

ADVANCING RESEARCH



IMPROVING EDUCATION



Benefits Summary

Plan Year

May 1, 2011 - April 30, 2012

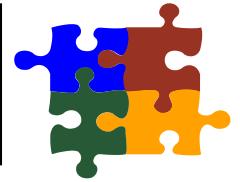
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****If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 8 - 9 for more details.**

Customer Service



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!**

Phone: (512) 499-8005 / (800) 492-8005

Hours of Operation:

Monday - Thursday	8:00 a.m. - 5:30 p.m. CST
Friday	8:00 a.m. - 5:00 p.m. CST

Fax: (512) 233-0102

Account Manager: **Terri East** terri_east@ajg.com

Benefit Specialists: Stephan Solano stephan_solano@ajg.com
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Bethany Davis bethany_davis@ajg.com

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:

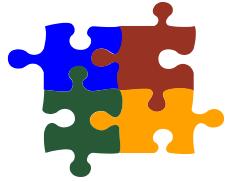
Healthcare - Medical and Dental

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

Additional Benefits - Flexible Spending Account and Health Savings Account



Carrier Information



The following benefits are offered through Blue Cross Blue Shield:

- Medical Insurance Group # 83593
- Dental Insurance
- Customer Service: 800-521-2227
- Login:** www.bcbstx.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: 866-401-5272
- Login to Check Balances & Submit Claims** www.bpas.com
- Fax Claims: 866-254-2942

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

Please contact your Human Resources Department for further information.



24/7 Nurseline



Experience. Wellness. Everywhere.SM



**BlueCross BlueShield
of Texas**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

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.

THE PAIN STOPS HERE!

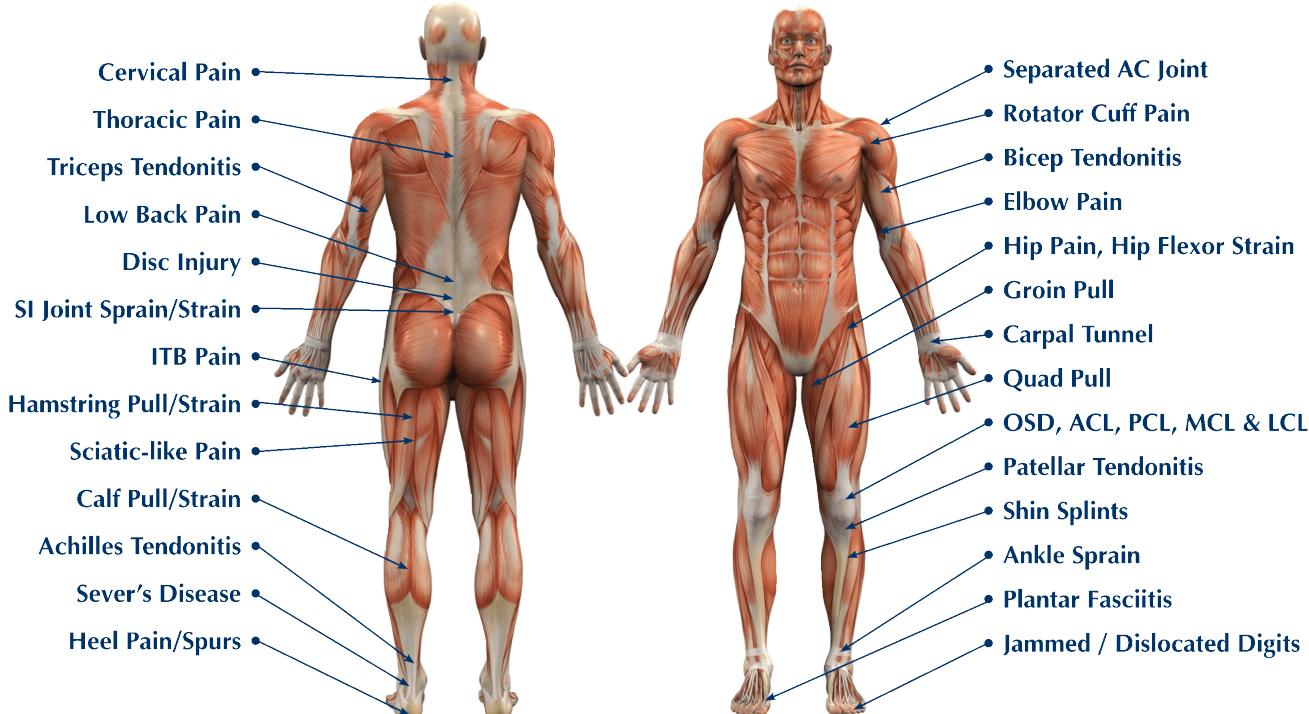


Airrosti is now an added benefit on most health insurance plans.

WHAT IS AIRROSTI?

