



Comprehensive Benefits Summary

May 1, 2010 - April 30, 2011

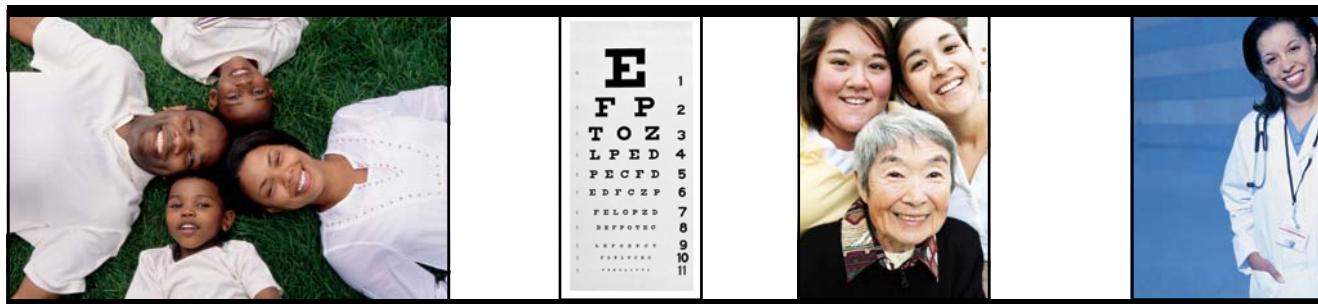


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****If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 11 - 12 for more details.**

A Word From Gallagher Benefit Services, Inc.

Gallagher Benefit Services, Inc. is here to act as a liaison in your dealings with insurance carriers. If you are having problems getting claims paid or have questions regarding your coverage, let us deal with the insurance company for you. Please contact anyone at Gallagher Benefit Services, Inc. with questions regarding your employee benefits package. **We are here to help!**



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The following pages give a brief description of the benefit plans eligibility requirements and the specific benefits available to you. SEDL provides several categories of benefits from which employees may choose to participate:

Healthcare - Medical and Dental

Life and Disability - Group Term Life and AD&D and Group Voluntary Universal Life

Additional Benefits - Flexible Spending Account, Health Savings Account



Benefits and Customer Service Information



The following benefits are offered through Blue Cross Blue Shield:

- Medical Insurance Group # 83593
- Dental Insurance
- Customer Service: 800-521-2227
- Provider Listing: www.bcbstx.com or www.bluecares.com
- Network: BlueChoice PPO

The following benefits are offered through Guardian:

- Group Term Life and AD&D Insurance Group # G-369187
- Dependent Life Insurance
- Optional Life Insurance
- Enhanced AD&D Insurance
- Customer Service: 800-541-7846
www.guardianlife.com

The following benefits are offered through FlexCorp:

- Flexible Spending Account
 - Premium and HSA Pre-taxing
 - \$4,000 Healthcare Reimbursement
 - \$5,000 Daycare Reimbursement
- Customer Service: 800-856-1816
www.bpas.com
- Fax Claims: 713-996-7626

The following benefits are offered through Wells Fargo:

- HSA Accounts
- Customer Service: 866-890-8309
<https://healthbenefits.wellsfargo.com>

The following benefits are self administered through SEDL:

- COBRA Administration
- State Continuation
- Customer Service: Please contact your Human Resources Department for further information.



Blue Cross Blue Shield Online Guide

Online | Blue Access® for Members



Information is a powerful tool

That's why we provide a variety of online resources for our members – from the status of medical claims to staying healthy. Blue Cross and Blue Shield of Texas conveniently delivers information and resources wherever you have access to the Internet.



When you log in to Blue Access for Members, you can view claim information for yourself and your spouse or dependents, if they are covered by your plan.

Blue Access® for Members—Personalized Information about Your Health Care Coverage

Would you like to know when your medical claims are paid and the payment amounts? Do you need to confirm who in your family is included under your coverage? Go to www.bcbstx.com, log in to Blue Access® for Members and:

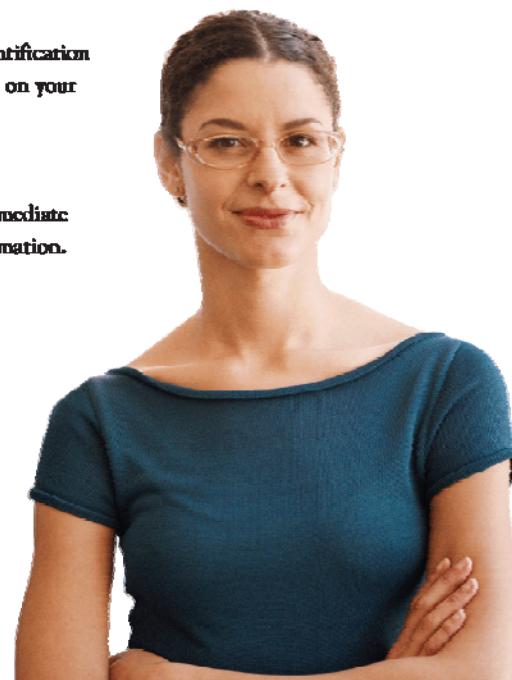
- Check the status of a claim and your claims history
- Confirm who in your family is covered under your plan
- View and print an Explanation of Benefits (EOB) for a claim
- Locate a doctor or hospital in the network
- Select option to stop receiving EOBs in the mail
- Sign up to receive claim status e-mail alerts
- Request a new or replacement member ID card or print a temporary member ID card
- Find and review outcome history for procedures previously performed in hospitals

It's easy to get started

1. Have your group and member identification numbers ready – you can find these on your Blue Cross and Blue Shield ID card
2. Go to www.bcbstx.com
3. Log in to Blue Access for Members
4. Create a user ID and password, for immediate and secure access to your personal information.



BlueCross BlueShield
of Texas





Blue Cross Blue Shield Online Guide

Personal Health Manager

Click on the Personal Health Manager icon on the home page of Blue Access for Members or the My Health section to access online resources and tools to help you set goals and improve your health.

Key features of the Personal Health Manager include:

- A health risk assessment to evaluate your personal health status;
- Fitness and weight loss advice from a team of personal trainers at Ask A Trainer;
- Nutrition advice from registered dieticians with Ask A Dietician;
- Help to manage stress, workplace conflicts and other issues with Ask A Life Coach;
- Health related questions answered online from registered nurses – Blue Care Advisors – with the Ask A Nurse feature;
- A personal health record to keep track of and manage health information within one secure web location;
- Targeted wellness information via e-mail to help manage specific medical conditions, including alerts for screening tests, and reminders for medical appointments and medication refills;
- Access to the online health content, including wellness tracking tools, videos and interactive tutorials; and
- Access to information on exercise, nutrition and lifestyle issues in the For Your Health area of Personal Health Manager.

You can earn Blue PointsSM by using the For Your Health features of Personal Health Manager. After accumulating points, you can redeem them online for gift certificates from major retailers or other rewards of your choice.

You can earn Blue Points for activities that help you take control of your health and wellness, such as,

- Planning and tracking a fitness workout;
- Recording meals and seeing how they fit into your fitness plan;
- Reading or rating articles or recipes, and
- Asking a question of a nurse, coach, trainer or dietitian.

The screenshot shows the homepage of the Blue Cross Blue Shield Online Guide. At the top, there's a navigation bar with links for 'Home' and 'My Home'. Below the navigation is a 'Reminders' section showing a yellow alarm clock icon. To the right is a 'For Your Health' section featuring icons for 'GET FIT', 'EAT RIGHT', 'LIVE WELL', 'KIDS & TEENS', 'ARTICLES & RECIPES', and 'BLUE POINTS'. Further down are sections for 'Common Conditions' (with an 'Allergy Guide' link), 'Know Your Risk' (with a 'Take Your Health Risk Assessment' link), 'Questions / Feedback' (with links for 'Ask A Nurse', 'Ask A Trainer', 'Ask A Dietician', 'Ask A Life Coach', and 'Feedback'), and 'Today's News' (with a news item about Thread Lift). On the left, there's a 'New Messages' section listing several messages and a 'My Tools' sidebar with links for Blood Glucose, Blood Pressure, HbA1C, Triglycerides, and Total Cholesterol.



Blue Cross Blue Shield Online Guide

We strive to maintain the highest level of security and confidentiality by using 128-bit encryption, the industry standard for Internet security.

The screenshot shows the homepage of the Blue Cross Blue Shield of Texas website. At the top, there's a navigation bar with links for Home, My Health, My Coverage, Visits & Claims, Doctors & Hospitals, and User Profile. Below the navigation, a banner says "Welcome to Blue Access for Members AARON! You will not be allowed access to this site after 5/30/4." On the left, there's a sidebar with sections for News & Updates, Message Center (with 2 new messages), and User Profile. The main content area features a "My Coverage" section with a photo of a couple, showing subscriber Aaron J. Smith and coverage details. Below that is a "Medical Visits & Claims" section listing three visits from March 1, 2006, to Nathan Johns MD. To the right, there's a "How Can We Help You?" section with links for various services like "Carry the Card," "Lost or needs temporary ID card?", and "Need to print a paper ID card?". At the bottom right is a "My Health" section with a link to "Visit our My Health section for tools and information to help you make informed health care decisions."

Finding the Provider That's Right for You

We know that finding doctor or hospital that meets your personal needs can be challenging. Our Provider Finder site makes it faster and easier to find providers within the United States with these capabilities:

- Search by Name – Find a doctor, hospital or other health care professional.
- Search by Health Plan/Network – Search for doctors, hospitals and other health care professionals in your health plan/network.
- Search by Provider Type – Find providers from specialists to general practitioners.
- Frequently Asked Questions – Answer common inquiries associated with the Provider Finder and how the tool functions.
- Specialists Glossary – View definitions for terms used to describe specialists.
- Spanish Version – Click on the en Español link to view the Provider Finder in Spanish.

* The HMO Blue® Texas network will not have access to national provider searches outside Texas.

Look no further. Downloadable forms are now available through Blue Access for Members. From applications and claim forms to mail order prescription forms — all are just a click away.



The screenshot shows the "Provider Finder" search interface. It has three main search options: "Search by Name" (search for a doctor, hospital or other health care professional by name), "Search by Health Plan" (search for doctors, hospitals and other health care professionals in your health plan/network), and "Search by Provider Type" (searching for pediatricians, dermatologists or general practitioners). There are also links for "More Searches" (Find Doctors Outside of Texas, Find Providers Outside the US, Find a Physician, Find a Dentist) and "Regional Directories" (a map of Texas). At the bottom, there's a small note about being a division of Health Care Service Corporation, an independent licensee of the Blue Cross and Blue Shield Association, and copyright information.



