HIGGINBOTHAM

Goodwill

Industries of South Texas, Inc.

Plan Year | 2020-2021

Full Time Employees

Enrollment Guide

Our employees are our most valuable asset.

This is why at Goodwill Industries of South Texas, Inc. we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure, and maintain a work/life balance.

What's New for 2020-2021?

- Medical will be moving to Blue Cross Blue Shield
- Basic Life, Voluntary Life, STD and LTD will be moving to Principal
- Increase in Employee Contributions for Retirement

Feeling Secure

- Tax Savings Opportunities
- 403 (b) Retirement Savings Plan
- Life and Accidental Death & Dismemberment
- Supplemental Life and Accidental Death & Dismemberment
- Income Protection Plan (Short and Long Term Disability)

Changes

- **Open Enrollment Period:** Enrollments and changes must be completed online between August 4 -14th.

Carrier Contact Information:

Refer to this list when you need to contact one of your benefit vendors. For general information, contact Payroll at x132.

HIGGINBOTHAM COMPANY:

Benefits Department:
1-800-756-0918 | 361-883-1711
www.higginbotham.net

Cliff Johnstone (Agent)
361-883-1711 | Ext 3918
cjohnstone@higginbotham.net

Odilia Robles (ACSR | Senior Account Manager)
361-883-1711 | Ext 4303
orobles@higginbotham.net

Iris Garcia (Account Coordinator)
361-883-1711 | Ext 4261
igarcia@higginbotham.net

Medical Insurance:
Available through— Blue Cross Blue Shield

Who is Eligible and When:

All full-time employees are eligible for Health Insurance. Newly hired Employees & their dependents enrolling will have coverage go in effect on the first of the month following 60 days of Full-Time employment. Eligible dependents include – Spouse or children (26 and younger).

Benefits You Receive: **Medical and Prescription Drugs:**

	Base Plan: MTBCB026 $3,000 70/50	
Medical Services	**In-Network**	**Out of Network**
Physician Visit - Primary Care (Designated) - Specialist (Designated) - Telemedicine/Virtual Visits	 $50 Copay $100 Copay $50 Copay	 50% after Deductible 50% after Deductible No Benefit
Preventive Care	Covered 100%	50% after Deductible
Deductible: Individual | Family	$3,000 | $9,000	$6,000 | $18,000
Coinsurance	70%	50%
Basic Lab/X-Rays	70% after Deductible	50% after Deductible
Total Out of Pocket Max: Individual | Family	$7,350 | $14,700	Unlimited
Urgent Care	$75 Copay	50% after Deductible
Emergency Room	70% after deductible + $500 Copayment	
Prescription Drugs - Level I - Level II - Level III - Level IV - Level V - Level VI	 $0|$10 $10|$20 $50|$70 $100|$120 $150 $250	 $10 $20 $70 $120 $150 $250 + 50% after Deductible
Retail/Mail Order – 90 Days Supply	3 x Copay	No Benefit

Website: www.bcbstx.com

2020 Base Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
SEMI-Monthly (per pay check)	$47.74	$334.19	$262.58	$572.90
2020 Base Payroll Deductions	**Employee Only**	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
WEEKLY (per pay check)	$23.87	$167.10	$131.29	$286.45

Medical Insurance:
Available through— Blue Cross Blue Shield

Who is Eligible and When:

All full-time employees are eligible for Health Insurance. Newly hired Employees & their dependents enrolling will have coverage go in effect on the first of the month following 60 days of Full-Time employment. Eligible dependents include – Spouse or children (26 and younger).

Benefits You Receive: **Medical and Prescription Drugs:**

	Buy-Up Plan: MTBCP022 $2,500 60/50	
Medical Services	**In-Network**	**Out-of-Network**
Physician Visit - Primary Care (Designated) - Specialist (Designated) - Telemedicine/Virtual Visits	 $35 Copay $70 Copay $35 Copay	 50% after Deductible 50% after Deductible No Benefit
Preventive Care	Covered 100%	50% after Deductible
Deductible: - Individual | Family	$2,500 | $7,500	$10,000 | $20,000
Coinsurance	60%	50%
Basic Lab/X-Rays	Covered 100%	50% after Deductible
Total Out of Pocket Max: Individual | Family	$7,500 | $15,800	Unlimited
Urgent Care	$75 Copay	50% after Deductible
Emergency Room	60% after deductible + $500 Copay	
Prescription Drugs - Level I - Level II - Level III - Level IV - Level V - Level VI **Retail/Mail Order – 90 Days Supply**	 $0|$10 $10|$20 $50|$70 $100|$120 $150 $250 3 x Copay	 $10 $20 $70 $120 $150 $250 (+ 50% after Deductible) No Benefit

Website: www.bluecrossblueshield.com

2020 Buy-Up Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
SEMI-Monthly (per pay check)	**$64.50**	**$371.06**	**$294.41**	**$626.52**
2020 Buy-Up Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
WEEKLY (per pay check)	**$32.25**	**$185.53**	**$147.21**	**$313.26**

Dental Insurance:
Available through— Humana


Who is Eligible and When:

All employees are eligible for dental insurance. Newly hired Employees & their dependents enrolling will have coverage go into effect on the first of the month following 60 days of continuous employment. Eligible dependents include – Spouse or children (26 and younger).

Benefits You Receive:

Preventative and Basic Coverage is available to the employee and their family. Employee Pays 100% of the premium cost. Below are the paycheck deductions.

	Base Dental Plan | Tx Prev + INFS 14 100/80 $1,000 Max		
Type of Service	In- Network	Out-Of- Network	Services
Preventive Services	100%	100%	• Cleanings • X-rays • Office Visits • Fluoride Treatments (through age 14) • Sealants (through age 14) • Space Maintainers (through age 14) • Oral Cancer Screening
Basic Services (Deductible Applies)	80%	80%	• Emergency care for pain relief • Amalgam fillings • Oral Surgery (routine extractions) after $50 Deductible
Major Services (Deductible Applies)	*No Benefit*		
Annual Maximum	The Maximum benefit paid per calendar year is $1,000 per person		
Orthodontic Benefit	*No Benefit*		

Website: www.humana.com

2020 Base Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
SEMI-Monthly (per pay check)	$4.32	$9.78	$11.48	$18.07
2020 Base Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
WEEKLY (per pay check)	$2.16	$4.89	$5.74	$9.04

Subject to Humana Dental Services Schedule

Dental Insurance:
Available through— Humana


Who is Eligible and When:

All employees are eligible for dental insurance. Newly hired Employees & their dependents enrolling will have coverage go into effect on the first of the month following 60 days of continuous employment. Eligible dependents include – Spouse or children (26 and younger).

