Greater Opportunities of the Permian Basin, Inc.

Building Families across the Permian Basin

EMPLOYEE BENEFITS GUIDE

PLAN YEAR: 2018 – 2019

INSURICA

CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit carriers. For general information, contact Human Resources.

MEDICAL Page 6

BlueCross BlueShield of Texas
800-521-2227
www.bcbstx.com

DENTAL Page 16

BlueCross BlueShield

800-521-2227

www.bcbstx.com

VISION Page 18

Dearborn - EyeMed Insight Network

844-323-8302

www.dearbornnational.com/vision

LIFE INSURANCE Page 19

Liberty Mutual

617-357-9500

LONG TERM DISABILITY Page 24

Liberty Mutual

800-538-4583

www.libertymutualgroup.com

IMPORTANT NOTICES Page 25

GLOSSARY OF TERMS Page 18

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

WELCOME TO OPEN ENROLLMENT FOR YOUR 2018-2019 BENEFITS

Elections you make during open enrollment will become effective October 1, 2018. Open Enrollment is the only time of year to add/drop dependents unless you have a qualifying event. Qualifying events include marriage, divorce, death birth or adoption of a child or if your dependent loses their insurance coverage elsewhere. **If you experience a qualifying event, you must notify Human Resources within 30 days of your wish to make a change in your coverage.**

Enrollers will be at your location the to enroll you in your plan selections and go over with you any changes you might want to make to your benefits for the upcoming year.

HIGHLIGHTS FOR THE 2018-2019 PLAN YEAR

- **Medical coverage will be offered through BlueCross BlueShield of Texas**
- **Dental coverage will be offered through BlueCross BlueShield of Texas**
- **Vision coverage will be offered through Dearborn/EyeMed with a $130 frame allowance and new frames 24 every months**
- **Liberty Mutual will continue to administer the Basic Life and AD&D , Voluntary Life and AD&D, and Long Term Disability**
- **Short-Term Disability, Accident, Cancer, Critical Illness, Medical Bridge/Gap Insurance and Whole Life will be available through Colonial Life**

WHO IS ELIGIBLE?

All Employees hired as full-time and are working 30 or more hours per week are eligible to enroll in benefits 90 days from date of hire.

HOW TO ENROLL

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it is time to make your benefit elections. The decisions you make during enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully. Enrollment elections and/or changes will be done through the enrollers who will be at your location during Open enrollment. New hires will be able to enroll through the ADP online enrollment system.

HOW TO MAKE CHANGES

Unless you experience a life-changing qualifying event, you **cannot** make changes to your Pre-Taxed benefits until the next open enrollment period . Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

PLEAE NOTE: It is your responsibility to notify HR within 30 days of your life-changing qualifying event to make changes.

MEDICAL INSURANCE

For full-time GOPB employees, medical insurance will be offered through BlueCross BlueShield of Texas. This year we will be changing plan coverage. Please note the information below and refer to your Summary of Benefits and Coverage (SBC) for more details.

The **Blue Choice PPO 713 plan** features in-network benefits only through the BlueCross BlueShield Blue Choice Network. This plan has a $5,000 individual deductible in which bloodwork and x-rays are not included in your office visit copay. You will have flat copays for office visits (although your wellness exam is provided at no cost to you*), urgent care and prescriptions. Most other services (including in patient hospital stay, outpatient surgery, and major diagnostic tests) require you to pay your calendar year deductible first. Emergency room care has a $500 per visit copay then deductible and coinsurance

We strongly encourage you to set-up your personal account at www.bcbstx.com From there you can see your Explanation of Benefits (EOBs), price a prescription, find a provider. You can also download the BlueCross BlueShield of Texas app and access your information via your smartphone or tablet.

***Please be aware, however, that although your Preventive Care visit is covered at no charge it is possible for certain preventive tests to have a cost. We suggest you check with your provider or BlueCross BlueShield of Texas to see what preventive tests are covered by your plan.**

MEDICAL INSURANCE

BlueCross BlueShield of Texas

This chart below is a snapshot of benefits provided under this plan. Please refer to your Benefit Plan Summary for more detailed descriptions of the benefits covered.

BlueCross BlueShield of Texas **Plan: Blue Choice PPO 713** **Network: Blue Choice PPO**	**In-Network**	**Out-of-Network**
Deductible	$5,000 Single $14,700 Family	$10,000 Single $29,400 Family
Coinsurance - Member Pays	30% after deductible	50% after deductible
Out-of-Pocket Maximum	$5,600 Single $14,700 Family	$20,000 Single $60,000 Family
Office Visit	Primary: $45 copay/visit Specialist: $90 copay/visit	50% after deductible 50% after deductible
Preventive Care	No charge	50% after deductible
Diagnostic X-Ray and Lab Services	30% after deductible	50% after deductible
Major Diagnostic Tests CT/PET scans MRIs	30% after deductible	50% after deductible
Virtual Visits	$45 copay	50% after deductible
Urgent Care	$75 copay; deductible does not apply	
Emergency Services	$500 copay plus 30% after deductible	
Outpatient Surgery Facility Fees Physician/Surgeon Fees	 30% after deductible 30% after deductible	 50% after deductible 50% after deductible
Inpatient Hospital Facility Fees Physician/Surgeon Fees	 30% after deductible 30% after deductible	 50% after deductible 50% after deductible
Prescription Drug Coverage Retail - Preferred Pharmacy Mail-Order	 $0/$10/$50/$100/$150/$250 3 times copay	 $10/$20/$70/$120/$150/$250 Not covered

MEDICAL RATES

Semi-Monthly*

BlueCross BlueShield of Texas Blue Choice PPO 713	
MEDICAL	**EE cost per paycheck**
Employee Only	**$58.48**
Employee/Spouse	**$362.57**
Employee/ Child(ren)	**$245.61**
Family	**$549.70**

***Please Note: There will be 2 pay periods a year that there will be no insurance deductions withheld**

BlueCross BlueShield of Texas

The BCBSTX App!