Blue Cross Blue Shield Online Guide

Other Online Resources for Health Care Information

Hospital Comparison Tool

When your physician has recommended a surgical treatment, you can easily find and review the outcome history of procedures previously performed at hospitals using HealthShare.*

For example, if you're having bypass surgery, you can review a hospital's performance based on factors such as:

- Mortality
- Length of stay
- Complications
- Number of procedures performed
- Cost

To review hospital outcome data, log on to Blue Access for Members, click on the My Health section and select on "Compare Hospitals."



*The relationship between Blue Cross and Blue Shield of Texas and HealthShare Technology, Inc. is solely that of independent contractor.

The screenshot shows the BlueCross BlueShield of Texas website's "My Health - Tools" section. It features a "Personal Health Manager" icon and a "Treatment Cost Advisor" icon. The "Treatment Cost Advisor" section includes a "I need to..." dropdown menu with options like "Find a doctor or hospital", "Compare Hospitals", and "Treatment Cost Advisor". A woman is smiling on the left side of the page.

Treatment Cost Advisor

Through the Treatment Cost Advisor** tool, you can find the typical cost of a health care procedure from a list of common medical conditions.

Members simply need to enter information, such as age, gender and state or zip code to help determine a cost estimate for a specified medical procedure.

Log on to Blue Access® for Members, click on the My Health section and select "Treatment Cost Advisor" to get started.

*All information is intended for your general use only and is not a substitute for medical advice or treatment for specific medical conditions. You should seek prompt medical care for any specific health issues and consult your physician before taking any action on your health conditions. Use of this online service is subject to the Terms and Conditions.

Need help?

If you have trouble logging in to Blue Access for Members, the Internet Help Desk staff is ready to assist you. Call toll-free at (888) 706-0583 between 7 a.m. to 10 p.m. (CT) Monday through Friday and from 7 a.m. to 3:30 p.m. (CT) on Saturday.



**BlueCross BlueShield
of Texas**

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Complementary Alternative Medicine Program



Your Blue Cross and Blue Shield of Texas (BCBSTX) ID card has always been your key to good health, and now it's more valuable than ever.

BlueExtras – our value-added discount program – provides you and your covered dependents access to discounted health-related services typically not covered by your health benefits plan. We're continually enhancing this program, and we're excited to announce the addition of **Complementary Alternative Medicine (CAM)**!

Healthways WholeHealth Networks, Inc. is providing BCBSTX members access to a network of more than 35,000 practitioners, spas, wellness and fitness centers.

What is CAM?

Complementary Alternative Medicine includes a variety of therapies that may help to improve wellness, prevent illness and address existing symptoms and conditions in conjunction with conventional health care (when applicable).

Through your BCBSTX membership, you're automatically eligible to receive **discounts of up to 30 percent off** services such as yoga, Pilates, massage therapy, acupuncture, Tai Chi, nutritional counseling and more! Also included are discounts to spas, and wellness and fitness centers.

BlueExtras

arranges for members and covered dependents to have access to discounts on a variety of alternative and complementary health care services and products.

Health-Related Information at wholehealthmd.com

As a BCBSTX member, you have access to **wholehealthmd.com** which provides guidance on the potential benefits of integrating alternative medicine with conventional health care. The information is developed by a team of board-certified doctors and specialists, and emphasizes collaboration with traditional health care providers. The site includes:

- A comprehensive reference library with information on chronic conditions, integrative therapies, supplements, foods and more
- Health-related news articles
- “The Healing Kitchen” where you can find food remedies and healthy recipes
- Online directory of participating practitioners

Vitamins and Herbal Supplement Discounts

You're also eligible to purchase vitamins and herbal supplements for up to **25 percent off** the regular price. You can order online through Blue Access® for Members (**BAM**) or call **(800) 917-3690**. When placing your order, be sure to provide the customer service agent with your unique code **(AWH-6100)** to receive your discount.

Note: No shipping fees apply when ordering via the Web site. However, there is a \$7 shipping and handling fee if you order by telephone.



**BlueCross BlueShield
of Texas**



Healthy Reading Discounts

Discounts of **50 to 80 percent** are available on health and wellness-related magazines. Topics include: massage, yoga, cooking light, fitness, health and vegetarian eating to name a few. There are no automatic renewals. You can order online through **BAM** or call **(800) 959-1676**.

Who is Eligible?

BlueExtras is available to all members of the BCBSTX plan. Just show your BCBSTX ID card at the time of service. **Note:** Your plan may provide benefits for chiropractic, physical, occupational and other therapies, as well as certain registered dietitian services. Please refer to your benefits booklet for specific benefit information under your health plan.

How do CAM Services Work?

- You pay the discounted member rate directly to participating practitioners, spas, wellness and fitness centers.
- There are no referrals, pre-authorizations or claims to file.
- You can change practitioners at any time and there are no annual limits on how many times you can use the discounts. However, you are obligated to any contracts, such as a fitness center membership.

How to Access CAM Services

For additional information, to find locations nearest you, to use wholehealthmd.com, and to order vitamins and magazines, log into BAM at **www.bcbstx.com/member**. Click on the **My Coverage** tab at the top, and then the **BlueExtras Discount Program** link.

Healthways WholeHealth Networks, Inc. ("Healthways") is an independent contractor which administers the Complementary Alternative Medicine (CAM) discount program for Blue Cross and Blue Shield of Texas (BCBSTX).

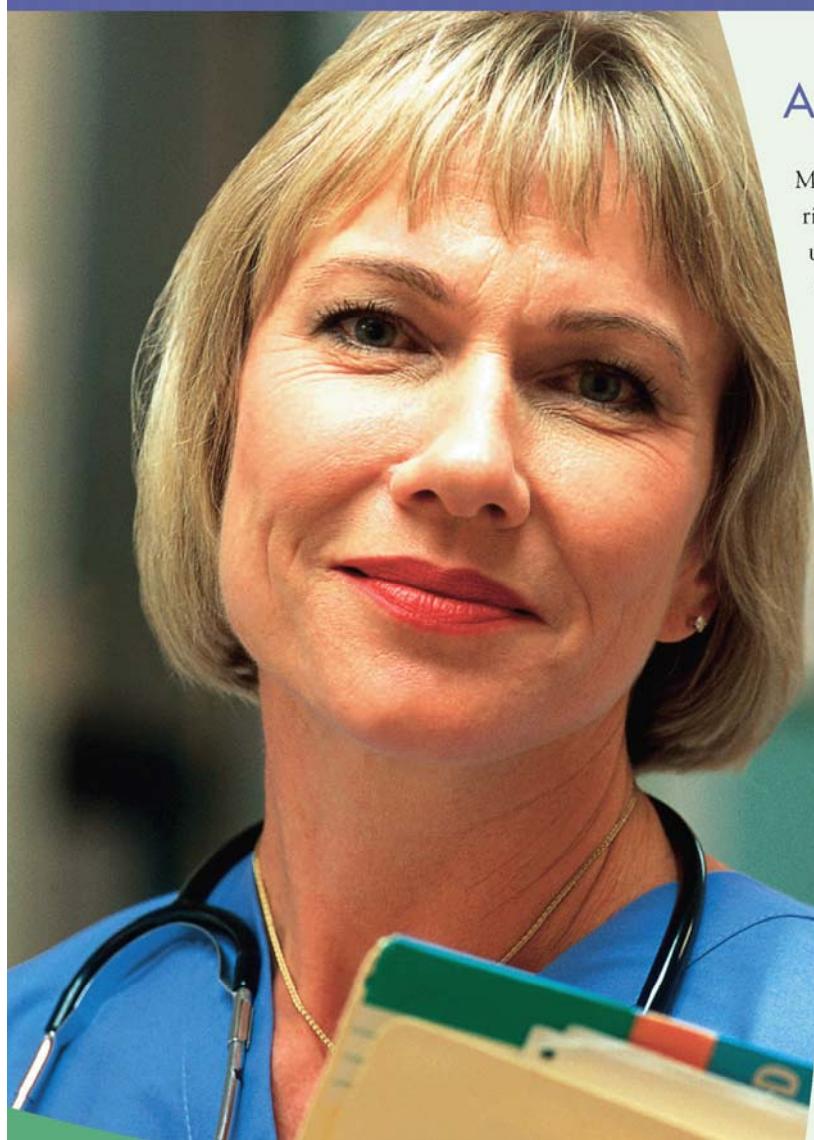
This is a discount program available to BCBSTX members. Some of the services offered through the CAM discount program may be covered under your health plan. Please refer to your benefit booklet or call the customer service number on the back of your ID card for specific benefit information under your health plan. Use of this discount program does not affect your premium, nor do costs of the discount program, services or products count toward your calendar year or lifetime maximums and/or plan deductibles. Discounts are only available through practitioners participating through Healthways in the CAM discount program.

BCBSTX does not guarantee or make any claims or recommendations regarding the services or products offered under the CAM discount program. You may want to consult with your physician prior to use of these services and products. BCBSTX reserves the right to discontinue or change this discount program at any time without notice.

Blue Extras

www.bcbstx.com

24/7 Nurseline



Experience. Wellness. Everywhere.SM



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Answering Your Health Care Needs

Maintaining your health starts by asking the right questions at the right time. And we all know that sometimes those questions come up unexpectedly, like when the doctor's office is closed. That's why Blue Cross and Blue Shield of Texas (BCBSTX) is proud to offer the **24/7 Nurseline**.

Around-the-Clock Access

As part of the **Blue Care® Connection program**, the 24/7 Nurseline provides you with 24-hours a day/seven days a week access via a toll-free telephone number to experienced registered nurses who understand your health care concerns.

The program covers four areas of medical decision making, including: medical concerns, major medical issues, chronic illness support and lifestyle change support.

You'll have around-the-clock access to a knowledgeable nursing staff with years of experience in multiple areas, including:

- Emergency room care
- Urgent care
- Clinical setting
- Family care
- Certified health triage

Audio Health Library

Sometimes you may want to get basic health information on a specific topic. We encourage you to use the 24/7 Nurseline audio library. Just call the 24/7 Nurseline number to choose a topic from more than 1,200 pre-recorded health topics. The program is available in English and Spanish.

Contact Information

The 24/7 Nurseline is available at no out-of-pocket expense to you. All it takes is a simple call to the toll-free phone number listed on the back of your ID card, or you can call the universal phone number through BCBSTX at **1-866-412-8795**.

Note: This service is not a substitute for medical care. You should consult a health professional for diagnosis and treatment.



Important Information

Important Things to Remember

- Be sure that all providers (doctors, labs, x-rays, etc.) participate in-network for the best coverage.
- The choices you make now will remain in effect until the next open enrollment period, unless you experience a family status change.
- **This book highlights some of the main features of your benefit programs, but does not include all plan rules, features, limitations or exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this book and the legal plan documents, the plan documents are the final authority. SEDL reserves the right to change or discontinue its benefit plans at any time.**

Pre-Existing Condition Limitation Notice

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. **All questions about the preexisting condition exclusion and creditable coverage should be directed to Human Resources.**

HIPAA Privacy Notice

HIPAA requires SEDL to notify you that a privacy notice is available. **Please contact Human Resources if you have any questions.**

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for a mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery / reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymphedemas.

