CAMERON COUNTY

2023-2024 EMPLOYEE BENEFIT GUIDE

Benefits Effective 10.1.23 — 9.30.24

STRIVING TO PROVIDE A BETTER BENEFITS SOLUTION

Cameron County will be utilizing **SIG Insurance** services for our benefit communication and enrollment this year. **SIG**'s Benefit Counselors will provide you with a detailed explanation of your entire benefit program. They will review your benefits with you on an individual, confidential basis. They will also be able to discuss any personal situations you may have that could potentially impact your benefit decision.

Each year, we strive to offer comprehensive and competitive benefit plans to our employees. In the following pages, you will find a summary of our **2023-2024** benefit plan for **10/1/2023** to **9/30/2024**. Please read this guidebook carefully as you prepare to make your elections for the upcoming **2023-2024** Plan Year.

ABOUT THIS BENEFITS GUIDEBOOK

This Benefits Guidebook describes the highlights Cameron County's benefits program in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents and not the information in this guidebook. If there is any discrepancy between the description of the program elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. Any and all elements of Cameron County's benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules or otherwise as decided by Cameron County.

ENROLLMENT INSTRUCTIONS

*Avoid making quick decisions - enroll early!

You have the option of online self-service or sitting with one of our Benefits Counselors in person to learn more about your benefits and complete your enrollment process by either electing, changing or waiving benefits.

CALL CENTER ASSISTANCE

956-554-0028

Before you speak with a Benefit Counselor, please have the following information ready: *dependents' names, birth dates, social security numbers, addresses, and phone numbers.*

Online Enrollment

Online Enrollment Website:

https://www.employeenavigator.com/benefits/Account/Register

For online enrollment use the following 'Company Identifier': Cameron County

Example: John Doe / 123-45-6789 / 01/01/2001
First Name: John
Last Name: Doe
Company Identifier: Cameron County
PIN: 6789
Birth Date: 01/01/2001

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GETTING STARTED

FAQs

When does coverage begin? The elections you make during Open Enrollment are effective October 1, 2023 - September 30, 2024.

New Hires: Employee medical, dental, vision, supplemental life, accidental death and dismemberment, short-term disability, accident, and critical illness coverage begins on the 1st day of the month following the 30 days of employment. FSA (flexible spending) reimbursement accounts are based on completed enrollment within the designated time frame.

Can I enroll my spouse or dependent on one plan and myself on another? No, all covered dependents, including spouse, must be on the same plan as the employee.

If I am already enrolled and not making any changes, do I have to complete the open enrollment process? Yes, it is important that you review any rate or plan changes to your current plan.

If I want to decline coverage, do I still need to complete the open enrollment process? Yes. It is important that Human Resources has a record of your decision. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special qualifying event.

Can I drop or change plans during the plan year? No, changes can only be made if there has been a qualifying life event or personal life change. See **page 6**.

Things to Consider:

Take the following situations into account before you enroll:

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? Do you need to add or remove any dependent(s) and/or update your beneficiary designation?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria.

Helpful Tips and Reminders

- Take the time to carefully review the guide for any changes and updates. Choose the right coverage level, such as individual or family. Open Enrollment is an excellent time to ensure that the person designated as your beneficiary is correct regarding your insurance and retirement benefits.
- Gather the correct information for your dependents such as social security numbers and birth dates.
- Make sure your address and personal information is current. If your information is not current you may miss out on important information such as insurance cards, plan documents, etc.
- Visit each vendor's website for additional information. Don't forget to review each provider directory.
- You may select any combination of Medical, Dental and/or Vision plan coverage categories. For example, you could select Medical coverage for you and your entire family, but select Dental and Vision coverage only for yourself.
- Benefits premiums are deducted on a pre-tax basis, which lessens your tax liability. Except for voluntary life & AD&D, short term disability, accident and critical illness.

ELIGIBILTY

Cameron County encourages the health and financial well-being of its employees by providing access to quality and affordable healthcare. Eligible full-time employees have access to Cameron County's comprehensive Benefits Program. Cameron County may conduct an audit requesting supporting documentation on all eligible dependents at any time during the plan year.

Please thoroughly review this Benefits Guide to learn more about these options.

EMPLOYEE ELIGIBILITY

Full-time employees who work a minimum of 30 hours per week and are at least age 18 are eligible to participate in the benefits program, **with an effective date of the first of the month following a 30-day waiting period**.

Once your enrollment is completed, you may not make any changes to your elections unless you have a Qualifying Life Event or your hours worked per week drop below the minimum.

DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Legal spouse, domestic partnership, common law
- Your eligible children up to age 26 for medical, dental and vision coverage.
- "Children" are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

QUALIFYING LIFE EVENTS

If you experience a Qualifying Life Event (QLE), such as getting married or having a baby, please contact Human Resources (HR); proof of the QLE must be submitted to your HR department within 30 days to change current benefit election.

QLE Examples:

- A change in the number of dependents (birth, adoption, death, guardianship);
- A change in marital status (marriage, divorce, death, legal separation);
- A dependent's loss of eligibility (attainment of limiting age or change in student status);
- A change in associate's, spouse's, or dependents' work hours;
- A termination or commencement of employment of associate's spouse or eligible dependent with coverage;
- An entitlement to Medicare or Medicaid;
- Other events as the administrator determines to be permitted or any other applicable guidelines issued by the Internal Revenue Service.

Employee Medical Benefits

MEDICAL

The medical programs, administered by Aetna, provides the framework for your health and well-being. To better meet the varying needs of our employees, Cameron County offers the medical plans described below.

Carefully assess which medical plan best suits your need.

Medical Plan Summary	Open Access Choice POSII		Aetna Whole Health-Rio Grand Valley-CPOSII	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	$750	$1,500	$750	$1,500
Family	$2,250	$4,500	$2,250	$4,500
Out-of-Pocket Maximum				
Individual	$3,500	$7,000	$3,500	$7,000
Family	$7,500	$15,000	$7,500	$15,000
Office Visits				
Preventive Services	100%	40% after deductible	100%	40% after deductible
Physician Office	$35 copay	40% after deductible	$10 copay	40% after deductible
Specialist	$45 copay	40% after deductible	$45 copay	40% after deductible
Tela Doc Visits	$10 copay	40% after deductible	$10 copay	40% after deductible
Urgent Care	$75 copay	40% after deductible	$75 copay	40% after deductible
Inpatient & Outpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room	Facility: $300 copay + 20% MD: 20% after deductible		Facility: $300 copay + 20% after deductible	
Prescription Copays				
Retail (30-day)/Mail (90-day) Generic Brand Formulary Brand Non-Formulary Specialty Formulary	$15/30 copay $40/80 copay $60/120 copay $80 copay, retail only	Not Covered New Prudent Rx coming directly to eligible members soon! If eligible and enrolled in the Prudent Rx Program: $0 copay. If eligible and not enrolled in the Prudent Rx Program: 30% coinsurance	$15/30 copay $40/$80 copay $60/120 copay $80 copay, retail only	Not Covered New Prudent Rx coming directly to eligible members soon! If eligible and enrolled in the Prudent Rx Program: $0 copay. If eligible and not enrolled in the Prudent Rx Program: 30% coinsurance

Medical Semi-Monthly	Open Access Choice POSII	Aetna Whole Health-Rio Grand Valley-CPOSII
Employee	$25.00	$7.50
Employee + Spouse	$190.00	$84.38
Employee + 1 Child	$136.50	$46.88
Employee + 2 or more Children	$159.00	$62.50
Family	$248.50	$125.00

Working Spouse Premium

The working spouse premium is a monthly charge in addition to your regular medical coverage contribution/premium for a spouse who is working or who is eligible for medical coverage through their employer or former employer.

