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Benefits Enrollment Guide

April 1, 2017—March 31, 2018

BancorpSouth Insurance Services, Inc.

Carrier Contact Information

We created this simple directory for you. It provides you with important information on your employee benefits and contact information for human resources. Contact Jenny Flores for more information.

Medical / Dental	
Provider Name:	Blue Cross Blue Shield of Texas
Phone Number:	1-800-521-2227
Website:	www.bcbstx.com
Pharmacy	
Provider Name:	Blue Cross Blue Shield of Texas
Phone Number:	1-800-521-2227
Website:	www.myprime.com
Voluntary Life & AD&D / Voluntary Accidental Death & Dismemberment / Voluntary Short Term Disability / Voluntary Accident / Voluntary Vision	
Provider Name:	Lincoln Financial Group
Phone Number:	1-800-423-2765
Website:	www.lfg.com

Your Enrollment Overview

WinCo Development, LLC knows how important it is to provide quality employee benefits to our employees and their dependents. We always strive to provide a total benefits package that meets your needs as well as the needs of the company.

The following plans are offered to our full time employees:

- Medical
- Dental
- Voluntary Life & AD&D
- Voluntary Accidental Death & Dismemberment
- Voluntary Short Term Disability
- Voluntary Accident
- Voluntary Vision

⇒ *New hires are eligible for coverage the 1st of the month following 60 days of employment.*

⇒ *Annually, March 1-31 during our Open Enrollment Period, you may request changes to the above plans subject to completion of the proper forms and approval by the insurance carriers. These changes will become effective 4/1/2017 subject to carrier approval.*

Please take the time to read the following benefit summaries carefully. This information along with your 2017 election documentation will help you in deciding the best benefit selections for you and your family.

At other times during the year, you may request changes ONLY when there is a Family Status Change, and the proposed change is consistent with the Family Status Change event. Family Status Changes include:

Change in legal marital status (e.g., marriage or divorce);

Change in the number of dependents (e.g., birth, adoption or placement for adoption, death);

Change in employment status or residency of the employee, spouse or dependent that affects eligibility;

Change in coverage under another employer's plan.

Changes, additions or voluntary cancellations generally cannot be made during the plan year unless the employee experiences a Family Status Change. Otherwise, the employee must wait until the annual enrollment period to change or cancel an election.

ALL EMPLOYEES MUST GO ONLINE THROUGH MYPAY
TO COMPLETE ENROLLMENT

Medical Insurance

PPO Plan

Benefits	In-Network Benefit	Out-Network Benefit
Deductible Individual Family	 $3,000 $6,000	 $6,000 $18,000
Coinsurance	70 / 30 %	50 / 50 %
Out-of-Pocket Maximum Individual Family	 $5,650 $11,300	 $15,000 $45,000
Deductibles & Copay amounts apply to Out of Pocket Maximum.		
Lifetime Maximum	Unlimited	
Office Visit (Primary / Specialist)	100% of allowable amount after $40 copay	70% of allowable amount after calendar year deductible
Preventive Care	100% of allowable amount	70% of allowable amount after calendar year deductible
Emergency Room	70% of allowable amount after $250 copay, waived if admitted Physician charge subject to deductible and coinsurance	
Inpatient Services	70% of allowable amount after calendar year deductible	50% of allowable amount after calendar year deductible, $250 penalty for failure to preauthorize
Lab & X-Ray	100% of allowable amount	70% of allowable amount after calendar year deductible
Urgent Care (visit including lab & x-ray services) For Certain Diagnostic Procedures performed, see below benefit	100% of allowable amount after $75 copay	70% of allowable amount after calendar year deductible
Certain Diagnostic Procedures Such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan	70% of allowable amount after calendar year deductible	50% of allowable amount after calendar year deductible
Prescription Drug Coverage Generic Preferred Brand Name Non Preferred Brand Name All Specialty Drugs Rx Out of Pocket Maximum	 $20 copay $50 copay $75 copay $125 copay Specialty drugs must be filled through Prime Specialty Pharmacy Program $1,500 Individual / $3,000 Family Copay amounts apply to Rx Out of Pocket	80% of allowable amount minus copay
ELECTION	**Monthly Employee Cost**	**Employee Payroll Deduction Per Paycheck**
Employee Only	$125.00	$57.69
Employee & Spouse	$603.75	$278.65
Employee & Child(ren)	$534.75	$247.81
Employee & Family	$1,092.50	$504.23

