2021 - 2022 BENEFITS

RoadVantage®
F&I Programs

April 1, 2021 - March 31, 2022

HUB | GUS BATES insurance & investments

WELCOME

Road Vantage offers you and your family members a comprehensive and valuable benefits program. Our employees are our most valuable asset. That is why we are committed to an employee benefit program that helps our employees stay healthy, feel secure, and maintain a work/life balance. Every effort is made to provide you with a thorough plan of benefits while still keeping costs fair and manageable for both the company and our employees. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

We encourage you to use this Guide as a reference throughout the year. If you have questions, contact Human Resources or the plan providers directly. Plan phone numbers and websites are listed throughout the document.

The information in this Benefits Guide is presented for illustrative purposes. The text contained in this Guide was taken from various summary plan descriptions and benefit information and has been summarized for your review. Please consult the plan documents for a complete description of benefits. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of a discrepancy between the Guide and the actual plan documents the actual plan document will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact HR.

ANNUAL OPEN ENROLLMENT

March 4-15, 2021

Gus Bates/HUB BENEFITS CONTACT:

Michelle Turner

michellet@gusbates.com

817-529-5349

ROAD VANTAGE HR CONTACT:

Elsa Guzman

eguzman@vtg-services.com

512-960-8133

IMPORTANT!

New Hires - you will become eligible for benefits 1st of the month following 30 days of employment.

Current Employees - Open Enrollment will occur annually during the month of March. The benefits you elect during open enrollment this year will be effective from April 1, 2021 through March 31, 2022 or until the last day of the month that you are employed with Road Vantage.

ROADVANTAGE®
F&I Programs

ELIGIBILITY GUIDELINES

Who Can you Cover?

You and your dependents are eligible to enroll in Road Vantage benefits if:

- ☑ You are a full-time benefits eligible team member
- ☑ The following dependents;
  - **Dependent Children to age 26**
  - **Spouse or Common Law Spouse**

When Can I Make Changes to My Benefits?

If you experience a qualifying life event for yourself and/or your dependents, **you must report it to HR within 30 days of the event.**

Examples of qualifying life events:

- Marriage or divorce
- Birth or adoption
- Death of spouse or child
- Gain or loss of other coverage
- You or your eligible family members experiences a change in employment status that affects benefits eligibility (e.g. transitioning from part-time to full time)
- Dependent child reaches 26 years of age
- FMLA leave, COBRA event, court judgment or decree
- Becoming eligible for Medicare
- Loss of Medicaid and/or CHIP
- Receiving a Qualified Medical Child Support Order

IMPORTANT

If you decide not to enroll in benefits for 2021, you will need to wait until the next open enrollment period to select benefits for 2022 unless you experience a qualifying life event.

How To Enroll

Step 1:

Review the Benefit Guide and contact HR or Gus Bates with any questions about your benefits package. Make sure you understand what is being offered.

Step 2:

Login to the enrollment portal by the deadline to elect your benefits at www.benefitsconnect.net/vantage

Step 3:

Once your elections are made and submitted to the carriers, you will receive ID cards. Please notify HR if you have not received within 14 days of your effective date.

MEDICAL INSURANCE

Copay Plan (MTBCP713)	
Benefits	**In-Network**
Deductible (Individual / Family) **Coinsurance** **Out-of-Pocket Max** (Individual / Family)	$5,000 / $14,700 30% after Deductible $5,600 / $14,700
Preventive Care	100% of Allowable Amount **Deductible and Copay Waived**
Virtual Visit (MD Live)	$45 Consultation Fee
Office / Specialist Visit	$45 Copay / $90 Copay
Labs and X-rays	Deductible then 30%
Urgent Care	$75 Copay
Emergency Room	$500 Copay + Deductible + 30%
Inpatient Hospital Services	Deductible then 30%
Outpatient Surgeries/Therapies	Deductible then 30%
Prescription Drugs Generic Brand Non-Preferred Specialty Mail Order	**Preferred / Participating** $ 0 Copay / $10 Copay $10 Copay / $20 Copay $50 Copay / $70 Copay $100 Copay / $120 Copay 3x Copay (90 day supply)
Out-of-Network Coverage	
Deductible (Individual / Family) **Coinsurance** **Out-of-Pocket Max** (Individual / Family)	$10,000 / $29,400 50% after Deductible $20,000 / $60,000

BlueCross BlueShield of Texas

bcbstx.com

800-521-2227

Network: Blue Choice PPO (BCA)

Certain high cost drugs require Prior Authorization (PA) and non - preferred drugs require Step Therapy (ST) to be covered by the pharmacy benefit plan. Visit **bcbstx.com** or call the number on the back of your ID card for the complete list of drugs that require these programs.

BCBS has a "mandatory generic clause" on the prescription plan, which says that you will pay the difference between the cost of a brand name drug and a generic if a generic drug is available.