- Highly specific diagnosis and treatment
- Great surgical alternative
- 95% pain free range of motion typically achieved in the first 1-3 visits
- Quality 1-on-1 care for an entire hour

COMMON INJURIES AIRROSTI CAN IMPACT



Airrosti Recovery Times: Average Number of Visits

- Back & Neck Conditions
- Shoulder & Arm Conditions
- Hand & Wrist Conditions
- Hip & Pelvis Conditions
- Lower Limb Conditions

3
visits

To schedule an appointment or find a location near you, please call or visit:

(800) 404-6050 • Airrosti.com
also visit us on:
YouTube & Facebook

Step Therapy

What You Need to Know



Q. What is step therapy?

A. Step therapy is a clinical program that only applies to certain types of prescription medications. With step therapy, members will receive benefits for drugs subject to step therapy only after first trying alternative medications which have been determined to be safe, effective and less costly. In cases where alternative drugs are not appropriate for you to use, your physician can request an exception to the step therapy program.

Q. Why does my prescription benefit include step therapy?

A. Step therapy programs help manage the rising cost of prescription drugs, and the overall cost of health care. A “step” approach encourages the safe, cost-effective use of medication by first trying lower-cost medications whenever appropriate.

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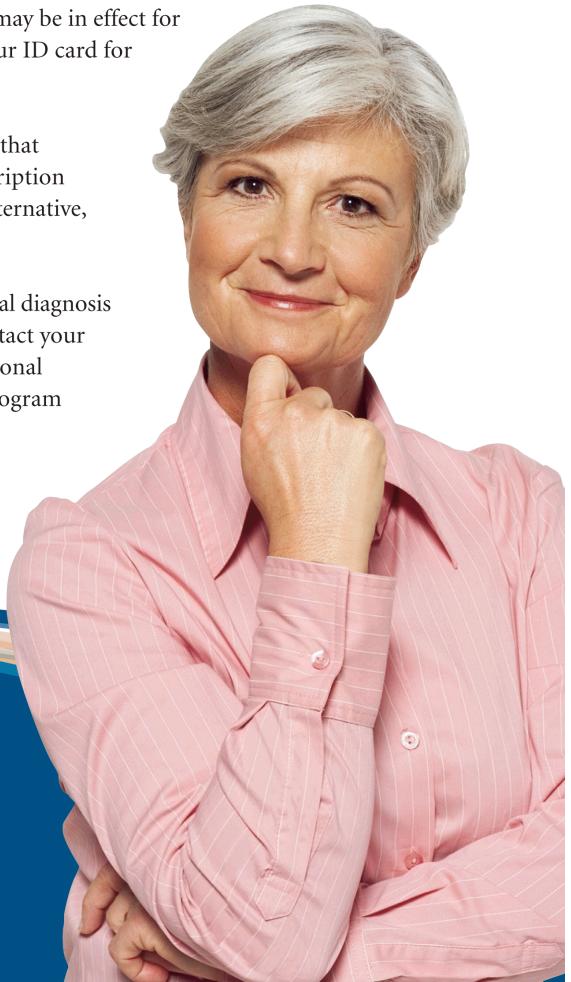
Q. How will step therapy affect me?

A. The vast majority of medications covered under your pharmacy benefit are not included in a step therapy program. Depending upon your specific benefit plan, a step therapy program may be in effect for one or more prescription drugs. Call the Customer Service number on the back of your ID card for more details.

When you present a prescription to the pharmacist for a drug subject to step therapy, that prescription will be immediately and automatically checked against your recent prescription claims history. If the available prescription history shows that you have already tried alternative, or first-line, drugs, your prescription may be automatically approved at the pharmacy.

In some instances, there may be no record of you receiving a first-line therapy, or medical diagnosis information may be needed. In these situations your pharmacist will advise you to contact your doctor. A toll-free phone number will be provided for your physician to call for additional information. However, the easiest way for you and your physician to obtain detailed program information and forms is by visiting the Provider section at bcbstx.com.

If you are prescribed a drug that is subject to step therapy, and believe that you have no pharmacy claims record of receiving a first-line drug, you may want to discuss other treatment options with your doctor to avoid any delay in your treatment.



BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.®

Step Therapy

What You Need to Know



BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.[®]

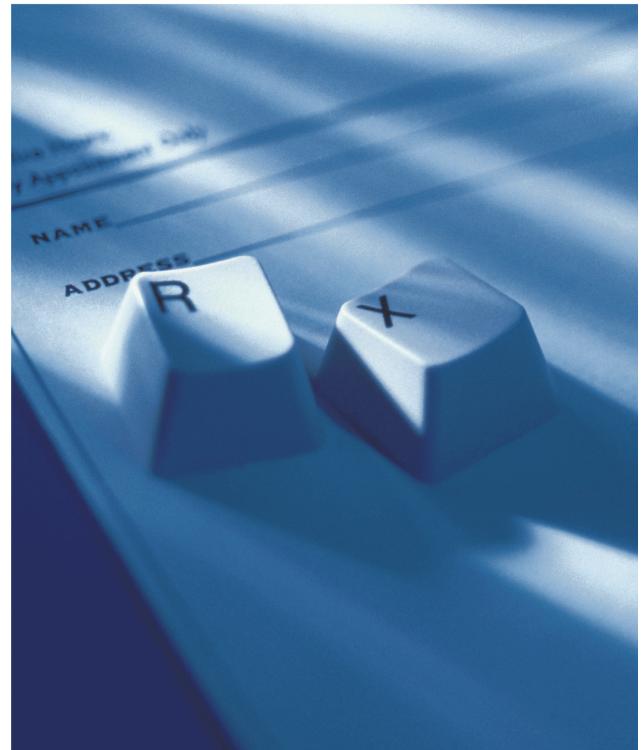
Q. How are medications selected for the step therapy program?

A. A team of physicians and pharmacists reviews categories of medications that are potentially over-prescribed and where more cost-effective alternative medications are available. The team recommends that specific drugs be added to the step therapy program list whenever safe and clinically sound therapeutic options are available.

Q. What medications are included in the step therapy program?

A. Examples of drug categories that may be included in the step therapy program and sample medications include^{†*}:

- Anticonvulsants: Lyrica, Topamax
- Antidepressants: brand name selective serotonin reuptake inhibitors, such as Lexapro, Zoloft
- COX-2 inhibitors: Celebrex
- Leukotriene inhibitors: Singulair
- Lipid management: Lipitor, Zetia
- Proton pump inhibitors: AcipHex, Dexilant, Zegerid
- Rheumatoid arthritis/psoriasis: Amevive, Kineret, Raptiva, Simponi
- Select high blood pressure medications, including the ARBs (Atacand, Avapro, Benicar, Cozaar (brand), Diovan, Micardis, Teveten), the ARB combination products, and Tekturna



If the available prescription history shows that you have already tried alternative, or first-line, drugs, your prescription may be automatically approved at the pharmacy.

†Additional categories may be added and the program may change from time to time.

*Third-party brand names are the property of their respective owners.

bcbstx.com

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.**

HIPAA Privacy Notice

HIPAA requires SEDL to notify you that a privacy notice is available upon request. **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 lymph edemas.

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.

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 under the age of 19.

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.**

Health Care Reform

SEDL's medical plan will not be considered "Grandfathered" under the terms of the Health Care Reform Bill. As a result, our plans will be expanded to encompass the following changes, effective 5/1/2011:

- Preventive Medical Care covered at 100% In Network
- Eliminate annual dollar limits on "essential benefits"
- Eliminate lifetime aggregate dollar limits on "essential benefits"
- Children can remain on parent's medical plan until they reach age 26, even if they are not financially dependent on employee, and/or they are married.
- Pre-Existing Limitations do not apply to anyone under age 19.

Opportunity to Enroll for Dependents to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the SEDL's health plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to May 1, 2011. For more information contact Human Resources.

Lifetime Limits Special Enrollment

The lifetime limit on the dollar value of benefits under the SEDL's health plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment.

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from 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 2011
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 & Enrollment

You are eligible for benefits on your Date of Hire. Submission of enrollment forms within your first 31 days of employment is required. If you miss this time frame, your next opportunity to enroll will be our **Annual Open Enrollment, which is in April.**

- You are eligible if you are a full-time employee regularly scheduled to work at least **20 hours a week**.
- Not enrolling "timely" as a new hire, or when you have Qualifying Events, can cause penalties and limitations on some of the coverages.
- 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 to SEDL's medical carrier.
- Outside of New Hire enrollment, the Open Enrollment period is the only time employees may enroll in the coverages without the occurrence of a qualifying event (see definition below).
- Open Enrollment is held from April 1st to 30th, annually. Deadlines for turning in forms may use different dates, but final changes are allowed up until April 30th.
- Open Enrollment applies to Medical, Dental and Flexible Spending Accounts only. Applying for any other coverages may require medical underwriting. Underwriting may be at your own expense, and you can be declined.

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.

Terms & Conditions

- **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 and are 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 children are eligible for coverage on your Medical plans until the age of 26, regardless of marital, financial or student status. Your unmarried dependent children are eligible for coverage on your dental plan until the age of 25, regardless of student status, and on your optional life and enhanced AD&D coverage to the age of 23, or 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 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.

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

Free Or Low-Cost Health Coverage To Children and Families

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 a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, 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.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 22, 2010. You should contact your State for further information on eligibility.