The Working Spouse Premium for this year is $100/month

made available through

Why wait for the care you need now?

Did you know there's a convenient and affordable healthcare alternative?

With Teladoc®, you can connect with a doctor in minutes, not hours or days like the ER, urgent care or doctor's office. Plus, you can get care from anywhere: home, office or on the road!

CONSIDER YOUR OPTIONS:

Teladoc:
Request a consult from work or home.

ER or urgent care:
Drive to the nearest office while sick.

Teladoc:
A doctor calls you back in minutes.

ER or urgent care:
Wait hours before seeing the doctor.

Teladoc:
Get the care you need at a price you can afford.

ER or urgent care:
Pay high ER and urgent care fees.

Talk to a doctor anytime for **$10!**

Less than an urgent care/ER visit, your cost is never more than a doctor visit!

Teladoc.com/Aetna

1-855-TELADOC (835-2362)

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Know your options when you need care

You have several affordable and convenient options for immediate care. Keep this chart handy to help you make a smart choice the next time you need medical care. You may save time and money. Just text **"GETAPP"** to **90156** for a link to the **Aetna Health℠ app**. You'll be able to find network providers and facilities near you. Message and data rates apply.* App Store Google play

	In-person options for care			
	Non-emergency	Non-emergency	Urgent	Emergency
Care options	**Primary care physician (PCP**)** Your PCP is the best option for in-person, non-emergency care. To find in-network PCPs near you, log in to your member website.	**MinuteClinic®** MinuteClinic offers convenient care 7 days a week from certified nurse practitioners and physician assistants at select CVS Pharmacy® and Target stores nationwide.	**Urgent care center** Urgent care centers provide quick care for serious, but not life-threatening, situations. Many urgent care centers offer imaging, X-ray and lab services.	**Emergency room** The emergency room (ER) is for emergencies that can permanently impair or endanger your life. Using the ER for non-life-threatening issues can be very costly and probably means a very long wait time.
When to use	• Physicals (wellness, screening) • Vaccinations & injections • Chronic condition management (heart disease, diabetes, arthritis, etc.) • Acute care (sinus infections and injuries) • Urgent care may be available by appointment	• Minor illnesses & injuries • Screenings & monitoring • Skin conditions • Vaccinations & injections • Wellness & physicals • Women's services • Travel health Visit **minuteclinic.com** to confirm services available at your location	• Back/neck pain • Cuts that require stitches • Minor burns • Flu • Sprains • Fractures • Bronchitis • Headaches and more	• Chest pain • Severe abdominal pain • Trouble breathing • Uncontrollable bleeding • Symptoms that may put your life at risk
Availability	Weekdays during business hours *(May be open extended hours and/or Saturdays)*	7 days a week *(including evenings and weekends)*	Many open 7 days a week with extended hours	24 hours a day 7 days a week 365 days a year
How to access	By appointment only	At select CVS Pharmacy and Target stores Schedule an appointment at **minuteclinic.com** or through the CVS Pharmacy App	Walk in	Walk in
Average wait time	Average wait time of 22 minutes upon arrival[1]	Make an appointment at **minuteclinic.com**	15 - 45 minutes[2]	2 - 4 hours for non-emergency care[2]
Average cost to you	$ $ • Pay your copay at appointment, if applicable. • Pay your estimated patient responsibility at time of visit, if applicable.**** • You may be billed for any balance.	$ • No-cost or low-cost access to all covered services.*** • Pay your estimated patient responsibility at time of visit, if applicable.**** • You may be billed for any balance.	$ $ $ • Pay your copay at time of visit, if applicable. • Pay your estimated patient responsibility at time of visit, if applicable.**** • You may be billed for any balance.	$ $ $ $ • Pay your copay at time of visit, if applicable. • Pay your estimated patient responsibility at time of visit, if applicable.**** • You may be billed for any balance.

[1] "Vitals' Annual Physician Wait Time Report," http://www.vitals.com/about/wait-time. [2] Urgent Care Locations, LLC. Urgent care center vs. emergency room. Available at: www.urgentcarelocations.com/urgent-care-101/faq/urgent-care-center-vs-emergency-room. Accessed April 4, 2018. *Terms and Conditions: bit.ly/2nIJFYG. Privacy Policy: aetna.com/legal-notices/privacy.html. By texting 90156, you consent to receive a one-time marketing automated text message from Aetna with a link to download the Aetna Health℠ app. Consent is not required to download the app. You can also download by going to the App Store or Google Play. **In Texas, PCP is known as physician (primary care). In the State of Washington, PCP refers to primary care provider. ***Applies only to covered services at MinuteClinic. Not applicable for HSA plans. Video Visits are not a covered service under this benefit. Members in health maintenance organization (HMO) and indemnity plans are not eligible for this benefit. Such members should refer to their benefits plan documents in order to determine coverage and applicable cost share for walk-in clinic benefits and services, as applicable. Visit MinuteClinic.com for age and service restrictions. This is not available for fully insured groups in AL, AK, AR, CA, CO, DE, GA, HI, IA, ID, MA, ME, MS, MT, ND, NM, NY, OR, SD, UT, VT, WA, WV and WY. ****Lab, tests and additional services may result in additional charges. Labs and tests cannot be purchased separately and are only performed as part of a standard visit.

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Helping you take charge

Staying healthy is important. So is taking control of your health care and benefits. But with everything else you have going on, managing it all can be a challenge. The Aetna Health app can help.

With the Aetna Health app, you can:

View your health plan summary and get detailed information about what's covered.

See claims details and pay claims for your whole family.

Search for providers, procedures and medications.

