



Employee Benefits Summary

Plan Year: September 2011



Prepared By:



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Employee Benefits Summary



Group Health Insurance

Dual Option

	RS08 PPO	RS18 PPO
LIFETIME MAXIMUM	Unlimited	Unlimited
Deductible	<i>In Network/Out Network</i>	<i>In Network/Out Network</i>
Individual	\$1,000	\$2,000
Family	\$3,000	\$6,000
OUT-OF-POCKET		
Individual	\$4,000/\$7,000	\$5,000/\$8,000
Family	\$12,000/\$21,000	\$15,000/\$24,000
HOSPITAL		
Inpatient	90/70% after deductible	80/60% after deductible
Emergency Room	90% after \$100 copay	80% after \$100 copay
ER Physician	90% after deductible	80% after deductible
URGENT CARE	\$50 copay, then 100%/70% after ded	\$45 copay, then 100%/70% after ded
DOCTOR VISITS	\$25 copay, then 100%/70% after ded	\$20 copay, then 100%/70% after ded
PREVENTIVE CARE	100% No Ded/70% After Ded	100% No Ded/70% after ded
PRE-EXISTING	6/12	6/12
PRESCRIPTIONS	\$15 Generic \$30 Pref. Brand Name \$45 Non-Pref. Brand Name	\$15 Generic \$40 Pref. Brand Name \$55 Non-Pref. Brand Name
Mail Order:	1x copay/30 days	1x copay/30 days

Neos Consulting Group will pay up to \$335.56 of the employee only cost for either plan. The employee will pay all dependent cost by payroll deduction.

This summary is not an Insurance Contract. This summary was compiled by employees of Ball Peoples. Changes, omissions or oversights are possible. Please refer to the actual policy for a full description of benefits.



Group Dental Insurance



R & C 90th Percentile

DEDUCTIBLE

Individual	\$ 50
Family	\$150

SERVICES

Preventive	100%
Basic	80%
<i>Waiting Period</i>	None
Major	50%
<i>Waiting Period</i>	None
Adult & Child Ortho	20% Discount
<i>Waiting Period</i>	None

MAXIMUM

Preventive, Basic, Major	\$1,500 Annual
Orthodontics Discount	No Maximum

100% of the Dental employee cost is paid by **Neos Consulting Group**.
All dependent cost is paid by the employee through payroll deduction.

Group Vision Insurance



- Exam: \$10 Copay, Once every 12 Months
- Conventional Contact Lenses: \$0 Copay/\$150 Allowance; 15% off balance over \$150
- Disposable Contact Lenses: \$0 Copay/\$150 Allowance; member responsible for balance over \$150
- Standard Plastic Lenses: \$25 Copay, Once every 12 Months
- Frames: \$0 Copay/\$130 allowance; 20% off balance over \$130, Once every 12 Months
- Access Choice Vision 7

100% of the Vision employee cost is paid by **Neos Consulting Group**.
All dependent cost is paid by the employee through payroll deduction.

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Group Life Insurance



- 50,000 Term Life
- 50,000 Accidental Death & Dismemberment
- Reduced by 35% at age 65, 25% at age 70, 15% at age 75
- Benefits terminate upon retirement
- 100% of cost is paid by **Neos Consulting Group**

Group Long Term Disability Insurance



- 60% to a maximum of \$6,000 per month
- 90 day Elimination Period
- Own occupation to later of age 65 or SSNRA
- Zero Day Residual
- 6/12 Pre-Existing
- 100% of cost is paid by **Neos Consulting Group**

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IMPORTANT INFORMATION

- Employees working 30 hours or more a week are eligible for coverage.
- New employees are eligible for coverage on the first of the month following date of hire.

To find a participating physician, dentist or vision provider near you:

Benefit	Website Address	Customer Service Number
Health	www.bcbstx.com	800-521-2227
Dental & Vision	www.dentalselect.com	800-999-9789
Life & LTD	clientservices@lfg.com	800-423-2765

	Blue Access	
Claims Information and Deductible Tracking	www.bcbstx.com	Set up username and password for Blue Access from top left corner of website.