Benefits You Receive:

Preventative and Basic Coverage is available to the employee and their family. Employee Pays 100% of the premium cost. Below are the semi-monthly per paycheck deductions.

	Buy Up Dental Plan | Tx Trad Plus 14 100/80/50 $1,000 Max		
Type of Service	In- Network	Out-Of- Network	Services
Preventive Services	100%	100%	• Cleanings • X-rays • Office Visits • Fluoride Treatments • Sealants • Space maintainers (through age 14) • Oral Cancer Screening
Basic Services (Deductible Applies)	80%	80%	• Emergency care for pain relief • Amalgam fillings • Oral Surgery (routine extractions) after $50 Deductible • Stainless steel crowns and harmful habit appliances for children (through age 14)
Major Services (Deductible Applies)	50%	50%	• Crowns • Inlays/Onlays • Bridges • Dentures • Denture Repair • Implants • Periodontics • Endodontics
Annual Maximum	The Maximum benefit paid per calendar year is $1,000 per person		
Orthodontic Benefit (children through age 19)	50% | (12 month waiting period applies if no prior dental coverage)		

Website: www.humana.com

2020 Buy-Up Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
SEMI-Monthly (per pay check)	$8.17	$16.33	$23.95	$32.74
2020 Buy-Up Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
WEEKLY (per pay check)	$4.08	$8.17	$11.97	$16.37

Subject to Humana Dental Services Schedule

Vision Insurance:
Available through— Humana

Who is Eligible and When:

All employees are eligible for dental insurance. Newly hired Employees & their dependents enrolling will have coverage go into effect on the first of the month following 60 days of continuous employment. Eligible dependents include – Spouse or children (26 and younger).

Benefits You Receive:

Preventative and Basic Coverage is available to the employee and their family. Employee Pays 100% of the premium cost. Below are the semi-monthly per paycheck deductions.

Type of Service	Participating Providers	Non-Participating Providers
Exam with Dilation as necessary **Retinal imaging**	100% After $10 Copay Up to $39	Up to $30 Allowance Not covered
Lenses: - Single - Bifocal - Trifocal - Lenticular	100% after $25 Copay 100% after $25 Copay 100% after $25 Copay 100% after $25 Copay	Up to $25 Allowance Up to $40 Allowance Up to $60 Allowance Up to $100 Allowance
Frames	$100 Frame Allowance 20% off balance over $100	$50 Allowance
Elective Contact Lenses: - Conventional - Disposable - Medically Necessary	$100 Allowance (15% off balance over $100) $100 Allowance 100% after Copay	$80 Allowance $80 Allowance $200 Allowance
Frequency: - Examination - Lenses or contacts - Frames	Once every 12 months Once every 12 months Once every 24 months	

Website: www.vsp.com

2020 Vision Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
SEMI-Monthly (per pay check)	$2.53	$5.06	$4.81	$7.56
2020 Vision Payroll Deductions	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
WEEKLY (per pay check)	$1.27	$2.53	$2.40	$3.78

Section 125: Pre-Tax Premium Plan

Who is Eligible and When:

All employees are eligible to participate in the Pre-Tax Premium Plan. Newly hired Employees & their dependents enrolling will have coverage go in effect on the first of the month following 60 days of continuous employment.

Benefits You Receive:

The Pre-Tax Premium Plan allows your insurance premiums to be deducted from your paychecks before deductions are taken for FICA, federal, and in most cases, state and local taxes. This will reduce your taxes, so you will end up with more take-home pay than if you have the premiums deducted after taxes. Having your insurance premium(s) taken pre-tax from your paycheck costs you nothing extra.

Each employee who participates in one of our insurance plans, and shares in the cost of coverage, will automatically be enrolled in this pre-tax program. If you do not wish to participate, thereby paying your group sponsored insurance premiums with after-tax dollars, contact the Payroll Department to sign the necessary waiver form.

It is important to know that once your insurance premiums are being deducted on a pre-tax basis, **you cannot change your deduction until the start of the next Plan Year unless you experience a qualifying event such as the following:**

- Marriage
- Birth
- Divorce
- Reduction in hours
- Change in eligibility status
- Spouse's employer's annual open enrollment

If you experience a qualifying event, you have 30 days to notify the Payroll Department in writing or email at payroll@goodwillsouthtexas.com for any necessary changes.

Basic Life and AD&D:
Available through — Principal

Who is Eligible and When:

All full-time employees are eligible for Life and AD&D Insurance. Newly hired Employees enrolling will have coverage go in effect on the first of the month following 60 days of continuous employment.

Basic Life & AD&D Insurance

Goodwill Industries of South Texas provides full-time employees with group life and accidental death and dismemberment (AD&D) insurance.

$50,000 for Class I employees – Directors and Above

$20,000 for Class II employees – All other full time employees

Goodwill Industries of South Texas pays the full cost of this benefit. Please complete a new beneficiary form and return to the Payroll Department.

Benefit Reduction to 35% of the original amount at age 65 & and 50% at age 70

Supplemental Life and AD&D:
Available through — Principal

Who is Eligible and When:

All full-time are eligible for Supplemental Life and AD&D Insurance. Newly hired Employees & their dependents enrolling will have coverage go into effect on the first of the month following 60 days of Full-Time employment. Eligible dependents include – Spouse or children (26 and younger).

Voluntary Life & AD&D Insurance:

You may purchase additional Life and AD&D insurance for you and your eligible dependents. If you decline Voluntary Life and AD&D insurance when first eligible or if you elect coverage and wish to increase your benefit amount at a later date, Evidence of Insurability (EOI), proof of good health, may be required before coverage is approved. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through semi-monthly payroll deductions.

Please Note:

* You must elect Voluntary Life and AD&D coverage for yourself in order to elect coverage for your spouse or children.
* Spouse & Child(ren) benefits cannot exceed 100% of the employee's coverage.