Medical Insurance

HSA Premium

Benefits	In-Network Benefit	Out-Network Benefit
Deductible Individual Family	 $3,000 $6,000	 $6,000 $12,000
Coinsurance	90 / 10%	70 / 30 %
Out-of-Pocket Maximum Individual Family	 $5,000 $10,000	 $12,000 $24,000
Family coverage: When one family member meets the individual deductible, benefits become available under the plan for that individual. Out of Pocket Maximum includes Deductible. $750 per year will be contributed into the employee's HSA account ($375 in April & $375 in October)		
Lifetime Maximum	Unlimited	
Office Visit (Primary / Specialist)	90% of allowable amount after calendar year deductible	70% of allowable amount after calendar year deductible
Preventive Care	100% of allowable amount	70% of allowable amount
Emergency Room	90% of allowable amount after calendar year deductible Physician charge subject to deductible and coinsurance	
Inpatient Services	90% of allowable amount after calendar year deductible	70% of allowable amount after calendar year deductible, $250 penalty for failure to preauthorize
Lab & X-Ray	90% of allowable amount after calendar year deductible	70% of allowable amount after calendar year deductible
Urgent Care (visit including lab & x-ray services) For Certain Diagnostic Procedures performed, see below benefit	90% of allowable amount after calendar year deductible	70% of allowable amount after calendar year deductible
Certain Diagnostic Procedures Such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan	90% of allowable amount after calendar year deductible	70% of allowable amount after calendar year deductible
Prescription Drug Coverage Generic Preferred Brand Name Non Preferred Brand Name	90% of allowable amount after calendar year deductible	90% of allowable amount after calendar year deductible
ELECTION	**Monthly Employee Cost**	**Employee Payroll Deduction Per Paycheck**
Employee Only	$75.00	$34.62
Employee & Spouse	$460.00	$212.31
Employee & Child(ren)	$402.50	$185.77
Employee & Family	$891.25	$411.35

For an individual, once the $3,000 deductible has been satisfied, the member will owe 10% of any future claims until the $5,000 Out of Pocket has been satisfied, assuming an In-Network provider was used. The total Out of Pocket, assuming In-Network benefits is $5,000. For a family, once the $6,000 deductible has been met, the member would owe 10% of any future claims until the $10,000 Out of Pocket has been satisfied, assuming an In-Network provider was used. The total Out of Pocket for a family is $10,000 assuming In-Network.

Medical Insurance

HSA Standard

Benefits	In-Network Benefit	Out-Network Benefit
Deductible Individual Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance	90 / 10%	70 / 30 %
Out-of-Pocket Maximum Individual Family	 $6,000 $12,000	 $20,000 $40,000
Family coverage: When one family member meets the individual deductible, benefits become available under the plan for that individual. Out of Pocket Maximum includes Deductible. $1,000 per year will be contributed into the employee's HSA account ($500 in April & $500 in October)		
Lifetime Maximum	Unlimited	
Office Visit (Primary / Specialist)	90% of allowable amount after calendar year deductible	70% of allowable amount after calendar year deductible
Preventive Care	100% of allowable amount	70% of allowable amount
Emergency Room	90% of allowable amount after calendar year deductible Physician charge subject to deductible and coinsurance	
Inpatient Services	90% of allowable amount after calendar year deductible	70% of allowable amount after calendar year deductible, $250 penalty for failure to preauthorize
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Prescription Drug Coverage Generic Preferred Brand Name Non Preferred Brand Name	90% of allowable amount after calendar year deductible	90% of allowable amount after calendar year deductible
ELECTION	**Monthly Employee Cost**	**Employee Payroll Deduction Per Paycheck**
Employee Only	$30.00	$13.85
Employee & Spouse	$264.50	$122.08
Employee & Child(ren)	$218.50	$100.85
Employee & Family	$592.25	$273.35

For an individual, once the $5,000 deductible has been satisfied, the member will owe 10% of any future claims until the $6,000 Out of Pocket has been satisfied, assuming an In-Network provider was used. The total Out of Pocket, assuming In-Network benefits is $6,000. For a family, once the $10,000 deductible has been met, the member would owe 10% of any future claims until the $12,000 Out of Pocket has been satisfied, assuming an In-Network provider was used. The total Out of Pocket for a family is $12,000 assuming In-Network.

