

EMPLOYEE BENEFITS GUIDE

MEDINA COUNTY

JANUARY 1, 2022 –
DECEMBER 31, 2022

NOTE: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal Law gives you more choices about your prescription drug coverage. Please see pages 22-23 for more details.

LIVE WELL

At Medina County, we believe that our employees are our most important asset. Helping you and your family achieve and maintain good health—physical, emotional and financial —is the reason Medina County offers you this benefits program.

This benefits overview will help you understand the benefit choices available to you and allow you to be the best healthcare consumer possible as you take an active role in managing your health. Please review it carefully and make sure to ask about any important issues that are not addressed here.

These benefits in this guide are effective:
JANUARY 1, 2022—DECEMBER 31, 2022

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Who is Eligible?

If you are an active, full-time employee working 30 or more hours per week, you are eligible to enroll in the benefits described in this guide. The following family members are eligible for medical, dental, and vision coverage:



- Legal Spouse — **(Effective 1/1/2018)** all dependent spouses applying for coverage who are eligible for employer-sponsored health coverage at their Employer, must first enroll in their employer-sponsored coverage in order to be eligible to enroll in the TAC HEBP plan.
- Dependent Child(ren) up to age 26 (Extended coverage available for Handicapped Children. Please see policy for details.)

New Hires: Benefits will begin for newly eligible employee on the **first of the month following 60 days** of employment.

Deferred Effective Date: *If you are not actively at work on the day coverage would otherwise take effect, then insurance will not take effect until the day you resume active work.*

If a dependent is in a period of limited activity on the day his or her dependent life insurance would otherwise take effect; then insurance for that dependent will not take effect until the day after:

- 1) *his or her final discharge from the health care facility; or*
- 2) *resuming the normal activities of a healthy person of the same age and sex.*



How to Make Changes After Enrollment Closes

After the Initial Enrollment/Annual Enrollment period is closed, you **cannot** make changes to the benefits you elect/waive until the next Annual Enrollment period unless you experience a Qualified Change in Status. Under the regulations, events falling within the following categories are change in status events:

- Change in legal marital status (marriage, divorce, death of spouse, legal separation, and annulment);
- Change in number of dependents (birth, adoption, placement for adoption, and death);
- Change in employment status (termination/commencement of employment, change in worksite);
- Dependent satisfies or ceases to satisfy dependent eligibility requirements;
- Residence change (only permissible where a change in residence affects the employee's eligibility for coverage)

You must notify Human Resources within 31 days of a family status change and within 60 days of a change in eligibility for Medicaid or CHIP coverage in order to be eligible to make changes; otherwise, you will have to wait until the next annual enrollment period.

MEDICAL & PRESCRIPTION DRUG

Blue Cross Blue Shield of Texas

1-855-357-5228

Policy Number: 217988

www.bcbstx.com

Medina County offers medical coverage through **BlueCross BlueShield of Texas**. You may go directly to any doctor in the **BlueChoice PPO Network** and no referrals are required for specialists.

When Accessing Care from a Network Provider:

- You receive a higher level of benefits (*In-Network benefits*)
- You are not required to file claim forms
- You are not balance billed
- Your provider will preauthorize necessary services

When Accessing Care from a Non-Network Provider:

- You receive a lower level of benefits (*Out-of-Network benefits*)
- You may be required to file your own claim forms
- You may be billed for charges exceeding BCBS's Allowable Amount for covered services
- You must preauthorize necessary services