In addition, the plan may not:

- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the healthcare provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance, and co-payments consistent with other coverage provided by the plan.

Medicare D Notice

Important Notice from SEDL 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 SEDL 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. SEDL has determined that the prescription drug coverage offered by the SEDL is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current SEDL coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current SEDL coverage, be aware that you and your dependents may not 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 SEDL and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

Medicare D Notice

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information or call **Gallagher Benefit Services, Inc. at (800) 492-8005**. **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 SEDL 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:	May 2010
Name of Entity/Sender:	SEDL
Contact--Position/Office:	Sue Liberty, Human Resources Department
Address:	4700 Mueller Blvd., Austin, TX 78723
Phone Number:	512-476-6861

Eligibility and Enrollment

The open enrollment period for eligible employees of SEDL will be March 26, 2010 to April 22, 2010. The new benefit plan will be effective May 1, 2010.

- You are eligible if you are a full-time employee regularly scheduled to work at least 20 hours a week.
- Individuals may make changes or add dependents without having to provide proof of insurability during the open enrollment period.
- Open enrollment applies to Medical, Dental, and Flexible Spending Account coverage.
- 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).
- You and/or your dependents will receive a HIPAA Certificate of Creditable Coverage at termination from your previous carrier to provide proof of prior coverage.



Making Enrollment Changes During the Year:

In most cases, your benefit elections will remain in effect for the entire plan year (May 1st - April 30th). During the annual enrollment period, you have the opportunity to review your benefit elections and make changes for the coming year.

You may only make changes to your elections during the year if you 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 you or your spouse's benefit eligibility.
- Your benefit change must be consistent with your change in family status.

IRS regulations require that for enrollment due to the qualifying events above, change forms must be submitted to your benefits office within 30 days of that qualifying event. Contact your Human Resources office for these forms.

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, and you live in one of these States, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan - as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**



Medical Terms and Conditions

We understand that, for many people, satisfying your family's health care needs is the first thing you look for in your benefits package. For 2010, SEDL is pleased to provide you with a choice of comprehensive medical plans. Please review each option and consider how it will benefit you and your family members.

PPO Terms and Conditions

** Note: Pre-Existing Condition Limitations do not apply to current SEDL employees who have been enrolled on the health plan for 12 months.

- **Pre-Existing Condition Limitations:** Conditions treated or diagnosed six months prior to your hire date will not be covered for 12 months unless you have maintained continuous coverage for the past 12 months with no more than a 63-day gap in coverage. You should receive a HIPAA certificate at termination from your current carrier to provide proof of coverage. **It is important that you keep this certificate and/or complete this section on the new carrier's application to avoid future claims being denied.**
- **Benefit Payments:** For benefits received in the Network, you are responsible only for your co-payment or deductible amount and coinsurance. Your provider will file the claim. Benefits for Non-Network visits are payable on a reimbursement basis only. You can be subject to additional charges over the reasonable and customary allowed amount.
- **Co-payment:** Co-payments for office visits and prescription drugs do not count toward the deductible or out-of-pocket maximum on the Copay Plan. The deductible on the High Deductible Health Plan (HDHP) does count toward the maximum out of pocket.
- **Dependent Age:** Your dependent children are eligible for coverage on your Medical and Dental plans until the age of 25. They are eligible for Optional Life and Enhanced AD&D coverage until age 23, or to age 25 if a full-time student.
- **Domestic Partners:** Same and opposite sex domestic partners qualify for coverage on the Medical and Dental plans. See Human Resources for an Affidavit of Domestic Partnership Form.
- **Calendar Year Deductible/Out-of-Pocket Maximum:** Expenses incurred towards your calendar year deductible and your out-of-pocket maximum are credited on a calendar year basis. A calendar year is January 1st - December 31st. Your deductible and out-of-pocket maximum will restart January 1st each year; regardless of the expenses you incurred in the prior calendar year or when your annual open enrollment period occurs.



Medical HDHP

**BlueEdge HSA
Embedded Deductible
MH2**



BlueCross BlueShield
of Texas

BENEFIT HIGHLIGHTS

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions

PPO
(In-Network)

Non-PPO
(Out-of-Network)

Calendar Year Deductible

Applies to all Eligible Expenses (unless otherwise indicated)

Family coverage: When one family member meets the individual Deductible, benefits become available under the plan for that individual.

NOTE: The individual Deductible amount must be equal to or greater than the minimum family Deductible amount. This qualification is established by the U. S. Treasury for a plan to be considered a qualified HSA plan.

4th quarter Deductible carryover provision does not apply

Deductible credit from prior carrier (applied on initial group enrollment only)

\$3,000 Individual /
\$6,000 Family

\$6,000 Individual /
\$12,000 Family

Out-of-Pocket Maximum

Deductible, Coinsurance Amounts, and Copayments (if any) apply to Out-of-Pocket Maximum

Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)

\$3,000 Individual /
\$6,000 Family

\$12,000 Individual /
\$24,000 Family

Network Deductible & Out-of-Pocket Maximum will only apply toward Network Deductible & Out-of-Pocket Maximum

Out-of-Network Deductible & Out-of-Pocket Maximum will also apply toward Network Deductible & Out-of-Pocket Maximum

Maximum Lifetime Benefits

Per individual

\$5,000,000*

Inpatient Hospital Expenses

Inpatient Hospital Expenses (must be preauthorized)

Inpatient Hospital Expenses

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Penalty for failure to preauthorize

None

\$250

Medical/Surgical Expenses

Medical / Surgical Expenses

Physician office visit/consultation, including lab & x-ray
Physician surgical services in any setting

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Lab & x-ray in other outpatient facilities & Certain Diagnostic Procedures:
Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast),
Ultrasound, MRI, Myelogram, PET Scan.

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Home Infusion Therapy (must be preauthorized)

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

In Vitro Fertilization Services

Declined

All other outpatient services and supplies

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated



Medical HDHP

**BlueEdge HSA
Embedded Deductible
MH2**



**BlueCross BlueShield
of Texas**

Extended Care Expenses

Extended Care Expenses (must be preauthorized)

Skilled Nursing Facility
Home Health Care
Hospice Care

**P P O
(In-Network)**

100% of Allowable Amount after
Calendar Year Deductible

**N o n - P P O
(Out-of-Network)**

70% of Allowable Amount after
Calendar Year Deductible

\$10,000 Calendar Year maximum*
\$10,000 Calendar Year maximum*
\$20,000 lifetime maximum*

Special Provisions Expenses

Treatment of Chemical Dependency (must be preauthorized)

Inpatient treatment must be provided in a Chemical Dependency Treatment Center
All other outpatient treatment

Three separate series of treatments for each covered individual*
Covered as any other physical illness

Covered as any other physical illness | Covered as any other physical illness

Serious Mental Illness (must be preauthorized)

Inpatient Services
Hospital services (facility)

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Physician services

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

45 inpatient days/45 inpatient Physician visits each Calendar Year*

Outpatient Services

Services performed in a Physician's office, including lab & x-ray

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Other outpatient services and psychological testing

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

60 outpatient visits each Calendar Year*

Mental Health Care (must be preauthorized)

Inpatient Services
Hospital services (facility)

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Physician services

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

30 inpatient days/30 inpatient Physician visits each Calendar Year*

Outpatient Services

Services performed in a Physician's office, including lab & x-ray

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Other outpatient services and psychological testing

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

30 visits each Calendar Year*

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated



Medical HDHP

**BlueEdge HSA
Embedded Deductible
MH2**



BlueCross BlueShield
of Texas

Special Provisions Expenses, cont.

PPO
(In-Network)

Non-PPO
(Out-of-Network)

Emergency Care/Outpatient Hospital Emergency Room

Accidental Injury & Medical Emergency Care (within 48 hours)
Facility charges

100% of Allowable Amount after Calendar Year Deductible

Physician charges

100% of Allowable Amount after Calendar Year Deductible

Non-Emergency Situations (after 48 hours)
Facility charges

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Physician charges

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Urgent Care

Each Urgent Care center visit, including all lab & x-ray services, Certain Diagnostic Procedures, and all other services and supplies

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Preventive Care

Routine annual physical exam office visit, well-baby exam office visit, immunizations (after 6th birthdate), & vision and hearing exams

100% of Allowable Amount

70% of Allowable Amount

Immunizations (birth to the day of the 6th birthdate)

100% of Allowable Amount

100% of Allowable Amount

Speech and Hearing Services

Services to restore loss of or correct an impaired speech or hearing function with hearing aids

Covered same as any other sickness

Covered same as any other sickness

Hearing Aids

100% of Allowable Amount after
Calendar Year Deductible

100% of Allowable Amount after
Calendar Year Deductible

Hearing Aids Maximum Benefit

Hearing aids are subject to a \$1,000 maximum amount each 36-month period*

Physical Medicine Services

Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy)

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

\$1,500 maximum benefit each Calendar Year*

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated

Prescription Drug Program

Participating Pharmacy

Non-Participating Pharmacy
(member files claim)

Prescription Drugs*

Retail Pharmacy

(Dispensing is limited to a 30-day supply, no more than a 90-day supply)

100% of Allowable Amount after the Calendar Year Deductible

Mail Service Pharmacy

(Dispensing is limited to a 30-day supply, no more than a 90-day supply)

100% of Allowable Amount after the Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, or Calendar Year Maximum amounts indicated



Medical HDHP

**BlueEdge HSA
Embedded Deductible
MH2**



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of Texas**

EMPLOYEE INFORMATION

- The following applies to dependent coverage:
 - Dependent children covered for maternity benefits.
 - Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.
- Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance or Out-of-Pocket Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are based on the BCBSTX-determined Allowable Amount. These providers may balance bill covered individuals for charges in excess of the BCBSTX Allowable Amount. The covered individual will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance or Out-of-Pocket Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.
- Preexisting Conditions: This term is defined in the benefit booklet. Conditions determined to be preexisting are excluded for 12 months. Appropriate credit will be given for time served under another health benefit plan as defined under the law.
- Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas State law, the following provisions apply to each eligible Participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the Contract Date):
 - Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
 - Eligible Expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.
- Deductible (Embedded): The benefits of the Plan will be available after satisfaction of the applicable Deductible. The Deductible will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U). The Deductibles are explained as follows:
 1. The individual Deductible amount as shown on this Benefits Highlights under "Calendar Year Deductible," must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will apply to all combined Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses you incur during a Calendar Year. This Deductible must be satisfied by each Participant under your coverage each Calendar Year before any benefits are available under the Plan.
 2. If you have several covered Dependents, all charges used to apply toward a "per individual" Deductible amount will be applied toward the "per family" Deductible amount shown on this Benefits Highlights. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the "per family" Deductible amount.
- Out-of-Pocket Maximum: Most of your Eligible Expense payment obligations are applied to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).
 1. The Out-of-Pocket Maximum will not include:
 - Services, supplies, or charges limited or excluded by the Plan;
 - Expenses not covered because of a benefit maximum has been reached;
 - Any Eligible Expense paid by the Primary Plan when BCBSTX is the Secondary Plan for purposes of coordination of benefits;
 - Penalties for failing to obtain preauthorization;
 2. When the Out-of-Pocket Maximum amount for the In-Network or Out-of-Network Benefits level for a Participant in a Calendar Year equals the "per individual" "Out-of-Pocket Maximum" shown on this Benefits Highlights for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.
 3. When the Out-of-Pocket Maximum amount for the In-Network or Out-of-Network Benefits level for all Participants under your coverage in a Calendar Year equals the "per family" "Out-of-Pocket Maximum" shown on this Benefits Highlights for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of the Calendar Year for that level. No Participant will be required to contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.

