



Medical



Dental



Vision



Life

2021

Your Guide
to
Open
Enrollment



Welcome



Goodwill Industries of South Texas recognizes that we would not be able to achieve the company’s level of success without you, their dedicated employees. Therefore, we have packaged a comprehensive Employee Benefits Plan for the 2021 plan year. This plan is designed to help you stay healthy, feel secure, and maintain balance in your life.

This guide is your opportunity to learn more about the benefits available to you and your eligible dependents beginning **September 1, 2021**.

To get the best value from your health care plan, please take the time to evaluate your coverage options and determine which plans best meet your health care and financial needs. By being a wise consumer, you can support your health and maximize your health care dollars.

Each year during Open Enrollment, you have the opportunity to make changes to your benefit plans. The enrollment decisions you make this year will remain in effect through **August 31, 2022**. You may make changes to your benefit elections only when you have a Qualifying Life Event. After such event, you can make changes to your health care coverage within 30 days; otherwise, you cannot make changes to your coverage until next Open Enrollment period.

Availability of Summary Health Information

Our Employee Benefits Program offers two health coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available, which summarizes important information about your health coverage options in a standard format. The SBC(s) are included in your insurance packet that is distributed at open enrollment.

Table of Contents

Cover Page	1
Welcome Page	2
Important Contacts	3
Eligibility	4
What to Expect in 2021?	5
Medical – Option 1	6
Medical – Option 2	7
Dental – Option 1	8
Dental – Option 2	9
Vision	10
Basic and AD&D	11
Voluntary Life and AD&D	12
Short Term & Long Term Disability	13
Section 125	14
Retirement	15
Legal Shield	16-18
Aflac	19-30
Questions & Answers	31
Legal Packet	32-41

IMPORTANT CONTACTS:

Please refer to this list when you need to contact your benefit vendor(s). For immediate assistance to general questions, please contact your Payroll Department.



Contact: Payroll Department
Phone Number: 361.884.4068
Email Address: payroll@goodwillsouthtexas.com

Do you have questions about your benefits or would you like help enrolling for the 2021 plan year? Benefit experts are available to assist you Monday through Friday, 8:00 a.m. – 5:00 p.m. CT.

Contact: Benefits Department
Phone Number: 800.756.0918 | 361.883.1711
Website: www.higginbotham.net



Contact: Jennifer Rector (Benefits Consultant)
Phone Number: 361.883.1711 | 4235
Email Address: jrector@higginbotham.net

Contact: Odilia Robles (ACSR | Senior Account Manager | Coastal Region Team Leader)
Phone Number: 361.883.1711 | 4303
Email Address: orobles@higginbotham.net

Contact: Iris Garcia (Account Coordinator)
Phone Number: 361.883.1711 | 4261
Email Address: igarcia@higginbotham.net

Get easy access to details about your benefits, doctors, eligibility, hospitals and so much more by visiting your vendor's websites or calling their toll free number.

Provider: Blue Cross Blue Shield
Coverage: Medical
Phone Number: 800.521.2227
Website: www.bcbstx.com

Provider: Principal
Coverage: Basic Life | Voluntary Life | STD & LTD
Phone Number: 800.986.3343
Website: www.principal.com

Provider: Humana Insurance Company
Coverage: Dental | Vision
Phone Number: 866.427.7478
Website: www.humana.com

Provider: AFLAC – Debbi LeGros
Coverage: Supplemental
Phone Number: 361.947.1971
Email Address: deborah_legros@us.aflac.com
Claims: groupclaimfiling@aflac.com

Contact: Alyssa Loya
Phone Number: 361.271.1211
Email Address: service@admin316.com

Contact: John A. Seaman
Phone Number: 361.993.8888
Email Address: www.seamanfinancial.com

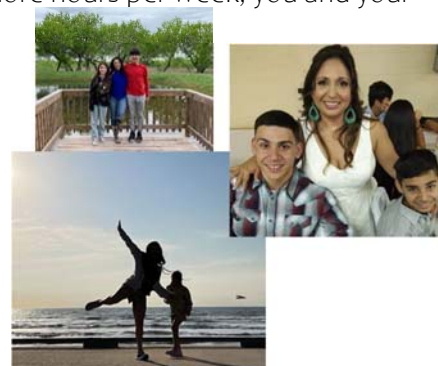
ELIGIBILITY

Who is Eligible?

If you are a **Goodwill Industries of South Texas** full-time employee, working 30 or more hours per week, you and your dependents are eligible to enroll in the benefits described in this guide.

Eligible Family Members:

- Legal Spouse
- Qualified Dependent Children Under the Age of 26
- Eligible Beneficiaries Under COBRA and/or Texas State Continuation



How to Enroll

First - Review your current benefit elections.

Second - Verify your personal information and make the necessary changes.

Third - Choose your benefit elections for the current plan year.

Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

How to Make Changes

You can make changes to your benefit elections **only** when you experience a Qualifying Life Event. After such event, you will have 30 days to submit the change(s) to in writing to your Human Resources Department; otherwise, your coverage will remain in effect until the group's next Open Enrollment period.



Qualified Change in status include:

- marriage, divorce, legal separation
- birth or adoption of a child, change in child's dependent status
- death of spouse, child or other qualified dependent
- Change in spouse's benefits employment status.



When to Enroll

The open enrollment period runs from July 19, 2021 through July 30, 2021. The benefits you elect during open enrollment will be effective from September 1, 2021 through August 31, 2022.

WHAT TO EXPECT IN 2021!



Our employees are our most valuable asset.

This is why at Goodwill Industries of South Texas, Inc. we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure, and maintain a work/life balance.

What to expect for 2021-2022?

- Medical will stay with Blue Cross Blue Shield
- Dental & Vision will continue with Humana
- Basic Life, Voluntary Life, STD and LTD will also continue with Principal

Feeling Secure

- Tax Savings Opportunities
- 403 (b) Retirement Savings Plan
- Life and Accidental Death & Dismemberment
- Supplemental Life and Accidental Death & Dismemberment
- Income Protection Plan (Short and Long Term Disability)

MEDICAL COVERAGE: OPTION 1

Blue Cross Blue Shield

Website: www.bcbstx.com

Who is Eligible and When:

All full-time employees are eligible for Health Insurance. Newly hired Employees & their dependents enrolling will have coverage go in effect on the first of the month following 60 days of Full-Time employment. Eligible dependents include – Spouse or children (26 and younger).