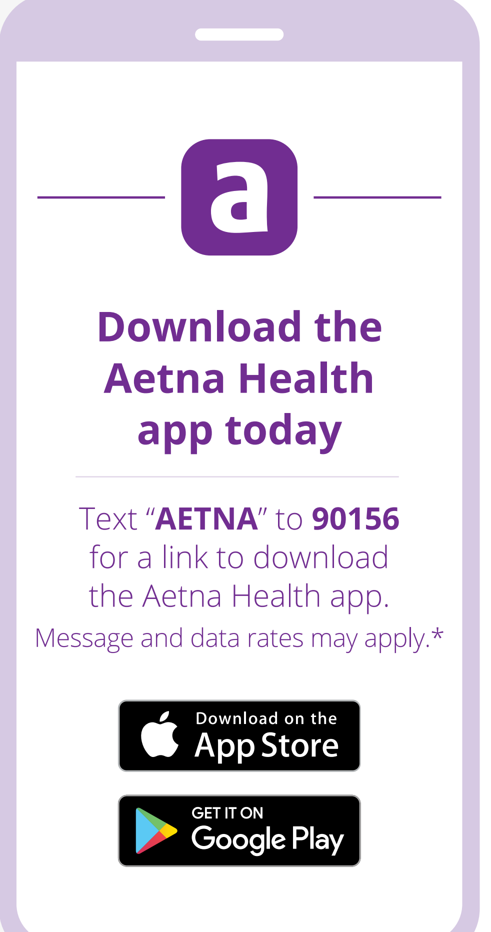
Get cost estimates before you get care.

Track spending and progress toward meeting your deductibles for you and your family.

Talk with a doctor anytime by phone or video chat from the comfort and safety of home.

Access your ID card whenever you need it.

Receive personalized health reminders.



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Health care in Mexico with the Aetna Cross-Border solution

aetna[SM]

Wherever you go in Mexico, you can rely on the combined strength of Aetna International and Sinergia Medica for your health care needs.

The **Sinergia Medica** network includes 9,000 hospitals, clinics and physicians in all 31 Mexican states and the Federal District. Your cobranded Member ID card gives you access to:

- Emergency care
- Urgent care
- Hospital inpatient care
- Outpatient care and consultations
- Appointment coordination
- Negotiated rates for care

Online directory

1. Go to: **https://www.sinergiamedica.net/v2/redmedica/seccionmedica/** (available in English and Spanish)

2. Click the “Hospital Information” button on the left

3. Use the drop-down menus to select state and municipality, then click “Send”

4. A list of hospitals will appear, which you can sort by name, state or municipality

5. Select a hospital name and the address will pop up

How to access care

It's customary under Mexico's health care system for you to pay for outpatient care at the time of service. However, **Sinergia Médica** can help you coordinate direct payment to providers at our negotiated local rates – avoiding the need for you to pay out of pocket – by following the steps below.

For outpatient care:

1. Contact **Sinergia Medica** using one of these three options:

   By form —
   Go to https://soporte.sinergiamedica.com/hc/en-us/requests/new and complete the form (available in English or Spanish)

   - **By email —**
     Send an email to servicio@sinergiamedica.com with the following information:

     First and last name

     Email address

     Telephone number

     Details of your request

     If a document has been requested, upload using the Attach option (Agregue un Archivo) CLICK ON "ENVIAR" TO SEND REQUEST

     This mailbox is monitored 24/7.

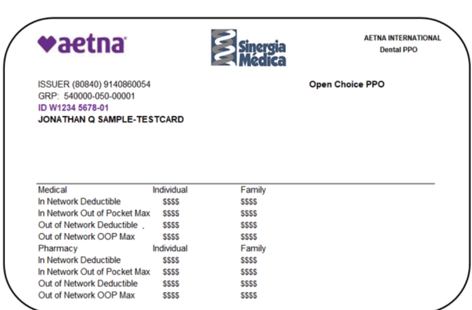
   - **By phone** — Contact **Sinergia Medica** at + (011) (52) 55-5249-8383 and select "Option 1" when prompted. (available 24/7)

2. Bring and show your cobranded Member ID card on the day of your appointment
3. **Sinergia Médica** will coordinate direct payment with the in-network outpatient provider

For inpatient care (including scheduled surgeries) and emergency/urgent care:

1. Go directly to the hospital, urgent care clinic or emergency department
2. Present your cobranded Member ID card and the care facility will contact **Sinergia Medica** to coordinate direct settlement arrangements
3. **Sinergia Médica** will coordinate direct payment with the in-network inpatient providers. There's no deductible, co-pay, or coinsurance payment required.

Aetna International Sample Card



www.aetnainternational.com PAYER NUMBER 60054 0049
TALK TO A DOCTOR 24/7: 1-855-TELADOC OR TELADOC.COM/AETNA
Benefits shown do not reflect benefits outside of the U.S.
See your plan documents for plan requirements, including precertification. This card does not guarantee coverage.

Sinergia Medica portal at: www.sinergiamedica.info
Sinergia Medica Customer Service:
Dial from USA: 011 52 55 5249 8383 Option 1
Dial from USA: 011 52 55 5249 8383 Option 1
Dial within Mexico: 55 52 49 8383 or 800 000 0277 Option 1

MEMBERS & NON US PROVIDERS	1-800-231-7729
U.S. PROVIDER SERVICES	1-888-632-3862
EVACUATIONS	1-877-242-5580
COLLECT/DIRECT DIAL NUMBER	1-813-775-0190
FAX CLAIMS AT&T ACCESS CODE	1-800-475-8751

LEGAL ENTITY NAME

Submit Claims To:
P.O. Box 981543
El Paso, TX 79998-1543

Questions?

If you have questions about how to get care in Mexico, please contact **Sinergia Medica** at + (011) (52) 55-5249-8383 and select "Option 1" when prompted.

For all other needs or for care inside the U.S., please call Aetna Member Service team using the number on your cobranded Member ID card.

Flexible Spending Account (FSA)

You can pay for eligible health care and dependent care expenses with pre-tax income through a Flexible Spending Account. You do not pay federal income tax on your deposit.

The Flexible Spending Account reimburses you for eligible health care expenses that are not covered by insurance. Expenses may be incurred by you, your spouse, and your dependent children, regardless of whether they are covered by the County's medical, dental or vision plans.

The Flexible Spending Account also reimburses you for certain dependent care expenses incurred while you and/or your spouse work.

How the Spending Accounts Work

You choose to contribute part of your earnings into the Medical Flexible Spending Account and/or the Dependent Care Flexible Spending Account. The accounts are maintained separately and you cannot make transfers between them. These accounts will reimburse you for eligible expenses that you submit throughout the year.

Health Care Flexible Spending Account

- √ Estimate your annual health care expenditures on items not reimbursed by insurance.
- √ Decide how much money you want to contribute to the account from $1 to $3,050 per year. The money is deducted before taxes, so taxes are withheld on a lower amount of your earnings.
- √ The County offers a debit card that allows eligible expenses to be deducted directly from your account.
- √ You may also file a paper or online claim when you have eligible health care expenses.
- √ The grace period allows you to incur expenses until December 15th, 2024. (75 days after plan year ends)
- √ The Rollout period allows you to submit claims for reimbursement until December 29th, 2024. (90 days window following end of plan year)

Dependent Care Flexible Spending Account

- √ Estimate your dependent care expenses for the coming year.
- √ Decide how much money you want to contribute to the account with a $5,000 maximum per year. The money is deducted before taxes are taken out, so taxes are withheld on a lower amount of your earnings (pre-tax basis).
- √ File a claim when you have eligible dependent care expenses.
- √ You will be reimbursed for eligible claims up to the current contributed amount available in your account.

