



COMPREHENSIVE BENEFITS SUMMARY

January 1, 2019 – December 31, 2019



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Benefit Enrollment Center & Vendor Contacts

For help with benefit enrollment, please contact:

The Human Resources Department

(512)421-7641

Hours

Monday-Friday 8:00 AM-5:00 PM

Vendor Contacts

Medical/Dental

- Group Pension Administrators (GPA)
- Group ID: H870827
- 800.827.7223
- Medical: www.multiplan.com
- Dental: www.cignadentalsa.com

Life & Disability

- Lincoln Financial Group
- 800.423.2765
- www.lfg.com

Vision

- Superior Vision
- Group ID: 035369
- 800.507.3800
- www.superiorvision.com

Retirement 401(k)

- Lincoln Financial Group
- 800.234.3500
- www.lfg.com/retirement

Voluntary Critical Illness & Accident

- MetLife Insurance Company
- 800.438.6388
- www.mybenefits.metlife.com

Flexible Spending Account

- TASC
- 800.257.0986
- www.tasconline.com

Employee Assistance Program

- Guidance Resources
- 888.628.4824
- www.guidanceresources.com

Identity Theft

- LifeLock
- 800.543.3562
- www.lifelock.com

Open Enrollment & Qualifying Life Events

OPEN ENROLLMENT

- Employees are eligible for TDS benefits if they are regularly scheduled to work at least thirty (30) hours a week.
- Employees may make changes or add dependents without having to provide proof of insurability during the open enrollment period; Except for increases to the amount of voluntary life and AD&D, which requires evidence of insurability.
- Open enrollment applies to Medical, Dental, Vision, Life, Flexible Spending Account, and Supplemental Coverages.
- If an employee has been offered the dental plan previously, and is enrolling for the first time, he/she will be subject to late entrant penalties.
- The open enrollment period is the only time employees may enroll in the above listed coverage without the occurrence of a qualifying event (see definition below).
- Upon request, Employees and/or their dependents can receive a HIPAA Certificate of Creditable Coverage at termination from their previous carrier to provide proof of prior coverage.

ENROLLMENT CHANGES DURING THE YEAR

In most cases, an employee's benefit elections will remain in effect for the entire plan year (January 1st – December 31st). During the open enrollment period, employees have the opportunity to review their benefit elections and make changes for the coming year. Employees may only make changes to their elections during the year if they have one of the following status changes:

- Marriage, divorce or legal separation;
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death, reaching the dependent child age limit; or
- Significant changes in employment or employer-sponsored benefit coverage that affect the employee's or their spouse's benefit eligibility.

Employee benefit changes must be consistent with the change in family status.

IRS regulations require that for changes in enrollment due to the qualifying events above, change forms must be submitted to Human Resources within 30 days of the event.

Important Information



The choices an employee makes now will remain in effect until the next open enrollment period, unless they experience a Qualifying Event.



This book highlights the main features of the employee benefit program, but does not include all plan rules, features, limitations or exclusions. The terms of the benefit plans are governed by legal documents, including insurance contracts, and the summary of benefits. Should there be any inconsistencies between this book and the legal plan documents, the plan documents are the final authority.



Texas Disposal Systems reserves the right to change or discontinue its benefit plans at any time.



Should an employee wish to review the Summary Plan Description, Summary of Benefits, and/or insurance contracts, they should make their request in writing and provide it to the Human Resources Department (HR). HR will provide you the opportunity to review the requested materials within 30 days of the request. These documents may be found on-line at the TDSHRConnect website. Employees who wish to have a paper copy should include that in their written request to HR.



TDS Benefit Premiums

TDS medical insurance premiums are based on several factors:

- Who is covered by the plan
- Whether the employee is a tobacco/nicotine user
- Whether the employee participates in the Wellness Program

Tobacco/Nicotine Users:

All employees have self-identified as tobacco/nicotine or non-tobacco/nicotine users for the purpose of assigning medical benefit classification. Individuals who refused to identify have been classified as tobacco/nicotine users. Use of tobacco/nicotine is a choice that negatively impacts a person's health and, for that reason, tobacco/nicotine users pay a higher medical insurance premium.

Employees that would like to stop smoking have access to a smoking cessation program through PHCS. For information on this program, refer to Human Resources. Employees who enroll in the smoking cessation program will be rewarded by receiving the non-tobacco/nicotine user rates.

Wellness Program:

Companies institute wellness programs to assist employees in achieving and maintaining optimum health. The purpose of a wellness program is to provide employees with the tools and resources necessary to manage health and healthcare costs.

TDS Wellness Program participants will qualify for a discounted medical insurance premium. To be considered a program participant an employee must submit documentation to the Human Resources Department, no later than March 31, 2019, which provides proof that the employee has had an annual physical exam within the previous 12 months. Physicals are considered preventative health appointments and are covered at 100% by PHCS.

If it is unreasonably difficult due to health factors for an employee to meet the requirements under the smoking cessation or wellness program, or if it is medically inadvisable for the employee to attempt to meet the requirements of this program, the employee may provide documentation from his/her physician along with a request for a reasonable alternative to the Human Resources Department. TDS will provide a reasonable alternative for the employee to avoid the premium surcharge.

Please note: The information in this booklet is for information and communication purposes only. This booklet does not constitute a Summary Plan Description. If there is any discrepancy between the plan documents and the information in this booklet, the plan document will override the booklet. The plan sponsor has the right to modify, amend, or terminate these plans at any time.

To obtain a copy of plan documents for the Medical Standard and Medical Premium plans, contact the Human Resources Department.



Medical Plans

COST PLUS STANDARD PLAN

TEXAS DISPOSAL SYSTEMS, INC. | Group # H870827 | Effective January 1, 2019

PLEASE CONTACT GROUP & PENSION ADMINISTRATORS OR THE PPO NETWORK AT THE PHONE NUMBER OR WEBSITE SHOWN ON YOUR PLAN I.D. CARD FOR INFORMATION ABOUT WHICH PROVIDERS ARE INCLUDED.

Deductible and Annual Out-of-Pocket Maximum	Facility and PPO Physicians	Non-PPO Physicians
Calendar Year Deductible <ul style="list-style-type: none">• Per Covered Person• Family Limit*	\$1,500 \$3,000	\$4,000 \$8,000
Annual Out-of-Pocket Maximum (Includes Deductible and Copays including RX) <ul style="list-style-type: none">• Per Covered Person• Family Limit*	\$6,000 \$12,000	\$15,000 \$30,000

*Applies collectively to all Covered Persons in the same Family.

LEVEL I-FACILITY BENEFITS – Payment Levels:

This section applies to covered expenses for services rendered by Hospitals and other types of facilities which are not included in the **Preferred Provider Organization (PPO) network**.

Benefit Percentage For:	Facility Benefit	Maximum Benefits, Limits & Provisions
Inpatient Hospital Services	100% after \$1,000 Confinement Copay; Deductible waived	\$250 for Non-Compliance Penalty per Admission (for failure to notify Utilization Review (UR) Company of Hospital admission).
Maternity Inpatient Hospital Services	100% after \$1,000 Confinement Copay; Deductible waived	Contact UR Company for coordination of care.
Routine Newborn Care Inpatient Hospital Services	100%; Deductible waived	Payable under covered mother's claim
Skilled Nursing Facility/ Rehabilitation Facility	100% after \$1,000 Confinement Copay; Deductible waived	UR Notification required or penalty applies. Limited to 100 days per Calendar Year.
Mental & Nervous Disorders/ Inpatient Hospital Services/ Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services	100% after \$1,000 Confinement Copay; Deductible waived	UR Notification required or penalty applies.

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Benefit Percentage For:	Facility Benefit	Maximum Benefits, Limits & Provisions
Hospital Emergency Room (ER Copay waived if admitted)	100% after \$300 Copay for Emergency 100% after \$600 Copay for Non-Emergency - Deductible applies	UR Notification required if admitted Inpatient or penalty applies.
Outpatient Surgical Facility	100% after \$750 Copay; Deductible waived	UR Notification required or penalty applies.
Routine Colonoscopy (includes polyp removal)	100%; Copay & Deductible waived	UR penalty waived for routine colonoscopy.
Outpatient Therapy/Other Services Occupational Therapy/Speech Therapy/Physical Therapy	80%; Deductible applies	Limited to 30 visits per therapy per Calendar Year.
Chemotherapy, Dialysis, Radiation Therapy	80%; Deductible applies	Contact UR Company for coordination of care.
Cardiac Rehabilitation	80%; Deductible applies	Limited to 30 visits per Calendar Year.
Outpatient Diagnostic Services Select Diagnostic Procedures (MRIs, CT scan, etc.)	80%; Deductible applies	
All Other Diagnostic Lab and X-ray	80%; Deductible applies	
Preventive and Wellness Lab and X-ray	100%; Deductible waived	

Continued...



COST PLUS STANDARD PLAN (CONT'D)

LEVEL II-PHYSICIAN BENEFITS – Payment Levels and Limits:

This section applies to Physicians and all other Providers of service not included as Facility Providers. Benefits shown are available **based upon the Provider's participation in the PPO network.**

If a PHCS Physician Only Network PPO physician provider is not available within 15 miles of an employee's home address, the physician provider selected will be covered as in-network at PPO level benefits.