	MTBCB026 \$3,000 70/50	
Medical Services	In-Network	Out of Network
Physician Visit		
- Primary Care (Designated)	\$50 Copay	50% after Deductible
- Specialist (Designated)	\$100 Copay	50% after Deductible
- Telemedicine/Virtual Visits	\$50 Copay	No Benefit
Preventive Care	Covered 100%	50% after Deductible
Deductible: Individual Family	\$3,000 \$9,000	\$6,000 \$18,000
Coinsurance	70%	50%
Basic Lab/X-Rays	70% after Deductible	50% after Deductible
Total Out of Pocket Max:		
- Individual	\$7,350 \$14,700	Unlimited
- Family		
Urgent Care	\$75 Copay	50% after Deductible
Emergency Room	70% after deductible + \$500 Copayment	
Prescription Drugs		
- Level I	\$0 \$10	\$10 } \$20 } \$70 } + 50% after \$120 } Deductible \$150 } \$250 } No Benefit
- Level II	\$10 \$20	
- Level III	\$50 \$70	
- Level IV	\$100 \$120	
- Level V	\$150	
- Level VI	\$250	
Retail/Mail Order – 90 Days Supply	3 x Copay	
	Option 1	

2021 Base Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
SEMI-Monthly (per pay check)	\$47.74	\$334.19	\$262.58	\$572.90
2021 Base Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
WEEKLY (per pay check)	\$23.87	\$167.10	\$131.29	\$286.45

MEDICAL COVERAGE: OPTION 2

Blue Cross Blue Shield
Website: www.bcbstx.com

Who is Eligible and When:

All full-time employees are eligible for Health Insurance. Newly hired Employees & their dependents enrolling will have coverage go in effect on the first of the month following 60 days of Full-Time employment. Eligible

	MTBCPo22 \$2,500 60/50	
Medical Services	In-Network	Out-of-Network
Physician Visit <ul style="list-style-type: none"> - Primary Care (Designated) - Specialist (Designated) - Telemedicine/Virtual Visits 	\$35 Copay \$70 Copay \$35 Copay	50% after Deductible 50% after Deductible No Benefit
Preventive Care	Covered 100%	50% after Deductible
Deductible: <ul style="list-style-type: none"> - Individual - Family 	\$2,500 \$7,500	\$10,000 \$20,000
Coinsurance	60%	50%
Basic Lab/X-Rays	Covered 100%	50% after Deductible
Total Out of Pocket Max: <ul style="list-style-type: none"> - Individual - Family 	\$7,500 \$15,800	Unlimited
Urgent Care	\$75 Copay	50% after Deductible
Emergency Room	60% after deductible + \$500 Copay	
Prescription Drugs <ul style="list-style-type: none"> - Level I - Level II - Level III - Level IV - Level V - Level VI 	\$0 \$10 \$10 \$20 \$50 \$70 \$100 \$120 \$150 \$250	\$10 \$20 \$70 \$120 \$150 \$250 + 50% after Deductible
Retail/Mail Order – 90 Days Supply	3 x Copay	No Benefit

Option 2

2021 Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
SEMI-Monthly (per pay check)	\$64.50	\$371.06	\$294.41	\$626.52
2021 Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
WEEKLY (per pay check)	\$32.25	\$185.53	\$147.21	\$313.26

DENTAL COVERAGE: OPTION 1

Humana Insurance

Website: www.humana.com

Who is Eligible and When:

All employees are eligible for dental insurance. Newly hired Employees & their dependents enrolling will have coverage go into effect on the first of the month following 60 days of continuous employment. Eligible dependents include – Spouse or children (26 and younger).

Benefits You Receive:

Preventative and Basic Coverage is available to the employee and their family. Employee Pays 100% of the premium cost. Below are the paycheck deductions.

Tx Prev + INFS 14 100/80 \$1,000 Max			
Type of Service	In- Network	Out-Of- Network	Services
Preventive Services	100%	100%	<ul style="list-style-type: none"> • Cleanings • X-rays • Office Visits • Fluoride Treatments (through age 14) • Sealants (through age 14) • Space Maintainers (through age 14) • Oral Cancer Screening
Basic Services (Deductible Applies)	80%	80%	<ul style="list-style-type: none"> • Emergency care for pain relief • Amalgam fillings • Oral Surgery (routine extractions) after \$50 Deductible
Major Services (Deductible Applies)	No Benefit		
Annual Maximum	The Maximum benefit paid per calendar year is \$1,000 per person		
Orthodontic Benefit	No Benefit		

Option 1

2021 Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
SEMI-Monthly (per pay check)	\$4.32	\$9.78	\$11.48	\$18.07
2021 Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
WEEKLY (per pay check)	\$2.16	\$4.89	\$5.74	\$9.04

Subject to Humana Dental Services Schedule

DENTAL COVERAGE: OPTION 2

Humana Insurance

Website: www.humana.com

Who is Eligible and When:

All employees are eligible for dental insurance. Newly hired Employees & their dependents enrolling will have coverage go into effect on the first of the month following 60 days of continuous employment. Eligible dependents include – Spouse or children (26 and younger).

Benefits You Receive:

Preventative and Basic Coverage is available to the employee and their family. Employee Pays 100% of the premium cost. Below are the semi-monthly per paycheck deductions.

Type of Service	Tx Trad Plus 14 100/80/50 \$1,000 Max		
	In- Network	Out-Of- Network	Services
Preventive Services	100%	100%	Cleanings X-rays Office Visits Fluoride Treatments Sealants Space maintainers Oral Cancer Screening
Basic Services (Deductible Applies)	80%	80%	Emergency care for pain relief Amalgam fillings Oral Surgery after \$50 Deductible Stainless steel crowns habit appliances
Major Services (Deductible Applies)	50%	50%	Crowns Inlays/Onlays Bridges Dentures Denture Repair Implants Periodontics Endodontics
Annual Maximum	The Maximum benefit paid per calendar year is \$1,000 per person		
Orthodontic Benefit (children through age 19)	50% (12 month waiting period applies if no prior dental coverage)		

2021 Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
SEMI-Monthly (per pay check)	\$8.17	\$16.33	\$23.95	\$32.74
2021 Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
WEEKLY (per pay check)	\$4.08	\$8.17	\$11.97	\$16.37

Subject to Humana Dental Services Schedule

VISION COVERAGE:

Humana Insurance

Website: www.vsp.com

Who is Eligible and When:

All employees are eligible for dental insurance. Newly hired Employees & their dependents enrolling will have coverage go into effect on the first of the month following 60 days of continuous employment. Eligible dependents include – Spouse or children (26 and younger).

Benefits You Receive:

Preventative and Basic Coverage is available to the employee and their family. Employee Pays 100% of the premium cost. Below are the semi-monthly per paycheck deductions.

Type of Service	Participating Providers	Non-Participating Providers
Exam with Dilation as necessary Retinal imaging	100% After \$10 Copay Up to \$39	Up to \$30 Allowance Not covered
Lenses: - Single - Bifocal - Trifocal - Lenticular	100% after \$25 Copay 100% after \$25 Copay 100% after \$25 Copay 100% after \$25 Copay	Up to \$25 Allowance Up to \$40 Allowance Up to \$60 Allowance Up to \$100 Allowance
Frames	\$100 Frame Allowance 20% off balance over \$100	\$50 Allowance
Elective Contact Lenses: - Conventional - Disposable - Medically Necessary	\$100 Allowance (15% off balance over \$100) \$100 Allowance 100% after Copay	\$80 Allowance \$80 Allowance \$200 Allowance
Frequency: - Examination - Lenses or contacts - Frames		Once every 12 months Once every 12 months Once every 24 months

2021 Vision Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
SEMI-Monthly (per pay check)	\$2.53	\$5.06	\$4.81	\$7.56
2021 Vision Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
WEEKLY (per pay check)	\$1.27	\$2.53	\$2.40	\$3.78

BASIC LIFE AND AD&D

Who is Eligible and When:

All full-time employees are eligible for Life and AD&D Insurance. Newly hired Employees enrolling will have coverage go in effect on the first of the month following 60 days of continuous employment.

Goodwill Industries of South Texas provides group basic life and accidental death and dismemberment (AD&D) insurance 100% of this benefit for their eligible full time employees. Please be sure to keep your beneficiary information up to date with the Human Resource Department.