Note: Dependent care deposits must be received and posted to your individual account before they can be used.

www.myameriflex.com I 888.868.3539

Calculating Flexible Spending Account Contributions

Medical Care Flexible Spending Account Worksheet

Enter your annual out-of-pocket expenses for each of the following. Do not include any amounts for medical, dental or vision care premiums.

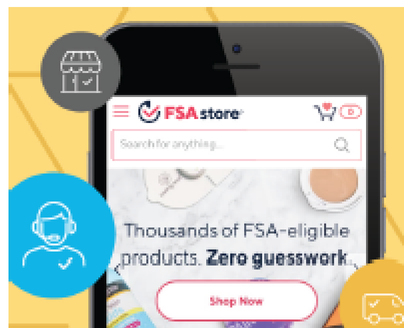
Health care $__________

Dental care $__________

Vision care $__________

Prescription drugs $__________

Total lines above $__________



• The largest selection of guaranteed eligible products
• Using pre-tax dollars lets you save on healthcare needs
• Use your FSA card, skip the paperwork
• 24/7 support and educational resources
• Free shipping on orders over $50

Visit **FSAstore.com/AMF19** and use coupon code **AMF19** for $5 off your first purchase.

FSA store

Copays, deductibles, and other payments you are responsible for under your health plan.

Routine exams, dental care, prescription drugs, eye care, and hearing aids.

Prescription glasses and sunglasses.

Certain over-the-counter (OTC) healthcare expenses such as Band-aids, medicine, First Aid supplies, etc. **Note:** OTC medicines require a doctor's prescription to be eligible.

Diabetic equipment and supplies, durable medical equipment, and qualified medical products or services provided by a doctor.

Dependent Care Flexible Spending Account Worksheet

Weekly day care costs $__________

Total lines above $__________

Number of weeks you will incur expenses **X**______

Multiply total by weeks $__________

(cannot exceed $5,100 married; $2,500 single)

Daycare

Summer day camp

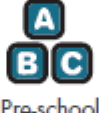
Custodial care for dependent adults

Nursery school

Before and after school programs

Private sitter

Nanny service



Pre-school

DELTA DENTAL

Keep smiling

Delta Dental PPO™

Stay in network to save

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

If you can't find a PPO dentist, consider a Delta Dental Premier® dentist. These dentists have agreed to set fees and offer another opportunity to save.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **deltadentalins.com**.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need to provide your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.[4] Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can receive significant savings on LASIK procedures and hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist

PPO

PREMIER

NON–DELTA DENTAL

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

[5] Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

West Virginia: Learn about our commitment to providing access to a quality dentist network at **deltadentalins.com/about/legal/index-enrollee.html**.

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HL_PPO-PRE #135419J (rev. 1/23)

Benefit Highlights: DPO from Delta Dental

Plan Benefit Highlights for: Cameron County
Group Number: 22541
Effective Date: 10/1/2023

Benefits	Delta Dental DPO dentists**	Delta Dental Premier dentists**	Non-Delta Dental dentists**
Deductibles per member / per family each calendar year	$50/ $150	$50/ $150	$50/ $150
Deductibles waived for Diagnostic & Preventive?	Yes, for all Dentists		
Deductibles waived for Orthodontics?	Yes, for all Dentists		
Maximums Per member each calendar year	$1,800	$1,800	$1,800
D&P counts toward maximum?	Yes, for all Dentists		

Covered Services*	Delta Dental DPO dentists**	Delta Dental Premier dentists**	Non-Delta Dental dentists**
Diagnostic & Preventive Services (D&P) Exams, Cleanings, X-Rays, Sealants and Space Maintainers	100%	100%	100%
Basic Services Fillings, Simple Extractions and Denture Repair/Reline/Rebase	80%	80%	80%
Endodontics Root Canals	80%	80%	80%
Periodontics Surgical and Non-Surgical Periodontics	80%	80%	80%
Oral Surgery	80%	80%	80%
Major Services Crowns, Inlays, Onlays and Cast Restorations	50%	50%	50%
Prosthodontics Bridges and Dentures	50%	50%	50%
Orthodontic Services Dependent Children	50%	50%	50%
Orthodontic Maximums	$1,500 Lifetime	$1,500 Lifetime	$1,500 Lifetime

For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on DPO contracted fees for DPO dentists, Premier contracted fees for Premier dentists and 80th percentile for non-Delta Dental dentists.

Delta Dental Insurance Company	Customer Service	Claims Address
1130 Sanctuary Parkway, Suite 600	800-521-2651	P.O. Box 1809
Alpharetta, GA 30009	deltadentalins.com	Alpharetta, GA 30023-1809

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

	Monthly Rates:	Semi-Monthly Rates:
Employee Only:	**$26.90**	**$13.45**
Employee + 1:	**$50.20**	**$25.10**
Employee + 2 or more:	**$75.92**	**$37.96**

VISION

Your vision health is an important part of complete wellness. Davis Vision is pleased to present to you vision benefits designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health. This plan encourages yearly exams along with the frames and lenses you want.

The plan will pay for a comprehensive exam, lenses and contact lenses once ever 12 months and will pay for frames once every 12 months. A single copay covers both frames and/or eyeglass lenses, or contact lenses instead of eyeglass frames and/or lenses. **Discounts are available on additional pairs of eyewear and contact lenses.**

Vision Plan Summary	Vision	
	In-Network	Out-of-Network (Reimbursement)
Exams	Covered in full after $10 copay	Up to $40 allowance
Lenses		
Single Bifocal Trifocal Lenticular	Covered	Up to $40 allowance Up to $60 allowance Up to $80 allowance Up to $100 allowance
Contact Lenses		
Medically-Necessary Elective*	Covered Up to $175 allowance + 15% off balance over allowance	Up to $225 allowance Up to $105 allowance
Frames*	Up to $175 allowance + 20% off balance over allowance	Up to $65 allowance
Laser Benefit**	$200 One-time/lifetime allowance	
Service Frequency		
Exams Lenses and Contact Lenses Frames	Once every 12 months Once every 12 months Once every 12 months	

* Contact lenses are in lieu of eyeglass lenses and frames benefit and frames are in lieu of contact lenses and contact lens benefit. Additional discounts not applicable at Walmart, Sam's Club, or Costco locations or where limited by law or manufacturer restrictions. Discounts are available on additional pairs of eyewear and contact lenses.

** Applicable both in- and out-of-network. Additional discounts apply in-network.

Vision Semi-Monthly	Vision
Employee	$4.29
Employee + 1	$6.44
Family	$8.57

Seeing the world in a whole new way!

Voluntary Benefits

LIFE & AD&D INSURANCE

VOLUNTARY LIFE AND AD&D INSURANCE

With Unum's Voluntary Life Insurance, Cameron County gives you the opportunity to buy valuable life insurance coverage for yourself, your spouse, and your dependent children — all at affordable group rates. You pay premiums on an after tax basis, so any insurance benefits paid are not taxable when your beneficiary receives them.

