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Employee Benefits Guide

For Medical Doctors, Optometrists, and PAs

Contents

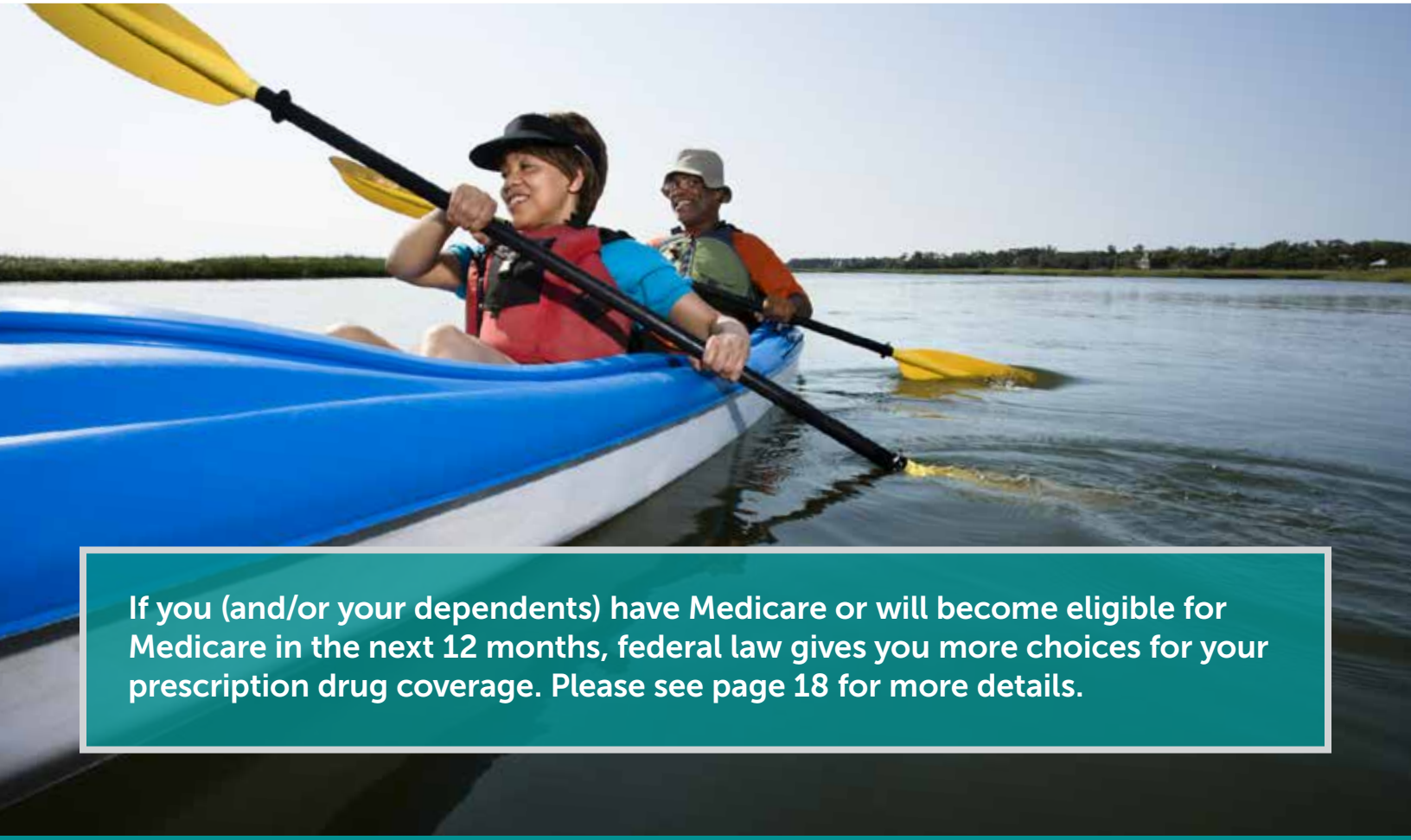
Welcome

We are pleased to offer a full benefits package to help protect your well-being and financial health. Read this guide to learn about the benefits available to you and your eligible dependents.

Each year during Open Enrollment, you may make changes to your benefit plans. The benefit choices you make this year will remain in effect from **July 1, 2024**, through **June 30, 2025.** Take time to review these benefit options and select the plans that best meet your needs. After Open Enrollment, you may only make changes to your benefit elections if you have a Qualifying Life Event.