Basic Life & AD&D Insurance	Class
\$50,000	Class I – Director and above
\$20,000	Class II – All other Full Time Employees

Goodwill Industries of South Texas pays the full cost of this benefit. Please complete a new beneficiary form and return to the Payroll Department.

Benefit Reduction to 35% of the original amount at age 65 & and 50% at age 70

VOLUNTARY LIFE AND AD&D

Who is Eligible and When:

All full-time are eligible for Supplemental Life and AD&D Insurance. Newly hired Employees & their dependents enrolling will have coverage go into effect on the first of the month following 60 days of Full-Time employment. Eligible dependents include – Spouse or children (26 and younger).

Voluntary Life & AD&D Insurance:

You may purchase additional Life and AD&D insurance for you and your eligible dependents. If you decline Voluntary Life and AD&D insurance when first eligible or if you elect coverage and wish to increase your benefit amount at a later date, Evidence of Insurability (EOI), proof of good health, may be required before coverage is approved. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through semi-monthly payroll deductions.

Please Note:

- * You must elect Voluntary Life and AD&D coverage for yourself in order to elect coverage for your spouse or children.
- * Spouse & Child(ren) benefits cannot exceed 100% of the employee's coverage.

Voluntary Life and AD&D	Benefit Amount
Employee	Increments of: \$10,000 Minimum Amount: \$10,000 Maximum Amount: \$500,000 Guaranteed Issue: Under age 70 – \$150,000 Age 70 and over – \$10,000
Spouse	Increments of: \$5,000 Minimum Amount: \$5,000 Maximum Amount: \$100,000 Guaranteed Issue: Under age 70 – \$30,000 Age 70 and over – \$10,000
Child(ren)	Increments of: Under 14 days – \$1,000 14 days to age 26 – \$5,000 Minimum Amount: Under 14 days: \$1,000 14 to age 26 – \$5,000 Maximum Amount: 14 to age 26 – \$10,000

Monthly Cost for Each \$1,000 of Employee & Spouse Life & AD&D Insurance Coverage										
Age	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-67	70-74
Employee	\$.097	\$.127	\$.137	\$.147	\$.217	\$.327	\$.597	\$.897	\$1.717	\$2.777
Spouse: *Charges based upon individual age.	\$.097	\$.127	\$.137	\$.147	\$.217	\$.327	\$.597	\$.897	\$1.717	\$2.777
Children:	Children 14 days to age 26 are covered at \$1,000 for \$.200									

How to Calculate Your Cost per Paycheck:

_____	X	_____	÷	1,000	=	_____
Your Rate per \$1,000		The amount of coverage you are electing				Your Total Monthly Rate
_____	X	12	÷	24	=	_____
Your Total Monthly Rate						Your Cost Per Paycheck

SHORT TERM | LONG TERM DISABILITY

Who is Eligible and When:

All full-time employees are eligible for Short Term and Long Term Disability Insurance. Employees enrolling will have coverage go into effect on the first of the month following 60 days of Full-Time employment.

Benefits You Receive:

In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

Employee Pays:

Goodwill provides Short Term Disability and Long Term Disability coverage to all full-time employees at no cost.

Benefits	Short-Term Disability	Long-Term Disability
Benefits Begin	On the 15 th day for Injury or Sickness	90 days from Injury or Sickness
Benefit Duration	Maximum of 11 weeks	To age 65 or Social Security
% of Income Replaced	60% of Base Weekly Earnings	60% of Base Monthly Earnings
Maximum Benefit	60% of Weekly Salary up to \$1,500 per month	60% of Monthly Salary up to \$8,000 per month

SECTION 125: PRE-TAX PREMIUM PLAN

Who is Eligible and When:

All employees are eligible to participate in the Pre-Tax Premium Plan. Newly hired Employees & their dependents enrolling will have coverage go in effect on the first of the month following 60 days of continuous employment.

Benefits You Receive:

The Pre-Tax Premium Plan allows your insurance premiums to be deducted from your paychecks before deductions are taken for FICA, federal, and in most cases, state and local taxes. This will reduce your taxes, so you will end up with more take-home pay than if you have the premiums deducted after taxes. Having your insurance premium(s) taken pre-tax from your paycheck costs you nothing extra.

Each employee who participates in one of our insurance plans, and shares in the cost of coverage, will automatically be enrolled in this pre-tax program. If you do not wish to participate, thereby paying your group sponsored insurance premiums with after-tax dollars, contact the Payroll Department to sign the necessary waiver form.

It is important to know that once your insurance premiums are being deducted on a pre-tax basis, **you cannot change your deduction until the start of the next Plan Year unless you experience a qualifying event such as the following:**

- Marriage
- Birth
- Divorce
- Reduction in hours
- Change in eligibility status
- Spouse's employer's annual open enrollment

***If you experience a qualifying event, you have 30 days to notify the Payroll Department in writing or email at payroll@goodwillsouthtexas.com for any necessary changes.**

RETIREMENT



403b Retirement Savings

Who is Eligible and When:

All Employees are eligible 1st day of the month after 60 days from date of hire.

Employees are eligible for matching in the 403(b) plan on the first day of the calendar quarter following 1 year of service.

Employee Contributions:

Employees can contribute up to 100% of salary up to a maximum of \$19,500 (eff. 2021) per calendar year into various investment options. Participants age 50 and older may make "catch-up" contributions subject to dollar limits. The catch-up contribution limit has increased to \$6,500 for the 2021 fiscal year.

Currently to help you save for retirement, Goodwill Industries of South Texas will match dollar per dollar up to 5% of the employee's compensation, when an employee contributes to the plan. This matching is subject to change annually at the discretion of the Board. You vest, or gain ownership, in the matching contributions from Goodwill based on the following schedule:

Vesting Schedule	
0%	1 Year of Service
20%	2 Year of Service
40%	3 Year of Service
60%	4 Year of Service
80%	5 Year of Service
100%	6 Year of Service

Cost to Employee:

Pre-Tax contributions: See Summary Plan for any additional fees and/or charges.

Contact Information:

Alyssa Loya 361-271-1211 Service@admin316.com	John A. Seaman, MSFS, CFP Bus. 361-993-8888 Fax: 361-992-5866 www.seamanfinancial.com	Toll Free Number: 1-800-528-9009 Address: 5830 Mc Ardle, Ste. 204 Corpus Christi, TX 78412
---	---	---



Have You Ever

- Needed your Will prepared or updated?
- Signed a contract?
- Received a moving traffic violation?
- Worried about being a victim of identity theft?
- Been concerned about your child's identity?
- Lost your wallet?