You must elect employee coverage to have Dependent Life Insurance.

If you are injured or die as a result of an accident, you or your beneficiary will receive a benefit based on the extent of the injury. AD&D pays benefits if death or dismemberment occurs as a result of and within 365 days following the covered accident. AD&D insurance pays benefits in addition to any other benefits you received under your life insurance coverage if you die as a result of an accident.

Employee	Spouse	Child
may elect up to 5 times annual salary in increments of $10,000 not to exceed $500,000	may elect up to 100% of employee amount in increments of $5,000 not to exceed $250,000	may elect up to 100% of employee amount in increments of $2,000 up to the amount of $10,000

Guaranteed Issue

Employee: $200,000	Spouse: $25,000	Child: $10,000

Note: Voluntary Life and AD&D reduces to 65% at age 70, and 50% at age 75.

If insured elected a minimum of $10,000 last year they may increase this year up to guaranteed issue without Evidence of Insurability (EOI). Insureds who elect over the guarantee issue this year on top of what they elected last year will be required to submit EOI. Late entrants, those who declined coverage during 10/1/2020 or as a new hire will be required to submit EOI for ANY amount of coverage.
No guarantee issue for late entrants.

Please speak to a licensed Benefits Counselor for personalized rates.

SHORT-TERM DISABILITY

Unum's Short-Term Disability Insurance is designed to maximize flexibility and simplicity. Non-occupational coverage will provide benefits to you when unable to work due to a covered illness or injury. You can receive payments for up to 24 weeks for as long as you remain disabled and would suffer monetarily as a result.

Benefit Amount:
60% of monthly salary, with a minimum of $25 per week up to a maximum of $1,000 per week

Elimination Period:
14 days following injury or illness

Benefit Duration:
24 weeks

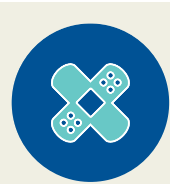
Pre-Existing Conditions:
3-month look back /
6-month waiting

You can use the money however you choose, be it for groceries, out-of-pocket expenses, or anything else. The cost is based on your age upon coverage and will not increase when moving into the next age bracket.

Note: Late entrants, those who declined coverage during 10/1/2020 or as a new hire will be required to submit EOI for ANY amount of coverage. No guarantee issue for late entrants.

Please speak to a licensed Benefits Counselor for personalized rates.

Cameron County



Accident Insurance

can pay you money for covered accidental injuries and their treatment.

How does it work?

Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur off the job. And it includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.

Who can get coverage?

You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

How much does it cost?

Your monthly premium	Option 1
You	$9.94
You and your spouse	$17.65
You and your children	$30.44
Family	$38.15

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 30 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 30 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/media/9486.

Accident Insurance – Schedule of Benefits

Accidental Death and Dismemberment

AD&D	
Employee	$50,000
Spouse	$25,000
Children	$12,500
Common Carrier Benefit can pay if the insured individual is injured as a fare-paying passenger on a common carrier (examples include mass transit trains, buses and planes)	
Employee	$50,000
Spouse	$25,000
Children	$12,500
Dismemberment	
Both Feet	$50,000
Both Hands	$50,000
One Foot	$25,000
One Hand	$25,000
Thumb and Index Finger of the same Hand	$12,500
Coma	
Coma	$10,000
Loss of Use	
Hearing	$25,000
Sight of one Eye	$25,000
Sight of both Eyes	$50,000
Speech	$25,000
Paralysis	
Uniplegia	$12,500
Hemi/Paraplegia	$25,000
Triplegia	$37,500
Quadriplegia	$50,000

Hospitalization

Admission	$1,500
Admission – Hospital ICU	$1,500
Daily Stay (amount)	$300
Daily Stay – Hospital ICU (amount)	$600
Short Stay	$200

Injury

Burns	
2nd Degree Burns - At least 5%, but less than 20% of skin surface	$750
2nd Degree Burns - 20% or greater of skin surface	$1,500
3rd Degree Burns - Less than 5% of skin surface	$3,000
3rd Degree Burns - At least 5%, but less than 20% of skin surface	$7,500
3rd Degree Burns - 20% or greater of skin surface	$15,000

Injury

Concussion	
Concussion	$200
Connective Tissue Damage	
One Connective Tissue (tendon, ligament, rotator cuff, muscle)	$90
Two or more Connective Tissues (tendon, ligament, rotator cuff, muscle)	$150
Dislocations	
Knee joint (other than patella)	$2,000
Ankle bone or bones of the foot (other than toes)	$2,000
Hip joint	$4,125
Collarbone (sternoclavicular)	$1,000
Elbow joint	$600
Hand (other than Fingers)	$600
Lower Jaw	$600
Shoulder	$600
Wrist joint	$600
Collarbone (acromioclavicular and separation)	$400
Finger or Toe (Digit)	$200
Kneecap (patella)	$600
Incomplete Dislocation - Payable as a % of the applicable Dislocations benefit	25%
Eye Injury	
Eye Injury	$200
Fractures	
Skull (except bones of Face or Nose), Depressed	$5,500
Hip or Thigh (femur)	$4,125
Skull (except bones of Face or Nose), Non-depressed	$2,750
Vertebrae, body of (other than Vertebral Processes)	$1,650
Leg (mid to upper tibia or fibula)	$1,650
Pelvis	$1,650
Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla)	$825
Upper Arm between Elbow and Shoulder (humerus)	$825
Upper Jaw, Maxilla (other than alveolar process)	$825
Ankle (lower tibia or fibula)	$550
Collarbone (clavicle, sternum) or Shoulder Blade (scapula)	$550
Foot or Heel (other than Toes)	$550

Injury

Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	$550
Kneecap (patella)	$550
Lower Jaw, Mandible (other than alveolar process)	$550
Vertebral Processes	$550
Rib	$550
Tailbone (coccyx), Sacrum	$550
Finger or Toe (Digit)	$275
Chip Fracture - Payable as a % of the applicable Fractures benefit	25%
Same bone maximum incurred per accident	1 Fracture
Maximum payable multiplier for multiple bones	2 Times
Internal Injuries	
Internal Injuries	$200
Lacerations	
No Repair	$65
Repair Less than 2 inches	$200
Repair At least 2 inches but less than 6 inches	$400
Repair 6 inches or greater	$800
Loss of a Digit	
One Digit (other than a Thumb or Big Toe)	$1,000
One Digit (a Thumb or Big Toe)	$1,500
Two or more Digits	$2,000
Knee Cartilage	
Knee Cartilage (Meniscus) Injury	$200
Ruptured or Herniated Disc	
One Disc	$180
Two or more Discs	$300

Recovery

Acquired Brain Injury	$25
At-Home Care	$100
Physician Follow-Up Visits	$75
Physician Follow-Up Maximum Visits	2 Visits
Prescription Drug	None
Prescription Benefit Incidence per covered accident	NA
Rehabilitation or Subacute Rehabilitation Unit	$100
Telehealth Service	$25
Telemedicine Medical Service	$25
Therapy Services (chiro, speech, PT, occ)	$25
Therapy Services Maximum Days	15 Days

Accident Insurance – Schedule of Benefits cont.