Availability of Summary Health Information

Your plan offers **five** health coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available **on the web at www.bcbstx.com or by contacting Human Resources.**



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices for your prescription drug coverage. Please see page 18 for more details.

Eligibilty

You are eligible for benefits if you are an active, full-time employee working an average of **30 or more hours per week.** If you are a new hire, your coverage will be effective on the first day of the month after your date of hire.

You may also enroll eligible dependents for benefits coverage. The cost for coverage depends on the number of dependents you enroll and the benefits you choose. When covering dependents, you must select and be on the same plans.

Eligible Dependents

- Your legal spouse
- Children under the age of 26, regardless of student, dependency, or marital status
- Children over the age of 26 who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

Qualifying Life Events

Once you elect your benefit options, they remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event, some of which include:

- Marriage, divorce, legal separation, or annulment
- Birth, adoption, or placement for adoption of an eligible child
- Death of your spouse or child
- Change in your spouse's employment status that affects benefits eligibility
- Change in your child's eligibility for benefits
- Significant change in benefit plan coverage for you, your spouse, or child
- FMLA leave, COBRA event, court judgment, or decree
- Becoming eligible for Medicare, Medicaid, or Tricare
- Receiving a Qualified Medical Child Support Order (QMCSO)

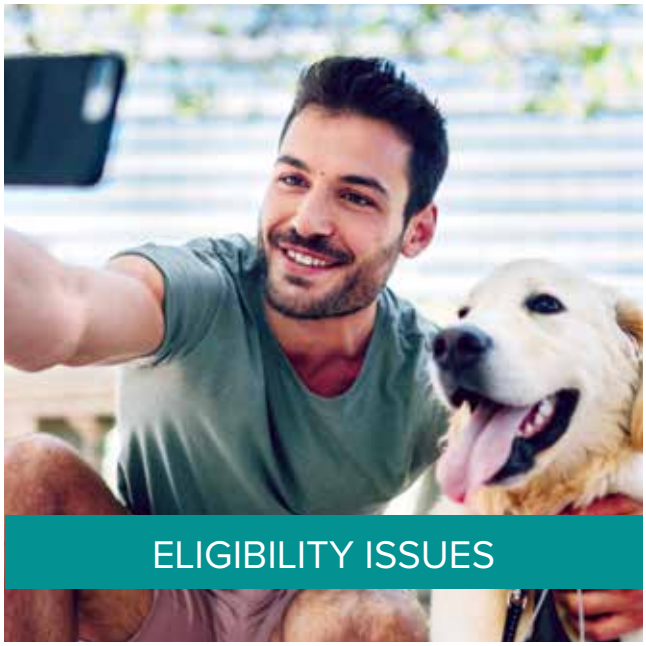
If you have a Qualifying Life Event and want to change your elections, you must notify Human Resources and complete your changes **within 30 days of the event**. You may be asked to provide documentation to support the change. Contact Human Resources for specific details.

Important Contacts

Program	Carrier Name	Policy Number	Phone Number	Website / Email
Medical	Blue Cross Blue Shield of Texas	278932	800-521-2227	**www.bcbstx.com**
Telemedicine	MDLIVE	278932	888-680-8646	**www.bcbstx.com**
Dental	Blue Cross Blue Shield of Texas	278932	877-442-4207	**www.bcbstx.com/ancillary**
Basic and Voluntary Life and AD&D	Dearborn National	VF027459	800-348-4512	**www.dearbornnational.com**
Short and Long Term Disability	Dearborn National	VF027459	800-348-4512	**www.dearbornnational.com**
Accident Hospital Indemnity Critical Illness	Dearborn National	VF027459	800-348-4512	**www.dearbornnational.com**
Benefits and Enrollment Assistance	Higginbotham Employee Response Center	N/A	866-419-3518	**helpline@higginbotham.net**

Employee Response Center

Employee benefits can be complicated. The **Higginbotham** Employee Response Center can assist you with the following:



Call **866-419-3518** to speak with a representative Monday through Friday from 7:00 a.m. to 6:00 p.m. CT. If you leave a voicemail message after 3:00 p.m. CT, your call will be returned the next business day. You can also email questions or requests to **helpline@higginbotham.net**. Bilingual representatives are available.