Ball Peoples Group Contact : Abby Caswell	abby@ballpeoples.com	512-478-9595
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BENEFIT HIGHLIGHTS

BlueChoice Network

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

Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
<p>Calendar Year Deductible Applies to all Eligible Expenses (unless otherwise indicated) 4th quarter Deductible carryover does not apply Deductible credit from prior carrier (applied on initial group enrollment only)</p>	\$1,000 Individual / \$3,000 Family	
<p>Copayment Amounts Required Physician office visit/consultation Urgent Care center visit Outpatient Hospital Emergency Room visit</p>	\$25 Copayment Amount \$50 Copayment Amount \$100 Copayment Amount	 \$100 Copayment Amount
<p>Coinsurance Stop-Loss Amount Deductibles are not applied to the Coinsurance Stop-Loss Amount. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details. No credit given for Coinsurance Stop-Loss Amount from prior carrier</p>	\$3,000 Individual / \$9,000 Family <i>Network Coinsurance Stop-Loss Amount will only apply toward Network Coinsurance Stop-Loss Amount</i>	\$6,000 Individual / \$18,000 Family <i>Out-of-Network Coinsurance Stop- Loss Amount will also apply toward Network Coinsurance Stop-Loss Amount</i>
<p>Maximum Lifetime Benefits Per individual</p>	Unlimited	
Inpatient Hospital Expenses		
<p>Inpatient Hospital Expenses (must be preauthorized) Inpatient Hospital Expenses (including Maternity Care) Penalty for failure to preauthorize</p>	90% of Allowable Amount after Calendar Year Deductible None	70% of Allowable Amount after Calendar Year Deductible \$250
Medical/Surgical Expenses		
<p>Medical / Surgical Expenses Physician office visit/consultation, including lab & x-ray Physician surgical services in any setting and Maternity Care Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures) Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan. Home Infusion Therapy (must be preauthorized) In Vitro Fertilization Services All other outpatient services and supplies</p>	100% of Allowable Amount after \$25 Copayment Amount 90% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount 90% of Allowable Amount after Calendar Year Deductible 90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible
	Declined	
	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible

Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Extended Care Expenses (must be preauthorized) Skilled Nursing Facility Home Health Care Hospice Care	100% of Allowable Amount Limited to 25 days maximum each Calendar Year* Limited to 60 visits each Calendar Year*	70% of Allowable Amount Unlimited
Special Provisions Expenses		
☆ Treatment of Chemical Dependency (must be preauthorized) Inpatient treatment must be provided in a Chemical Dependency Treatment Center All other outpatient treatment	Three separate series of treatments for each covered individual* Covered as any other physical sickness Covered as any other sickness	
☆ Serious Mental Illness / Mental Health Care (must be preauthorized)		
Inpatient Services Hospital services (facility) Physician services	90% of Allowable Amount after Calendar Year Deductible 90% of Allowable Amount after Calendar year Deductible	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible
Outpatient Services Physician office visit/consultation, including lab & x-ray Other outpatient services, including psychological testing Calendar Year Maximum	100% of Allowable Amount after \$25 Copayment Amount 90% of Allowable Amount after Calendar Year Deductible Limited to 10 inpatient hospital days and 25 outpatient visits each Calendar Year*	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible
Emergency Care/Outpatient Hospital Emergency Room		
Accidental Injury & Medical Emergency Care Facility charges Physician charges	90% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted) 90% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Situations Facility charges Physician charges	90% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted) 90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after \$100 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted) 70% of Allowable Amount after Calendar Year Deductible
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services (does not include Certain Diagnostic Procedures) Certain Diagnostic Procedures and all other Medically Necessary services and supplies	100% of Allowable Amount after \$50 Copayment Amount 90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible
Preventive Care		
Routine annual physicals, well-baby exam, immunizations, and other preventive health services as determined by the USPSTF (Deductibles will not be applicable to immunizations of a Dependent child age seven years or younger)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible

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

☆ **Mental Health Parity and Addiction Equity Act of 2008:** The Mental Health Parity and Addiction Equity (MHPAE) Act is a federal law that applies to employers who employed an average of more than 50 employees on business days during the preceding Calendar Year. The law generally requires that group health insurers apply the same treatment and financial limits to mental health and substance use disorder benefits as apply to the predominant medical- surgical benefits of the plan. If this law applies to your coverage, you will receive a Benefit Highlights amendment form that shows your mental health and substance use disorder (chemical dependency) benefits.

Special Provisions Expenses, cont.		
	PPO (In-Network)	Non-PPO (Out-of-Network)
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function with hearing aids	Covered same as any other sickness	Covered same as any other sickness
Hearing Aids	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Hearing Aids Maximum Benefit	Hearing aids are subject to a \$1,000 maximum amount each 36-month period*	
Physical Medicine Services		
Physical Medicine Services (includes but is not limit to physical, occupational, and manipulative therapy)	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	Limited to 35 visits each Calendar Year*	

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

Prescription Drug Program		
	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
Prescription Drugs*		
Retail Prescription (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	\$15 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name	\$30 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	\$45 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Mail Service Prescription (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	\$15 Copayment Amount	
Preferred Brand Name	\$30 Copayment Amount	
Non-Preferred Brand Name	\$45 Copayment Amount	
<p>* Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Preferred/Non-Preferred Brand Name Drug, plus the Preferred Brand Name Copayment Amount.</p> <p>Diabetes Supplies are available under the Prescription Drug Program portion of your plan. Diabetes Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucagon emergency kits, and other injection aids. All provisions of this portion of the plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.</p> <p>Flu vaccinations are available through certain pharmacies for BCBSTX members. You will be charged \$15.00 Copayment Amount for each vaccination received. Additional information is available on our website at www.bcbstx.com.</p>		

