April 1, 2019 Plan Year

Arista considers our employees our best asset. As such, we work to ensure that our employees are offered the best benefits possible. Arista has four goals in regards to the benefits that we offer:

1.) To Be Among the Best in the Industry
2.) Represent the Best New Ideas
3.) Employees are Proud of Their Benefits Package
4.) Ensure Financial Security for All Long Term Employees

The Arista Benefit Guide provides a general overview of your benefit choices and is intended as a quick reference guide to help you select the coverage that is right for you. We encourage you to review each section and to discuss your benefits with your family members.

Carrier plan documents govern all benefit plans.

Table of Contents

Medical & Prescription Drugs – Humana

	BASE NPOS EHDHP/ HSA $3,000 / 100% HSA		BUY-UP NPOS $1,500 / 80%	
Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible Type	Embedded Deductible		Embedded Deductible	
Deductible Individual / Family	$3,000 / $6,000	$9,000 / $18,000	$1,500 / $3,000	$4,500 / $9,000
Coinsurance Level	100%	70%	80%	50%
Out of Pocket Max Individual / Family (Deductibles & Copays Included)	$3,000 / $6,000	$11,000 / $23,000	$4,000 / $8,000	$12,000 / $24,000
Preventive Care	100%	70% After Ded	100%	50% After Ded
Inpatient & Outpatient Hospital Physician / Facility	100% After Ded	70% After Ded	80% After Ded	50% After Ded
Physician Visit PCP / Specialist	100% After Ded	70% After Ded	$35 Copay $60 Copay	50% After Ded
Urgent Care	100% After Ded	70% After Ded	$100 Copay	50% After Ded
Emergency Room	100% After Ded	100% After Ded	$400 Copay	$400 Copay
Prescription Drug Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Retail – 30 Day Supply Level 1 Level 2 Level 3 Level 4 Specialty (Preferred Pharmacy) Specialty (Non-Preferred Pharmacy)	100% After Ded	70% After Ded	$10 Copay $35 Copay $55 Copay 25% Coinsurance 25% Coinsurance 35% Coinsurance	$10 Copay $40 Copay $75 Copay 25% Coinsurance 50% Coinsurance 50% Coinsurance
Mail Order – 90 Day Supply	100% After Ded	Not Covered	2.5 x Retail Price	Not Covered

Medical
Semi-Monthly Payroll Deductions

24 Pay Period Deductions	BASE NPOS EHDHP / HSA $3,000 / 100%	BUY-UP NPOS $1,500 / 80%
Employee Only	$36.00	$77.00
Employee & Spouse	$112.00	$220.00
Employee & Children	$99.00	$192.00
Employee & Family	$189.00	$374.00

Humana Go365™

When employees reach *Silver Status* on Humana's Go365™ Wellness Program, employees will receive a discount to their medical payroll deductions.

HUMANA - GO 365 SILVER STATUS		
24 Pay Period Deductions	BASE NPOS EHDHP / HSA $3,000 / 100%	BUY-UP NPOS $1,500 / 80%
Employee Only	$32.00	$70.00
Employee & Spouse	$100.00	$198.00
Employee & Children	$90.00	$172.00
Employee & Family	$170.00	$336.00

Health Savings Account (HSA)

Health Savings Accounts (HSAs) are a great way to save money and budget for qualified medical, dental and vision expenses with pre-tax dollars.

What is a Health Savings Account (HSA)?

- A savings account owned and funded by you with pre-tax dollars to pay for medical, dental, and vision expenses not covered by insurance now and in retirement.
- HSA's allow you to rollover unspent money from year to year.
- HSA money always belongs to you and there is no "use it or lose it" rule. Any unspent balances in your account remain until spent.
- Your account is portable.
- You can change contribution election amounts during the plan year.
- Distributions for qualified expenses are tax-free.
- Participation in an HSA disqualifies you from enrolling in a Flexible Spending Account Healthcare Reimbursement Account.

Who is eligible to contribute to an HSA?

- An employee insured by a High Deductible Health Plan (HDHP)
- Not covered by other insurance that is not a HDHP
- Not enrolled in Medicare or Medicaid
- Not eligible to be claimed as a dependent on another's tax return

2019 HSA	
HSA CONTRIBUTION LIMITS	
Single	$3,500
Family	$7,000
55 & Over Catch Up (Employees Not Enrolled in Medicare)	$1,000

HSA CONTRIBUTION SCHEDULE				
BASE – NPOS EHDHP/ HSA $3,000 / 100% HSA	Employee only	Employee + Spouse	Employee + Children	Family
First Contribution 2/15/2019	$250	$375	$375	$375
Second Contribution 8/15/2019	$350	$525	$525	$825
Year End Total	$600	$900	$900	$1,200

Limited-Purpose (FSA) – Americomp

Arista offers Limited-Purpose FSA for Dental and Vision care needs for employees who enroll in the Humana Base EHDHP $3,000 / 100% plan and are contributing to a Health Savings Account (HSA).

