2020 - 2021 Employee Benefits Guide

EFFECTIVE 10.1.2020 — 9.30.2021

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Welcome

Cameron County is proud to provide you and your family with valuable and significant benefits. This Employee Benefits Guide was designed with you and your family in mind. This valuable reference guide, is an overview of the services and benefits available to you as an employee of the Cameron County. Please take the time to carefully review the guide for any changes or updates. Inside you will find the information you need to make informed decisions regarding the selection and continued management of your benefits for the 2020 - 2021 Plan Year.

The information in this enrollment guide is intended to help you enroll in your 2020 - 2021 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern. Cameron County reserves the right to change or terminate benefits at any time. Neither the benefits, nor this enrollment guide, should be interpreted as a guarantee of future benefits.

Important Contacts

Human Resources Department 956-544-0827 1100 E. Monroe St. Suite 118, Brownsville, TX 78520			
Coverage	**Company**	**Phone Number**	**Website**
Medical Plan	Aetna	855.824.5361	www.aetna.com
Rx Plan	CVS Caremark	888.792.3862	www.aetna.com
Dental Plan	Aetna (Ortegon)	877.238.6200 (Aetna) 956.373.1109 (Ortegon)	www.aetna.com yvonne@ortegonagency.com
Voluntary Life / AD&D, Short Term Disability / Accident & Critical Illness	UNUM (GEF)	855.756.8719 (UNUM) 956.943.9131 (GEF)	www.unum.com elizabeth.juarez@gefinsurance.com
EAP	Deer Oaks	866.327.2400	www.deeroakseap.com
Flexible Spending Account	Ameriflex	888.868.3539	www.myameriflex.com
Vision Plan	Davis Vision	800.523.2847	www.davisvision.com
Enrollment Call Center	PEC M-F: 8a.m. - 7p.m. Sat: 9a.m. - 3p.m.	855.756.8719	-

Glossary

Allowed Fees
Term used by some dental plans for their participating dentist fees and/or maximum payable for a non-participating dentist.

Annual Deductible
The amount you must pay for covered health services based on contracted rates (also referred to as eligible charges/expenses) in a year before the plan will begin paying certain benefits in that year. Medical and Dental deductible runs from January through December.

COBRA
Consolidated Omnibus Budget Reconciliation Act of 1985. This Act requires that continuation of group insurance be offered to covered persons who lose health, dental or vision coverage due to a qualifying life event as defined in the Act.

Co-insurance
The portion of covered health care costs for which the covered person is financially responsible, usually according to a fixed percentage. Co-insurance may be applied after a deductible requirement is met.

Copay
The charge you are required to pay for certain covered health services, such as a prescription or office visit.

Eligibility
Eligibility for benefits is the first of the month following regular fulltime employment.

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.

Incurred Expense
An expense is considered incurred on the date services were rendered or supplies were received.

Initial Enrollment Period
The first of the month following 30 days of fulltime employment or 30 days from a covered life event.

In-Network
In-network providers are doctors, hospitals and other providers that contract with your insurance company to provide health care services at discounted rates.

Out-of-Network
Out-of-network providers are doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.

Out-of-Pocket Maximum
The maximum amount of co-insurance you pay every year. Once you reach the out-of-pocket maximum, as an individual or family, benefits for those covered health services that apply to the out-of-pocket maximum are paid at a percent of eligible charges during the rest of that year. Deductibles and copays apply to the out-of-pocket maximum.

Plan Year
October 1, 2020 through September 30, 2021.

Getting Started

FAQs

When does coverage begin? The elections you make during Open Enrollment are effective October 1, 2020 - September 30, 2021.

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.

IMPORTANT
Once your benefits have been selected, please review, as your selected benefits will be effective until the next plan year begins, unless you have a qualifying life event.

In the case of a qualifying event allowing you to add or delete dependents from your coverage, that includes current coverage only. Changing plan types is not allowed under the Plan.

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.
- Avoid making quick decisions — **enroll early!**

Qualifying Life Events

Due to IRS regulations, once you have made your choices for the 2020/2021 Plan Year, you won't be able change your benefits until the next enrollment period unless you experience a Qualifying Life Event.