EMPLOYEE INFORMATION

The following benefits apply to dependent coverage:

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

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

Preexisting conditions Provision: Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the individual's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period. In accordance with state and federal law, certain conditions will not be considered Preexisting Conditions and the Preexisting Condition exclusion will not apply to certain individuals. Details are provided in the benefit booklet.

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

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

Members residing in other states may use that state's network through the BlueCard program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our web site at www.bcbstx.com to use our Provider Finder® tool. In addition to the benefits stated herein, benefits for covered persons who reside outside of Texas will conform to all extraterritorial requirements of those states

Coverage is contingent upon the following:

- The employer must maintain enrollment of at least 75% of eligible employees and pay at least 50% of the employee only cost.
- The replacement of coverage stipulation in the contract.

BENEFIT HIGHLIGHTS

BlueChoice Network

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

Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
<p>Calendar Year Deductible Applies to all Eligible Expenses (unless otherwise indicated) 4th quarter Deductible carryover does not apply Deductible credit from prior carrier (applied on initial group enrollment only)</p>	\$2,000 Individual / \$6,000 Family	
<p>Copayment Amounts Required</p> <p>Physician office visit/consultation</p> <p>Urgent Care center visit</p> <p>Outpatient Hospital Emergency Room visit</p>	<p>\$20 Copayment Amount</p> <p>\$45 Copayment Amount</p> <p>\$100 Copayment Amount</p>	<p>\$100 Copayment Amount</p>
<p>Coinsurance Stop-Loss Amount Deductibles are not applied to the Coinsurance Stop-Loss Amount. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details. No credit given for Coinsurance Stop-Loss Amount from prior carrier</p>	<p>\$3,000 Individual / \$9,000 Family</p> <p><i>Network Coinsurance Stop-Loss Amount will only apply toward Network Coinsurance Stop-Loss Amount</i></p>	<p>\$6,000 Individual / \$18,000 Family</p> <p><i>Out-of-Network Coinsurance Stop-Loss Amount will also apply toward Network Coinsurance Stop-Loss Amount</i></p>
<p>Maximum Lifetime Benefits Per individual</p>	Unlimited	
Inpatient Hospital Expenses		
<p>Inpatient Hospital Expenses (must be preauthorized) Inpatient Hospital Expenses (including Maternity Care)</p> <p>Penalty for failure to preauthorize</p>	<p>80% of Allowable Amount after Calendar Year Deductible</p> <p>None</p>	<p>60% of Allowable Amount after Calendar Year Deductible</p> <p>\$250</p>
Medical/Surgical Expenses		
<p>Medical / Surgical Expenses Physician office visit/consultation, including lab & x-ray</p> <p>Physician surgical services in any setting and Maternity Care</p> <p>Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)</p> <p>Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.</p> <p>Home Infusion Therapy (must be preauthorized)</p> <p>In Vitro Fertilization Services</p> <p>All other outpatient services and supplies</p>	<p>100% of Allowable Amount after \$20 Copayment Amount</p> <p>80% of Allowable Amount after Calendar Year Deductible</p> <p>100% of Allowable Amount</p> <p>80% of Allowable Amount after Calendar Year Deductible</p> <p>80% of Allowable Amount after Calendar Year Deductible</p>	<p>70% of Allowable Amount after Calendar Year Deductible</p> <p>60% of Allowable Amount after Calendar Year Deductible</p> <p>70% of Allowable Amount after Calendar Year Deductible</p> <p>60% of Allowable Amount after Calendar Year Deductible</p> <p>60% of Allowable Amount after Calendar Year Deductible</p> <p>Declined</p> <p>60% of Allowable Amount after Calendar Year Deductible</p>

Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Extended Care Expenses (must be preauthorized) Skilled Nursing Facility Home Health Care Hospice Care	100% of Allowable Amount Limited to 25 days maximum each Calendar Year* Limited to 60 visits each Calendar Year* Unlimited	70% of Allowable Amount
Special Provisions Expenses		
☆ Treatment of Chemical Dependency (must be preauthorized)		
Inpatient treatment must be provided in a Chemical Dependency Treatment Center	Three separate series of treatments for each covered individual* Covered as any other physical sickness	
All other outpatient treatment	Covered as any other sickness	Covered as any other sickness
☆ Serious Mental Illness / Mental Health Care (must be preauthorized)		
Inpatient Services Hospital services (facility)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Physician services	80% of Allowable Amount after Calendar year Deductible	60% of Allowable Amount after Calendar Year Deductible
Outpatient Services Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after \$20 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	Limited to 10 inpatient hospital days and 25 outpatient visits each Calendar Year*	
Emergency Care/Outpatient Hospital Emergency Room		
Accidental Injury & Medical Emergency Care Facility charges	80% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted)	
Physician charges	80% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Situations Facility charges	80% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted)	60% of Allowable Amount after \$100 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted)
Physician charges	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services (does not include Certain Diagnostic Procedures)	100% of Allowable Amount after \$45 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures and all other Medically Necessary services and supplies	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Preventive Care		
Routine annual physicals, well-baby exam, immunizations, and other preventive health services as determined by the USPSTF (Deductibles will not be applicable to immunizations of a Dependent child age seven years or younger)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible

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

☆ **Mental Health Parity and Addiction Equity Act of 2008:** The Mental Health Parity and Addiction Equity (MHPAE) Act is a federal law that applies to employers who employed an average of more than 50 employees on business days during the preceding Calendar Year. The law generally requires that group health insurers apply the same treatment and financial limits to mental health and substance use disorder benefits as apply to the predominant medical- surgical benefits of the plan. If this law applies to your coverage, you will receive a Benefit Highlights amendment form that shows your mental health and substance use disorder (chemical dependency) benefits.

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

Special Provisions Expenses, cont.			PPO (In-Network)	Non-PPO (Out-of-Network)
Speech and Hearing Services				
Services to restore loss of or correct an impaired speech or hearing function with hearing aids		Covered same as any other sickness	Covered same as any other sickness	
Hearing Aids		80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible	
Hearing Aids Maximum Benefit		Hearing aids are subject to a \$1,000 maximum amount each 36-month period*		
Physical Medicine Services				
Physical Medicine Services (includes but is not limit to physical, occupational, and manipulative therapy)		80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible	
Calendar Year Maximum		Limited to 35 visits each Calendar Year*		

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

Prescription Drug Program		Participating Pharmacy	Non-Participating Pharmacy (member files claim)
Prescription Drugs*			
Retail Prescription (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)			
Generic		\$15 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name		\$40 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name		\$55 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Mail Service Prescription (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)			
Generic		\$15 Copayment Amount	
Preferred Brand Name		\$40 Copayment Amount	
Non-Preferred Brand Name		\$55 Copayment Amount	

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

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

EMPLOYEE INFORMATION

The following benefits apply to dependent coverage:

- Dependent children are covered for maternity benefits.
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Preexisting conditions Provision: Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the individual's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period. In accordance with state and federal law, certain conditions will not be considered Preexisting Conditions and the Preexisting Condition exclusion will not apply to certain individuals. Details are provided in the benefit booklet.

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

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

Members residing in other states may use that state's network through the BlueCard program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our web site at www.bcbstx.com to use our Provider Finder[®] tool. In addition to the benefits stated herein, benefits for covered persons who reside outside of Texas will conform to all extraterritorial requirements of those states

Coverage is contingent upon the following:

- The employer must maintain enrollment of at least 75% of eligible employees and pay at least 50% of the employee only cost.
- The replacement of coverage stipulation in the contract.



Personalized Information about Your Health Care Coverage

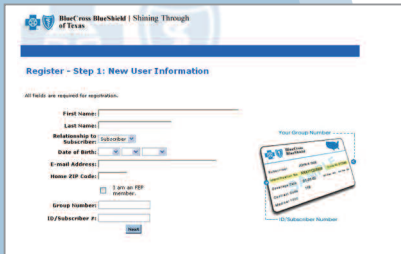
Would you like to know when your medical claims are paid and the payment amounts?

Do you need to confirm who in your family is included under your coverage? Go to www.bcbstx.com, log in to Blue Access® for Members and:

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

It's easy to get started

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



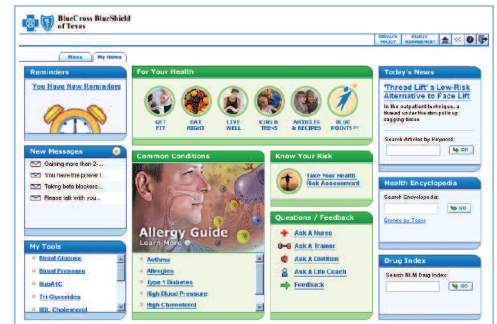
We provide a variety of online resources for our members – from the status of medical claims to staying healthy. Blue Cross and Blue Shield of Texas conveniently delivers information and resources wherever you have access to the Internet.