Surgery

Dislocations	
Dislocation, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Anesthesia	
Epidural or Regional Anesthesia	$100
General Anesthesia	$250
Connective Tissue	
Exploratory without Repair	$100
Repair for One Connective Tissue	$800
Repair for Two or more Connective Tissues	$1,200
Eye Surgery	
Eye Surgery, Requiring Anesthesia	$300
Fractures	
Fractures, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Surgical Repair same bone maximum incurred per accident	1 Fracture
Surgical Repair same bone maximum payable multiplier for multiple bones	2 Times
General Surgery	
Abdominal, Thoracic, or Cranial	$1,500
Exploratory	$150
Incidence per covered accident	1 Per Insured
Hernia Surgery	
Hernia Surgery	$150
Knee Cartilage	
Knee Cartilage (Meniscus) Exploratory without Repair	$150
Knee Cartilage (Meniscus) with Repair	$750
Outpatient Surgical Facility	
Outpatient Surgical Facility	$300
Ruptured or Herniated Disc Surgery	
Exploratory without Repair	$125
One Disc	$675
Two or more Discs	$1,000

Treatment

Ambulance	
Air	$1,500
Ground	$300
Durable Medical Equipment	
Tier 1 (arm sling, cane, medical ring cushion)	$75

Treatment

Tier 2 (bedside commode, cold therapy system, crutches)	$150
Tier 3 (back brace, body jacket, continuous passive movement, electric scooter)	$300
Emergency Dental Repair	
Dental Crown	$600
Dental Extraction	$200
Filling or Chip Repair	$150
Imaging	
Tier 1: X-rays or Ultrasound	$100
Tier 2: Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	$200
Medical Imaging Incidence allowance covered accident per Tier	1 Per Insured Per Tier
Lodging	
Lodging (per night)	$250
Prosthetic Device	
One Device or Limb	$1,250
Two or more Devices or Limbs	$2,500
Skin Grafts	
For Burns - Payable as a % of the applicable Burn benefit	50%
Not Burns - Less than 20% of skin surface	$500
Not Burns - 20% or greater of skin surface	$1,000
Treatment	
Emergency Room Treatment	$200
Injections to Prevent or Limit Infection (tetanus, rabies, antivenom, immune globulin)	$50
Pain Management Injections (epidural, cortisone, steroid)	$200
Transfusions	$600
Transportation (per trip)	$200
Treatment in a Physician's Office or Urgent Care Facility (initial)	$125

Better benefits at work.

Cameron County

Critical Illness Insurance

can pay money directly to you when you're diagnosed with certain serious illnesses.

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.
- You can use this coverage more than once.
  Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit pays 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

What's covered?

Critical illnesses	
• Heart attack • Stroke • Major organ failure • End-stage kidney failure	• Coronary artery disease Major (50%): Coronary artery bypass graft or valve replacement Minor (10%): Balloon angioplasty or stent placement

Cancer conditions	
• Invasive cancer — all breast cancer is considered invasive	• Non-invasive cancer (25%) • Skin cancer — $500

Progressive diseases	Supplemental conditions
• Amyotrophic Lateral Sclerosis (ALS) • Dementia, including Alzheimer's disease • Multiple Sclerosis (MS) • Parkinson's disease • Functional loss	• Loss of sight, hearing or speech • Benign brain tumor • Coma • Permanent Paralysis • Occupational HIV, Hepatitis B, C or D • Infectious Diseases (25%)

Why should I buy coverage now?

- It's more affordable when you buy it through your employer and the premiums are conveniently deducted from your paycheck.
- If you apply during your enrollment, you can get coverage without a health exam or medical questions.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

Who can get coverage?

You:	Choose $10,000, $20,000 or $30,000 of coverage with no medical questions if you apply during this enrollment.
Your spouse:	Spouses can get 100% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 30 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 30 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/media/9486.
Please refer to the certificate for complete definitions about these covered conditions. Coverage may vary by state. See exclusions and limitations.

Critical Illness Insurance benefit and cost

Monthly costs		
Age	Employee coverage: $10,000 Spouse coverage: $10,000	
	Employee	Spouse
under 25	$1.70	$1.70
25 - 29	$2.50	$2.50
30 - 34	$3.70	$3.70
35 - 39	$5.20	$5.20
40 - 44	$7.70	$7.70
45 - 49	$11.30	$11.30
50 - 54	$16.80	$16.80
55 - 59	$23.90	$23.90
60 - 64	$35.00	$35.00
65 - 69	$51.80	$51.80
70 - 74	$78.80	$78.80
75 - 79	$111.90	$111.90
80 - 84	$156.90	$156.90
85+	$248.70	$248.70

Monthly costs		
Age	Employee coverage: $20,000 Spouse coverage: $20,000	
	Employee	Spouse
under 25	$3.40	$3.40
25 - 29	$5.00	$5.00
30 - 34	$7.40	$7.40
35 - 39	$10.40	$10.40
40 - 44	$15.40	$15.40
45 - 49	$22.60	$22.60
50 - 54	$33.60	$33.60
55 - 59	$47.80	$47.80
60 - 64	$70.00	$70.00
65 - 69	$103.60	$103.60
70 - 74	$157.60	$157.60
75 - 79	$223.80	$223.80
80 - 84	$313.80	$313.80
85+	$497.40	$497.40

Monthly costs		
Age	Employee coverage: $30,000 Spouse coverage: $30,000	
	Employee	Spouse
under 25	$5.10	$5.10
25 - 29	$7.50	$7.50
30 - 34	$11.10	$11.10
35 - 39	$15.60	$15.60
40 - 44	$23.10	$23.10
45 - 49	$33.90	$33.90
50 - 54	$50.40	$50.40
55 - 59	$71.70	$71.70
60 - 64	$105.00	$105.00
65 - 69	$155.40	$155.40
70 - 74	$236.40	$236.40
75 - 79	$335.70	$335.70
80 - 84	$470.70	$470.70
85+	$746.10	$746.10

Your paycheck deduction will include the cost of coverage. Actual billed amounts may vary.

Pre-existing conditions

We will not pay benefits for a claim when the Covered Loss occurs in the first 12 months following an Insured's Coverage Effective Date and the Covered Loss is caused by, contributed to by or occurs as the the result of any of the following:

- a Pre-existing Condition; or
- complications arising from treatment or surgery for, or medications taken for, a Pre-existing Condition.

An Insured has a Pre-existing Condition if, within the 12 months just prior to their Coverage Effective Date, they have an injury or sickness, whether diagnosed or not, for which:

- medical treatment, consultation, care or services, or diagnostic measures were received or recommended to be received during that period;
- drugs or medications were taken, or prescribed to be taken during that period; or
- symptoms existed.

The Pre-existing Condition provision applies to any Insured's initial coverage and any increases in coverage. Coverage Effective Date refers to the date any initial coverage or increases in coverage become effective.