When one of the following events occurs, you have **30 days** from the date of the event to request changes to your Medical, Dental, Vision, Supplemental Life, Dependent Life or Voluntary Accidental Death and Dismemberment plans, or the Health Care and Dependent Care Spending Accounts only:

- Change in your legal marital status (marriage, divorce, annulment, legal separation or death).
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent) or your dependent becomes eligible or loses eligibility for coverage due to age.
- Change in your dependent or spouse's employment status or your spouse's employer offers benefit plans with a different plan year that affects your coverage.
- Change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of coverage.
- You or your eligible dependent take or return from an unpaid leave of absence that affects coverage.
- Entitlement to Medicare or Medicaid (or loss of).
- Change in your address or location that may affect the coverage for which you are eligible.

They are referred to as life changes, qualifying events, family status changes, IRS changes. Regardless of the terminology, your new election must be consistent with your status change. Consistent means the change must result in the gain or loss of coverage by you, your spouse, or any of your dependents and the new election must reflect that gain or loss. An employee with current coverage may add or delete dependents to or from that coverage.

TIP: Having existing family coverage DOES NOT enroll the new dependent

In the case of a qualifying event allowing you to add or delete dependents from your coverage, that includes current coverage only. Changing plan types is not allowed under the Plan.

Eligibility

If you are a full-time employee regularly scheduled to work 30 hours or more a week, you are eligible to enroll in the benefit plans described in this Employee Benefit Guide. You are required to enroll no later than 30 days after your first day of regular, full-time work with the County. ***If enrollment is not completed within this time period, you will have no coverage for the remainder of the plan year for the following voluntary plans:***

- Medical Plan
- Dental Plan
- Vision Plan
- FSA-health account
- FSA-dependent care account
- Supplemental Life Insurance Plan
- Accident Plan
- Short Term Disability Plan
- Critical Illness Plan

Eligible Dependents

Dependents eligible for coverage include:

- Your legal spouse. Keep reading for specific restrictions on eligibility requirements for employed spouse.
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26.

Dependent children are eligible for insurance until age 26. Please keep in mind you may be required to furnish evidence of dependency at any time, as requested, on anyone listed as eligible for coverage, and eligibility audits may be conducted by the audit companies.

Medical Benefits

Aetna
Open Access Aetna Select

	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE		
Individual	$750	$1,500
Family	$2,250	$4,500
Coinsurance (You Pay)	20%	40%
ANNUAL OUT-OF-POCKET MAXIMUM (Includes Calendar Year Deductible)		
Individual	$3,500	$7,000
Family	$7,500	$15,000
OFFICE VISITS		
Physician Office	$10 copay—Valley Baptist PCP $35 copay - In-Network PCP	40% after deductible
Specialist Office	$45 copay	40% after deductible
Virtual Visits	$10 copay	40% after deductible
Airrosti	$35 copay	40% after deductible
HOSPITAL CHARGES		
Inpatient & Outpatient	20% after deductible	40% after deductible
Emergency Room	Facility: $300 copay + 20% MD: 20% after deductible	Facility: $300 copay + 20%
Urgent Care	$75 copay	40% after deductible
MENTAL/NERVOUS		
Inpatient	20% after deductible	40% after deductible
Outpatient	PCP $35 / Specialist $45 copay	40% after deductible
PRESCRIPTION DRUGS*		
Retail (30 day supply)		
Generic	$15 copay	Not Covered
Brand Formulary	$40 copay	
Brand Non-Formulary	$60 copay	
Specialty Formulary	$80 copay	
Mail Order (90 day supply)	Mail Service Pharmacy or CVS Retail Pharmacy (31-90 day supply)	
Generic	$30 copay	N/A
Brand Formulary	$80 copay	
Brand Non-Formulary	$120 copay	

Deductible and copays will apply to the out of pocket maximum.
*If the drug cost is lower than the copay, the member pays the lower cost
Note: Please refer to Summary Plan Description for a full outline of your medical coverage.