Dental Insurance

Benefits	Standard	Premium
Deductible	$50 Indiv / $150 Family	$50 Indiv / $150 Family
Benefit Year Maximum	$1,000	$2,000
Diagnostic & Preventive Services	100%	100%
Endodontic Services	50%	80%
Periodontal Services	50%	80%
Oral Surgery Services	50%	80%
Crowns, Inlays/Onlays	50%	50%
Prosthodontic Services	50%	50%
Orthodontic Benefits	N/A	50%
Orthodontic Lifetime Maximum	N/A	$1,500

Dental Insurance Cost

Employee pays the entire Dental Insurance premium.

ELECTION	Employee Payroll Deduction Per Paycheck	Employee Payroll Deduction Per Paycheck
Employee Only	$14.31	$18.46
Employee / Spouse	$30.00	$39.23
Employee / Child(ren)	$29.08	$42.00
Family	$46.15	$64.62

Voluntary Life & AD&D

Life Benefit	Employee	Spouse	Dependent
	Employee must elect coverage for Spouse or dependents to be eligible.		
Amount	Choice of $10,000 increments	Choice of $5,000 increments	Age 14 Days to 6 months: $250 6 months to age 25: $10,000 Newborn children to age 14 days are not eligible for a benefit
Minimum Amount	$10,000	$5,000	$10,000
Maximum Amount	$500,000, limited to 5 times your annual salary Employees age 70 and older, maximum benefit is $50,000	$500,000, limited to 100% of employee amount	$10,000
Guarantee Issue for Newly Eligible Employee	$150,000	$30,000	
Current Eligible Employees	You or your Spouse may elect or increase insurance coverage equal to 2 benefit levels on a guaranteed acceptance basis during your company's defined annual open enrollment period, provided that you or your Spouse have not been previously declined, withdrawn, or pending for coverage.		

AD&D Benefit	Employee	Spouse
Amount	Benefit amount equal to the life amount elected by you. Cost included in the schedule.	Same as employee

Benefit Reduction	Employee	Spouse
Benefits will reduce:	35% at age 65; Additional 25% of original amount at age 70; Additional 15% of original amount at age 75; Additional 15% of original amount at age 80; Benefits terminate at retirement	35% at Employee Age 65 Benefits terminate at Employee Age 70 or Retirement, whichever occurs first

Eligibility	Employee	Spouse and Dependents
	All employees in an eligible class.	Cannot be in a period of limited activity on the day coverage takes effect.

Additional Benefits	
See Definition:	Accelerated Death Benefit
See Definition:	Portability
See Definition:	Conversion
See Definition:	Seat Belt, Airbag, and Common Carrier

Only new hires are eligible for guarantee issue amounts.
All other employees wanting to increase their benefit more than 2 benefit levels or elect for the first time must complete an Evidence of Insurability form and return to Human Resources.

Voluntary Life & AD&D

Bi-Weekly Employee Premium
Life and Accidental Death and Dismemberment Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