Summary of Employee Costs

	Total Monthly Cost	Employer Contribution	Employee Monthly Cost	Employee Semi-Monthly Cost	Employee Weekly Cost
Employee Only	$557.76	$498.84	$58.92	$29.46	$13.60
Employee + Spouse	$1,358.66	$498.84	$859.82	$429.91	$198.42
Employee + Child(ren)	$1,088.92	$498.84	$590.08	$295.04	$136.17
Family	$1,855.92	$498.84	$1,357.08	$678.54	$313.17

MEDICAL INSURANCE

Base H.S.A. Plan 1 (009H)	
Benefits	**In-Network**
Deductible (Individual / Family) **Coinsurance** **Out-of-Pocket Max** (Individual / Family)	$6,650 / $14,700 0% after Deductible $6,650 / $14,700
Preventive Care	100% of Allowable Amount **Deductible Waived**
Virtual Visit (MD Live)	$45 Consultation Fee
Office / Specialist Visit	Covered 100% after Deductible
Labs and X-rays	Covered 100% after Deductible
Urgent Care	Covered 100% after Deductible
Emergency Room	Covered 100% after Deductible
Inpatient Hospital Services	Covered 100% after Deductible
Outpatient Surgeries/Therapies	Covered 100% after Deductible
Prescription Drugs Generic Brand Non-Preferred Specialty Mail Order	Covered 100% after Deductible
Out-of-Network Coverage	
Deductible (Individual / Family) **Coinsurance** **Out-of-Pocket Max** (Individual / Family)	$13,300 / $29,400 50% Unlimited / Unlimited

BlueCross BlueShield of Texas

bcbstx.com

800-521-2227

Network: Blue Choice PPO (BCA)

Certain high cost drugs require Prior Authorization (PA) and non - preferred drugs require Step Therapy (ST) to be covered by the pharmacy benefit plan. Visit **bcbstx.com** or call the number on the back of your ID card for the complete list of drugs that require these programs.

Summary of Employee Costs

	Total Monthly Cost	Employer Contribution	Employee Monthly Cost	Employee Semi-Monthly Cost	Employee Weekly Cost
Employee Only	$428.23	$428.23	$0.00	$0.00	$0.00
Employee + Spouse	$1,043.14	$428.23	$614.91	$307.46	$141.90
Employee + Child(ren)	$836.05	$428.23	$407.82	$203.91	$94.11
Family	$1,424.92	$428.23	$996.69	$498.35	$230.01

MEDICAL INSURANCE

Buy Up H.S.A. Plan 2 (005H)	NEW
Benefits	**In-Network**
Deductible (Individual / Family) **Coinsurance** **Out-of-Pocket Max** (Individual / Family)	$3,500 / $7,000 20% after Deductible $5,000 / $10,000
Preventive Care	100% of Allowable Amount **Deductible Waived**
Virtual Visit (MD Live)	$45 Consultation Fee
Office / Specialist Visit	Covered 80% after Deductible
Labs and X-rays	Covered 80% after Deductible
Urgent Care	Covered 80% after Deductible
Emergency Room	Covered 80% after Deductible
Inpatient Hospital Services	Covered 80% after Deductible
Outpatient Surgeries/Therapies	Covered 80% after Deductible
Prescription Drugs Generic Brand Non-Preferred Specialty Mail Order	 Covered 90% after Deductible Covered 80% after Deductible Covered 60% after Deductible Covered 50% after Deductible Covered 50% after Deductible
Out-of-Network Coverage	
Deductible (Individual / Family) **Coinsurance** **Out-of-Pocket Max** (Individual / Family)	$7,000 / $14,000 60% Unlimited / Unlimited

BlueCross BlueShield of Texas

bcbstx.com

800-521-2227

Network: Blue Choice PPO (BCA)

Certain high cost drugs require Prior Authorization (PA) and non - preferred drugs require Step Therapy (ST) to be covered by the pharmacy benefit plan. Visit **bcbstx.com** or call the number on the back of your ID card for the complete list of drugs that require these programs.

Summary of Employee Costs

	Total Monthly Cost	Employer Contribution	Employee Monthly Cost	Employee Semi-Monthly Cost	Employee Weekly Cost
Employee Only	$505.12	$428.23	$76.89	$38.45	$17.74
Employee + Spouse	$1,230.41	$428.23	$802.18	$401.09	$185.12
Employee + Child(ren)	$986.14	$428.23	$557.91	$278.96	$128.75
Family	$1,680.72	$428.23	$1,252.49	$626.25	$289.04

Health Savings Accounts (HSA)

- A HSA is a healthcare savings account held at a bank for you to set aside pre-tax contributions. HSA contributions can be used now or later for medical, prescription, dental and vision expenses. If you do not spend HSA dollars in a plan year, the money in your account may accumulate through investments free of taxes.
- Contributions, investments and withdrawals for qualified healthcare expenses are not taxed. Health Savings Accounts are similar to a Flexible Spending Account in that you are eligible to pay for healthcare expenses with pre-tax dollars. However, the FSA is designed to be used with ah PPO Health Plan. The HSA is designed to be used with the High Deductible Health Plan.
- HSAs offer a triple tax advantage:
  - Tax-free contributions
  - Tax-free earnings
  - Tax-free withdrawals (when used for eligible expenses)
- If HSA funds are used for non-qualified expenses, you may be charged a 20% penalty tax. Save your receipts!
- At retirement age, funds can be withdrawn and used for any reason - normal taxes would just be paid
- If you leave your current employment, you may use your HSA funds to pay for COBRA premium

IRS Maximum Contribution Limits for 2021:

- **Individual: $3,600**
- **Family: $7,200**
- **Age 55 or older: $1,000 Catch Up Contribution**
  - ⇒ **Maximum amounts DO include employer and employee contributions**

Employer Contributions to your Health Savings Account		
	Monthly	Annually
Employee Only	$65.61	$787.32
Employee + Spouse	$159.83	$1,917.96
Employee + Child(ren)	$128.10	$1,537.20
Family	$218.33	$2,619.96

hsabank
own your health®
A Division of Webster Bank, N.A.

www.hsabank.com

1-800-357-6246

Manage your Health Savings Account (HSA) online:

Access real-time account balances, transaction history and statements, as well as track your expenses online. Sign up for online banking today.

