If your **Spouse** is enrolled in a Flexible Spending Account

You may **NOT** contribute to a Health Savings Account.

A Flexible Spending Account (FSA) is considered first dollar coverage for the Beneficiary and their Dependents, therefore you may not open your HSA until your Spouse no longer participates in a Medical Reimbursement FSA.
DocFind® Online Directory
Find the right doctor and quality care

Fast, accurate results 24/7
Whether you’re looking for a new doctor, pharmacy or dentist, our online directory will help you find what you need. You can even use the DocFind tool to see if your doctors are in our networks.

Make the best choice
There are lots of ways to search for a doctor with DocFind:
• Name
• City, state, zip
• Specialty
• Hospital affiliation
• Gender

To make your choice easier, DocFind gives you key information about a doctor:
• Plans accepted
• Office locations
• Maps and driving directions
• Medical school attended
• Board certification
• Languages spoken

You can even see which facilities specialize in:
• Transplants
• Children’s heart surgery
• Bariatric procedures
• Orthopedic procedures

They’re included in the Institutes of Excellence®/Institutes of Quality® network.
A 24-hour nurse line for your health questions

Informed Health® Line

Talk to a registered nurse anytime
Sometimes your health question can’t wait until your doctor’s visit. Or even the next morning!
With the Informed Health Line, you can speak to a registered nurse about any health issue on your mind — whenever you need to.⁶

Plus —
• It’s toll-free
• You can call as many times as you need — at no extra cost
• Your covered family members can use it, too

You could save time, money and a trip to the ER
You can turn to the Informed Health Line for helpful health information — instead of an unneeded trip to the ER. That can help you budget your money for when you really need to use it. Plus, you’ll be able to make smarter health decisions because you have good information — always only a phone call away.

⁶While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.
Aetna Navigator® Secure Member Website
Know more. Save money. Stay healthy.

Aetna Navigator puts all of your plan information and cost-saving tools in one place

Find doctors, dentists, pharmacies and hospitals
- Make sure your doctor is in our network before you go
- Look for a new doctor near your home or work

Get an ID card
- Print a temporary card or order a new card

Look up a claim
- Check to see what your doctor billed, how much your health benefits and insurance plan paid and what you have to pay
- Find out how claims work

Check your coverage
- Check who is on your plan and check what your plan covers

Keep track of health care costs
- Check what a procedure may cost in your area
- Look up a health savings account® or health fund balance
- See how much you’ve paid so far and how much you have left to pay
- Check the price of a drug before you go to the pharmacy

Smart technology and easy-to-use tools help you make the most of your plan’s benefits.

Health benefits and health insurance plans are offered, underwritten and/or administered by Aetna Health Inc., Aetna Health of California Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.
WhiteGlove Frequently Asked Questions

What kind of care do you provide?
Our scope-of-care is routine primary care. With that said, we provide two types of care:
- **Get-well care**: on these visits, we diagnose and treat anyone that is 2 years old and older for most of the same complaints that you would go to a primary care physician, family physician, or minor care clinic for. For example: flu, colds, sinus infections, skin rashes, nausea, vomiting, ear infections, urinary tract infections, etc.
- **Stay-well care**: on these visits, we perform wellness assessments, diagnostics tests, and other preventive care to help you avoid serious illness.

How does the WhiteGlove service benefit me?
WhiteGlove’s service offers you the following benefits:
- Higher quality medical care experience – gives you the time and attention you deserve
- Everything comes to you – more convenient and saves precious time
- Fixed cost and affordable – no big surprise medical bills
- Hassle free – no long waits, no running around, no exposure to everyone’s germs
- Great alternative for weekends, nights, and holidays – an alternative to expensive emergency rooms and urgent care centers for routine primary care

Who provides the care to me?
Our care is provided by licensed nurse practitioners. All of our clinicians are dedicated to WhiteGlove and have family medicine and emergency room or urgent care experience.

Will you come to ________?
Today, Aetna fully-insured customers in Texas have access to WhiteGlove’s service if they live or work in the following areas:
- Austin (Hays, Travis, and Williamson counties)
- Dallas (Collin, Dallas, and Rockwall counties)
- Fort Worth (Tarrant and Denton counties)
- Houston (Harris county)
- San Antonio (Bexar, Comal, and parts of Guadalupe county)

In addition, if you live or work in one of the service areas listed above you also have access to WhiteGlove’s service outside of Texas, including:
- Boston (Essex, Suffolk, Norfolk, Middlesex, and part of Worcester county)
- Phoenix (Most of Maricopa county) - Effective January 1, 2011

Which Aetna plans have access to WhiteGlove’s service?
You are automatically a WhiteGlove member on your Fully-Insured health plan at no cost to you.
Aetna’s Self-Funded employer groups may contract directly with WhiteGlove to have access to our service.

What does each visit cost?
In Texas:
- **Co-Pay Plan**: You pay your specialist co-pay but not more than $35 until your deductible and max out-of-pocket has been met. You then pay $0 for WhiteGlove visits.
- **No Co-Pay Plan**: You pay $35 for each WhiteGlove visit until your deductible has been met. You then pay your out-of-pocket percentage until your max out-of-pocket has been met. You then pay $0 for WhiteGlove visits.

Outside of Texas:
- Aetna insured that are WhiteGlove members in Texas pay a visit fee of $35 in any of our service areas outside of Texas.

More Questions ➔
For Aetna Insured
How quickly will you come to me when I call for care?