TEXAS

Stay connected with Blue Cross and Blue Shield of Texas (BCBSTX) and access important health benefit information wherever you are.

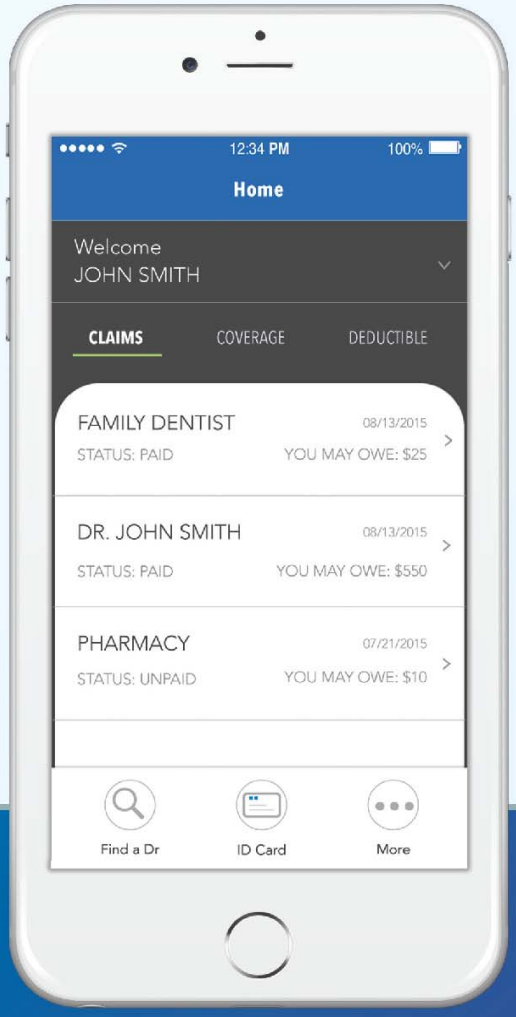
- Find a doctor, hospital or urgent care facility
- Access your claims, coverage and deductible information
- View and use your member ID card

Text* **BCBSTXAPP** to **33633** to get the app.

* Message and data rates may apply. Terms and conditions and privacy policy at bcbstx.com/mobile/text-messaging.

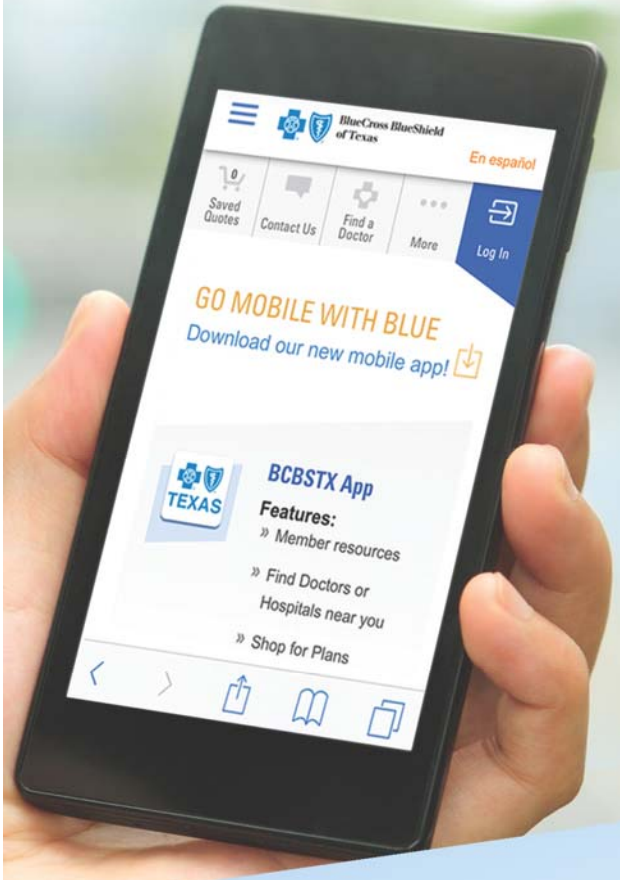
Download on the App Store

GET IT ON Google play



bcbstx.com/mobile

BlueCross BlueShield of Texas



Blue Access Mobile℠

allows you to conveniently and securely access your health coverage and wellness information via your mobile devices anywhere, anytime.

Learn more about Blue Access Mobile at bcbstx.com/mobile or text* GOTX to 33633.

*Message and data rates may apply. Terms and conditions and privacy policy at bcbstx.com/mobile/text-messaging.