To see if any more States have added a premium assistance program since January 22, 2010, or for more information on special enrollment rights, you can contact either:

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

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

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150
ALASKA – Medicaid	IDAHO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588
ARIZONA – CHIP	INDIANA – Medicaid
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (In state): 1-877-764-5437	Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479
ARKANSAS – CHIP	IOWA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
CALIFORNIA – Medicaid	KANSAS – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443	Website: https://www.khpa.ks.gov Phone: 800-766-9012
COLORADO – Medicaid and CHIP	KENTUCKY – Medicaid
Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http://www.CHPplus.org CHIP Phone: 303-866-3243	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
FLORIDA – Medicaid	LOUISIANA – Medicaid
Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237	Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207

CHIPRA Notice

MAINE – Medicaid	OKLAHOMA – Medicaid
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MASSACHUSETTS – Medicaid and CHIP	OREGON – Medicaid and CHIP
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678
MINNESOTA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.dpw.state.pa.us/partnersproviders/ medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730
MISSOURI – Medicaid	RHODE ISLAND – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: www.dhs.ri.gov Phone: 401-462-5300
MONTANA – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/_clientindex.shtml Telephone: 1-800-694-3084	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
NEBRASKA – Medicaid	TEXAS – Medicaid
Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
NEVADA – Medicaid and CHIP	UTAH – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
NEW HAMPSHIRE – Medicaid	VERMONT – Medicaid
Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
NEW JERSEY – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/_dmahs/clients/medicaid/Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
NEW MEXICO – Medicaid and CHIP	WASHINGTON – Medicaid
Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
NEW YORK – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.nyhealth.gov/health_care/_medicaid/ Phone: 1-800-541-2831	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
NORTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.nc.gov Phone: 919-855-4100	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
NORTH DAKOTA – Medicaid	WYOMING – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

Medical HDHP Plan



**BlueEdge HSA
Embedded Deductible
RMH2**



**BlueCross BlueShield
of Texas**

BENEFIT HIGHLIGHTS		BlueChoice Network			
<i>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.</i>					
Overall Payment Provisions		PPO (In-Network)	Non-PPO (Out-of-Network)		
Calendar Year Deductible					
Applies to all Eligible Expenses (unless otherwise indicated)					
<i>Family coverage: When one family member meets the individual Deductible, benefits become available under the plan for that individual.</i>		\$3,000 Individual / \$6,000 Family	\$6,000 Individual / \$12,000 Family		
4 th quarter Deductible carryover provision does not apply					
Deductible credit from prior carrier (applied on initial group enrollment only)		Yes	Yes		
Out-of-Pocket Maximum					
Deductible, Coinsurance Amounts, and Copayments (if any) apply to Out-of-Pocket Maximum		\$3,000 Individual / \$6,000 Family	\$12,000 Individual / \$24,000 Family		
Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)		<i>Network Deductible & Out-of-Pocket Maximum will only apply toward Network Deductible & Out-of-Pocket Maximum</i>	<i>Out-of-Network Deductible & Out-of-Pocket Maximum will also apply toward Network Deductible & Out-of-Pocket Maximum</i>		
Maximum Lifetime Benefits					
Per individual		Unlimited			
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		100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible		
Physician surgical services in any setting					
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		

Medical HDHP Plan



**BlueEdge HSA
Embedded Deductible
RMH2**



**BlueCross BlueShield
of Texas**

Extended Care Expenses		PPO (In-Network)	Non-PPO (Out-of-Network)
Extended Care Expenses (must be preauthorized)		100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility Home Health Care Hospice Care		Limited to 25 days maximum each Calendar Year* Limited to 60 visits each Calendar Year* Unlimited	
Special Provisions Expenses			
Treatment of Chemical Dependency (must be preauthorized)			
Inpatient treatment must be provided in a Chemical Dependency Treatment Center		Covered as any other sickness	Covered as any other physical illness
All other outpatient treatment		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
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
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
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

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

Medical HDHP Plan



**BlueEdge HSA
Embedded Deductible
RMH2**



**BlueCross BlueShield
of Texas**

Special Provisions Expenses, cont.	P P O (In-Network)	N o n - P P O (Out-of-Network)
Emergency Care/Outpatient Hospital Emergency Room		
Accidental Injury & Medical Emergency Care Facility charges	100% of Allowable Amount after Calendar Year Deductible	
Physician charges	100% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Situations 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 physicals, well-baby care, immunizations(after 6 th birthdate), and other preventive health services as determined by the USPSTF	100% of Allowable Amount	70% of allowable Amount
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 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	Limited to 35 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

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 Plan



**BlueEdge HSA
Embedded Deductible
RMH2**



**BlueCross BlueShield
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 Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are also based on the BCBSTX-determined Allowable Amount. Covered individuals will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance 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 Provision: Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the individual's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period. In accordance with state and federal law, certain conditions will not be considered Preexisting Conditions and the Preexisting Condition exclusion will not apply to certain individuals. Details are provided in the 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.
- 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.
 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 20% penalty. HSA dollars can be contributed by the employer, employee or others and 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, enrolled in Part A or B
 - * 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) and you have a current prescription on file for the medication

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 (with prescription);
- 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 a HDHP, you can set aside money in a HSA account to pay for eligible out-of-pocket expenses. Money can be contributed to your HSA by you, SEDL, or anyone else.