‡ Please be reminded that Health Savings Accounts (HSA's) have tax and legal ramifications. Blue Cross and Blue Shield of Texas does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on, for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.



Health Savings Account

Participants in the SEDL High Deductible Health Plan (HDHP) may be eligible to open a Health Savings Account.

A Health Savings Account (HSA) is a tax-advantaged account participants can use to pay for qualified health expenses they incur while covered under a High Deductible Health plan. HSA dollars may also be used to pay for non-qualified health expenses, however the dollars will be taxable income and subject to a 10% penalty. HSA dollars which can be contributed by the employer, employee or others, accumulate over time with interest; investment earnings are tax-free and are portable after employment.

Eligibility Requirements:

In order to open a Health Savings Account, you **MUST** meet the following requirements:

- Covered by the SEDL qualified HDHP
- **NOT** covered by another health insurance plan that is not a qualified HDHP including:
 - * A spouse's medical plan
 - * Medicare
 - * Tricare
 - * Note: Does not apply to specific injury, accident, disability, dental care, vision care and/or long term care insurance plans.
- **NOT** have received VA benefits within the past 3 months
- **NOT** participating in an employer-sponsored unlimited Flexible Spending Account
- **NOT** claimed as a dependent on someone else's tax return
- Your spouse may **NOT** participate in an unlimited Flexible Spending Account.

HSAs allow:

- **Tax-free** contributions by employer, employee or others
- **Tax-free** growth of interest or investment earnings
- **Tax-free** distributions of principal and interest to pay for qualified medical expenses
- **Accumulation** of unused funds and **portability** between employers. No "Use it or Lose it" rules. Portable from employer to employer and across state lines.
- **Flexible use** – You choose whether or when to use the account for health expenses, now or after employment.

In addition to Paying for Current Expenses, funds can be used to pay for:

- COBRA premiums
- Long-term Care premiums
- Out-of-Pocket expenses for Medicare
- Medical insurance during unemployment
- Services not covered under a future health plan



Health Savings Account

If you are covered under the qualified High Deductible Health Plan and meet the eligibility requirements you may open a Health Savings Account (HSA). HSA plans are intended to be used to pay for healthcare for the individual and his or her covered dependents. Distributions from an HSA to pay for qualified health care expenses are not taxable. Qualified health care expenses are expenses which are:

- Incurred for the individual, his/her spouse or a tax dependent;
- Eligible as defined in Internal Revenue Code Section 213(d) – generally defined as expenses for the diagnosis, cure, mitigation, treatment or prevention of disease;
- Not reimbursed by insurance or another health plan; and
- Not deducted on the individual's tax return.

Over-the-counter drugs and medicines can be reimbursed from the HSA as long as they meet the criteria set out in Internal Revenue Code Section 213(d).

Medical expenses that may be reimbursed through a Health Savings Account under IRS Code Section 213 include (but are not limited to) the following:

- Deductible payments;
- Coinsurance payments;
- Dental care not provided through another health insurance plan;
- Prescription drugs;
- Over-the-counter drugs;
- Emergency ambulance service;
- Chiropractic services;
- Eyeglasses and/or contact lenses;
- Hearing devices;
- Psychiatric care; and
- Psychologists' fees.
- Acupuncture

*** You are responsible for the eligibility of all items and keeping receipts for tax purposes ***

Not all expenses that are qualified health care expenses under the HSA count towards the satisfaction of the calendar year deductible. ie; over the counter medications



Health Savings Account

Contributing to your HSA

When you participate in an HDHP, you set aside money to pay for eligible out-of-pocket expenses. Money can be contributed to your HSA by you, SEDL, or anyone else. The IRS 2010 calendar year maximums for these savings accounts will be as follows:

HSA Contributions for 2010:

	2010 Annual Max	Employer Payment	**Employee Can Add Maximum
Single Coverage	\$3,050	\$803.28	\$2,246.72
Family Coverage	\$6,150	\$803.28	\$5,346.72
Catch-up provision for ages 55 & older	\$1,000	\$0	\$1,000

A Calendar Year is the 12-month period of January 1st - December 31st

If you are age 55 or older, you can make an additional contribution amount of \$1000. **The HSA cannot receive contributions after the individual has enrolled in Medicare.** For the most current HSA contribution information, please go to the U.S. Dept. of Treasury web site at <http://www.ustreas.gov/offices/public-affairs/hsa>.

****Note for Newly Eligible and Partial Year Participants:** If you become newly eligible to contribute to an HSA during the year, you may contribute the maximum contribution for the year (without incurring taxes or a penalty on the amount of the contribution) provided you continue to remain eligible for a 13 - month period beginning December 1 of the year in which you become eligible and ending on December 31st of the following year.

If you are eligible to contribute to an HSA for a partial year (less than 12 months between January 1st and December 31st) and do not remain eligible for the 13 - month period shown above, then your excess HSA contributions will be subject to Federal income taxes and a 10% penalty. Please contact your tax advisor for assistance determining if your partial year contributions will be subject to taxes and penalties.

Using your HSA

With an HSA, your contributions, earnings and eligible withdrawals are all tax-free at the federal level. As long as your withdrawals are used to pay for qualified health care expenses, you won't pay taxes. Contributions that SEDL makes to your HSA are yours. There are no vesting requirements or forfeiture provisions. And unlike flexible spending accounts, HSAs do not have a "use it or lose it" requirement. Your account balance rolls over from year to year and may earn interest - tax-free at the federal level. You may contribute to your account until the April 15 tax deadline following the year for which you want to make contributions.

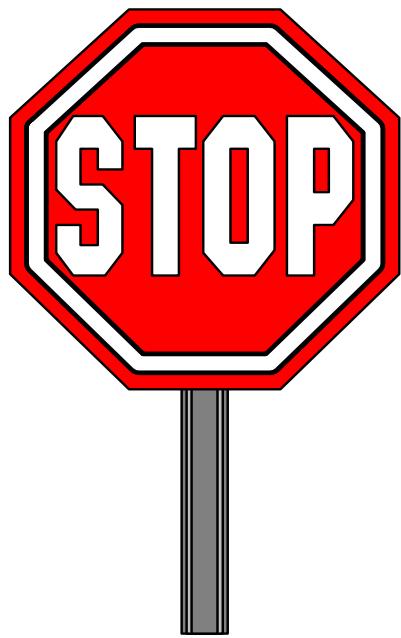
Tax Filing

You will receive a 1099SA and a 5498SA and be required to file Form 8889 with your annual tax return. Please see your tax advisor if you have any questions.



Health Savings Account

**If your Spouse is enrolled
in a Flexible Spending
Account**



**You may NOT contribute to a
Health Savings Account**

A Flexible Spending Account (FSA) is considered first dollar coverage for the Beneficiary and their Dependents therefore you may not open your HSA until your Spouse no longer participates in a FSA.



Medical Copay Plan

Preferred Provider Benefit Plan (PPO) – M25



BlueCross BlueShield
of Texas

BENEFIT HIGHLIGHTS

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
Calendar Year Deductible (Combined) Applies to all Eligible Expenses (unless otherwise indicated)	\$3000 Individual / \$9000 Family	
4 th quarter Deductible carryover applies Deductible credit from prior carrier (applied on initial group enrollment only)	Yes Yes	
Copayment Amounts Required Physician office visit/consultation Urgent Care center visit Outpatient Hospital Emergency Room visit	\$30 Copayment Amount \$55 Copayment Amount \$100 Copayment Amount	\$100 Copayment Amount
Coinurance Stop-Loss Amount Deductibles are not applied to Coinsurance Stop-Loss Amount. Your benefit booklet will provide more details. Credit for Coinsurance Stop-Loss Amount from prior carrier (applied on initial group enrollment only)	\$0 Individual / \$0 Family Network Coinsurance Stop-Loss Amount will only apply toward Network Coinsurance Stop-Loss Amount Yes	\$10,000 Individual / \$30,000 Family Out-of-Network Coinsurance Stop-Loss Amount will also apply toward Network Coinsurance Stop-Loss Amount Yes
Maximum Lifetime Benefits Per individual	\$5,000,000*	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses (must be preauthorized) Inpatient Hospital Expenses Penalty for failure to preauthorize	100% of Allowable Amount after Calendar Year Deductible None	70% of Allowable Amount after Calendar Year Deductible \$250
Medical/Surgical Expenses		
Medical / Surgical Expenses Physician office visit/consultation, including lab & x-ray Physician surgical services in any setting Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures) Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan Home Infusion Therapy (must be preauthorized) In Vitro Fertilization Services All other outpatient services and supplies	100% of Allowable Amount after \$30 Copayment Amount 100% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount 100% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount after Calendar Year Deductible Declined 100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, or Calendar Year Maximum amounts indicated



Medical Copay Plan

Preferred Provider Benefit Plan (PPO) – M25



BlueCross BlueShield
of Texas

Extended Care Expenses

Extended Care Expenses (must be preauthorized)

Skilled Nursing Facility
Home Health Care
Hospice Care

PPO (In-Network)

100% of Allowable Amount

Non-PPO (Out-of-Network)

70% of Allowable Amount after
Calendar Year Deductible

\$10,000 Calendar Year maximum*
\$10,000 Calendar Year maximum*
\$20,000 lifetime maximum*

Special Provisions Expenses

Treatment of Chemical Dependency (must be preauthorized)

Inpatient treatment must be provided in a Chemical Dependency Treatment Center

Three separate series of treatments for each covered individual*

All other outpatient treatment

Covered as any other sickness

Covered as any other sickness

Serious Mental Illness (must be preauthorized)

Inpatient Services
Hospital services (facility)

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Physician services

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

45 inpatient days/45 inpatient Physician visits each Calendar Year*

Outpatient Services

Physician office visit/consultation, including lab & x-ray

100% of Allowable Amount after \$30
Copayment Amount

70% of Allowable Amount after
Calendar Year Deductible

Other outpatient services, including psychological testing

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

60 outpatient visits each Calendar Year*

Mental Health Care (must be preauthorized)

Inpatient Services
Hospital services (facility)

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Physician services

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

30 inpatient days/30 inpatient Physician visits each Calendar Year*

Outpatient Services

Physician office visit/consultation, including lab & x-ray

100% of Allowable Amount after \$30
Copayment Amount

70% of Allowable Amount after
Calendar Year Deductible

Other outpatient services, including psychological testing

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

30 visits each Calendar Year*

Emergency Care/Outpatient Hospital Emergency Room

Accidental Injury & Medical Emergency Care (within 48 hours)
Facility charges

100% of Allowable Amount after \$100 Copayment Amount
(Copayment Amount waived if admitted)

Physician charges

100% of Allowable Amount after Calendar Year Deductible

Non-Emergency Situations (after 48 hours)
Facility charges

100% of Allowable Amount after \$100
Copayment Amount (Copayment
Amount waived if admitted)
70% of Allowable Amount after \$100
Copayment Amount & Calendar Year
Deductible (Copayment Amount
waived if admitted)

Physician charges

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, or Calendar Year Maximum amounts indicated



Medical Copay Plan

Preferred Provider Benefit Plan (PPO) – M25



BlueCross BlueShield
of Texas

Special Provisions Expenses, cont.

