

Important Notices

I. Initial Notice About Special Enrollment Rights and Pre-existing Condition Exclusion Rules in Your Group Health Plan

A federal law called Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its “special enrollment provision” without being considered a late applicant if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Second, this notice advises you of the plan’s pre-existing condition exclusion rules that may temporarily exclude coverage for certain pre-existing conditions that you or a member of your family may have. Section I of this notice may not apply to certain self-insured, non-federal governmental plans. Contact your employer or plan administrator for more information.

A. SPECIAL ENROLLMENT PROVISIONS

Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program) If you are declining enrollment for yourself or your eligible 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 you move out of an HMO service area, or the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 31 days after you or your dependents’ other coverage ends (or move out of the prior plan’s HMO service area, or after the employer stops contributing toward the other coverage).

Loss of Coverage For Medicaid or a State Children’s Health Insurance Program

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for State Premium Assistance for Enrollees of Medicaid or a State Children’s Health Insurance Program

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after you or your dependents’ determination of eligibility for such assistance. You or your spouse or dependents may also have special enrollment rights in another group health plan at the time a claim is denied as a result of a lifetime limit on all benefits, if you request enrollment within 30 days after the claim has been denied.

For more information, call Customer Service at the phone number on the back of your ID card.

B. PRE-EXISTING CONDITION EXCLUSION RULES

Most health plans impose pre-existing condition exclusions. This means that if you have a medical condition before coming to our plan you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before your enrollment date. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-

month period ends on the day before the waiting period begins. "Waiting period" generally refers to a delay between the first day of employment and the first day of coverage under the plan. The pre-existing condition exclusion does not apply to pregnancy or to an individual under the age of 19. This pre-existing condition exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days you had prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, you have a right to request one from your prior plan or issuers. We will help you obtain one from your prior plan or issuer, if necessary. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

For more information about the pre-existing condition exclusion and creditable coverage rules affecting your plan, call Customer Service at the phone number on the back of your ID card.

II. Additional Notices

Other federal laws require we notify you of additional provisions of your plan.

A. ENROLLMENT NOTICE FOR ADULT CHILDREN UNDER AGE 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan. Individuals may request enrollment for such children during an enrollment period that continues for at least 30 days, beginning not later than the first day of the first plan year beginning on or after September 23, 2010. If an individual is timely enrolled, enrollment will be effective retroactively to the first day of the first plan year, beginning on or after September 23, 2010.

For more information, call Customer Service at the phone number on the back of your ID card.

Special Rule for grandfathered group health plans (if applicable) – The plan may exclude an adult child who has not obtained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer sponsored health plan other than a group health plan of a parent.

B. NOTICES OF RIGHT TO DESIGNATE A PRIMARY CARE PROVIDER (NON-GRANDFATHERED PLANS ONLY)

For plans that require or allow for the designation of primary care providers by participants or beneficiaries:

If the plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, **call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.**

For plans that require or allow for the designation of a primary care provider for a child: For children, you may designate a pediatrician as the primary care provider.

For plans that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider: You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in pediatrics, obstetrics or gynecology, call Customer Service at the phone number on the back of your ID card.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by *CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA)*. See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens: Your spouse dies;

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

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

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

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

HIPAA NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Our Responsibilities

We are required by applicable federal and state law to maintain the privacy of your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We use and disclose PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures that we are permitted to make.

Treatment: We may use or disclose your PHI to a physician or other health care provider providing treatment to you. We may use or disclose your PHI to a health care provider so that we can make prior authorization decisions under your benefit plan.

Payment: We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.

Health Care Operations: We may use and disclose your PHI in connection with our health care operations. Health care operations include the business functions conducted by a health insurer. These activities may include providing customer services, responding to complaints and appeals from members, providing case management and care coordination under the benefit plans, conducting medical review of claims and other quality assessment and improvement activities, establishing premium rates and underwriting rules. In certain instances, we may also provide PHI to the plan sponsor of a group health plan. We may also in our health care operations disclose PHI to business associates¹ with whom we have written agreements containing terms to protect the privacy of your PHI. We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, case management and care coordination, or detecting or preventing health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give us an authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. We will make disclosures of any psychotherapy notes we may have only if you provide us with a specific written authorization or when disclosure is required by law.

Personal Representatives: We will disclose your PHI to your personal representative when the personal representative has been properly designated by you and the existence of your personal representative is documented to us in writing through a written authorization.

Disaster Relief: We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Health Related Services. We may use your PHI to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities. (A "business associate" is a person or entity who performs or assists us with an activity involving the use or disclosure of medical information that is protected under the Privacy Rules.) We may use or disclose your PHI to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Public Benefit: We may use or disclose your PHI as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, certain Food and Drug Administration (FDA) oversight purposes with respect to an FDA-regulated product or activity, and to employers regarding work-related illness or injury required under the Occupational Safety and Health Act (OSHA) or other similar laws;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to avert a serious threat to health or safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by and to the extent necessary to comply with state worker's compensation laws.

