	
11. Phone number (if different from above)	12. Email address
	amy.ahrens@ahrensnaefconsulting.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:
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are:
  - [ ] We do not offer coverage.

[ ] 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)