PECAN VALLEY CENTERS
for
BEHAVIORAL & DEVELOPMENTAL HEALTHCARE

BENEFITS GUIDE 2019

Things to know about your 2019 Benefits

Pecan Valley Centers works hard to offer exceptional options for medical and prescription drug insurance, dental insurance, vision care, and voluntary lines of insurance coverages at a reasonable cost to the agency and our employees.
This year, we are pleased to, once again, offer an excellent array of insurance benefits. This booklet should provide the information you need to make the best decision for you and your dependents.
If you have any questions not answered here, please contact:

Karyn Reno, Employee Benefits
Ph. 817-579-4437 | Email: kreno@pecanvalley.org

WHO'S ELIGIBLE

If you are a benefit-eligible employee (working 30 hours or more per week), you are eligible to enroll in the benefits described in this guide. All family members including legal spouse and children under the age of 26 are eligible for medical and dental coverage.

HOW AND WHEN TO ENROLL

Your elections will be made in paycom during the Open Enrollment period **Tuesday, February 5, 2019 to Thursday, February 14, 2019**. You will be able to access paycom from any computer, tablet, or smartphone.

You are encouraged to log in at home and review your benefit options with your family. Be sure to review and compare your current benefits with your 2019 benefit options, before making your benefit elections.

Paycom is available throughout the year to view your benefits, plan information, and deductions. Check out the "Benefit Forms and Links" tab to view Plan Summaries and other helpful information for each benefit.

If you have any questions, or need assistance enrolling, please contact:

Karyn Reno, Employee Benefits
Ph. 817-579-4437 | Email: kreno@pecanvalley.org

CAN I MAKE CHANGES LATER?

Unless you have a qualifying event, you cannot make changes to the benefits you elect until the next open enrollment period. Qualifying events include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse or other qualified dependent, change in residence due to an employment transfer for you or your spouse, or change in spouse's benefits or employment status. For a comprehensive listing of Change of Status qualifying events, please refer to the website at: http://www.changeofstatus.com/index.asp

TAXING POLICY

Pre-Tax Contributions:
Employee contributions for medical, dental, vision, accident, HSA, and FSA are deducted from the employee's paychecks on a pre-tax basis, meaning before *applicable* Federal and FICA taxes are calculated.

OPEN ENROLLMENT BENEFITS PACKAGE

Eligibility for Coverage:
Newly employed full-time employees will be offered the following benefits once they have fulfilled a two-month New Hire waiting period; benefits will be effective the 1st of the month following two months continuous employment.

Pecan Valley Centers provides the following benefits to full time employees when eligible:

- $30,000 of Employer-Paid Basic Term Life and AD&D Life Insurance Benefits
- Medical Insurance (PPO and HDHP Plan options available)
- Health Savings Account (HSA - paired with High Deductible Health Plan)
- Flexible Spending Account (FSA), and Limited Purpose Flexible Spending Account (LFSA)
- Telehealth and Advocacy Services
- Employer Paid Long-Term Disability Insurance (after 24 months of continuous FT employment)
- Employee Assistance Program (5 face-to-face visits per issue, per person, per year)
- Dental Insurance (High and Low plan options available)
- Vision Insurance
- Voluntary Life & AD&D Insurance
- Voluntary Short-Term Disability Insurance
- Voluntary Accident, Critical Illness, and Hospital Indemnity policies

Section 125/Cafeteria Tax Plan

The following benefits will be deducted from your paycheck before income taxes are paid:

- Medical Insurance
- Dental Insurance
- "Off the Job" Accident Insurance
- Vision Insurance
- HSA, FSA, and LFSA Contributions

The following benefits will deducted from your paycheck after income taxes are paid:

- Term Life & AD&D Insurance
- Hospital Indemnity
- Short Term Disability Insurance
- Dependent Life & AD&D Insurance
- Critical Illness Insurance

MEDICAL INSURANCE

This chart gives a side-by-side look at your Medical plan options and the amounts you pay when you use In-Network providers. Utilizing Out-of-Network providers will be a greater cost; please refer to Summary of Benefits and Coverages for more details.