We will make disclosures for the following public interest purposes, only if you provide us with a written authorization or when disclosure is required by law:

- to coroners, medical examiners, and funeral directors;
- to an organ procurement organization; and
- in connection with certain research activities.

Use and Disclosure of Certain Types of Medical Information. For certain types of PHI we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your PHI:

- *Communicable Disease Test Results.* We may not disclose the result of any communicable disease test, unless the disclosure is required by law or the disclosure is to you, your personal representative, a physician or other person who ordered the test, or a health care worker who has a legitimate need to know the results of the test for safety purposes, or pursuant to an authorization signed by you.
- *HIV Test Results.* We may not disclose the result of any HIV test unless required by law or the disclosure is to you, your personal representative, a physician or other person who ordered the test, or a health care worker who has a legitimate need to know the results of the test for safety purposes; or pursuant to an authorization signed by you providing us permission to disclose to an insurance medical information exchange, a reinsurer, or to our attorneys.
- *Genetic Information.* We may not disclose genetic information unless the disclosure is authorized under state or federal criminal law and the disclosure relates to identifying an individual in the course of a criminal or judicial proceeding; is required under specific order of a state or federal court; is authorized under state or federal law to establish paternity; is made to a blood relative of a decedent for purposes of medical diagnosis; or is made to identify a decedent.
- *Status as Victim of Family Violence.* We may not disclose your status as a victim of family violence unless the disclosure is to you; to a physician or health care provider for the provision of health care services; to a licensed physician designated by you; as required by law or pursuant to an order of the Texas Insurance Commissioner or a court order; to our attorneys; or when necessary for our payment and health care operations if to a reinsurer, a party to a sale of all or part of our business or to medical and claims personnel we contract with, providing we cannot without undue hardship first segregate the medical information in a way that does not disclose your status as a victim of family violence.
- *Mental Health Information.* We may not disclose your mental health information except for the same purposes for which we received the information or as may be required by law.
- *Confidential Communications from a Physician.* We may not disclose confidential information about you that we receive from a physician for any purpose other than for which we received the information or as may be required by law.
- *Medical Information Maintained by Our HMO.* Your medical information that is maintained by our HMO may only be disclosed for the HMO's payment and health care operations purposes or as allowed by Texas law pertaining to HMOs.
- *Medical Information We Receive While Performing Utilization Review.* If we collect or receive your medical information while performing utilization review activities, we may not disclose that information unless the disclosure is required by law or to an individual or entity that we have contracted with to aid us in performing utilization review.

Individual Rights

You may contact us using the information at the end of this notice to obtain the forms described here, explanations on how to submit a request, or other additional information.

Access: You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. A "designated record set" contains records we maintain such as enrollment, claims processing, and case management records. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI and may obtain a request form from us. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

Disclosure Accounting: You have the right to receive a list of instances since April 14, 2003 in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, health care operations, or as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fee structure at your request.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is in writing.

Confidential Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the basis for your request, but you must state that the information could endanger you if the communication means or location

is not changed. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment. You have the right, with limited exceptions, to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive a Copy of the Notice: You may request a copy of our notice at any time by contacting our office .

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services; see information at its Web site: www.hhs.gov. If you request, we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact :

Director, Privacy Office Health Care Service Corporation
P.O. Box 804836
Chicago, IL 60680-4110
Telephone: 1.800.607.7418

Important Notice from *Iraan-Sheffield ISD* 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 *Iraan-Sheffield ISD* 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. *Iraan-Sheffield ISD* has determined that the prescription drug coverage offered by our *Employee Medical Benefit 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.
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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 November 15th through December 31st.

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 *Iraan-Sheffield ISD* coverage may be affected. If you drop your coverage with *Iraan-Sheffield ISD Employee Medical Benefit Plan* and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You may also want to visit the CMS website for 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 *Iraan-Sheffield ISD Employee Medical Benefit Plan* coverage, be aware that you and your dependents may or 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 *Iraan-Sheffield ISD* 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 November to join.

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

Contact the person listed below for further information Insurance One Management, Inc. / Don Crawford & Associates at (432) 687-0213. **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 *Iraan-Sheffield ISD* 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).

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:	<i>September 1, 2013</i>
Name of Entity/Sender:	<i>Iraan-Sheffield ISD</i>
Contact/Office:	<i>Kevin Allen</i>
Address:	<i>100 South Farr, Iraan, Texas 79744</i>
Phone Number:	<i>(432) 639-2512</i>

IRAAN-SHEFFIELD INDEPENDENT SCHOOL DISTRICT

IMPORTANT EMPLOYEE NOTICE

**INTERIM BENEFITS TO COMPLY WITH THE FEDERAL PATIENT PROTECTION
AND AFFORDABLE CARE ACT**

Effective Date: September 1, 2013

Summary of the Federal Patient Protection and Affordable Care Act (PPACA):

The Federal Patient Protection and Affordable Care Act (PPACA) requires that insurance policies for all-sized employers provide certain benefits for the members and dependents as well as contain certain eligibility provisions. To comply with PPACA, we will provide the interim benefits outlined below.