The LegalShield Membership Includes:

- **Dedicated Law Firm** Direct access, no call center
- **Legal Advice/Consultation** on unlimited personal issues
- **Letters/Calls** made on your behalf
- **Contracts/Documents Reviewed** up to 15 pages each
- **Residential Loan Document Assistance** for the purchase of your primary residence
- **Will Preparation** - Living Will, Health Care Power of Attorney, Financial Power of Attorney
- **Speeding Ticket Assistance** Upload your speeding ticket from the mobile app directly to law firm
- **IRS Audit Assistance** (begins with the tax return due April 15th of the year you enroll)
- **Trial Defense** (if named defendant/respondent in a covered civil action suit)
- **Uncontested Divorce, Separation, Adoption and/or Name Change Representation** (available 90 days after enrollment)
- **25% Preferred Member Discount** (bankruptcy, criminal charges, DUI, personal injury, etc.)
- **24/7 Emergency Access** for covered situations

The IDShield Membership Includes:

- **1B 1 Bureau Credit Monitoring** from TransUnion with activity alerts
- **High Risk Application and Transaction Monitoring** detects fraud up to 90 days earlier than traditional credit monitoring services. We carefully watch your accounts, reorders, loans and more. If a new account is opened, you will receive an alert
- **Social Media Monitoring** for privacy and reputational risks
- **Credit Inquiry Alerts** when your Personally Identifiable Information (PII) is used to apply for bank/credit cards, utilities or rentals, and many other types of loans
- **Consultation** on any cyber security question
- **\$1 Million Protection Policy** coverage for lost wages, legal defense fees, stolen funds and more
- **Unlimited Service Guarantee** ensures that we won't give up until your identity is restored!
- **Identity Restoration** performed by Licensed Private Investigators to restore your identity to its pre-theft status.
- **24/7 Emergency Access** in the event of an identity theft emergency



Put your law firm and identity theft protection in the palm of your hand with the LegalShield & IDShield Plus mobile apps

Plan	Family Price	Individual Price
	(Weekly/Semi-Monthly)	(Weekly/Semi-Monthly)
LegalShield	\$4.37/\$9.38	\$3.91/\$8.48
IDShield	\$4.37/\$9.48	\$2.07/\$4.48
Combined	\$7.82/\$16.95	\$5.98/\$12.95

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under the age 18 for whom the member is the legal guardian; never married dependent children up to age 26 if a full-time college student; or physically or mentally disabled dependent children.

IDShield is a product of Pre-Paid Legal Services, Inc. d/b/a LegalShield ("LegalShield"). LegalShield provides access to identity theft protection and restoration services. For complete terms, coverage and conditions, please see www.idshield.com. IDShield plans are available at individual or family rates. A family rate covers the named member, named member's spouse and up to 10 dependent children under the age of 18. It also provides consultation and restoration services for dependent children ages 18 to 26. All Licensed Private Investigators are licensed in the state of Oklahoma. A \$1 million protection policy is issued through a nationally recognized carrier. LegalShield/IDShield is not an insurance carrier. Certain limitations apply. Dependent children of the named member or named member's spouse under the age of 23 who permanently live in the same residence as the named member at the time of the stolen identity event are eligible for the protection policy coverage. For a summary description of benefits for the personal identity coverage see <https://idshield.cloud/summary-of-benefits>.

For more information, call
LegalShield Member Services at 800-654-7757.

G FLIER_LS+IDS_1B_USA_061719



Comprehensive Coverage. Direct Access.
Easy to Use Services. Affordable Solution.

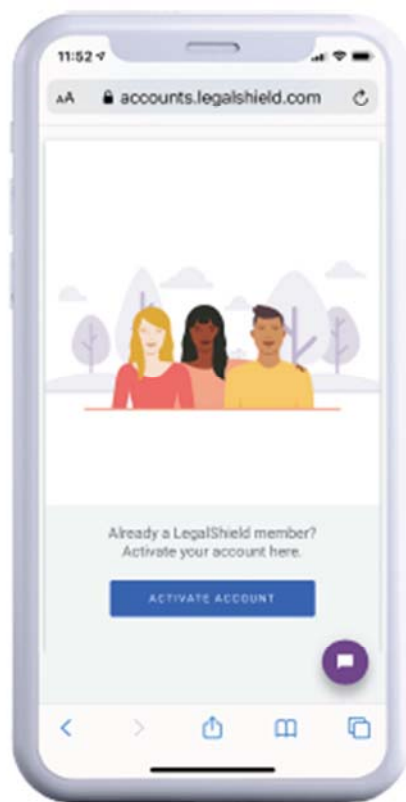
Create Your Account

Legal protection is just a tap away.



Follow these steps to create your LegalShield account.

- 1. CREATE** your account at accounts.legalshield.com.
- 2. ENTER** in your member number and create a username and password.
- 3. DOWNLOAD** the LegalShield mobile app and use your account username and password to log in. Access your provider law firm, Will preparation steps and more!



If you have questions about setting up your account or forgot your member number, please call **LegalShield Member Services at 1-800-654-7757**.
LegalShield Member Services is available 7 a.m.-7 p.m. CT, Monday-Friday.

Apple and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc., registered in the U.S. and other countries. Google Play and the Google Play logo are trademarks of Google Inc. The LegalShield apps are available for download at no cost. Some services require an active LegalShield Membership to be accessed.

US_08_14_21_08_0766000000000000_01_000000

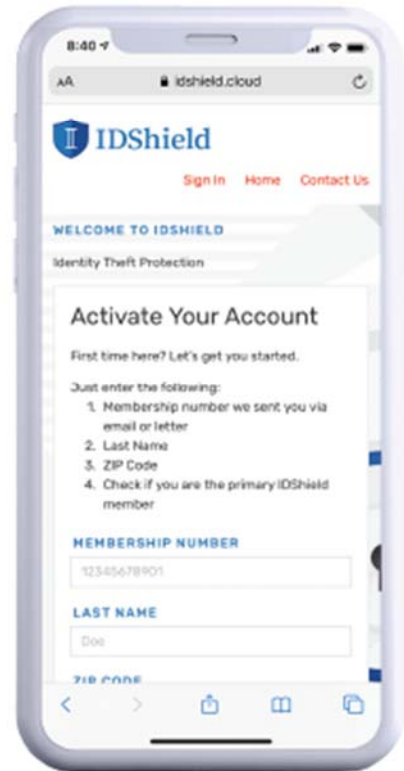


Identity Theft and Privacy Protection

*Guarding your personal information
is as EASY as 1-2-3!*

Follow these steps to create your IDShield account.

1. **CREATE** your account at idshield.cloud/activate using your Member number.
2. **ADD** the personal information you want to monitor, including your social media accounts.
3. **DOWNLOAD** the IDShield mobile app for immediate alerts and to track your monthly credit score.



If you have questions about setting up your account or forgot your member number, please call **IDShield Member Services at 1-800-654-7757**. IDShield Member Services is available 7 a.m.-7 p.m. CT, Monday-Friday.

Apple and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc., registered in the U.S. and other countries. Google Play and the Google Play logo are trademarks of Google Inc. The LegalShield apps are available for download at no cost. Some services require an active LegalShield Membership to be accessed.

US_M_P_10_P9_EN_C18862225536363636_04.20



Who is Eligible and When:

All employees, Full Time and Part-Time are eligible for Voluntary Supplemental Insurance. Newly hired Employees & their dependents enrolling will have coverage go into effect on the first of the month following 60 days of Full-Time employment. Eligible dependents include – Spouse or children (26 and younger).

Benefits You Receive:

Lump Sum Critical Illness (Heart Attack/Stroke Policy with Cancer)

Supplemental policy that pays a Lump Sum in the event you are diagnosed with a Cancer, Heart Attack, Stroke, Coma, Paralysis, Renal failure or Human Organ Transplant. This is a \$20,000 **Guaranteed Issue** amount and the spouse gets a guaranteed issue of \$10,000. Wellness benefit is \$50 a year.

