Special Enrollment Rights

Under the group Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may be entitled to enroll in a group health plan at times other than initial eligibility or the Annual Enrollment period. You have special enrollment rights if you and/or your eligible dependents lose other group health coverage or you gain a new dependent. If either of these events occurs, you must enroll within the 31-day time limit explained here, or you will lose your special enrollment rights for that event.

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 the medical and/or dental 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 you 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 or your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you fail to request enrollment within the 31 day time period, you and your dependents will lose the special enrollment rights for that event.

If you or your dependent is eligible, but not enrolled, for health coverage under your employer's medical plan, you and/or your dependent may enroll in the plan if (i) your Medicaid or CHIP coverage is terminated as a result of loss of eligibility or (ii) you and/or your dependent become eligible for employment assistance under Medicaid or CHIP. However, to be eligible for this special enrollment opportunity, you must request coverage under the group health plan within 60 days after the date you and/or your dependent become eligible for premium assistance under the Medicaid or CHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends. For more information on CHIP and Medicaid, please see the section below entitled CHIP Premium Assistance.

To request enrollment due to a special enrollment right or obtain more information, contact your Human Resources Department.

Michelle's Law

Subject to future regulations and the Affordable Care Act, your employer will comply with all the required provisions of Michelle's Law with respect to health benefits provided under this plan to dependent children over the age of 18 who are enrolled in an institution of higher education on a full-time basis. If the dependent child is enrolled on a full-time basis and subsequently loses his/her fulltime status at his/her institution of higher education as a result of taking a "medically necessary leave of absence" (as defined under Michelle's Law) due to a serious illness or injury, coverage for the dependent under your employer's medical plan will not terminate until the earlier of (i) the date that is one year after the first day of the medially necessary leave of absence or (ii) the date coverage would other wise terminate under the plan. The student/dependent on leave is entitled to the same benefits as if he/she had not taken a leave. If coverage changes during the student's leave, then this law applies in the same manner as the prior coverage. For more information about Michelle's Law and your dependent's benefit coverage under Michelle's Law, please contact your Human Resources Department.

Important Health Notice

Mental Health Parity Act (MHPA)

Your employer's medical plan complies with the Mental Health Parity Act of 1996 ("MHPA"). Pursuant to such compliance, the annual and lifetime limits on Mental Health Benefits, if any, will not be less than the annual and lifetime plan limits on other types of medical and surgical services (if any limits apply). The plan does utilize cost containment methods, applicable for Mental Health Benefits, including cost-sharing, limits on the number of visits or days of coverage, and other terms and conditions that relate to the amount, duration and scope of Mental Health Benefits.

Newborns' and Mothers' Health Protection Act (NMHPA)

Your employer's medical plan will comply with all required provisions of the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA") with respect to health benefits provided under this plan. The plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother of a newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. You only need to pre-certify maternity hospital stays if the hospital stay will be longer than the periods specified above. However, you must still pre-certify any hospital admission during your pregnancy that is not due to delivery or is in excess of the applicable timeframes outlined above. In addition, the plan will not require that a provider obtain authorization from the plan an insurer for prescribing a length of stay not in excess of the above periods. However, the NMHPA generally does not prohibit the mother's or newborn's attending provider, after consulting with and obtaining consent from the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act (WHCRA)

Your employer's medical plan complies with all required provisions of the Women's Health and Cancer Rights Act of 1998 ("WHCRA") with respect to health benefits provided under this plan. The plan will cover certain breast reconstruction and other benefits in connection with a mastectomy. If you elect breast reconstruction in connection with a mastectomy, coverage is available in a manner determined in consultation with you and your physician 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, (3) prosthesis and (4) treatment of physical complications for all stages of mastectomy, including lymphedemas. Such coverage remains subject to the terms of the Plan, including normal deductible, copay and coinsurance provisions.