Bi-Weekly RATE Per $1000	AGE	$ 10,000	$20,000	$ 30,000	$ 40,000	$ 50,000	$ 60,000	$ 70,000	$ 80,000	$ 90,000	$100,000
0.0655	<25	$0.66	$1.31	$1.97	$2.62	$3.28	$3.93	$4.59	$5.24	$5.90	$6.55
0.0655	25-29	$0.66	$1.31	$1.97	$2.62	$3.28	$3.93	$4.59	$5.24	$5.90	$6.55
0.0725	30-34	$0.73	$1.45	$2.18	$2.90	$3.63	$4.35	$5.08	$5.80	$6.53	$7.25
0.0863	35-39	$0.86	$1.73	$2.59	$3.45	$4.32	$5.18	$6.04	$6.90	$7.77	$8.63
0.1218	40-44	$1.22	$2.44	$3.65	$4.87	$6.09	$7.31	$8.53	$9.74	$10.96	$12.18
0.1777	45-49	$1.78	$3.55	$5.33	$7.11	$8.89	$10.66	$12.44	$14.22	$15.99	$17.77
0.3254	50-54	$3.25	$6.51	$9.76	$13.02	$16.27	$19.52	$22.78	$26.03	$29.29	$32.54
0.5082	55-59	$5.08	$10.16	$15.25	$20.33	$25.41	$30.49	$35.57	$40.66	$45.74	$50.82
0.5995	60-64	$6.00	$11.99	$17.99	$23.98	$29.98	$35.97	$41.97	$47.96	$53.96	$59.95
1.0352	65-69	*$6,500*	*$13,000*	*$19,500*	*$26,000*	*$32,500*	*$39,000*	*$45,500*	*$52,000*	*$58,500*	*$65,000*
		$6.73	*$13.46*	*$20.19*	*$26.92*	*$33.64*	*$40.37*	*$47.10*	*$53.83*	*$60.56*	*$67.29*
2.4263	70-74	*$4,000*	*$8,000*	*$12,000*	*$16,000*	*$20,000*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
		$9.71	*$19.41*	*$29.12*	*$38.82*	*$48.53*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
9.2285	75-79	*$2,500*	*$5,000*	*$7,500*	*$10,000*	*$12,500*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
		$23.07	*$46.14*	*$69.21*	*$92.29*	*$115.36*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
9.2285	80-99	*$1,000*	*$2,000*	*$3,000*	*$4,000*	*$5,000*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
		$9.23	*$18.46*	*$27.69*	*$36.91*	*$46.14*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Bi-Weekly Spouse Premium
Life and Accidental Death and Dismemberment Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Spouse premiums will be calculated based on the Employee Age
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

Bi-Weekly RATE Per $1000	AGE	$ 5,000	$10,000	$ 15,000	$ 20,000	$ 25,000	$ 30,000	$ 35,000	$ 40,000	$ 45,000	$ 50,000
0.0655	<25	$0.33	$0.66	$0.98	$1.31	$1.64	$1.97	$2.29	$2.62	$2.95	$3.28
0.0655	25-29	$0.33	$0.66	$0.98	$1.31	$1.64	$1.97	$2.29	$2.62	$2.95	$3.28
0.0725	30-34	$0.36	$0.73	$1.09	$1.45	$1.81	$2.18	$2.54	$2.90	$3.26	$3.63
0.0863	35-39	$0.43	$0.86	$1.29	$1.73	$2.16	$2.59	$3.02	$3.45	$3.88	$4.32
0.1218	40-44	$0.61	$1.22	$1.83	$2.44	$3.05	$3.65	$4.26	$4.87	$5.48	$6.09
0.1777	45-49	$0.89	$1.78	$2.67	$3.55	$4.44	$5.33	$6.22	$7.11	$8.00	$8.89
0.3254	50-54	$1.63	$3.25	$4.88	$6.51	$8.14	$9.76	$11.39	$13.02	$14.64	$16.27
0.5082	55-59	$2.54	$5.08	$7.62	$10.16	$12.71	$15.25	$17.79	$20.33	$22.87	$25.41
0.5995	60-64	$3.00	$6.00	$8.99	$11.99	$14.99	$17.99	$20.98	$23.98	$26.98	$29.98
1.0352	65-69	*$3,250*	*$6,500*	*$9,750*	*$13,000*	*$16,250*	*$19,500*	*$22,750*	*$26,000*	*$29,250*	*$32,500*
		$3.36	*$6.73*	*$10.09*	*$13.46*	*$16.82*	*$20.19*	*$23.55*	*$26.92*	*$30.28*	*$33.64*

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Dependent Children Rate = $0.92 Bi-Weekly. Premium covers all dependent children regardless of the number of children.

Stand Alone Voluntary Accidental Death & Dismemberment

Benefit	Employee Plan	Spouse Plan	Child Plan
Amount	Choice of $10,000 increments, subject to a maximum of $500,000. Not to exceed 5 times annual salary.	Choice of $5,000 increments, subject to a maximum of $500,000. Not to exceed 100% of the employee benefit.	Each Child (6 months to age 25): $5,000 or $10,000
Minimum Amount	$10,000	$5,000	$5,000
Maximum Amount	$500,000	$500,000	$10,000
Benefit Reduction	**Employee**	**Spouse**	
Benefits will reduce:	35% at age 70 An additional 25% of original amount at age 75 An additional 15% of the original amount at age 80 Benefits terminate at retirement.	Benefits terminate at spouse age 70 or employee retirement whichever occurs first.	
Additional Benefits			
	Safe Driver Education Spouse Training Felonious Assault Alternate Child Care Coma Common Disaster Exposure Disappearance Common Carrier		
Eligibility	**Employee**	**Spouse and Dependents**	
	All full-time employees working 30 or more hours per week in an eligible class are eligible for coverage on the policy effective date. A delayed effective date will apply if the employee is not actively	Cannot be in a period of limited activity on the day coverage takes effect. Employee must elect coverage for Dependent to be eligible.	