Benefit Percentage For:	PPO Benefit	Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Physician Hospital Visits/Surgeon	80% of PPO rate Deductible applies	50% of Usual and Customary fees; Deductible applies	
Physician Hospital Visit for Mental & Nervous Disorders/Chemical Dependency, Drug and Substance Abuse	80% of PPO rate Deductible applies	50% of Usual and Customary fees; Deductible applies	
Maternity (Including prenatal, delivery and postnatal care.) Initial Visit Office Visit Copay does not apply after initial visit	80% of PPO rate Deductible applies 100%; \$30 copay; Deductible waived	50% of Usual and Customary fees; Deductible applies 50% of Usual and Customary fees; Deductible applies	Contact UR Company for coordination of care.
Routine Newborn Care (Pediatric care to date of mother's discharge)	80% of PPO rate Deductible waived	50% of Usual and Customary fees; Deductible waived	Payable under covered mother's claim.
Office Visit (including Mental/Nervous Disorders, Substance Abuse, Allergy Testing and Injections and Lab and X-ray, except Select Diagnostic Medical Procedures)	100% of PPO rate after \$30 PCP/Specialist Copay	50% of Usual and Customary fees Deductible applies if a PHCS network provider is not available within 15 miles of employee's address, the provider selected will be covered as in network.	For the purpose of this plan, PCP means Family Practitioner, General Practitioner, Internal Medicine, Pediatrician and OB/GYN. All others are considered Specialist. A referral to a Specialist is not required.
Allergy Serum	100% of PPO rate Deductible waived	50% of Usual and Customary fees; Deductible applies	

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Benefit Percentage For:	PPO Benefit	Non-PPO Benefit	Maximum Benefits, Limits & Provisions
Office Surgery	80% of PPO rate Deductible applies	50% of Usual and Customary fees; Deductible applies	
Urgent Care Facility	100% of PPO rate after \$50 Copay	50% of Usual and Customary fees; Deductible applies	
¹Outpatient Therapy (Occupational Therapy/Speech Therapy/Physical/Cardiac Rehabilitation)	80% of PPO rate Deductible applies	50% of Usual and Customary fees; Deductible applies	Limited to 30 visits per therapy per Calendar Year.
One Call Radiological Benefit (CT scans, MRIs, Pet Scans)	100% of One Call negotiated rate Deductible waived	N/A	
Diagnostic X-ray (Outpatient Hospital, freestanding facility) Select Diagnostic Medical Procedures (CT scans, MRIs, PET scans, etc.) Physician's office, OP Hospital, freestanding facility or independent lab.	80% of PPO rate Deductible applies 80% of PPO rate Deductible applies	50% of Usual and Customary fees Deductible applies 50% of Usual and Customary fees Deductible applies	
Diagnostic Lab (Outpatient Hospital, freestanding facility or independent lab)	100% of PPO rate Deductible waived	50% of Usual and Customary fees Deductible applies	
¹Chemotherapy, Dialysis, Radiation Therapy	80% of PPO rate Deductible applies	50% of Usual and Customary fees Deductible applies	Contact UR Company for coordination of care.
Home Health Services	80% of PPO rate Deductible applies	50% of Usual and Customary fees Deductible applies	Limited to 100 visits per Calendar Year.
Hospice (Inpatient Hospice and Home Hospice)	80% of PPO rate Deductible waived	50% of Usual and Customary fees Deductible applies	UR Notification required for Inpatient Hospice. Contact UR Company for coordination of care for Hospice.

Continued...

¹ If these services are rendered by providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.

Benefit Percentage For:	PPO Benefit	Non-PPO Benefit	Maximum Benefits, Limits & Provisions
¹Durable Medical Equipment/Prosthetics	80% of PPO rate Deductible applies	50% of Usual and Customary fees Deductible applies	
Ambulance	80% of PPO rate Deductible applies	80% of Usual and Customary fees; PPO Deductible and Out Of Pocket (OOP) applies	
Restorative Health Services -Chiropractic Care -Acupuncture -Pain Management/ Massage -Airrosti -Weight/Nutritional Counseling² (Licensed Dietician or Licensed Nutritionist)	100% of PPO rate after \$30 Copay	50% of Usual and Customary fees Deductible applies	Limited to 15 visits per each type of service listed per Calendar Year.
-Annual Hearing Exam	100%; Copay and Deductible waived	50% of Usual and Customary fees Deductible applies	
-Hearing Aids/Devices	100%; Copay and Deductible waived	100% of Usual and Customary fees Copay/Deductible waived	Hearing aids/devices limited to \$3,000 maximum per 36 month period.

Continued...

¹ If these services are rendered by providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.

² Physician Prescription Required



COST PLUS STANDARD PLAN (CONT'D)

Preventive and Wellness Care Benefits

This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam/or as specified below.

Benefit Percentage For:	Level II PPO Benefit	Level II Non-PPO Benefit	Maximum Benefits, Limits & Provisions
All Covered Wellness Benefits	100%; Copay and Deductible waived	50%; Deductible applies	See age and frequency limits and other special provisions below

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. *Annual Pap smear and other routine lab
4. *Annual Routine Mammogram
5. *Bone Density test (routine)
6. Annual PSA test (routine)
7. Well Baby Care Exam/Well Child Care Exam
8. Routine Immunizations
9. Flu vaccine/pneumonia vaccine
10. *Routine lab, x-ray, diagnostic testing and other medical screenings
11. Vision screening to age 19
12. Hearing screening for Newborns
13. Smoking/Tobacco Use Cessation
14. *All FDA-approved Women's Contraceptive methods/Sterilization procedures
15. *Routine Colonoscopy (includes polyp removal)
16. Annual Mole Check (includes mole removal)

* If these services are rendered by providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.



COST PLUS STANDARD PLAN (CONT'D)

Prescription Drugs

Prescription Drugs	
Prescription Drug Card (Retail – 30 day supply)	Generic: \$0 Copay Preferred Brand: \$25 Copay Non Preferred Brand: \$75 Copay
Mail Order (90 day supply)	Generic: \$0 Copay Preferred Brand: \$50 Copay Non Preferred Brand: \$150 Copay
Specialty Drugs (30 day supply)	20% Copay per fill (20% copay is capped at a maximum copay of \$200 per fill)
Specialty Drugs Accredo¹	20% Copay up to \$200 per fill (Copay is dependent on SaveonSP program participation)

¹ Specialty Drugs must be obtained through the Prescription Drug Plan's Specialty Pharmacy. Certain specialty drugs, such as injectables, must be obtained through Accredo, an Express Scripts Specialty Pharmacy. There is no opportunity for a one month's supply through a retail pharmacy. Covered Persons may be required to enroll in SaveonSP's Co-Pay assistance program through Accredo to maximize their savings on the cost of such drugs otherwise the prescription drug will be at a higher copay (and will not count toward the out-of-pocket maximum) stated on the list of SaveonSP Co-Pay assistance prescriptions. Accredo and/or SaveonSP will contact the Covered Person directly. For a list of SaveonSP Co-Pay assistance prescriptions, please call SaveonSP at (800) 683-1074.



COST PLUS PREMIUM PLAN

TEXAS DISPOSAL SYSTEMS, INC. | Group # H870827 | Effective January 1, 2019

PLEASE CONTACT GROUP & PENSION ADMINISTRATORS OR THE PPO NETWORK AT THE PHONE NUMBER OR WEBSITE SHOWN ON YOUR PLAN I.D. CARD FOR INFORMATION ABOUT WHICH PROVIDERS ARE INCLUDED.

Deductible and Annual Out-of-Pocket Maximum	Facility and PPO Physicians	Non-PPO Physicians
Calendar Year Deductible • Per Covered Person • Family Limit*	\$750 \$1,500	\$2,000 \$4,000
Annual Out-of-Pocket Maximum (Includes Deductible and Copays including RX) • Per Covered Person • Family Limit*	\$3,000 \$6,000	\$15,000 \$30,000
*Applies collectively to all Covered Persons in the same Family.		

LEVEL I-FACILITY BENEFITS – Payment Levels:

This section applies to covered expenses for services rendered by Hospitals and other types of facilities which are not included in the **Preferred Provider Organization (PPO) network**.

Benefit Percentage For:	Facility Benefit	Maximum Benefits, Limits & Provisions
Inpatient Hospital Services	100% after \$750 Confinement Copay; Deductible waived	\$250 for Non-Compliance Penalty per Admission (for failure to notify Utilization Review (UR) Company of Hospital admission).
Maternity Inpatient Hospital Services	100% after \$750 Confinement Copay; Deductible waived	Contact UR Company for coordination of care.
Routine Newborn Care Inpatient Hospital Services	100%; Deductible waived	Payable under covered mother's claim
Skilled Nursing Facility/ Rehabilitation Facility	100% after \$750 Confinement Copay; Deductible waived	UR Notification required or penalty applies. Limited to 100 days per Calendar Year.
Mental & Nervous Disorders/ Inpatient Hospital Services/ Chemical Dependency, Drug and Substance Abuse Inpatient Hospital Services	100% after \$750 Confinement Copay; Deductible waived	UR Notification required or penalty applies.

Continued...



Benefit Percentage For:	Facility Benefit	Maximum Benefits, Limits & Provisions
Hospital Emergency Room (ER Copay waived if admitted)	100% after \$200 Copay for Emergency 100% after \$400 Copay Non-Emergency Deductible Applies	UR Notification required if admitted Inpatient or penalty applies.
Outpatient Surgical Facility	100% after \$500 Copay; Deductible waived	UR Notification required or penalty applies.
Routine Colonoscopy (includes polyp removal)	100%; Copay & Deductible waived	UR penalty waived for routine colonoscopy
Outpatient Therapy/Other Services Occupational Therapy/Speech Therapy/Physical Therapy Chemotherapy, Dialysis, Radiation Therapy	90%; Deductible applies 90%; Deductible applies	Limited to 30 visits per therapy per Calendar Year. Contact UR Company for coordination of care.
Cardiac Rehabilitation	90%; Deductible applies	Limited to 30 visits per Calendar Year.
Outpatient Diagnostic Services Select Diagnostic Procedures (MRIs, CT scan, etc.)	90%; Deductible applies	
All Other Diagnostic Lab and X-ray	90%; Deductible applies	
Preventive and Wellness Lab and X-ray	100%; Deductible waived	

Continued...