Online Enrollment Instructions

To begin the enrollment process, go to **www.benefitsinhand.com.** First-time users, follow steps 1-4. Returning users, log in and start at step 5.

1. If this is your first time to log in, click on the *New User Registration* link. Once you register, you will use your username and password to log in.
2. Enter your personal information and Company Identifier of **Valley Retina** and click *Next.*
3. Create a username (work email address recommended) and password, then check the *I agree to terms and conditions* box before you click *Finish*.
4. If you used an email address as your username, you will receive a validation email to that address. You may now log in to the system.
5. Click the *Start Enrollment* button to begin the enrollment process.
6. Confirm or update your personal information and click *Save & Continue.*
7. Edit or add dependents who need to be covered on your benefits. Once all dependents are listed, click *Save & Continue.*
8. Follow the steps on the screen for each benefit to make your selection. Please notice there is an option to Decline Coverage. If you wish to decline, click the *Don't want this benefit?* button and select the reason for declining.

Once you have elected or declined all benefits, you will see a summary of your selections. Click the *Click to Sign* button. Your enrollment will not be complete until you click the *Click to Sign* button.

Have questions about your benefits or need help enrolling? Call the Employee Response Center at **866-419-3518**. Benefits experts are available to take your call Monday through Friday, 7:00 a.m. – 6:00 p.m. CT.

Medical Coverage

The medical plan options through **Blue Cross Blue Shield of Texas (BCBSTX)** protect you and your family from major financial hardship in the event of illness or injury. You have a choice of one of five plans:

- Plan 1 – MTBCP013H – This plan is an **HDHP/HSA**.
- Plan 2 – MTBAB028 – This plan is an **HMO**.
- Plan 3 – MTBCP006H – This plan is an **HDHP/HSA**.
- Plan 4 – MTBCB028 – This plan is a **PPO**.
- Plan 5 – MTBCP014 – This plan is a **PPO**.

High Deductible Health Plan (HDHP)

An HDHP allows you to see any provider when you need care, but you will pay less for care when you go to in-network providers. In exchange for a lower per-paycheck cost for medical benefits, you must satisfy a higher plan deductible that applies to almost all health care expenses, including prescription drugs. If you enroll in the HDHP, you may be eligible to open a Health Savings Account.

Find a Network Provider

www.bcbstx.com 800-521-2227

Health Maintenance Organization (HMO)

With an HMO, you must seek care from in-network providers in the **BCBSTX** HMO network. The selection of a primary care physician is required, and you need a referral to see a specialist. Always confirm that your doctors and specialists are in-network before seeking care.

Preferred Provider Organization (PPO)

A PPO allows you to see any provider when you need care. When you see network providers for care, you will pay less and get the highest level of benefits. You will pay more for care if you use non-network providers. When you see network providers, your office visits, urgent care, and prescription drugs are covered with a copay and most other network services are covered at the deductible and coinsurance level.

Medical Plans

	PLAN 1 MTBCP013H HDHP/HSA		PLAN 2 MTBAB028 HMO	
Network Name	**Blue Choice**		**Blue Choice**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible • Individual • Family	 $6,900 $13,800	 $13,800 $27,600	 $3,000 $9,000	Not covered
Calendar Year Out-of-Pocket Maximum (includes deductible) • Individual • Family	 $6,900 $13,800	 Unlimited Unlimited	 $8,150 $16,300	Not covered
	You Pay		**You Pay**	
Preventive Care	$0	30% after deductible	$0	Not covered
Primary Care Physician	$0 after deductible	30% after deductible	$35 copay	Not covered
Specialist	$0 after deductible	30% after deductible	$70 copay	Not covered
Urgent Care	$0 after deductible	30% after deductible	$75 copay	Not covered
Diagnostic X-ray and Lab	$0 after deductible	30% after deductible	20% after deductible	Not covered
Complex Imaging (CT/PET scan, MRI)	$0 after deductible	30% after deductible	20% after deductible	Not covered
Emergency Room	$0 after deductible	$0 after deductible	$500 copay plus 20% deductible	$500 copay plus 20% deductible
Inpatient Hospital Services	$0 after deductible	$0 after deductible	20% after deductible	Not covered
Outpatient Services	$0 after deductible	$0 after deductible	$35 copay office visit; 20% after deductible	Not covered
Retail Pharmacy (up to a 30-day supply) • Preferred Generic • Non-Preferred Generic • Preferred Brand Name • Non-Preferred Brand Name • Preferred Specialty • Non-Preferred Specialty	 $0 after deductible $0 after deductible $0 after deductible $0 after deductible $0 after deductible $0 after deductible	 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible	 $0 $10 copay $50 copay $70 copay $150 copay $250 copay	Not covered
Mail Order Pharmacy (up to a 90-day supply) • Preferred Generic • Non-Preferred Generic • Preferred Brand Name • Non-Preferred Brand Name	 $0 after deductible $0 after deductible $0 after deductible $0 after deductible	 50% after deductible 50% after deductible 50% after deductible 50% after deductible	 $0 $30 copay $150 copay $300 copay	Not covered