We typically see you within hours of your call and almost always the same day. Many of our members prefer to schedule a specific time that is convenient for them and we allow you to do that as well.

Is the visit fee all inclusive?

Most of the time yes. Our visit fee includes medical care, most of the generic Rx medications that we prescribe on the visit, and our well-kit that comes with chicken soup, crackers, Gatorade, ginger ale, Tylenol, Jell-O, Kleenex, cough drops, and more. The visit fee does not include any brand name Rx medications or non-S4 generics.

Will you share my information with others?

We will not share information beyond what is allowed by HIPAA in order to provide your care and manage our business. However, you can share any information that is captured in our system with your other healthcare providers, whenever you want.

Are there any limits to using the service?

Some:
- You have to be a WhiteGlove member and over 2 years old
- We provide routine primary care
- We are available from 8am to 8pm, 365 days a year
- You must have no outstanding balance owed WhiteGlove

There are no limits on the number of visits.

How do I use the service?

First Time:
- Register yourself on our website and complete your member profile and medical history or call us at 877-329-8081 and we can walk you through the registration process. Once registered, you may schedule a visit.

After the first time:
- Call us at 877-329-8081 or go online to request a visit.

What happens when I schedule a visit?

When you contact us by phone or the web, we:
- Ensure you are a registered WhiteGlove member (if not registered, we can register you)
- We ensure you have coverage with a qualified Aetna plan
- Perform triage
- Schedule a visit at your convenience
- During the visit (get-well):
  - Diagnose, test, and treat you at home of work
  - Bring a well-kit with foods, beverages, and over-the-counter remedies
  - Prescribe, order, and deliver any medications you need
- Bill your credit card, debit card, FSA card, or HSA card for the visit fee and prescription co-pay (if needed)
- Follow-up to see how you are doing

How do I access my healthcare information?

Go to www.whiteglove.com and click on Member Login, then enter your login and password information.
Dental Benefits
Savings, flexibility and service. For healthier smiles.

Overview of Benefits for: City of Georgetown

With all of the emphasis on healthy living, it may be refreshing to know you have access to a group dental plan that helps you maintain an oral health regimen with the savings you need, the flexibility you want and service you can count on.

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>In-Network % of PDP Fee</th>
<th>Out-of-Network % of R&amp;C Fee¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A - Preventive</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Type B - Basic Restorative</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Type C - Major Restorative</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Type D - Orthodontia</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Deductible: Per Individual</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td></td>
<td>Applies to Type B &amp; C services only</td>
<td>Applies to Type B &amp; C services only</td>
</tr>
<tr>
<td>Deductible: Per Family</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td></td>
<td>Applies to Type B &amp; C services only</td>
<td>Applies to Type B &amp; C services only</td>
</tr>
<tr>
<td>Orthodontia Lifetime Maximum: Per Individual</td>
<td>$1500</td>
<td>Ortho applies to Child Only up to Age 19</td>
</tr>
<tr>
<td>TMJ</td>
<td>Type C - Major Service as part of Annual Maximum</td>
<td></td>
</tr>
</tbody>
</table>

¹. The Reasonable and Customary charge is based on the lowest of the: “Actual Charge” (the dentist’s actual charge); or “Usual Charge” (the dentist’s usual charge for the same or similar services); or “Customary Charge” (the 90th Percentile charge of most dentists in the same geographic area for the same or similar services as determined by MetLife).

Understanding Your Dental Plans

The MetLife Preferred Dentist Program (PDP) is designed to provide the dental coverage you need with the features you want. Take advantage of all that this plan has to offer without compromising what matters most — including the freedom to visit the dentist of your choice — an “in-network” dentist or an “out-of-network” dentist.

If you receive in-network services, you will be responsible for any applicable cost sharing, PDP charges in excess of the benefit maximums, and for non-covered services. If you receive out-of-network services, you will be responsible for any applicable cost sharing, charges in excess of the benefit maximum, charges in excess of the PDP fee schedule amount, and charges for non-covered services.

Plan benefits for in-network services are based on the percentage of the PDP fee — MetLife’s negotiated fees that PDP dentists have agreed to accept as payment in full.

Plan benefits for out-of-network services are based on the percentage of the Reasonable and Customary (R&C) charges. If you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible for paying any difference between the dentist’s fee and your plan’s payment for the approved service.

Take advantage of online self-service capabilities with MyBenefits.
- Check the status of your claims
- Locate a participating PDP dentist
- Access MetLife’s Oral Health Library
- Elect to view your Explanation of Benefits online

To registered, just go to www.metlife.com/mybenefits and follow the easy registration instructions.
## An Example of Savings

**An Example of Savings* When You Visit a MetLife PDP Dentist**

Take a look at an example that shows how receiving services from a MetLife PDP dentist can save you money:

<table>
<thead>
<tr>
<th>(IN-NETWORK) When you receive care from a MetLife PDP dentist...</th>
<th>(OUT-OF-NETWORK) When you receive care from a Non-Participating dentist...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Dentist says you need a Crown, Type C Service**</td>
<td></td>
</tr>
<tr>
<td>PDP Fee: $375.00</td>
<td>P&amp;O Fee: $500.00</td>
</tr>
<tr>
<td>Dentist’s Usual Fee: $550.00</td>
<td></td>
</tr>
<tr>
<td>The PDP Fee is: $375.00</td>
<td>Dentist’s Usual Fee is: $550.00</td>
</tr>
<tr>
<td>Your Plan Pays: (50% x $375.00 PDP Fee)</td>
<td>Your Plan Pays: (50% x $500.00 P&amp;O Fee)</td>
</tr>
<tr>
<td>-$187.50</td>
<td>-$250.00</td>
</tr>
<tr>
<td>Your Out-of-Pocket Cost: $187.50</td>
<td>Your Out-of-Pocket Cost: $300.00</td>
</tr>
</tbody>
</table>

In this example, YOU SAVE $112.50 ($300.00 minus $187.50) ... by using a MetLife PDP dentist! Please note, this is only an example and may not match your plan design.