Stand Alone Voluntary Accidental Death & Dismemberment

Employee Bi-Weekly Premium Accidental Death and Dismemberment premium for sample benefit amounts

Refer to Program Specifications for your maximum benefit amounts. Benefits and premium amounts reflect age reductions.

AGE	Bi-Weekly Rate per $1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
<70	0.026	$0.26	$0.52	$0.78	$1.04	$1.30	$1.56	$1.82	$2.08	$2.34	$2.60
70-75	0.026	**$6,500**	**$13,000**	**$19,500**	**$26,000**	**$32,500**	**$39,000**	**$45,500**	**$52,000**	**$58,500**	**$65,000**
		$0.17	$0.34	$0.51	$0.68	$0.85	$1.01	$1.18	$1.35	$1.52	$1.69
75-80	0.026	**$4,000**	**$8,000**	**$12,000**	**$16,000**	**$20,000**	**$24,000**	**$28,000**	**$32,000**	**$36,000**	**$40,000**
		$0.10	$0.21	$0.31	$0.42	$0.52	$0.62	$0.73	$0.83	$0.94	$1.04
80+	See HR Administrator for details.										

Spouse Bi-Weekly Premium Accidental Death and Dismemberment premium for sample benefit amounts

Refer to Program Specifications for your maximum benefit amounts. Benefits and premium amounts reflect age reductions.

AGE	Bi-Weekly Rate per $1,000	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
<69	0.027	$0.14	$0.27	$0.41	$0.54	$0.68	$0.81	$0.95	$1.08	$1.22	$1.35
70+	Spouse coverage terminates when spouse attains age 70 or employee retirement, whichever comes first.										

Child(ren) Bi-Weekly Premium Accidental Death and Dismemberment premium for sample benefit amounts

Refer to Program Specifications for your maximum benefit amounts. Benefits and premium amounts reflect age reductions.

AGE	Bi-Weekly Rate per $1,000	$5,000	$10,000
<25	0.016	$0.08	$0.16

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Voluntary Short Term Disability

Short-term disability is intended to protect your income for a short duration in case you become ill or injured.

STD Benefit

Weekly Benefit	Elimination Period (Accident/Illness)	Duration
60% of weekly salary up to **$1,000** per week	Benefits begin on: **8** days/**8** days	**12** weeks

Pre-Existing Condition You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 6 months

Integration of Benefits Your benefits will be reduced by benefits received from any state disability program. The total of all benefits received from this policy, state disability plans, and your employer's sick pay plan may not exceed 100% of your income prior to disability.

Waiver of Premium You will not be required to pay premium during any time of approved total or partial disability.

Additional Benefits

Survivor Income Benefit
Rehabilitation Assistance Benefit
Portability
See your Schedule of Benefits on your Certificate for more information

Enrolling for Coverage

Eligibility: All full-time active employees working 30 or more hours per week in an eligible class are eligible for coverage on the policy effective date.

Bi-Weekly Premium Cost

		Example John Doe, Age 33
List your Weekly earnings (Maximum covered payroll is $1,666.67 Weekly)	$_____	$610.00
Multiply by 60% This is your Weekly benefit amount.	$_____	$366.00
Find your age and multiply by your premium factor (see table)	_____	.015535
Estimated Bi-Weekly premium	$_____	$5.68

Attained Age	Premium Factors
0 - 24	0.014926
25 - 29	0.014926
30 - 34	0.015535
35 - 39	0.015535
40 - 44	0.021323
45 - 49	0.021628
50 - 54	0.026806
55 - 59	0.035031
60 - 64	0.043865
65 - 69	0.043865
70 - 99	0.043865

**This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Pre-Existing Condition Any sickness or injury for which you have received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to your coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date.

Benefit Exclusions You will not receive benefits in the following circumstances:

- Your disability is the result of a self-inflicted injury.
- You are not under the regular care of a doctor when requesting disability benefits.
- Your disability is covered under a worker's compensation plan and/or is due to a job-related sickness or injury.