Voluntary Life and AD&D	Benefit Amount
Employee	**Increments of:** $10,000 **Minimum Amount:** $10,000 **Maximum Amount:** $500,000 **Guaranteed Issue:** Under age 70 – $150,000 Age 70 and over – $10,000
Spouse	**Increments of:** $5,000 **Minimum Amount:** $5,000 **Maximum Amount:** $100,000 **Guaranteed Issue:** Under age 70 – $30,000 Age 70 and over – $10,000
Child(ren)	**Increments of:** Under 14 days – $1,000 14 days to age 26 – $5,000 **Minimum Amount:** Under 14 days: $1,000 14 to age 26 – $5,000 **Maximum Amount:** 14 to age 26 – $10,000

Monthly Cost for Each $1,000 of Employee & Spouse Life & AD&D Insurance Coverage										
Age	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-67**	**70-74**
Employee	**$.097**	**$.127**	**$.137**	**$.147**	**$.217**	**$.227**	**$.597**	**$.897**	**$1.717**	**$2.777**
Spouse: *Charges based upon individual age.	**$.097**	**$.127**	**$.137**	**$.147**	**$.217**	**$.227**	**$.597**	**$.897**	**$1.717**	**$2.777**
Children:	Children 14 days to age 26 are covered at $1,000 for $0.200									

How to Calculate Your Cost per Paycheck:

_____ X _____ ÷ ____1,000____ = _____

Your Rate per $1,000 | **The amount of coverage you are electing** | **Your Total Monthly Rate**

_____ X _____12_____ ÷ _____24_____ = _____

Your Total Monthly Rate | **Your Cost Per Paycheck**

Short | Long Term Disability:
Available through — Principal


Who is Eligible and When:
All full-time employees are eligible for Short Term and Long Term Disability Insurance. Employees enrolling will have coverage go into effect on the first of the month following 60 days of Full-Time employment.

Benefits You Receive:
In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

Employee Pays:
Goodwill provides Short Term Disability and Long Term Disability coverage to all full-time employees at no cost.

Benefits	Short-Term Disability	Long-Term Disability
Benefits Begin	On the 15th day for Injury or Sickness	90 days from Injury or Sickness
Benefit Duration	Maximum of 11 weeks	To age 65 or Social Security
% of Income Replaced	60% of Base Weekly Earnings	60% of Base Monthly Earnings
Maximum Benefit	60% of Weekly Salary up to $1,500 per month	60% of Monthly Salary up to $8,000 per month

Have You Ever

- ☐ Needed your Will prepared or updated?
- ☐ Signed a contract?
- ☐ Received a moving traffic violation?
- ☐ Worried about being a victim of identity theft?
- ☐ Been concerned about your child's identity?
- ☐ Lost your wallet?

The LegalShield Membership Includes:

- **Dedicated Law Firm** Direct access, no call center
- **Legal Advice/Consultation** on unlimited personal issues
- **Letters/Calls** made on your behalf
- **Contracts/Documents Reviewed** up to 15 pages each
- **Residential Loan Document Assistance** for the purchase of your primary residence
- **Will Preparation** – Living Will, Health Care Power of Attorney, Financial Power of Attorney
- **Speeding Ticket Assistance** Upload your speeding ticket from the mobile app directly to law firm
- **IRS Audit Assistance** (begins with the tax return due April 15th of the year you enroll)
- **Trial Defense** (if named defendant/respondent in a
- covered civil action suit)
- **Uncontested Divorce, Separation, Adoption and/or Name Change Representation** (available 90 days after enrollment)
- **25% Preferred Member Discount** (bankruptcy, criminal charges, DUI, personal injury, etc.)
- **24/7 Emergency Access** for covered situations

The IDShield Membership Includes:

- **1 Bureau Credit Monitoring** from TransUnion with activity alerts
- **High Risk Application and Transaction Monitoring** detects fraud up to 90 days earlier than traditional credit monitoring services. We carefully watch your accounts, reorders, loans and more. If a new account is opened, you will receive an alert
- **Social Media Monitoring** for privacy and reputational risks
- **Credit Inquiry Alerts** when your Personally Identifiable Information (PII) is used to apply for bank/credit cards, utilities or rentals, and many other types of loans
- **Consultation** on any cyber security question
- **$1 Million Protection Policy** coverage for lost wages, legal defense fees, stolen funds and more
- **Unlimited Service Guarantee** ensures that we won't give up until your identity is restored!
- **Identity Restoration** performed by Licensed Private Investigators to restore your identity to its pre-theft status.
- **24/7 Emergency Access** in the event of an identity theft emergency

Put your law firm and identity theft protection in the palm of your hand with the LegalShield & IDShield Plus mobile apps

Plan	Family Price (Weekly/Semi-Monthly)	Individual Price (Weekly/Semi-Monthly)
LegalShield	$4.37/$9.38	$3.91/$8.48
IDShield	$4.37/$9.48	$2.07/$4.48
Combined	$7.82/$16.95	$5.98/$12.95

For more information, call
LegalShield Member Services at 800-654-7757.

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under the age 18 for whom the member is the legal guardian; never married dependent children up to age 26 if a full-time college student; or physically or mentally disabled dependent children.

IDShield is a product of Pre-Paid Legal Services, Inc. d/b/a LegalShield ("LegalShield"). LegalShield provides access to identity theft protection and restoration services. For complete terms, coverage and conditions, please see www.idshield.com. IDShield plans are available at individual or family rates. A family rate covers the named member, named member's spouse and up to 10 dependent children under the age of 18. It also provides consultation and restoration services for dependent children ages 18 to 26. All Licensed Private Investigators are licensed in the state of Oklahoma. A $1 million protection policy is issued through a nationally recognized carrier. LegalShield/IDShield is not an insurance carrier. Certain limitations apply. Dependent children of the named member or named member's spouse under the age of 23 who permanently live in the same residence as the named member at the time of the stolen identity event are eligible for the protection policy coverage. For a summary description of benefits for the personal identity coverage see https://idshield.cloud/summary-of-benefits.

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AFLAC is offering NEW Group Products for all Employees this year. We will no longer be offering the Traditional AFLAC products as we have in the past. This is being done in an effort to simplify the enrollment process.