COST PLUS PREMIUM PLAN (CONT'D)

LEVEL II-PHYSICIAN BENEFITS – Payment Levels and Limits:

This section applies to Physicians and all other Providers of service not included as Facility Providers. Benefits shown are available **based upon the Provider's participation in the PPO network.**

If a PHCS Physician Only Network PPO physician provider is not available within 15 miles of an employee's home address, the physician provider selected will be covered as in-network at PPO level benefits.

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Physician Hospital Visits/Surgeon	90% of PPO rate Deductible applies	50% of Usual and Customary fees Deductible applies	
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Continued...

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COST PLUS PREMIUM PLAN (CONT'D)

Preventive and Wellness Care Benefits

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5. *Bone Density test (routine)
6. Annual PSA test (routine)
7. Well Baby Care Exam/Well Child Care Exam
8. Routine Immunizations
9. Flu vaccine/pneumonia vaccine
10. *Routine lab, x-ray, diagnostic testing and other medical screenings
11. Vision screening to age 19
12. Hearing screening for Newborns
13. Smoking/Tobacco Use Cessation
14. *All FDA-approved Women's Contraceptive methods/Sterilization procedures
15. *Routine Colonoscopy (includes polyp removal)
16. Annual Mole Check (includes mole removal)

* If these services are rendered by providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.



COST PLUS PREMIUM PLAN (CONT'D)

Prescription Drugs

Prescription Drugs	
Prescription Drug Card (Retail – 30 day supply)	Generic: \$0 Copay Preferred Brand: \$25 Copay Non Preferred Brand: \$75 Copay
Mail Order (90 day supply)	Generic: \$0 Copay Preferred Brand: \$50 Copay Non Preferred Brand: \$150 Copay
Specialty Drugs (30 day supply)	20% Copay per fill (20% copay is capped at a maximum copay of \$200 per fill)
Specialty Drugs Accredo¹	20% Copay up to \$200 per fill (Copay is dependent on SaveonSP program participation)

¹ Specialty Drugs must be obtained through the Prescription Drug Plan's Specialty Pharmacy. Certain specialty drugs, such as injectables, must be obtained through Accredo, an Express Scripts Specialty Pharmacy. There is no opportunity for a one month's supply through a retail pharmacy. Covered Persons may be required to enroll in SaveonSP's Co-Pay assistance program through Accredo to maximize their savings on the cost of such drugs otherwise the prescription drug will be at a higher copay (and will not count toward the out-of-pocket maximum) stated on the list of SaveonSP Co-Pay assistance prescriptions. Accredo and/or SaveonSP will contact the Covered Person directly. For a list of SaveonSP Co-Pay assistance prescriptions, please call SaveonSP at (800) 683-1074.

United Concierge Medicine



UNITED CONCIERGE MEDICINE
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**Speak with an Emergency Medicine Provider.
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- One Click Call to request consults with an Emergency Trained Provider
- Schedule consults from your App or Online
- Prescriptions sent directly to your pharmacy
- Share pictures and/or video with a provider
- Follow up to track your recovery
- Access to your own patient portal
- Labs, x-rays, and diagnostics ordered STAT
- Eliminate travel time and copays

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Nurse Navigator



GPA's Nurse Navigator Program is available to you!

We Can Help!

-  Locate Provider Options for Medical Services
-  Schedule Appointments
-  Obtain Your Medical Records for Appointments
-  Assist with Health Plan Benefits
-  Medication Coordination
-  Bilingual Staff Members are Available
-  Locate Diagnostic and Lab Testing

THE GPA NURSE NAVIGATORSM program of Nurses and Benefit Advocates are ready to assist you in identifying options for your medical care, providing benefit information, assisting with claims questions or delivering clinical education regarding your medical condition or treatment. For example, should you need to see a physician for a symptom you are having, but you do not know of a physician that could best treat that symptom, you can call GPA Nurse Navigator and they will help you locate a physician, schedule the appointment, gather previous medical records including testing and treatments already completed, and send them to the provider for your upcoming appointment.

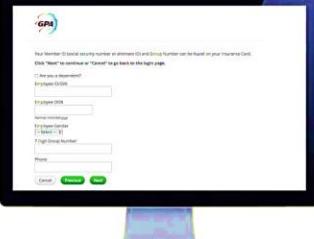
Disclaimer: GPA Nurse NavigatorSM is brought to you by your employer and administered by Group & Pension Administrators, Inc. This program is offered at no cost to you as part of your health plan benefits. Your participation is voluntary with privacy, confidentiality and protection of your health information a priority for your employer and Group & Pension Administrators, Inc.

LOCAL PHONE: **972.619.2531 OPTION 1**
TOLL FREE PHONE: **800.843.6705 OPTION 1**
EMAIL: **nursenavigator@gpatpa.com**

GPA Member Portal


MAXIMIZE YOUR HEALTH PLAN
with the GPA
Member Portal

The GPA Member Portal provides a streamlined, easy-to-navigate platform to access all of your health insurance information, including your:

Coverage and plan benefits	Claims status and account balances	Wellness program information
 Signing up takes less than 10 minutes: <ul style="list-style-type: none"> STEP 1 Begin by visiting www.gpatpa.com and selecting the “Members” button on the top right corner of the homepage STEP 2 Next, click the “Proceed to our sign up process” link located on the bottom left of your screen STEP 3 After agreeing to the license agreement, you will be able to fill in your member information using your benefits card STEP 4 Now, you will create your GPA account profile using any email address and password you’d like STEP 5 The last step will be ensuring your member profile and information are correct and choosing your EOB delivery method 	 To view or print an image of your ID card: <ul style="list-style-type: none"> STEP 1 Click on the HOME tab STEP 2 Click Print or Request ID Card located under the Quick Links Menu to the far right side of the screen <div style="border: 1px solid #ccc; padding: 10px; margin-top: 10px;"> <p style="color: #E69138; font-weight: bold;">Quick Links</p> <ul style="list-style-type: none"> Print or Request ID Card Ask a Question Frequently Asked Questions </div> STEP 3 Click the view a temporary ID card link. This will populate an ID card image for you to view or print.	

Have any questions?
Be sure to contact the GPA customer service department to learn more about the GPA Member Portal and how it can make managing your healthcare easier than ever.
www.gpatpa.com



ELAP

Send any balance bill or collection notices from a hospital/facility to ELAP immediately!

Helpful facts to assist you with any balance bill or collection notices

WHY DID I GET A BILL?

The reimbursement paid by your benefits plan conforms to allowable claim limits that the plan is permitted to pay for the service provided. The provider is seeking reimbursement in excess of what your plan has paid already.

WHAT SHOULD I DO IF I GET A BILL?

If you receive a bill from the hospital/facility it is VERY important that you notify ELAP immediately. ELAP will arrange for an attorney to represent you, and that attorney is responsible for your defense in this matter. This defense is made available through ELAP services. ELAP will work directly with the law firm and the hospital/facility to limit your involvement. The key for you is to notify ELAP each time you receive a bill or a call.

WHAT HAPPENS AFTER ELAP IS INVOLVED?

ELAP will ask you to sign a form, officially appointing a lawyer to represent you in this matter. Once you return the signed representation form, you send all correspondence that you receive from the medical provider to ELAP.

WHAT DO I HAVE TO PAY UNDER MY PLAN?

Under your plan, you are responsible for paying the out-of-pocket expenses (co-pay, co-insurance and/or deductible) that are associated with these services. This amount is listed on your Explanation of Benefits (EOB).

WHO DO I CALL IF I HAVE A QUESTION ABOUT WHAT I OWE UNDER THE PLAN?

Group & Pension Administrators, Inc. (GPA) Customer Service 800.827.7223



How do I contact ELAP?

ELAP Services, LLC is located at
1550 Liberty Ridge Drive, Suite 330
Wayne, PA 19087

Email: balancebills@elapservices.com
Customer Service Phone: Toll Free - 800.977.7381
Fax: 888.560.2447
Web: www.elapservices.com

ELAPulse



elapulse
STAY CONNECTED

Manage your balance bills online. Anytime.

ELAP Services is your health plan's affordability partner, and **ELAPulse** is your online portal.

STAY CONNECTED | 24/7



Balance Bill Support

- Submit hospital and facility bills
- Check the **status of claims**
- Contact a **Member Services Advocate**



Educational Resources

- Get answers to **Frequently Asked Questions**
- Watch videos to learn more about **how ELAP saves you money**

TIP

When you submit your bills quickly and easily through the online portal, ELAP Services can get to work resolving the bill. And when you understand how your health plan works, you benefit the most!



9 a.m. – 7 p.m. ET | **Member Services:** 1-800-977-7381
FAX: 1-888-560-2447 | balancebills@elapservices.com



ELAP Portal

A screenshot of a computer monitor displaying the GPA Portal login page. The background features a hexagonal pattern. The GPA logo is at the top left. The main area shows fields for "Member Name", "Member Date of Birth", "Effective Date", and "Group Number". A "Forgot Password" link is highlighted with a green oval. A "Log In" button is at the bottom right. To the right of the login form is a sidebar titled "Quick Links" with several items like "Print or Request ID Card", "Not in Database", "Frequently Asked Questions", "Glossary", and "Employee Log Activities".

A screenshot of a computer monitor displaying the ELAPulse "Submit a Bill" page. The GPA logo is at the top left. The main area shows a table of recent activities with columns for "DATE OF SERVICE", "SERVICE PROVIDER", "REFERENCE #", "STATUS", and "TAKE ACTION". One row in the table has a question mark icon in the "TAKE ACTION" column, which is highlighted with a green oval. A "Document Icon" (a small document with a camera icon) is also highlighted with a green oval. Below the table, there's a "Please send feedback to elapservicessupport.com" link. To the right is a sidebar with links for "Search Frequently Asked Questions", "How to...", "Who is ELAP?", and "Submit Bill Online".