Medical Premiums

AETNA

	Actual Cost of Insurance	County Monthly Contribution ($)	Employee Monthly Premiums ($)	Employee Semi-Monthly Contribution ($)
CONTRIBUTIONS				
Employee Only	$600.00	$600.00	$0.00	$0.00
Employee +Spouse	$768.75	$600.00	$168.75	$84.38
Employee + Child	$693.75	$600.00	$93.75	$46.88
Employee + Child(ren)	$725.00	$600.00	$125.00	$62.50
Employee + Family	$850.00	$600.00	$250.00	$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

Need to locate a network physician or hospital?

Log on to www.aetna.com or call customer service at 1-855-824-5361

Making healthy simpler
Your member website

Clean, simple screen

Easy claims walk-through

Money-saving tools

Fitness and wellness perks

Visit **aetna.com** and log in to your member website.

Health management at your fingertips

We know you're busy and that you live life on the go. That's why the Aetna Mobile app makes it easy for you to manage your health wherever, whenever you need to.

aetna®

aetna.com

Your pharmacy plan
An easy way to manage your prescriptions

Getting started is easy

Step 1:
Join us

- Review your plan materials to see covered medicines and costs.
- Sign up during the open enrollment period.
- Register for your member account at **aetna.com**.

Step 2:
Sign in at aetna.com

- Find a pharmacy.
- Find out your costs.
- Order medicines.
- Learn more about your plan.

Step 3:
Make the most of your plan

- Use pharmacies in our network.
- Compare costs with the plan tools.
- Ask your doctor about lower-price options.

Have any questions? Just call us at the number on your member ID card.

Managing your medicines

Here's what your plan includes:

- Coverage for most medicines
- The convenience of home delivery
- Personal support for specialty medicine needs
- Your personal member website with tools to help you find what you need fast
- A pharmacy help line you can call 24/7 if you have questions

How to find out if your medicines are covered and what they'll cost

Before you enroll:
In your plan materials, you can see what medicines are covered and how much they'll cost. Or you can visit **aetna.com/formulary** and choose your plan name. You'll find covered medicines, along with alternatives that cost less. Don't see it, or need your plan name? Just ask your employer.

After you enroll:
Visit **aetna.com** to register and sign in to your member website. There, you can estimate your costs. And also compare what you'd pay through your local pharmacies versus home delivery.

What is preauthorization?

Some medicines your doctor prescribes may need preauthorization. This means they may need approval before they can be covered. Or we may ask your doctor to prescribe a lower-cost version. If needed, you or your doctor can always ask for an exception.

Where can I get my medicines?

Retail pharmacy — occasional prescriptions
For medicines like antibiotics that you take short term, you can visit any retail pharmacy — whether you're at home or on the go. For your best price, choose a network pharmacy on **aetna.com**.

Home delivery pharmacy — long-term prescriptions
You can use this service for medicines you need to take for conditions like high blood pressure or diabetes. Your medicines are mailed to you quickly and safely at no extra charge. And you may get up to a 90-day supply.

Specialty pharmacy — long-term special medicines
Some long-term health conditions, like multiple sclerosis or cancer, require special medicines. They often need special storage and handling. That's when you'd use a **specialty pharmacy**. With Aetna Specialty Pharmacy® medicine and support services,* your medicines are packed securely, so they arrive safe. And we can help you learn how to use them and how to manage side effects.

made available through
aetna™

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.

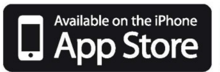
ER or urgent care:
Pay high ER and urgent care fees.

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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Medical Benefits

WHERE TO GO GUIDE

The cost for care and time you wait can vary greatly depending on where you go. Below is a simple guide to choosing the right place to go for health care. In addition to clinical settings, you have access to virtual visits.