BCBSTX App and Mobile Website:

- Find a doctor, hospital or urgent care facility or search for Spanish-speaking providers
- Register or log in to Blue Access for Members℠
  - View coverage details
  - Check claims status
  - Access ID card information

Centered App for iPhone®:

- Promote wellness through mindful meditation and activity
  - Set a daily steps goal and a weekly meditation goal
  - Choose from three meditation sessions - short, mindful or body awareness
  - Record activity automatically

Text Messaging:

- Set up personalized, daily reminders to take your prescriptions, multi-vitamins or check your blood glucose
- Get weekly diet, exercise and fitness tips
- Send texts to BCBSTX when you need instant account information

54192.0215

BlueCross BlueShield of Texas

Would you pay up to10 times more for the same pair of shoes just because of the store location?

Why is your health care any different?

Where you go matters

There are times when a health issue needs an Emergency Room (ER) visit. Any life-threatening or disabling health problem such as loss of consciousness, broken bones or severe shortness of breath is an emergency. You should go to the nearest hospital ER or call 911. When you only use the ER for emergencies, you help keep your out-of-pocket costs lower. But, in many cases, people have more routine health issues like a cold or sprained ankle, and they do not need an ER. Going to an ER for routine health issues like this can cost you – sometimes up to 10 times the cost you would pay at an urgent care center.[1]

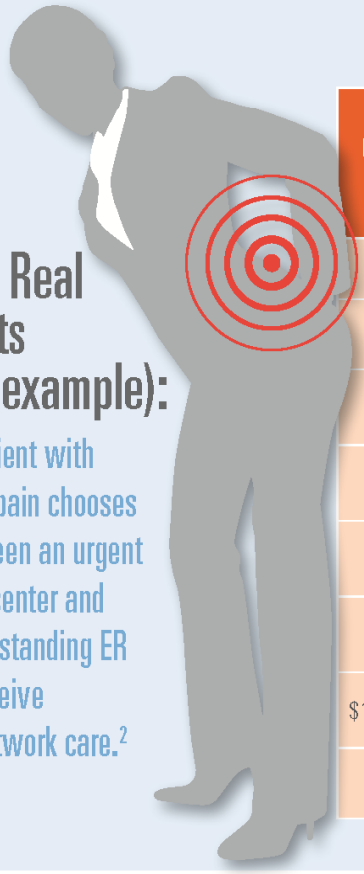
Prices can be up to

10 times higher

at freestanding ERs than urgent care centers.[1]

The Real Costs (an example):

A patient with back pain chooses between an urgent care center and a freestanding ER to receive in-network care.[2]



Freestanding ER Charges	VS. Service Description	Urgent Care Center Charges
$895	Family Charge - Level 3	$0
$53	Pulse Ox, Single (blood oxygen test)	$0 (Included in physician charge)
$96	Prescription Drugs (Toradol 15mg)	$40
$83	Intramuscular injection (IM/SQ) (drug injection into the muscles)	$28
$298	Physician Evaluation and Management	$150
$1,425	$ TOTAL BILLED CHARGES	$218
$1,196 Contract Rate	$ Insurance Benefit (Consumer has not met deductible)	$125 Contract Rate + $25 copay
$1,196 Paid by Consumer	$ TOTAL	$150 Paid by Consumer

bcbstx.com

BlueCross BlueShield of Texas

How can you tell them apart?

A freestanding Emergency Room (ER) looks and feels like an urgent care center. A freestanding ER is just like a hospital ER except that it is not attached to a hospital. People also come in for emergency care. Freestanding ERs can be found close to residential neighborhoods. Because they are ERs, they charge a facility fee just like a conventional hospital ER. This can cause you to end up with a much higher bill. Here are some ways to tell freestanding ERs from urgent care centers.

Freestanding ERs:

- Have the word EMERGENCY in the name
- Are not attached to a hospital
- Are staffed by board-certified ER doctors and are subject to the same ER copay

If you have a non-emergency condition after normal hours, you can find an urgent care center[3] by texting[4] **URGENTTX** to **33633**.

Need help finding a network provider?

Use Provider Finder® at **bcbstx.com** or call the number on the back of your member ID card. If you need emergency care, call 911 or get help from a doctor or hospital right away.

[1] The Texas Association of Health Plans, Emergency Care Cost Crisis in Texas.

[2] The Texas Association of Health Plans Out-of-Network Claims Survey and Analysis of Three Large Texas Health Plans: 2015 Claims; May 2016.

[3] The closest urgent care center may not be in your network. Be sure to check Provider Finder to make sure the center you go to is in-network.

[4] Message and data rates may apply. Read terms, conditions and privacy polity at bcbstx.com/mobile/text-messaging.

bcbstx.com

732614.0617

BlueCross BlueShield of Texas

Because Your Health Counts

It's Important to Know Where to Go When You Need Care

Sometimes it's easy to know when you should go to an emergency room (ER), at other times, it's less clear. You have choices for receiving in-network care that will work with your schedule and also give you access to the kind of care you need. Know when to use each for non-emergency treatment.

Virtual Visits

There's never a convenient time to get sick. But now you have access to a board-certified doctor around the clock for non-emergency health issues. Connect by mobile app, online video or telephone. Register at **MDLIVE.com/bcbstx** or by calling **888-680-8646**.

Your Doctor's Office

Your own doctor's office may be the best place to go for non-emergency care, such as health exams, routine shots, colds, flu and minor injuries. Your doctor knows your health history, the medicine you take, your lifestyle and can decide if you need tests or specialist care. Your doctor can also help you with care for a chronic health issue, such as asthma or diabetes.