GET MORE INFORMATION

- 1) Read **Frequently Asked Questions**
- 2) Access videos about ELAP
- 3) Submit your questions online



ELAP Services is a leading healthcare solution for self-funded employers across the U.S., offering a full-service program that ensures employers, members, and hospitals and health systems receive a fair price for healthcare.



9 a.m. – 7 p.m. ET | **Member Services:** 1-800-977-7381
FAX: 1-888-560-2447 | balancebills@elapservices.com



ELAP Frequently Asked Questions

A provider is stating that they do not accept my insurance, what do I do?

It is likely they do not recognize the Physicians Only logo on the ID card. Explain that you have health benefits and request that they call GPA to verify your benefits – at (972)744-2486 or 1(800)206-3224 M-TH 8:00a-7:00p and Fri 8:00a-5:00p. If you are still having difficulties call GPA for assistance.

Could the provider ask me to pay for my procedure upfront?

The hospital performing your medical procedure may request money from you upfront however you as the patient are only responsible for your co-pay, co-insurance, and deductible. To confirm this dollar amount, contact GPA. You can also refer to your Employee Benefit Booklet in the schedule of benefits. The only out-of-pocket you should pay upfront is your co-pay. Your deductible and co-insurance is determined once the hospital has sent their bill to GPA. This amount will be listed on your Explanation of Benefits (EOB).

What if the provider asks me to pay more than my out-of-pocket (OOP)?

Your benefits plan does not require you to pay anything upfront outside of your co-pay, co-insurance, or deductible. If the provider will not perform your treatment without money being paid upfront outside of your personal responsibility, contact GPA immediately and have a GPA representative speak to the provider.

I have been balance billed; will my account be put into collections?

Each provider treats its billing practices differently. When a provider sends a bill to a collections agency, it does not necessarily mean that it was reported to any credit reporting agency impacting your credit score. This means that the provider has ceased their collections efforts within the hospital billing department and sent

your bill to an outside vendor to attempt to collect the alleged balance due. If you receive a collection notice, please send it to ELAP right away.

The collection notice will clearly state that you have 30 days to respond and dispute the debt, and it must be sent to an attorney in a timely manner so that they have enough time to respond on your behalf. It is very important to remember that if your bill is sent to collections, once the collections agency is made aware that you are represented by an attorney they are no longer, by law, permitted to communicate with you in any way other than continued mail notices.

Please contact ELAP immediately if you continue to be contacted by the collection agency at 1(800)560-7381 M-F between 9:00a-7:00p EST.

Balance bills can be sent to:

balancebills@elapservices.com or fax to 1(888)560-2447.

Why is the provider center still calling me?

The provider is within their legal rights to attempt to contact you by telephone, but there is no reason for you to speak to them. If you need to speak to a representative, take their name and their phone number and relay that information to your assigned ELAP Claim Examiner.

How long will the provider continue to bill me?

Different providers have different collection practices. Please be assured that ELAP will continue to support you throughout this process. It is important that you send ELAP all correspondence that you receive in a timely manner.

What if I need additional treatment at this hospital/surgery center? Will they turn me away?

It has not been ELAP's experience to have a provider turn away a member due to balance billing. If you encounter any admissions issues, please call GPA right away so that ELAP and GPA can work together to resolve the issue.



Dental Plan

TDS offers a comprehensive dental plan. Below is a benefit summary.

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out-of-network.

Dental Benefits	Coverage	
	Plan Pays	You Pay
Calendar Year Maximum (Preventative, Basic, and Major Dental Services Combined)	\$2,000	
Annual Deductible	\$50 per person, \$100 per family	
Class I – Preventative & Diagnostic Services Routine oral exams (2 per Calendar Year) Fluoride Application (1 per Calendar Year to age 19) Prophylaxis (2 per Calendar Year) Emergency Care to relieve pain Bitewing x-rays (2 series per Calendar Year) Sealants (to age 14) Full mouth x-rays (once per 3 years) Space Maintainers	100%	No charge
Class II – Basic Restorative Services Fillings General anesthesia Periodontics Re-cement bridges, crowns and inlays Antibiotic drugs Periodontal scaling Endodontics (root canal therapy) Oral surgery Repairs to dentures/bridges Extractions Local anesthesia	80%	20%
Class III – Major Restorative Services Crowns Dentures Bridges Inlays/Onlays Implants	80%	20%
Class IV – Orthodontic Services Diagnostic procedures including oral exam, surgery, and extractions Cephalometric x-rays	50% \$2,000 Lifetime Maximum	No Charge



Vision Plan

TDS offers the following vision plan through Superior Vision. Below is a benefit summary.

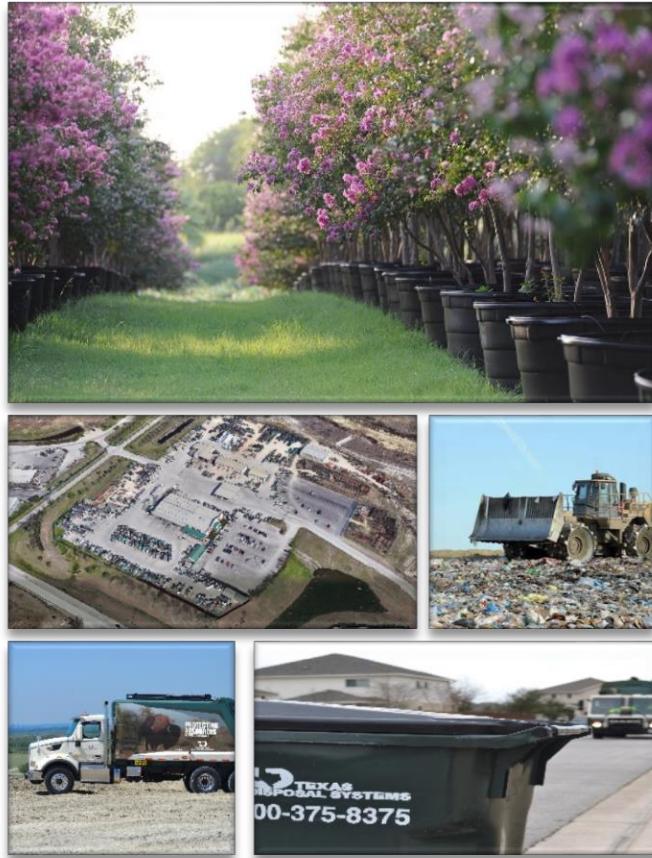
Vision Care Service	In-Network Member Cost		Out-of-Network Reimbursement
Exam with Dilation as Necessary Ophthalmologist Optometrist	\$10 Copay \$10 Copay		Up to \$42 Up to \$37
Frames	\$150 retail allowance		Up to \$60
Standard Plastic Lenses Single Vision Bifocal Trifocal Progressives (standard) Polycarbonate for Dependent Children	\$25 Copay \$25 Copay \$25 Copay \$25 Copay \$25 Copay		Up to \$26 Up to \$34 Up to \$50 Up to \$34 N/A
Maximum Member Out-of-Pocket Scratch coat Ultraviolet coat Tints, solid or gradients Anti-reflective coat High index 1.6 Photochromics	Single \$13 \$15 \$25 \$50 \$55 \$80	Bifocal/Trifocal \$13 \$15 \$25 \$50 20% off retail 20% off retail	N/A N/A N/A N/A N/A N/A
Contact Lens and Follow-Up Standard Contact Lens Fit & Follow up Specialty Contact Lens Fit & Follow up	\$25 Copay \$50 Allowance		N/A N/A
Contact Lenses	\$125 Retail Allowance		Up to \$100 Retail
Laser Vision Correction Lasik	15%-50% Discount		N/A
Frequency Examination Lenses or Contact Lenses Frame	Once every 12 months Once every 12 months Once every 24 months		

Basic Life and AD&D

Eligibility	Employee You must be actively at work (able to perform all normal duties of your job) and you must be working a minimum of 30 hours per week to be eligible for coverage.
Life Benefit	Employee
Amount	Equal to 2 times your annual salary, rounded
Maximum Amount	\$400,000
Guaranteed Issue	\$400,000
AD&D Benefit	Employee
Amount	The principal Sum amount is equal to the amount of life insurance benefit.
Maximum Amount	\$400,000
Guaranteed Issue	\$400,000
Benefit Reduction	Employee
Benefits will reduce:	35% at age 65 An additional 25% reduction of the original amount at age 70 An additional 15% reduction of the original amount at age 75 Benefits will terminate upon retirement
Additional Features	Employee
	Accelerated Death benefit Seat Belt, Airbag, Common Carrier Conversion
Enrolling in Coverage	Employee
	All employees in an eligible class.

Definitions	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to be paid a portion of your life insurance benefit when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you must be covered under this policy for the amount of time defined by the policy.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes death or dismemberment (e.g., the loss of a hand, foot, or eye), subject to policy limitations.

Continued...



Additional Benefits	
LifeKeys	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
TravelConnect	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

Definitions	
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election normally must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without providing Evidence of Insurability. Evidence of Insurability will be required for any amount above this, for late enrollees or increases in insurance, and it will be provided at your own expense.
Seatbelt Benefit – Air Bag Benefit – Common Carrier Benefit	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to \$10,000 or 10% of the principal sum, whichever is less. If loss occurs due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Term Life	A death benefit is paid to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash associated with this product.