- **Mobile App** - Use your IOS (iPhone, iPod Touch, or iPad) or Android-powered device to check available balances in your account and view HSA transaction details, save and store receipts using your device's camera, receive account balances and configurable alerts via text message, and access customer service contact information.
- **myHealth Portfolio** - Use this tool to track your healthcare expenses, submit and retain receipts and claims from multiple insurance and financial account providers. Also view expenses by provider, description and more.

How to deposit funds into your HSA

To maximize HSA tax and savings benefits, begin funding your account as soon as you can. HSA Bank offers several convenient methods for making contributions to your HSA.

- **Payroll Deductions** - If your employer offers this option, HSA Bank will facilitate recurring pre-tax payroll deductions. Contact your employer to complete the appropriate paperwork.
- **Online Transfers** - On HSA Bank's member website, you can transfer funds from an external bank account, such as personal checking or savings account, to your HSA

How to pay for expenses from your HSA.

- **Debit Card**
- **Checks**
- **Online Transfers**
- **Online Bill Pay**

MEDICAL PLAN COMPARISONS

Employee Only Coverage

Below are examples of how much you could pay in a year based on your medical needs.

Scenario 1a: Healthy Individual; one sick visit and one specialist office visits for the year. No labs or medications.

Low Spend - Individual			
	HSA Plan 1	**HSA Plan 2**	**COPAY Plan**
Amount Owed to Provider for Services	$300	$300	$300
Employee Responsibility	$300	$300	$135
Employee Annual Premium Cost	**$0.00**	**$923**	**$707**
Vantage HSA Contribution	($787)	($787)	$0
Total Expected Cost for Employee	**Saved ($487)**	**Spent $136**	**Spent $842**

Scenario 1b: Individual breaks their leg & goes to the E.R. followed by surgery; has 2 follow up specialist visits; and 3 Physical Therapy visits.

High Spend - Individual			
	HSA Plan 1	**HSA Plan 2**	**COPAY Plan**
Amount Owed to Providers for Services	$50,000	$50,000	$50,000
Employee Responsibility	$6,650	$5,000	$5,600
Employee Annual Premium Cost	**$0.00**	**$923**	**$707**
Vantage HSA Contribution	($787)	($787)	$0
Total Expected Cost for Employee	**Spent $5,863**	**Spent $5,136**	**Spent $6,307**

Family Coverage

Below are examples of how much you could pay in a year based on your medical needs.

Scenario 2a: Healthy family of 4; two pediatric sick office visits and two specialist care office visits with prescription for generic antibiotics.

Low Spend - Family			
	HSA Plan 1	**HSA Plan 2**	**COPAY Plan**
Amount Owed to Provider for Services	$500	$500	$500
Family Responsibility	$500	$500	$280
Employee Annual Premium Cost	$11,960	$15,029	$16,285
Vantage HSA Contribution	($2,619)	($2,619)	$0
Total Expected Cost for Employee	**$9,841**	**$12,910**	**$16,565**

Scenario 2b: Family of 3; Mother gives birth to child; baby spends two nights in NICU; 4 follow up specialty pediatric visits; Dad gets strep throat and fills 1 generic prescription.

High Spend - Family			
	HSA Plan 1	**HSA Plan 2**	**COPAY Plan**
Amount Owed to Provider for Services	$300,000	$300,000	$300,000
Family Responsibility	$13,300	$10,000	$11,255
Employee Annual Premium Cost	$11,960	$15,029	$16,285
Vantage HSA Contribution	($2,619)	($2,619)	$0
Total Expected Cost for Employee	**$22,641**	**$22,410**	**$27,540**

VIRTUAL VISITS

Convenient

Access where mobile app, online video or telephone is available

Interact

Real-time consultation with an independently contracted, board-certified doctor or therapist

Diagnose

Prescriptions sent to a pharmacy of your choice

Virtual visits provide a live consultation between a doctor and a member for many non-emergency medical and behavioral health needs.

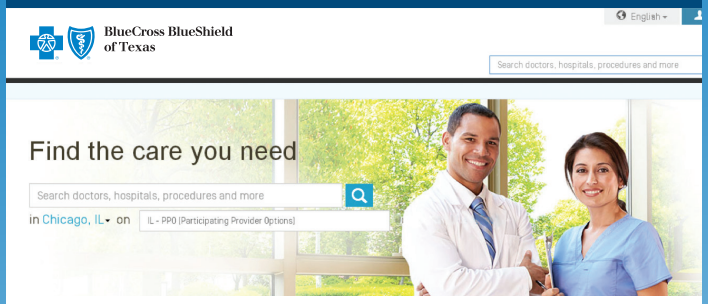
The virtual visits program offers employers:

- Convenience with doctors available 24 hours a day, seven days a week
- Potential decrease in employee absences and improved productivity.
- Seamless access to the portal from Blue Access for Members
- Integration with Blue Cross and Blue Shield of Texas (BCBSTX) transparency products

For cost of coverage please refer to the medical insurance summary page

BCBSTX Members Also Have Access To:

Provider Finder®*



This innovative cost-transparency tool helps our PPO members make more informed health care decisions. It allows members to:

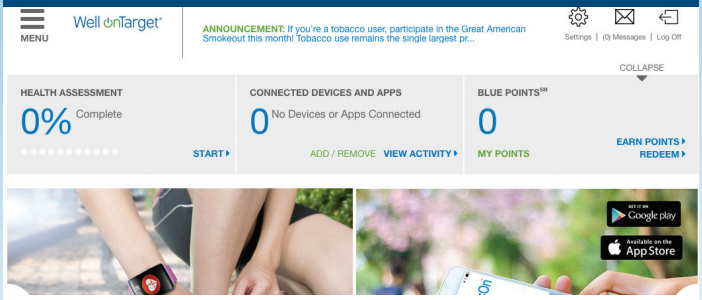
- Search for providers
- Estimate the cost of treatments, procedures, tests and other health care services (PPO network only)
- Read and submit health care provider reviews
- Compare physicians and facilities based on procedure costs and third-party clinical quality indicators
- Determine if Blue Distinction® Centers or Blue Distinction® Centers+ are right for their situation

Blue Access for Members℠ (BAM)

This secure member portal from BCBSTX gives members immediate online access to health, wellness and health benefit information. It allows members to stay connected — anytime, anywhere. With BAM, members can:

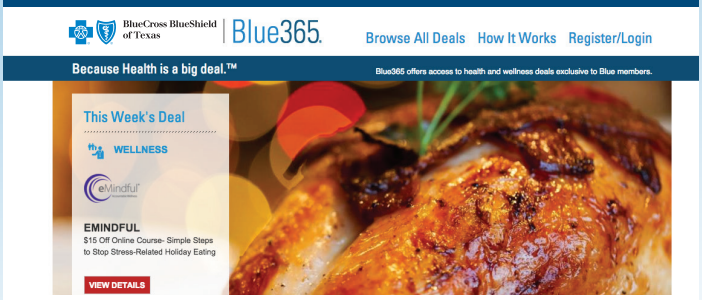
- Check the status and history of a claim
- Locate a doctor, hospital or other health care provider in the plan's network
- Request a new ID card and access a temporary one
- Receive text message tips and reminders
- Access health and wellness information

Well OnTarget®



This online portal is personalized to help engage members to reach their wellness goals. It offers valuable health resources, such as an online health assessment, self-directed courses, health and wellness content, fitness tracking and more.

Blue365®



This discount program offers exclusive health and wellness deals to BCBSTX members, including discounts from top national and local retailers on fitness gear, family activities, healthy eating options and much more.

* This tool provides general plan information, out-of-pocket expense estimates and national industry cost averages for general comparison purposes only. Actual costs may vary, and it is important to note that the out-of-pocket estimates do not include applicable plan premiums. BCBSTX is not responsible for any actions taken or decisions made based on the information provided by this tool.

Blue365 is a discount program only for BCBSTX members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Please check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of Blue365 does not change your monthly payment, nor do costs of the services or products count toward any maximums and/ or plan deductibles. Discounts are only given through vendors who take part in this program. BCBSTX does not guarantee or make any claims or recommendations about the program's services or products. You may want to talk to your doctor before using these services and products. BCBSTX reserves the right to stop or change this program at any time without notice.

MEDICAL RESOURCES

Preventive Care

Preventive care is important. All medical plan options provide 100% coverage for preventive care including

Children and Adolescents

- **Well-Child Exam**
- **Immunizations**
  - Diptheria, tetanus, pertussis
  - Hepatitis A and B
  - HPV
  - Influenza (Flu)
  - Measles, mumps, rubella
- **Screening Tests**
- **Preventive Treatments**

Adults

- **Preventive Exam**
- **Immunizations**
  - Hepatitis A and B
  - HPV
  - Influenza (Flu)
  - Measles, mumps, rubella
  - Varicella (chickenpox)
- **Screening Tests**
- **Health Counseling**

Women's Preventive Care

- **Annual well woman visit**
- **Breast cancer screening**
- **Cervical cancer screening**
- **Contraception**
- **Pregnant Women**
  - Alcohol screening and counseling
  - Anemia screening
  - Gestational diabetes screening
  - HIV screening

For a full list of preventive services please visit: www.healthcare.gov/what-are-my-preventive-care-benefits

URGENT CARE VS. EMERGENCY ROOM

You can benefit from significant savings using an urgent care facility versus a hospital Emergency Room (ER) without sacrificing quality of care.

Avoid Free Standing Emergency Clinics!

URGENT CARE

Sprains
Strains
Minor broken bones
Mild asthma attacks
Minor infections
Small cuts
Minor burns
Urinary tract infections
Pelvic infections
Sore throats
Rashes

Emergency Room

Heavy Bleeding
Trouble breathing
Severe head injury
Chest pain or pressure
Sudden or severe pain
Coughing or vomiting blood
Sudden dizziness, weakness or changes in vision
Severe or persistent vomiting or diarrhea
Changes in mental status, such as confusion
Loss of consciousness
Major burns
Spinal injuries

PHARMACY DISCOUNTS

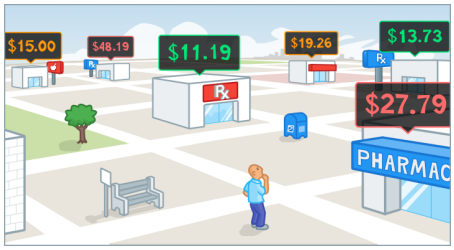
GoodRx

www.goodrx.com

100% FREE to use this service!

Why do I need GoodRx?

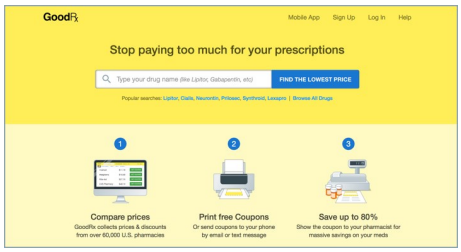
Prescription drug prices are not regulated. The cost of a prescription may differ by more than $100 between pharmacies across the street from each other!