Medical Plans

	PLAN 3 MTBCP006H HDHP/HSA		PLAN 4 MTBCB028 PPO	
Network Name	**Blue Choice**		**Blue Choice**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible • Individual • Family	 $4,000 $8,000	 $8,000 $16,000	 $3,000 $9,000	 $10,000 $20,000
Calendar Year Out-of-Pocket Maximum (includes deductible) • Individual • Family	 $4,000 $8,000	 Unlimited Unlimited	 $8,150 $16,300	 Unlimited Unlimited
	You Pay		**You Pay**	
Preventive Care	$0	30% after deductible	$0	40% after deductible
Primary Care Physician	$0 after deductible	30% after deductible	$35 copay	40% after deductible
Specialist	$0 after deductible	30% after deductible	$70 copay	40% after deductible
Urgent Care	$0 after deductible	30% after deductible	$75 copay	40% after deductible
Diagnostic X-ray and Lab	$0 after deductible	30% after deductible	20% after deductible	40% after deductible
Complex Imaging (CT/PET scan, MRI)	$0 after deductible	30% after deductible	20% after deductible	40% after deductible
Emergency Room	$0 after deductible	$0 after deductible	$500 copay plus 20% after deductible	$500 copay plus 20% after deductible
Inpatient Hospital Services	$0 after deductible	30% after deductible	20% after deductible	40% after deductible
Outpatient Services	$0 after deductible	30% after deductible	$35 copay office visit; 20% after deductible	40% after deductible
Retail Pharmacy (up to a 30-day supply) • Preferred Generic • Non-Preferred Generic • Preferred Brand Name • Non-Preferred Brand Name • Preferred Specialty • Non-Preferred Specialty	 $0 after deductible $0 after deductible $0 after deductible $0 after deductible $0 after deductible $0 after deductible	 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible	**Preferred Pharmacy/ Non-Preferred Pharmacy** $0 / $10 copay $10 / $20 copay $50 / $70 copay $100 / $120 copay $150 copay $250 copay	 $10 copay + 50% $20 copay + 50% $70 copay + 50% $120 copay + 50% $150 copay + 50% $250 copay + 50%
Mail Order Pharmacy (up to a 90-day supply) • Preferred Generic • Non-Preferred Generic • Preferred Brand Name • Non-Preferred Brand Name	 $0 after deductible $0 after deductible $0 after deductible $0 after deductible	 50% after deductible 50% after deductible 50% after deductible 50% after deductible	 $0 $30 copay $150 copay $300 copay	 Not covered Not covered Not covered Not covered

Medical Plans

	PLAN 5 MTBCP014 PPO	
Network Name	**Blue Choice**	
	In-Network	**Out-of-Network**
Calendar Year Deductible • Individual • Family	 $1,500 $4,500	 $3,000 $9,000
Calendar Year Out-of-Pocket Maximum (includes deductible) • Individual • Family	 $4,500 $13,500	 Unlimited Unlimited
	You Pay	
Preventive Care	$0	40% after deductible
Primary Care Physician	$35 copay	40% after deductible
Specialist	$70 copay	40% after deductible
Urgent Care	$75 copay	40% after deductible
Diagnostic X-ray and Lab	$0	40% after deductible
Complex Imaging (CT/PET scan, MRI)	20% after deductible	40% after deductible
Emergency Room	$500 copay plus 20% after deductible	$500 copay plus 20% after deductible
Inpatient Hospital Services	20% after deductible	40% after deductible
Outpatient Services	$35 copay office visit; 20% after deductible	40% after deductible
Retail Pharmacy (up to a 30-day supply) • Preferred Generic • Non-Preferred Generic • Preferred Brand Name • Non-Preferred Brand Name • Preferred Specialty • Non-Preferred Specialty	**Preferred Pharmacy/ Non-Preferred Pharmacy** $0 / $10 copay $10 / $20 copay $50 / $70 copay $100 / $120 copay $150 copay $250 copay	 $10 copay + 50% $20 copay + 50% $70 copay + 50% $120 copay + 50% $150 copay + 50% $250 copay + 50%
Mail Order Pharmacy (up to a 90-day supply) • Preferred Generic • Non-Preferred Generic • Preferred Brand Name • Non-Preferred Brand Name	 $0 $30 copay $150 copay $300 copay	 Not covered Not covered Not covered Not covered