* Savings from enrolling in the MetLife PDP Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered.

** Please note: this example assumes that your annual deductible has been met.
## Selected Covered Services and Frequency Limitations

<table>
<thead>
<tr>
<th>Type A - Preventive</th>
<th>How Many / How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prophylaxis - Cleanings</td>
<td>1 in 6 months.</td>
</tr>
<tr>
<td>• Oral Examinations</td>
<td>1 in 6 months.</td>
</tr>
<tr>
<td>• Topical Fluoride Applications</td>
<td>1 in 12 months for children up to 14th birthday.</td>
</tr>
<tr>
<td>• Full Mouth X-Rays</td>
<td>1 in 60 months.</td>
</tr>
<tr>
<td>• Bite-wing X-Rays (Adult/Child)</td>
<td>Adult 1 in 12 months / Child 1 in 12 months up to 14th birthday.</td>
</tr>
<tr>
<td>• Space Maintainers</td>
<td>Children up to 14th birthday, Limited to 1 per lifetime per area.</td>
</tr>
<tr>
<td>• Sealants</td>
<td>1 per tooth in 60 months (per permanent 1st &amp; 2nd non-restored molar) children up to 14th birthday.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type B - Basic Restorative</th>
<th>How Many / How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Endodontics - Root Canal</td>
<td>1 per tooth in 24 months.</td>
</tr>
<tr>
<td>• General Anesthesia</td>
<td>For oral surgery, extractions or other covered services.</td>
</tr>
<tr>
<td>• Oral Surgery (Simple Extractions)</td>
<td>1 in 60 months.</td>
</tr>
<tr>
<td>• Oral Surgery (Surgical Extractions)</td>
<td>1 in 60 months.</td>
</tr>
<tr>
<td>• Other Oral Surgery</td>
<td>4 in 1 year, includes 2 cleanings.</td>
</tr>
<tr>
<td>• Periodontal Surgery</td>
<td>1 in 24 months. Composite Fillings covered on all teeth.</td>
</tr>
<tr>
<td>• Periodontal Scaling &amp; Root Planing</td>
<td>1 per tooth in 5 Years.</td>
</tr>
<tr>
<td>• Periodontal Maintenance</td>
<td></td>
</tr>
<tr>
<td>• Amalgam &amp; Composite Fillings</td>
<td></td>
</tr>
<tr>
<td>• Emergency Palliative Treatment</td>
<td></td>
</tr>
<tr>
<td>• Prefabricated Stainless Steel &amp; Resin Crowns</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type C - Major Restorative</th>
<th>How Many / How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Repairs</td>
<td>1 per tooth in 12 months.</td>
</tr>
<tr>
<td>• Implants</td>
<td>Services: 1 per tooth in 10 years. Repairs: 1 per tooth in 10 years.</td>
</tr>
<tr>
<td>• Bridges</td>
<td>1 per tooth in 5 years.</td>
</tr>
<tr>
<td>• Dentures</td>
<td>1 per tooth in 5 years.</td>
</tr>
<tr>
<td>• Crowns/Inlays/Onlays</td>
<td>1 per tooth in 5 years.</td>
</tr>
<tr>
<td>• Consultations</td>
<td>1 in 12 months.</td>
</tr>
<tr>
<td>• TMJ</td>
<td>TMJ – Major Service as part of Annual Maximum.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type D - Orthodontia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent children are covered up to 19th birthday. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.</td>
</tr>
<tr>
<td>All procedures performed in connection with orthodontic treatment are payable as Orthodontia.</td>
</tr>
<tr>
<td>Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary.</td>
</tr>
<tr>
<td>Orthodontic benefits end at cancellation of coverage.</td>
</tr>
</tbody>
</table>

*Alternate Benefits: Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you receive a more costly treatment alternative, your dentist may charge you or your dependent for the difference between the cost of the service that was performed and the least costly treatment alternative.
MyBenefits Registration Overview

MyBenefits provides you with a personalized, integrated and secure view of your MetLife-delivered benefits. You can take advantage of a number of self-service capabilities as well as a wealth of easy to access information including planning tools and oral health awareness material.* MetLife is able to deliver services to you that empower you to manage your benefits and not have to rely on your employer. As a first time user, you will need to register on MyBenefits. This will require you to follow the steps outlined below.

Registration Process for MyBenefits

Provide Your Company Name
Access MyBenefits at www.metlife.com/mybenefits and enter your company name and click "Submit."

Step 1: The Login Screen
On the Home Page, you can access general information. To begin accessing personal plan information, click on 'Register Now' and perform the one-time registration process. Going forward, you will be able to log-in directly.

Step 2: Enter Personal Information
Enter your first and last name, Social Security or Employee ID number, date of birth, and e-mail address.

Step 3: Create a User Name and Password
Then you will need to create a unique user name and password for future access to MyBenefits.