The Limited-Purpose FSA can only be used for your dental and vision care needs. Contributing to a Limited-Purpose FSA for your dental and vision needs in addition to contributing to a Health Savings Account (HSA) allows you to maximize your savings and tax benefits***.***

Limited-Purpose FSA Rules

- ***Covered procedures limited to dental and vision care needs.***
- ***2019 contribution limit - $2,700***.
- ***No "double-dipping"*** **- meaning that employees are unable to pay for procedures using both their HSA and Limited-Purpose FSA.**
- **"Use-it-or-loose-it", rule applies.**

If you have planned future dental or vision expenses, a Limited-Purpose FSA can make a lot of sense, especially when used in conjunction with an HSA.

Typical eligible limited FSA expenses:

Dental

- Cleaning
- Fillings
- Crowns
- Orthodontia

Vision

- Contact Lenses
- Eyeglasses
- Refractions
- Vision correction procedures

Flexible Spending Accounts – Americomp
Plan Year: April 1, 2019 – March 1, 2020

Health Care FSA

How much will you pay out-of-pocket for healthcare expenses this year? Whether it is hundreds or thousands, you can save money by paying for these expenses with tax-free money…if you sign up to participate in the Health Care FSA. This account offers reimbursement for eligible medical, dental and vision expenses not reimbursed by insurance, including deductibles, copays, prescriptions, certain over-the-counter drugs, orthodontic care, glasses, contacts and even laser surgery. You may contribute up to $2,700. Remember you can use the Health Care FSA for eligible expenses for yourself and all of your eligible dependents, even if they are not enrolled in Arista Consulting Group's medical plan.

Eligible Expenses	Non-Eligible Expenses
Some examples of healthcare expenses that may be reimbursed through your Health Care FSA: • Acupuncture • Alcohol or chemical dependency treatment • Ambulance • Chiropractors • Copays, coinsurance and deductibles • Crutches • Dental Care • Diabetic supplies • Eye exams, eyeglasses and contact lenses • Fertility treatments • Healthcare equipment • Hearing aids and batteries • Immunizations • Laser eye surgery • Lab tests and X-rays • Orthodontia services • Physical therapy • Smoking cessation program	The following expenses are among those that are not eligible for reimbursement: • Alternative medicines • Cosmetic surgeries and procedures • Cosmetics and toiletries • Food and food supplements • Funeral or burial expenses • Hair growth, removal or transplants • Health club fees • Household help • Insurance premiums • Marriage or family counseling • Vitamins

Fund Availability
Make sure to budget conservatively. Once you sign up for a Health Care FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available through your period of coverage (April 1, 2019 – March 31, 2020). Since you do not have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses such as after school care, baby-sitting fees, daycare services, nursery and preschool. Eligible dependents include your qualifying child, spouse and/or relative. You may contribute up to $5,000 depending on your tax filing status.

Fund Availability
Make sure to budget conservatively. Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Medical Expense FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll, deductions are received.

Flexible Spending Accounts Worksheet

This worksheet will help you determine the amount of your before-tax pay you want to contribute to the Health Care and/or Dependent Day Care Flexible Spending Account.

HEALTH CARE FSA WORKSHEET	
ANNUAL FAMILY MEDICAL EXPENSES	
Deductibles	$
Your Share of Doctor's Office Visit Costs	$
Your Share of Hospital Costs	$
Your Out-of-Pocket Costs	$
ANNUAL MEDICATION EXPENSES	
Your Share of Prescription Drug Costs	$
ANNUAL FAMILY DENTAL EXPENSES	
Deductibles	$
Your Share of Dental Expenses	$
Orthodontia Expenses	$
ANNUAL FAMILY VISION EXPENSES	
Your Share of Vision Exam Costs	$
Eyewear Costs	$
OTHER EXPENSES	
Hearing Care Costs	$
Other Expenses	$
TOTAL AMOUNT:	$

DEPENDENT CARE FSA WORKSHEET	
ANNUAL FAMILY DAY CARE EXPENSES	
Annual Childcare Expenses	$
Annual Elder Care Expenses	$
Summer Day Care Expenses	$
After School Program Expenses	$
Eligible Nursery School Expenses	$
TOTAL AMOUNT:	$