Genetic Information Nondiscrimination Act of 2008 (GINA)

Your employer's medical plan will comply with all required provisions of GINA with respect to health benefits and coverage under this plan. The plan will not discriminate on the basis of genetic information, including information about manifestation of a disease or disorder in a family in addition to information about genetic tests. Furthermore, genetic information will not be before enrollment, participants and covered dependents will not be required to undergo genetic testing and premiums or contributions for groups under your employer's medical plan. However, the plan and/or employer may use, in accordance with GINA, a minimum necessary amount of genetic testing results in order to make a determination about a claim payment where such information is necessary and/or required. For more information about GINA, please contact Human Resources.

IMPORTANT!

Please read this notice carefully. 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Your Prescription Drug Coverage and Medicare

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Your employer has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare – General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from mid October to early December. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go 63 continuous days or longer without "creditable" prescription drug coverage (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do

so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time. In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
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. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Human Resources.

Coordinating Other Coverage with Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under your employer's plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under your employer's plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.
If you do decide to join a Medicare drug plan and drop your employer's prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For more information about this notice or your current prescription drug coverage
Contact your Human Resources Department

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 and 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 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).

NOTE

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 whether or not you are required to pay a higher premium (a penalty).

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') rights to coverage under the Plan is determined solely under the terms of the Plan.

IMPORTANT NOTICES

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act ("HIPAA") deals primarily with how your employer can enforce eligibility and enrollment for health care benefits.

The Plan will not base eligibility rules or waiting periods on any of the following factors: health status, mental or physical medical condition, and genetic information, evidence of insurability or disability. Evidence of insurability will not be required when health care coverage is requested during a special enrollment period or during an annual enrollment.

However, the Plan may continue to provide for the exclusion of specified health conditions and apply lifetime maximums on either specific benefits or all benefits provided under the Plan. These restrictions also do not preclude the Plan from applying differing benefit levels, benefit schedules or premium rates in certain situations as provided under HIPAA.

Pre-Existing Condition Exclusions

Your medical plan imposes pre-existing condition exclusion on those covered individuals who are 19 years of age or older. This means that if you have a medical condition before enrolling in the medical plan, and you are 19 years of age or older, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period immediately prior to your effective date. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This pre-existing condition exclusion may last up to 12 months (18 months if you are a HIPAA late enrollee) from your first day of coverage, or, if you were subject to a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the 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 give us a copy of any certificates of creditable coverage you have received from prior coverage. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show proof of creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Human Resources.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

This section of the enrollment guide contains important information about your right to group health plan continuation coverage, which is a temporary extension of coverage under the Plan after you (and/or your qualified dependent) would otherwise lose group health coverage under the Plan. The right to this continuation coverage (COBRA continuation coverage) was created by Federal law under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, you may elect to temporarily continue your group health coverage for yourself and any eligible dependents covered by the medical, dental, or vision plans (your employer's group health plans) on the day of your (or your qualified dependents) group health benefits ceased because of a qualifying event. You and your eligible dependents are eligible to elect COBRA continuation coverage even if you (or they) have health coverage under another group health plan. Please read this section carefully as it generally explains COBRA continuation coverage, when it may be available to you and your eligible dependents and what you (and they) need to do to protect the right to receive it.

Eligibility for COBRA Continuation Coverage
COBRA continuation coverage is continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each plan participant who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if group health coverage under the plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

Qualifying Events and COBRA Continuation Coverage
The qualifying events for COBRA continuation coverage and the maximum COBRA continuation coverage period are shown in the charts that follow.

Qualifying Event	Maximum Continuation Period
Termination of your employment (for reasons other than gross misconduct)	18 months
Reduction in your hours of employment with loss of eligibility for benefits	18 months

Employee COBRA Continuation Coverage
If you are covered by your employer's medical, dental and/or vision plan, you have the right to COBRA continuation coverage (for the period stated) if you lose coverage due to the following qualifying events:

Qualifying Event	Maximum Continuation Period
The employee's termination of employment (for reasons other than gross misconduct) or a reduction in the employee's hours of eligibility for benefits	18 months
The death of the employee	36 months
Divorce or legal separation from the employee	36 months
The employee's entitlement to Medicare	36 months