BlueCross BlueShield of Texas	**Plan 1** **HDHP (HSA MEDICAL PLAN)**	**Plan 2** **PPO Plan**
Plan Feature	**In-Network** (See SBC for Out-of-Network benefits)	**In-Network** (See SBC for Out of network benefits)
Deductible per calendar year **Coinsurance** **Out-of-Pocket Maximums** *(include copays, deductible, and coinsurance)*	$3,500 Individual / $7,000 Family 20% Coinsurance $5,000 Individual / $10,000 Family Integrated Medical & Rx Deductible	$5,000 Individual / $10,000 Family 30% Coinsurance Medical /RX : $6,600 Individual/$13,200 Family
Preventive Copay	No Charge	No Charge
Physician Office Visit	20% after Deductible	$40 Copay
Specialist Office Visit	20% after Deductible	$60 Copay
Chiropractic Office Visit *(limited to 35 visits each year)*	20% after Deductible	Please Refer to Plan Details
Emergency Room	20% after Deductible	$300 Copay + 30% after Deductible
Urgent Care Facility	20% after Deductible	$75 Copay
In-Patient Hospital	20% after Deductible	30% after Deductible
Out-Patient Surgery	20% after Deductible	30% after Deductible
Diagnostic	20% after Deductible	No Charge for X-Ray, Bloodwork 30% after Deductible for Imaging
Prescription Drug Coverage: *Generic/Preferred Brand/Non-Preferred Brand*	20% after Deductible	$20/$40/$60 Copay
Specialty Medication: *Preferred Specialty/Non Preferred Specialty*	20% after Deductible	$150 Copay/See SBC

Note that premiums for Medical coverage <u>have not</u> increased again in 2019.

DENTAL INSURANCE

This chart gives a side-by-side look at your Dental plan options and the amounts you pay when you use In-Network providers. Utilizing Out-of-Network providers will be a greater cost; please refer to Summary of Benefits and Coverages for more details.

BlueCross BlueShield of Texas	Plan 1 High Dental Plan	Plan 2 Low Dental Plan
Deductible	$50 Individual/$150 Family	$50 Individual/$150 Family
Annual Maximum Benefit	$2,000	$750
Preventive Services	No Charge	No Charge
Basic Services	20%	20%
Major Services (Crowns, Inlays Implants)	50%	Not covered
Orthodontia (Adult or Child)	50% ($2000 lifetime maximum)	Not Covered

Important Notes about Dental Plans

- It is important to refer to the Summary of Benefits for complete details on the Dental plans.
- Late Entrant Rules apply. Please see Plan Summary for more details.
- **Note that premiums for Dental coverage have not increased again in 2019.**

VISION INSURANCE

Routine Eye Exam: $10.00 copay; Single Vision Lenses: $25 copay; Frames: $130 allowance for frames of your choice (every 24 months) or Contact lenses (in lieu of glasses)

Important Notes about Vision Plan

- VSP Network! For a provider listing, go to www.metlife.com/mybenefits or call 1-855-638-3931.
- Optional items like designer frames, anti-reflective lenses, and scratch resistant coating are an additional cost.
- No ID card required.
- Laser Vision Correction discounts are available. Refer to the Plan Summary for more details.
- **Note that premiums for Vision coverage have not increased in 2019!**

VOLUNTARY BENEFITS

Life Insurance & Accidental Death and Dismemberment (AD&D):

- Purchase up to 5 times your basic annual pay, in units of $10,000, to a maximum of $500,000. Your Voluntary Life Policy includes AD&D coverage. AD&D pays an equal amount of benefit if your death is the result of an accident or you become dismembered.
- Purchase coverage for your spouse in multiples of $5,000, up to half the Employee election.
- Purchase coverage for your children, under age 26.
- Premiums are based on age and amount of benefit elected.
- During Open enrollment you may increase your coverage by $10,000 without evidence of insurability, if you have not exceeded the guarantee issue amount of $100,000.
- Evidence of Insurability required for all new elections not in the New Hire enrollment period.

Short-Term Disability Insurance:

- A.K.A. "income protection" or "paycheck insurance." Short-Term Disability Insurance can replace a portion of your **weekly income**, if you are unable to work due to an illness, injury, or childbirth.
- You can be covered for up to **60% of your weekly income.**
- There is an elimination period of **15 days** that must pass prior to the benefits being paid. Benefits can continue for up to **11 weeks** of disability.
- The amount of benefit you receive from the plan may be reduced or offset by income from other sources.
- **All new enrollments, after the new hire enrollment period,** are limited to $100 worth of benefit.