In the past 10 years, insurance companies have passed 25-80% more of the cost of drugs to the patient.

How do I find discounts for my drug?

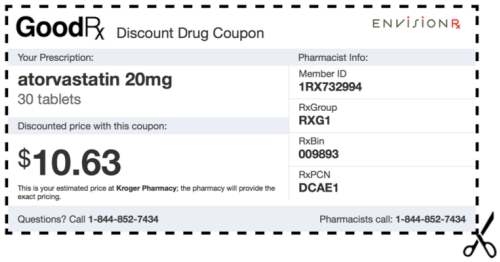
It's easy. Just go to the home page, type in the drug's name in the search field, and click the "Find the Lowest Price" button.



GoodRX gathers current prices and discounts to help you find the lowest cost pharmacy. *The average customer saves $276 a year.*

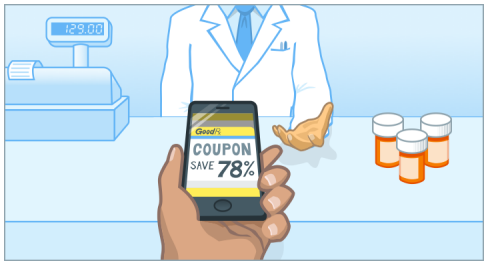
What are GoodRx coupons?

GoodRx coupons will help you pay less than the cash price for the prescription. They are free to use and are accepted at virtually every U.S. pharmacy. Your pharmacist will know how to enter the codes on the coupon to give you the lowest discount available.



How do I use a GoodRx coupon?

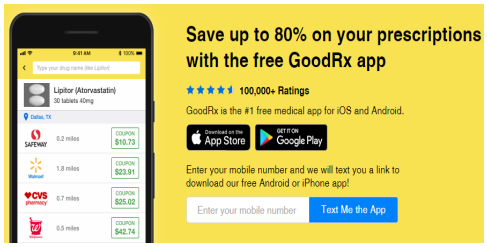
It's similar to using a coupon at a grocery store. Simply print the coupon and bring it with you to the pharmacy when you pick up your prescription. The pharmacist will enter the numbers on the coupon into their system to find the discount.



You can show the coupon on your phone by:

A) Sending the coupon to yourself via email or text

B) Download the mobile app



PLEASE NOTE: You have a choice to use your insurance or the coupon but you cannot use both. If you use the coupon, the cost of that medication will not apply toward your deductible or max out of pocket.

DENTAL INSURANCE

Plan Features	LOW PLAN (M08)
Network	Blue Care Dental
Annual Dental Max Benefit (per person)	$1,500 / covered individual
Preventive Services *i.e. exams, cleanings, routine x-rays*	Covered 100% (Deductible Waived)
Deductible *Applies to basic and major services*	$50 / Individual $150 / Family (Maximum)
Basic Services *i.e. fillings, endodontics, periodontics, oral surgery*	80% after Deductible
Major Services *i.e. anesthesia, crowns, bridges, dentures*	50% after Deductible
Orthodontia Services *Adults and Children up to age 19*	Covered 50% (No Deductible)
Orthodontia Lifetime Max	$1,000
Out-of-Network Claims	Reimbursement based on MAC Fee Schedule

BlueCross BlueShield of Texas

bcbstx.com

1-800-521-2227

Group #: 267413

Using your PPO Dental Plan

With a dental PPO plan you have greater flexibility and choice to use both in-network and out-of-network dentists.

Generally a PPO operates as follows:

- You and any enrolled dependent(s) are permitted to visit any dentist or facility without a referral from a Primary Care Dentist.
- You have access to a large PPO network and can see providers that are out-of-network
- In-network providers have agreed to discounted and negotiated rates for services, and the dentist is passing on those discounts to you as a member.
- Out-of-network providers can balance bill you for the difference in billed services and payment received from the plan.
- There is a set coinsurance amount for services.

Summary of Employee Costs					
	Total Monthly Cost	**Employer Contribution**	**Employee Monthly Cost**	**Employee Semi-Monthly Cost**	**Employee Weekly Cost**
Employee Only	$33.08	$33.08	$0.00	$0.00	$0.00
Employee + Spouse	$63.65	$33.08	$30.57	$15.29	$7.05
Employee + Child(ren)	$79.01	$33.08	$45.93	$22.97	$10.60
Family	$120.16	$33.08	$87.08	$43.54	$20.10

DENTAL INSURANCE

Plan Features	HIGH PLAN (R01)
Network	Blue Care Dental
Annual Dental Max Benefit (per person)	$3,000 / covered Individual
Preventive Services *i.e. exams, cleanings, routine x-rays*	Covered 100% (Deductible Waived)
Deductible *Applies to basic and major services*	$50 / Individual $150 / Family (Maximum)
Basic Services *i.e. fillings, endodontics, periodontics, oral surgery*	80% after Deductible
Major Services *i.e. anesthesia, crowns, bridges, dentures*	50% after Deductible
Orthodontia Services *Adults and Children up to age 19*	Covered 50% (No Deductible)
Orthodontia Lifetime Max	$2,000
Out-of-Network Claims	Reimbursement based on 90th Percentile (Usual & Customary)

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- In-network providers have agreed to discounted and negotiated rates for services, and the dentist is passing on those discounts to you as a member.
- Out-of-network providers can balance bill you for the difference in billed services and payment received from the plan.
- There is a set coinsurance amount for services.