Retail Health Clinic

When you can't get to your regular doctor, walk-in clinics – available in many retail stores – can be a lower-cost choice for treatment. Many stores have a physician assistant or nurse practitioner who can help treat ear infections, rashes, minor cuts and scrapes, allergies and colds.

Urgent/Immediate Care Clinic

These facilities can treat you for more serious health issues, such as when you need an X-ray or stitches. You will probably have a lower out-of-pocket cost than at a hospital ER, and you may have a shorter wait.

Hospital Emergency Room

Any life-threatening or disabling health problem is a true emergency. You should go to the nearest hospital ER or call **911**. When you use the ER for true emergencies, you help keep your out-of-pocket costs lower.

Knowing where to go for care can make a big difference in cost and time. Here's how your options compare†:

	Average Costs	Average Wait Times	Examples of Health Issues	
Virtual Visits Convenient and lower cost	$	10 minutes or less	• Allergies • Cold and flu • Nausea	• Sinus infections • Asthma • Pinkeye
Your Doctor's Office Your doctor knows your medical history best	$	24 minutes*	• Fever, colds and flu • Sore throat • Minor burns • Stomach ache	• Ear or sinus pain • Physicals • Shots • Minor allergic reactions
Retail Health Clinic Convenient, low-cost care in stores and pharmacies	$	15 minutes	• Infections • Cold and flu • Minor injuries or pain • Shots	• Flu shots • Sore and strep throat • Skin problems • Allergies
Urgent Care Clinic Immediate care for issues that are not life-threatening	$$$$	11-20 minutes**	• Migraines or headaches • Cuts that need stitches • Abdominal pain • Sprains or strains	• Urinary tract infection • Animal bites • Back pain
Hospital Emergency Room For serious or life-threatening conditions	$$$$$$	4 hours, 7 minutes***	• Chest pain, stroke • Seizures • Head or neck injuries • Sudden or severe pain	• Fainting, dizziness, weakness • Uncontrolled bleeding • Problem breathing • Broken bones

* Medical Practice Pulse Report 2009, Press Ganey Associates.

** Urgent Care Benchmarking Study Results. Journal of Urgent Care Medicine. January 2012.

*** Emergency Department Pulse Report 2010 Patient Perspectives on American Health Care. Press Ganey Associates.

Urgent Care or Freestanding Emergency Room

Urgent care centers and freestanding ERs can be hard to tell apart. Freestanding ERs often look a lot like urgent care centers and treat most major injuries, except for trauma, but costs are higher. Unlike urgent care centers, freestanding ERs are often out of network and can charge patients up to 10 times more for the same services.[1] Here are some ways to know if you are at a freestanding ER.

Freestanding ERs:

- Look like urgent care centers, but have EMERGENCY in the facility name.
- Are separate from a hospital but are equipped and work the same as an ER.
- Are staffed by board-certified ER physicians and are subject to the same ER copay.

Find urgent care centers[2] near you by texting[3] **URGENTTX** to **33633**.

Need help finding a network provider?

Use Provider Finder® at **bcbstx.com** or call the Customer Service number on the back of your member ID card. If you need emergency care, call **911** or seek help from any doctor or hospital right away.

BlueCross BlueShield of Texas

Powered by MDLIVE®

Virtual Visits

Convenient health care at your fingertips

Getting Care Just Got Easier

Getting sick is never convenient, and finding time to get to the doctor can be hard. Blue Cross and Blue Shield of Texas (BCBSTX) provides you and your covered dependents access to care for non-emergency medical issues and behavioral health needs through MDLIVE.

Speak to a doctor immediately or schedule an appointment for later.* The doctor can send prescriptions electronically to a pharmacy of your choice (when appropriate).

MDLIVE doctors and therapists can help treat the following conditions and more:

General Health
- Allergies
- Asthma
- Nausea
- Sinus infections

Pediatric Care
- Cold
- Flu
- Ear problems
- Pinkeye

Behavioral Health
- Anxiety and depression
- Child behavior and learning issues
- Marriage problems

Access a virtual visit anywhere through the mobile app, online video or telephone.*

Telephone:
- Call **MDLIVE (888-680-8646)**
- Speak with a health service specialist
- Speak with a doctor

Register today!

To register, go to MDLIVE.com/bcbstx. Enter your first and last name, date of birth and BCBSTX member ID number.

24/7 Nurseline

Nurses available anytime you need them

BlueCross BlueShield of Texas

Call the 24/7 Nurseline with any health questions.

Toll-free: **800-581-0393**

Hours of Operation: **Anytime**

Health happens – good or bad, 24 hours a day, seven days a week. That is why we have registered nurses waiting to talk to you whenever you call our 24/7 Nurseline.

Our nurses can answer your health questions and try to help you decide whether you should go to the emergency room or urgent care center or make an appointment with your doctor. You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions about:

- Asthma
- Back pain
- Diabetes
- Dizziness or severe headaches
- High fever
- A baby's nonstop crying
- Cuts or burns
- Sore throat
- And much more

Plus, when you call, you can access an audio library of more than 1,000 health topics – from allergies to surgeries – with more than 500 topics available in Spanish.