	P P O (In-Network)	N o n - P P O (Out-of-Network)
Urgent Care Services		
Urgent Care center visit, including all lab & x-ray services, except Certain Diagnostic Procedures	100% of Allowable Amount after \$55 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures and all services and supplies	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Preventive Care		
Routine annual physicals, well-baby care, immunizations (after 6 th birthdate), vision and hearing exams	100% of Allowable Amount after \$30 Copayment Amount	70% of allowable Amount after Calendar Year Deductible
Immunizations (birth through the day of the 6 th birthdate)	100% of Allowable Amount	100% of Allowable Amount
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function	Covered same as any other sickness	Covered same as any other sickness
Hearing Aids	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Hearing Aids Maximum Benefit	Hearing aids are subject to a \$1,000 maximum amount each 36-month period*	
Physical Medicine Services		
Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy)	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	\$1,500 maximum benefit each Calendar Year*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, or Calendar Year Maximum amounts indicated

Prescription Drug Program	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
Prescription Drugs		
Retail Prescription** (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	\$10 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name	\$40 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	\$60 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Mail Service Prescription** (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	\$10 Copayment Amount	
Preferred Brand Name	\$40 Copayment Amount	
Non -Preferred Brand Name	\$60 Copayment Amount	

**Generic Incentive-Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Preferred/Non-Preferred Brand Name Drug, plus the Preferred Brand Name Copayment Amount.

Diabetes Supplies are available under the Prescription Drug Program portion of your plan. Diabetes Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucagon emergency kits, and other injection aids. All provisions of this portion of the plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.

Flu vaccinations are available through certain pharmacies for BCBSTX members. You will be charged \$15.00 Copayment for each vaccination received. Additional information is available on our website at www.bcbstx.com.



Medical Copay Plan

Preferred Provider Benefit Plan (PPO) – M25



BlueCross BlueShield
of Texas

EMPLOYEE INFORMATION

The following benefits apply to dependent coverage:

- Dependent children are covered for maternity benefits.
- Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.

Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance or Out-of-Pocket Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are based on the BCBSTX-determined Allowable Amount. These providers may balance bill covered individuals for charges in excess of the BCBSTX Allowable Amount. The covered individual will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance or Out-of-Pocket Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

Preexisting conditions are defined in the benefit booklet and are excluded for 12 months. Appropriate credit will be given for time served under Creditable Coverage as defined under the law and shown in your benefit booklet.

Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas State law, the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the contract date):

- Benefits for Eligible Expenses incurred for any service or supplies prior to the Contract Date, are not covered under the contract.
- Eligible Expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

Members residing in other states may use that state's network through the BlueCard program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our web site at www.bcbstx.com to use our Provider Finder® tool.



Dental Plan Summary

Blue Cross® and Blue Shield® of Texas*
BlueCare® Freedom Dental
D202 Summary of Benefits

TYPE OF SERVICE	BENEFIT**
GENERAL PROVISIONS Calendar Year Deductible (4th quarter carryover applies) Deductible Credit from Prior Carrier Calendar Year Maximum per Participant	\$50 Indiv/\$150 Family No \$1500
DIAGNOSTIC AND PREVENTIVE CARE BENEFITS (deductible waived) Oral Examinations (2 exams per Calendar Year) Prophylaxis (2 cleanings per Calendar Year) Fluoride Treatment Dental X-rays (Subject to booklet provisions)	100%
MISCELLANEOUS SERVICES Sealants/ Space Maintainers / Lab Tests / Palliative Care	80%
RESTORATIVE SERVICES Amalgams & Composites / Simple Extractions / Pin Retention	80%
GENERAL SERVICES Anesthesia / Stainless Steel Crowns	50%
ENDODONTIC SERVICES Root canal therapy/ Direct pulp cap / Apicoectomy/apexification / Retrograde filling Root amputation/hemisection / Therapeutic pulpotomy / Gross pulpal debridement	50%
PERIODONTAL SERVICES Periodontal scaling and root planning / Full mouth debridement / Gingivectomy/gingivoplasty Gingival flap procedure/ Osseous surgery/ Osseous grafts / Soft tissue grafts	50%
ORAL SURGERY SERVICES Surgical tooth extractions/ Alveoloplasty / Vestibuloplasty	50%
CROWNS, INLAYS/ONLAYS SERVICES Prefabricated post and cores / Recementation of crowns, inlays/onlays / Crown repair	50%
PROSTHODONTIC SERVICES Reline/Rebase / Bridges and dentures / Recementation and repair of bridges	50%
ORTHODONTIC BENEFITS Orthodontic Diagnostic Procedures and Treatment / Available to Adults and Children Lifetime Maximum per Participant	N/A N/A

** Each time you need dental care, you can choose to:

See a Contracting Dentist	See a Non-Contracting Dentist
BlueCare Dentist	DentaBlue Dentist

- This is a general summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.
- The following eligibility provisions apply:
 - Dependent children are covered to age 25. Disabled dependent children can be covered beyond age 25.
 - Retirees are not eligible for coverage.
 - Employees may enroll dependent children up to age 5 on the first of the month following application with no late enrollment penalty.
 - Open enrollment – employees and/or dependents not presently covered may enroll for dental 31 days prior to the anniversary date.
- An exclusion will apply to expenses involving the replacement of teeth that were missing prior to the effective date of the dental contract. All other benefits will begin on the first day of coverage. This exclusion will not apply to:
 - Any participant who becomes effective on the dental contract date who was covered under a previous group dental care contract by the Employer.
 - Any participant who has been continuously covered for 24 months under a group dental care contract with BCBSTX which included prosthetic benefits.
 - A partial or full denture or fixed bridge which includes replacement of a missing tooth which was extracted after coverage becomes effective.
- When the course of treatment will be in excess of \$300, a predetermination request should be submitted to BCBSTX in advance of treatment.
- Plan D202 is available to group sizes of 2 or more employees.



Group Term Life and AD&D Insurance

Basic Group Term Life for Employees:

Applies Only to:

Excludes:

100% Employer Paid

Benefit =

Regular Employees

Temps and Board Members

1 x Annual Salary to a maximum of \$100,000

Basic AD&D for Employees:

Applies Only to:

Excludes:

100% Employer Paid

Benefit =

Regular Employees

Temps and Board Members

1 x Annual Salary to a maximum of \$100,000

(Optional) Basic Dependent Term Life

Available only to:

Excludes:

100% Employee Paid

Spouse Benefit =

Child(ren) Benefit =

Dependents of regular employees

Dependents of Temps or Board Members

\$5,000

\$2,000

Enhanced AD&D Insurance for Employees:

Applies only to:

100% Employer Paid

Benefit =

Regular Employees and Temps who travel,
and Board Members

\$100,000 per employee covered

(Optional) Enhanced AD&D Insurance for Dependents

Applies only to:

Excludes:

100% Employee Paid

Employee & Spouse Benefit =

Employee & Child(ren) Benefit =

Employee, Spouse & Child Benefit =

Dependents of Regular Employees

Dependents of Temps who travel

and Board Members

Spouse amount is 60% of the employee amount

Child amount is 20% of the employee amount

Spouse amount is 40% of the employee amount

Child amount is 10% of the employee amount





Group Voluntary/Universal Life

Group Voluntary Term/Universal Life

Plan Options

Option	Employee	Spouse*	Children 14 days to 6 months*	Children 6 months to 23 years*
A	\$ 25,000	\$ 12,500	\$ 500	\$ 2,500
B	\$ 50,000	\$ 25,000	\$ 500	\$ 5,000
C	\$ 75,000	\$ 37,500	\$ 500	\$ 7,500
D	\$ 100,000	\$ 50,000	\$ 500	\$10,000

***Dependent Coverage:** Your spouse is eligible for up to 50% of the employee's approved amount. Your dependent child(ren) is eligible for up to 10% of the employee's approved amount to a maximum of \$10,000, for ages 6 months to 23 (25 if a full time student); \$500 for ages 14 days to 6 months.

GROUP TERM LIFE

- ❖ Temporary Insurance
- ❖ Initially Lower Group Rates adjusted on 5 Year Age Bands
- ❖ Pure Insurance
- ❖ No Cash Accumulation
- ❖ Lower cost in short run
- ❖ Benefits start reducing at age 65

Amounts of life insurance are reduced by 35% at age 65, an additional 25% at age 70, an additional 15% at age 75, and a final 10% at age 80. Spouse coverage will terminate at age 70.

GROUP UNIVERSAL LIFE

- ❖ Permanent Protection
- ❖ Level Premiums
- ❖ Tax-Deferred Cash Accumulation
- ❖ Lowest cost in long run
- ❖ No Benefit reduction schedule

Combined Guaranteed Issue amounts of coverage

The proposed plan offers the following guaranteed issue amounts for employees and their dependents under age 65. The guaranteed amount applies to the GUL election first.

<u>Employee</u>	<u>Spouse</u>	<u>Child(ren)</u>
\$ 100,000	\$ 10,000	\$ 10,000

Employees and dependents declining coverage during their initial eligibility period are late entrants and must complete a health statement for all amounts.