Pre-existing Condition requirements are not applicable to children who are newly acquired after your Coverage Effective Date.

Continuity of coverage

We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date. Coverage is subject to payment of premium and all other terms of the certificate. If an employee is on a temporary Layoff or Leave of Absence on the Policy Effective Date of this certificate, we will consider your temporary Layoff or Leave of Absence to have started on that date and coverage will continue for the period provided temporary Layoff or Leave of Absence under Continuation of your Coverage During Extended Absences in the certificate. If you have not returned to Active Employment before any Insured's Date of Diagnosis, any benefits payable will be limited to what would have been paid by the prior carrier.

If the Employer replaces a critical illness policy with this Policy, or the employee becomes insured due to a merger, acquisition or affiliation, and the prior carrier's pre-existing condition requirement has been satisfied, the Pre-existing Condition requirement under this coverage will not apply. However, if the Unum certificate provides a higher level of coverage at the time it becomes effective, its Pre-existing Condition requirement will apply to any increase in coverage. If the prior carrier's pre-existing condition requirement has not been satisfied, periods of coverage applicable to the prior carrier's Pre-existing Condition will count towards satisfying the Pre-existing Condition requirement under this coverage.

Date of diagnosis must be after the coverage effective date.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of any of the following:

committing or attempting to commit a felony; being engaged in an illegal occupation or activity; injuring oneself intentionally or attempting or committing suicide, whether sane or not; active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, injury as an innocent bystander, or injury for self-defense; participating in war or any act of war, whether declared or undeclared; combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations; voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; being intoxicated; and a Date of Diagnosis that occurs while an Insured is legally incarcerated in a penal or correctional institution.

Additionally, no benefits will be paid for a Date of Diagnosis that occurs prior to the Coverage Effective Date.

End of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the: date this policy is canceled by Unum or your employer; date you are no longer in an eligible group; date your eligible group is no longer covered; date of your death; last day of the period any required premium contributions are made; or last day you are in active employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage during Absences provision or if you elect to continue coverage for you, your Spouse, and Children under Portability of Critical Illness Insurance.

Unum will provide coverage for a payable claim that occurs while you are covered under this certificate.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and imitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GCIP16-1 or the Certificate Form GCIC16-1 or contact your Unum representative.

Underwritten by: Unum Insurance Company, Portland, Maine

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Hospital Indemnity

Covered Benefits

Please contact MetLife for detailed definitions and state variations of covered benefits.

Hospital Benefits				
Subcategory	**Benefit Limits (Applies to Subcategory)**	**Benefit**	**Low Plan**	**High Plan**
Admission Benefit	4 time(s) per calendar year[1]	Admission	$1,000	$2,000
		ICU Supplemental Admission (Benefit paid concurrently with the Admission benefit when a Covered Person is admitted to ICU)	$1,000	$2,000
Confinement Benefit	15 days per calendar year ICU Supplemental Confinement will pay an additional benefit for 15 of those days	Confinement[4]	$200	$300
		ICU Supplemental Confinement (Benefit paid concurrently with the Confinement benefit when a Covered Person is admitted to ICU)	$200	$300
Confinement Benefit for Newborn Nursery Care	2 day(s) per confinement	Confinement Benefit for Newborn Nursery Care[5]	$50	$75

[1] If a covered person is readmitted within 90 days for the same or related sickness/injury for which we paid an Admission Benefit, an additional Admission Benefit is not payable.
[4] If the Admission Benefit is payable for a Confinement, the Confinement Benefit will begin to be payable the day after Admission.
[5] Payable for the period of newborn confinement for a newborn child who is not sick or injured.

Please contact MetLife for detailed definitions and state variations of covered benefits.

Proposed Rates – Low Plan

Type	Monthly (12)
Employee Only	$19.16
Employee + Spouse	$41.94
Employee + Children	$31.09
Employee + Spouse and Children	$53.87

Proposed Rates – HighPlan

Type	Monthly (12)
Employee Only	$35.33
Employee + Spouse	$77.35
Employee + Children	$57.30
Employee + Spouse and Children	$99.31

Note: Final implemented rates may vary slightly due to rounding.

Healthcare Navigation Services	
Healthcare Navigation Services – added at no additional cost to you or your employees	As an added benefit your employees will have access to education and support from personal consultants with healthcare expertise, including the following: decision support related to health care services and benefits; assistance with understanding health benefits; concierge services to coordinate care, assess costs of care, find doctors and facilitate appointments; and medical claim/bill review and correction. The services also include access to self-service decision support tools via a web portal that can be used to assess costs of care and find doctors.

MetLife Advantages[SM]	
MetLife Advantages[SM] – Services or Discounts added at no additional cost to you or your employees	**Will Preparation Services[1]** As an added benefit your employees will have access to MetLife's online will preparation services provided by SmartLegalForms to create a binding will, living will or assign a power of attorney. **MetLife VisionAccess[2]** As an added benefit your employees will have access to the MetLife VisionAccess discount program. The program provides a discount on eye exams, glasses and frames, and laser vision correction when visiting a participating private practice.

MetLife Advantages[SM] Disclaimers

MetLife Advantages[SM] availability may vary by state.

[1]WillsCenter.com is a document service provided by SmartLegalForms, Inc., an affiliate of Epoq Group, Ltd. SmartLegalForms, Inc. and is not affiliated with MetLife. The WillsCenter.com service is separate and apart from any insurance or service provided by MetLife. The WillsCenter.com service does not provide access to an attorney, does not provide legal advice, and may not be suitable for your specific needs. Please consult with your financial, legal, and tax advisors for advice with respect to such matters. WillsCenter.com is available to anyone regardless of affiliation with Metlife.

[2]MetLife Vision Access is a discount program and not an insured benefit. It is provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with MetLife or its affiliates. MetLife Vision Access is available to anyone regardless of affiliation with MetLife.

Employee Assistance Program

The Deer Oaks Employee Assistance Program (EAP) is a free service provided for you, your dependents, and household members by your employer. This program offers a wide variety of counseling, referral, and consultation services, which are all designed to assist you and your family in resolving work and life issues in order to live happier, healthier, more balanced lives. From stress, addiction, and change management, to locating child care facilities, legal assistance, and financial challenges, our qualified professionals are here to help. These services are completely confidential and can be easily accessed 24/7, offering you around-the-clock assistance for all of life's challenges.