	Base PPO Plan		Buy-Up PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	*Separate Rx Deductible		*Separate Rx Deductible	
Individual	\$2,000	\$6,000	\$1,000	\$3,000
Family	\$4,000	\$12,000	\$2,000	\$6,000
Coinsurance (Plan Pays)	80%	60%	80%	60%
Out-of-Pocket Max ¹	<i>Includes Coinsurance, Deductible and Medical Copays</i>		<i>Includes Coinsurance, Deductible and Medical Copays</i>	
Individual	\$5,000	\$14,000	\$4,000	\$9,000
Family	\$10,000	\$28,000	\$8,000	\$18,000
Lifetime Maximum	Unlimited		Unlimited	
Percentage of Eligible Expenses Payable by the Plan:				
Office Visit				
Preventive Care	100%	70% ²	100%	70% ²
Primary Care	\$35 copay	70% ²	\$30 copay	70% ²
Specialist	\$45 copay	70% ²	\$40 copay	70% ²
Virtual Visit	\$10 copay	n/a	\$10 copay	n/a
Urgent Care	\$35/\$45 copay	70% ²	\$30/\$40 copay	70% ²
Emergency Room	\$500 copay + 80% ² <i>Copay Waived if Admitted</i>		\$500 copay + 80% ² <i>Copay Waived if Admitted</i>	
Hospitalization	80% ²	60% ²	80% ²	60% ²
Lab and X-ray	100%	70% ²	100%	70% ²
Major Diagnostics <i>CT, PET, MRI, MRA</i>	80% ²	60% ²	80% ²	60% ²
Rx Deductible	\$250 Individual / \$500 Family		\$250 Individual / \$500 Family	
Retail Pharmacy				
Tier I	\$10 copay		\$10 copay	
Tier II	\$30 copay		\$30 copay	
Tier III	\$50 copay		\$50 copay	
Mail-Order Rx <i>(up to 90 days)</i>	2x applicable copay	n/a	2x applicable copay	n/a

¹ Once you reach the out-of-pocket expense limit (non-covered benefits are excluded from this total) in any one calendar year, covered services will be payable at 100% for the remainder of the year.

² Coinsurance applies after deductible is met.

2020 Monthly Medical Costs

NON TOBACCO USER / COMPLETED WELLNESS	Base Plan <i>\$2,000 / \$4,000 Deductible</i>	Buy-Up Plan <i>\$1,000 / \$2,000 Deductible</i>
Employee Only	\$50.00	\$60.00
Employee + 1 Dependent	\$150.00	\$185.00
Employee + 2 Dependents	\$200.00	\$260.00
Employee + 3 Dependents	\$250.00	\$335.00
Employee + 4 Dependents	\$300.00	\$410.00
Employee + 5 Dependents	\$350.00	\$485.00

NON TOBACCO USER / DID NOT COMPLETE WELLNESS	Base Plan <i>\$2,000 / \$4,000 Deductible</i>	Buy-Up Plan <i>\$1,000 / \$2,000 Deductible</i>
Employee Only	\$75.00	\$85.00
Employee + 1 Dependent	\$175.00	\$210.00
Employee + 2 Dependents	\$225.00	\$285.00
Employee + 3 Dependents	\$275.00	\$360.00
Employee + 4 Dependents	\$325.00	\$435.00
Employee + 5 Dependents	\$375.00	\$510.00

TOBACCO USER / COMPLETED WELLNESS	Base Plan <i>\$2,000 / \$4,000 Deductible</i>	Buy-Up Plan <i>\$1,000 / \$2,000 Deductible</i>
Employee Only	\$75.00	\$85.00
Employee + 1 Dependent	\$175.00	\$210.00
Employee + 2 Dependents	\$225.00	\$285.00
Employee + 3 Dependents	\$275.00	\$360.00
Employee + 4 Dependents	\$325.00	\$435.00
Employee + 5 Dependents	\$375.00	\$510.00

TOBACCO USER / DID NOT COMPLETE WELLNESS	Base Plan <i>\$2,000 / \$4,000 Deductible</i>	Buy-Up Plan <i>\$1,000 / \$2,000 Deductible</i>
Employee Only	\$100.00	\$110.00
Employee + 1 Dependent	\$190.00	\$235.00
Employee + 2 Dependents	\$250.00	\$310.00
Employee + 3 Dependents	\$300.00	\$385.00
Employee + 4 Dependents	\$350.00	\$460.00
Employee + 5 Dependents	\$400.00	\$535.00

***Tobacco user is defined as using any tobacco product more than 4 times per week.**

**** All employees will need to complete a wellness visit by November 30 to avoid the \$25 wellness surcharge. New hires that start July-December will not have to complete the exam until the following year.**

Airrosti

☎ 1.800.404.6050
🌐 www.airrosti.com

Fix Pain Fast!