Voluntary Life AD&D

Eligibility	Employee You must be actively at work (able to perform all normal duties of your job) and you must be working a minimum of 30 hours per week to be eligible for coverage.		
Coverage Guidelines	Employee	Spouse	Child(ren)
Minimum	\$10,000	\$5,000	\$20,000
Maximum	5 times annual salary, up to \$500,000	100% of employee's benefit, up to \$100,000	100% of employee's benefit, up to \$20,000
Guaranteed Issue	5 times annual salary, up to \$150,000	100% of employee's benefit, up to \$25,000	100% of employee's benefit, up to \$20,000
Features	Living Care/Accelerated Death Benefit Waiver of Premium Annual Benefit Amount Increase Child Care Center, Seat Belt, Airbag, Spouse Education, Common Carrier Portability Conversion		
Age Reductions and Exclusion	At age 70+, amounts reduce to 50%; Coverage terminates at retirement Spouse coverage terminates at age 70		

For assistance or additional information, contact Lincoln Financial Group

Reference ID: TXDISPOSA3

1-800-423-2765

www.lfg.com



Voluntary Life AD&D Rates

Employee and Dependent Weekly Premiums

- Employee and Spouse premiums are calculated separately.
- Spouse premiums will be calculated based on the Employee Age.
- Refer to Program Specifications for your maximum benefit amount.

Employee Premium Table (Weekly Deductions)*

Weekly RATE Per \$1000	AGE	\$ 10,000	\$20,000	\$ 30,000	\$ 40,000	\$ 50,000	\$ 60,000	\$ 70,000	\$ 80,000	\$ 90,000	\$100,000
0.0242	<25	\$0.24	\$0.48	\$0.73	\$0.97	\$1.21	\$1.45	\$1.69	\$1.94	\$2.18	\$2.42
0.0242	25-29	\$0.24	\$0.48	\$0.73	\$0.97	\$1.21	\$1.45	\$1.69	\$1.94	\$2.18	\$2.42
0.0293	30-34	\$0.29	\$0.59	\$0.88	\$1.17	\$1.47	\$1.76	\$2.05	\$2.34	\$2.64	\$2.93
0.0346	35-39	\$0.35	\$0.69	\$1.04	\$1.38	\$1.73	\$2.08	\$2.42	\$2.77	\$3.11	\$3.46
0.0395	40-44	\$0.40	\$0.79	\$1.19	\$1.58	\$1.98	\$2.37	\$2.77	\$3.16	\$3.56	\$3.95
0.0547	45-49	\$0.55	\$1.09	\$1.64	\$2.19	\$2.74	\$3.28	\$3.83	\$4.38	\$4.92	\$5.47
0.0856	50-54	\$0.86	\$1.71	\$2.57	\$3.42	\$4.28	\$5.14	\$5.99	\$6.85	\$7.70	\$8.56
0.1463	55-59	\$1.46	\$2.93	\$4.39	\$5.85	\$7.32	\$8.78	\$10.24	\$11.70	\$13.17	\$14.63
0.2028	60-64	\$2.03	\$4.06	\$6.08	\$8.11	\$10.14	\$12.17	\$14.20	\$16.22	\$18.25	\$20.28
0.3203	65-69	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
		\$3.20	\$6.41	\$9.61	\$12.81	\$16.02	\$19.22	\$22.42	\$25.62	\$28.83	\$32.03
0.5984	70-99	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
		\$2.99	\$5.98	\$8.98	\$11.97	\$14.96	\$17.95	\$20.94	\$23.94	\$26.93	\$29.92

Spouse Premium Table (Weekly Deductions)*

Weekly RATE Per \$1000	AGE	\$ 5,000	\$10,000	\$ 15,000	\$ 20,000	\$ 25,000	\$ 30,000	\$ 35,000	\$ 40,000	\$ 45,000	\$ 50,000
0.0242	<25	\$0.12	\$0.24	\$0.36	\$0.48	\$0.61	\$0.73	\$0.85	\$0.97	\$1.09	\$1.21
0.0242	25-29	\$0.12	\$0.24	\$0.36	\$0.48	\$0.61	\$0.73	\$0.85	\$0.97	\$1.09	\$1.21
0.0293	30-34	\$0.15	\$0.29	\$0.44	\$0.59	\$0.73	\$0.88	\$1.03	\$1.17	\$1.32	\$1.47
0.0346	35-39	\$0.17	\$0.35	\$0.52	\$0.69	\$0.87	\$1.04	\$1.21	\$1.38	\$1.56	\$1.73
0.0395	40-44	\$0.20	\$0.40	\$0.59	\$0.79	\$0.99	\$1.19	\$1.38	\$1.58	\$1.78	\$1.98
0.0547	45-49	\$0.27	\$0.55	\$0.82	\$1.09	\$1.37	\$1.64	\$1.91	\$2.19	\$2.46	\$2.74
0.0856	50-54	\$0.43	\$0.86	\$1.28	\$1.71	\$2.14	\$2.57	\$3.00	\$3.42	\$3.85	\$4.28
0.1463	55-59	\$0.73	\$1.46	\$2.19	\$2.93	\$3.66	\$4.39	\$5.12	\$5.85	\$6.58	\$7.32
0.2028	60-64	\$1.01	\$2.03	\$3.04	\$4.06	\$5.07	\$6.08	\$7.10	\$8.11	\$9.13	\$10.14
0.3203	65-69	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
		\$1.60	\$3.20	\$4.80	\$6.41	\$8.01	\$9.61	\$11.21	\$12.81	\$14.41	\$16.02
0.5984	70-99	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
		\$1.50	\$2.99	\$4.49	\$5.98	\$7.48	\$8.98	\$10.47	\$11.97	\$13.46	\$14.96

Dependent Child Benefit: \$20,000
 Weekly Rate: \$0.60**

* This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

** Premium covers all dependent children regardless of the number of children.



Employee and Dependent Bi-Weekly Premiums

- Employee and Spouse premiums are calculated separately.
- Spouse premiums will be calculated based on the Employee Age.
- Refer to Program Specifications for your maximum benefit amount.

Employee Premium Table (Bi-Weekly Deductions)*

Bi-Weekly Per \$1000	AGE	\$ 10,000	\$ 20,000	\$ 30,000	\$ 40,000	\$ 50,000	\$ 60,000	\$ 70,000	\$ 80,000	\$ 90,000	\$ 100,000
0.0485	<25	\$0.49	\$0.97	\$1.46	\$1.94	\$2.43	\$2.91	\$3.40	\$3.88	\$4.37	\$4.85
0.0485	25-29	\$0.49	\$0.97	\$1.46	\$1.94	\$2.43	\$2.91	\$3.40	\$3.88	\$4.37	\$4.85
0.0586	30-34	\$0.59	\$1.17	\$1.76	\$2.34	\$2.93	\$3.52	\$4.10	\$4.69	\$5.27	\$5.86
0.0692	35-39	\$0.69	\$1.38	\$2.08	\$2.77	\$3.46	\$4.15	\$4.84	\$5.54	\$6.23	\$6.92
0.0789	40-44	\$0.79	\$1.58	\$2.37	\$3.16	\$3.95	\$4.73	\$5.52	\$6.31	\$7.10	\$7.89
0.1094	45-49	\$1.09	\$2.19	\$3.28	\$4.38	\$5.47	\$6.56	\$7.66	\$8.75	\$9.85	\$10.94
0.1712	50-54	\$1.71	\$3.42	\$5.14	\$6.85	\$8.56	\$10.27	\$11.98	\$13.70	\$15.41	\$17.12
0.2926	55-59	\$2.93	\$5.85	\$8.78	\$11.70	\$14.63	\$17.56	\$20.48	\$23.41	\$26.33	\$29.26
0.4057	60-64	\$4.06	\$8.11	\$12.17	\$16.23	\$20.29	\$24.34	\$28.40	\$32.46	\$36.51	\$40.57
0.6406	65-69	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
		\$6.41	\$12.81	\$19.22	\$25.62	\$32.03	\$38.44	\$44.84	\$51.25	\$57.65	\$64.06
1.1968	70-99	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
		\$5.98	\$11.97	\$17.95	\$23.94	\$29.92	\$35.90	\$41.89	\$47.87	\$53.86	\$59.84

Spouse Premium Table (Bi-Weekly Deductions)*

Bi-Weekly RATE Per \$1000	AGE	\$ 5,000	\$ 10,000	\$ 15,000	\$ 20,000	\$ 25,000	\$ 30,000	\$ 35,000	\$ 40,000	\$ 45,000	\$ 50,000
0.0485	<25	\$0.24	\$0.49	\$0.73	\$0.97	\$1.21	\$1.46	\$1.70	\$1.94	\$2.18	\$2.43
0.0485	25-29	\$0.24	\$0.49	\$0.73	\$0.97	\$1.21	\$1.46	\$1.70	\$1.94	\$2.18	\$2.43
0.0586	30-34	\$0.29	\$0.59	\$0.88	\$1.17	\$1.47	\$1.76	\$2.05	\$2.34	\$2.64	\$2.93
0.0692	35-39	\$0.35	\$0.69	\$1.04	\$1.38	\$1.73	\$2.08	\$2.42	\$2.77	\$3.11	\$3.46
0.0789	40-44	\$0.39	\$0.79	\$1.18	\$1.58	\$1.97	\$2.37	\$2.76	\$3.16	\$3.55	\$3.95
0.1094	45-49	\$0.55	\$1.09	\$1.64	\$2.19	\$2.74	\$3.28	\$3.83	\$4.38	\$4.92	\$5.47
0.1712	50-54	\$0.86	\$1.71	\$2.57	\$3.42	\$4.28	\$5.14	\$5.99	\$6.85	\$7.70	\$8.56
0.2926	55-59	\$1.46	\$2.93	\$4.39	\$5.85	\$7.32	\$8.78	\$10.24	\$11.70	\$13.17	\$14.63
0.4057	60-64	\$2.03	\$4.06	\$6.09	\$8.11	\$10.14	\$12.17	\$14.20	\$16.23	\$18.26	\$20.29
0.6406	65-69	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
		\$3.20	\$6.41	\$9.61	\$12.81	\$16.02	\$19.22	\$22.42	\$25.62	\$28.83	\$32.03
1.1968	70-99	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
		\$2.99	\$5.98	\$8.98	\$11.97	\$14.96	\$17.95	\$20.94	\$23.94	\$26.93	\$29.92

Dependent Child Benefit: \$20,000
 Bi-Weekly Rate: \$1.20**

* This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

** Premium covers all dependent children regardless of the number of children.

Short Term Disability

Short-term disability is intended to protect your income for a short duration in the event you become ill or injured.