- If you have existing policies with AFLAC you can keep them on a direct basis and have them Bank Draft out of your personal bank account at the same Monthly rates & Benefits.
- Or you can switch over to the New Group Products which are very similar to what was being offered. Just go online at Kronos and choose which products you would like.
- The Cancer benefit is now included with the Critical Illness policy and pays $20,000.
- For employees with an existing Cancer policy I highly recommend you keep your old policy in effect!!!
- The easiest way to keep your existing AFLAC policies is to call AFLAC direct at 1-800-992-3522 and tell them to start bank drafting after 9-1-2020.
- Wave goodbye to the waiting room. Aflac introduces MeMD, a telemedicine service. With MeMD, you can get care right where you are using your phone, app or by going online - applicable copay will apply for each visit - see flyer for treatments, conditions and prescriptions MeMD provides.

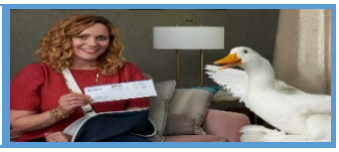
If you are unsure which product is better for you, or if you have any questions concerning AFLAC's benefits or how to keep your current policies in effect please call:

Debbi LeGros your AFLAC Agent
361-947-1971
deborah_legros@us.aflac.com

Listed below are the new products and prices:

Supplemental Insurance:

Available through – Aflac



Who is Eligible and When:

All employees, Full Time and Part-Time are eligible for Voluntary Supplemental Insurance. Newly hired Employees & their dependents enrolling will have coverage go into effect on the first of the month following 60 days of Full-Time employment. Eligible dependents include – Spouse or children (26 and younger).

Benefits You Receive:

Lump Sum Critical Illness (Heart Attack/Stroke Policy with Cancer)

Supplemental policy that pays a Lump Sum in the event you are diagnosed with a Cancer, Heart Attack, Stroke, Coma, Paralysis, Renal failure or Human Organ Transplant. This is a $20,000 Guaranteed Issue amount and the spouse gets a guaranteed issue of $10,000. Wellness benefit is $50 a year.

**Semi Monthly Deductions*

Enrollment Age	Employee- Non Tobacco $20,000	Spouse- Non Tobacco $10,000	Employee- Tobacco $20,000	Spouse - Tobacco $10,000
18-29	$4.77	$2.72	$6.66	$3.67
30.-39	$7.68	$4.18	$11.94	$6.31
40-49	$14.82	$7.75	$23.30	$11.99
50-59	$28.64	$14.66	$46.38	$23.53
60 +	$54.77	$27.72	$85.79	$43.23

Children are covered at 50% of the employee amount and are FREE

Off the Job Accident Policy

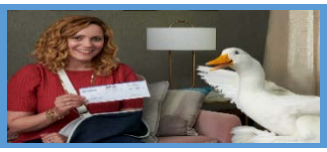
Supplemental policy that pays directly to you in the event of a covered accident to help cover out of pocket expenses associated with having an accident. These plans also have a $50.00 Wellness Benefit and are Guaranteed Issued.

**Semi Monthly Deductions*

Enrollment Type	Cost
Employee Only	$4.30
Employee & Spouse	$7.59
Employee & Child(ren)	$10.30
Employee & Family	$13.59

Supplemental Insurance:

Available through – Aflac



Hospital Advantage:

Supplemental policy that pays directly to you in the event you are confined INPATIENT to a hospital for a covered event. The Initial Hospital Confinement Benefit pays $1,000 and $100 a day there after.

Semi – Monthly Deductions

Age	Premium
Employee Only 18-75	$6.91

Age	**Premium**
Employee/Spouse 18-75	$13.92

Age	**Premium**
Employee/Child(ren) 18-75	$10.86

Age	**Premium**
Employee/ Family 18-75	$17.87

Supplemental Insurance:

Available through – Aflac

20 Year Term Life Insurance Policy:

A Supplemental life insurance policy that allows you to apply for volumes for coverage of $25,ooo or $50,000. No Physical examinations and Guaranteed issued as long as participation requirements are met.

***Semi-Monthly Deductions*

Employee

Enrollment Age	$25,000- Non Tobacco	$50,000- Non Tobacco
25	$3.21	$5.59
35	$4.45	$8.05
45	$7.98	$15.12
55	$14.58	$28.33
65	$29.17	$57.52

Enrollment Age	$25,000- Tobacco	$50,000- Tobacco
25	$5.38	$9.93
35	$7.96	$15.07
45	$15.62	$30.41
55	$30.06	$59.29
65	$61.09	$121.36

Spouse

Enrollment Age	$25,000- Non Tobacco
25	$2.38
35	$3.61
45	$7.14
55	$12.96
65	$28.34

Enrollment Age	$25,000- Tobacco
25	$4.54
35	$7.12
45	$14.79
55	$27.57
65	$60.26

Rates shown are for example only; Specific rates for EXACT age and benefit amount will be provided at time of enrollment.

2020 AFLAC BENEFIT

Ben Extend Insurance

3 PRODUCTS IN 1

AFLAC has come up with an Innovative Cost Solution by combining our 3 most popular products in to 1 benefit. You can still purchase or keep your traditional AFLAC products (i.e. Cancer, Accident, Critical Illness), but you also have the option to purchase BenExtend.

See the rates below and the BenExtend flyer attached.

Semi-Monthly Rates	
Employee	$14.60
Employee & Spouse	$28.69
Employee & Children	$21.29
Family	$35.38

Weekly Rates	
Employee	$6.74
Employee & Spouse	$13.24
Employee & Children	$9.82
Family	$16.33

BenExtend®

Aflac

You can't predict the unexpected, now you don't have to.

Life is fast-paced. Who has time (or wants) to research insurance? Aflac understands that knowing which benefits are right for you isn't always easy. That's why we created *BenExtend*, a new kind of product – one that takes the guesswork out of choosing your benefits. *BenExtend* features commonly-used benefits from three different types of insurance – accident, hospital indemnity and critical illness. You'll get a range of benefits in one simple plan at one straightforward price. And you'll know the benefits are there when you need them – for greater financial security and even greater peace-of-mind.

BenExtend

- **Critical Illness Benefits**
- **Accident Benefits**
- **Hospital Indemnity Benefits**

BenExtend combines commonly-used benefits of hospital indemnity, critical illness and accident insurance products into a simple plan design.