Telemedicine

Your medical coverage offers telemedicine services through **MDLIVE**. Connect anytime day or night with a board-certified doctor via your mobile device or computer at little or no cost to you.

While telemedicine does not replace your primary care physician, it is a convenient and cost-effective option when you need care and:

- Have a non-emergency issue and are considering an after hours health care clinic, urgent care clinic, or emergency room for treatment
- Are on a business trip, vacation, or away from home
- Are unable to see your primary care physician

Registration is Easy

Register with MDLIVE so you are ready to use this valuable service when and where you need it.

- **Online** – www.MDLIVE.com/bcbstx
- **Phone** – 888-680-8646
- **Text** – **BCBSTX** to 635-483
- **Mobile** – download the mobile app to your smartphone or mobile device

When to Use Teladoc

Use telemedicine for minor conditions such as:

- Sore throat
- Cold
- Allergies
- Headache
- Flu
- Fever
- Stomachache
- Mental health issues
- Urinary tract infections

Do not use telemedicine for serious or life-threatening emergencies.

Dental Coverage

Our dental plans help you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work. Coverage is provided through **Blue Cross Blue Shield of Texas**.

DPPO Plan

Two levels of benefits are available with the DPPO plan: in-network and out-of-network. You may see any dental provider for care, but you will pay less and get the highest level of benefits with network providers. You could pay more if you use an out-of-network provider.

Dental Plans

	PLAN 1 DTNLM38 DPPO		PLAN 2 DTNLM57 DPPO	
Network	**Blue Care**		**Blue Care**	
	In-Network	**Out-of-Network[1]**	**In-Network**	**Out-of-Network[1]**
Calendar Year Maximum Benefit	$1,500	$1,500	$1,500	$1,500
Orthodontia Lifetime Maximum Benefit	$1,000	$1,000	$1,500	$1,500
	You Pay		**You Pay**	
Calendar Year Deductible • Individual • Family	$50 $150	$50 $150	$50 $150	$50 $150
Type A - Preventive Care	0%	0%	0%	0%
Type B - Basic Restorative	20%	20%	0%	0%
Type C - Major Restorative	50%	50%	40%	40%
Type D - Orthodontia • Covered Individuals • Benefit	Adults & Child(ren) 50%		Adults & Child(ren) 50%	

[1]All benefits are based upon the Allowable Amount, which is the amount determined by BCBSTX as the maximum amount eligible for payment of benefits. A Contracting Dentist cannot balance bill for charges in excess of the Allowable Amount. Benefits for covered services provided by a Non-Contracting Dentist will be based upon the same Allowable Amount, and it is likely that the Non-Contracting Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses.

Find a Network Dentist

www.bcbstx.com/ancillary 877-442-4207

Life and AD&D Insurance

Life and Accidental Death and Dismemberment (AD&D) insurance through **Dearborn National** are important to your financial security, especially if others depend on you for support or vice versa. With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D benefit would be paid to you or your beneficiary(ies). Life and AD&D coverage amounts reduce by 35% at age 65, by 60% of the original amount at age 70, by 75% of the original amount at age 75, and 85% of the original amount at age 80.

Basic Life and AD&D

Basic Life and AD&D insurance are provided at no cost to you. You are automatically covered at $25,000 for each benefit.

Voluntary Life and AD&D

You may buy more Life and AD&D insurance for you and your eligible dependents. If you do not elect Voluntary Life and AD&D insurance when first eligible or if you want to increase your benefit amount at a later date, you may need to show proof of good health. You must elect Voluntary Life and AD&D coverage for yourself before you may elect coverage for your spouse or children. If you leave the company, you may be able to take the insurance with you.