**Semi Monthly Deductions*

Enrollment Age	Employee- Non Tobacco \$20,000	Spouse- Non Tobacco \$10,000	Employee- Tobacco \$20,000	Spouse - Tobacco \$10,000
18-29	\$4.77	\$2.72	\$6.66	\$3.67
30-39	\$7.68	\$4.18	\$11.94	\$6.31
40-49	\$14.82	\$7.75	\$23.30	\$11.99
50-59	\$28.64	\$14.66	\$46.38	\$23.53
60 +	\$54.77	\$27.72	\$85.79	\$43.23

Children are covered at 50% of the employee amount and are **FREE**

Off the Job Accident Policy

Supplemental policy that pays directly to you in the event of a covered accident to help cover out of pocket expenses associated with having an accident. These plans also have a \$50.00 Wellness Benefit and are **Guaranteed Issued**.

**Semi Monthly Deductions*

Enrollment Type	Cost
Employee Only	\$4.30
Employee & Spouse	\$7.59
Employee & Child(ren)	\$10.30
Employee & Family	\$13.59



Hospital Advantage:

Supplemental policy that pays directly to you in the event you are confined INPATIENT to a hospital for a covered event. The Initial Hospital Confinement Benefit pays \$1,000 and \$100 a day there after. This is **Guaranteed Issued**.

**Semi Monthly Deductions*

Age	Premium
Employee Only 18-75	\$6.91
Employee/Spouse 18-75	\$13.92
Employee/Child(ren) 18-75	\$10.86
Employee/ Family 18-75	\$17.87

BenExtend Insurance 3 PRODUCTS IN 1

AFLAC has come up with an Innovative Cost Solution by combining our 3 most popular products in to 1 benefit. This benefit combines Hospital, Accident, and Critical Illness **with limited benefits**.

You can still purchase AFLAC Group products (i.e. Hospital, Accident, and Critical Illness) separately, but you also have the option to purchase BenExtend.

**Semi Monthly Deductions*

Age	Premium
Employee Only	\$14.39
Employee/Spouse	\$28.31
Employee/Child(ren)	\$20.56
Employee/ Family	\$34.48

**Weekly Deductions*

Age	Premium
Employee Only	\$6.64
Employee/Spouse	\$13.06
Employee/Child(ren)	\$9.49
Employee/ Family	\$15.91



20 Year Term Life Insurance Policy:

A Supplemental life insurance policy that allows you to apply for coverage of \$25,000 or \$50,000 .

No Physical examinations and Guaranteed Issued.

*Please note – you can only apply up to age 65.

Employee

***Semi-Monthly Deductions**

Enrollment Age	\$25,000- Non Tobacco	\$50,000- Non Tobacco
25	\$3.21	\$5.59
35	\$4.45	\$8.05
45	\$7.98	\$15.12
55	\$14.58	\$28.33
65	\$29.17	\$57.52

Enrollment Age	\$25,000- Tobacco	\$50,000- Tobacco
25	\$5.38	\$9.93
35	\$7.96	\$15.07
45	\$15.62	\$30.41
55	\$30.06	\$59.29
65	\$61.09	\$121.36

Spouse

Enrollment Age	\$25,000- Non Tobacco
25	\$2.38
35	\$3.61
45	\$7.14
55	\$12.96
65	\$28.34

Enrollment Age	\$25,000- Tobacco
25	\$4.54
35	\$7.12
45	\$14.79
55	\$27.57
65	\$60.26

Child Rider - \$10,000 15 days - 25 years old – no limit on the amount of children being enrolled – semi-monthly total will remain \$2.50

Rates shown are for example only; Specific rates for EXACT age and benefit amount will be provided at time of enrollment.

You can't predict the unexpected, now you don't have to.

Life is fast-paced. Who has time (or wants) to research insurance? Aflac understands that knowing which benefits are right for you isn't always easy. That's why we created *BenExtend*, a new kind of product – one that takes the guesswork out of choosing your benefits. *BenExtend* features commonly-used benefits from three different types of insurance – accident, hospital indemnity and critical illness. You'll get a range of benefits in one simple plan at one straightforward price. And you'll know the benefits are there when you need them – for greater financial security and even greater peace-of-mind.

BenExtend	Critical Illness Benefits		<i>BenExtend</i> combines commonly-used benefits of hospital indemnity, critical illness and accident insurance products into a simple plan design.
	Accident Benefits		
	Hospital Indemnity Benefits		

Best of all, Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Benefits can be used to help with your every day living expenses, like your rent or mortgage, utility bills, groceries and more.

BenExtend plans are designed to help ease the financial stress of a critical illness, accident or hospital stay with benefits such as:

- Hospital Admission Benefit
- Hospital Confinement Benefit
- Initial Injury Treatment
- Pays a lump sum benefit for a covered critical illness such as a heart attack or stroke

Learn more about *BenExtend* today!



Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in California, group coverage is underwritten by Continental American Life Insurance Company.

aflacgroupinsurance.com | 1.800.433.3036
Continental American Insurance Company • Columbia, South Carolina

This filer provides a brief description of coverage and is not a contract. Read the certificate carefully for exact terms and conditions. This is subject to the terms, conditions and limitations of Policy Series 81000.



By purchasing just 1 AFLAC product, MeMD is available to you at no additional cost.

*See flyer for details.

Wave goodbye to the waiting room.

With MeMD, available through Aflac, care is just a click away.

Not feeling so great? Avoid the waiting room, and get care right where you are — from your phone, app or online. Introducing MeMD™ telemedicine service.

It's natural during times like this for individuals to be wary of physically visiting a care facility, even if they need to consult with a medical professional. Telehealth services provide access to medical providers or licensed behavioral health specialists online for personalized treatment anytime, almost anywhere. MeMD has also made a resource widely available to provide **COVID-19 facts and tips to minimize workplace risks.**

With MeMD, you or your family members can connect to a board-certified, U.S.-licensed medical provider from almost any location. Day and night. Weekends and holidays. All using your phone or computer. You'll get a confidential diagnosis, along with a treatment plan and needed prescriptions for common medications.



MeMD PROVIDES CARE WHEN YOU NEED IT.



Private consultations with U.S. licensed medical providers or licensed behavioral specialist



Get help 24/7 nearly anywhere in the U.S.



Connect by phone, web or mobile app



Visit fee per service



Easy registration and payment



With MeMD, get help for conditions like:



Abrasions, bruises, sprains and strains



Allergies, asthma, hives, skin infections, bites and stings



Sinus infections and symptoms, fever, sore throat, cough, body aches



Dehydration, vomiting, nausea, urinary tract infections



Anxiety, insomnia, migraines



Short-term medication refills and more

For help, when and where you need it.

When your coverage begins, call: **855-636-3669** | visit: MeMD.me/Aflac.

Available through Aflac, powered by MeMD™.

CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service providers, and does not own or administer any of the products or services provided by the Value-Added Service providers. Each Value-Added Service provider offers its products and services subject to its own terms, limitations and exclusions. Value-Added Services are not available in Idaho or Minnesota. State availability may vary. Continental American Insurance Company, a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated.

When medically necessary, MeMD's providers (except therapists) can submit a prescription electronically for purchase and pick-up at your local participating pharmacy; however, MeMD providers cannot prescribe elective medications, narcotic pain relievers, or controlled substances. MeMD's providers are each licensed by the appropriate licensing board for the state in which they are providing services and all have prescriptive authority for each of the states in which they are licensed.

aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company | Columbia, South Carolina

HealthAdvocate™

Health Advocacy & Medical Bill Saver

Great News: By purchasing just 1 **AFLAC** product, **HealthAdvocate** is also available to you at no additional cost.

*See flyer for details.