Eligibility	Employee
	You must be actively at work (able to perform all normal duties of your job) and you must be working a minimum of 30 hours per week to be eligible for coverage.
Maximum Weekly Benefit	60% of weekly earning, not exceed \$750 per week
Maximum Benefit Duration	12 weeks
Benefits Begin	On the 8th day of your disabling injury or illness
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.





Long Term Disability

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

Eligibility	Employee You must be actively at work (able to perform all normal duties of your job) and you must be working a minimum of 30 hours per week to be eligible for coverage.
Monthly Benefit	60% of monthly earning, not to exceed \$6,000 per month.
Maximum Benefit Duration	If you become disabled prior to age 62, benefits are payable to age 65 or your Social Security Normal Retirement Age. At age 62 (or older), the benefit period will be based on a reduced duration schedule.
Benefits Begin	90 days after the onset of your disabling injury or illness.
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
Survivor Benefit	If you pass away while receiving long-term disability benefits, your benefits will be provided to your beneficiaries for a period of time after your death.
Additional Features	Waiver of Premium Employee Assistance Program Alcohol & Drug Abuse Mental Disorder Self-Reported/Specific Enhanced Disability
Pre-Existing Conditions Exclusion	Disabilities that occur during the first 12 months of coverage due to a pre-existing condition during the 3 months prior to coverage are excluded.



Employee Assistance Program

Life brings challenges. EmployeeConnect delivers help.

Everyone needs help solving problems sometimes. EmployeeConnect offers confidential assistance to help you and your family meet the challenges that life, work, and relationships can bring.

Who is Eligible?

You and your immediate household family members are eligible to access EmployeeConnect services as part of your long-term disability coverage from Lincoln.

What services can I access?

Unlimited, 24/7 toll free phone and online access to:

- Family and personal convenience information and referrals for topics such as child and elder care, kennels and pet care, vacation planning, relocation, car buying and colleges.
- Legal information and referrals for situations requiring expertise in family law, estate planning, landlord/tenant relations, consumer and civil law, and more.
- Financial information and referrals to assist with concerns such as household budgeting, as well as short-term and long-term planning.
- In-person help for short-term issues; up to four (4) sessions with a counselor per person, per issue, per year.
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and subsequent meetings at a reduced fee.
- Web-based resources
 - Articles
 - Tutorials
 - Streaming videos
 - Interactive tools and assessments such as financial calculators, budgeting spreadsheets and a language translator
- Customized information packets to accompany all work-life services.

What experience and credentials will my counselors have?

- By phone: Your EmployeeConnect counselor is the first point of contact when you call the toll-free line. This individual performs counseling and work-life triage, assessment, intake and referral. All counselors hold master's degrees in counseling, social work or other related majors. In addition, they have broad-based clinical skills and at least three years of experience in assessing and counseling related to a variety of issues.
- In person: When you schedule a face-to-face meeting, you will be referred to a fully credentialed, state-licensed clinician.

Who may I contact?

- By phone: 888-628-4824
- Online: www.GuidanceResources.com

User ID: LFGsupport | **Password:** LFGsupport1

LifeLock

Choose the LifeLock Service that's Right for You!

Service Features	LifeLock Benefit Elite	LifeLock Ultimate Plus
LifeLock Identity Alert System	✓	✓
Lost Wallet Protection	✓	✓
Address Change Verification	✓	✓
Black Market Website Surveillance	✓	✓
Reduced Pre-Approved Credit Card Offers	✓	✓
Live Member Service Support	✓	✓
Identity Restoration Support	✓	✓
\$1 Million Total Service Guarantee	✓	✓
Fictitious Identity Monitoring	✓	✓
Court Records Scanning	✓	✓
Data Breach Notification	✓	✓
Investment Account Activity Alerts	✓	✓
Credit Card, Check & Savings Account Activity Alerts		✓
Online Tri-Bureau Annual Credit Reports		✓
Online Tri-Bureau Annual Credit Score		✓
Checking & Savings Account Application Alerts		✓
Bank Account Takeover Alerts		✓
Credit Inquiry Alerts		✓
Monthly Credit Score Tracking		✓
File-Sharing Network Searches		✓
Sex Offender Registry Reports		✓
Priority Member Service Support		✓

LifeLock Benefit Elite service searches over a trillion data points every day for potential threats to your identity. We start by looking for suspicious uses of your name, address, phone number, birth date and Social Security number to get loans, credit and services in your name. Then we help protect what might be your biggest financial assets – your 401(k) and investment accounts.

LifeLock Ultimate Plus service provides peace of mind knowing you have the most comprehensive identity theft protection available. Enhanced services include important notifications beyond financial and credit fraud. Extra protection includes bank account activity alerts, bank account application and takeover alerts, online credit reports and credit scores.

LifeLock Service Payroll Deduction Pricing

Weekly

Plan Options*	LifeLock Benefit Elite	LifeLock Ultimate Plus
EE Only	\$1.96	\$5.88
EE + Spouse	\$3.92	\$11.76
EE + Child(ren)	\$3.43	\$8.33
EE + Family	\$5.39	\$14.22

Bi-Weekly

Plan Options*	LifeLock Benefit Elite	LifeLock Ultimate Plus
EE Only	\$3.92	\$11.76
EE + Spouse	\$7.85	\$23.53
EE + Child(ren)	\$6.86	\$16.67
EE + Family	\$10.78	\$28.44

* The benefits under the Service Guarantee are provided under Master Insurance Policy underwritten by State National Insurance Company. As this is only a summary please see the actual policy for applicable terms and restrictions at LifeLock.com | Network does not cover all transactions and is only provided in the U.S. Valid U.S. SSN required for LifeLock Membership. No one can prevent all identity theft.



Retirement – 401(k) Information

Saving is not always easy with today's demands on your money. The Texas Disposal Systems, Inc. 401(k) Profit Sharing Plan offers a convenient way to get into the savings routine and save for one of the most important goals of your life... Retirement!

It's never too early or too late to save. We encourage you to start today.

Am I eligible for the Texas Disposal Systems, Inc. 401(k) Profit Sharing Plan?

You are eligible to join the plan if you:

- Are 18 years old, and
- Have completed 3 months of employment during which you worked 250 hours

How can I access my account information?

You may obtain account information through:

- Participant Statement [quarterly]
- Call the interactive voice response system | Lincoln Financial – 800.234.3500
- Visit the website www.lfg.com/Retirement to view your account.

Does my employer automatically enroll me into the plan?

Your retirement plan includes an automatic enrollment feature that will enroll you at 3% of pay if you do nothing once you are eligible for the plan. If you opt out of the plan, or if you choose your own percent to save, you will not be auto-enrolled. Your retirement plan also includes an automatic increase feature that will increase your contribution rate by 1% beginning January 1st of each year, unless you opt out of this feature or choose your own percent to save. These increases will stop once you are deferring 10%.

Are there limits to my contribution?

Your total salary deferral in 2019 may not be more than \$19,000. If you are age 50 or older during the plan year, you can choose to contribute an additional \$6,000 to the plan

Does my employer match my contributions?

Yes, TDS will match 100% of the first 2.5% of pay you contribute to the plan.

How do I enroll in the 401(k) plan?

Approximately 30 days before you become eligible, you will receive a letter from Lincoln Financial Services with detailed instructions on how to enroll in the plan.

If you have misplaced that letter, you can enroll in the plan by logging onto the Lincoln Financial Services website at www.lfg.com/Retirement. If you have any questions during the enrollment process, you can contact a Lincoln Financial Representative at (800) 234-3500.

Flexible Spending Account

TASC will continue to be your FSA administrator in 2019.

TASC will administer the Flexible Spending Accounts (FSA's) for TDS employees. Flexible Spending Accounts (FSAs) allow you to set aside pre-tax payroll deductions to pay for out-of-pocket expenses with pre-tax dollars, which will reduce the amount of your taxable income and increase your take-home pay. FSA's include:

- Health Care Flexible Spending Accounts
- Dependent Care Flexible Spending Accounts

HEALTH CARE FLEXIBLE SPENDING ACCOUNTS

The Health Care Flexible Spending Account sets aside pre-tax funds for eligible medical, dental and vision expenses not paid for by insurance.