Dental – United Concordia

	PPO	
Services	In-Network	Out-of-Network
Deductible Type	Embedded Deductible	
Deductible Individual / Family	$50 / $150	
Calendar Year Maximum	$1,500	
Preventive Services • Cleanings • X-rays • Sealants • Palliative Treatment	Deductible waived, plan pays 100%	
Basic Services • Fillings • Simple Extractions • Space Maintainers • General Anesthesia • Oral Surgery (Simple and Complex) • Endodontics • Periodontics (Nonsurgical and Surgical) • Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	Deductible, then plan pays 80%	
Major Services • Crowns • Inlays and Onlays • Prosthetics (Bridges, Dentures)	Deductible, then plan pays 50%	
Orthodontia	Not Covered	
UCR	90%	

Dental
Semi-Monthly Payroll Deductions

24 Pay Period Deductions			
Employee Only	Employee & Spouse	Employee & Children	Employee & Family
$9.00	$17.00	$16.00	$27.00

Vision – Humana

	PPO	
Services	In-Network	Out-of-Network
Eye Exam Copay	$10 copay	Reimbursed up to $40
Frames (once per 24 months)	$50 Wholesale Allowance, Retail Value $100-$150	Reimbursed up to $57
Lenses • Single • Bifocal • Trifocal	 $15 Copay $15 Copay $15 Copay	 Reimbursed up to $33 Reimbursed up to $50 Reimbursed up to $65
Contacts • Elective (conventional / disposable) • Medically necessary (1pair)	$150 lens allowance 100% Covered	$150 lens allowance $280 allowance
Laser Vision Correction	Discount Only	None

These benefits are 100 % funded by Arista Consulting Group

Basic Life Insurance/AD&D – Hartford

Basic Life Benefits	
Benefit Amount	One times annual earnings up to $500,000
Age Reduction Provision	Benefits will reduce by 50% at age 70. Benefits will terminate at retirement.
Accelerated Benefit	You may collect a portion of your benefits during your lifetime if you become terminally ill.
Waiver of Premium	If you are disabled and unable to work, your premiums may be waived.
Conversion	Group Life coverage may be converted to Universal Life coverage without Evidence of Insurability
Accidental Death & Dismemberment Benefits	
Benefit Amount	One times annual salary up to $500,000
Age Reduction Provision	Benefits will reduce by 33% at age 65, and additional 50% at age 70. Benefits will terminate at retirement.

These benefits are 100% funded by Arista Consulting Group

Voluntary Life Insurance – Hartford

Benefit Amount Employee Spouse	Available in increments of $10,000 Five times annual earnings up to $300,000 Available in increments of $5,000 50% of employee election up to $150,000
Guarantee Issue Employee Spouse	$150,000 Under Age 60 $50,000 Under Age 60
Age Reduction Provision	Employee benefits amounts reduce to 50% at age 70. All coverage cancels at retirement.
Accelerated Benefit	You may collect a portion of your benefits during your lifetime if you become terminally ill.
Waiver of Premium	If you are disabled and unable to work, your premiums may be waived.
Conversion	Group Life coverage may be converted to your own individual policy.
Portability	If you terminate your employment prior to Social Security Normal Retirement Age, you may continue all or a portion of your life insurance coverage under a separate term policy. Evidence of Insurability is not required.

Monthly Rate Per $1,000			
Age Bracket	Employee		Spouse
	Non-Tobacco	Tobacco	Non-Tobacco & Tobacco
<25	$.04	$.08	$.04
25-29	$.04	$.08	$.04
30-34	$.06	$.10	$.06
35-39	$.07	$.13	$.07
40-44	$.12	$.21	$.12
45-49	$.20	$.36	$.20
50-54	$.33	$.60	$.33
55-59	$.57	$1.03	$.57
60-64	$.61	$1.09	$.61
65-69	$1.07	$1.93	$1.07
70-74	$1.90	$3.41	$1.90

Short Term Disability Income Benefits – Hartford

Benefits	
Definition of Disability	Regular Pay Commission (Sales Income) & Bonus Income For One Calendar Year
Definition of Disability	Own Occupation Only
% of Income Replaced	60% of Weekly Earnings up to $1,500 Per Week
Benefit Period	Begins on the 15th day after your injury or the 15th day of sickness and continues up to 11 Weeks.
Is there a Preexisting Condition Clause?	No

Long Term Disability Income Benefits – Symetra

Benefits	
Definition of Disability	5 year own occupation/any thereafter
Coverage	On and Off-the job
Benefits Begin	91st Day
Benefits Payable	Up to SSNRA
% of Income Replaced	60% of Salary
Maximum Benefit	Up to $15,000 Per Month

These benefits are 100% funded by Arista Consulting Group

401(k) / Employee Retirement Plan – Empower Retirement

Following 90 days of employment, ARISTA employees are AUTOMATICALLY enrolled in the company 401(k) plan at 3% of their annual salary. Employees are encouraged and able to contribute additional investments into the plan. Employees will have the option to invest the money in funds of their choosing or they can elect from preset Professional Managed Target Retirement Date Investment plans. In addition, ARISTA contributes 3% of your annual salary through a Safe Harbor contribution. Since employees are 100% vested in the 3% employer contribution, YOU are entitled to all amounts in your accounts from day one.