Health care doesn't have to be hard

Meet Health Advocacy and Medical Bill Saver,™ available through Aflac.

Dealing with health care and health coverage can be complicated — and often stressful. But now you have Health Advocacy and Medical Bill Saver.

With Health Advocacy, you have a team of experts who can help solve your health care and insurance-related questions. They can assist you with a variety of needs like finding specialists, clarifying coverage, addressing claim issues, getting second opinions — and even help negotiating medical bills.



Get care for your health care.



HEALTH ADVOCACY AND MEDICAL BILL SAVER CAN HELP:

- Find doctors and treatment centers
- Coordinate care and second opinions
- Untangle medical bill and claim issues
- Negotiate bills \$400 or more
- Available 24/7, anytime, anywhere

Aflac | Value-Added Services

Get confidential, personalized help with Health Advocate:



Find doctors, specialists, hospitals and other providers



Schedule appointments for treatments and tests



Coordinate second opinions and care



Resolve issues, from claims problems and medical bills, to coordinating benefits



Get help with eldercare issues, including Medicare and related healthcare issues for your parents and parents-in-law



Get answers about your test results, treatments, prescriptions and more



Work with your insurance companies to get approvals and clarify coverage



Transfer medical records, lab results and X-rays



Here for you 24/7 by convenient app or phone

Medical Bill Saver™ gives you access to skilled negotiators who can help reduce your out-of-pocket costs from medical or dental bills not covered by insurance. And it's as easy as just sending in your bill.

HERE'S HOW IT WORKS:

- 1)** Send in your medical or dental bills of \$400 or more.
- 2)** Your negotiator contacts the provider to negotiate a discount.
- 3)** If an agreement is reached, the provider approves payment terms and conditions.
- 4)** You get an easy-to-read personal Savings Result Statement, summarizing the outcome and payment terms.

Health care just got easier with Health Advocacy and Medical Bill Saver.™

When your coverage begins, call **855.423.8585** or visit healthadvocate.com/aflac.

Available through Aflac, powered by Health Advocate.

CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service providers, and does not own or administer any of the products or services provided by the Value-Added Service providers. Each Value-Added Service provider offers its products and services subject to its own terms, limitations and exclusions. Value-Added Services are not available in Idaho or Minnesota. State availability may vary. Continental American Insurance Company, a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated.

Medical Bill Saver has restrictions for negotiations on in-network deductibles and co-insurance in Arizona, Colorado, District of Columbia, Illinois, Indiana, New Jersey, North Carolina, South Dakota and Utah.

aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company | Columbia, South Carolina

Group Hospital Indemnity Insurance

Even a small trip to the hospital can have a major impact on your finances.

As health care costs continue to rise, employees realize they are responsible for paying more and more out-of-pocket costs with every accident and illness. Aflac is designed to help families plan for the health care bumps ahead and take some of the uncertainty and financial insecurity out of getting better.

How will you help protect your savings when you have a covered accident or sickness?

If you are confined to the hospital, major medical insurance will help with many medical expenses, but you could be left with out-of-pocket expenses. You could also lose pay while you're out of work. And you can be sure that the bills will keep coming. Aflac is here to help.

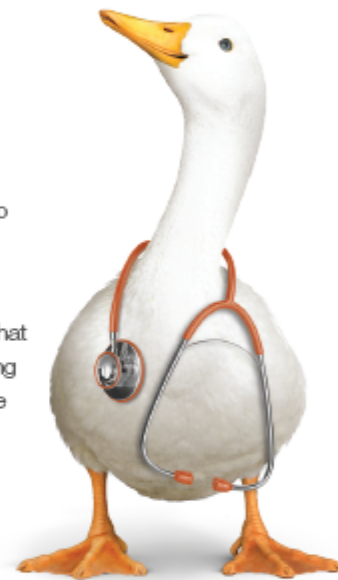
It's insurance for daily living:

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group hospital indemnity insurance plans are designed to provide you with cash benefits to help with the following:

- A covered hospital stay
- Everyday living expenses, like your rent or mortgage, utility bills, groceries, and more
- It even provides coverage for newborn children for 60 days from the date of birth*

Enroll today

Learn how group hospital indemnity insurance can help you.



*Applies to newly adopted children as well. Refer to the plan for complete details.

This is a brief product overview only. The plan has limitations and exclusions that may affect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

In Arkansas, Policy C80100AR. In Idaho, Policy C80100ID. In New York, Policy AF80100NY. In Oklahoma, Policy C80100OK. In Oregon, Policy C80100OR. In Pennsylvania, Policy C80100PA. In Texas, Policy C80100TX. In Virginia, Policy C80100VA.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in California, group coverage is underwritten by Continental American Life Insurance Company. For groups situated in New York, coverage is underwritten by American Family Life Assurance Company of and customer service is administered by Continental American Insurance Company, 22 Corporate Woods Boulevard Albany, New York 12211.

Continental American Insurance Company • Columbia, South Carolina

AGC1501067 R1

IV (1/20)

AC^G

ACCIDENT

Accidents happen to all kinds of people every day.

What would the financial impact of an injury mean to you? Are you prepared for high medical costs in addition to everyday household expenditures and lost wages? Out-of-pocket expenses associated with an accident are unexpected, but an accident's impact on your finances and your well-being certainly can be reduced.

Aflac is here to help. If you have an accident, major medical insurance will help with many medical expenses, but you could be left with out-of-pocket expenses. You could also lose pay while you're out of work. And you can be sure that the bills will keep coming.

IT'S INSURANCE FOR DAILY LIVING:

Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group accident insurance plans are designed to provide you with cash benefits throughout the different stages of care, such as the following:

- Emergency treatment
- Hospital admission
- Intensive care unit
- Ambulance transportation
- Travel expenses to distant treatment centers
- Everyday living expenses, like your rent or mortgage, utility bills, groceries, and more



DEDICATED LOCAL SERVICE

Ask your Aflac agent how group accident insurance can help you. Remember, we're always by your side. And you're always under our wing.

This is a brief product overview only. Products and benefits vary by state and may not be available in some states. Plan design and optional benefits are selected at the employer level. The plan has limitations and exclusions that may affect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

This brochure is subject to the terms, conditions, and limitations of Policy Series C70000. In Arkansas, C70100AR. In Idaho, C70100ID. In Oklahoma, C70100OK. In Oregon, C70100OR. In Pennsylvania, C70100PA. In Texas, C70100TX. In Virginia, C70100VA.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.



Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in California, group coverage is underwritten by Continental American Life Insurance Company. For groups situated in New York, coverage is underwritten by American Family Life Assurance Company of New York.

Continental American Insurance Company • Columbia, South Carolina

Group Term Life Insurance

Even starting with a little can add up to a lot.

Aflac's group term life insurance helps take care of your loved ones' immediate and future needs if you should pass away. Immediate needs can include burial/funeral expenses, uninsured medical costs and current bills and debts. Future needs could include income replacement, education plans, ongoing family obligations, emergency funds, and retirement expenses.

It's insurance for daily living:

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that your family will have added financial resources to help with ongoing living expenses. Aflac's group term life insurance offers an option that can help protect your financial freedom.

Enroll today

Learn how group term life insurance can help you.



This is a brief product overview only. The plan has limitations and exclusions that may affect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

In Idaho, Policy CA9100R. In Oklahoma, Policy CA91000K.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in California, group coverage is underwritten by Continental American Life Insurance Company. For groups situated in New York, coverage is underwritten by American Family Life Assurance Company of York and customer service is administered by Continental American Insurance Company, 22 Corporate Woods Boulevard Albany, New York 12211.