Spouse of an Employee COBRA Continuation Coverage
If you are the spouse of an employee and are covered by the employer's medical, dental and/or vision plan, you have the right to COBRA continuation (for the period stated) if you lose coverage due to the following qualifying events:

Qualifying Event	Maximum Continuation Period
The employee's termination of employment (for reasons other than gross misconduct) or a reduction in the employee's hours of eligibility for benefits	18 months
The death of the employee	36 months
Divorce or legal separation from the employee	36 months
The employee's entitlement to Medicare	36 months
Loss of eligible dependent status	36 months

Dependent Children of an Employee COBRA Continuation Coverage
Dependent children of an employee who are covered by the employer's medical, dental and/or vision plan have the right to COBRA continuation coverage (for the period stated) if they lose coverage due to the following qualifying events:

The maximum period of COBRA continuation coverage is measured from the date of the loss of coverage due to the applicable qualifying event specified above.

The plan will offer COBRA continuation coverage to a qualified beneficiary only after Human Resources has been properly notified that a qualifying event has occurred.

You must notify Human Resources within sixty (60) days of the following qualifying events: divorce or legal separation of the employee; spouse or a dependent child losing eligibility for coverage as a dependent under the plan, or Medicare entitlement.

You must provide this notice to Human Resources within the sixty (60) day deadline or your right to COBRA continuation coverage will be lost and will not be reinstated. Notice requirements are detailed below.

A special rule applies if you drop coverage for your spouse and/or eligible dependent children because you are planning to divorce. In such a case, your spouse and/or dependent children who had previously been covered under the plan would be entitled to elect COBRA continuation coverage for up to thirty-six (36) months from the date the divorce is final, but only if the Human Resources Department is notified of the divorce within sixty (60) days from the date of final judgment. No retroactive coverage before the date of divorce is available.

If it is determined that an individual is not eligible for COBRA continuation coverage, Human Resources will notify such individual of his or her failure to qualify for COBRA continuation coverage. This notice will explain why the individual is not entitled to COBRA continuation coverage and will be sent within fourteen (14) days after the receipt of the individual's notice of a qualifying event.

Subsequent Qualifying Event

If a subsequent qualifying event that is not your termination of employment or reduction in work hours (such as your divorce, legal separation, your death or your dependent child ceasing to be eligible under the plan) occurs during an initial eighteen (18) month period of coverage COBRA continuation coverage may be extended for your eligible dependents who are qualified beneficiaries for up to a maximum period of thirty-six (36) months measured from the date of the first qualifying event. An event shall not be a subsequent qualifying event unless that event would cause a loss of coverage under the Plan independent of the initial qualifying event. The covered employee will not be eligible for an extension of your maximum 18-month period of COBRA continuation coverage for a subsequent qualifying event.

Notice of a subsequent qualifying event must be given to Human Resources within a maximum of sixty (60) days in order to extend COBRA continuation coverage. If you fail to inform Humana Resources, you will lose your right to extend your COBRA continuation coverage and this right will not be reinstated. Notice requirements are detailed below. Please see the special COBRA continuation coverage for Disabled Persons section of this guide for information on disability as a subsequent qualifying event.

COBRA administration for your employer is conducted by your employer's Human Resources Department.

Notice Requirements

In most cases, your employer will notify you of your right to elect COBRA continuation coverage. However, if your eligible dependent has a qualifying event as a result of your divorce, legal separation, Medicare entitlement or lose their status as a dependent, you or your covered dependent must properly notify Human Resources within a maximum of sixty (60) days of the qualifying event. In addition, if you have a child born, legally adopted or placed for adoption with you during your period of COBRA continuation coverage, you must notify Human Resources within sixty (60) days of the event in order to cover the child.

Notice must be submitted to Human Resources. The form must be completed and submitted to Human Resources before the end of the applicable deadline. The forms, information and deadlines for certain events are outlined in the table below.

Failure to properly provide the required notice may result in loss of any COBRA continuation right and, if lost, this right will not be reinstated.

The Human Resources Department is the designated recipient for all COBRA continuation coverage notices.