Best of all, Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Benefits can be used to help with your every day living expenses, like your rent or mortgage, utility bills, groceries and more.

BenExtend plans are designed to help ease the financial stress of a critical illness, accident or hospital stay with benefits such as:

- Hospital Admission Benefit
- Hospital Confinement Benefit
- Initial Injury Treatment
- Pays a lump sum benefit for a covered critical illness such as a heart attack or stroke

Learn more about *BenExtend* today!

aflacgroupinsurance.com | 1.800.433.3036
Continental American Insurance Company • Columbia, South Carolina

MeMD™

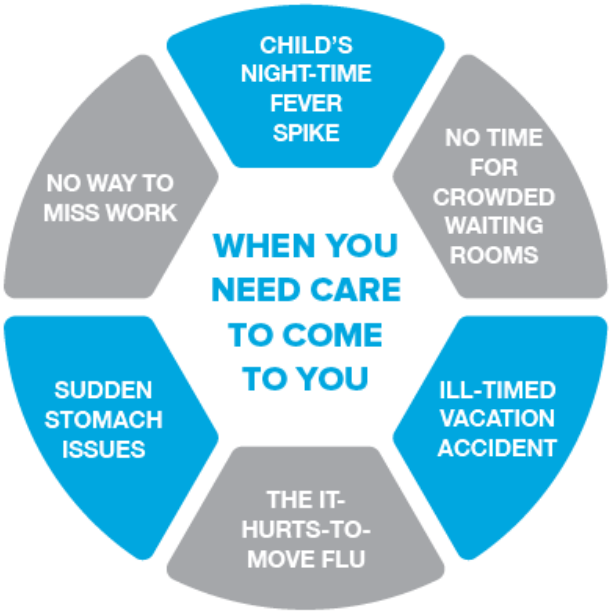
Wave goodbye to the waiting room.

With MeMD, available through Aflac, care is just a click away.

Not feeling so great? Avoid the waiting room, and get care right where you are — from your phone, app or online. Introducing MeMD™ telemedicine service.

It's natural during times like this for individuals to be wary of physically visiting a care facility, even if they need to consult with a medical professional. Telehealth services provide access to medical providers or licensed behavioral health specialists online for personalized treatment anytime, almost anywhere. MeMD has also made a resource widely available to provide **COVID-19 facts and tips to minimize workplace risks.**

With MeMD, you or your family members can connect to a board-certified, U.S.-licensed medical provider from almost any location. Day and night. Weekends and holidays. All using your phone or computer. You'll get a confidential diagnosis, along with a treatment plan and needed prescriptions for common medications.



MeMD PROVIDES CARE WHEN YOU NEED IT.

- **Private consultations** with U.S. licensed medical providers or licensed behavioral specialist
- **Get help 24/7** nearly anywhere in the U.S.
- **Connect** by phone, web or mobile app
- **Visit fee** per service
- **Easy registration** and payment

Aflac | Value-Added Services

With MeMD, get help for conditions like:


Abrasions, bruises, sprains and strains


Allergies, asthma, hives, skin infections, bites and stings


Sinus infections and symptoms, fever, sore throat, cough, body aches


Dehydration, vomiting, nausea, urinary tract infections


Anxiety, insomnia, migraines


Short-term medication refills and more

For help, when and where you need it.

When your coverage begins, call: **855-636-3669** | visit: **MeMD.me/Aflac.**

Available through Aflac, powered by MeMD™.

CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service providers, and does not own or administer any of the products or services provided by the Value-Added Service providers. Each Value-Added Service provider offers its products and services subject to its own terms, limitations and exclusions. Value-Added Services are not available in Idaho or Minnesota. State availability may vary. Continental American Insurance Company, a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated.

When medically necessary, MeMD's providers (except therapists) can submit a prescription electronically for purchase and pick-up at your local participating pharmacy; however, MeMD providers cannot prescribe elective medications, narcotic pain relievers, or controlled substances. MeMD's providers are each licensed by the appropriate licensing board for the state in which they are providing services and all have prescriptive authority for each of the states in which they are licensed.

aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company | Columbia, South Carolina

Group Hospital Indemnity Insurance

Even a small trip to the hospital can have a major impact on your finances.

As health care costs continue to rise, employees realize they are responsible for paying more and more out-of-pocket costs with every accident and illness. Aflac is designed to help families plan for the health care bumps ahead and take some of the uncertainty and financial insecurity out of getting better.

How will you help protect your savings when you have a covered accident or sickness?

If you are confined to the hospital, major medical insurance will help with many medical expenses, but you could be left with out-of-pocket expenses. You could also lose pay while you're out of work. And you can be sure that the bills will keep coming. Aflac is here to help.

It's insurance for daily living:

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group hospital indemnity insurance plans are designed to provide you with cash benefits to help with the following:

- A covered hospital stay
- Everyday living expenses, like your rent or mortgage, utility bills, groceries, and more
- It even provides coverage for newborn children for 60 days from the date of birth*

Enroll today

Learn how group hospital indemnity insurance can help you.

Aflac®

*Applies to newly adopted children as well. Refer to the plan for complete details.

This is a brief product overview only. The plan has limitations and exclusions that may affect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

In Arkansas, Policy C80100AR. In Idaho, Policy C80100ID, In New York, Policy AF80100NY. In Oklahoma, Policy C80100OK, In Oregon, Policy C80100OR. In Pennsylvania, Policy C80100PA. In Texas, Policy C80100TX. In Virginia, Policy C80100VA.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, group coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by American Family Life Assurance Company of and customer service is administered by Continental American Insurance Company, 22 Corporate Woods Boulevard Albany, New York 12211.

Continental American Insurance Company • Columbia, South Carolina

AGC1501067 R1 IV (1/20)

AC^G | ACCIDENT

Accidents happen to all kinds of people every day.

What would the financial impact of an injury mean to you? Are you prepared for high medical costs in addition to everyday household expenditures and lost wages? Out-of-pocket expenses associated with an accident are unexpected, but an accident's impact on your finances and your well-being certainly can be reduced.

Aflac is here to help. If you have an accident, major medical insurance will help with many medical expenses, but you could be left with out-of-pocket expenses. You could also lose pay while you're out of work. And you can be sure that the bills will keep coming.