Personal Health Manager

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

Key features of the Personal Health Manager include:

- A health risk assessment to evaluate your personal health status;
- Fitness and weight loss advice from a team of personal trainers at *Ask A Trainer*;
- Nutrition advice from registered dietitians with *Ask A Dietician*;
- Help to manage stress, workplace conflicts and other issues with *Ask A Life Coach*;
- Health related questions answered online from registered nurses – Blue Care Advisors – with the *Ask A Nurse* feature;
- A personal health record to keep track of and manage health information within one secure Web location;
- Targeted wellness information via e-mail to help manage specific medical conditions, including alerts for screening tests, and reminders for medical appointments and medication refills;
- Access to the online health content, including wellness tracking tools, videos and interactive tutorials; and
- Access to information on exercise, nutrition and lifestyle issues in the For Your Health area of Personal Health Manager.
- 24/7 Nurseline Around the clock access through a toll-free number to experienced registered nurses who understand and can help with your health care concerns.



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

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

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



Other Online Resources for Health Care Information

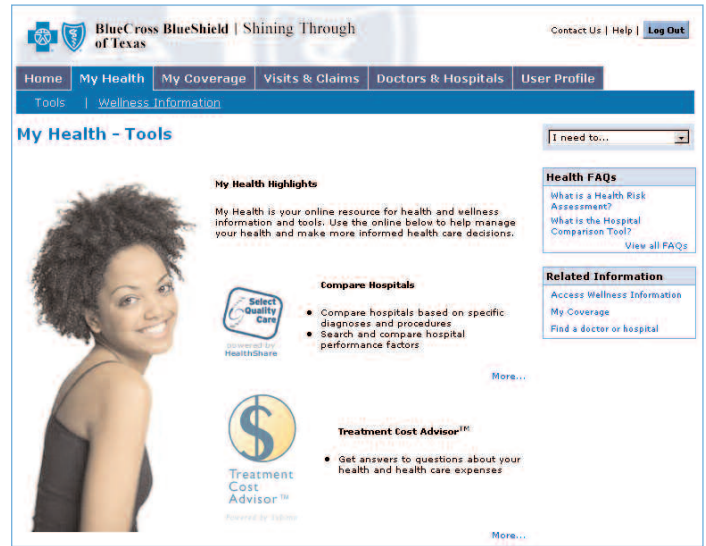
Hospital Comparison Tool

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

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

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

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



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



Treatment Cost Advisor

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

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

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

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



A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association 48133.0507



**BlueCross BlueShield
of Texas**

Experience. Wellness. Everywhere.™

BlueExtrasSM

More ways to save money with your member ID card

Through the **BlueExtrasSM** discount program, all Blue Cross and Blue Shield of Texas (BCBSTX) members are eligible to save money on value-added health care products and services that help support healthy lifestyles. These discounts are for health care products and services not usually covered by your health care benefits plan. There are no claims to file, no referrals or pre-authorizations, and no additional fees to participate – it's just one more benefit of being a BCBSTX member!

To use BlueExtras, simply show your BCBSTX ID card to a BlueExtras provider to receive your discount.

For additional information about the products and services offered through BlueExtras, log into **Blue Access[®] for Members (BAM)** at www.bcbstx.com. Click on the **My Coverage** tab, and then the **BlueExtras Discount Program** link.

BlueExtras Newest Program



Complementary Alternative Medicine

www.bcbstx.com/member
(866) 656-6069

Complementary Alternative Medicine (CAM) includes a variety of therapies that may help to improve your health, prevent illness, and address existing symptoms and conditions. As a BCBSTX member, you're automatically eligible to receive up to 30 percent off standard fees through a national network of more than 35,000 practitioners, spas, wellness and fitness centers.

You're also eligible to receive discounts on vitamins, herbal supplements, and health and wellness magazines. To learn more about CAM discounts, log into **BAM**.



Jenny Craig

www.jennycraig.com
(800) 597-Jenny (800-597-5366)

Jenny Craig is a long-term food/body/mind solution that can help you manage your weight by teaching you how to create a healthy relationship with food, build an active lifestyle and develop a balanced approach to living. You have the option to choose the right program for your lifestyle by conducting your weekly consultations at a Jenny Craig Centre or over the phone with Jenny

Direct — the at-home program. It's up to you! To learn more about the Jenny Craig discount and to download your discount coupon, log into **BAM**.



Curves

www.curves.com
(800) CURVES-30 (800-287-8373)

Curves offers a 30-minute workout that combines strength training and sustained cardiovascular activity through safe and effective resistance equipment. Curves has made exercise available to more than four million women, many of whom are in the gym for the first time. To learn more about the Curves discount, log into **BAM**.