Accident Insurance:

- Provides a fixed benefit for accidental injuries and related expenses, such as emergency room visits, physical therapy, or surgery due to accidents that happen on or off the job. Daily hospital and ICU benefits are included.
- Includes an AD&D benefit as well as an Annual $50.00 Wellness Benefit, per covered member.

Critical Illness Insurance:

- Pays a lump sum benefit at the first diagnosis of certain critical illnesses, including heart attack, paralysis, internal cancers, and more.
- Includes an Annual $50.00 Wellness Benefit, per covered member.
- Premiums based on age at issue of policy, amount of benefit elected, and Tobacco/Non-Tobacco usage. Guarantee Issue in the amounts of $5,000, $10,000, or $20,000.

Hospital Indemnity Insurance:

- Pays a lump sum benefit and a daily benefit if you are admitted and confined to the hospital for an accident or illness.

Metlife Group Auto and Home Insurance:

- Watch your mail for additional information on group rates for your personal Auto and Homeowners

SAVINGS & REIMBURSEMENT ACCOUNT INFORMATION

Health Savings Accounts (HSA) Information:

- The HSA will continue to be offered to employees enrolled in the High Deductible Health Plan (HDHP Medical Plan).
- HSA funds can be used to offset the cost of your family's medical, dental, and vision care expenses, including copays, deductibles and other eligible expenses.
- Pecan Valley Centers will help you open an HSA at EECU, if you elect to do so. (Account pays interest and there is no monthly maintenance fee.)
- Employee contributions are payroll deducted.
- Pecan Valley Centers will match up to $100 of your monthly contributions to your HSA.
- These funds can only be used for qualifying expenses, and you will need to keep all receipts of medical, dental, and vision services paid for with these funds.

Flexible Spending Accounts (FSA) Information:

- The FSA and LFSA will continue to be offered through Discovery Benefits.

MEDICAL/HEALTH FSA AND LIMITED FSA

Set aside money to pay **eligible expenses** not covered by your medical insurance. There are two FSA options:

- **Medical/Health FSA**
  Use a medical/health flexible spending account with traditional insurance plans. You can use a medical FSA/health FSA to pay for things like coinsurance, prescriptions and medical equipment.
- **Limited Health FSA**
  Use a limited flexible spending account when you have both a high deductible health plan (HDHP) and a health savings account (HSA). The limited FSA is available for dental and vision expenses only.

- You will need to keep all receipts of medical, dental, and vision services paid for with these funds.

For more information visit https://www.discoverybenefits.com/employees

TELEDOC SERVICES AND MORE WITH HEALTHJOY

New!
Details coming Soon!

BKCW

HealthJoy

ADDITIONAL EMPLOYEE BENEFITS

<table>
<tr><th>BENEFIT</th><th>DESCRIPTION</th></tr>
<tr><td>Retirement Plan</td><td>Full-time employees who have completed six months of service are eligible to participate in the retirement plan. Once enrolled, your account will grow two ways: through the funds you contribute, and through our employer contribution plan. Contribute as little as 4% of your pay (or more if you choose), and Pecan Valley will add an extra 8%, for a total of 12% saved monthly for your future. Receive additional 1:1 matches after 5, 10, and 15 years of service! Contributions are made on a pre-tax basis through payroll deduction.

Vesting Schedule
2 years FT employment: 25% vested
3 years FT employment: 50% vested
4 years FT employment: 75% vested
5 years FT employment: 100% vested</td></tr>
<tr><td>Closure Day Pay
and
PTO (Paid Time Off)</td><td>Full-time employees are paid for seven closure days, annually: New Year’s Day, Memorial Day Independence Day, Labor Day, Thanksgiving Day and Friday after, and Christmas Day

Full-time employees earn paid leave at the following rates, based on duration of employment:

<table><tr><td>1st year</td><td>12.00 hours monthly</td><td>5.54 hours biweekly</td></tr><tr><td>2nd year</td><td>14.00 hours monthly</td><td>6.46 hours biweekly</td></tr><tr><td>3rd year and thereafter</td><td>18.00 hours monthly</td><td>8.31 hours biweekly</td></tr></table></td></tr>
<tr><td>EECU</td><td>As a Pecan Valley employee, you’re eligible to become a member of EECU. For just $5, you’ll gain access to all the benefits of EECU membership. For more information or to open an account, visit your nearby branch or visit www.eecu.org.</td></tr>
<tr><td>Wellness Resources</td><td>When you enroll in one of the Medical plans, you can access wellness resources – get information on weight management and how to improve your nutrition; track your diet and exercise; and get information on stress management. You can earn and redeem points for rewards by completing qualified activities. Sign up for the Fitness Program and receive a discount that gives you access to the entire network of fitness centers, including national and regional chains, participating YMCAs, and locally owned exercise facilities. Just go to bcbstx.com/member and create an account.