Note: For medical emergencies, call 911. This program is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

Blue Care Connection®

729699.0216

DENTAL INSURANCE AND RATES

BlueCare Dental - BlueCross BlueShield of Texas

Dental insurance is available for all GOPB full-time employees and their dependents. It is available through BlueCross BlueShield on a voluntary basis. You will be responsible for the cost of coverage.

GOPB's dental plan provides you with a PPO option that provides coverage in and out-of-network. However, by using and in-network provider you may be able to save on charges and not be balanced billed.

On the following page is a brief summary of the Dental PPO benefits that will take effect October 1, 2018. Please refer to your BlueCross BlueShield Blue Care Dental benefit summary for a more detailed list of coverage. Once enrolled, you can contact BlueCross BlueShield's customer service department with any questions related to your benefits or claims. You will also have availability to the BlueCross BlueShield of Texas website which allows easy access to all of your dental benefit information, including a list of network providers. We strongly encourage you to register (and create a user ID and password) at www.bcbstx.com

BlueCross BlueShield of Texas - DPPO	
DENTAL	**EE cost per paycheck**
Employee Only	**$10.82**
Employee + Spouse	**$21.99**
Employee + Child(ren)	**$24.68**
Employee + Family	**$39.56**

DENTAL

BlueCare Dental - BlueCross BlueShield of Texas

Dental Plan	Benefits
	In-Network/Out-of-Network
Deductible **Individual** **Family**	 $50 $150
Annual Benefit Maximum	$1,500
Preventive Services	**100% - Deductible Waived** Exams, x-rays, cleanings, sealants, fluoride, space maintainers, lab tests
Basic Services	**80% - After Deductible** Amalgams and resin-based composite restorations, emergency treatment, deep sedation, anesthesia, simple extractions, root canal, non-surgical periodontal services, surgical periodontal services, oral surgery services
Major Services	**50% - After Deductible** Crowns, dentures, denture repairs, implants
Orthodontics **Diagnostic Procedures and Treatment** **Lifetime Maximum**	Adults and Children are covered 50% $1,500

VISION

Dearborn National Through EyeMed

Vision insurance is available for all GOPB full-time employees and their dependents, It is available through Dearborn/ EyeMed on a voluntary basis. You will pay the full cost of coverage through payroll deductions. As with the medical and dental plans, the vision plan uses a network of vision providers. Your cost will be less if you use a network vision provider.

On the next page is a summary of the benefits that will take effect October 1, 2018. Once enrolled, you can contact Dearborn National's customer service department with any questions related to your benefits or claims. You will also have availability to the Dearborn National website which allows easy access to all of your vision benefit information, including a list of network providers. To access your plan information, go to www.dearbornnational.com/vision or call customer service at 844-323-8302.

Dearborn National through EyeMed - Vision	
Vision	**EE Cost per paycheck**
Employee Only	**$4.21**
Employee + Spouse	**$8.01**
Employee + Child(ren)	**$8.43**
Employee + Family	**$12.39**

LIFE AND AD&D

Liberty Mutual

Head Start of Greater Dallas provides all full-time employees with $15,000 group life and accidental death and dismemberment (AD&D) at no cost to you. **PLEASE NOTE: Your Basic Life amount will reduce at age 65 or older as follows:**

Age 65 to 69 - to 65%
Age 70 to 74 - to 50%
Age 75 and up - to 35%

You also have an opportunity to purchase additional life coverage for you and your dependents through Liberty Mutual. The premiums will be payroll deducted if you choose to purchase additional coverage. Any increase above the Guaranteed Issue Amount will require an Evidence of Insurability form submitted

To make sure your benefits are paid to those you want to receive them, it is important to update your beneficiaries after marriage birth, adoption of a child or after the death of a named beneficiary.

	Supplemental Voluntary Life and AD&D	Guaranteed Issue Amount
Employees:	Increments of $10,000 up to a maximum of lesser of 5 times annual earnings or $500,000	$100,000
Spouse:	Increments of $5,000 up to a maximum of $100,000 Dependent life may not exceed 50% of the Employee amount in force	$30,000
Dependent Children:	Live Birth, but under 6 months: $500 6 months but under 26 years if a full-time student: Increments of $1,000 up to a maximum of $10,000 Dependent life may not exceed 50% of the Employee amount in force	$10,000

Age	Employee and Spouse Rates Per $1,000 of Coverage
Under 25	$0.057
25-29	$0.064
30-34	$0.079
35-39	$0.108
40-44	$0.156
45-49	$0.240
50-54	$0.367
55-59	$0.534
60-64	$0.719
65-69	$1.104
70-74	$1.871
75+	$5.530
Child Life	$0.170 per $1,000 of coverage

PLEASE NOTE: Your Voluntary Life amount will reduce at age 65 or older as follows:

Age 65 to 69 - to 65%
Age 70 and up - to 50%

Dependent Voluntary Life will reduce as follows:

Age 65 to 69 - to 65%
Age 70 and up - to 50%

Life Insurance Needs

Planning Worksheet

Use the following worksheet to estimate how much life insurance you may need in addition to the amount you may already have.

1 Estimate Your Family's Income Needs

This is the income replacement your family would need based on their monthly income and expenditure.