Coverage is for off the job injury only.

Voluntary Accident

Emergency care	Choice Plan
Ambulance/Air Ambulance	$150/$600
Initial physician office visit/ER visit	$50/$150
Major diagnostic care	$100
Treatment care	
Hospital admission	$1,000
Hospital confinement daily benefit	$200
Intensive care daily benefit	$400
Alternate care and rehabilitative facility daily benefit	$100
Follow-up doctor/patient care up to 6 sessions	$50
Transportation for care (up to 3 times per accident)	$175
Companion lodging (up to 30 days per accident)	$100
Family care per child (up to 30 days)	$20
Fractures	**Nonsurg/Surg**
Per fracture	$50-$2,500/$100-$5,000
Chip fractures	25% benefit
Dislocations	**Nonsurg/Surg**
Per injury	$50-$1,200/$100-$2,400
Partial dislocation	25% benefit
Specific injuries or treatments	**Choice Plan**
Transfusions	$150
Burns	$100 - $6,400
Skin Grafts	Additional 25%
Joint replacement	$1,500-$2,000
Coma	$2,000
Concussion	$100
Dental crown once per accident	$150
Dental extraction once per accident	$50
Eye (removal of foreign body) once per eye/accident	$100
Eye (surgical repair) once per eye/accident	$300
Laceration	$50-$400
Surgery	$250-$1,000
Treatment of ligaments/tendons, knee cartilage, rotator cuff, ruptured disc	$300-$400
Transitional care benefits	
Crutches, wheelchair, walker	$25-$350
Prosthesis per limb/device	$500
Reasonable modifications to home or vehicle	$2,500

Accidental Death & Dismemberment (AD&D)	Choice Plan
Accidental death	
Employee	$30,000
Spouse	$10,000
Child	$5,000
Loss of or loss of use of one: hand, foot, arm, leg, eye	$7,000
Loss of or loss of use of any one finger, thumb, or toe	$300
Common carrier enhanced death benefit	2x benefit amt
Transportation of remains	$5,000
Seat belt/helmet AD&D benefit	10% of AD&D
Common disaster enhanced death benefit	2x benefit amt
Catastrophic loss	$50,000
Additional benefits	
Accident EAP services	Included
TravelConnect℠	Included
Health assessment (wellness) benefit: If an insured undergoes a defined health assessment, a benefit will be paid.	$50

	Choice Plan
Accident base coverage	**Bi-Weekly Cost**
Employee only	$7.67
Employee + spouse	$11.33
Employee + child(ren)	$12.53
Employee + family	$17.24
Group level benefit options *Additional benefits selected by employer for all enrolled employees – cost included in the base coverage rates above*	
Health Assessment (wellness)	Included

Coverage is for off the job injury only.

Voluntary Vision

- You may choose any provider. However, using providers participating in the network should lower your out-of-pocket expenses.
- A list of participating providers may be accessed at http://lvc.lfg.com or by calling toll-free at 1-800-440-8453.
- Members may purchase mail order contact lenses online at a 10% discount.
- Through Laser Vision Network of America (LVNA), we can provide our members with access to discounted laser vision correction procedures. Members may choose an NCQA-credentialed surgeon from LVNA's nationwide network of more than 400 laser vision correction surgeons.
- Patient options, such as ultraviolet protection and progressive lenses, are offered at a 20% to 40% discount, which results in substantial member savings from the provider's usual and customary charges.

	Network[1]	Out of Network[2]
EXAM COPAY	$10	Not applicable
MATERIAL COPAY	$25	Not applicable
Service Frequencies – based on the last date of service.		
Exam: 12 months		
Lenses: 12 months		
Frames: 24 months		
EYE EXAMINATION	100%	Up to $40.00
EYEGLASS LENSES		
Single Lenses	100%	Up to $40.00
Bifocal	100%	Up to $60.00
Trifocal	100%	Up to $80.00
Lenticular	100%	Up to $80.00
As a value-added benefit, standard scratch-resistant coating is provided at no additional charge for all lenses covered in full.		
FRAMES[3]	100%	Up to $45.00
ELECTIVE CONTACT LENSES[4]		
Covered Contact Lens Selection (material copay applies)	100%	Up to $125.00
All other elective contact lenses (no copay)	Up to $125.00	Up to $125.00
NECESSARY CONTACT LENSES[5]	100%	Up to $210.00

Members will not receive an ID card. Providers can verify benefits by calling 1-800-440-8453.