Airrosti providers are experts at diagnosing and rapidly resolving the source of your injury. For just the cost of your Primary Care Copay (\$35/\$30), you will receive a one full hour of assessment, diagnosis, treatment, and education designed to eliminate the pain associated with many common conditions, allowing you to quickly and safely return to activity—usually within 3 visits (based on patient-reported outcomes). **This benefit is only included for employees and their dependents that have medical coverage with BCBSTX.**

Airrosti Can Help With...

- Neck Pain
- Mid Back Pain
- Triceps Tendonitis
- Low Back Pain
- Disc Injury
- SI Joint Sprain
- Hip Pain
- Headaches
- Rotator Cuff Pain
- Bicep Tendonitis
- Elbow Pain
- Hip Flexor Strain
- Groin Pull
- Carpal Tunnel
- Hamstring Pull/Strain
- Sciatic-like Pain
- Calf Pull/Strain
- Achilles Tendonitis
- Sever's Disease
- Heel Pain/Spurs
- Quad Pull
- Knee Pain
- Patellar Tendonitis
- Shin Splints
- Ankle Sprain
- Plantar Fasciitis

Airrosti is the Same Cost as a Primary Care Visit!

Virtual Visits

MDLive

☎ 1.888.680.8646
🌐 www.MDLive.com

Care when and where you need it just got easier with **MDLive** — convenient health care at your fingertips. Whether you're at home or traveling, access to a board-certified doctor is available 24/7 via online video, mobile app or phone. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits can also be a better alternative than going to the emergency room or urgent care center. **This benefit is only included for employees and their dependents that have medical coverage with BCBSTX.**

Access Your Account

- Visit the BCBSTX website at www.bcbstx.com
- Call MDLIVE at **(888) 680-8646**
- Download the **MDLive Mobile App** from the Apple App Store or Google Play

To register, you'll need to provide your first and last name, date of birth and BCBSTX member ID number.



Conditions Commonly Treated Through MDLive

General Health

- Allergies
- Asthma
- Nausea
- Sinus infections

Pediatric Care

- Cold/flu
- Ear problems
- Pinkeye

Behavioral Health

- Anxiety/depression
- Child behavior/learning issues
- Marriage problems

FLEXIBLE SPENDING ACCOUNT (FSA)

EBSO

1.800.558.7798

www.EBSOBenefits.com

General Purpose Health FSA

Medina County offers you the opportunity to pay for out-of-pocket medical, dental and vision expenses with pre-tax dollars through the Flexible Spending Account (FSA). You may set aside **up to \$2,750 for the 2022 calendar year** from your paycheck on a pre-tax basis to the Medical FSA to use for eligible expenses including but not limited to:

- Out-of-Pocket plan expenses such as Deductibles, Coinsurance and Copays incurred by you and your qualified dependents
- Most Prescription Drugs and Insulin
- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, eye examinations, eyeglasses and laser eye surgery
- Dental Services and Orthodontia (except for those considered cosmetic in nature)
- Chiropractic Services and/or Acupuncture
- Some over-the-counter items with a prescription

The General Purpose Health FSA plan has a carryover feature allowing participants to roll over up to \$500 of unused FSA dollars to the next year. Any amount over \$550 at year-end will be forfeited. Any allowable amount that rolls over into the new plan year will not affect the maximum election that employees can make.

To check the balance on your pre-loaded FSA card you can go to www.EBSObenefits.com/members and click on **Flex Direct Access**

If you need to file a claim directly with EBSO you can do so by going to www.EBSObenefits.com/downloadforms

DENTAL

UnitedHealthcare

1.800.996.0271

Policy Number: 708013

www.myuhcdental.com

Medina County offers dental PPO coverage through **UnitedHealthcare**. Under the PPO dental plan, you may receive care from any dentist of your choosing. However, choosing dental services from a dentist participating in the network will provide you with substantial savings. Providers participating in the network agree to accept the negotiated amount as payment in full—the enrollee is only responsible for the patient share.