The User Name must be a minimum of 8 characters and include at least one letter and one number (i.e. johnsmith1 or 12345678). The Password must be a minimum of 6 characters and include at least one letter and one number (i.e. jsmith12 or 234516).

Step 4: Security Verification Questions
Lastly, you will need to choose and answer three identity verification questions, to be utilized in the event you forget your password. Finally, you will be asked to read and agree to the Web site's Terms of Use.

Step 5: Process Complete
Now you will be brought to the "Thank You" page.

Lastly, a confirmation of your registration will be sent to the e-mail address you provided during registration.

*Available only to dental benefits participants.
**Block Vision of Texas, Inc.**  
**Benefit Illustration**  
**City of Georgetown**  

*Platinum $150 Vision Plan with Lasik*  
*$10 Exam/$25 Eyewear Copayments Full Service – Illustration*

<table>
<thead>
<tr>
<th>Service / Material</th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Examination:</td>
<td>Paid in full*</td>
<td>Up to: $40.00 Retail Value*</td>
</tr>
<tr>
<td>Frame:</td>
<td>Up to: $150.00 Retail Value*</td>
<td>Up to: $45.00 Retail Value*</td>
</tr>
<tr>
<td>Lenses: (Clear, Standard, Glass or Plastic)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision (per pair)</td>
<td>Paid in full*</td>
<td>Up to: $40.00 Retail Value*</td>
</tr>
<tr>
<td>Bifocal (per pair)</td>
<td>Paid in full*</td>
<td>Up to: $60.00 Retail Value*</td>
</tr>
<tr>
<td>Trifocal (per pair)**</td>
<td>Paid in full*</td>
<td>Up to: $80.00 Retail Value*</td>
</tr>
<tr>
<td>Lenticular (per pair)</td>
<td>Paid in full*</td>
<td>Up to: $80.00 Retail Value*</td>
</tr>
<tr>
<td>Contact Lenses:***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>Up to $175.00*</td>
<td>Up to: $105.00 Retail Value*</td>
</tr>
<tr>
<td>Medically Required</td>
<td>Paid in full*</td>
<td>Up to: $210.00 Retail Value*</td>
</tr>
</tbody>
</table>

**Laser Vision Correction:**  
$200.00 allowance (in or out of network)  
*(Laser Vision Correction is in lieu of eyewear benefit, subject to routine regulatory filings and certain exclusions and limitations)*

* After applicable copayment listed above are fulfilled.
** Member pays difference in retail price between standard trifocal lenses and progressive lenses.
*** Contact lenses and related professional services (fitting, evaluation and follow-up) are covered in lieu of eyeglasses. Coverage to include all contact lens types (i.e. standard daily wear, extended wear, disposable, toric, gas permeable, and bifocal).

**Frequency:**
- Vision Examination: Once Each 12 Months
- Frame: Once Each 12 Months
- Lenses: Once Each 12 Months
- Contact Lenses: Once Each 12 Months

**Rates:**
- Voluntary Participation:  
  - Employee: $6.65  
  - Employee + Spouse: $11.35  
  - Employee + Child(ren): $12.00  
  - Family: $18.00

Non-Covered Eyewear Discount: Members may also receive a discount of 20% from a participating provider’s usual and customary fees for eyewear purchases which exceed the benefit coverage (except disposable contact lenses, for which no discount applies). This includes eyeglass frames which exceed the selected benefit coverage, specialty lenses (i.e. progressives) and lens “extras” such as tints and coatings. Eyewear purchased from a Wal-Mart Vision Center does not qualify for this additional discount because of Wal-Mart’s “Always Low Prices” policy.

**WE FOCUS ON YOU SO YOU CAN FOCUS ON LIFE**

For more information please contact us toll-free at (866) 265-0517 or visit our website at www.blockvision.com

10/31/2011
Choosing to protect your family

Life Insurance

If something unexpected happens, how can I be sure my family will be all right?

No one wants to think about it. But an unexpected death can have devastating financial consequences for survivors — consequences that can linger long after the initial shock and grief. Adequate life insurance can help your family manage expenses and make a very difficult transition less painful.

How do I know if I’m eligible to participate in this plan?

You’re eligible to buy Life insurance through this plan if you are a full-time employee of the policyholder or an associated company. Full-time employment means you are working 20.0 hours or more per week. Temporary or seasonal workers are not eligible.

How much coverage can I buy?

You can purchase up to 5 times your basic annual pay, in units of $10,000, to a maximum of $500,000; $20,000 is the minimum you can purchase. You also can purchase coverage for your spouse and children (see “Can I buy coverage for my family?”).

You can effectively double your protection by purchasing an equal amount of Accidental Death and Dismemberment (AD&D) coverage.

What is AD&D?

AD&D pays an amount equal to your Life benefit if you die as a direct result of an accident. In addition, your AD&D coverage includes:

- A Higher Education Benefit that pays an additional $3,000 per year for up to four consecutive years for eligible dependent students. (Applies to Employee AD&D Only.)
- An Automobile Accident Benefit that pays an additional 20% of the AD&D benefit, to a maximum of $100,000 should you or your covered dependent die as a result of a car accident while wearing a seatbelt.
- An Accidental Dismemberment benefit that pays 50% of the AD&D coverage for the loss of one hand, one foot or the sight of one eye; and 100% for the loss of two or more of the above.