IT'S INSURANCE FOR DAILY LIVING:

Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group accident insurance plans are designed to provide you with cash benefits throughout the different stages of care, such as the following:

- Emergency treatment
- Hospital admission
- Intensive care unit
- Ambulance transportation
- Travel expenses to distant treatment centers
- Everyday living expenses, like your rent or mortgage, utility bills, groceries, and more

DEDICATED LOCAL SERVICE

Ask your Aflac agent how group accident insurance can help you. Remember, we're always by your side. And you're always under our wing.

AGC1700402

IV (2/17)

Group Term Life Insurance

Even starting with a little can add up to a lot.

Aflac's group term life insurance helps take care of your loved ones' immediate and future needs if you should pass away. Immediate needs can include burial/funeral expenses, uninsured medical costs and current bills and debts. Future needs could include income replacement, education plans, ongoing family obligations, emergency funds, and retirement expenses.

It's insurance for daily living:

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that your family will have added financial resources to help with ongoing living expenses. Aflac's group term life insurance offers an option that can help protect your financial freedom.

Enroll today

Learn how group term life insurance can help you.

Aflac

This is a brief product overview only. The plan has limitations and exclusions that may affect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

In Idaho, Policy CAI9100R. In Oklahoma, Policy CAI9100OK.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situsedin California, group coverage is underwritten by Continental American Life Insurance Company. For groups situsedin New York, coverage is underwritten by American Family Life Assurance Company of York and customer service is administered by Continental American Insurance Company, 22 Corporate Woods Boulevard Albany, New York 12211.

Continental American Insurance Company • Columbia, South Carolina

AG9180 R3 IV (2/20)

Group Critical Illness Insurance

You can count on Aflac to help ease the financial impact of surviving a critical illness.

Chances are you know someone who's been diagnosed with a critical illness such as cancer, a heart attack (myocardial infarction), or stroke. You can't help but notice the strain it's placed on the person's life–both physically and emotionally. What's not so obvious is the impact on that person's personal finances. While the person is busy getting well, the bills may continue to pile up.

Would you have the money to cover the out-of-pocket expenses such as:

- Transportation to a distant medical facility.
- Specialized treatment costs.
- Living expenses like rent, mortgage, and utility bills.

It's insurance for daily living:

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group critical illness insurance plans are designed to provide you with a lump sum benefit for a covered critical illness such as: cancer, heart attack, or stroke.

Enroll Today

Learn how critical illness insurance can help you.

Aflac

AG28802 R4 IV (4/19)

Questions & Answers

Changes that can be made effective September 1, 2020:

- Enroll or terminate individual and/or dependent coverage in the medical, dental, vision and voluntary life plans.

Forms to be completed if making changes:

- Online Enrollment

What Forms MUST be completed?

- Online Enrollment

Will I get new ID cards?

- Yes. You will receive a new medical card since Goodwill Industries of South Texas will be switching medical carriers. You can request a card directly from Blue Cross Blue Shield if you misplace your card and you can also contact the Account Manager Odilia Robles at 361-883-1711 ext. 4303. Dental and Vision cards will not be reissued; you can use the same card unless you make a plan change.

Should I assume my provider still takes my insurance? Or my prescription is still covered?

- No, throughout the year providers are either joining or dropping the networks. Always make sure your provider is in-network by referring to the Blue Cross Blue Shield website at www.bcbstx.com
- Every year carriers change their prescription drug list. Please refer to the Blue Cross Blue Shield website at www.bcbstx.com to see if you current prescriptions will be affected.

Urgent Care vs. Emergency Rooms?

- The cost of treating **MOST** common medical conditions can be up *5 times greater* in the Emergency Room than in a physician's office or an **Urgent Care Center**.
- Up to 1/3 of all ER visits are for the treatment of non-emergent conditions.
- Urgent Care Symptoms may include: Moderate Fever, Colds, Flu, Bruises, Abrasions, Minor Cuts or Minor Burns.
- Persons experiencing a situation requiring prompt medical attention, that is not life-threatening, may receive faster care at an urgent care clinic or by scheduling a same-day appointment with their primary care physician, if available.

Members seeking care at an Urgent Care Center vs. the Emergency Room will save at least $50 per visit!

Go to www.bcbstx.com or download the Blue Cross Blue Shield app on you smartphone to find a clinic located the closest to you.

More Questions & Answers:

It's Ok to Ask…

- When receiving a prescription from your physician, ask the doctor for free samples. It will save you money!

Did you Know….

- You can use your smartphone to download the apps for Blue Cross Blue Shield, Humana, Principal, and even Aflac?
- The apps give you complete access to your ID cards and group numbers; you can also search for in-network doctors and pharmacies in your area.

403b Retirement Savings-Mass Mutual

Who is Eligible and When:

All Employees are eligible 1st day of the month after 60 days from date of hire.
Employees are eligible for matching in the 403(b)plan on the first day of the calendar quarter following 1 year of service.

Employee Contributions:

Employees can contribute up to 100% of salary up to a maximum of $19,500 (eff. 2020) per calendar year into various investment options. Participants age 50 an older may make "catch-up" contributions subject to dollar limits. The catch-up contribution limit has increased to $6,500 for the 2020 fiscal year.

Currently to help you save for retirement, Goodwill Industries of South Texas will match dollar per dollar up to 5% of the employee's compensation, when an employee contributes to the plan. This matching is subject to change annually at the discretion of the Board. You vest, or gain ownership, in the matching contributions from Goodwill based on the following schedule:

Vesting Schedule	
0%	1 Year of Service
20%	2 Year of Service
40%	3 Year of Service
60%	4 Year of Service
80%	5 Year of Service
100%	6 Year of Service

Cost to Employee:

Pre-Tax contributions: See Summary Plan for any additional fees and/or charges.

Contact Information:

Alyssa Loya 361-271-1211 Service@admin316.com	John A. Seaman, MSFS, CFP Bus. 361-993-8888 Fax: 361-992-5866 www.seamanfinancial.com	Toll Free Number: 1-800-528-9009 Address: 5830 Mc Ardle, Ste. 204 Corpus Christi, TX 78412

EASY ACCESS to your account

Two easy ways to monitor and manage your account.