TruHearing

www.truhearing.com
(877) 882-2020

Save on digital hearing aids through TruHearing. Get a free hearing test by a licensed hearing specialist when performed for the purpose of a fitting for a hearing aid. Enjoy a 45-day money back guarantee, a two-year warranty and a selection of hearing aid styles at various price levels. To learn more about the TruHearing discount, log into **BAM**.



Davis Vision

www.davisvision.com
(800) 501-1459

Save on eyeglasses (frames and lenses), as well as contact lenses, laser vision correction services, examinations and accessories through one of the nation's leading providers of routine vision care programs. The Davis Vision network consists of major national and regional retail locations, such as Eyemasters and Visionworks, as well as independent ophthalmologists and optometrists. To learn more about the Davis Vision discount, log into **BAM**.

The relationship between these vendors and Blue Cross and Blue Shield of Texas (BCBSTX) is that of independent contractors.

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

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

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Neos Consulting Group

90% R&C

DENTAL

9/1/2011

Contributory Indemnity		
PLATINUM NETWORK		
	Network Dentist	Non-Network Dentist
Preventive Routine exams, cleanings (2 per year), topical fluoride, x-rays, space maintainers, and sealants	100%	100% of R&C
Basic Fillings, extractions, oral surgery, endodontics and periodontics	80%	80% of R&C
Major Crowns, bridges, dentures	50%	50% of R&C
No Waiting Period		
Orthodontics Children under 19 Lifetime Maximum:	20% Discount No Waiting Period No Maximum	No Coverage
All Members	20% Discount	No Discount
Maximum Benefit Per Year Preventive, Basic and Major services per person per year.	\$1,500.00	
Deductible Per Year Applies to Basic and Major services. Per Person: Family Maximum:	\$50.00 \$150.00	\$50.00 \$150.00
Specialists Endodontists, Oral Surgeons, Pediatric Specialists, Periodontists, Prosthodontists.	SEE NOTES	PAID SAME AS GENERAL DENTISTS
Rates Single (Employee Only) Employee + Spouse Employee + Child(ren) Employee + Spouse + Child(ren)	1 Year Rate Guarantee \$38.45 \$86.98 \$74.01 \$123.99	
Access Discount Vision Included		

Reasonable and Customary (R&C): means benefits based only on "Reasonable and Customary" fee criteria.

Neos Consulting Group

Vision Access Choice Vision 7

	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilatation as Necessary	\$10 Co-Pay	Up to \$45
Contact Lens Options		
Standard fit and follow-up	Up to \$55	N/A
Premium Fit and Follow-up*	10% off retail	N/A
Standard Plastic Lenses		
Single Vision	\$25 Co-Pay	Up to \$40
Bifocal	\$25 Co-Pay	Up to \$60
Trifocal	\$25 Co-Pay	Up to \$80
Frames Any frame at provider location	\$0 Copay, \$130 allowance; 20% off Balance over \$130	Up to \$45
Lens Options		
UV Coating	\$0	
Tint (Solid and Gradient)	\$0	
Standard Scratch-Resistance	\$0	N/A
Standard Polycarbonate	\$0	
Standard Anti-Reflective	\$45	
Other Add-ons and Services	20% Discount	
Contact Lenses Declining Balance Allowance		
Conventional	\$0 copay; \$150 Allowance; 15% off balance over \$150	Up to \$150
Disposables	\$0 copay; \$150 Allowance; member responsible for balance over \$150	Up to \$150
Medically Necessary	\$0 copay; Paid in Full	Up to \$210
Laser Correction		
Lasik or PRK From US Laser Network	15% off retail price -or- 5% off promotional price	Not Covered
Frequency		
Examination	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Rates		
Single (Employee Only)		\$7.31
Employee + Spouse		\$13.89
Employee + Child(ren)		\$14.63
Employee + Spouse + Child(ren)		\$21.94

Group Life Insurance

Life and AD&D

SUMMARY OF BENEFITS

Sponsored by: Neos Consulting Group

Effective date: 9/1/11

Life Benefit	Employee
Amount	Flat \$50,000
Minimum Amount	\$50,000
Maximum Amount	\$50,000
Guarantee Issue	\$50,000
AD&D Benefit	Employee
Amount	Flat \$50,000
Minimum Amount	\$50,000
Maximum Amount	\$50,000
Guarantee Issue	\$50,000
Benefit Reduction	Employee
Benefits will reduce:	35% at age 65 An additional 25% of the original amount at age 70; and An additional 15% of the original amount at age 75 Benefits terminate at retirement
Additional Benefits	Employee
See Definitions page for:	Accelerated Death Benefit
See Definitions page for:	Seat Belt, Airbag, and Common Carrier
See Definitions page for:	Conversion
Eligibility	Employee
	All full-time active employees working 30 or more hours per week in an eligible class are eligible for coverage on the policy effective date. A delayed effective date will apply if the employee is not actively at work.