ADDITIONAL AMOUNT QUESTION (on enrollment form): Dependent spouses under age 65 can qualify for up to an additional \$40,000 of coverage by answering "No" to the additional question. A "Yes" response to the additional question requires proof of insurability for all amounts above the Guarantee Issue levels shown above. An Evidence of Insurability Form must be completed and submitted with the Enrollment Form.

*Testing may be required for higher amounts.

If you are age 65 to 69 you must complete the simple health questionnaire for amounts over \$10,000; over \$5,000 if your spouse is age 65 to 69. If you are age 70 or older you must complete the simple health questionnaire for all amounts.

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



Group Voluntary/Universal Life

Group Voluntary Term/Universal Life

Plan Features

Group Voluntary Term Life:

Waiver of Premium to age 60: If an employee becomes totally and permanently disabled prior to age 60, with premiums waived to age 65 his/her life insurance will continue in force without further payment of premium on a year-to-year basis, subject to periodic submission of evidence of total and permanent disability.

Conversion: Allows you to convert your insurance without evidence of insurability to an individual Life policy issued by Guardian. You are eligible for this benefit if your employment or membership in the eligible class terminates. Election and premium payment must be made within 31 days of termination.

Portability: Allows employees to continue low cost term protection if they no longer work for the group (for reasons other than injury or illness or the termination of the policy), provided the employee and any eligible dependents have been insured for Voluntary Life at least three months. Surviving spouses may also elect to continue coverage for themselves and all eligible child(ren).

Seatbelt and Airbag Benefit: The beneficiary will receive an additional \$10,000 benefit for the employee, \$5,000 for the dependent if properly wearing a seatbelt; and an additional \$5,000 for the employee, \$2,500 for the dependent if you are sitting in a seat equipped with an airbag.

Accelerated Life Benefit: If an employee has a medical condition that is expected to result in his or her death within 12 months, such employee may apply for an Accelerated Life Benefit. An Accelerated Life Benefit is a payment of part of an employee's group term life insurance made to him or her before he or she dies. The minimum benefit amount is the lesser of: (a) \$10,000; or (b) 50% of the in force amount. The maximum benefit amount is the lesser of: (a) \$100,000; or (b) 50% of the in force amount. A fee of up to \$150 may also be required for the administrative cost of evaluating and processing an employee's Accelerated Life Benefit.

Group Universal Life

Waiver of Premium to age 60: If an employee becomes totally and permanently disabled prior to age 60, his/her life insurance will continue in force without further payment of premium, but not beyond age 70. This excludes the cost for any additional benefit riders. It is also subject to periodic submission of evidence of total and permanent disability.

Portability: GUL has portability built into the certificate, providing you with truly permanent protection at no extra cost. You may take the coverage with you if you retire or change jobs. Guardian will simply bill you at home.

Accelerated Life Benefit: Up to 50% of the death benefit if terminally ill (with a minimum of \$10,000 and a maximum of \$100,000) available for groups who qualify.

Accidental Death: You may elect additional coverage (up to two times the employee's life amount), which provides protection in the event of an accidental death.

Accessible Funds: Various life events may create a need to access money. College funding, the down payment on a home, a supplement to retirement income or an emergency are just a few examples. Employees have easy access to their money through partial withdrawals or loans.



Group Voluntary/Universal Life

Group Voluntary Term/Universal Life

Questions & Answers

Group Universal Life:

What is Group Universal Life (GUL) Insurance?

GUL is permanent, flexible life insurance. It allows you to change the death benefit (with satisfactory evidence of insurability for increases) and vary the amount or timing of premium payments. GUL offers employees a chance to purchase permanent life coverage, with little or no underwriting, through the workplace.

How is GUL similar/different to a whole life policy?

GUL offers many of the same features as a whole life policy such as lifetime guarantees, tax deferred cash accumulation and loan provisions. With whole life insurance, premiums are not flexible and the interest is generally adjusted annually, with GUL it is adjusted monthly.

When do my cash values begin to accumulate, and how can I track how much cash is in my fund?

GUL is designed so that cash values begin appearing during the second certificate year when minimum premiums are paid, but if you decide to pay an amount higher than the minimum your cash value may appear by the end of the first year. In fact, our product's cash values appear far earlier than is generally found in the marketplace. To keep you up to date on the growth of your plan, each year you will receive an annual report. However, anytime you need, you may contact a Guardian representative to inquire about your cash value amount.

Are the cash values easily accessible?

Yes. You have the option of taking a partial withdrawal (a full withdrawal/surrender would result in a termination of coverage) or a loan. What's more, even when you take out a loan, your cash fund will continue to earn interest. (A full withdrawal/surrender from your fund would result in termination of coverage.)

What additional benefits does GUL offer?

GUL offers flexible premiums that do not increase every five years; tax favored cash accumulation and coverage that can extend past retirement.

Group Universal Life and Group Voluntary Term Life:

How do I elect a beneficiary?

Indicate the beneficiary(ies) on your enrollment form. You can elect anyone you wish, except for your employer. You (or your estate) are the beneficiary if your covered spouse or child dies.

If my future needs change, can I increase my insurance?

Yes, but any increase is subject to evidence of insurability.

Do I need to get a physical exam?

Generally, no. In a few cases, for excess amounts of coverage, a physical exam may be required. If so, Guardian will assume the costs of the exam. In addition, if you choose to enroll at a later date, a health statement will be required for all amounts and approval is not guaranteed.

How are my rates determined?

The employee and spouse rates are based on the employee's age and the individual's premium class for Group Universal Life. The rates for Term Life are grouped in five-year age bands and will change as you move from one age band to the next. Your premiums will be adjusted either on the group's anniversary date or on your actual birthdate, depending upon which option your employer elected.

Important Information about Group Universal Life Insurance and Group Voluntary Term Life: The Guardian's liability is limited if an insured's death occurs due to an injury or sickness and before an employee completes a specified waiting period on a full-time basis without missing a work day due to that injury or sickness. We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefits. This exclusion may vary according to state law. We pay no accidental death benefits for an insured where death or dismemberment occurs: while driving an automobile legally intoxicated; while voluntarily using a non-prescription controlled substance; through intentional self-injury; while participating in a civil disorder or undeclared or committing a felony; while the member of a flight crew or a trainee in an aircraft; by declared or undeclared war or act of war or armed aggression; while a member of any armed force; or as the result of disease or bodily infirmity. Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses their group coverage before an accelerated benefit is paid.



Group Voluntary/Universal Life

OPTIONAL TERM LIFE COST SUMMARY - MONTHLY PREMIUMS

EMPLOYEE'S AGE:	PLAN 1	PLAN 2	PLAN 3	PLAN 4	PLAN 5	PLAN 6
	\$ 25,000	\$ 50,000	\$ 75,000	\$ 100,000	\$ -	\$ -

LESS THAN AGE 30

EMPLOYEE ONLY	\$1.50	\$3.00	\$4.50	\$6.00	\$0.00	\$0.00
EMP. & SPOUSE	2.25	4.50	6.75	9.00	0.00	0.00
EMP. & CHILDREN	1.93	3.85	5.78	7.70	0.00	0.00
EMP/SPOUSE/CHILDREN	2.68	5.35	8.03	10.70	0.00	0.00

AGE 30-34

EMPLOYEE ONLY	\$2.00	\$4.00	\$6.00	\$8.00	\$0.00	\$0.00
EMP. & SPOUSE	3.00	6.00	9.00	12.00	0.00	0.00
EMP. & CHILDREN	2.43	4.85	7.28	9.70	0.00	0.00
EMP/SPOUSE/CHILDREN	3.43	6.85	10.28	13.70	0.00	0.00

AGE 35-39

EMPLOYEE ONLY	\$3.00	\$6.00	\$9.00	\$12.00	\$0.00	\$0.00
EMP. & SPOUSE	4.50	9.00	13.50	18.00	0.00	0.00
EMP. & CHILDREN	3.43	6.85	10.28	13.70	0.00	0.00
EMP/SPOUSE/CHILDREN	4.93	9.85	14.78	19.70	0.00	0.00

AGE 40-44

EMPLOYEE ONLY	\$4.50	\$9.00	\$13.50	\$18.00	\$0.00	\$0.00
EMP. & SPOUSE	6.75	13.50	20.25	27.00	0.00	0.00
EMP. & CHILDREN	4.93	9.85	14.78	19.70	0.00	0.00
EMP/SPOUSE/CHILDREN	7.18	14.35	21.53	28.70	0.00	0.00

AGE 45-49

EMPLOYEE ONLY	\$8.75	\$17.50	\$26.25	\$35.00	\$0.00	\$0.00
EMP. & SPOUSE	13.13	26.25	39.38	52.50	0.00	0.00
EMP. & CHILDREN	9.18	18.35	27.53	36.70	0.00	0.00
EMP/SPOUSE/CHILDREN	13.55	27.10	40.65	54.20	0.00	0.00

AGE 50-54

EMPLOYEE ONLY	\$14.75	\$29.50	\$44.25	\$59.00	\$0.00	\$0.00
EMP. & SPOUSE	22.13	44.25	66.38	88.50	0.00	0.00
EMP. & CHILDREN	15.18	30.35	45.53	60.70	0.00	0.00
EMP/SPOUSE/CHILDREN	22.55	45.10	67.65	90.20	0.00	0.00

AGE 55-59

EMPLOYEE ONLY	\$24.00	\$48.00	\$72.00	\$96.00	\$0.00	\$0.00
EMP. & SPOUSE	36.00	72.00	108.00	144.00	0.00	0.00
EMP. & CHILDREN	24.43	48.85	73.28	97.70	0.00	0.00
EMP/SPOUSE/CHILDREN	36.43	72.85	109.28	145.70	0.00	0.00

AGE 60-64

EMPLOYEE ONLY	\$35.75	\$71.50	\$107.25	\$143.00	\$0.00	\$0.00
EMP. & SPOUSE	53.63	107.25	160.88	214.50	0.00	0.00
EMP. & CHILDREN	36.18	72.35	108.53	144.70	0.00	0.00
EMP/SPOUSE/CHILDREN	54.05	108.10	162.15	216.20	0.00	0.00



Flexible Spending Account

FLEX  CORP

FLEXIBLE EMPLOYEE BENEFIT PLAN (CAFETERIA PLAN) GENERAL OVERVIEW

Flex Corp, a BPAH company, is a nationally recognized provider of cafeteria and flexible employee benefit plan administration. Since 1986, Flex Corp has provided professional expertise in the consulting, design and administration of cafeteria plans, and healthcare/ dependent care reimbursement accounts, servicing clients throughout the United States from its headquarters in Houston, Texas.

CAFETERIA PLAN

A Flexible Employee Benefit Plan is a voluntary plan, which allows you to pay for the following expenses before taxes:

- Group Insurance Premiums
- Medical, dental and vision care costs not covered by insurance
- Over-the-counter drugs/medicines
- Dependent care expenses

The plan allows you to reduce your taxable income by the cost of your benefits. This results in both social security and federal withholding taxes being reduced, producing a net increase in your take home pay.