Calendar Year HSA Contribution Maximums:

	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

	2011 Annual Max	Employer Payment	Employee Can Add Maximum
Single Coverage	\$3,050	\$427.68	\$2,622.32
Family Coverage	\$6,150	\$427.68	\$5,722.32
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 20% 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, as long as you have not filed taxes for that year yet.

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.

Medical Co-Pay Plan



**Preferred Provider Benefit Plan (PPO) –
RM25**



BlueCross BlueShield
of Texas

BENEFIT HIGHLIGHTS

BlueChoice Network

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) 4 th quarter Deductible carryover applies Deductible credit from prior carrier (applied on initial group enrollment only)	\$3000 Individual / \$9000 Family 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 <i>will only apply toward Network Coinsurance Stop-Loss Amount</i> Yes	\$10,000 Individual / \$30,000 Family Out-of-Network Coinsurance Stop-Loss Amount <i>will also apply toward Network Coinsurance Stop-Loss Amount</i> Yes
Maximum Lifetime Benefits Per individual	Unlimited	
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	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	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible
All other outpatient services and supplies	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible

Medical Co-Pay Plan



**Preferred Provider Benefit Plan (PPO) –
RM25**



BlueCross BlueShield
of Texas

Extended Care Expenses	P P O (In-Network)	N o n - P P O (Out-of-Network)
Extended Care Expenses (must be preauthorized)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility Home Health Care Hospice Care	Limited to 25 days maximum each Calendar Year* Limited to 60 visits each Calendar Year* Unlimited	
Special Provisions Expenses		
Treatment of Chemical Dependency (must be preauthorized)		
Inpatient treatment must be provided in a Chemical Dependency Treatment Center	Covered as any other sickness	Covered as any other sickness
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
	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
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
	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
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
	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
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
	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Emergency Care/Outpatient Hospital Emergency Room		
Accidental Injury & Medical Emergency Care Facility charges	100% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted)	
	100% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Situations 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)
	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 Co-Pay Plan



**Preferred Provider Benefit Plan (PPO) –
RM25**



**BlueCross BlueShield
of Texas**

Special Provisions Expenses, cont.	PPO (In-Network)	Non-PPO (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), and other preventive health services as determined by the USPSTF	100% of Allowable 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	Limited to 35 visits each Calendar Year*	

* All benefit payments made for both In-Network and Out-of-Network services will apply toward any 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.



Medical Co-Pay Plan

**Preferred Provider Benefit Plan (PPO) –
RM25**



**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 Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are also based on the BCBSTX-determined Allowable Amount. Covered individuals will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance 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 Provision: Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the individual's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period. In accordance with state and federal law, certain conditions will not be considered Preexisting Conditions and the Preexisting Condition exclusion will not apply to certain individuals. Details are provided in the 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.

This proposal assumes the group contract will be issued in Texas. In addition to the benefits stated herein, benefits for covered persons who reside outside of Texas will conform to all Extraterritorial requirements of those states.

This proposal is made on the condition you are not a Small Employer as defined in the Texas Insurance Code. A proposal to a Small Employer would have to contain specific contractual elements and mandated insurance plans not contained in this proposal. Should it be determined you were a Small Employer, this proposal and any health insurance contract issued to you, shall be null and void.

Dental Plan



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

- Your out-of-pocket cost will generally be the least amount because BlueCare Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses
- You are not required to file claim forms
- You are not balance billed for costs exceeding the BCBSTX Allowable Amount for BlueCare Dentists
- Your out-of-pocket cost may be greater because DentaBlue Dentists have contracted to accept a higher Allowable Amount as payment in full for Eligible Dental Expenses
- You are not required to file claim forms
- You are not balance billed for costs exceeding the BCBSTX Allowable Amount for DentaBlue Dentists
- Your out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with BCBSTX to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses
- You are required to file claim forms
- You are balance billed for costs exceeding the BCBSTX Allowable Amount

Group Term Life Insurance

BE SURE to keep your Beneficiary Information up-to-date!



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

	PLAN 1	PLAN 2	PLAN 3	PLAN 4	PLAN 5	PLAN 6
EMPLOYEE'S AGE:	\$ 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

Don't Think A
Flexible Spending Account
Is Right For You?

Think Again



Save time, money and paperwork!