Life and AD&D Available Coverage

Employee	• Increments of $10,000 up to $500,000 • New Hire Guaranteed Issue $100,000
Spouse	• Increments of $5,000 up to $250,000 not to exceed 50% of employee amount • New Hire Guaranteed Issue $25,000
Child(ren)	• Birth to six months – $1,000 • Six months to age 26 – Increments of $1,000 up to $10,000

Designating a Beneficiary

A beneficiary is the person or entity you elect to receive the death benefits from your Life and AD&D insurance policies. You can name more than one beneficiary, and you can change beneficiaries at anytime. If you name more than one beneficiary, you must identify how much each beneficiary will receive (e.g., 50% or 25%).

MONTHLY VOLUNTARY LIFE AND AD&D RATES PER $1,000	
Age Band	**Rates**
<30	$0.044
30-34	$0.052
35-39	$0.095
40-44	$0.116
45-49	$0.175
50-54	$0.313
55-59	$0.506
60-64	$0.794
65-69	$2.296
70+	$3.724
Child(ren)	$0.170
Employee AD&D	$0.024
Spouse AD&D	$0.024
Child(ren) AD&D	$0.030

Disability Insurance

Disability insurance provides partial income protection if you are unable to work due to a covered accident or illness. We offer Short Term Disability (STD) and Long Term Disability (LTD) insurance for you to purchase through **Dearborn National**.

Voluntary Short Term Disability

STD coverage pays a percentage of your weekly salary if you are temporarily disabled and unable to work due to an illness, nonwork-related injury, or pregnancy. STD benefits are not payable if the disability is due to a job-related injury or illness. If a medical condition is job-related, it is considered Workers' Compensation, not STD.

Short Term Disability

Benefits Begin	8th day
Percentage of Earnings You Receive	60%
Maximum Weekly Benefit	$1,000
Maximum Benefit Period	13 weeks
Preexisting Condition Exclusion	3/12*

*Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.

MONTHLY RATE PER $10 OF WEEKLY BENEFIT	
Age	**Rate**
Under 20	$0.758
20-24	$0.760
25-29	$0.806
30-34	$0.705
35-39	$0.632
40-44	$0.557
45-49	$0.563
50-54	$0.661
55-59	$0.837
60-64	$1.017
65-69	$1.040
70+	$1.175

Sample STD Premium Calculation

(Sample assumes a 30-year-old employee with $45,000 in annual earnings.)

Annual Salary ÷ 52	=	Weekly Earnings	x	STD Benefit %	=	÷ 10 (max. $100)	x	STD Rate (from table above)	=	Monthly Premium	x 12 ÷ 26 =	Biweekly Premium
$45,000 ÷ 52	=	$865	x	0.60	=	$51.90	x	$0.705	=	$36.59	x 12 ÷ 26 =	$16.89

Your STD Premium Calculation

(Enter your salary and the rate for your current age from the table above.)

Annual Salary ÷ 52	=	Weekly Earnings	x	STD Benefit %	=	÷ 10 (max. $100)	x	STD Rate (from table above)	=	Monthly Premium	x 12 ÷ 26 =	Biweekly Premium
$ ÷ 52	=	$	x	0.60	=	$	x	$	=	$	x 12 ÷ 26 =	$

To determine Biweekly Premium, multiply Monthly Premium by 12, and then divide by 26. To determine Semimonthly Premium, multiply Monthly Premium by 12, and then divide by 24. To determine Weekly Premium, multiply Monthly Premium by 12, and then divide by 52.

Voluntary Long Term Disability

LTD insurance pays a percentage of your monthly salary for a covered disability or injury that prevents you from working for more than 90 days. Benefits begin at the end of an elimination period and continue while you are disabled up to Social Security Normal Retirement Age (SSNRA).

Long Term Disability

Benefits Begin	91st day
Percentage of Earnings You Receive	60%
Maximum Monthly Benefit	$6,000
Maximum Benefit Period	SSNRA
Pre-existing Condition Exclusion	3/12*

*Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.

MONTHLY RATE PER $100 OF COVERED PAYROLL	
Age	**Rate**
Under 20	$0.210
20-24	$0.275
25-29	$0.455
30-34	$0.766
35-39	$0.982
40-44	$1.390
45-49	$2.062
50-54	$2.448
55-59	$2.779
60-64	$1.941
65-69	$2.243
70-74	$1.647
75+	$1.813

Sample LTD Premium Calculation

(Sample assumes a 30-year-old employee with $2,500 in monthly earnings.)