If you choose to seek care outside the network, the plan generally pays benefits at a lower level. A non-participating provider may charge any amount and balance bill the enrollee for the difference between the in-network benefit allowance and the actual charge. You may want to ask the non-network Dentist about their billed charges before you receive care.

PPO P3087

Annual Deductible	
Individual	\$50
Family	\$150
Annual Maximum Benefit	\$1,000 per member per year
Diagnostic/Preventive Services	Plan covers 100% (deductible is waived) <i>Periodic Oral Evaluation, X-rays, Lab and Other Diagnostic Tests, Prophylaxis (Cleanings), Fluoride Treatments, Sealants, Space Maintainers</i>
Basic Services	Plan covers 80% after deductible <i>Fillings, Simple Extractions, Oral Surgery (including surgical extractions), Periodontics (gum treatment), Endodontics (root canals), General Anesthesia</i>
Major Services	Plan covers 50% after deductible <i>Crowns, Inlays/Onlays, Bridges, Dentures</i>
Orthodontia Services* <i>Dependent child(ren) to age 26</i>	Plan covers 50% after deductible \$1,000 lifetime maximum benefit per covered child

* 12 Month Waiting Period before Benefits are available

Monthly Dental Cost

Employee Only	\$0.00
Employee & Spouse	\$15.78
Employee & Child(ren)	\$24.14
Employee & Family	\$39.97

VISION

UnitedHealthcare (Spectera)

☎ Customer Service: 1.800.638.3120

☎ Provider Locator: 1.800.839.3242

Policy Number: 708013

🌐 www.myuhcvision.com

Medina County offers vision coverage through **UnitedHealthcare Vision**. There are "in-network" providers (contracted with UnitedHealthcare Vision) and "out-of-network" providers (no PPO contract). This means that you can obtain products or services through any provider you choose, though you'll generally pay less with in-network providers. When visiting an in-network provider, you are responsible for paying any applicable co-pay for covered expenses. You are also responsible for items that are not covered, or that exceed your benefit limitations. When visiting out-of-network providers, you pay for all services in full, and then file a claim for reimbursement according to your out-of-network benefits schedule.

UHC Vision Plan

	In-Network	Out-of-Network <i>(copays do not apply)</i>
Eye Exam	\$10 comprehensive exam copay	Plan covers up to \$40
Lenses (Standard) Per Pair	<i>Standard scratch-resistant coating covered-in-full. Other optional lens upgrades may be offered at a discount. Discount varies by provider.</i>	
Single	\$25 copay	Plan covers up to \$40
Bifocal	\$25 copay	Plan covers up to \$60
Trifocal	\$25 copay	Plan covers up to \$80
Lenticular	\$25 copay	Plan covers up to \$80
Frames	\$130 retail frame allowance after \$25 copay	Plan covers up to \$45
Contact Lenses	<i>In lieu of eyeglass lens and frame benefit</i>	
Covered-in-Full Selection	\$25 copay covers fitting/evaluation fees, contact lenses (up to 4 boxes), and up to 2 follow-up visits	Plan covers up to \$105 applicable to materials only. The fitting/evaluation is not included.
Non-Selection	\$105 allowance (materials copay waived) applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection.	
Medically Necessary	\$25 copay	Plan covers up to \$210
Service Frequencies	Eye Exam covered once every 12 months Lenses for glasses covered once every 12 months Frames covered once every 12 months Contact lenses covered once every 12 months in lieu of glasses	

Monthly Vision Cost

Employee Only	\$6.34
Employee & Spouse	\$12.02
Employee & Child(ren)	\$14.10
Employee & Family	\$19.82

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

UnitedHealthcare—Term Life

Policy Number: 708013

Medina County provides a Basic Life and Accidental Death and Dismemberment (AD&D) benefit for all eligible full-time employees. This life insurance plan can protect your survivors from financial difficulty in the event of your death. AD&D insurance can provide assistance if you suffer accidental dismemberment or death as the result of a covered accident. *(Please see “Deferred Effective Date” on page 4.)*