Everyday Monthly Expenses	
Mortgage or Rent	$
Insurance Coverage *(e.g. auto, home, medical insurance premiums and expenses)*	$
Household Expenses *(e.g. food, utilites, clothes)*	$
Other *(e.g., child care, tuition)*	$
Subtotal 1 *(Add above items)*	$
Sources of Monthly Income	
Spouse's Income	$
Income Producing Assets *(e.g. investments, rent)*	$
Social Security Survivor Benefits *(See your Social Security statement for estimated benefits)*	$
Other	$
Subtotal 2 *(Add above items)*	$
Estimate Total Income Replacement Needs	
Annual Everyday Expenses (***Subtotal 1*** *x 12)*	$
Annual Income (***Subtotal 2*** *x 12)*	$
Annual Income Replacement Needs *Subtract Total Annual Income from Total Annual Everyday Expenses.*	$
Number of Years to Provide Income *For example 5, 10 or 15+ years.*	years
A. Total Income Replacement Needs *(Multiply Annual Income Replacement Needs by the Number of Years.)*	$

2 Estimate Other Expenses

There are additional expenses and debt that would be difficult for your family to manage without your income. Reference the callout box below for average cost information as needed.

Other Expenses	
Final Expenses	$
Current Debt	$
College	$
Child's Wedding	$
Elder Care	$
Other *Include credit cards and loan debts, e.g. tuition, auto, etc.*	$
B. Total Other Expenses *(Add above items)*	$

3 Estimate Available Assets

Additional sources of funds your family could use to meet its needs.

Available Assets	
Current Owned Life Insurance *Include both Supplemental and Basic Life Insurance*	$
Cash, Savings, Bonds, Investments	$
Retirement Funds *(e.g. IRA, 401(k), 403(B), and pension)*	$
Other	$
C. Total Available Assets *(Add above items)*	$

4 Estimate Life Insurance Coverage Needs

Value is based on your Total Income Replacement Needs, Total Other Expenses and Total Available Assets.

Total Estimate		
(A + B)	Add Total Income Replacement Needs (**A**) and Total Other Expenses (**B**)	$
- C	Subtract Total Available Assets (**C**)	$
Total Coverage Needed *Subtract **C** from **(A+B)***		$

Did you know?

- Final expenses including funeral average **$15,000**.[1]
- College costs an average of **$24,357** annually[2]
- An average wedding costs **$25,656**.[3]
- Eldercare costs average between **$3,415** (assisted living) to **$6,296** (nursing home) per month[4]

1. Life Foundation. Life Insurance Needs Calculator. 2012.
2. U.S. Department of Education. National Center for Education Statistics. Web Tables. September 2010. NCES2010-205.
3. The Wedding Report. Wedding Statistics Summary for United States. 2012.
4. Genworth Financial, Inc. Genworth 2013 Cost of Care Survey. 2013.

Note: This calculation does not incorporate any assumptions about investment results, changes in annual income, estate taxes, or inflation. Disclaimer: This worksheet is intended to provide an estimate of your potential life insurance needs and is only one of many ways to analyze your insurance needs. Please seek professional guidance to assess your actual life insurance needs and the types of policies that best meet those needs. Group products and services are offered by Liberty Life Assurance Company of Boston, a Liberty Mutual company. Home Office: Boston, MA. GRP 117

Liberty Mutual. INSURANCE

MyLibertyAssist®

Beneficiary Services

Lincoln Financial Group* is pleased to offer beneficiary services through an arrangement with Morneau Shepell.

Beneficiaries of employees covered under group term life insurance policies from Lincoln Financial Group are eligible for MyLibertyAssist Beneficiary Services. These services, provided by Morneau Shepell, offer additional support to cope with the loss of a loved one.

MyLibertyAssist: Beneficiary Services

MyLibertyAssist Beneficiary Services are available to beneficiaries of covered employees one year from the date the services first become available.

Grief	Financial	Legal
24/7 telephonic access to counselors **Face-to-face sessions**[1,2,3]	**Toll-free information line:** ■ Credit ■ Debt ■ Request educational material **Financial advice sessions:** ■ Free telephonic session and financial worksheet review	**Assistance from attorneys:** ■ Free face-to-face or telephonic session[2] ■ Up to 25% employee discount on additional services **Assistance with:** ■ Wills and trusts ■ Estates

1 In California, sessions are limited to three (3) in a six-month period, not to exceed a total of five (5) sessions per year.

2 Beneficiaries are eligible for a combined total of five (5) face-to-face sessions covering grief and/or legal sessions. Individual face-to-face sessions are available for beneficiaries 16 years and older. Family or group face-to-face sessions are available for beneficiaries 12 years and older, and their parents. Face-to-face sessions are not available to children under the age of 12.

3 Beneficiaries with complex and/or longer-term problems will be referred by your Morneau Shepell clinician or counselor to another professionally trained clinician. This referral will be billed to your health insurance plan or a community provider and does not count toward your five (5) grief and/or legal sessions.

* Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Group insurance products and services described herein are issued by Liberty Life Assurance Company of Boston, a Lincoln Financial Group company.

Access MyLibertyAssist Beneficiary Services
Contact us by phone at 866-685-6236, email, or live chat by visiting workhealthlife.com/mllife

Lincoln Financial Group®

MyLibertyAssist®

Employee Assistance Program (EAP)

Lincoln Financial Group* is pleased to offer an EAP through an arrangement with Morneau Shepell.

As an employee covered under your employer's group long-term disability and/or life policy from Lincoln Financial Group, you are eligible for MyLibertyAssist, an EAP provided by Morneau Shepell.