Frame Benefit: Our generous frame benefit applies to virtually all of the frames on the market today, and most of those are covered-in-full, with no additional cost to the member, other than applicable copay. Plan participants receive a $130.00 retail frame allowance for frames purchased at retail chain providers, and for any frame above $130.00, the member will only pay the difference. A 30% discount is applied in excess of the allowance.
Elective Contact Lenses: Contact lenses are provided in lieu of eyeglasses (lenses and frame). When purchasing from the Covered Contact Lens Selection, the benefit is covered-in-full (after copay if applicable). This includes:

- fitting/evaluation fees
- contacts (including up to 4 boxes of disposables, depending on prescription and plan selected)
- up to two follow-up visits.

Bi-Weekly Premium

Employee Only	$3.21
Employee & Spouse	$5.94
Employee & Child(ren)	$6.21
Employee & Family	$9.30

Eligibility:
Employee—a full time employee actively at work
Dependent—unmarried dependent children may be covered to age 25, regardless of student status.

REMINDERS

Employees are responsible for notifying Human Resources if a dependent is no longer eligible for coverage. Failure to notify HR will affect COBRA availability and premium refunds.

From time to time other coverage information and accident details may be requested by the carriers—please respond promptly to expedite processing of claims.

Questions & Answers

How do I enroll?

- Online enrollment will be completed through MyPay. ***It is MANDATORY that every employee login and select benefits for the 2017/2018 plan year.***
- The only paper enrollment form a person may have is the Evidence of Insurability form through Lincoln Financial. If an employee/spouse elects an increase more than 2 increments levels, this form must be completed. New hires electing under the guarantee issue amount do not have to complete the form.

What is the deadline to enroll?

- Any forms, such as the Evidence of Insurability form, must be completed, signed, dated and returned to Jenny Flores. She can be reached at the following:

  Phone: 830-996-3002 Fax: 830-996-3027 Email: Jenny.Flores@coastalplainsllc.com

Who do I contact with questions?

- Contact Jenny Flores at 830-996-3002 or Lacey Parmer/BancorpSouth Insurance at 866-279-0520 with any questions you may have.

NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 or NMHPA provision, an amendment to ERISA, establishes restrictions on the extent to which group health plans and health insurance issuers may limit hospital length of stay for mothers and newborn children following delivery. NMIHPA states that:

> "Group health plans and health insurance issuers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. However, the Plan may pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier."

ERISA RIGHTS

As a participant in this Employee Health Benefit Plan, an Employee is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents, including copies of any documents filed by the Plan with the U.S. Department of Labor.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a Reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Employee Benefit Plan.

The Plan Administrator has a duty to operate this Plan prudently and in the interest of the Employee and other Plan participants and beneficiaries.

No one, including the employer, may terminate an Employee or otherwise discriminate against an Employee in any way to prevent him/her from obtaining a welfare benefit or exercising their rights under ERISA.

If an Employee's claim for a welfare benefit is denied, in whole or in part, the Employee must receive a written explanation of the reason for the denial. The Employee has the right to have the Plan reviewed and reconsider his or her claim.

Under ERISA there are steps an Employee can take to enforce the above rights. For instance, if the Employee requests materials from the Plan and does not receive them within 30 days, the Employee may file suit in a federal court. In such a case the court may require the Plan Administrator to provide the materials and pay the Employee up to $110.00 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If the Employee has a claim for benefits which is denied or ignored, in whole or in part, the Employee may file suit in a state or federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if the Employee is discriminated against for asserting his/her rights, the Employee may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Employee is successful, the court may order the person being sued to pay these costs and fees. If the Employee loses, the court may order the Employee to pay these costs and fees, for example if it finds the claim to be frivolous.