Monthly Earnings (maximum $10,000)	x	Rate (from table above)	=	Amount ÷ 100	=	Monthly Premium	x 12 ÷ 26 =	Biweekly Premium
$2,500	x	$0.766	=	$1,915.00 ÷ 100	=	$19.15	x 12 ÷ 26 =	$8.84

Your Premium Calculation

(Enter your salary and the rate for your current age from the table above.)

Monthly Earnings (maximum $10,000)	x	Rate (from table above)	=	Amount ÷ 100	=	Monthly Premium	x 12 ÷ 26 =	Biweekly Premium
$	x	$	=	$ ÷ 100	=	$	x 12 ÷ 26 =	$

To determine Biweekly Premium, multiply Monthly Premium by 12, and then divide by 26. To determine Semimonthly Premium, multiply Monthly Premium by 12, and then divide by 24. To determine Weekly Premium, multiply Monthly Premium by 12, and then divide by 52.

Supplemental Benefits

You may enroll in additional coverage that complements our traditional health care programs. Health insurance covers medical bills, but if you have an emergency, you may face unexpected out-of-pocket costs such as deductibles, coinsurance, travel expenses, and non-medical related expenses. Coverage is offered through **Dearborn National**.

Accident Insurance

Accident insurance provides affordable protection against a sudden, unforeseen accident. The Accident plan helps offset the direct and indirect expenses resulting from an accident such as copayments, deductible, ambulance, physical therapy, and other costs not covered by traditional health plans.

Accident	Dearborn Plan
Service	**Benefit**
Emergency Room	$150
Urgent Care Center	$150
Ambulance – Ground/Air	$200/$1,500
Initial Hospitalization	$1,200
Hospital Confinement	$250 per day – up 365 days
Intensive Care Unit	$500 per day – up to 15 days
Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, etc.	$35 - $5,000
Accidental Death & Dismemberment* • Employee • Spouse • Child	 $150,000 $150,000 $25,000
Monthly Rates	**Dearborn Plan**
Employee **Employee + Spouse** **Employee + Child(ren)** **Employee + Family**	$12.95 $21.44 $25.01 $39.21

*Percentage of benefit paid for dismemberment is dependent on type of loss.

Hospital Indemnity Insurance

The Hospital Indemnity plan helps you with the high cost of medical care by paying you a set amount when you have an inpatient hospital stay. Unlike traditional insurance which pays a benefit to the hospital or doctor, this plan pays you directly based on the care or treatment that you receive. These costs may include meals and transportation, childcare, or time away from work due to a medical issue that requires hospitalization.

Hospital Indemnity	Dearborn Plan
Service	**Benefit**
Hospital Admission	$1,000 per admission (one per calendar year)
Hospital Confinement	$100 per day, when confined at least 20 hours; limited to 30 days per insured per year
ICU Admission	$1,000 per admission (one per calendar year)
ICU Confinement	$100 per day, payable up to 10 days per year
Newborn Confinement	$50 per day, payable up to 3 days
Wellness Benefit	$50 per year per covered spouse, child, and employee
Monthly Rates	**Dearborn Plan**
Employee **Employee + Spouse** **Employee + Child(ren)** **Employee + Family**	$21.69 $43.26 $39.82 $65.70

Critical Illness Insurance

Critical Illness insurance helps pay the cost of non-medical expenses related to a covered critical illness or cancer. The plan provides a lump sum benefit payment to you upon first and second diagnosis of any covered critical illness or cancer. The benefit can help cover expenses such as lost income, out-of-town treatments, special diets, daily living, and household upkeep costs.

Critical Illness	Dearborn Plan
Coverage Level	**Benefit Amounts Available**
Employee	Up to $20,000 in $5,000 increments
Spouse	Up to $10,000 in $2,500 increments, not to exceed employee benefit amount
Child	Up to $10,000 in $2,500 increments, not to exceed employee benefit amount
Condition	**First Occurrence Benefit**
Full Coverage Invasive Cancer, Heart Attack, Stroke, Major Organ Transplant, Major Burns, Coma-Brain Injury	100% of benefit amount
Partial Coverage Major Heart Surgery, Carcinoma In Situ	25% of benefit amount
Wellness Benefit One per covered person per calendar year	$50
Pre-existing Condition Limitation	None