MyLibertyAssist: EAP

MyLibertyAssist EAP services are available to you and your immediate family members.[1]

Services	Financial	Legal	Family
Face-to-face sessions[2,3,4] **Telephonic assistance:** ▪ Unlimited 24/7/365 telephonic assessments ▪ Text ▪ Live chat via website **Assistance with:** ▪ Marital and family concerns ▪ Stress and anxiety management ▪ Depression ▪ Alcohol and drug abuse ▪ Grief and loss **Also available:** ▪ Resource center for daily living discounts ▪ Better Living wellness portal	**Assistance from financial counselors:** ▪ Address financial concerns ▪ Request educational material **Financial advice sessions:** ▪ One free telephonic session and financial worksheet review **Assistance with:** ▪ Financial Planning ▪ Credit and Debt Management ▪ Real Estate/ Mortgage Information	**Assistance from attorneys:** ▪ Free 30-minute telephonic or face-to-face session ▪ Up to 25% employee discount on additional services **Assistance with:** ▪ Document preparation ▪ Divorce and separation ▪ Real estate ▪ Civil matters	**Assistance from work-life specialists and care consultants:** ▪ Free telephonic session ▪ Online access to information and provider locators **Assistance with:** ▪ Child care ▪ Elder care ▪ Adoption ▪ Education **Care consultant assistance with:** ▪ Apartment locators ▪ Home repair contractors ▪ Pet care and training ▪ Transportation and travel

1 "Immediate Family Member" means, with respect to a covered employee, those individuals who reside in the employee's household and are related to the employee by kinship, adoption or marriage, including any foster children. Minor children of the employee will be considered to be an "Immediate Family Member" regardless of whether or not they are living in the same household as the employee.

2 In California, sessions are limited to three (3) in a six-month period, not to exceed a total of five (5) sessions per year.

3 Covered individuals are eligible for a combined total of five (5) face-to-face sessions (per presenting problem) with Morneau Shepell clinicians. Individual face-to-face sessions are available for covered individuals 16 years and older. Family/group face-to-face sessions are available for covered individuals 12 years and older, and their parents. Face-to-face sessions are not available to children under the age of 12.

4 Covered individuals with complex and/or longer-term problems will be referred by your Morneau Shepell clinician to another professionally trained clinician. This referral will be billed to your health insurance plan or a community provider and does not count toward your five (5) grief and/or legal sessions.

* Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Group insurance products and services described herein are issued by Liberty Life Assurance Company of Boston, a Lincoln Financial Group company.

Lincoln Financial Group®

MyLibertyAssist EAP: Web Services

The MyLibertyAssist website is user-friendly and offers practical EAP-related information that addresses emotional well-being, health and wellness, and daily living concerns. Resources available include interactive self-assessments, a comprehensive library of articles and guides, and financial calculators. The website provides employees and their immediate family members with the information they need and is conveniently organized in the following categories:

Health and Well-Being: Improve your physical and mental well-being with helpful health information. Utilize self-help tools, self-assessments, and information on emotional resilience, self-esteem, grief and bereavement, as well as guidance on how to access help for conditions such as anxiety, depression, and addiction.

Career and Workplace: Access tools to help you manage your career, better handle workplace relationships, and find work-life balance. Resources include employee and supervisor work performance toolboxes with articles, and information to help develop workplace and leadership skills. Information on managing work-related issues such as conflict and communication is also available.

Financial Security: Achieve financial well-being with a better understanding of financial matters. Read articles to help address financial and legal questions, such as debt, investments, retirement, taxes, bankruptcy, wills and estate planning, and identity theft. State-specific legal forms and documents are available for personal use and can be stored on a secure server.

Financial calculators are also available for the following topics:

- Mortgage
- Loan
- Auto
- Credit cards and debt management
- Retirement saving

Life Events: Find useful information to better inform and support you during life events and times of change. Resources are available to help address responsibilities and issues concerning the family, such as pregnancy, child care, parenting, child and adolescent development, and elder care. This site also includes a locator that allows users to search for child and elder care options.

To access MyLibertyAssist EAP
Online: workhealthlife.com/mlassist
Telephone: 877-695-2789

LONG TERM DISABILITY

Liberty Mutual

GOPB provides all full-time employees with long term disability income benefits and pays the full cost for this benefit. In the event that you become disabled from a non-work related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive long term disability benefits if you are receiving Workers' Compensation benefits.

Long-Term Disability Benefits

Who is Eligible?	All active full-time and part-time employees working a minimum of 25 regularly scheduled hours per week. This excludes temporary and seasonal employees.
Waiting Period	You are eligible on the first of the month on or after 90 days following date of hire.
Monthly Benefit	66.7% of basic monthly earnings not to exceed a maximum monthly benefit of $5,000, less benefits from other income.
Elimination Period	Benefits are payable after a period of 90 consecutive days of disability.
Definition of Disability	You will be considered disabled if, during the elimination period and the next 24 months of disability, you are unable to perform the duties of your "own occupation" and thereafter, you are unable to perform the duties of "any occupation." Refer to your certificate of coverage for definitions of "own occupation" and "any occupation."
Maximum Benefit Period	**Age at Disability** — **Maximum Benefit Period** Less than age 60---------- to age 65 or greater of SSNRA (but not less than 5 years 61 ---------- 48 months 62---------- 42 months 63 ---------- 36 months 64 ---------- 30 months 65 ---------- 24 months 66 ---------- 21 months 67 ---------- 18 months 68 ---------- 15 months 69 and over ---------- 12 months
Successive Disability	If you become disabled for the same condition within six months following your prior disability, your benefits will continue under the same claim.
Survivor Benefit	A lump sum payment, equal to three months of benefits paid, to an eligible survivor or estate if you are receiving a benefit and have been disabled for at least 180 days.