Electing COBRA Continuation Coverage

Once Human Resources receives notice that a qualifying event has occurred, COBRA continuation coverage will then be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. However, you may elect COBRA continuation coverage on behalf of your spouse and parents may elect COBRA continuation coverage on behalf of their children.

If you wish to elect COBRA continuation coverage, you must notify Human Resources within a maximum of sixty (60) days of the later of: (i) the date of the qualifying event or (ii) the date you received your COBRA notice from your employer. If you choose to continue benefits for yourself and your eligible dependents, before the maximum sixty (60) day election deadline, your coverage will continue uninterrupted. If you (or your eligible dependent) fail to elect COBRA continuation coverage within the maximum sixty (60) days after you are notified by Human Resources, you will lose your right to COBRA continuation coverage and that right will not be reinstated.

You must also keep Human Resources informed of all the information needed to meet its obligation of both providing notice to you or your right to COBRA continuation coverage and providing the actual COBRA continuation coverage. Such information includes your current contact information and administrative information about yourself, your spouse and/or dependents. You or your spouse's election to take COBRA continuation coverage can also be an election to cover all the other qualified beneficiaries in the family, unless the election is specific as to which qualified beneficiaries are to be covered.

You must notify the Human Resources Department to request alternate coverage if you move outside the service area of the benefit network for your elected coverage. Alternate coverage will be made available (if available) to you not later than the date of the relocation or the first day of the month following the month in which the request is made.

Special Enrollment Events and COBRA
If you have a child born to, adopted or placed for adoption with you during your period of COBRA continuation coverage, you must notify Human Resources and elect coverage within sixty (60) days of the child's birth, adoption or placement for adoption. If you get married during your COBRA continuation coverage, you may add your new spouse to your COBRA continuation coverage if you notify Human Resources within thirty-one (31) days of the date of the marriage. A new dependent may be a participant under this coverage for the remainder of your maximum COBRA continuation period (eighteen (18), twenty-nine (29) or thirty-six (36) months, depending on the applicable qualifying event).

Cost and Payment of COBRA Premiums
You must pay the full cost for COBRA continuation coverage (plus a two percent (2%) administrative fee). Your employer will determine this cost, but it generally cannot exceed one hundred two percent (102%) of the plan's cost for providing coverage to similar situated covered active employees and their covered dependents. COBRA premiums are subject to change annually. If you and your covered dependents are receiving an additional eleven (11) months of COBRA continuation coverage due to disability as the qualifying event, your employer will determine COBRA premium which will not exceed one hundred fifty percent (150%) of the plan's cost for providing coverage, if the disabled qualified beneficiary is part of the COBRA continuation coverage group or one hundred two percent (102%) if the disabled qualified beneficiary is not receiving COBRA continuation coverage.

Once an election for COBRA continuation coverage is made, you (or your covered dependents) have a maximum of forty-five (45) days from the date of election to pay the premium for the current month and any retroactive COBRA premiums then due for the elected coverage. Although coverage is retroactive to the date of loss of coverage due to the initial qualifying event, no COBRA continuation coverage benefits will be paid until this first COBRA premium is received by Human Resources. If payment is not received within the forty-five (45) day period, then coverage will either be revoked retroactively or not become effective, you will lose your right to COBRA continuation coverage and it will not be reinstated.

All subsequent COBRA premium payments are due on the first day of the month. The plan allows a thirty (30) day grace period for payment of required COBRA premiums (except the first payment previously discussed). Even is you do not receive a bill, you must still submit your COBRA premium within the required time period. **The thirty (30) day grace period does not apply to the forty-five (45) day period for**

payment of the initial COBRA premium. If your COBRA premium payment is not postmarked by the last day of the grace period, your COBRA continuation coverage will end as of the last day of the last month for which a full COBRA premium payment was made.

If timely payment of the COBRA premium is made to the plan in an amount that is not more than fifty dollars ($50) or ten percent (10%) less than the required COBRA premium payment, then the amount paid is deemed to satisfy the plan's requirement for full COBRA premium payment, unless Human Resources notifies the qualified beneficiary of the amount of the deficiency and allows thirty (30) days for payment of the deficiency to be made.