THE TAX BENEFIT CAN WORK FOR YOU:

	WITHOUT PLAN	WITH PLAN
Annual Salary	\$40,000	\$40,000
Pre-taxed Insurance Premiums	0	2,400
Expenses Paid by Reimbursement Account	0	1,000
Taxable Salary	\$40,000	\$36,600
Taxes (25%)	10,000	9,150
After-tax Premiums	2,400	0
Out of Pocket Medical Expenses	1,000	0
TAKE-HOME PAY	\$26,600	\$27,450
SAVINGS WITH CAFETERIA PLAN AND REIMBURSEMENT ACCOUNTS	N/A	\$850

Individuals are often under the impression that all "medical expenses" can be deductible from the individual's tax return. Generally, that is not the case. The expenses that can be deducted on the tax return are those expenses over 7.5% of the individual's adjusted gross income. The expenses incurred under the 7.5% of adjusted gross income cannot be deducted. (See the following example.)

Adjusted Gross Income: \$20,000

Flexible Spending Account (FSA) Limit: \$3,000

Tax Return Deduction:

Ex. 1) $\$20,000 \times 7.5\% = \$1,500$ Incurred medical expenses: \$1,000 Amount deductible from tax return: \$0
 $\$20,000 - \$0 = \$20,000$ taxable income

Ex. 2) $\$20,000 \times 7.5\% = \$1,500$ Incurred medical expenses: \$2,000 Amount deductible from tax return: \$500
 $\$20,000 - \$500 = \$19,500$ taxable income

Can only deductable expense over the 7.5% of adjusted gross income.

Flexible Spending Account Reimbursement:

Ex. 1) FSA Election: \$1,000 Incurred medical expenses: \$1,000 Amount deductible from gross income: \$1,000
 $\$20,000 - \$1,000 = \$19,000$ taxable income

Ex. 2) FSA Election: \$2,000 Incurred medical expenses: \$2,000 Amount deductible from gross income: \$2,000
 $\$20,000 - \$2,000 = \$18,000$ taxable income

Also note that the tax deduction is only reducing Federal Taxes while the FSA contribution is reducing both Federal and FICA Taxes

FLEX  CORP



Flexible Spending Account

GENERAL OVERVIEW

HEALTH CARE REIMBURSEMENT ACCOUNT (HCRA)

A reimbursement account is a voluntary tax-free account designed to allow you to keep more of your paycheck and lower your taxable W-2 wages. Through payroll reduction you can set aside money on a tax-free (you pay no federal or FICA taxes) basis to reimburse yourself for eligible non-insured medical, dental, vision care and over-the-counter drug/medicine expenses incurred by you, your spouse and your eligible dependents. Reimbursable expenses include, but are not limited to, doctor visit co-pays, prescription co-pays, medical and dental deductibles, co-insurance, eyeglasses, contacts, saline solution, lasik procedures, orthodontia and over-the-counter drugs/medicines.

Each time you have an out-of-pocket expense, simply submit your receipts along with a completed request for reimbursement form directly to Flex Corp. Flex Corp will process the receipts and a reimbursement check will be sent to your home or if elected, deposited directly to your checking or savings account.

ELIGIBLE DEPENDENTS

Reimbursement accounts are designed to provide for both you and your family. You may use your reimbursement account to cover the expenses for any eligible dependent, whether or not that dependent is covered under your employer's health insurance. Your dependents do not have to be covered under the company's medical or dental plans to participate in the Health Care Reimbursement Account for eligible medical or dental expenses. Eligible dependents are your spouse and/or any "qualifying child(ren)" and/or individuals that meet the definition of a "qualifying relative" as described below.

"Qualifying child(ren)" must:

- Bear a specified relationship to the taxpayer;
- Have the same principal place of residence as the taxpayer for more than one-half of the taxable year;
- Satisfy age requirements (i.e. must not have attained age 19 or age 24 for a student, before the close of the calendar year in which the taxable year of the taxpayer begins) or must be totally and permanently disabled; and
- Not provide more than one-half of his or her own support.

It should be noted that the new definition did not change the rules as they apply to children of divorced parents; those rules remain intact.

Expenses for other dependents are eligible provided the individual meets the definition of a "qualifying relative" as described below:

- Bear a specified relationship to the taxpayer or be an individual (other than a spouse) who has the same principal place of residence as the taxpayer and is a member of the taxpayer's household;
- Receive over one-half of his or her support from the taxpayer; and
- Not be a qualifying child of the taxpayer or any other taxpayer.

As described by IRS rules under The Working Families Tax Relief Act of 2004, an employee's domestic partner is not eligible for benefits under the flexible spending accounts unless the individual meets the definition of a "qualifying relative" as described above.

ELECTIONS CHANGES

You may change your election for any new plan year prior to the beginning of the year. An election, once made, cannot be changed during the year unless there has been a qualified change in status. Examples of status changes are:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a spouse or child
- Beginning or end of spouse's employment
- Reduction in hours worked, which affects eligibility for benefits



Flexible Spending Account

GENERAL OVERVIEW

ELIGIBLE EXPENSES

The IRS has defined a list of expenses, which you can purchase with your tax-free dollars. As a general rule, if a doctor deems an item medically necessary, it is considered an eligible expense. Below is a listing of eligible expenses as listed under Section 213 of the IRS Code as modified from time to time:

DENTAL SERVICES

- Crowns/Bridges
- Dental X-Rays
- Dentures
- Exams/Teeth Cleaning
- Extractions
- Fillings
- Gum Treatment
- Oral Surgery
- Orthodontia/Braces

INSURANCE-RELATED ITEMS

- Co-pay Amounts
- Deductibles
- Private Hospital Room Differential

LAB EXAMS/TESTS

- Blood Tests
- Cardiographs
- Diagnostic
- Laboratory Fees
- Metabolism Tests
- Spinal Fluid Tests
- X-Rays

MEDICATIONS

- Insulin
- Prescribed Birth Control
- Prescription Drugs

OBSTETRIC SERVICES

- Mid-Wife Expenses
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees
- Post-Natal/Pre-Natal Treatment
- Pre-Natal Vitamins (during pregnancy)

PRACTITIONERS

- Allergist
- Anaesthetist
- Chiropodist
- Chiropractor
- Christian Science Practitioners
- Dermatologist
- Gynecologist
- Homeopath
- Naturopath
- Nurse
- Obstetrician
- Oculist
- Osteopath
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Practical Nurse
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychopathist
- Sanitarium
- Surgeon

MEDICAL TREATMENTS/PROCEDURES

- Abortion
- Acupuncture
- Alcoholism (inpatient treatment)
- Clinic Services
- Counseling
- Drug Addiction
- Healing Services
- Hearing Exams
- Hospital Services
- Infertility
- In-Vitro Fertilization
- Norplant Insertion or Removal
- Patterning Exercises
- Physical Examination (not employment related)
- Physical Therapy
- Pregnancy Tests
- Rolfing
- Speech Therapy
- Sterilization
- Transplants (includes organ donor)
- Treatment for Handicapped
- Vaccinations/Immunizations
- Vasectomy
- Well Baby Care

MEDICAL EQUIPMENT, SUPPLIES AND SERVICES

- (May require letter of medical necessity)
- Abdominal/Back Supports
 - Ambulance Services
 - Arches/Orthopedic Shoes
 - Automobile Modifications (cost of hand controls, special equipment, mechanical lifts)
 - Bandaids, Bandages, Gauze, Tape, etc.
 - Braille Books and Magazines
 - Crutches
 - Elastic Hose – medically prescribed
 - Hearing Aids & Batteries
 - Hospital Bed
 - Iron Lung – operating cost
 - Lipreading Lessons for the Deaf
 - Medic Alert Bracelet or Necklace
 - Oxygen Equipment
 - Prosthesis
 - Rental of Medical or Healing Equipment
 - Seeing-eye Dog and Hearing Assisting Cat (including maintenance)
 - Support or Corrective Devices (including special mattress and board for arthritis)
 - Syringes
 - Telephone for Deaf
 - Transportation Expenses
 - Wheelchair

VISION SERVICES

- Artificial Eyes
- Contact Lenses
- Contact Lens Solution
- Eye Examinations
- Eyeglasses
- Laser Eye Surgeries
- Ophthalmologist
- Optician
- Optometrist
- Prescription Sunglasses
- Radial Keratotomy



Flexible Spending Account

GENERAL OVERVIEW

INELIGIBLE EXPENSES

Breast Pumps*	Maternity Clothes
Calcium Supplements*	Personal Hygiene Products
Contact Lens Insurance	Personal Trainer
Cosmetic Surgery/Procedures	Prescription Drug Discount Cards
Custom Fitovers (clip-ons)	Retin-A*
Diaper Service	Rogaine*
Electrolysis	Special Foods
Exercise Equipment*	Swimming Lessons
Eyeglass Insurance	Tattoo Removal
Fitness Programs	Teeth Whitening/Bleaching
Hair Loss Medication	Toiletries, Toothpaste, etc.
Hair Transplant	Varicose Vein Treatment*
Health Club Dues	Vision Discount Programs
Insurance Premiums	Vitamins
Marriage Counseling	Weight Loss Programs*
Massage Therapy**	

* Eligible only with Doctor's certification identifying the medical condition and length of treatment program

** Eligible only with Doctor's certification identifying the physical nature of the medical condition and length of treatment program. Massage therapy for the sole purpose of tension/stress relief or depression (even with a Doctor's statement) does not qualify as an eligible expense.

OVER-THE-COUNTER DRUGS/MEDICINES

The IRS also states that Over-The-Counter Drugs (items that can be purchased without a prescription) can be eligible expenses. This allows you to use tax-free dollars to purchase routine items your family always keeps on hand, such as pain relievers, allergy medication and cold medications. Basically, it's any over-the-counter medicines used to cure or treat a medical condition.

Over-the-counter drugs/medicines do not include vitamins or daily supplements if they are taken for general good health. Supplements may be reimbursable if a doctor prescribes them as part of a treatment for a diagnosed illness. Your request for reimbursement of supplements will require a doctor's diagnosis indicating medical necessity.