Key Advantages of This Plan

- This plan is offered through your employer, so premium rates may be more competitive than similar products you could buy as an individual.
- Your premiums are paid through a convenient payroll deduction.
- If you enroll within 31 days of becoming eligible, you can purchase coverage without providing proof of good health, up to the Guarantee Issue amount.
- Your Life insurance includes an online Will Preparation, part of AEB’s Assurant Answers™ program. For more information, visit www.assurantemployebenefits.com/AssurantAnswers.
Life Q&A

Q. Do I have to answer health questions to enroll for this coverage?
   A. You can enroll for amounts up to $200,000 for yourself, up to $50,000 for your spouse, and up to $10,000 for each child without answering health questions. These amounts are known as Guarantee Issue and are only available if you sign up within 31 days of becoming eligible for coverage. To enroll for more coverage than the amounts shown above, you’ll need to answer a simple health statement.

   If you had coverage with the prior carrier on the day before this plan takes effect you can continue that level of coverage for yourself and your dependents, without answering health questions. Your amount will be limited to the Guarantee Issue amounts until documentation of the prior coverage amount is received and approved by us.

Q. I didn’t sign up when my employer offered this coverage with another carrier. Can I sign up now?
   A. Yes. A one time “Open” enrollment is being offered that applies only for this plan’s effective date. Even if you didn’t sign up before, you can enroll now, without answering health questions, up to the Guarantee Issue amounts shown above.

Q. What happens if I become disabled?
   A. If you become disabled prior to age 60 while insured for Voluntary Life and remain continuously disabled as defined in the policy for the qualifying period, your coverage, including any dependent coverage will continue without further premium payment until age 65, recovery or retirement, whichever is earliest. Any time Life insurance is continued under this disability benefit, AD&D insurance also will be continued (and the premium waived) for up to 1 year from the date of disability. For disabilities beginning between age 60 and 65, the insurance can be continued (and premium waived) for up to one year, but not past the earlier of age 65 or the date you retire.

Q. Can I access my Life insurance benefit if I’m terminally ill?
   A. Yes. The Accelerated Benefit lets you request payment for up to 80% of your or your spouse’s Voluntary Life benefit in the event of a life-threatening medical condition where there is a life expectancy of 12 months or less.

Q. Can I take my insurance with me if I leave my employer?
   A. Yes. You have two options. Portability allows you to continue this group life coverage for up to 3 years after terminating current employment. Conversion allows you to convert to an individual policy if any or all of your Life insurance ends while you are insured under our group Life policy.

Q. When will my coverage become effective?
   A. Your coverage becomes effective on the entry date specified in the group policy, provided you are at active work on that date. Otherwise, your coverage will begin on the day you return to full-time duties.

   Dependent coverage will become effective according to the policy entry date unless your dependent is in a hospital or similar facility on that day or if your dependent spouse is disabled on that day.

How do I estimate my premium?

You can choose employee coverage in $10,000 units, from a minimum of $20,000 up to 5 times your basic annual pay, but not more than $500,000.

To calculate your maximum benefit:

1. Enter your basic annual pay.

   \[ \times 5 \]

   Round to the next higher $10,000.

   This is your maximum coverage. (Cannot exceed $500,000)

2. Select a benefit amount in the Life or Life and AD&D chart, then find your age to determine your

   Monthly premium deduction. (Cannot exceed $500,000)
Voluntary Short-Term Disability (STD)

Choosing to protect your income

Short-Term Disability Insurance

What happens if I can’t work for a month or two ... or more?
A broken arm, surgery or having a baby could keep you out of commission and off
the job for six to eight weeks or longer. Your medical insurance will help cover
the cost of treatment. But what about other expenses — your mortgage or
rent, car payment, groceries and utilities? Once you’ve used up your sick
leave and vacation time, the paychecks stop. But the bills do not.

Think of Short-Term Disability insurance as
income protection insurance

The chances of suddenly not being able to work are greater than you may
realize, and the financial consequences can be serious:

• Within one year, one in 13 working people will suffer a short-term
disability for more than one week.¹

• Over 90% of disabling illnesses or injuries are not work-related,² so most
disabled workers are not eligible for workers’ compensation.

• Even a short disruption of income can be bad news because two-thirds of American
families live from paycheck to paycheck.³

Short-Term Disability insurance provides income assistance and a way to help you pay your bills
and keep your life as normal as possible if you become sick or injured and cannot work. And
through your employer, you can get this protection at an affordable group rate.

How do I know if I’m eligible to participate in this plan?
You’re eligible to buy Short-Term Disability insurance through this plan if you are a full-time
employee of the policyholder or an associated company. Full-time employment means you are
working 20.0 hours or more per week and earn at least $12,000 annually. Temporary or
seasonal workers are not eligible.

Key Advantages of This Plan

• Your premiums are paid through a convenient payroll deduction.
• You can purchase coverage without providing proof of good health.
• This plan provides a benefit for a disabling illness or injury that is not
work-related, including pregnancy.
• Your plan also includes Rehabilitation benefits that provide services
and support targeted at helping you return to active work.
Short-Term Disability Q&A

Q. How do I qualify for benefits?
   A. You’ll start receiving disability payments if you satisfy the qualifying period and meet the definition of disability. You’re considered disabled if either of the following apply:
      • You’re under the regular care and attendance of a doctor, and an injury, sickness or pregnancy prevents you from performing at least one of the material duties of your job; OR
      • An injury, sickness or pregnancy prevents you from earning more than 80% of your covered pre-disability pay.