COBRA premiums can be paid by you or by a third party on your behalf. Here are a few other details about COBRA premium payments you need to be aware of:

- No late or reminder notices will be sent for payments that have not been made.
- Once COBRA continuation coverage is terminated, if cannot be reinstated.
- All terms and conditions that apply to active participants in the plan are also applicable to COBRA continuation coverage participants.
- All rules and procedures for filing and determining benefit claims and appeals under the plan that apply to active employees also apply to COBRA continuation coverage.

For additional information about COBRA contact Human Resources.

Trade Act Credit
The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PGBC) (eligible individuals) and pay for health coverage. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 866.628.4282. TTD/TTY callers may call toll-free at 866.626.4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Responses to Information Regarding a Qualified Beneficiary's Right to Coverage
Upon request, the plan must inform health care providers regarding the qualified beneficiary's right to coverage during the applicable grace periods. In addition, the plan is required to respond to inquiries from health care providers regarding the qualified beneficiary's right to coverage during the election period and his or her right to retroactive coverage if COBRA continuation coverage is elected.

HIPPA and COBRA
In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage may affect your future rights under Federal law. First, you may lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a sixty-three (63) day gap in health plan coverage (election of COBRA continuation coverage may help you avoid such a gap). Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose a pre-existing condition exclusion if you do not elect COBRA continuation coverage for the maximum time available to you. Finally, you should take into account that you also have special enrollment rights under Federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage ends because of a qualifying event listed above. You will also have the same special enrollment right at the termination of your COBRA continuation coverage if you elect COBRA continuation coverage for the maximum period available to you.

Changes in Benefits under COBRA
If you or any covered dependents elect COBRA continuation coverage, benefits will be the same as were in effect at the time of your qualifying

event. You will be able to change your plan coverage option during annual enrollment to the same extent as similarly situated active employees. You will not, however, be able to add coverage for a dependent. If the group health plan benefits of active employees change, benefits for qualified beneficiaries on COBRA continuation coverage will also change in the same manner.

Special COBRA Continuation Coverage for Disabled Persons

If you (and your covered dependents) are receiving eighteen (18) months of COBRA continuation coverage and your qualifying event is a termination of employment or a reduction of hours, your maximum COBRA continuation coverage period may be extended by eleven (11) months to up to a maximum of twenty-nine (29) months in total provided the following requirements are met:

- The Social Security Administration determines that your (or your dependent who is a qualified beneficiary) are disabled within the meaning of the Social Security Act;
- This disability exists as of the date of the qualifying event or at any time during the first sixty (60) days of COBRA continuation coverage following the qualifying event; and
- The disability lasts at least until the end of the eighteen (18) month period of COBRA continuation coverage.

Notice of the determination of disability under the Social Security Act must be provided to Human Resources within the initial eighteen (18) month coverage period and within sixty (60) days after the latest of: (1) the date of the Social Security Administration determination of disability; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses coverage; or (4) the date on which the qualified beneficiary is informed of the obligation to provide the notice of disability. If you fail to properly notify Human Resources within the deadline above, you will lose your right to the extension of COBRA continuation coverage and this right will not be reinstated. Please refer to the Notice Requirements section above for information about proper notice to the plan.

If the Social Security Administration determines later that the qualified beneficiary is no longer disabled, Human Resources must be properly notified within thirty (3) days of the Social Security Administration's determination. This notice will end the extended COBRA continuation coverage for all qualified beneficiaries within the coverage group. Failure to notify Human Resources that a qualified beneficiary is no longer disabled will result in termination of COBRA continuation coverage for all qualified beneficiaries within the coverage group effective on the date of the Social Security Administration determination and such coverage will not be reinstated. When the disabled qualified beneficiary becomes eligible for Medicare, Human Resources must be properly notified to end the extended coverage for the affected disabled qualified beneficiary. Please refer to the Notice section above for information about proper notice to the plan.