Continental American Insurance Company • Columbia, South Carolina

AG9180 R3

IV (2/20)

Group Critical Illness Insurance

You can count on Aflac to help ease the financial impact of surviving a critical illness.

Chances are you know someone who's been diagnosed with a critical illness such as cancer, a heart attack (myocardial infarction), or stroke. You can't help but notice the strain it's placed on the person's life—both physically and emotionally. What's not so obvious is the impact on that person's personal finances. While the person is busy getting well, the bills may continue to pile up.

Would you have the money to cover the out-of-pocket expenses such as:

- Transportation to a distant medical facility.
- Specialized treatment costs.
- Living expenses like rent, mortgage, and utility bills.

It's insurance for daily living:

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group critical illness insurance plans are designed to provide you with a lump sum benefit for a covered critical illness such as: cancer, heart attack, or stroke.

Enroll Today

Learn how critical illness insurance can help you.



This is a brief product overview only. The plan has limitations and exclusions that may affect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in California, group coverage is underwritten by Continental American Life Insurance Company. For groups situated in New York, coverage is underwritten by American Family Life Assurance Company of New York.

Continental American Insurance Company • Columbia, South Carolina

QUESTIONS & ANSWERS

Changes that can be made effective September 1, 2021:

- ✚ Enroll or terminate individual and/or dependent coverage in the medical, dental, vision and voluntary life plans.

Making changes or Enrolling:

- ✚ You will need to Enroll or make changes in Kronos or you can ask your payroll department for an Enrollment Form

Will I get new ID cards?

- ✚ Medical cards will not be reissued; you can use the same card unless you make a plan change.
- ✚ If you are making a plan change, you will receive a new ID card - which takes 7-10 business days to arrive.
- ✚ If you misplace your card you can request a card directly from Blue Cross Blue Shield or you can contact the Account Manager, Odilia Robles at 361-883-1711 ext. 4303.
- ✚ Dental and Vision cards will not be reissued; you can use the same card unless you make a plan change.

Should I assume my provider still takes my insurance? Or my prescription is still covered?

- ✚ No, throughout the year providers are either joining or dropping the networks. Always make sure your provider is in-network by referring to the Blue Cross Blue Shield website at www.bcbstx.com
- ✚ Every year carriers change their prescription drug list. Please refer to the Blue Cross Blue Shield website at www.bcbstx.com to see if you current prescriptions will be affected.

Urgent Care vs. Emergency Rooms?

- ✚ The cost of treating **MOST** common medical conditions can be up *5 times greater* in the Emergency Room than in a physician's office or an **Urgent Care Center**.
- ✚ Up to 1/3 of all ER visits are for the treatment of non-emergent conditions.
- ✚ Urgent Care Symptoms may include: Moderate Fever, Colds, Flu, Bruises, Abrasions, Minor Cuts or Minor Burns.
- ✚ Persons experiencing a situation requiring prompt medical attention, that is not life-threatening, may receive faster care at an urgent care clinic or by scheduling a same-day appointment with their primary care physician, if available.
- ✚

Members seeking care at an Urgent Care Center vs. the Emergency Room will save at least \$50 per visit!

Go to www.bcbstx.com or download the Blue Cross Blue Shield app on you smartphone to find a clinic located the closest to you.

More Questions & Answers:

It's Ok to Ask...

- ✚ When receiving a prescription from your physician, ask the doctor for free samples. It will save you money!

Did you Know....

- ✚ You can use your smartphone to download the apps for Blue Cross Blue Shield, Humana, Principal, and even Aflac?
- ✚ The apps give you complete access to your ID cards and group numbers; you can also search for in-network doctors and pharmacies in your area.

Important Notices About Your Health Plan & Rights

HEALTH CARE REFORM NOTICE

Non-Grandfathered Plan

This group health plan is a non-grandfathered plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As a non-grandfathered plan, the plan sponsor is able to make changes that reduce benefits or increase costs to consumers. However, these plans gain additional benefits including:

- Coverage of recommended preventive services with no cost sharing; and
- Patient protections such as guaranteed access to OB-GYNs and pediatricians.

All health plans, whether or not they are grandfathered plans, must provide certain benefits to their employees for plan years starting on or after September 23, 2010 including:

- No lifetime limits on coverage for all plans;
- No rescissions of coverage when people get sick and have previously made an unintentional mistake on their application
- Extension of parents' coverage to your adults under 26 years of age;
- No coverage exclusions for children with pre-existing conditions; and
- No "restricted" annual limits (e.g. annual dollar-amount limits on coverage below standards to be set in future regulations).

You should contact your plan administrator at (361) 884-4068 if you have any questions. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

PATIENT PROTECTION AND AFFORDABLE CARE ACT 2010 ("PPACA")

Special Enrollment Notice for Dependent Coverage of Children Up To Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Goodwill Industries of South Texas Employee Benefit Plan. Individuals may request enrollment for such children for 30 days from the date of this notice. Enrollment will be effective retroactively to the Plan Year Effective Date. For more information, contact your employer or Blue Cross Blue Shield Insurance Company at (800) 521-2227.

Special Enrollment Notice for Individuals Who Have Reached Lifetime Limit

The lifetime limit on the dollar value of benefits under Goodwill Industries of South Texas Group no longer applies. Individuals whose coverage ended because of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information, contact your employer or Blue Cross Blue Shield Insurance Company at (800) 521-2227.

IMPORTANT INFORMATION CONCERNING PRE-EXISTING

HIPAA regulations allow an individual to obtain new health coverage regardless of any pre-existing medical conditions, upon "proof of creditable coverage".

Creditable coverage for HIPAA purposes means an individual's coverage under a previous group health plan, individual coverage, Medicare, Medicaid, a public health plan, a medical or dental plan for members of the uniformed services and their dependents, an Indian or tribal organization medical program, a State health risk pool, the Federal Employees Health Benefits program or a Peace Corps health benefits plan. A college plan is considered creditable coverage, and colleges must provide certification of health insurance coverage to students losing coverage, even temporarily.

Creditable coverage from a previous health plan or policy is used to shorten or waive the pre-existing condition limitation when an individual leaves one plan and joins another. An individual's pre-existing condition exclusion period is reduced or eliminated by such individual's days of creditable coverage provided that there was not a break in coverage of 63 or more consecutive days. Any waiting period for benefit coverage from an employer must run concurrently with any pre-existing limitation.

HIPAA reduces or eliminates pre-existing condition exclusions depending on the circumstances under which the new employee enters the plan. Group health plans and/or their insurers will not be able to deny employee coverage or apply pre-existing conditions exclusions to individuals who had prior health coverage for at least 12 months.

When enrolling, an individual should present a letter of Creditable Coverage to Blue Cross Blue Shield Insurance Company in order to satisfy pre-existing requirements of prior coverage. Without this letter of Creditable Coverage, Blue Cross Blue Shield Insurance Company may assume that there was no prior coverage and initiate an investigation of possible pre-existing claims.

IMPORTANT NOTE: According to the Patient Protection and the Affordable Care Act of 2010 ("PPACA"), pre-existing condition exclusions do not apply for any enrollee under the age of 19 for plan years beginning on or after September 23, 2010.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Your Group Health Plan (the “Plan”), and its selected Third Party Administrator, All Savers Insurance Company, understands the importance of keeping your personal health information private and is committed to maintaining and protecting the confidentiality of this sensitive information. We are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information and to send you this Notice about our policies, safeguards and practices. When we use or disclose your confidential information, we are bound by the terms of this Notice or our revised notice, if we revise it.