OVER-THE-COUNTER DRUGS INCLUDE:

Acne Treatments	Allergy Medicines	Antacids
Anti-diarrhea Medicines	Aspirin/Tylenol/Ibuprofen	Athlete's Foot Medication
Bactine	Ben Gay/Theragesic	Bug Bite Medications
Calamine Lotion	Cold Medicines like Nyquil	Cough Drops/Throat Lozenges
Diaper Rash Ointments	Eye Drops like Visine	First Aid Creams
Herbs & Herbal Medicines*	Homeopathic Drugs*	Lactose Intolerance Pills
Laxatives	Lip Balms (for chapped lips)	Menstrual Cycle Medication
Motion Sickness Pills	Nasal Sinus Sprays	Pain Relievers
Pedialyte for ill child dehydration	Sinus Medications	Sleeping Aids
Sunburn Treatments	Suppositories and Creams for Hemorrhoids	
Topical Ointments	Wart Remover Treatments	

*If taken for a medical condition

OVER-THE-COUNTER DRUGS REQUIRING LETTER OF MEDICAL NECESSITY:

Dietary supplements or herbal medicines to treat a specific medical condition
Fiber supplements to treat a specific medical condition for a limited time
Glucosamine/Chondroitin for arthritis or other medical condition
Menopause treatments for hot flashes and night sweats
Hormone therapy
Sunscreens
St. John's Wort for depression
Weight-loss drugs to treat obesity



Flexible Spending Account

GENERAL OVERVIEW

ORTHODONTIA

Unlike most qualified expenses, orthodontia is generally reimbursable over the life of the contract. So if the individual (child or adult) will have the braces for 24 months, the expense is reimbursed over the 24-month period even if the entire expense is paid in full at the beginning of the service. Your orthodontia contract should be attached to your first request for reimbursement.

Using the 24-month example and a total expense of \$3,000. In the first plan year, after insurance has paid any eligible benefits (if any) and the down payment amount is deducted (assume \$500), the remaining balance is divided by 24 and is reimbursed over the 24 months.

First plan year (appliances placed in April) - \$3,000 - \$1,000 (Insurance benefit) - \$500 (Down Payment) = \$1,500 (Remaining balance). $\$1,500 / 24 = \62.50 . First plan year reimbursement - \$500 + $\$62.50 \times 8$ months = \$1,000.

Second plan year - $\$62.50 \times 12$ months = \$750

Third plan year - $\$62.50 \times 4$ months = \$250

Assume you pay remaining balance of \$1,000 in full at the beginning of the second plan year. The above schedule would still apply. You can only be reimbursed 1/12th of the \$750 per month. You cannot request reimbursement of the \$750 at the beginning of the plan year. You can submit a request monthly for the \$62.50; you can submit a request quarterly, in July for the May, June and July amounts or even at the end of the plan year for the total of the \$750. Remember, expenses are reimbursed based on when they are considered incurred, not when they are paid.

USE-IT OR LOSE IT PROVISION

Generally speaking, unused balances at the end of the plan year cannot be carried over into the following plan year. Your annual election must be used by the end of the plan year or any remaining balance will be forfeited back to your employer. You should plan cautiously in order to avoid forfeiting your money at the end of the plan year.

REIMBURSEMENT REQUESTS

Your annual election is available at any time during the plan year. Claims can be filed at any time during the plan year; as you incur the expenses, monthly, quarterly even annually. To submit a claim, simply complete the request for reimbursement form (available at www.bpas.com) click on "Plan Participants" then scroll down to "Forms" then click on the "Health Care Reimbursement"), attach your receipts and mail, fax or email the claim directly to Flex Corp. Claims are generally processed within 48 to 72 hours of receipt and reimbursement checks are mailed the following day, directly to your home address. Along with the check, you will receive a Reimbursement Account Worksheet, which provides an explanation of the benefits paid and the remaining account balance.

You have the option of receiving your reimbursements via direct deposit. Direct deposit allows you to have your reimbursements electronically transmitted to a designated bank for deposit into your checking or savings account. This option provides faster receipt of claim reimbursement and is provided at no cost to you.

MAIL:
Flex Corp
820 Gessner
#1225
Houston, TX 77024

FAX:
866-254-2942

Phone:
800-856-1816



Flexible Spending Account

GENERAL OVERVIEW

RECEIPTS

Receipts for eligible expenses must contain the following information:

- 1) Date of service
- 2) Patient's name
- 3) Description of service provided
- 4) Provider's name and address
- 5) Amount charged

Prescription receipts must contain the following information:

- 1) Date filled
- 2) Patient's name
- 3) Name of the medicine prescribed
- 4) Doctor's name
- 5) Amount charged

Legible cash register tapes for over-the-counter drugs must contain the following information:

- 1) Date of purchase
- 2) Name of item purchased (must be clearly identified on the cash register tape; if not, send packaging)
- 3) Merchant name
- 4) Cost of item including sales tax, if any

Missing information cannot be hand written on the receipt per IRS rules. Also, please mark the over-the-counter drugs listed on the cash register tape for which you are requesting reimbursement, as some generic names can be difficult to identify. Sales tax charged on any over-the-counter medicines is also reimbursable.

DIRECT DEPOSIT

Flex Corp offers the advantage of having all of your reimbursements deposited directly to your checking or savings account. The direct deposit feature eliminates waiting for checks to arrive by mail and then having to drive to the bank to make a deposit. To select the direct deposit option, complete the Authorization Agreement For Direct Deposit form and return it to Flex Corp. Direct deposit generally requires six business days to initiate and during this six-day period you will continue to receive your reimbursements in the form of a check through the mail. Once the direct deposit option takes effect, you will receive a worksheet by mail or email notifying you of the deposit being made.



Flexible Spending Account

GENERAL OVERVIEW

DEPENDENT CARE REIMBURSEMENT ACCOUNT (DCRA)

This benefit works much like the HCRA but it is designed to enable you to pay for dependent daycare services on a pre-tax basis. To use the account, the daycare expenses incurred must be as a result of your being gainfully employed or being a fulltime student. If married, the incurred expenses must be a result of you and your spouse being gainfully employed or fulltime students. Daycare expenses incurred while there is a stay-at-home parent are not reimbursable.

Each time eligible dependent daycare services are incurred, obtain a receipt with the dates of services, cost of services, the name of the dependent(s), and the provider of services. Send a copy of this receipt to Flex Corp along with a completed request for reimbursement form. For your convenience, Flex Corp has incorporated a receipt within the request for reimbursement form. Flex Corp will process the receipts and send you a reimbursement check.

Note: There is a childcare tax credit available at the end of the year so it is important to compare the tax credit to the Dependent Care Reimbursement Account to determine which option is better for you - you cannot do both with the same expenses.

REIMBURSEMENT REQUESTS

Unlike the HCRA, the DCRA will only reimburse you up to your actual account balance at the time the reimbursement request is processed. If a reimbursement request is received for more than the account balance, a check will be issued for the account balance and a pending request for the difference will be noted on your account. Once additional contributions are received, the pending request will be automatically processed and a check will be issued the following day.

Claims can be filed as you incur expenses, monthly, quarterly even annually. To submit a claim, simply complete the request for reimbursement form (available at www.bpas.com click on "Plan Participants" then scroll down to "Forms" then click on the "Dependent Care Reimbursement"), attach your receipts and mail, fax or email the claim directly to Flex Corp. Claims are generally processed within 24 to 48 hours of receipt and reimbursement checks are mailed the following day, directly to your home address. Along with the check, you will receive a Reimbursement Account Worksheet, which provides an explanation of the benefits paid and the remaining account balance. Reimbursement via direct deposit is also available in the Dependent Care Reimbursement Account.

MAIL:
Flex Corp
820 Gessner
#1225
Houston, TX 77024

FAX:
866-254-2942

Phone:
800-856-1816

DAYCARE PROVIDERS

Your daycare provider can be an individual or a corporate daycare. Individuals can include parents, grandparents or even a neighbor. For tax purposes, you will need the corporate provider's identification number or the individual's social security number. Tax Form 2441 requires that you provide information regarding the daycare provider. Individual providers can provide a receipt with the information mentioned above or can simply complete the receipt information on the reimbursement claim form.

ELECTIONS CHANGES

You may change your election for any new plan year prior to the beginning of the year. An election, once made, cannot be changed during the year unless there has been a qualified change in status. Examples of status changes are:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a spouse or child
- Beginning or end of spouse's employment
- Change in cost of care or provider

USE-IT OR LOSE-IT PROVISION

Unused balances at the end of the plan year cannot be carried over into the following plan year. Your annual election must be used by the end of the plan year or any remaining balance will be forfeited back to your employer. You should plan cautiously in order to avoid forfeiting your balance at the end of the plan year.



Flexible Spending Account

GENERAL OVERVIEW

ACCOUNT INFORMATION

Participants will receive quarterly account statements. You can elect to have the quarterly account statement e-mailed directly to you. To elect this option, simply logon to www.bpas.com select Plan Participants / Account Access and enter your social security number and date of birth and select Email Delivery Preference. Enter your email address and click on the save button.

Account information on both the Health Care and Dependent Care accounts can also be accessed through our website at www.bpas.com or telephone voice response system by calling 713-939-5858 or 800-856-1816. Both the website and voice response system are available 24-hours a day, year around. Both systems are real-time systems and are automatically updated throughout the day.

TO ACCESS YOUR ACCOUNT ONLINE:

Select: Plan Participants

Click: Account Access

Enter: Your Social Security number and your Date of Birth, select "Reimbursement Account Activity", then click the "CONTINUE" button

TO ACCESS YOUR ACCOUNT USING THE TELEPHONE VOICE RESPONSE SYSTEM:

Dial: 713-939-5858 or 800-856-1816

Enter: Your Social Security using the phone key pad

Press: "1" For information on Dependent Care Account

"2" For information on Health Care Account

You can always contact Customer Service Representatives at 800-856-1816 or 713-939-5858. Representatives are available Monday – Friday from 7:30 am to 5:00 pm central standard time.

SUMMARY PLAN DESCRIPTION (SPD)

This short summary is a brief overview and does not replace the summary plan description or the legal plan documents. For full information regarding the plan, you should read thoroughly the summary plan description provided to you by your employer.



Payroll Deductions

Anyone electing the HDHP medical plan will receive \$66.94 per month in a HSA account, unless ineligible, then a FSA account.

Medical HDHP Plan		
	Monthly	Semi-Monthly
Employee Only:	\$0.00	\$0.00
Employee + Spouse:	\$464.44	\$232.22
Employee + Child(ren):	\$365.49	\$182.74
Employee + Family:	\$829.98	\$414.99

Medical Copay Plan		
	Monthly	Semi-Monthly
Employee Only:	\$89.73	\$44.86
Employee + Spouse:	\$690.70	\$345.35
Employee + Child(ren):	\$562.67	\$281.33
Employee + Family:	\$1,163.68	\$581.84

Dental Plan		
	Monthly	Semi-Monthly
Employee Only:	\$0.00	\$0.00
Employee + Spouse:	\$30.64	\$15.32
Employee + Child(ren):	\$29.44	\$14.72
Employee + Family:	\$62.38	\$31.19

Employee Basic Term Life and AD&D

100% Employer Paid

Employee Enhanced AD&D

100% Employer Paid

Dependent Basic Life

\$1.75 per family

Dependent Enhanced AD&D

\$3.00 per family

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

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