If the Employee has any questions about the Plan, the Employee should contact the Plan Administrator. If the Employee has any questions about this statement or about his/her rights under ERISA, the Employee should contact the nearest area office of the U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998, an amendment to ERISA, requires Employee Benefit Plans which cover mastectomy to also provide coverage for the following:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to provide a symmetrical appearance, and
- prosthesis and physical complications during all stages of the mastectomy. These are covered expenses under the terms of this Plan as any other covered surgical procedure.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

The Uniformed Services Employment and Reemployment Rights Act of 1994 provides that upon notification by the Employee/Service member to the Employer of pending uniformed service, an Employer who provides Employee health plan coverage, including group health plans' must allow the Service member to elect to continue personal coverage, and coverage for his or her Dependents under the following circumstances:

- The maximum period of coverage of an Employee and Covered Dependents under such an election shall be the lesser of:
  - The 18 month period beginning on the date on which the Employee's absence begins; or
  - The day after the date on which the person was required to apply for or return to a position of employment as specified in section 4312 (e) of the Uniformed Services and Reemployment Rights Act of 1994.
- An Employee and/or Covered Dependents who elect to continue health plan coverage may be required to pay up to 102 percent of the full premium under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

An Employee who applies for reemployment within the time limit specified under the Uniformed Services Employment and Reemployment Rights Act of 1994, will have coverage under the Plan reinstated for the Employee and his or her Dependents. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

In addition, 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with **WinCo Development's** Employee Benefit Plan provided by **WinCo Development** to its employees, its employee's dependents. This Notice describes how **WinCo Development**, may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law. This Notice is effective March 1, 2013.

Copy of this Notice: The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

HIPAA PRIVACY

Definitions

Breach means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or uture physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

The Plan's disclosures and uses of PHI;
The Participant's privacy rights with respect to his/her PHI;
The Plan's duties with respect to his/her PHI;
The Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. If a Plan engages in underwriting: Not use or disclose genetic information for underwriting purposes.
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
14. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
15. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
16. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

a) The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

i Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

b) In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information; and
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a) a public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
    b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    c) locate and notify persons of recalls of products they may be using; and
    d) a person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;
3. The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a 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;
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance 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 threat to health or safety of a person or to the public;
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Participant; and

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

1. If the Plan maintains psychotherapy notes: Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;

2. Right to Receive Confidential Communication: The Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests;
3. The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six (6) years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Compliance Coordinator;
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial;
6. Amendment: The Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and
7. Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services

Contact Information

Privacy Compliance Coordinator Contact Information:
WinCo Development
Kim Watson
701 N First Street
Lufkin, TX 75901
Phone: (936) 632-6033

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

1. "*Electronic Protected Health Information*" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.
2. "Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504 (a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach. Breach Notification must be provided to individual by:
   a) Written notice by first-class mail to Participant (or next of kin) at last known address or, if specified by Participant, e-mail;
   b) If Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a "substitute form;
   c) If an urgent notice is required, Plan may contact the Participant by telephone.
      i. The Breach Notification will have the following content:
         1. Brief description of what happened, including date of breach and date discovered;
         2. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
         3. Steps Participant should take to protect from potential harm;
         4. What the Plan is doing to investigate the branch, mitigate losses and protect against further breaches;
2. Notify the media if the breach affected more than five hundred (500) residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered;

3. Notify the HHS Secretary if the breach involves five hundred (500) or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each Calendar Year; and
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected Participants may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

<table>
<tr><td>ALABAMA – Medicaid</td><td>COLORADO – Medicaid</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447</td><td rowspan="2">Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td><td rowspan="2"></td></tr>
<tr><td>ARIZONA – CHIP</td></tr>
<tr><td>Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
</table>

IDAHO – Medicaid and CHIP Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	**MONTANA** – Medicaid Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid Website: http://www.in.gov/fssa Phone: 1-800-889-9949	**NEBRASKA** – Medicaid Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	**NEVADA** – Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	**NEW HAMPSHIRE** – Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	**NEW JERSEY** – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	**NEW YORK** – Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	**NORTH CAROLINA** – Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	**NORTH DAKOTA** – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	**UTAH** – Medicaid and CHIP Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	**VERMONT**– Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	**VIRGINIA** – Medicaid and CHIP Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid Website: www.ohhs.ri.gov Phone: 401-462-5300	**WASHINGTON** – Medicaid Website: http://hrsa.dshs.wa.gov/premiumpymt/Appty.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid Website: http://www.scdhhs.gov Phone: 1-888-549-0820	**WEST VIRGINIA** – Medicaid Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059	**WISCONSIN** – Medicaid Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	**WYOMING** – Medicaid Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

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 entitle 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.