- You can contribute up to \$2,700.
- You can use funds in your FSA to pay for certain medical and dental expenses for you, your spouse if you're married, and your dependents.
- As of January 1, 2011, over-the-counter medications are allowed only when purchased with a doctor's prescription, except for insulin.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Dependent Care FSA sets aside pre-tax funds to help pay for expenses associated with caring for elder and child dependents. Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- You can contribute up to \$5,000.
- Eligible dependents include children younger than the age of 13 and dependents of any age who are incapable of caring for themselves.
- Dependent care expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes.
- In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. The dependent must be a child younger than age 13 and claimed as a dependent on your federal income tax return or a disabled dependent that spends at least eight hours a day in your home. Examples of eligible dependent care expenses include:

- In-house babysitting services (not by an individual you claim as a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before and after-school care
- Day camp
- In-house dependent day care



Weekly Payroll Deductions

Medical Deductions

	Wellness Participant		Non-Wellness Participant	
Standard Plan	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
Employee Only	\$20.06	\$44.21	\$38.32	\$62.35
Employee + Spouse	\$113.58	\$138.62	\$135.53	\$160.65
Employee + Child(ren)	\$91.32	\$113.75	\$109.85	\$132.62
Employee + Family	\$154.49	\$182.31	\$184.56	\$210.56
	Wellness Participant		Non-Wellness Participant	
Premium Plan	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
Employee Only	\$40.84	\$63.19	\$57.92	\$79.08
Employee + Spouse	\$134.35	\$156.68	\$155.06	\$174.69
Employee + Child(ren)	\$107.54	\$129.06	\$124.22	\$143.92
Employee + Family	\$181.60	\$207.61	\$208.68	\$229.80

Dental Deductions

Employee Only	\$4.54
Employee + Spouse	\$10.78
Employee + Child(ren)	\$9.04
Employee + Family	\$14.97

Vision Deductions

Employee Only	\$1.54
Employee + 1	\$3.05
Employee + 2 or More	\$4.25



Bi-Weekly Payroll Deductions

Medical Deductions

	Wellness Participant		Non-Wellness Participant	
Standard Plan	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
Employee Only	\$40.13	\$88.42	\$76.63	\$124.69
Employee + Spouse	\$227.17	\$277.25	\$270.86	\$321.31
Employee + Child(ren)	\$182.64	\$227.51	\$219.71	\$265.25
Employee + Family	\$308.98	\$362.62	\$369.12	\$374.97
	Wellness Participant		Non-Wellness Participant	
Premium Plan	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
Employee Only	\$81.68	\$126.38	\$115.84	\$158.16
Employee + Spouse	\$268.70	\$313.36	\$310.12	\$349.39
Employee + Child(ren)	\$215.08	\$258.12	\$248.45	\$287.82
Employee + Family	\$363.21	\$415.21	\$417.37	\$459.60



Dental Deductions

Employee Only	\$9.08
Employee + Spouse	\$21.57
Employee + Child(ren)	\$18.08
Employee + Family	\$29.94

Vision Deductions

Employee Only	\$3.08
Employee + 1	\$6.10
Employee + 2 or More	\$8.50



MetLife Accident Insurance

MetLife's Accident Insurance helps pay for unexpected healthcare expenses due to accidents that occur every day – from the soccer field to the ski slope and the highway in-between. Accident insurance provides benefits due to covered accidents for initial care, injuries and follow-up care. Benefits are paid directly to the employee, in addition to any other coverage they have.

Plan Features

- Choice between two comprehensive plans
- 24 hour coverage (on/off job)
- No limitations for pre-existing conditions
- Portable Coverage – Employees can continue coverage if they leave or retire
- Plan designs based on highest recorded utilization, so employees get the most comprehensive coverage when they need it most

Eligibility

- Employees: Ages 18 to 80; and actively working full-time (30+ hours per week) and employed for at least 30 days
- Spouses: Ages 18 to 80, who are not disabled
- Children: Legal dependents up to age 26 who are unmarried

Benefits for 24-Hour Coverage	Low Plan	High Plan
Physician Follow-Up	\$50	\$75
Accidental Death Benefit Rider	EE \$25,000 SP \$12,500 CH \$5,000	EE \$50,000 SP \$25,000 CH \$10,000
Accidental Death Benefit Rider Common Carrier	EE \$75,000 SP \$37,500 CH \$15,000	EE \$150,000 SP \$75,000 CH \$30,000
Ambulance		
Ground	\$200	\$300
Air	\$750	\$1,000
Appliance	Up to \$500	Up to \$1,000
Blood, Plasma and Platelets	\$300	\$400
Burns – Flat Amount for:		
2 nd degree 10-25% surface burn	\$500	\$1,000
2 nd degree 25-35% surface burn	\$250	\$500
2 nd degree 35% or more surface burn	\$100	\$200
3 rd degree 10-25% surface burn	\$1,000	\$2,000
3 rd degree 25-35% surface burn	\$2,500	\$5,000
3 rd degree 35% or more surface burn	\$5,000	\$10,000
Catastrophic Accident Benefit - Employee receives 100% of amount shown, spouse receives 50% and children receive 20% of amount shown	\$25,000 \$75,000 for Common Carrier	\$50,000 \$150,000 for Common Carrier
Concussion	\$200	\$400
Dislocations		
Open reduction	Up to \$3,000	Up to \$6,000
Closed reduction	Up to \$1,500	Up to \$3,000

Continued...



Benefits for 24-Hour Coverage	Low Plan	High Plan
Emergency Care		
Emergency Room	\$50	\$100
Urgent Care	\$25	\$50
Physician's Office	\$25	\$50
Emergency Dental Benefit		
Extraction	\$50	\$100
Crown	\$100	\$200
Filling	\$25	\$50
Eye Injury	\$200	\$300
Fractures		
Open reduction	Up to \$3,000	Up to \$6,000
Closed reduction	Up to \$1,500	Up to \$3,000
Chips	25% of closed amount	25% of closed amount
Health Screening Benefit	\$0	\$0
Herniated Disc	\$500	\$1,000
Hospital Admission		
Non-ICU	\$500	\$1,000
ICU	\$1,000	\$2000
Hospital Confinement (per day up to 31 days)		
Non-ICU	\$100	\$200
ICU	\$200	\$400
Laceration	\$25 to \$200	\$50 to \$400
Lodging (per night up to 31 days)	\$100 per night up to \$3,100	\$200 per night up to \$6,100
Loss of one finger, one toe	\$250	\$500
Loss of 1 arm, leg, hand or foot	\$2,500	\$10,000
Loss of two or more fingers or toes	\$500	\$1,000
Loss of sight in one eye or hearing in one ear	\$2,500	\$10,000
Loss of both arms, legs, hands or feet	\$10,000	\$50,000
Loss of sight in both eyes or hearing in both ears	\$10,000	\$50,000
Loss of ability to speak	\$10,000	\$50,000
Therapy Services (Behavioral, Occupational, Physical, Respiratory, Speech and Vocational)	\$15	\$25
Prosthetic Device or Artificial Limb		
More than one	\$1,000	\$1,500
One	\$500	\$750
Skin Grafts (2nd & 3rd degree)	50% of burn benefit	50% of burn benefit
Surgery		
Cranial, thoracic, abdominal	\$1,000	\$2,000
Exploratory and Hernia Repair	\$100	\$200
Tendon/Ligament/Rotator Cuff		
Repair of more than one	\$750	\$1,000
Repair of one	\$500	\$750
Exploratory without repair	\$100	\$150
Torn Knee Cartilage	\$500	\$750
Exploratory	\$100	\$150
Transportation (100 miles up to three trips)	\$200	\$400

Continued...

MetLife Accident Insurance Rates

LOW PLAN RATES

	Weekly	Bi-Weekly
Employee Only	\$2.02	\$4.03
Employee + Spouse	\$3.49	\$6.99
Employee + Child(ren)	\$4.15	\$8.31
Employee + Family	\$5.20	\$10.40

HIGH PLAN RATES

	Weekly	Bi-Weekly
Employee Only	\$3.90	\$7.79
Employee + Spouse	\$6.57	\$13.14
Employee + Child(ren)	\$7.85	\$15.70
Employee + Family	\$9.76	\$19.52





MetLife Critical Illness Insurance

MetLife's Critical Illness insurance offers a lump-sum benefit payable upon first diagnosis (Initial Benefit) of a Covered Condition, including:

100% Benefit

- Alzheimer's disease
- Coronary Artery Bypass Graft
- Full Benefit Cancer
- Major organ transplant
- Renal failure
- Heart Attack
- Stroke

25% Benefit

- Addison's Disease
- Lou Gehrig's Disease
- Cerebrospinal Meningitis
- Cerebral Palsy
- Cystic Fibrosis
- Diphtheria

- Encephalitis
- Huntington's Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Sickle Cell Anemia
- Systemic Lupus
- Tetanus

Plan Features

- Unique underwriting – Guaranteed Issue
- No Benefit Reduction
- Level Premiums – Rates do not increase with age
- Guaranteed Renewable – Coverage remains in force to age 100, as long as premiums are paid
- Waiting Period – 30 day waiting period waived if coverage begins more than 30 days after enrollment
- Portable Coverage – Employees can continue coverage if they leave or retire
- Maximum – The maximum amount you may receive (Total Benefits) is 3 times the amount of your Initial Benefit

Eligibility

- Employees – Ages 18 to 70, actively working, full time (30+ hours per week) and employed at least 30 days
- Spouses – Ages 18 to 70
- Children – Under the age of 26, who are unmarried, natural, adopted or step children and dependent grandchildren

Health Screening Benefit

MetLife will provide an annual benefit of \$50 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year. For a complete list of eligible screening/prevention measures, please refer to the Disclosure Statement/Outline of Coverage.