Q. When would I start receiving benefits and how long could I receive them?
   A. Your benefits begin on the 8th day of disability for accidents or injuries, and on the 8th day of disability for sickness or pregnancy. Your benefits can continue for up to 13 weeks.

Q. Do I need to answer any health questions to enroll for this coverage?
   A. No. You can’t be turned down for coverage on the basis of your health. However, a pre-existing conditions limitation applies. A pre-existing condition is one for which you’ve seen a medical practitioner or taken medication in the 6 months before your coverage effective date. If your disability begins in the first 12 months of your coverage and is due to a pre-existing condition, full benefits are not payable. This limitation no longer applies after the earlier of 12 consecutive months ending on or after the effective date of coverage during which you have not consulted with or seen a medical practitioner or received treatment or medication for that condition or 12 consecutive months of coverage under this plan.

If you become disabled, but there is a question about whether the disability is caused by a pre-existing condition, we will pay 25% of your gross benefit for up to 4 weeks. This provides you with a financial bridge while we conduct our claims investigation. If we conclude your claim is due to a pre-existing condition, no further payment will be made. If your disability is not due to a pre-existing condition and your claim is approved, you will receive the balance of any benefit due.

Q. I didn’t sign up for this coverage when my employer previously offered it. Can I sign up now?
   A. Yes. A one-time “open” enrollment is being offered right now that applies for this plan’s effective date. This means that even if you did not sign up before, you can enroll now without answering health questions. The pre-existing conditions limitation still applies.

Q. Will benefits or payments I receive from other sources affect the amount of benefit I receive under this plan?
   A. Yes. Your benefit may be reduced by disability benefits from retirement or government plans, other group disability plans, no-fault benefits, salary continuance or sick leave, and return-to-work earnings.

Q. What happens if I can work, but only on a limited basis? Can I still receive a benefit?
   A. Yes, provided you meet the definition of disability. If you’re performing limited work, you’ll receive your full benefit unless the combination of your benefit and your new earnings is more than your covered pre-disability weekly pay.

Q. When does my coverage become effective?
   A. Your coverage starts on the entry date specified in your group policy, provided you’re at active work on that date. Otherwise, your coverage becomes effective on the day you return to full-time duties.
City of Georgetown TX
Long-Term Disability Insurance Benefit Summary
Presented by: Assurant Employee Benefits
Effective: January 1, 2013

Eligibility
You are eligible to participate if you are a full-time employee, as defined by your employer, at active work and working in the United States. Other policyholder-defined eligibility requirements may apply. Temporary or seasonal workers are not eligible.

Plan Description
<table>
<thead>
<tr>
<th>Monthly Benefit</th>
<th>60.00% of covered monthly pre-disability pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Maximum Benefit</td>
<td>$8,000</td>
</tr>
<tr>
<td>Benefits Begin</td>
<td>After 90 day(s) of disability</td>
</tr>
<tr>
<td>Maximum Benefit Duration</td>
<td>For disabilities occurring before age 60, Social Security Normal Retirement Age (SSNRA)</td>
</tr>
</tbody>
</table>

Commonly asked questions about Long-Term Disability insurance:

Q: Who will pay the premium for this coverage?
A: Premiums are paid by your employer.

Q: How do I qualify for benefits?
A: By meeting the definition of disability and satisfying the qualifying period (the length of time you must be disabled before benefits can begin.)

Q: What is the definition of disability for my plan?
A: Assurant Employee Benefits' Dual Definition of Disability allows you to qualify for benefits under a regular occupation or an earnings test. You need to satisfy only one test to be considered disabled. See your certificate of group insurance which provides this and other important plan definitions.

Q: How long will benefits be paid?
A: If you become disabled prior to age 60, the plan can pay benefits up to the Social Security Normal Retirement Age. If you become disabled after age 60, additional benefit duration restrictions apply.

Q: What if I try to come back to work during a disability?
A: Your plan has many provisions that encourage and support your return to work. You may receive a portion of your regular Long-Term Disability benefit while working and still be considered disabled.
Q: Will my benefits be reduced by other sources of income?
A: That depends on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement or government plans, other group disability plans, salary continuance or sick leave, settlements or payments received, no-fault benefits, and return-to-work earnings.

Q: Does this plan cover me if I become disabled due to an injury at work?
A: Yes. Your Long-Term Disability insurance provides benefits on- and off- the- job coverage for disabilities due to injury or illness.

Q: Are there any excluded medical conditions?
A: This plan does not exclude specific medical conditions, but a pre-existing condition may affect your eligibility for benefits. Please see your certificate of group insurance for limitations as some conditions may only qualify for a limited benefit duration.

Q: Does my plan have a pre-existing conditions limitation?
A: Yes. A pre-existing condition is one for which you have seen a medical practitioner or taken medication in the 3 months prior to your coverage effective date. We will not pay benefits for any disability resulting directly or indirectly from a pre-existing condition unless the disability begins after the earlier of 3 consecutive months ending on or after the effective date of coverage during which you have not consulted with or seen a medical practitioner or received medical care, treatment or services, or taken medication for that condition; OR 12 consecutive months during which you are continuously insured under this plan.

This summary provides only a general overview and does not contain or describe all plan details. Issued insurance policies determine all plan features and policy benefits. Please consult your certificate or group policy for a complete description, including all applicable limitations, exclusions, reductions, and restrictions. Please contact Assurant Employee Benefits for additional information.