Extension of Dependent Coverage to Age 26:

PACAA requires group medical policies to provide coverage to dependent children to age 26, regardless of marital status, student status, financial dependency or residency.

We have changed our definition of a Dependent Child to include your natural, stepchild or legally adopted child, if that child is less than 26 years of age. Your foster child may be eligible if the foster child is less than 26 years of age, that child has been placed with you or your spouse insured under this policy by an authorized state placement agency or by order of a court, the required documentation has been provided to Us and the child is approved in Writing by Us as a Dependent Child.

IMPORTANT NOTICE

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in this policy, if otherwise eligible. Individuals may request enrollment for such children for the 30 day period prior to the policy's renewal date. Enrollment will be effective the first day of the first plan year beginning on or after January 1, 2011.

Lifetime and Annual Limits:

PPACA prohibits policies from applying lifetime and annual limits on the dollar value of a benefit.

If your group medical expense policy contained a lifetime limit on the dollar value of any of the following benefits, the lifetime limit on the dollar value of such benefits under your policy no longer applies:

- Overall lifetime maximums;
- Prosthetics lifetime maximum;
- Hospice lifetime maximum; or
- Transplant lifetime maximum for out-of-transplant-network providers.

IMPORTANT NOTICE

Individuals whose coverage ended by reason of reaching an overall lifetime limit under the group medical expense policy are eligible to enroll in the policy. Individuals who are otherwise eligible may request enrollment for 30 days prior to the policy's renewal date. Enrollment will be effective the first day of the first plan year beginning on or after January 1, 2011.

If your policy contains an annual limit on the dollar value of any of the following benefits, the annual limits on the dollar value of such benefits included in your policy no longer applies:

- Back/Neck/Spine;
- Occupational/Physical/Speech Therapy; or
- Durable Medical Equipment.

Pre-Existing Conditions Limitations for Individuals under Age 19:

PPACA prohibits policies from imposing pre-existing condition limitations or exclusions on benefits for individuals under the age of 19. The Pre-Existing Condition limitations contained in your Medical Expense policy will not be applied to individuals under age 19. **With respect to a Member or Dependent who is under 19 years of age, this group policy will cover any condition that may have been previously excluded by name or specific description as a pre-existing condition. Coverage will be effective for that condition according to the policy coverage provisions for the first plan year beginning on or after January 1, 2011.**

Preventive Care Services:

PPACA requires policies provide coverage for certain preventive care services at 100% (or no member cost-sharing).

If you are insured under a Preferred Provider policy (including a High Deductible Health Plan) and the specific preventive services are provided by a Preferred Provider, the preventive services listed below will be paid at 100%.

If you are insured under a Comprehensive Medical policy, the specific preventive services listed below will be paid at 100%.

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (except the recommendations regarding breast cancer screening, mammography, and prevention issued on or around November 2009 will not be current for these purposes).
- Immunizations that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- Preventive care and screenings for infants, children, and adolescents according to the guidelines supported by the Health Resources and Services Administration.
- In addition to the benefits or services listed under the first item above, additional preventative care and screening for women according to the guidelines supported by the Health Resources and Services Administration (these guidelines are expected by August 2011).

A complete list of recommended preventive services can be found at the following URL and is expected to be updated annually by the federal government. Note: this web-site is maintained by the federal government.

www.HealthCare.gov/center/regulations/prevention.html.

External Review Process:

A policy must also develop an external review process.

If the state of jurisdiction for this policy does not already have an external review law, your policy will now include an external review process consistent with the National Association of Insurance Commissioner's Model External Review Act until this section of PPACA is further clarified by the federal government or state legislative action.

When BlueCross BlueShield / Iraan-Sheffield Independent School District has denied, reduced, or terminated payment for a requested service based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, the Member has the right to have that decision reviewed by an independent review organization not associated with BlueCross BlueShield / Iraan-Sheffield Independent School District.

Except where a covered person's life or health would be seriously jeopardized, a Member must first exhaust the internal review process set forth within the Group Policy before BlueCross BlueShield / Iraan-Sheffield Independent School District will grant an external independent review. A Member, or Dependent or a designated representative or provider acting on behalf of the Member or Dependent has the right to apply to the Insurance Commissioner for an external review of an adverse determination or final adverse determination which involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness.

NOTE: These benefits represent a good faith effort of Iraan-Sheffield Independent School District to comply with federal law. The implementation date of any revised benefits will be communicated in the future on a timely basis.