Summary of Employee Costs					
	Total Monthly Cost	**Employer Contribution**	**Employee Monthly Cost**	**Employee Semi-Monthly Cost**	**Employee Weekly Cost**
Employee Only	$52.97	$33.08	$19.89	$9.95	$4.59
Employee + Spouse	$103.46	$33.08	$70.38	$35.19	$16.24
Employee + Child(ren)	$121.34	$33.08	$88.26	$44.13	$20.37
Family	$187.54	$33.08	$154.46	$77.23	$35.64

VISION INSURANCE

Plan Features	In-Network	Out-of-Network
Network	EyeMed	
Frequency of Benefits		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
	You Pay:	
Examination	$10 Copay	Reimbursed up to $30
Lenses		
Single	$25 Copay	Reimbursed up to $25
Bifocal	$25 Copay	Reimbursed up to $40
Trifocal	$25 Copay	Reimbursed up to $55
Lenticular	$25 Copay	Reimbursed up to $55
Frames	$130 Allowance, 20% off balance	Reimbursed up to $65
Contacts		
Elective	$130 Allowance, 15% discount off balance	Reimbursed up to $104
Medically Necessary	Paid in Full	Reimbursed up to $210

BlueCross BlueShield of Texas

eyemedvisioncare.com/bcbstxvis

855-556-8796

Group Number: F025527

With the BCBS EyeMed Vision Plan you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in network.
- Freedom of Choice:
  - ANY Frame
  - ANY Lens
  - ANY Contacts
- Purchase Frames AND Contacts in the same plan year.

Summary of Employee Costs			
	Total Monthly Cost	**Employee Semi-Monthly Cost**	**Employee Weekly Cost**
Employee Only	$7.60	$3.80	$1.75
Employee + Spouse	$14.44	$7.22	$3.33
Employee + Child(ren)	$15.20	$7.60	$3.51
Family	$22.35	$11.18	$5.16

DISABILITY INSURANCE

BlueCross BlueShield of Texas

Voluntary Short-Term Disability Coverage (STD)

All active full-time employees are eligible to enroll in short-term disability insurance. ***The cost for this plan is paid 100% by you***. This policy provides protection in the event you become temporarily disabled as a result of an non-work related accident or illness. This coverage replaces 60% of your base income, up to $2,000 per week, that you would have earned had you been able to continue working.

- 60% of base weekly wage
- Maximum weekly benefit amount is $2,000
- 14-day elimination period
- Maximum of 13 weeks duration for payments for anything other than maternity.

  Maternity coverage - 4 weeks for non complicated vaginal deliver / 6 weeks for cesarean delivery (C-section) (This includes your 14 day elimination period)
- Eligibility begins on the 1st day of the pay period following 30 days of employment. **If you do not enroll when you are first eligible, you must wait until the next Annual Enrollment period and will be subject to completion of a Statement of Health Questionnaire.**
- Pre-Existing Clause: When you file a claim, BCBS will verify if you received treatment or consultation from a medical doctor for that condition 12 months prior to your effective date on the policy. If answer is yes, then that condition will be excluded for the first 12 months.
- Payroll Deductions will be taken post tax so that when/if you need to file a claim, the benefit will NOT be taxed. You will receive a W2 directly from BCBS

- Rates will be calculated as you make your elections through the enrollment portal.
- Rates will be based on your age and your income.

www.bcbstx.com

877-442-4207
FAX: 877-404-6457

Group Number: F025527

LIFE INSURANCE

Basic Life and AD&D

The company provides all active full-time employees with a Basic Life Insurance and Accidental Death and Dismemberment (AD&D) through BCBS of TX. The benefit is as outlined below

All Full Time Employees

- Basic Life and AD&D Insurance of $10,000

Age Reduction (Applies to Basic Life and AD&D)

For the age(s) shown below, your amount of insurance will be the percentage of the Scheduled Benefit as shown below.

- Age 65 but less than age 70 - benefit is reduced to 65% of the original amount
- Age 70 and older - benefit is reduced to 50% of the original amount

Conversion to a personal policy may be available upon termination of employment. Employees are solely responsible for requesting conversion, completing the forms and returning the forms to BCBS of TX within 31 days of termination of employment. Please contact your HR department for additional information.

Remember to designate a beneficiary for you Life and AD&D benefits! This can be updated at anytime in the Benefits Connect System.

BlueCross BlueShield of Texas

www.bcbstx.com

877-442-4207
FAX: 855-645-8242

Group Number: F025527

Voluntary Life and AD&D

Employees have the opportunity to purchase additional life insurance coverage. Premiums are calculated based on age of the employee and the amount of coverage elected. These are employee-paid benefits that are paid on a post tax basis.

Employee

- Increments of $10,000 up to a maximum of $500,000
  Guarantee Issue is $100,000 (for new hires or 1st opportunity to enroll only)

Spouse

- Rate is based on employee's age
- Increments of $5,000 up to 50% of the employee's election amount with a maximum of $250,000
- Guarantee Issue amount is $25,000 (for new hires or 1st opportunity to enroll only)

AGE REDUCTION

(applies to Voluntary Life of employee and spouse):
For the age(s) shown below, your amount of insurance will be the percentage of the Scheduled Benefit (or approved amount, if applicable) as show below.