(Please see other side)

Definitions

Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance and it will be provided at your own expense.
Seat Belt, Airbag, Common Carrier	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, benefits are payable up to \$10,000 or 10% of the principal sum, whichever is less. If loss occurs for you due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Term Life	Coverage provided to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Exclusion: Suicide	Benefits will not be paid if the death results from suicide within two years after coverage is effective. May apply if employee contributes toward the premium.

Additional Benefits

BeneficiaryConnectSM	Support services for beneficiaries who have experienced a loss.
TravelConnectSM	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information

Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

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Group Long-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: Neos Consulting Group

Effective date: 9/1/11

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

Eligibility	All full-time active employees working 30 or more hours per week in an eligible class are eligible for coverage on the policy effective date.
Maximum Monthly Benefit	60% of salary up to \$6,000 per month
Maximum Benefit Duration	Social Security Normal Retirement Age
Own Occupation Period	End of Maximum Benefit Period
Elimination Period	90 days
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability. If you are working on a partial basis, you will have 2x the elimination period days to satisfy the total of 90 days.
Pre-Existing Condition	You may not be eligible for benefits if you have received treatment for a condition within the past 6 months until you have been covered under this plan for 12 months
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.
Survivor Income Benefit	A survivor benefit may be paid to your beneficiary if you should die while receiving qualifying disability payments.
EmployeeConnectSM	Access to an employee assistance program for the employee or an immediate household family member who may be experiencing personal or workplace issues.
Benefit Limitations	Mental Illness: 24 months Substance Abuse: 24 months Specified Illness: No Limit
Progressive Income Benefit	If you are disabled and have a loss of two or more Activities of Daily Living, you will receive an additional benefit of 10% to a maximum of \$5000.

(Please see other side)

Understanding Your Benefits

Own Occupation	The occupation trade or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles.
Total Disability	You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your own occupation. Your “own” occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education, or training.
Partial Disability	You are considered partially disabled if you are unable, due to an injury or illness, to perform the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within six months of returning to work, you will begin receiving benefits again immediately.
Benefit Duration Reduction	Your benefit duration may be reduced if you become disabled after age 65.
Pre-Existing Condition	Any sickness or injury for which you have received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to the coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date, unless no treatment was received for the specified consecutive months after the coverage effective date.
Benefit Exclusions	You will not receive benefits in the following circumstances: <ul style="list-style-type: none">• Your disability is the result of a self-inflicted injury.• You are not under the regular care of a doctor when requesting disability benefits.• You were involved in a felony commission, act of war, or participation in a riot.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: <ul style="list-style-type: none">• Any compulsory benefit act or law (such as state disability plans);• Any governmental retirement system earned as a result of working for the current policyholder;• Any disability or retirement benefit received under a retirement plan;• Any Social Security, or similar plan or act, benefits;• Earnings the insured earns or receives from any form of employment;• Workers compensation;• Salary continuance or employer contributions to an employer sponsored retirement plan.
Benefit Termination	This coverage will terminate when you terminate employment with this policyholder, or at your retirement.

For assistance or additional information

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NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describe the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

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FEDERAL (COBRA)

TEXAS

<p>Covered Employers and Plan Coverage</p>	<p>Group health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments; coverage must be identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage)</p>	<p>Texas compels all employers, including those with 2-19 employees that are required to comply with state mandates to provide continuation coverage. This includes fully insured plans, as well as governmental entities.</p> <p>Dental, vision and prescription plans are not required to be included.</p>
<p>Qualified Beneficiaries (Employee / Dependents)</p>	<p>Individual covered by a group health plan on the day before a qualifying event - either an employee, the employee's spouse, or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.</p>	<p>Employees and dependents with at least 3 consecutive months of coverage prior to termination</p>
<p>Continuation Period</p>	<p>18 months - COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours worked.</p> <p>29 months - Disability can extend the 18 month period of continuation coverage for a qualifying event that is a termination of employment or reduction of hours. If certain requirements are met, the entire family qualifies for an additional 11 months of COBRA continuation coverage. Plans can charge 150% of the premium cost for the extended period of coverage.</p> <p>36 months - 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.</p> <p>36 months - Under COBRA, participants, covered spouses and dependent children may continue their plan coverage when they would otherwise lose coverage due to divorce (or legal separation) for a maximum of 36 months.</p>	<p>9 months (or 6 months where COBRA eligible) – Eligible employees and dependents must be offered up to a 9 month continuation period. Where eligible for COBRA, eligible employees and dependents must be offered 6 additional months following COBRA.</p>
<p>Qualifying Events</p>	<p>For Employees: Voluntary or involuntary termination of employment for reasons other than gross misconduct – 18 months.</p> <p>Reduction in the number of hours of employment – 18 months.</p> <p>For Spouses: Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct – 18 months</p> <p>Reduction in the hours worked by the covered employee – 18 months</p> <p>Covered employee's becoming entitled to Medicare – 36 months</p> <p>Divorce or legal separation of the covered employee – 36 months</p> <p>Death of the covered employee – 36 months</p> <p>For Dependent Children: Loss of dependent child status under the plan rules – 36 months</p> <p>Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct – 18 months</p> <p>Reduction in the hours worked by the covered employee – 18 months</p> <p>Covered employee's becoming entitled to Medicare – 36 months</p> <p>Divorce or legal separation of the covered employee – 36 months</p> <p>Death of the covered employee – 36 months</p>	<p>For Employees: Coverage ends for any reason other than involuntary termination of employment for cause</p> <p>For Spouses: Coverage ends for any reason other than involuntary termination of employment for cause.</p> <p>Divorce or legal separation of group member.</p> <p>Death of group member</p> <p>For Dependent Children: Coverage end for any reason other than involuntary termination of employment for cause</p> <p>Divorce or legal separation of group member</p> <p>Death of group member</p>