1. ONLINE

Log into our website at **www.massmutual.com/serve.** Here you can access powerful retirement planning tools and calculators, and manage your account — anytime, from virtually anywhere.

You'll be able to:

- Obtain current account balances
- Change your investment options
- Perform account transactions
- Transfer (exchange) balances between investment options*
- Check current investment prices and performance
- View and download your quarterly electronic statements
- Reset/enable your PIN and user ID

If you are having trouble accessing your account for the first time, please contact your Participant Service Center at 1-800-528-9009 for assistance.

2. BY PHONE

1-800-528-9009

With our voice-activated telephone system, you control the call to get the information you need from any telephone, at any time, simply by speaking.

Please provide your user ID and PIN when prompted. This will help expedite your call should you need to speak with a MassMutual customer service representative.

The system will ask you to state the reason for your call. Simply speak clearly and the system will respond accordingly.

Do you prefer receiving your retirement account information in a language other than English? Access to the Language Line is available in over 140 languages through a Customer Service Representative during normal business hours.

* You are allowed to submit a total of 20 transfer requests each calendar year for your participant account by any permitted means. Once these 20 transfers have been requested, you may submit any additional transfer requests only in writing by U.S. mail. Transfers as a result of dollar-cost averaging (if applicable) do not count toward the 20-transfer limit. Each calendar year, MassMutual resets your transfers to allow 20 new transfers by all approved methods.

QUICK LINK TIP

Want quick access to your account?

1. Go to **www.massmutual.com/serve.**
2. Click *Login* at the top right of the screen.
3. Log in to view or manage your account.

Important Notices About Your Health Plan & Rights

HEALTH CARE REFORM NOTICE

Non-Grandfathered Plan

This group health plan is a non-grandfathered plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As a non-grandfathered plan, the plan sponsor is able to make changes that reduce benefits or increase costs to consumers. However, these plans gain additional benefits including:

- Coverage of recommended preventive services with no cost sharing; and
- Patient protections such as guaranteed access to OB-GYNs and pediatricians.

All health plans, whether or not they are grandfathered plans, must provide certain benefits to their employees for plan years starting on or after September 23, 2010 including:

- No lifetime limits on coverage for all plans;
- No rescissions of coverage when people get sick and have previously made an unintentional mistake on their application
- Extension of parents' coverage to your adults under 26 years of age;
- No coverage exclusions for children with pre-existing conditions; and
- No "restricted" annual limits (e.g. annual dollar-amount limits on coverage below standards to be set in future regulations).

You should contact your plan administrator at (361) 884-4068 if you have any questions. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

PATIENT PROTECTION AND AFFORDABLE CARE ACT 2010 ("PPACA")

Special Enrollment Notice for Dependent Coverage of Children Up 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 Goodwill Industries of South Texas Employee Benefit Plan. Individuals may request enrollment for such children for 30 days from the date of this notice. Enrollment will be effective retroactively to the Plan Year Effective Date. For more information, contact your employer or Blue Cross Blue Shield Insurance Company at (800) 521-2227.

Special Enrollment Notice for Individuals Who Have Reached Lifetime Limit

The lifetime limit on the dollar value of benefits under Goodwill Industries of South Texas Group no longer applies. Individuals whose coverage ended because 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. For more information, contact your employer or Blue Cross Blue Shield Insurance Company at (800) 521-2227.

IMPORTANT INFORMATION CONCERNING PRE-EXISTING

HIPAA regulations allow an individual to obtain new health coverage regardless of any pre-existing medical conditions, upon "proof of creditable coverage".

Creditable coverage for HIPAA purposes means an individual's coverage under a previous group health plan, individual coverage, Medicare, Medicaid, a public health plan, a medical or dental plan for members of the uniformed services and their dependents, an Indian or tribal organization medical program, a State health risk pool, the Federal Employees Health Benefits program or a Peace Corps health benefits plan. A college plan is considered creditable coverage, and colleges must provide certification of health insurance coverage to students losing coverage, even temporarily.

Creditable coverage from a previous health plan or policy is used to shorten or waive the pre-existing condition limitation when an individual leaves one plan and joins another. An individual's pre-existing condition exclusion period is reduced or eliminated by such individual's days of creditable coverage provided that there was not a break in coverage of 63 or more consecutive days. Any waiting period for benefit coverage from an employer must run concurrently with any pre-existing limitation.

HIPAA reduces or eliminates pre-existing condition exclusions depending on the circumstances under which the new employee enters the plan. Group health plans and/or their insurers will not be able to deny employee coverage or apply pre-existing conditions exclusions to individuals who had prior health coverage for at least 12 months.

When enrolling, an individual should present a letter of Creditable Coverage to Blue Cross Blue Shield Insurance Company in order to satisfy pre-existing requirements of prior coverage. Without this letter of Creditable Coverage, Blue Cross Blue Shield Insurance Company may assume that there was no prior coverage and initiate an investigation of possible pre-existing claims.

IMPORTANT NOTE: According to the Patient Protection and the Affordable Care Act of 2010 ("PPACA"), pre-existing condition exclusions do not apply for any enrollee under the age of 19 for plan years beginning on or after September 23, 2010.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Your Group Health Plan (the "Plan"), and its selected Third Party Administrator, All Savers Insurance Company, understands the importance of keeping your personal health information private and is committed to maintaining and protecting the confidentiality of this sensitive information. We are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information and to send you this Notice about our policies, safeguards and practices. When we use or disclose your confidential information, we are bound by the terms of this Notice or our revised notice, if we revise it.

How your personal health information is protected

The Plan is required by law to take reasonable steps to ensure the privacy of your personal health information and to inform you about:

- The Plan's uses and disclosures of Protected Health Information (PHI);
- Your privacy rights with respect to your PHI including;
- Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- The Plan's duties with respect to your PHI;
- The person or office to contact for further information about the Plan's privacy practices.
- The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Uses and disclosures of your PHI

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it. The Plan and its Business Associates will not use your PHI or disclose it to others without your authorization, except for the following purposes:

- **Treatment.** The Plan may disclose your PHI for its provision, coordination or management of your health care and related services. It also includes, but is not limited to, consultations or referrals to one or more of your providers.

Example: The Plan may disclose to a treating orthodontist the name of the participant's treating dentist so that the orthodontist may ask for the dental x-rays from the treating dentist.