COBRA Continuation Coverage and Medicare

If your dependent is receiving COBRA continuation coverage and you become entitled to Medicare benefits, your coverage will end but COBRA continuation coverage for your qualified dependents may continue for up to thirty-six (36) months measured from the date of the initial qualifying event.

In addition, if you become entitled to Medicare and then later terminate employment (for reasons other than gross misconduct) or have a reduction in hours, your qualified dependents who are eligible for COBRA continuation coverage will be eligible for thirty-six (36) months of COBRA continuation coverage measured from the date you became entitled to Medicare. However, you will only be eligible for eighteen (18) months of COBRA continuation coverage measured from the qualifying event.

Termination of COBRA Continuation Coverage

COBRA continuation coverages shall not be provided beyond the earliest of the following dates:

- The date the maximum COBRA continuation coverage period expires based upon the qualifying event;
- The date the plan is terminated and no other group health plan is provided to active employees;
- The last day of the month preceding the month for which the qualified beneficiary fails to pay the premium for COBRA continuation coverage by the last day of the grace period;
- The date the qualified beneficiary first becomes entitled to Medicare, including Medicare entitlement due to End Stage Renal Disease (ESRD), after the person elects COBRA continuation coverage;
- The date that initial payment is not received within a maximum of forty-five (45) days after the election of COBRA continuation coverage is made.
- The date the qualified beneficiary first becomes covered under another group health plan or policy (and is no longer subject to, a pre-existing condition exclusion or limitation under the other group health benefit plan) after the date the person elects COBRA continuation coverage; or
- For a disabled qualified beneficiary receiving COBRA continuation coverage during the eleven (11) month disability extension period (and their covered family members), the date the disabled person receives a final determination by the Social Security Administration that he or she is no longer "disabled." This final determination shall end COBRA continuation coverage for all qualified beneficiaries as of the later of either: (a) the first day of the months following thirty (30) days from the final determination date; or (b) the end of the COBRA continuation coverage period based on the initial qualifying event without regard to a disability extension.

If your COBRA continuation coverage is terminated for any of the reasons noted above, your coverage will end and will not be reinstated.

In the event that your COBRA continuation coverage is terminated before the end of the maximum coverage period, Human Resources will notify you of the termination of your coverage as soon as administratively possible. This notice will explain why and when COBRA continuation coverage has ended.

Contact Information for COBRA Administrator

Questions concerning the plan or your COBRA continuation coverage right should be addressed to Human Resources if you are an active employee or if you are eligible for COBRA continuation coverage or a COBRA continuation participant. For more information about your rights under ERISA, including COBRA, HIPAA 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 the EBSA website at www.dol.gov/ebsa.

CHIP Premium Assistance

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1.877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance

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

Texas – Medicaid
http://www.gethipptexas.com
1.800.440.0493

Notice of Privacy Practices
This Notice is for employees (and their dependents) participating in your employer's health plans (medical, dental, and vision), which together have been designated as your employer's Employee Benefits Plan (the "Plan"). If you are not currently participating in these plans, but begin participating in the future, this Notice will apply to you once you begin participating.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the Health Insurance Portability and Accountability Act (HIPAA), the Plan is required to:

- take reasonable steps to ensure the privacy of your personally identifiable health information;
- give you this Notice of our legal duties and privacy practices with respect to medical information about you (the participant); and
- follow the terms of this Notice.

In addition to the requirements above, this Notice is intended to inform you about:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- the Plan's duties with respect you're your PHI;
- 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 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).

If you have any questions about this Notice, please contact Human Resources.

Who Will Follow This Notice
This Notice describes the health information practices of the Plan, and that of third parties that provides services to the Plan. All references to "you" include employee/retiree participants and their dependent(s) who participate in the Plan.

Our Pledge Regarding Medical Information
The Plan understands that medical information about you and your health is personal. The Plan is committed to protecting medical information about you. The Plan creates a record of the health care claims reimbursed under the Plan for Plan administration purposes. This Notice applies to all of the health records that the Plan maintains. Your personal doctor or health care provider may have different policies or Notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This Notice will tell you about the ways in which the Plan may use and disclose medical information about you. It also describes the Plan's obligations and your rights regarding the use and disclosure of medical information.