A 10% discount off Camp Gladiator outdoor fitness program fees is available to all employees. Just tell them you are an employee of Pecan Valley Centers.</td></tr>
<tr><td>Employee Assistance Program</td><td>Pecan Valley Centers offers LifeWorks Employee Assistance Program to full time employees at no cost. LifeWorks provides immediate crisis resolution and referrals to counseling and support for a broad range of issues.</td></tr>
<tr><td>Will Preparation</td><td>As part of the Voluntary Life Insurance benefit, you have access to a No Cost online or in person Will preparation tool through Hyatt Legal. This valuable resource will help you with the process of creating your own Will or other estate planning documents.</td></tr>
<tr><td rowspan="2">Employee Discounts</td><td>Call plan discounts are available through AT&T (15%), Sprint (15%), and Verizon (up to 25%). For more information, visit your provider’s store. (new contract may be required)</td></tr>
<tr><td>Get discounted tickets and season passes to Six Flags Over Texas and Hurricane Harbor. For more information or to purchase tickets, go to www.sixflags.com/partnerlogin. (User ID: PVMHMROT; Password: SixFlags9)</td></tr>
</table>

IMPORTANT DISCLOSURES

Employers must provide disclosures to employees regarding certain legal requirements; including the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act (PPACA). This document provides you with certain required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator:

Karyn Reno, Employee Benefits
2101 West Pearl Street, Granbury, TX 76048
Ph. (817) 579-4437 | Email: kreno@pecanvalley.org

This Document Is For Information Purposes Only
This communication is intended for illustrative and information purposes only. The plan documents, summary plan descriptions, insurance certificates, and policies serve as the governing documents to determine plan eligibility, benefits, andpayments.

Limitations and Exclusions
Insurance and benefit plans always contain exclusions and limitations. Please see benefit booklets and/or contracts for complete details of coverage and eligibility.

Future of the Plan
Your Employer reserves the right to amend, modify, or terminate its benefit plan at any time, including during treatment.

Notice Regarding Special Enrollment Rights
If you do not timely or properly complete the enrollment process, you and your eligible dependents generally will not be covered under the Plan, upon your initial eligibility date. Also, if you fail to specifically enroll your eligible dependents on the enrollment form, your eligible dependents will not be covered under the Plan upon the dependent's initial eligibility date. If enrollment does not occur on an individual's initial eligibility date, coverage may not be applied for until the next annual open enrollment period. However, if an employee or dependent experiences a special enrollment rights circumstance, coverage may begin immediately, before the next annual open enrollment. This section explains the special enrollment rights rules.
If an individual experiences a loss of health coverage, if an employee has a new dependent, or an individual loses or gains eligibility with respect to Medicaid or a State Children's Health Insurance Program ("CHIP"), an eligible employee and/or a dependent may have special enrollment rights to participate in coverage under the group health plan immediately without being required to wait until the next annual open enrollment period.

- A loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), employer contributions for the coverage have been terminated, the other coverage is an HMO and the individual no longer lives or works in the HMO service area, coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (such as part-time employees), or a benefit package option is terminated unless the individual is provided a current right to enroll in alternative coverage. A loss of other coverage for this purpose does not include, however, termination due to the nonpayment of required contributions, for cause due to the filing of a fraudulent application or claim, or where the individual voluntarily terminates other coverage.
- The addition of a new dependent may occur due to marriage, birth, adoption or placement foradoption.
- If an individual's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or ifthe individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP, the individual has special enrollmentrights.

Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable. However, in the case of loss or gain of Medicaid or CHIP eligibility, a health plan must allow immediate enrollment if the individual submits a request within 60 days after the loss or gain of eligibility.