**With the Benny™
Prepaid Benefits
Card, your FSA is:**

Cash-flow friendly –
No cash to pay
at the time of
purchase

Easy – Simply a swipe
of the Card

Convenient – No
forms to fill out

Fast – Funds auto-
matically deducted
from your FSA

Simple to track –
Your current balance
available online 24/7

**What are YOU
waiting for?**

**Sign up now and let
your savings begin!**

Yes, it's that time of year again, and a Health Care Flexible Spending Account (FSA) is being offered as part of your benefits program. Access to your FSA will be as easy as a swipe of a Card, and the more you put into it, the more you save. So, if you haven't considered an FSA in the past, it pays to take another look.

An FSA adds spendable income.

Let's face it, you work hard for your money and you want to keep as much of it as you can. A Health Care FSA helps you do just that!

You elect to have your annual health care contribution deducted from your paycheck each pay period in equal installments throughout the year – before federal income, state income (in most cases) and Social Security taxes are taken out. So every dollar you put in your FSA is tax-free, spendable income.

An FSA covers many expenses!

Your tax-free FSA dollars are ready to pay for health-related, out-of-pocket costs not covered by your insurance for you, and for your spouse and dependents covered under your plan – things like copayments, deductibles, prescriptions, dental bills and vision expenses. And don't forget eligible over-the-counter (OTC) items*. Even if your annual health care expenses are just a few hundred dollars, an FSA can keep more money in your wallet.

Did you know?

The average family of four in the U. S. can expect to pay over \$3,000 each year on out-of-pocket expenses like doctor visits, prescription copays, dental work and new glasses – or an unexpected hospital stay.

**If that \$3,005 goes into a Health Care FSA,
a family can save over \$811 in taxes.**

And how do you get your Benny?

Look for details during open enrollment, or ask your Human Resources representative for more information.



(Continued from page 1)



Your FSA includes **Benny™,** the fast and easy way to access your account.

An FSA is a good idea, and here's a feature that makes it even better – the Benny™ Prepaid Benefits Card. The Card contains the value of your annual Health Care FSA election amount, so you can use Benny to pay for eligible out-of-pocket medical expenses such as:

- Prescription and health plan copayments, deductibles and coinsurance
- Orthodontics
- Mail-order or online prescription invoices
- Vision services and eyeglasses
- LASIK surgery
- Eligible over-the-counter (OTC) items*

Say hello to Benny and good-bye to “paying twice.”

Using the Card helps you keep cash in your wallet. You'll never “pay twice” with the Card – first from your paycheck into your FSA and then again at the time of purchase. You'll have less claim forms to complete and you won't have to wait to get a check in the mail. You can check balances or account details online anytime, or with a quick phone call.

Simply swipe your Card and the amount of your eligible expense will be automatically deducted from your account. And, there are now tens of thousands of merchant locations where you can use the Card for eligible out-of-pocket prescription and OTC expenses, and for those items you will NOT have to provide a receipt to verify the purchase!

Already have an FSA? Perhaps now is the time to increase your contributions. Already have a Card? Hang on to it and your new election amount will be added.

An FSA is a valuable benefit – and the Card can make it even better. If you're not currently participating in a Health Care FSA, now's the time to enroll!

* Effective 1/1/11, the list of eligible OTC items is changing per the Patient Protection and Affordable Care Act of 2010. Contact your Plan Administrator for more information.

Know Your FSA Eligible and Ineligible Expenses

Use Your Health Care FSA Wisely

The Flexible Spending Account (FSA) is an IRS sanctioned benefit that allows you to use pretax dollars to cover eligible expenses. The IRS defines eligible health care expenses as amounts paid for the diagnosis, cure, mitigation or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness.

Take a look at the following lists for a better understanding of what is and isn't eligible. Other expenses not specifically mentioned may also qualify (for additional information, please call our Customer Service Department at (866) 401-5272.)