Eligibility	To be eligible for COBRA coverage, must have been enrolled in employer's health plan when employed and health plan must continue to be in effect for active employees. COBRA continuation coverage is available upon the occurrence of a qualifying event that would, except for the COBRA continuation coverage, cause an individual to lose his or her health care coverage.	Eligibility is dependent upon whether the covered individual had been covered for at least 3 consecutive months prior to the termination of coverage.
Notice Requirements	<p>Employers or health plan administrators must provide an initial general notice when employee is hired if entitled to COBRA benefits.</p> <p>When no longer eligible for health coverage, employer has to provide a specific notice regarding rights to COBRA continuation benefits.</p> <p>Employers must notify their plan administrators within 30 days after an employee's termination or after a reduction in hours that causes an employee to lose health benefits.</p> <p>The plan administrator must provide notice to individual employees of their right to elect COBRA coverage within 14 days after the administrator has received notice from the employer.</p> <p>Employee must respond to this notice and elect COBRA coverage by the 60th day after the written notice is sent or the day health care coverage ceased, whichever is later. Otherwise, employee will lose all rights to COBRA benefits.</p> <p>Spouses and dependent children covered under such health plan have independent right to elect COBRA coverage upon employee's termination or reduction in hours.</p>	<p>The individual must apply for continuation coverage within 60 days of the later of: (1) termination of group coverage; or (2) the date on which the notice of continuation rights was received.</p> <p>Employers must provide a written notice to each covered individual that is affected by the termination of conversion or continuation privileges.</p> <p>Employers are required to notify individuals on continuation coverage that they may be entitled to coverage under the Texas Health Insurance Risk Pool. This notice must be sent at least 30 days prior to the end of the continuation period applicable to the individual.</p>
Termination of Coverage	<p>Coverage begins on the date that coverage would otherwise have been lost by reason of a qualifying event and will end at the end of the maximum period. It may end earlier if:</p> <p>Premiums are not paid on a timely basis.</p> <p>The employer ceases to maintain any group health plan.</p> <p>After the COBRA election, coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.</p> <p>After the COBRA election, a beneficiary becomes entitled to Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.</p>	<p>Continuation coverage must be allowed to continue until the earliest of the following:</p> <ul style="list-style-type: none"> - the date coverage would end due to the individual's failure to pay required premiums; - the group policy terminates; - the individual becomes eligible for Medicare or similar benefits under another plan; - the individual becomes eligible for coverage under a state or federal law other than COBRA

QUALIFYING EVENTS

Qualifying Events for adding individuals to the Health Plan outside the open enrollment period.

- 1.) **Loss of Other Coverage** – Election of Health Care coverage can be made within 30 days after losing other Health Care coverage, but only if (i) coverage under this plan was initially rejected because of that other coverage, and (ii) the other coverage is lost because of termination of a spouse's employment, death of a spouse, divorce, exhaustion of COBRA continuation, or other involuntary reason.

- 2.) **Marriage or Birth or Adoption of a Child** – An employee covered under this plan can enroll his or her eligible dependents within 30 days after the employee's marriage or within 30 days after the employee acquires a child through birth, adoption or placement for adoption. If the employee is eligible but not covered under this plan at that time, the employee can enroll for both employee and dependent Healthcare coverage.

- 3.) **Court Order** – An eligible spouse or child can be enrolled within 30 days after the issuance of a court order that requires the employee to provide Health Care coverage for the spouse or child.

- 4.) **Open Enrollment** – During an open enrollment period, an employee can enroll or, if permitted by the plan, change to a different Health Care coverage offered by the employer.



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