IMPORTANT NOTICES

Important Notice from Greater Opportunities of the Permian Basin (GOPB, Inc.) 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 GOPB, Inc. 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. GOPB, Inc. has determined that the prescription drug coverage offered by the GOPB, Inc. Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. 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.

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.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current GOPB, Inc. coverage will not be affected. [*See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current GOPB, Inc. coverage, be aware that you and your dependents will 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 GOPB, Inc. 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 below 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 GOPB, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

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

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

CMS Form 10182-CC **Updated April 1, 2011**

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).

Date: October 1, 2018
Name of Entity/Sender: Greater Opportunities of the Permian Basin, Inc.
Contact: LeeAnn Unruh, Fiscal Manager
Address: 206 W. 5th Street, Odessa, TX 79761
Phone Number: 432-337-1352

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complication of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage
If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIPS)

If you and your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for those programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid of 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.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the **Health Insurance Marketplace.** To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment through the Market place for health insurance coverage begins November 1, 2018 and ends December 15, 2018 for coverage starting as early as January 1, 2019.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost -sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any members of your family) is more than 9.56 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less that 60 percent of such costs.)

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Administrator. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

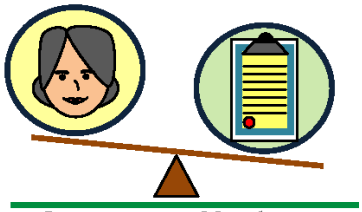
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance ***plus*** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.



Jane pays 20% | Her plan pays 80%

(See page 4 for a detailed example.)

Complications of Pregnancy

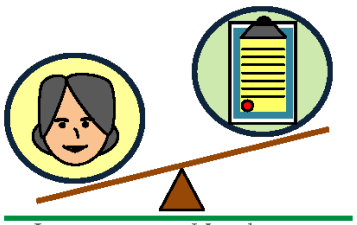
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Jane pays 100% | Her plan pays 0%

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or **plan**.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance.**

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments.**

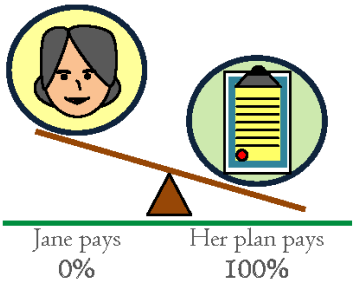
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments.**

Out-of-Pocket Limit


The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.

(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

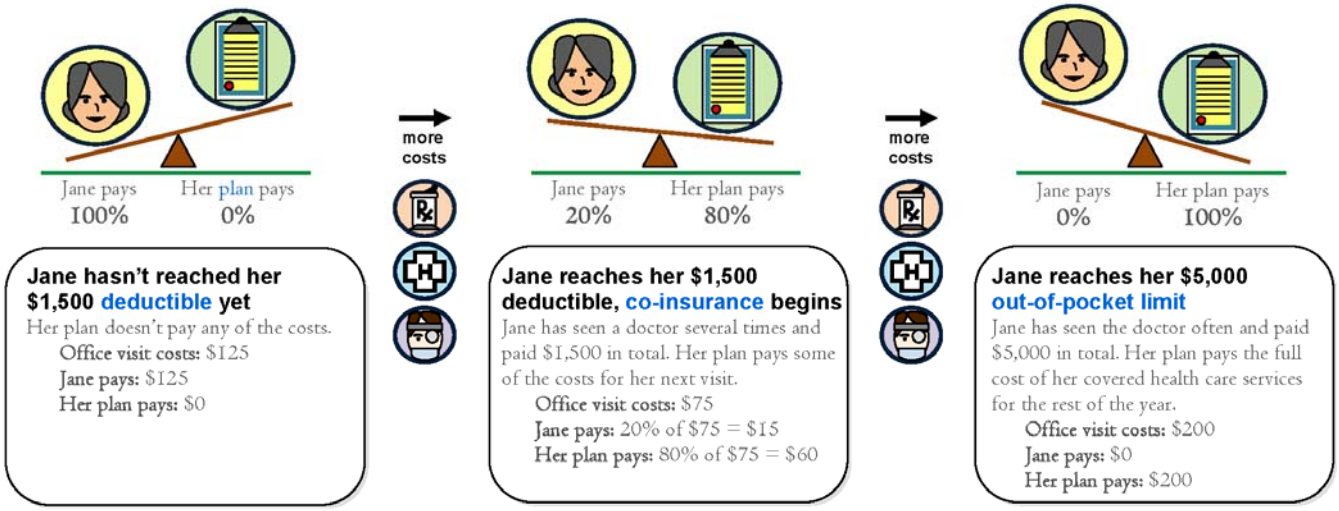
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



Jane hasn't reached her $1,500 deductible yet
Her plan doesn't pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, co-insurance begins
Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.
Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

Jane reaches her $5,000 out-of-pocket limit
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $200
Jane pays: $0
Her plan pays: $200

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