Eligible Expenses		
BABY/CHILD TO AGE 13 <ul style="list-style-type: none">▪ Lactation Consultant*▪ Lead-Based Paint Removal▪ Special Formula*▪ Tuition: Special School/Teacher for Disability or Learning Disability*▪ Well Baby Care	MEDICAL EQUIPMENT/SUPPLIES <ul style="list-style-type: none">▪ Abdominal and Back Supports*▪ Air Purification Equipment*▪ Arches and Orthopedic Shoes▪ Contraceptive Devices▪ Crutches and Wheel Chairs▪ Exercise Equipment*▪ Hospital Beds▪ Mattresses*▪ Medic Alert Bracelet or Necklace▪ Oxygen*▪ Post-Mastectomy Prosthesis▪ Prosthesis▪ Splints/Casts or Support Hose*▪ Syringes▪ Wigs*	MEDICATION <ul style="list-style-type: none">▪ Birth Control▪ Homeopathic Medications*▪ Insulin▪ Prescription Drugs▪ Weight Loss Drugs*
DENTAL <ul style="list-style-type: none">▪ Dental X-Rays▪ Dentures and Bridges▪ Exams and Teeth Cleaning▪ Extractions and Fillings▪ Gum Treatment▪ Oral Surgery▪ Orthodontia and Braces		OBSTETRICS <ul style="list-style-type: none">▪ Lamaze Class▪ Midwife Expenses▪ OB/GYN Exams▪ OB/GYN Prepaid Hospital Fees (reimbursable after date of birth)▪ Pre- and Postnatal Treatments
EYES <ul style="list-style-type: none">▪ Artificial Eyes▪ Eyeglasses and Contact Lenses▪ Laser Eye Surgeries▪ Prescription Sunglasses▪ Radial Keratotomy/LASIK	MEDICAL PROCEDURES/SERVICES <ul style="list-style-type: none">▪ Acupuncture▪ Alcohol and Drug Addiction (inpatient and outpatient treatment)▪ Ambulance▪ Hospital Services▪ Infertility Treatment▪ In Vitro Fertilization▪ Norplant Insertion or Removal▪ Physical Examination (not employment-related)▪ Reconstructive Surgery (due to a congenital defect or accident)▪ Service Animals*▪ Sterilization/Sterilization Reversal▪ Transplants (including organ donor)▪ Transportation*▪ Vaccinations and Immunizations	PRACTITIONERS <ul style="list-style-type: none">▪ Allergist▪ Chiropractor▪ Christian Science Practitioner▪ Dermatologist▪ Homeopath or Naturopath*▪ Osteopath▪ Physician▪ Psychiatrist or Psychologist
HEARING <ul style="list-style-type: none">▪ Hearing Devices and Batteries▪ Hearing Examinations		THERAPY <ul style="list-style-type: none">▪ Alcohol and Drug Addiction▪ Counseling (not marital or career)▪ Exercise*▪ Hypnosis▪ Massage*▪ Occupational▪ Physical▪ Speech▪ Weight Loss Programs*
LAB EXAMS/TESTS <ul style="list-style-type: none">▪ Blood Tests and Metabolism Tests▪ Body Scans▪ Cardiographs▪ Laboratory Fees▪ Urine and Stool Analyses▪ X-Rays		

Note: This list is not meant to be all-inclusive. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Letter of Medical Necessity from your health care provider to qualify for reimbursement.

Over-the-Counter Items Now through 12/31/2010

The IRS allows certain over-the-counter (OTC) medicines to be reimbursed using your FSA dollars. Here is a brief listing of some of those items:

Eligible Over-the-Counter Items		
<ul style="list-style-type: none">▪ Acne Treatment Products▪ Allergy/Asthma/Sinus Medications: Antihistamines, Asthma Flow Meters and Nebulizers, Nasal Spray, Nasal Strips, Asthma Mist▪ Anti-arthritis: Chondroitin, Glucosamine▪ Anti-fungal Products▪ Baby Care: Diaper Rash Ointment, Pediatric Electrolyte Solutions, Thermometers▪ Cold, Cough and Flu Medications: Capsules, Drops, Rubs, Syrups▪ Condoms/Contraceptive Devices▪ Denture Care Products▪ Diabetes Care: Blood Test Strips, Glucose Food, Glucose Kits, Monitors and Testers▪ Digestive Aids/Medications : Antacids, Antidiarrheals, Lactose Intolerance Medications, Laxatives▪ Ear Care: Ear Drops, Ear Wax Removal	<ul style="list-style-type: none">▪ Eye Care : Contact Lens Supplies, Eye Drops, Eye Patches, Reading Glasses▪ First Aid Products: Analgesics, Antibiotic Ointments, Bandages, Bug Bite and Anti-Itch Medications, First Aid Kits, Gauze, Gloves, Hydrogen Peroxide, Medical Tape, Ointments, Pads and Elastic Bandages, Rubbing Alcohol, Sunburn Cream, Supports and Braces, Wart Removal Products, Wound Care Products▪ Foot Care: Callous and Corn Removers, Creams, Cushions, Pads, Supports▪ Health Monitors/Medical Equipment: Blood Pressure and Heart Rate Monitors, Cholesterol Tests, Crutches, Medical Bracelets and Necklaces▪ Hemorrhoid Treatments▪ Homeopathic Medicines*▪ Incontinence Supplies	<ul style="list-style-type: none">▪ Lice and Scabies Treatment▪ Nausea and Motion Sickness Medications▪ Pain and Fever Reducers: Acetaminophen, Aspirin, Heating Pads, Ibuprofen, Menstrual Cycle and Migraine Medications, Muscle/Joint Pain Relief Creams and Balms▪ Pregnancy Products: Ovulation Monitor, Pregnancy Testing Kits, Prenatal Vitamins▪ Smoking Cessation Products: Gum and Lozenges, Inhalers, Nicotine Patches▪ Thermometers for Adults▪ Toothache and Teething Pain Relievers▪ Weight Loss Drugs (to treat a specific medical condition)*

Over-the-Counter Items Effective 1/1/2011

Employees with an FSA can no longer use their account funds to purchase OTC drugs and medicines (e.g. Advil, ibuprofen, cough syrup) unless they have a legible prescription from a physician.