Basic Life and Accidental Death and Dismemberment (AD&D)

Benefit Amount	Flat \$10,000
Other Features	Accelerated Death Benefit Seat Belt and Air Bag Benefit Conversion Option
Benefit Reduces to: <i>(Benefits terminate at retirement)</i>	65% upon attainment of age 65 50% upon attainment of age 70

Conversion Option

When you terminate employment, retire or lose insurance eligibility due to a status change, you have the Conversion Privilege available to continue your current group term life insurance. You have 31 days immediately following loss of your coverage to apply and submit first premium payment. Subject to the terms as described in the Certificate of Coverage.



Monthly Basic Life and AD&D Cost

Employee Only

NO PAYROLL DEDUCTION

Basic Life and AD&D coverage is paid on your behalf by Medina County

This guide is a general description of coverage(s) provided. For a detailed description of policy terms and conditions, please refer to the policy itself. If a conflict exists between this guide and the policy, the policy will be controlling.

VOLUNTARY LIFE

UnitedHealthcare—Term Life

Group Number: 303910

Employees who want to supplement the Basic Life benefit may purchase additional coverage through **UnitedHealthcare**. You also have the opportunity to have coverage for your dependents. When you enroll yourself and your dependents in this benefit, you pay the full cost through payroll deductions. **If you are a new hire and waive this coverage and decide to enroll later you must complete an Evidence of Insurability form along with your enrollment form.** United Healthcare will then either approve or deny coverage. *(Please see “Deferred Effective Date” on page 4.)*

	Employee	Spouse*	Child(ren)*
Benefit Amount	\$10,000 increments	\$5,000 increments	Children 14 days to age 26: \$2,000 increments to \$10,000
Maximum Benefit	\$300,000 not to exceed 5x's Annual Salary	The lesser of 50% of your amount of insurance or \$100,000	Newborn children to age 14 days are not eligible for a benefit
Guarantee Issue Amount <i>(initial eligibility only)</i>	\$100,000	\$25,000	Not to exceed 100% of employee amount
Benefit Reduces to: <i>(Benefits terminate at retirement)</i>	65% upon attainment of age 65 50% upon attainment of age 70		n/a

* Spouse and/or Child(ren) coverage is only available if Voluntary Employee Life is elected.

Monthly Voluntary Life AD&D Cost

Insured Employee's Attained Age	Monthly Cost Per \$1,000		
	Employee	Spouse*	Child(ren)*
0—25	\$0.060	\$0.060	\$0.15 per \$1,000 Per Month Regardless of number of children
25—29	\$0.070	\$0.070	
30—34	\$0.090	\$0.090	
35—39	\$0.120	\$0.120	
40—44	\$0.170	\$0.170	
45—49	\$0.270	\$0.270	
50—54	\$0.440	\$0.440	
55—59	\$0.670	\$0.670	
60—64	\$0.910	\$0.910	
65—69	\$1.460	\$1.460	
70—74	\$2.460	\$2.460	
75+	\$7.300	\$7.300	

*Spouse rate is determined using employee's attained age. In order to purchase Voluntary Life coverage for spouse and/or children, employee Voluntary Life coverage must be purchased.

SHORT TERM DISABILITY

UnitedHealthcare

Policy Number: 708013

Medina County provides Short Term Disability (STD) benefits to all eligible full-time employees. This STD plan provides financial protection for you by paying a portion of your income while you are disabled (non-work related). The amount you receive is based on the amount you earned before your disability began. *(Please see “Deferred Effective Date” on page 4.)*

Employer-Paid Short Term Disability

Benefits Begin	1st day of accident and 8th day of illness
Duration of Benefits	13 weeks
Percentage of Income Replaced	60% of weekly earnings
Maximum Weekly Benefit	\$500



Monthly Short Term Disability Cost

Employee Only


NO PAYROLL DEDUCTION

Short Term Disability coverage is paid on your behalf by Medina County.