- Age 65 but less than age 70 - benefit is reduced to 65% of voluntary amount elected
- Age 70 and older - benefit is reduced to 50% of voluntary Amount elected

Child(ren)

- Increments of $5,000 or $10,000
  Age birth to 6 months = $100
- Guarantee Issue amount is $10,000 (for new hires or 1st opportunity to enroll only)

In no event will a Dependent's Schedule Benefit be more than 50% of the Employee benefit amount

Conversion to a personal policy may be available upon termination of employment. Employees are solely responsible for requesting conversion, completing the forms and returning the forms to BCBS of TX National within 31 days of termination of employment. Please contact your HR department for additional information.

ENROLLMENT INSTRUCTIONS

We are now conducting benefit enrollment online at:

www.benefitsconnect.net/vantage

Online enrollment with Benefits Connect is simple, secure, and can be done in a few minutes from any computer with internet access. After enrolling online, you will have access to your benefit information 24 hours a day, from any computer. Follow the steps below to learn how to access the system and enroll. You must type in entire site each time you access the site, you cannot bookmark to come back later. It is best to use Google Chrome or Mozilla from a desktop computer.

What you need to get started...

During the enrollment process you will be asked to provide some basic information that you should have available.

- Your social security number
- Your dependent's social security numbers and birth dates

User Name and Password

Initially your user name and password are defaulted to a standard format. Upon completing your first login you will be prompted to change your password. Let's walk through a sample login...

USERNAME: First six letters of your last name, followed by your **first initial** and **the last four numbers of your social security number**.

Note: If your last name is not six letters please use your entire last name, first initial, and last four of your social security number as your username.

PASSWORD: The **initial password** for the system is your **social security number** (without dashes).

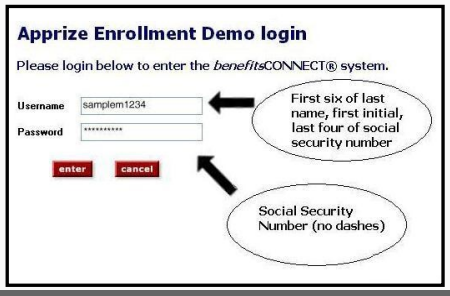
Example:

Employee Name: Matt Sample

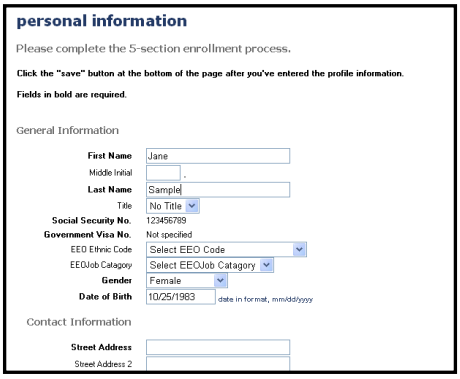
Social Security Number: 949-12-1234

User Name: samplem1234

Password: 949121234



Entering Personal Profiles



After your initial login, the system will take you to the "Personal Information" section. Please complete all fields.

Bolded fields are required, and must be completed. When you have completed all of the fields, **click *save & continue*** to proceed to the next screen.

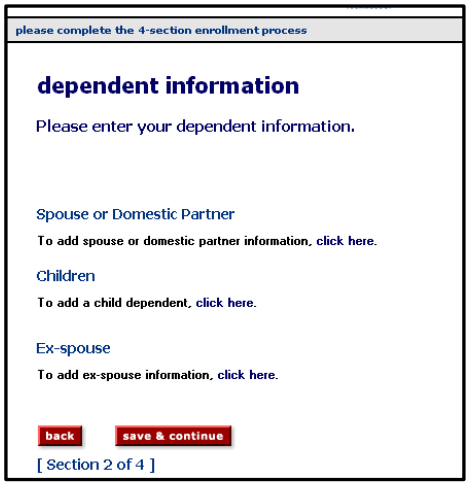
ENROLLMENT INSTRUCTIONS

Entering Dependent Profiles

The system will now take you to the **DEPENDENT INFORMATION** section:

- To enter a spouse, click the icon under Spouse, enter information and click Save.
- To enter a child, click the icon under Children, enter information and click Save. If your child is age 19+ and enrolled as a full time student, you must indicate so under the School Information to make them eligible for benefits.
- To edit a dependent, click the pencil icon next to the dependent you want to edit, make changes and click Save.
- Note: You only need to add dependents that you would like to enroll for coverage. You will choose which dependents to enroll for each plan when you reach the election screens.

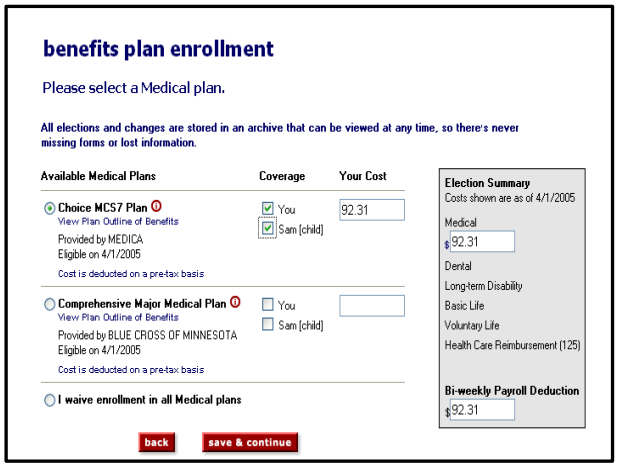
When you are finished entering dependents, click **Save & Continue**.