- **Payment**. The Plan may disclose your PHI for the payment of your benefits under the Plan. This includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

Example: The Plan may tell a doctor whether the plan participant is eligible or what percentage of the bill will be paid by the Plan.

- **Health Care Operations.** The Plan may use or disclose your PHI for the health care operations of the Plan. This includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

Example: The Plan may use information about the participant's claim to refer the participant to a disease management program, project future costs, or audit the accuracy of its claims processing functions.

- **Required by Law.** The Plan must disclose your PHI when required by law.

Individual Rights

- *Right to Request Restrictions on PHI Uses and Disclosures*
  You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

  The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Privacy Officer as identified below.

- *Right to Inspect and Copy PHI*
  You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

  PHI includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

  "*Designated Record Set"* includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analysis and not used to make decisions about individuals is not the designated record set.
  The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.
  You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Privacy Officer as identified below.

  If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the secretary of the U.S. Department of Health and Human Services.

- *Right to Amend PHI*
  You have the right to request the Plan to amend your PHI or request a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

  The plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

  Requests for amendment of PHI in a designated record set should be made to the Privacy Officer as identified below.

- *The Right to Receive an Accounting of PHI Disclosures*
  At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; (4) based on your written authorization.

If accounting cannot be provide within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

- *The Right to Receive a Paper Copy of This Notice Upon Request*
  To obtain a paper copy of this Notice contact the Privacy Officer as identified below.

- *A Note About Personal Representatives*
  You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:
    - A power of attorney for health care purposes, notarized by a notary public;
    - A court order of appointment of the person as the conservator or guardian of the individual; or
    - An individual who is the parent of a minor child.

The Plan Duties

The Plan and its Business Associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations.

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning April 14, 2004 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior that date. If a privacy practice is changed, a revised version of this notice will be provided [to all past and present participants and beneficiaries] for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

- *Minimum Necessary Standard*
  When using or disclosing PHI or when requesting PHI for another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount or PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

  However, the minimum necessary standard will not apply in the following situations:
    - Disclosures to or request by a health care provider for treatment;
    - Uses or disclosures made to individual;
    - Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
    - Uses or disclosures that are required by law;
    - Uses or disclosures that are required for the Plan's compliance with legal regulations

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. De-identifiable information is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summaries the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

If you want more information about your privacy rights, do not understand your privacy rights, are concerned that the Plan has violated your privacy rights or disagree with a decision that the Plan has made about access to your confidential information, you may contact the Plan's Privacy Officer Privacy Officer. You may also file written complaints with the Secretary of the U.S. Department of Health and Human Services. Please call the Plan's Privacy Officer to obtain the correct address for the Secretary. The Plan will not take any action against you if you file a complaint with the Secretary against the Plan.

You may contact the Plan's Privacy Officer at:
Goodwill Industries of South Texas Group
John Spencer
2961 S. Port Ave.
Corpus Christi, TX | 78405
(361) 884-4068

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 codes of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

GENERAL NOTICE OF SPECIAL ENROLLMENT RIGHTS
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your group health plan is required to provide you this notice explaining your group health plan's procedures for your special enrollment rights

Your Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or your spouse or dependents may also have special enrollment rights in another group health plan at the time a claim is denied as a result of a lifetime limit on all benefits, if you request enrollment within 31 days after the claim has been denied.
Contact your plan administrator to request a special enrollment.

CONTINUATION COVERAGE RIGHTS UNDER COBRA (General Notice)
Introduction:

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."
-

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this written notice to:

Goodwill Industries of South Texas Group
John Spencer
2961 S. Port Ave.
Co0rpus Christi, TX | 78405
(361) 884-4038

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

IMPORTANT NOTICE FROM GOODWILL INDUSTRIES OF SOUTH TEXAS GROUPABOUT 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 Goodwill Industries of South Texas Group Employee Health Plan and 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. Blue Cross Blue Shield Insurance Company has determined that the prescription drug coverage offered by Goodwill Industries of South Texas Group is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current Blue Cross Blue Shield Insurance Company coverage may be affected. The Goodwill Industries of South TX, Employee Benefit Plan provides prescription coverage for certain covered medications. The prescription coverage for both of the adopted Blue Cross Blue Shield Insurance Company MTBCB026 - Base plan has a $0 |$10 co-pay for tier 1 prescriptions, a $10 | $20 co-pay for tier 2 prescriptions, a $50|$70 co-pay for tier 3 prescriptions, and a $100|$120 co-pay for tier 4 prescriptions, a $150 co-pay for tier 5, and a $250 co-pay for tier 6. For the MTBCP022 – Buy-Up plan, that has a $0 |$10 co-pay for tier 1 prescriptions, a $10 | $20 co-pay for tier 2 prescriptions, a $50|$70 co-pay for tier 3 prescriptions, and a $100|$120 co-pay for tier 4 prescriptions, a $150 co-pay for tier 5, and a $250 co-pay for tier 6. Further details of your prescription coverage can be found in your Summary Benefit of Coverage documents. If you do decide to join a Medicare drug, plan and drop your current Goodwill Industries of South Texas Group coverage, be aware that you and your dependents may be able to get this coverage back at our next open enrollment or upon a qualifying event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact human resources for further information or call Blue Cross Blue Shield Insurance Company at (800) 521-2227. **Note:** You will 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 Goodwill Industries of South Texas Group 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).

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Federal law (Newborns' and Mothers' Health Protection Act of 1966) prohibits the plan from limiting a mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery for from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

NOTICE OF THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998 (WHCRA). As part of the Plan's compliance with the WHCRA, the Plan is required to provide you with this notice outlining the coverage that this law requires the Plan to provide.

The Plan provides coverage for medically necessary mastectomies. This coverage includes procedures to reconstruct the breast, on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. As a result of WHCRA, the Plan also provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance and any complications that could result from that surgery.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed;
3. Prostheses; and
4. Treatment of physical complications resulting from any stage of the mastectomy, including lymphedema.

These benefits are subject to the same deductible, co-pays and coinsurance that apply to other medical and surgical benefits provided under this plan.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP

programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084

CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	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
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK** – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone:1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	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
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

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

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November and continues thru February of each year.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. For more information on the Marketplace, please visit www.healthcare.gov.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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