MetLife Critical Illness Insurance Rates

Weekly Rates

- Employee \$15,000 to \$30,000
- Spouse and Child(ren) 50% of Employee Initial Benefit, \$7,500 to \$15,000

Example of Initial & Recurrence Benefit Payments

Illness – Covered Condition	Payment	Total Benefit Remaining
Heart Attack – First Diagnosis	Initial Benefit Payment of \$15,000 or 100%	\$30,000
Heart Attack – Second Diagnosis, two years later	Recurrence Benefit Payment of \$7,500 or 50%	\$22,500
Kidney Failure – First Diagnosis, three years later	Initial Benefit Payment of \$15,000 or 100%	\$0

\$15,000 NON-TOBACCO

	EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
	Weekly	Bi-Weekly	Weekly	Bi-Weekly	Weekly	Bi-Weekly	Weekly	Bi-Weekly
<25	\$1.56	\$3.12	\$2.42	\$4.85	\$2.11	\$4.22	\$3.01	\$6.02
25-49	\$1.56	\$3.12	\$2.42	\$4.85	\$2.11	\$4.22	\$3.01	\$6.02
30-34	\$2.25	\$4.50	\$3.29	\$6.58	\$2.80	\$5.61	\$3.88	\$7.75
35-39	\$3.18	\$6.37	\$4.57	\$9.14	\$3.74	\$7.48	\$5.16	\$10.32
40-44	\$5.02	\$10.04	\$7.03	\$14.05	\$5.61	\$11.22	\$7.62	\$15.23
45-49	\$7.10	\$14.19	\$9.90	\$19.80	\$7.68	\$15.37	\$10.49	\$20.98
50-54	\$9.76	\$19.52	\$13.47	\$26.93	\$10.35	\$20.70	\$14.05	\$28.11
55-59	\$12.53	\$25.06	\$17.27	\$34.55	\$13.12	\$26.24	\$17.86	\$35.72
60-64	\$15.40	\$30.81	\$21.29	\$42.58	\$15.96	\$31.92	\$21.88	\$43.75
65-69	\$17.13	\$34.27	\$23.99	\$47.98	\$17.72	\$35.45	\$24.58	\$49.15
70+	\$20.22	\$40.43	\$28.45	\$56.91	\$20.80	\$41.61	\$29.01	\$58.02

\$15,000 TOBACCO

	EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
	Weekly	Bi-Weekly	Weekly	Bi-Weekly	Weekly	Bi-Weekly	Weekly	Bi-Weekly
<25	\$2.32	\$4.64	\$3.57	\$7.13	\$2.87	\$5.75	\$4.15	\$8.31
25-49	\$2.32	\$4.64	\$3.57	\$7.13	\$2.87	\$5.75	\$4.15	\$8.31
30-34	\$3.46	\$6.92	\$5.02	\$10.04	\$4.02	\$8.03	\$5.61	\$11.22
35-39	\$5.02	\$10.04	\$7.20	\$14.40	\$5.61	\$11.22	\$7.79	\$15.58
40-44	\$8.10	\$16.20	\$11.32	\$22.64	\$8.69	\$17.38	\$11.91	\$23.82
45-49	\$11.67	\$23.33	\$16.20	\$32.40	\$12.25	\$24.51	\$16.79	\$33.58
50-54	\$16.23	\$32.47	\$22.33	\$44.65	\$16.82	\$33.65	\$22.88	\$45.76
55-59	\$21.05	\$42.09	\$28.87	\$57.74	\$21.60	\$43.20	\$29.42	\$58.85
60-64	\$26.07	\$52.13	\$35.83	\$71.65	\$26.65	\$53.31	\$36.42	\$72.83
65-69	\$29.35	\$58.71	\$40.85	\$81.69	\$29.94	\$59.88	\$41.40	\$82.80
70+	\$35.00	\$69.99	\$48.91	\$97.82	\$35.55	\$71.10	\$49.50	\$99.00

Continued



\$30,000 NON-TOBACCO

	EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
	Weekly	Bi-Weekly	Weekly	Bi-Weekly	Weekly	Bi-Weekly	Weekly	Bi-Weekly
<25	\$3.12	\$6.23	\$4.85	\$9.69	\$4.22	\$8.45	\$6.02	\$12.05
25-49	\$3.12	\$6.23	\$4.85	\$9.69	\$4.22	\$8.45	\$6.02	\$12.05
30-34	\$4.50	\$9.00	\$6.58	\$13.15	\$5.61	\$11.22	\$7.75	\$15.51
35-39	\$6.37	\$12.74	\$9.14	\$18.28	\$7.48	\$14.95	\$10.32	\$20.63
40-44	\$10.04	\$20.08	\$14.05	\$28.11	\$11.22	\$22.43	\$15.23	\$30.46
45-49	\$14.19	\$28.38	\$19.80	\$39.60	\$15.37	\$30.74	\$20.98	\$41.95
50-54	\$19.52	\$39.05	\$26.93	\$53.86	\$20.70	\$41.40	\$28.11	\$56.22
55-59	\$25.06	\$50.12	\$34.55	\$69.09	\$26.24	\$52.48	\$35.72	\$71.45
60-64	\$30.81	\$61.62	\$42.58	\$85.15	\$31.92	\$63.83	\$43.75	\$87.51
65-69	\$34.27	\$68.54	\$47.98	\$95.95	\$35.45	\$70.89	\$49.15	\$98.31
70+	\$40.43	\$80.86	\$56.91	\$113.82	\$41.61	\$83.22	\$58.02	\$116.03

\$30,000 TOBACCO

	EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
	Weekly	Bi-Weekly	Weekly	Bi-Weekly	Weekly	Bi-Weekly	Weekly	Bi-Weekly
<25	\$4.64	\$9.28	\$7.13	\$14.26	\$5.75	\$11.49	\$8.31	\$16.62
25-49	\$4.64	\$9.28	\$7.13	\$14.26	\$5.75	\$11.49	\$8.31	\$16.62
30-34	\$6.92	\$13.85	\$10.04	\$20.08	\$8.03	\$16.06	\$11.22	\$22.43
35-39	\$10.04	\$20.08	\$14.40	\$28.80	\$11.22	\$22.43	\$15.58	\$31.15
40-44	\$16.20	\$32.40	\$22.64	\$45.28	\$17.38	\$34.75	\$23.82	\$47.63
45-49	\$23.33	\$46.66	\$32.40	\$64.80	\$24.51	\$49.02	\$33.58	\$67.15
50-54	\$32.47	\$64.94	\$44.65	\$89.31	\$33.65	\$67.29	\$45.76	\$91.52
55-59	\$42.09	\$84.18	\$57.74	\$115.48	\$43.20	\$86.40	\$58.85	\$117.69
60-64	\$52.13	\$104.26	\$71.65	\$143.31	\$53.31	\$106.62	\$72.83	\$145.66
65-69	\$58.71	\$117.42	\$81.69	\$163.38	\$59.88	\$119.77	\$82.80	\$165.60
70+	\$69.99	\$139.98	\$97.82	\$195.65	\$71.10	\$142.20	\$99.00	\$198.00



Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage

to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.⁹

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:

Sarah Adams
3306 FM 1327
Creedmoor, Texas 78610
(512) 421-1317
sadams@texasdisposal.com

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.

⁹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.



PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Texas Disposal Services	4. Employer Identification Number (EIN) 75-1579711	
5. Employer address 3306 FM 1327	6. Employer phone number (512) 421-1384	
7. City Creedmoor	8. State Texas	9. ZIP code 78610
10. Who can we contact about employee health coverage at this job? Sarah Adams		
11. Phone number (512) 421-1317	12. Email address sadams@texasdisposal.com	

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

As your employer, we offer a health plan to:

- All employees.

With respect to dependents:

- We do offer coverage. Eligible dependents are: as defined by the IRS.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

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 (or if the employer stops contributing toward 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).

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.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Sarah Adams at 3306 FM 1327, Creedmoor, Texas 78610, (512) 421-1317, sadams@texasdisposal.com



Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Sarah Adams at 3306 FM 1327, Creedmoor, Texas 78610, (512) 421-1317, sadams@texasdisposal.com and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Notice of Privacy Practices

Texas Disposal Services
3306 FM 1327
Creedmoor, Texas 78610
(512) 421-1384

Privacy Official

Janice Brewster Martinez
3306 FM 1327
Creedmoor, Texas 78610
(512) 421-1384

jbmartinez@texasdisposal.com

Effective Date: 04/14/2004

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.



- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:

Janice Brewster Martinez

3306 FM 1327

Creedmoor, Texas 78610

(512) 421-1384

jbmartinez@texasdisposal.com

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- Example: We use health information about you to develop better services for you.
- Pay for your health services



- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your Company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html



Employer's Children's Health Insurance Program (CHIP) Notice

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.askaesa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	FLORIDA – Medicaid Website: http://flmedicaidtplecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – 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	GEORGIA – Medicaid Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	INDIANA – Medicaid 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+) 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	IOWA – Medicaid Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
	KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
	KENTUCKY – Medicaid Website: https://chfs.ky.gov Phone: 1-800-635-2570



LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447
MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/mass-health/
Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipo.htm
Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPPP
Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/ombp/nhcpp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999
NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462
RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347
SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669
VERMONT- Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427



VIRGINIA – Medicaid and CHIP	WEST VIRGINIA – Medicaid
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
Medicaid Phone: 1-800-432-5924	WISCONSIN – Medicaid and CHIP
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
CHIP Phone: 1-855-242-8282	WYOMING – Medicaid
WASHINGTON – Medicaid	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

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



Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

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

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

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits under the plan.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the Texas Disposal Systems, Inc. Health Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (512) 421-7665.

Newborns' and Mothers' Health Protection Act Notice

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).

Medicare Part D Creditable Coverage Notice

Important Notice from Texas Disposal Services 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 Texas Disposal Services 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. Texas Disposal Services has determined that the prescription drug coverage offered by the Texas Disposal Systems Employee Benefit Plan 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 Texas Disposal Services coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current Texas Disposal Services coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Texas Disposal Services and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information call Sarah Adams at (512) 421-1317.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Texas Disposal Services changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).



Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/15/2018
Name of Entity/Sender: Texas Disposal Services
Contact--Position/Office: Sarah Adams, HR Business Partner
Address: 3306 FM 1327 Creedmoor, Texas 78610
Phone Number: (512) 421-1317

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

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

General Notice of COBRA Rights

(For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA

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;

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

- 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 notice to:

Sarah Adams
HR Business Partner
3306 FM 1327
Creedmoor, Texas 78610
(512) 421-1317
sadams@texasdisposal.com



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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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.

Plan contact information: Texas Disposal Systems Employee Benefit Plan

Sarah Adams
3306 FM 1327
Creedmoor, Texas 78610
(512) 421-1317
sadams@texasdisposal.com

General FMLA Notice

Employee Rights under the Family and Medical Leave Act

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;



- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave,* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd



USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

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

B. Reemployment Rights

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

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

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

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights.

including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

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

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at <http://www.dol.gov/vets>. An interactive online USERRA Advisor can be viewed at <http://www.dol.gov/elaws/userra.htm>.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: <http://www.dol.gov/vets/programs/userra/poster.htm>.

Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.



TEXAS DISPOSAL SYSTEMS