For more information regarding claims and services, please visit our website at: www.assurantemployeefbenefits.com or call us at 800.733.7879
Your EAP Benefits Include

1 to 8 Counseling Sessions
Short term counseling sessions, per problem, per year, which includes assessment, referral and crisis services.

LawAccess
Provides legal and financial services with a Lawyer or Financial Professional specializing in your area of concern, at no cost to you. Available on-line or by telephone.

HelpNet
Your customized AWP EAP website providing skill builders, on-line assessments, information and referrals.

WorkLife
Resources and referrals for everyday needs available by telephone.

WellCoach
Provides you with a coach to help improve your health and well-being. Available on-line or by telephone.

SafeRide
Reimbursement for emergency cab fare for eligible employees and dependents that opt to use a cab service instead of driving while impaired.

We’re here for you as life happens!

Visit your customized EAP website
www.AllianceWP.com

To create an online account:
Go to www.AllianceWP.com
Click “Member” tab
Log in using:
Username: COGEmember@alliancewp.com
Password: AWP-4me (case sensitive)

You will be prompted to create your own unique username and password

Dependents and partners residing in the employee’s household are fully covered. The EAP is available at no cost to the employee or family member and is completely confidential.

All Benefits can be accessed by calling
512-328-1144
toll free 1-800-343-3822

Alliance Work Partners (AWP) is your Employee Assistance Program (EAP) offering you and your family valuable, confidential services at no cost to you. Designed to help you manage daily responsibilities, life events, work stresses or issues affecting your quality of life, AWP is available to take your call 24 hours a day, 7 days a week.
Alliance Work Partners Eligibility Criteria

Full Benefits:
- Employee, Retiree, Married/Divorced Spouse, Significant Other, Partner.
- All covered employees may bring anyone with them to their authorized/covered sessions regardless of relationship to employee.
- Any household member, regardless of age or relationship, residing in employee’s home, including significant other and their children.
- Children and grandchildren, age 26 or under – residing in the US or Puerto Rico. This includes children and grandchildren of significant other or partner.
- Any person meeting benefit eligibility prior to lay-off or termination of an employee will continue to be eligible for benefits up to 6 months from the date of employee’s lay-off or termination. Benefits are extended for 6 months from date of employee's call within this timeframe.

Assessment & Referral:
- Children and grandchildren age 27 and over of employee, married/divorced spouse, significant other or partner living outside employee’s home.
- Employee instructed by law to receive court-ordered counseling.
- All crisis cases (suicidal/homicidal, domestic violence, chemical dependence, substance abuse, child/elderly abuse) not otherwise covered.
- Any person meeting benefit eligibility prior to lay-off or termination of an employee will continue to be eligible for assessment and referral after 6 months and up to 1 year from the date of employee’s lay-off or termination. Benefits are extended 1 year from date of employee's call within this timeframe.

Information & Referral:
- Anyone contacting Alliance Work Partners regardless of contract status.

*Children under the age of 18 must have a written, signed release by their guardian who has custody (whether living in the home or not) to attend counseling on their own. This release is given to their affiliate. Divorced parents who bring their children in for counseling must bring a copy of their divorce decree or have signed permission from the other parent before bringing a child into counseling. Grandparents who bring their grandchildren into counseling must have proof of guardianship or written permission from the child’s parents.
Explanation of Benefits

**ID Theft coverage includes:**
(Covered members include: employee, spouse and dependent children under 18*)

Evaluation of your current credit standing with detailed analysis:
- An up-to-date credit report (looking for accounts you may not be aware of etc...)
- A personal credit score

Continuous (Daily) Credit Monitoring looking for:
- New accounts opened in your name
- Derogatory notations
- Public records
- Inquiries made
- Change of address requests
  (updates daily w/Post Office)

Complete Identity Restoration:
- Trained Experts will take the steps to restore your good name and credit for you
- Reduce out of pocket expenses and time spent away from work
- Fraud alert notifications will be sent on your behalf
- Applicable follow ups will be done with affected agencies and institutions, including:
  - Credit card companies
  - Social Security Administration
  - Financial Institutions
  - Federal Trade Commission
  - All three credit repositories
  - Department of Motor Vehicles

Proactive searches after a theft occurs:
- Proactive searches of applicable local and national databases will be made on your behalf

**Legal Shield coverage includes:**
(Covered members include: employee, spouse, and dependent children under 23*)

Preventive Legal Services:
- Unlimited Phone Consultations on Unlimited Matters
  - Divorce
  - Child custody
  - Bankruptcy
  - Real Estate
  - Healthcare
  - Taxes
- Unlimited letters written on members Behalf (1 per issue) plus 2 business letters per year
- Unlimited contract/document review (10 pages or less per document) plus 1 business document per year
- Initial preparation and yearly updates on:
  - Last will and testament
  - Living will
  - Durable power of attorney
  - Medical directive

Additional Legal Services:
- Moving traffic violations and tragic accident representation
- Uncontested separation, uncontested divorce, uncontested adoption, and uncontested name change
- Trial defense services (pre-trial and trial representation)
- IRS audit services (pre-trial and trial representation)
- Preferred member discount on issues not covered in plan including pre-existing
- 24-hour toll-free access to legal assistance in the event of an emergency on or off the job

Available through your employer as a payroll deduction at the following rates:

<table>
<thead>
<tr>
<th>Service</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID Theft &amp; Legal Shield</td>
<td>$25.90/mo</td>
</tr>
<tr>
<td>Minor dependents add</td>
<td>$1/mo</td>
</tr>
</tbody>
</table>

www.idtsoa.com • info@idtsoa.com • 800.735.4850
Important Notice from City of Georgetown
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Georgetown and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. City of Georgetown has determined that the prescription drug coverage offered by the company’s Medical Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

Medicare D Notice

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Georgetown coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current City of Georgetown coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage . . .

Contact the person listed on the next page for further information.

NOTE:

You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Georgetown changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938–0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
For More Information About Your Options Under Medicare Prescription Drug Coverage . . .

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Plan Dates January 1, 2012 to December 31, 2012
Name of Entity/Sender City of Georgetown
Contact Office Human Resources Department
Address 113 East 8th Street
Georgetown, Texas 78626
Phone Number (512) 930-3676
CHIPRA Notice

Medicaid & the Children’s Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premiums 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 employersponsored health coverage, but need assistance in paying their health premiums.

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

If you or your dependants are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependants 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 dependants are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependants to enroll in the plan - as long as you and your dependants are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

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

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-855-962-5447</td>
</tr>
<tr>
<td>Alaska - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Arizona - CHIP</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Colorado - Medicaid and CHIP</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Florida - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Georgia - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Idaho - Medicaid and CHIP</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Indiana - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Iowa - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Kansas - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Kentucky - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Louisiana - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Maine - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Massachusetts - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Minnesota - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Missouri - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Montana - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Nebraska - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Nevada - Medicaid and CHIP</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>New Hampshire - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>New Jersey - Medicaid and CHIP</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>New York - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>North Carolina - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>North Dakota - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Ohio - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Oklahoma - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Oregon - Medicaid and CHIP</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Pennsylvania - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Rhode Island - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>South Carolina - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>South Dakota - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Texas - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Utah - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Vermont - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Virginia - Medicaid and CHIP</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Washington - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>West Virginia - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Wisconsin - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
<tr>
<td>Wyoming - Medicaid</td>
<td>[Website]</td>
<td>Phone: 1-866-966-3013</td>
</tr>
</tbody>
</table>

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-4383

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323 Ext. 6156
<table>
<thead>
<tr>
<th><strong>FEDERAL (COBRA)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Employers and Plan Coverage</strong></td>
</tr>
<tr>
<td>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).</td>
</tr>
<tr>
<td><strong>Qualified Beneficiaries (Employee / Dependents)</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Continuation Period</strong></td>
</tr>
</tbody>
</table>
| 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 of work.  
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.  
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.  
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. |
| **Qualifying Events** |
| **Qualifying Events for Employees:**  
Voluntary or involuntary termination of employment for reasons other than gross misconduct – 18 months  
Reduction in the number of hours of employment – 18 months  
**Qualifying Events for Spouses:**  
Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct – 18 months  
Reduction in the hours worked by the covered employee – 18 months  
Covered employee's becoming entitled to Medicare – 36 months |
| Divorce or legal separation of the covered employee – 36 months |
| Death of the covered employee – 36 months |

**Qualifying Events for Dependent Children:**
- Loss of dependent child status under the plan rules – 36 months
- Voluntary or involuntary termination of the covered employee’s employment for any reason other than gross misconduct – 18 months
- Reduction in the hours worked by the covered employee – 18 months
- Covered employee’s becoming entitled to Medicare – 36 months
- Divorce or legal separation of the covered employee – 36 months
- Death of the covered employee – 36 months

**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.

**Notice Requirements**
Employers or health plan administrators must provide an initial general notice when employee is hired if entitled to COBRA benefits.

When no longer eligible for health coverage, employer has to provide a specific notice regarding rights to COBRA continuation benefits.

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.

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.

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.

Spouses and dependent children covered under such health plan have independent right to elect COBRA coverage upon employee’s termination or reduction in hours.

**Termination of Coverage**
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:
- Premiums are not paid on a timely basis.
- The employer ceases to maintain any group health plan.

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.

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.

| Conversion Rights | Some plans allow participants and beneficiaries to convert group health coverage to an individual policy. If this option is generally available from the plan, a qualified beneficiary who pays for COBRA coverage must be given the option of converting to an individual policy at the end of the COBRA continuation coverage period. The option must be given to enroll in a conversion health plan within 180 days before COBRA coverage ends. The premium for a conversion policy may be more expensive than the premium of a group plan, and the conversion policy may provide a lower level of coverage. The conversion option, however, is not available if the beneficiary ends COBRA coverage before reaching the end of the maximum period of COBRA coverage. |

| Other | |

| Applicable Statutes | IRC § 4980B, ERISA §601 et seq. |

| Government Agency Contact | Depts. of Labor and Treasury (private sector plans); Dept. of Health and Human Services (public sector plans) |

This Chart is provided to you for general informational purposes only. It broadly summarizes state and federal statutes, but does not include references to other legal resources (e.g., supporting regulations, or formal or informal opinions of state offices of commissioners of insurance) unless specifically noted. Please seek qualified and appropriate counsel for further information and/or advice regarding the application of the topics discussed herein to your employee benefits plans.

Content © 2006-2011 Zynwave, Inc. Images © 2000 Getty Images, Inc. All rights reserved.

(6/09, KMP 2/11)
The BeneTex Group
Division of Gallagher Benefit Services, Inc.

711 E. University Avenue
Georgetown, Texas 78626
(512) 930-7700 Phone  (512) 930-7701 Fax
www.gallagherbenefits.com