	Conditions Treated*	Your Cost & Time
Emergency Room		
For the immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room. Open 24/7.	▪ Sudden numbness, weakness ▪ Uncontrolled bleeding ▪ Seizure or loss of consciousness ▪ Shortness of breath ▪ Chest pain ▪ Head injury/major trauma ▪ Blurry or loss of vision ▪ Severe cuts or burns ▪ Overdose	▪ Costs are highest ▪ No appointment needed ▪ Wait times may be long, averaging over 4 hours
Urgent Care Center		
For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	▪ Minor cuts, sprains, burns, rashes ▪ Fever and flu symptoms ▪ Headaches ▪ Chronic lower back pain ▪ Joint pain ▪ Minor respiratory symptoms ▪ Urinary tract infections	▪ Costs are lower than an ER visit ▪ No appointment needed ▪ Wait times vary
Doctor's Office		
The best place to receive routine or preventive care, track medications.	▪ General health issues ▪ Preventive services ▪ Routine checkups ▪ Immunizations and screenings	▪ May include coinsurance and / or deductible ▪ Appointment usually needed ▪ May have little wait time
Convenience Care Clinic		
Staffed by nurse practitioners and physician assistants. Treat minor medical concerns that are not life threatening. Located in retail stores and pharmacies, they're often open nights and weekends.	▪ Common cold/flu ▪ Rashes or skin conditions ▪ Sore throat, earache, sinus pain ▪ Minor cuts or burns ▪ Pregnancy testing ▪ Vaccinations	▪ Costs are same or lower than office visit ▪ No appointment needed ▪ Wait times typically 15 minutes or less
Virtual Medicine		
Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or smartphone mobile app.	▪ Cold and flu symptoms such as a cough, fever and headaches ▪ Allergies ▪ Sinus infections ▪ Family health questions	▪ Cost is $10 ▪ No appointment needed ▪ Immediate, private, and secure visits

Cost & Time: GREATER (Emergency Room) → LOWER (Virtual Medicine)

*List is not all inclusive. To find a specific health care facility or doctor, go to your medical carrier's website or call the number on your ID card. The listing of a health care professional or facility in the online directory does not guarantee that the services rendered by that professional or facility are covered under your specific medical plan. Check your official plan document for information about the services covered under your plan benefits. The information provided here is for informational purposes only. During a medical emergency, you should always visit the nearest hospital or call 911 for assistance.

Dental Benefits

	Monthly Cost	Semi-Monthly Cost
Employee Only	$20.11	$10.06
Employee +1	$37.54	$18.77
Employee + 2 or more	$56.77	$28.40

Waiting Periods

Basic Services: None
Major Services: None
Orthodontics: None

Get the Aetna Health app

Get the Aetna Health app by texting “GETAPP” to **90156** for a link to download the app and create an account. Message and data rates may apply.*

	Aetna Texas Dental PPO (PDN) Network
ANNUAL DEDUCTIBLE	
Individual	$50
Family	$150
Per Person	$1,500
Diagnostic & Preventive Services	100% of Aetna’s allowed (UCR) amount Deductible is waived
Basic Services	80% of Aetna’s allowed (UCR) amount*
Major Services	50% of Aetna’s allowed (UCR) amount*
Orthodontia Covers child(ren) up to age 19	50% of Aetna’s allowed amount Deductible does not apply
Orthodontia Lifetime Maximum	$1,500

***After Deductible**

Note: Please refer to Certificate of Coverage for a full outline of your dental coverage.