Employee Monthly Premium				
Attained Age	$5,000	$10,000	$15,000	$20,000
<30	$2.74	$5.47	$8.21	$10.94
30–39	$3.95	$7.90	$11.85	$15.80
40–49	$7.99	$15.97	$23.96	$31.94
50–59	$15.51	$31.02	$46.53	$62.04
60–64	$26.21	$52.41	$78.62	$104.82
65+	$32.28	$64.56	$96.84	$129.12
Spouse Monthly Premium				
Attained Age	$2,500	$5,000	$7,500	$10,000
<30	$2.12	$4.23	$6.35	$8.46
30–39	$2.77	$5.54	$8.31	$11.08
40–49	$4.83	$9.67	$14.50	$19.33
50–59	$8.64	$17.28	$25.91	$34.55
60–64	$14.00	$28.00	$42.00	$56.00
65+	$17.71	$35.42	$53.12	$70.83
Child Monthly Premium				
	$2,500	$5,000	$7,500	$10,000
Child(ren)	$1.92	$3.84	$5.75	$7.67

Contribution Worksheet

Your 2024-2025 Monthly Cost

MEDICAL COVERAGE					
MEDICAL	**Plan 1 MTBCP013H HDHP/HSA**	**Plan 2 MTBAB028 HMO**	**Plan 3 MTBCP006H HDHP/HSA**	**Plan 4 MTBCB028 PPO**	**Plan 5 MTBCP014 PPO**
Employee Only	$55.00	$120.09	$133.61	$194.52	$302.16
Employee + Spouse	$446.86	$594.73	$622.81	$749.93	$973.18
Employee + Child(ren)	$415.98	$557.34	$584.25	$705.69	$920.29
Employee + Family	$807.87	$1,032.02	$1,073.51	$1,260.67	$1,591.36

DENTAL COVERAGE			
	Plan 1 DTNLM38 DPPO	**Plan 2 DTNLM57 DPPO**	
Employee Only	$4.87	$15.99	**$**
Employee + Spouse	$25.68	$48.97	
Employee + Child(ren)	$37.76	$63.75	
Employee + Family	$66.14	$107.70	
Basic Life and AD&D	**Paid by Valley Retina Institute**		**$** **0**
Voluntary Life and AD&D	See Page 12 for rates		**$**
Short Term Disability	See Page 13 for rates		**$**
Long Term Disability	See Page 14 for rates		**$**
SUPPLEMENTAL BENEFITS			
Accident Insurance	See Page 15 for rates		
Hospital Indemnity Insurance	See Page 15 for rates		
Critical Illness Insurance	See Page 16 for rates		
Your Total 2024-2025 Monthly Benefit Cost			**$**

Important Notices

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

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

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

Marriage, Birth or Adoption

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

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Valley Retina Institute
Human Resources
PO Box 4830
Edinburg, TX 78540
956-631-8875

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 Valley Retina Institute and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription 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. Valley Retina Institute has determined that the prescription drug coverage offered by the Valley Retina Institute medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

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

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Valley Retina Institute at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current Valley Retina Institute prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater

Important Notices

for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at **956-631-8875**.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription 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 **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

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

July 1, 2024
Valley Retina Institute
Human Resources
PO Box 4830
Edinburg, TX 78540
956-631-8875

Notice of HIPAA 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.

Effective Date of Notice: September 23, 2013

Valley Retina Institute's Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1 – Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

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

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

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

Important Notices

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In which case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2 – Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

Important Notices

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

Protected Health Information (PHI)

Includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set

Includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3 – The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised

Important Notices

version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4 – Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5 – Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

Valley Retina Institute
Human Resources
PO Box 4830
Edinburg, TX 78540
956-631-8875

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your 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 allow you to enroll in your employer plan if you aren't 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 questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **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, 2024. Contact your State for more information on eligibility.

Important Notices

Texas – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493

To see if any other States have added a premium assistance program since **January 31, 2024**, or for more information on special enrollment rights, you can contact either:

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

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under the Valley Retina Institute group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the Valley Retina Institute plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

Valley Retina Institute
Human Resources
PO Box 4830
Edinburg, TX 78540
956-631-8875

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency services – If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

Higginbotham™

This guide highlights the main features of the Valley Retina Institute employee benefits program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Valley Retina Institute reserves the right to change or discontinue its employee benefits plans at anytime.