Additionally, we may provide our employees with a Profit-Sharing Contribution. A separate vesting schedule applies to the Profit-Sharing Contribution.

Arista Consulting Group, 4550 N Point Pkwy, Suite 250, ALPHARETTA, GA, 30022
Sherry Crowe, Plan Administrator, (678) 533-6060

Effective Date: March 05, 2019

Employee & Eligible Beneficiaries,

As an employee of Arista Consulting Group and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. In the past, many of these notices were sent individually and are now grouped together to more clearly communicate your rights, and to simplify distribution. If you have any questions please contact Sherry Crowe, HR Administrative Assistant, Arista Consulting Group at: (678) 533-6060

For individuals who elect to waive coverage, some of these notices will not apply to you. See the plan administrator for further details.

IMPORTANT INFORMATION

MEDICARE PART D NOTICE

Medical Plan: Humana

About Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage 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. We have determined 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 to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. 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 coverage will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D.
Visit http://www.cms.hhs.gov/CreditableCoverage/ which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will be able to get this coverage back. Refer to plan documents or contact your provider or the plan administrator before making any decisions.

Note: In general, different guidelines exist for retirees regarding cancelation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know if you drop or lose your current coverage 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 19 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 in this notifications report. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage 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 or 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 800-MEDICARE (800-633-4227). TTY users should call (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 (800) 772-1213 (TTY 1-800-325-0778).

Remember to 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).

NOTIFICATIONS

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other 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. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the plan administrator.

If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

QMCSO (Qualified Medical Child Support Order)
QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer; know the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

WHCRA
The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at the number listed above.

NMHPA

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with 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 or 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

RESCISSIONS
The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

PREVENTIVE CARE
Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

WOMEN'S PREVENTIVE HEALTH SERVICES
All of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in-network:

- Well-woman visits (annually)
- Prenatal visits (routine preventive visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved, over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

COBRA NOTICE
This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. 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 coverage would otherwise end because of a life event known as a "qualifying event." 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. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the Plan Year (e.g., $2,550 of coverage); (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the 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.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator indicated above or in the summary plan description. 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.

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 January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**

Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

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

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

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Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

With the key parts of the health care law that took effect in 2014, there is 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 Arista Consulting Group.

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.

The Open Enrollment period is November 1st through December 15th of the year preceding the benefit plan year. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events. (See Special Enrollment Period and Qualifying Life Event)

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 9.56% 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. *Note: For plan years beginning in 2019 the income rate will change to 9.86%.*

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 your employer.

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

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.

1. Employer Name: Arista Consulting Group
2. Employer Identification Number (EIN): 56-2499552
3. Employer Address: 4550 N Point Pkwy, Suite 250
4. Employer phone number: (678) 533-6062
5. City: ALPHARETTA
6. State: GA
7. ZIP code: 30022
8. Who can we contact about employee health coverage at this job: Sherry Crowe
9. Phone number for contact: (678) 533-6060
10. Email address: scrowe@aristacg.com

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

- As your employer, we offer a health plan to: Eligible Employees.

Eligible employees are: Full-time employees who work at least 30 hous per week .

- With respect to dependents: We do offer coverage to all eligible dependents.

Eligible dependents are: legal spouse and dependent children of eligible employee.

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.

* 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.

Important Telephone Numbers & Websites

Questions	Company	Telephone	Email or Web
Employee Benefit Assistance	Arista Consulting Group	(866) 370-3119	help@aristacg.com
Medical & Vision **Group #763626**	Humana	(866) 537-0229	Medical – www.Humana.com Vision – HumanaVisionCare.com
Dental **Group # 005903410000**	United Concordia	(800) 332-0366	www.ucci.com
Basic Life / AD&D / **Voluntary Life** **Short Term Disability** **Policy #87766**	Hartford	(800) 549-6514	www.thehartford.com
Long Term Disability **Policy #01 016213 00**	Symetra	(800) 423-2765	http://www.symetra.com
Identity Theft / Legal Plans	LegalShield	(800) 654-7757	www.legalshield.com
Health Savings Account	Health Equity	(866) 346-5800	www.healthequity.com
Flexible Spending Accounts (FSA) - **Healthcare** - **Limited-Purpose (Dental/Vision)** - **Dependent Care**	Americomp	(706) 327-6511	www.americompbenefits.com
401(k) / Employee Retirement Plan	Newport Group	(844) 749-9981	www.newportgroup.com/ login/participant

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