If an employee has a prescription for an OTC medicine or drug, the employee must pay out of pocket at the point of sale, then submit a manual claim that includes a legible copy of a customer receipt issued by a pharmacy that reflects the date of sale and the amount of the charge along with a copy of the legible prescription when requesting reimbursement. Beginning 1/1/11, employees will not be able to use the Benny Card to purchase these items.

Employees can continue to use their FSA funds to purchase OTC items that are not considered a drug or a medicine (e.g. bandages, wound care, contact lens solution). If your company offers the use of the Benny card, these cards can continue to be used for these purchases.

Ineligible Expenses

The IRS does not allow the following expenses to be reimbursed under FSA's, as they are not prescribed by a physician for a specific ailment. Note: This list is not meant to be all-inclusive. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Letter of Medical Necessity from your health care provider to qualify for reimbursement.

Ineligible Expenses		
<ul style="list-style-type: none">▪ Baby-sitting and Child Care*▪ Contact Lens or Eyeglass Insurance▪ Cosmetic Surgery/Procedures▪ Dancing/Exercise/Fitness Programs*▪ Diaper Service▪ Electrolysis	<ul style="list-style-type: none">▪ Exercise Equipment or Personal Trainers▪ Hair Loss Medication▪ Hair Transplant▪ Health Club Dues*▪ Insurance Premiums and Interest▪ Long-Term Care Premiums	<ul style="list-style-type: none">▪ Marriage Counseling▪ Maternity Clothes▪ Sunscreen▪ Swimming Lessons▪ Teeth Bleaching or Whitening▪ Vitamins or Nutritional Supplements*

For additional information, please contact the Flex Corp Customer Service Department at (866) 401-5272.

Click... Click... Submit

your FSA claims online

Now you can quickly and easily submit your Flexible Spending Account claims online! Follow the detailed instructions below and have your claim processed in no time at all!

From www.bpas.com, select Participant Accounts and Flex Account from the drop down menu. From the Flex Account page, select Account Access and log into the web using your login and password.

1. Scan the document or receipt. Please submit only one receipt per submission in one of the following file types: .doc, .pdf, .tif.
2. Navigate to the **New Claim** page (*My Account>New Claim*).
3. Complete the following fields:
 - **Plan**-Select the reimbursement plan from the pull-down list.
 - **Provider**-Enter the provider's name (i.e Dr. Jones, Day Care for Kids, My Pharmacy).
 - **Claimant Name**-Enter the name of the person who received the service (i.e. your name, your spouse's, or your dependent's name).
 - **Description**-Enter a short description of the care, prescription, or services received (i.e. co-pay, weekly day care fees).
 - **From**-Enter the beginning date of service, or select the date from the calendar (*this is not necessarily the date the expense was paid*).
 - **To**-Select the ending date of service. For a purchase or an appointment, change both date fields to the same day. For hospital stays or a range of dependent care, enter the last date of service.
 - **Requested**-Enter the amount of your claim (the amount of reimbursable expenses).
*** NOTE: If you are submitting documentation for a Benny Card transaction, please enter 0.00 as the "Requested" amount.*
 - **Notes**-Enter any relevant information about this claim that you feel the claim processor should be aware of.
4. Click BROWSE, navigate to the scanned document or image, and click Open.
5. Click Submit to enter your claim.

When the **Claim Confirmation Receipt** report is displayed, if you have another claim to enter, click Enter a New Claim. Otherwise, navigate to another page or log out.

Should you have any questions, please contact our Customer Service Department at 1-866-401-5272.

Payroll Deductions

*Anyone electing the HDHP medical plan will receive an employer contribution of **\$35.64 per month** in a HSA account, unless ineligible, then a FSA account.



Medical HDHP Plan*		
	Monthly	Semi-Monthly
Employee Only:	\$0.00	\$0.00
To Include Your Spouse	\$ 517.85	\$258.92
To Include Your Child(ren):	\$ 407.52	\$203.76
To Include Your Spouse and Child(ren):	\$ 925.43	\$462.71
Medical Copay Plan		
Employee Only:	\$111.46	\$55.73
To Include Your Spouse:	\$ 757.50	\$378.75
To Include Your Child(ren):	\$ 619.87	\$309.93
To Include Your Spouse and Child(ren):	\$1,265.96	\$632.98
Dental Plan		
Employee Only:	\$0.00	\$0.00
To Include Your Spouse:	\$32.39	\$16.19
To Include Your Child(ren):	\$31.13	\$15.56
To Include Your Spouse and Child(ren):	\$65.95	\$32.97
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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