Your weekly Short Term Disability benefit may be reduced by other income you receive.

VOLUNTARY LONG TERM DISABILITY COVERAGE

Reliance Standard

 1.800.351.7500

Medina County offers all eligible full-time employee the option to enroll in Long Term Disability (LTD) coverage. This LTD plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled. ***(Please see “Deferred Effective Date” on page 4.)***

Employee-Paid Long Term Disability

Benefits Begin	180th day of accident or illness
Duration of Benefits	Normal Retirement Age
Percentage of Income Replaced	Increments of \$100 from \$500 up to the Monthly Maximum, not to exceed 60% of covered Monthly earnings
Maximum Monthly Benefit	\$5,000
Minimum Monthly Benefit	\$50
Pre-Existing Condition Limitation	3 / 12
Own Occupation coverage	24 Months

Monthly Voluntary Long Term Disability Cost

Age	Per \$100 of Monthly Benefit
18—24	\$0.16
25—29	\$0.25
30—34	\$0.45
35—39	\$0.72
40—44	\$1.25
45—49	\$1.65
50—54	\$2.30
55—59	\$2.95
60—64	\$2.30
65—69	\$1.55
70+	\$1.15

TRAVEL ASSISTANCE

UnitedHealthcare

1-410-453-6300

www.UHCglobal.com

To protect your physical and financial well-being, **UnitedHealthcare** life insurance products automatically include travel assistance services. **These services are available to all members and dependents covered by our Life Insurance plan.** Services can be accessed by phone or online, 24/7, from anywhere in the world.

Emergency Help When and Where You Need It

Travel Assistance Services:

- Emergency travel arrangements
- Assistance in replacing lost or stolen travel documents
- Emergency translation services
- Emergency pet housing and or pet return

Medical Assistance Services:

- Referrals to medical or dental providers worldwide
- Assistance with monitoring of medical treatment, hospital payment, transfer of insurance information, coordination of medication and vaccine transfers
- Help replacing corrective lenses and medical devices



ADDITIONAL BENEFITS

As a United Healthcare Member You Also Have Access To:

- **Will and Trust Preparation:** Available at no extra premium cost to all employees and dependents covered by our life insurance products, these services are designed to help employees with estate planning.
- **Beneficiary Services:** We provide additional services for beneficiaries including grief and loss consultation and financial and legal assistance.
- **Wealth Management Account:** This beneficiary owned account provides the security of an FDIC insured account, the convenience of using a check or debit card and the flexibility to withdraw all or part of the policy payment funds at any time.

VOLUNTARY ACCIDENT COVERAGE

Allstate

www.allstatebenefits.com/mybenefits

Today, active lifestyles in or out of the home may result in bumps, bruises and sometimes breaks. Getting the right treatment can be vital to recovery, but it can also be expensive. And if an accident keeps you away from work during recovery, the financial worries can grow quickly. Most major medical plans only pay a portion of the bills. **Allstate** coverage can help pick up where other insurance leaves off and provide cash to help cover expenses.

Voluntary Accident Coverage		
	Option 1	Option 2
Emergency Care		
Ground Ambulance Transportation	\$200	\$300
Air Ambulance Transportation	\$600	\$900
Emergency Room Treatment	\$200	\$300
Initial Physician / Urgent Care Visit	\$100	\$150
General Treatment		
Initial Hospital Admission (pays once/year)	\$1,000	\$1,500
Hospital Confinement per day (up to 365)	\$200	\$300
ICU Confinement per day (up to 180)	\$400	\$600
Specified Covered Injury & Treatment Benefits		
Fractures	Up to \$4,000	Up to \$6,000
Dislocations	Up to \$4,000	Up to \$6,000
Blood, Plasma, Platelets	\$600	\$900
Burns < 15% of body	\$200	\$300
Burns > 15% of body	\$1,000	\$1,500
Concussion	\$600	\$900
Paralysis Benefits		
Paralysis– Paraplegia	\$15,000	\$22,500
Paralysis– Quadriplegia	\$30,000	\$45,000
Accidental Death and Dismemberment		
Death Benefit (per member)	\$50,000	\$50,000
Loss of one hand or foot	\$25,000	\$25,000
Loss of both hands or feet	\$50,000	\$50,000
Loss of fingers or toes	\$5,000	\$5,000
Wellness Health Screening	\$50 per person	\$50 per person