- Program Access: You may access the EAP by calling the toll-free Helpline number, using our iConnectYou App, or instant messaging with a work-life consultant through our online instant messaging system.
- Telephonic Assessments & Support: In-the-moment telephonic support and crisis intervention are available 24/7 along with intake and clinical assessments.
- Short-term Counseling: Counseling sessions with a qualified counselor to assist with issues such as stress, anxiety, grief, marital/family challenges, relationship issues, addiction, etc. Counseling is available via structured telephonic sessions, video, and in-person at local provider offices.
- Referrals & Community Resources: Our team provides referrals to local community resources, member health plans, support groups, legal resources, and child/elder care/daily living resources.
- Advantage Legal Assist: Free 30 minute telephonic or in-person consultation with a plan attorney; 25% discount on hourly attorney fees if representation is required; unlimited online access to a wealth of educational legal resources, links, tools and forms; and interactive online Simple Will preparation.
- Advantage Financial Assist: Unlimited telephonic consultation with an Accredited Financial Counselor qualified to advise on a range of financial issues such as bankruptcy prevention, debt reduction, financial planning, and identity theft; supporting educational materials available; unlimited online access to a wealth of educational financial resources, links, tools and forms (i.e. tax guides, financial calculators, etc.).
- Alternate Modes of Support: Your EAP offers support alternatives in addition to traditional short-term counseling including telephonic life coaching, AWARE stress reduction sessions, and virtual group counseling. During your call with one of our counselors, ask if these programs would be right for you.
- Work-life Services: Our work-life consultants are available to assist you with a wide range of daily living resources such as locating pet sitters, event planners, home repair, tutors, travel planning, and moving services. Simply call the Helpline for resource and referral information.
- Child & Elder Care Referrals: Our child and elder care specialists can help you with your search for licensed child and elder care facilities in your area. They will discuss your needs, provide guidance, resources, and qualified referral packets. Searchable databases and other resources are also available on the Deer Oaks member website.
- Take the High Road Ride Reimbursement Program: Deer Oaks reimburses members for their cab, Lyft and Uber fares in the event that they are incapacitated due to impairment by a substance or extreme emotional condition. This service is available once per year per participant, with a maximum reimbursement of $45.00 (excludes tips).

Contact Us:
Toll-Free: (866) 327-2400

Website: www.deeroakseap.com
Email: eap@deeroaks.com

HEALTH INSURANCE TERMS

- **Benefits -** The amount of money payable by an insurance company to a claimant under the insurance policy.
- **Claim -** A request by an individual (or his /her provider) for the insurance company to pay for services obtained.
- **Co-insurance -** The money that an individual is required to pay for services, after deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20% of the charges while the health plan pays 80%.
- **Co-payment -** An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered.
- **Deductible -** A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual or contract year basis.
- **Exclusions and Limitations -** Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).
- **Health Savings Account (HSA) -** An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **Flexible Spending Account (FSA) -** An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **High Deductible Health Plan (HDHP) -** A health plan that meets the requirements of being considered an HDHP. There are NO copayments on an HDHP. All medical and prescription drug expenses are applied towards the calendar year deductible first, then once a member has satisfied his/her deductible, the coinsurance will apply.
- **In-Network -** Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.
- **Medically Necessary -** A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.
- **Out-of-Network -** Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.
- **Maximum Out-of-Pocket Maximum -** The total amount paid each year by the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that calendar year.
- **Pre-Existing Condition -** Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.
- **Preferred Provider Organizations (PPO) -** A type of managed care plan in which doctors and hospitals agree to provide discounted rates to plan members. Patients are typically reimbursed 80-100% for treatment received withing the network, versus 50-70% outside the network.
- **Primary Care Physician (PCP) -** A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP services as a gatekeeper for an individual's care, referring him or her to specialists and admitting him or her to hospitals when needed.
- **Reasonable and Customary Charges -** The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.
- **Explanation of Benefits (EOB)-** A summary of claims processed which will be provided to you after a claim is processed for you or for a dependent. This statement outlines year-to-date deductible and out-of-pocket amounts met during the year. This statement will be mailed unless it is turned off on the website.

LEGAL NOTICES

HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan — whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan), sponsored by **Cameron County** hereinafter referred to as the plan sponsor.

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duty and privacy practices with respect to your health information.

It is important to note that these rules apply to the Plan, not the plan sponsor as an employer.

You have the right to inspect and copy pr.8otected health information which 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 the Human Resource Department 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 the Human Resources Department.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, please contact the Plan Administrator.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your

dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility **– Texas - Medicaid**

Website: https://www.gethipptexas.com

Phone: 800.440.0493

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Refer to the medical insurance section of this guide to find the deductible and coinsurance that apply to you. If you would like more information on WHCRA benefits, call the toll free phone number on your medical id card.

NEWBORNS' ACT

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

SPECIAL ENROLLMENT RIGHTS

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

Loss of Other Coverage

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

However, you must enroll within 30 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

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

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 30 days after the marriage, birth, or placement for adoption.

To request special enrollment or obtain more information, contact your plan administrator.

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. **Cameron County** has determined that the prescription drug coverage offered by **Cameron County** medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

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

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

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

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

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans Visit www.medicare.gov, call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help, or call 800.633.4222. TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 800.772.1213. TTY users should call 800.325.0778.

Date: October 1, 2022
Name of Entity/Sender: Cameron County
Contact Office: Human Services Dept.
Address: Dancy Building, Civil Service Coordinator, 1100 E. Monroe St. #118
Phone Number: (956) 544-0827

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, 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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any 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.[1]

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 Jessica Olivares
.

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.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. 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.

3. Employer name Cameron County		4. Employer Identification Number (EIN) 74-6000420
5. Employer address Dancy Building, 1100 E. Monroe St. #118		6. Employer phone number (956) 544-0827
7. City Brownsville	8. State TX	9. ZIP code 78520
10. Who can we contact about employee health coverage at this job? Jessica Olivares		
11. Phone number (if different from above)	12. Email address jessica.olivares@co.cameron.tx.us	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:

    X

    Full-time employees who work a minimum of 30 hours per week and are at least age 18 are eligible to participate in the benefits program, with an effective date of the first of the month following a 30-day waiting period.
  - ☐ Some employees. Eligible employees are:

    X

    - Legal spouse, domestic partnership, common law
    - Your eligible children up to age 26 for medical, dental and vision coverage.
    - "Children" are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
    - Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:

    X
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

CONTACTS

For any questions or concerns you may have regarding your **2023-2024** Benefits you can contact the following:

MEDICAL
Aetna - P# 143726
(855) 824-5361
www.aetna.com

FSA
Ameriflex
(888) 868-3539
www.myameriflex.com

DENTAL
DELTA (Ortegon) -Group #22541
(800) 521-2651
956) 373-1109 (Ortegon)
www.deltadentalins.com
yvonne@ortegonagency.com

VISION
Davis Vision - P# 505072
(800) 523-2847
www.davisvision.com

VOLUNTARY
Voluntary Life and AD&D
Short Term Disability
Accident
Critical Illness
Unum
To file a claim call (855) 756-8719
www.unum.com
elizabeth.juarez@gefinsurance.com

HOSPITAL BENEFITS
MetLife
(800) GET-MET8
www.metlife.com

MEDICAL - Prescription
CVS Caremark
(888) 792-3862
www.aetna.com

EAP
Deer Oaks
(866) 327-2400
www.deeroakseap.com

BENEFITS SERVICE CENTER:
(956)550-0028

2023-2024
EMPLOYEE BENEFIT GUIDE

NOTES