Making Benefit Plan Elections

Next, the system will take you to the **BENEFIT PLAN ENROLLMENT** Section. Each benefit and your options will be displayed one by one.

- To enroll in a plan, check next to the plan, and check any dependents you want to cover. If applicable, indicate the amount for which you would like to enroll.
- To waive coverage, check next to "I waive enrollment".
- For information about a plan, click View Plan Outline of Benefits.
- For plans provided by your company at no cost to you, enrollment is already checked.
- **Click Save & Continue after each benefit selection**.



Completing Your Enrollment

Once you have gone through enrollment for each plan available, the system will take you to the **CONSOLIDATED ENROLLMENT FORM** page. This screen will show you a summary of the information you entered and the benefit elections you made.

- **To complete the enrollment process: Please Click "Finished"**
- If you need to log off before completing the enrollment, any data you entered will be saved.
- Always make sure to logout upon completing any action on the system.
- **For Online Enrollment Technical Assistance - Please call GIS Benefits at (972) 478-7770 ext. 6 and customer service will be able to assist you. Our office is open Monday through Friday from 8:30 a.m. to 5 p.m. EST. If you are prompted to leave a message, someone will return your call within 1 business day.**

REQUIRED NOTICES

The following list of notices applies to all benefits eligible full time employees:

- Notice Regarding Availability of Health Insurance Marketplace Coverage Options (Employer Exchange Notice)
- Summary of Benefits and Coverage (SBC) and Uniform Glossary
- Notice of Special Enrollment Rights
- Women's Health and Cancer Rights Act (WHCRA) Notices
- Employer CHIP Notice
- HIPAA Notice of Privacy Practices for Protected Health Information
- General Notice of COBRA Rights
- Plan Document
- Summary Plan Description (SPD)
- Notice of Patient Protections

GUS BATES
insurance & investments

REQUIRED NOTICES

Health Care Reform

The federal health reform law called the "Affordable Care Act") focuses on establishing new state-based mechanisms for obtaining coverage and establishes federal standards for benefit designs and costs of coverage. Many of the significant reforms, including Exchanges and guarantee issue requirements, became effective in 2014. Other less significant reforms have already been implemented in 2011, 2012 and 2013 plan years.

HIPAA NOTICE OF 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, you and your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period. However, you must request enrollment within 30 days after you or your dependents' other coverage ends.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact HR.

HIPAA NOTICE OF PRIVACY PRACTICES FOR PHI

HIPAA imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information.

This information, known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan—whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan), sponsored by the Company (hereinafter, referred to as the plan sponsor).

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer.

You have the right to inspect and copy protected health information that is maintained by and for the Plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask the Human Resources department to amend the information. For a full copy of the Notice of Privacy Practices describing how protected health information about you may be used and disclosed and how you can get access to the info

PATIENT PROTECTION DISCLOSURE

You do not need prior authorization from the Company or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit your medical carriers website.

WOMEN'S HEALTH & CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see the Plan's summary plan description for details of the Plan's deductible, benefit percentage, and copayment requirements. If you would like more information on WHCRA benefits, contact HR.

NEWBORN & MOTHER PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to

join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Company has determined that the prescription drug coverage offered by the Aetna 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 during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You many also enroll from October 15th through December 7th, your coverage will begin January 1st.

However, if you lost 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 coverage with the Company may or may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do not decide to join a Medicare drug plan and drop your current Company coverage, be aware that you and your dependents will not be able to get this coverage back until open enrollment or if you have a special enrollment 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 The Company 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 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).

REQUIRED NOTICES

Initial Cobra Notice

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are 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 additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact HR.

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 [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

If you are an employee, you will 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 are the spouse of an employee, you will 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 enrolled in 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 reduces
- 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;
- 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)

Required Notice

You must give notice of some qualifying events for the other qualifying events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How is COBRA Coverage Provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your

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.

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.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Company informed of any address changes. You should also keep a copy, for your records, of any notices you send to the Company.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

One of the key provisions of the health care law was 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 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 Marketpace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a certain kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November of every year for coverage starting as early as January 1st.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your montlhly 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 9.8% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: 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?

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.

Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used for disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.

- Health care operations include the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction, unless the request is made to restrict disclosure to the insurer for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the protected health information pertains solely to a health care item or service for which you have paid out-of-pocket in full. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of non-routine disclosures of protected health information.
- We have the obligation to provide and you have the right to obtain a paper copy of this notice from us at least every three years.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of May 20,2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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

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

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

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

REQUIRED NOTICES

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100

REQUIRED NOTICES

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

MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-88-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

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

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

GUS BATES RESOURCES

Do you have questions concerning your benefits?

The Gus Bates team is here to assist you with all your benefits needs. Your designated account manager is an expert when it comes to your benefits package and is able to assist you with the following:

- Benefits plan selection
- Submission of claims
- Appeal of claims
- Provider networks
- Qualifying life events

Gus Bates/HUB International offers a direct line for all of your employee benefits related claims and questions. You can send your questions by email or call to speak with a representative. A GBC team member will respond to your inquiry as promptly as possible.

Benefits Account Manager
Michelle Turner
michellet@gusbates.com
(817) 529-5349

Benefits Consultant
Cammie Nowell
cammie@gusbates.com
(817) 529-5323

Escalated Claims Specialist
April Harris
april@gusbates.com
(817) 529-5328

Gus Bates/HUB Office
3221 Collinsworth Street
Fort Worth, Texas 76107
(817) 335-9547

Customer Service / Bilingual Representative
Claudia Deleon
claudia@gusbates.com
(817) 529-5310

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