Monthly Voluntary Accident Cost		
	Option 1	Option 2
Employee Only	\$11.95	\$15.69
Employee and Spouse	\$20.68	\$27.11
Employee and Child(ren)	\$30.05	\$40.30
Family	\$39.26	\$52.74

VOLUNTARY CRITICAL ILLNESS COVERAGE

Allstate

www.allstatebenefits.com/mybenefits

No one is ever really prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments and medication can add to your stress levels. **Allstate's** Critical Illness coverage helps provide financial support if you are diagnosed with a covered critical illness. **If you are a new hire and waive this coverage and decide to enroll later you must complete an Evidence of Insurability form along with your enrollment form.** Allstate will then either approve or deny coverage.

Voluntary Critical Illness Coverage

Benefit Amount	
Employee	\$10,000 or \$20,000 Option
Spouse	50% of Employee Election
Child(ren)	50% of Employee Election
Guarantee Issue	All amounts guarantee issue
Waiver of Premium	Included
Wellness Benefit	\$50 once per person per year
Benefit Amounts	
100% Covered Conditions	<ul style="list-style-type: none"> • Heart Attack • Stroke • End State Renal Failure • Major Organ Transplant • Invasive Cancer
25% Covered Conditions	<ul style="list-style-type: none"> • Carcinoma in Situ • Coronary Artery Bypass Surgery

Voluntary Critical Illness Coverage

Age	\$10,000 Option		\$20,000 Option	
	<i>Employee Only</i> OR <i>Employee + Child(ren)</i>	<i>Employee + Spouse</i> OR <i>Employee + Family</i>	<i>Employee Only</i> OR <i>Employee + Child(ren)</i>	<i>Employee + Spouse</i> OR <i>Employee + Family</i>
	18—29	\$4.34	\$7.14	\$7.46
30—39	\$8.99	\$14.11	\$16.72	\$25.71
40—49	\$18.20	\$27.96	\$35.19	\$53.38
50—59	\$32.13	\$48.83	\$63.04	\$95.17
60—64	\$43.78	\$66.29	\$86.32	\$130.09
65+	\$67.89	\$102.46	\$134.53	\$202.42

VOLUNTARY HOSPITAL INDEMNITY

Allstate

www.allstatebenefits.com/mybenefits

Expenses associated with a hospital stay can be financially difficult if money is tight and you are not prepared. But having the right coverage in place before you experience a sickness or injury can help eliminate your financial concerns and provide support at a time it is needed most. **Allstate** Benefits offers a solution to help you protect your income and empower you to seek treatment. **If you are a new hire and waive this coverage and decide to enroll later you must complete an Evidence of Insurability form along with your enrollment form.** Allstate will then either approve or deny coverage.

Voluntary Hospital Indemnity Coverage

	Option 1	Option 2
Initial Hospital Admission	\$750 Limit 1 per year	\$1,500 Limit 1 per year
Daily Hospital Benefit	\$150 per day 30 Day Maximum	\$200 per day 30 Day Maximum
Intensive Care	\$150 per day 30 Day maximum	\$200 per day 30 Day Maximum



Voluntary Hospital Indemnity Coverage

	Option 1	Option 2
Employee Only	\$15.47	\$26.91
Employee and Spouse	\$40.04	\$72.54
Employee and Child(ren)	\$26.78	\$46.67
Family	\$43.55	\$78.39

The following pages are
Annual Required Notices
(no action required)

REQUIRED NOTICES

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources .

HIPAA Pre-existing Condition Exclusions

Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a participant who is under the age of 19.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates of creditable coverage. If you do not receive a certificate for past coverage, contact Human Resources.