Required PHI Uses and Disclosures
Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosure to carry out treatment, payment and health care operations.
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 also will disclose PHI to the Plan Sponsor, your employer, for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes, but is not limited to, actions to make payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization) payment for the health care services you receive. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational or medically necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or precertification service provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Furthermore, the Plan may, for payment purposes, take actions to make coverage determinations. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include, but are 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.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Other examples include the Plan using your health information to review the performance of our staff and vendors. The Plan may also use your information and the information of other members to plan what services the Plan needs to provide, expand, or reduce. The Plan may disclose your health information as necessary to others who the Plan contracts with to provide administrative service, which includes the Plan's lawyers, auditors, accreditation services, and consultants, for instance.

Uses and disclosures that require your written authorization.
Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you form your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

In addition, your written authorization is required for any marketing communication which includes a communication about a product or service that encourages you to buy or use the product or service being marketed. However, if there is no direct or indirect fee to the Plan, an authorization is not required. Moreover, communications the Plan makes about its own health care products or services, communications for treatment purposes, and communications for purposes of

case management or Personal Health Support or to recommend alternative treatments, therapies, providers or settings of care are accepted from the authorization requirement.

Use and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.
Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which consent, authorization or opportunity to object is not required.
Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

To Avert a Serious Threat to Health or Safety. The Plan may disclose your health information if the Plan decides that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release medical information about you as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release medical information about you for workers' compensation or similar programs.

Public Health Risks. The Plan may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if the Plan believes a participant has been the victim of abuse, neglect or domestic violence.

The Plan will only make disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement. The Plan may release medical information if asked to do so by a law enforcement official: in response to a court order, subpoena, warrant, summons or similar process;

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement;
- about a death the Plan believes may be the result of criminal conduct;
- about criminal conduct at the hospital; and

- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Plan may release medical information to a coroner or medical examiner. This may be necessary , for example, to identify a deceased person or determine the cause of death. The plan may also release medical information about patients of a hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institutions.

Rights of Individuals

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. For example, you could ask that the Plan not use or disclose information about a surgery you had.

The Plan is not required to agree to your request.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. To requite restrictions, you must make your request in writing to your Human Resources Department. In your request, you must tell the Plan (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Inspect and Copy PHI
You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. You also 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.

"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 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 analyses and not used to make decisions about individuals is not in 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.

To inspect and copy medical information that may be used to make decisions about you or to inspect and copy a designated record set, you must submit your request in writing to Human Resources. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. 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 a record about you in a designated

record set for as long as the PHI is maintained in the designated record set or by the Plan.

To request an amendment, your request must be made in writing and submitted to Human Resources. In addition, you must provide a reason that supports your request.

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. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask the Plan to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

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.

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; or (3) prior to the compliance date.

If the accounting cannot be provided 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. To request an accounting of disclosures, your request must be made in writing and submitted to Human Resources. In addition, you must provide a reason that supports your request and in what form you want the list (for example, paper or electronic)

The Right to Request Confidential Communications

You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Human Resources.

The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

The Right to Receive a Paper Copy of This Notice Upon Request

You have a right to receive a paper copy of this Notice even if you have previously received a copy or agreed to receive this Notice electronically.

You may also obtain a copy of this Notice on the intranet.

To obtain a paper copy of this Notice, please contact Human Resources.

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 retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties and Right to Change This Notice

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, 2003, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change their privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to 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 who the Plan still maintains PHI. You will receive notice of any revised Notice from the Plan by mail or by e-mail, but only if e-mail delivery is offered by the Plan and you agree to such delivery.

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 from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of 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 to the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures 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.

In addition, the Plan may use or disclose "summary health information" to your employer for obtaining premium bids or modifying, amending or terminating the Plan, which summarizes the claims history, claims expenses or type of claims provided health benefits under the Plan; and from which identifying information has been deleted in accordance with HIPAA.

Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to Human Resources.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Conclusion

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 Code 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.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact your employer's Human Resources Department.