Notice Regarding Women's Health and Cancer Rights Act (Janet's Law)
The Women's Health and Cancer Rights Act requires group health plans and insurers offering mastectomy coverage to also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breastto produce a symmetrical appearance;and
- Prostheses and treatment of physicalcomplications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and copayments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of the fact that employer's health plan has been amended to comply with this law.

Notice Regarding Newborns and Mothers Health Protection Act
Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital 10length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer to prescribe a length of stay not in excess of the above periods.

Notice Regarding Gina's Law
The Genetic Information Nondiscrimination Act of 2008 (GINA) states that group health plans and insurance issues may not:

- Adjust group premium or contribution amounts on the basis of genetic information.
- Request or require individuals to undergo a genetic test
- Request, require or purchase genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.

Notice Regarding Patient Protection Rights
The following paragraphs outline certain protections under the PPACA and only apply when the Plan requires the designation of a Primary Care Physician.

One of the provisions in the PPACA is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights.

You will have the right to designate any primary care provider who

participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

Other PPACA Protections
Other PPACA requirements include allowing eligible dependent children to continue health coverage until age 26, not retroactively rescinding coverage except as permitted by law and issuing eligible individuals a summary of benefits and coverage (SBC) describing the terms of the group health plan. You will be provided with an SBC as required by law.

Medicare Notice
You must notify your Employer when you or your dependents become Medicare eligible. Your Employer is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll free number to Medicare Coordination of Benefits is 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Non-Creditable Coverage Notice.

Important Information about Your Prescription Drug Coverage and Medicare
Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

If you are covered by 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 Your Employer 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:

Medicare prescription drug coverage became available in 2006 to everyone eligible for 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

1. 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. Your Employer has determined that the prescription drug coverage offered by their carrier's Benefits 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. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you may have to wait to join a Medicare Prescription Drug Plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave employer-sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current prescription drug 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.

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 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...
Contact your HR Representative. 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 your company 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 copyof 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, visit Social Security at www.socialsecurity.gov , or call 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 require to pay a higher premium (penalty).

Notice Regarding Pre-Existing Conditions And Certificates Of Creditable Coverage

Here is an overview of the pre-existing condition exclusions and limitations that are allowed under HIPAA as modified by PPACA. If the Plan does not impose a pre- existing condition limitation, much of this information does not apply to you; however, this information is provided to make you aware of the rules.

A pre-existing condition exclusion or limitation means that if you have a medical condition before enrolling in a group health 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 6-month look-back period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a new hire waiting period for coverage, the 6-month period ends on the day before the waiting period begins.

Any pre-existing condition exclusion or limitation may not apply to pregnancy nor to a child who is enrolled in the plan or who has other creditable coverage within 30 days after birth, adoption, or placement for adoption. For plan years beginning before 2011 this exclusion or limitation was permitted to 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. Under the PPACA, pre-existing condition exclusions and limitations were no longer permitted with respect to individuals under age 19 as of the first day of a plan's 2011 plan year and are no longer permitted with respect to any individual as of the first day of a plan's 2014 plan year.

While any exclusion or limitation was in effect, 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 pre-existing 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 promptly give the plan administrator a copy of any certificate of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, the plan administrator can help you obtain one from your prior plan or insurer. There are also other ways that you can show that you have creditable coverage. Please contact the plan administrator if you need help demonstrating creditable coverage.

Through December 31, 2014, group health plans and health insurance issuers must provide individuals with a certificate of creditable coverage following termination of coverage. Through December 31, 2014, individuals may request a certificate of creditable coverage if the request is made to the insurer within 24 months after coverage ends. To request a HIPAA Certificate of Creditable Coverage, please contact the insurance company customer service department by calling the phone number on your healthcare identification card.

HIPAA Privacy And Security

Employer and any health insurance issuer in connection with employer's group health plan are committed to complying with the privacy and security requirements of HIPAA as modified by a subsequent federal law known as HITECH. Participants will receive a notice of privacy practices in connection with the Plan. You will also receive a new copy in the event the notice is modified. If you would like to receive another copy of the notice of privacy practices, you may do so at any time, by contacting the plan administrator. Duplicate copies are provided free of charge.

Premium Assistance Under Medicaid And The Children's Health Insurance Program (CHIP)

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

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

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

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