You can add up any creditable coverage you have. However, if at any time you went for 63 days or more without any coverage (called a lapse in coverage) a plan may not have to count the coverage you had before the lapse.

Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day lapse.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Human Resources.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) 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 towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);

REQUIRED NOTICES

(continued from previous page)

- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Reaching the plan's lifetime benefit maximum on all benefits, if the person is covered under a separate plan or a single plan with multiple options and the other option has a higher lifetime maximum, or the benefits paid under the first option were not integrated with the second option;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

Newborn's and Mothers' Health Protection Act Notice

Under federal law known as the "Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act) group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Under Virginia State law, if your Plan provides benefits for obstetrical services your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and Copayments that are no less favorable than for physical illness generally.

Military Leaves of Absence (USERRA)

Eligible employees are entitled to continue health benefits under the Uniformed Services Employment and Reemployment Rights Act (USERRA). USERRA guarantees certain rights to eligible employees who enter military service. More information is available at: http://www.dol.gov/vets/programs/userra/USERRA_Private.pdf

Family and Medical Leave Act (FMLA)

If you qualify for an approved family or medical leave of absence as defined in the Family and Medical Leave Act of 1993 (FMLA), health care coverage may continue if you pay any required contributions for coverage. Failure to make payment will result in the termination of your health care coverage. Failure to make payment will result in the termination of your health care coverage. If you fail to return to work after the leave of absence, the Company has the right to recover any contributions toward the cost of your health care coverage incurred during your leave.

MEDICARE PART D NOTICE

Important Notice from Medina County About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Medina County has determined that the prescription drug coverage offered by the BCBS of Texas plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

Your current Medina County coverage pays for other health expenses in addition to prescription drug. If you decide to join a Medicare drug plan, your current Medina County coverage will not be affected. If you elect Medicare drug coverage in addition to your Medina County coverage, the pharmacy benefits you are eligible for under your Medina County coverage will coordinate with your Medicare drug plan. The prescription drug coverage under the Medina County plan is provided below:

	Base Plan	Buy-Up Plan
Rx Deductible	\$250 Individual / \$500 Family	\$250 Individual / \$500 Family
Tier I	\$10 copay	\$10 copay
Tier II	\$30 copay	\$30 copay
Tier III	\$50 Copay	\$50 Copay

If you do decide to join a Medicare drug plan and drop your current Medina County coverage, be aware that you and your dependents will be able to get this coverage back at open enrollment or qualifying event loss of coverage.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Medina County changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2022

Name of Entity/Sender: Medina County

Contact--Position/Office: Human Resources

Address: 1300 Avenue M, Room 130
Hondo, TX 78861

Phone Number: 830-741-6111

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE – PART A

General Information

When key parts of the health care law take effect in 2015, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums on the Marketplace?

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED

This section contains information about any health coverage offered by Medina County. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer Name Medina County		Employer Identification Number (EIN) 74-6001106
Employer Address : 1300 Avenue M Room 130		Employer Phone Number 830-741-6111
Employer City Hondo	Employer State Texas	Employer Zip Code 78861
Who can we contact about employee health coverage at this job Glenda Moody – Director of Human Resources		
Employer Contact Phone Number 830-741-6111	Employer Contact Email Glenda.Moody@medinatx.org	

Here is some basic information about health coverage offered by this employer:

- ***As your employer, we offer a health plan to all full-time employees***
- ***This offering includes your spouse and dependent children to age 26.***
- ***This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on the employee's wage.***

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premium

MEDINA COUNTY

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

These notices contained herein are, in some instances, required by law and are intended to help you understand some of the features of the plans. It should not be considered a substitute for the applicable plan documents, which govern the operation of the plans. Those official documents set forth all of the details and provisions concerning the plans and are subject to amendment. If any questions rise that are not covered in these notices or if this document appears to conflict with the official plan documents, the text of the official plan documents will determine how questions will be resolved.

If you have any questions about your Guide or to request a copy of any plan document, please contact Human Resources.