How your personal health information is protected

The Plan is required by law to take reasonable steps to ensure the privacy of your personal health information and to inform you about:

- The Plan’s uses and disclosures of Protected Health Information (PHI);
- Your privacy rights with respect to your PHI including;
- Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- The Plan’s duties with respect to your PHI;
- The person or office to contact for further information about the Plan’s privacy practices.
- The term “Protected Health Information” (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Uses and disclosures of your PHI

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it. The Plan and its Business Associates will not use your PHI or disclose it to others without your authorization, except for the following purposes:

- **Treatment.** The Plan may disclose your PHI for its provision, coordination or management of your health care and related services. It also includes, but is not limited to, consultations or referrals to one or more of your providers.

Example: The Plan may disclose to a treating orthodontist the name of the participant's treating dentist so that the orthodontist may ask for the dental x-rays from the treating dentist.

- **Payment.** The Plan may disclose your PHI for the payment of your benefits under the Plan. This includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

Example: The Plan may tell a doctor whether the plan participant is eligible or what percentage of the bill will be paid by the Plan.

- **Health Care Operations.** The Plan may use or disclose your PHI for the health care operations of the Plan. This includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

Example: The Plan may use information about the participant’s claim to refer the participant to a disease management program, project future costs, or audit the accuracy of its claims processing functions.

- **Required by Law.** The Plan must disclose your PHI when required by law.

Individual Rights

- *Right to Request Restrictions on PHI Uses and Disclosures*

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Privacy Officer as identified below.

- *Right to Inspect and Copy PHI*

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan maintains the PHI. PHI includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

“Designated Record Set” includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analysis and not used to make decisions about individuals is not the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Privacy Officer as identified below.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the secretary of the U.S. Department of Health and Human Services.

- ***Right to Amend PHI***

You have the right to request the Plan to amend your PHI or request a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the Privacy Officer as identified below.

- ***The Right to Receive an Accounting of PHI Disclosures***

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; (4) based on your written authorization.

If accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

- ***The Right to Receive a Paper Copy of This Notice Upon Request***

To obtain a paper copy of this Notice contact the Privacy Officer as identified below.

- ***A Note About Personal Representatives***

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Plan Duties

The Plan and its Business Associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations.

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning April 14, 2004 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior that date. If a privacy practice is changed, a revised version of this notice will be provided [to all past and present participants and beneficiaries] for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

- ***Minimum Necessary Standard***

When using or disclosing PHI or when requesting PHI for another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or request by a health care provider for treatment;
- Uses or disclosures made to individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for the Plan's compliance with legal regulations

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. De-identifiable information is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summaries the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

If you want more information about your privacy rights, do not understand your privacy rights, are concerned that the Plan has violated your privacy rights or disagree with a decision that the Plan has made about access to your confidential information, you may contact the Plan's Privacy Officer. You may also file written complaints with the Secretary of the U.S. Department of Health and Human Services. Please call the Plan's Privacy Officer to obtain the correct address for the Secretary. The Plan will not take any action against you if you file a complaint with the Secretary against the Plan.

You may contact the Plan's Privacy Officer at:
Goodwill Industries of South Texas Group
Tami Randel
2961 S. Port Ave.
Corpus Christi, TX | 78405
(361) 884-4068

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 codes of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

GENERAL NOTICE OF SPECIAL ENROLLMENT RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your group health plan is required to provide you this notice explaining your group health plan's procedures for your special enrollment rights

Your Special Enrollment Rights:

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 towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your 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 31 days after the marriage, birth, adoption, or placement for adoption.

You or your spouse or dependents may also have special enrollment rights in another group health plan at the time a claim is denied as a result of a lifetime limit on all benefits, if you request enrollment within 31 days after the claim has been denied.

Contact your plan administrator to request a special enrollment.

CONTINUATION COVERAGE RIGHTS UNDER COBRA (General Notice)

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 continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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 written notice to:

Goodwill Industries of South Texas Group
Tami Randel
2961 S. Port Ave.
CoOpus Christi, TX | 78405
(361) 884-4038

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. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

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.

If you have questions

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.

Important Notice from Goodwill Industries of South Texas Group 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 Goodwill Industries of South Texas Group Employee Health Plan and 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. Blue Cross Blue Shield Insurance Company has determined that the prescription drug coverage offered by Goodwill Industries of South Texas Group 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.

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 Blue Cross Blue Shield Insurance Company coverage may be affected. The Goodwill Industries of South TX, Employee Benefit Plan provides prescription coverage for certain covered medications. The prescription coverage for both of the adopted Blue Cross Blue Shield Insurance Company:

- MTBCB026 - Base plan has a \$0 | \$10 co-pay for tier 1 prescriptions, a \$10 | \$20 co-pay for tier 2 prescriptions, a \$50 | \$70 co-pay for tier 3 prescriptions, and a \$100 | \$120 co-pay for tier 4 prescriptions, a \$150 co-pay for tier 5, and a \$250 co-pay for tier 6.
- MTBCP022 – Buy-Up plan, that has a \$0 | \$10 co-pay for tier 1 prescriptions, a \$10 | \$20 co-pay for tier 2 prescriptions, a \$50 | \$70 co-pay for tier 3 prescriptions, and a \$100 | \$120 co-pay for tier 4 prescriptions, a \$150 co-pay for tier 5, and a \$250 co-pay for tier 6.

Further details of your prescription coverage can be found in your Summary Benefit of Coverage documents. If you do decide to join a Medicare drug, plan and drop your current Goodwill Industries of South Texas Group coverage, be aware that you and your dependents may be able to get this coverage back at our next open enrollment or upon a qualifying event.

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 Goodwill Industries of South Texas Group 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 human resources for further information or call Blue Cross Blue Shield Insurance Company at (800) 521-2227. **Note:** You will 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 Goodwill Industries of South Texas Group 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).

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Federal law (Newborns' and Mothers' Health Protection Act of 1966) prohibits the plan from limiting a mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery for from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

NOTICE OF THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998 (WHCRA). As part of the Plan's compliance with the WHCRA, the Plan is required to provide you with this notice outlining the coverage that this law requires the Plan to provide.

The Plan provides coverage for medically necessary mastectomies. This coverage includes procedures to reconstruct the breast, on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. As a result of WHCRA, the Plan also provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance and any complications that could result from that surgery.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed;
3. Prostheses; and
4. Treatment of physical complications resulting from any stage of the mastectomy, including lymphedema.

These benefits are subject to the same deductible, co-pays and coinsurance that apply to other medical and surgical benefits provided under this plan.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 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, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	COLORADO – Medicaid Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	FLORIDA – Medicaid Website: https://www.flmedicaidtprecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	MONTANA – Medicaid Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid Website: http://www.in.gov/fssa Phone: 1-800-889-9949	NEBRASKA – Medicaid Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	NEVADA – Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	NEW HAMPSHIRE – Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	VERMONT– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethiptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

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, Ext. 61565

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

After key parts of the health care law took effect in 2014, there became 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 November and continues thru February of each year.

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 Human Resources. For more information on the Marketplace, please visit www.healthcare.gov.

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.*