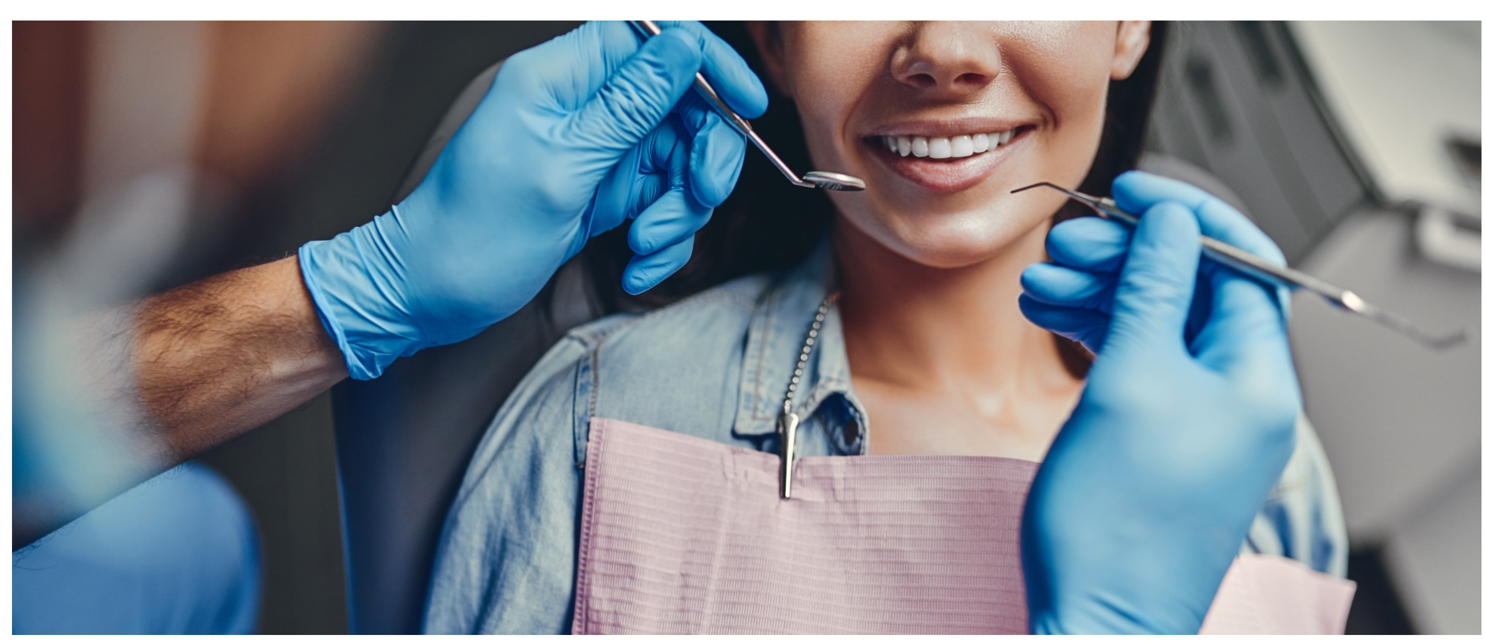
√ **Dental PPO (PDN) Network**

√ **Free to visit dentist of your choice**

√ **Must meet a deductible - $50**

√ **Maximum Annual Benefit - $1,500**

√ **Includes Orthodontic Benefits**



Vision Benefits

Vision coverage is provided through Davis Vision. The plan pays benefits for annual exams and corrective lenses. You pay a copayment for exams, and the plan pays benefits for frames and lenses up to certain limits. Under this plan, you may use in-network or out-of-network vision care providers, but you will receive greater benefits when you use in network providers.

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.**

	In-Network	Out-of-Network
COPAY		
Comprehensive Eye (Optometrist & Ophthalmologist)	Covered in full after $10 copay*	$40 Allowance
LENSES		
Single Vision	After $25 copay	$40 Allowance
Bifocal	After $25 copay	$60 Allowance
Trifocal	After $25 copay	$80 Allowance
Lenticular	After $25 copay	$100 Allowance
FRAMES**		
Standard***	Up to $130 Allowance + 20% off balance over allowance ($180 allowance plus 20% off balance toward any frame from VisionWorks store locations)	$65 Allowance
CONTACTS**		
Cosmetic (elective)***	Up to $130 Allowance + 15% off balance over allowance	$105 Allowance
Medically Necessary	Covered in full with prior approval	$225 Allowance

*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.
***Contact lenses are in lieu of eyeglass lenses and frames benefit and frames are in lieu of contact lenses and contact lens benefit.
Note: Please refer to Certificate of Coverage for a full outline of your vision coverage.

	Cost per Month	Cost Semi-Monthly
Employee Only	**$7.47**	**$3.74**
Employee + 1	**$11.22**	**$5.61**
Employee + Family	**$14.93**	**$7.47**

Income Protection

Voluntary Life Insurance

All full time employees may elect Supplemental Life coverage in $10,000 increments up to but not more than the lesser of five times annual salary or $500,000. You pay premiums on an after tax basis, so any insurance benefits paid are not taxable when your beneficiary receives them.

If you are a new hire, you can elect voluntary life up to $200,000 without answering a health questionnaire. If you are a new hire that elects more than $200,000 or a late entrant, you will need to answer a health questionnaire. At future enrollments, you can increase your coverage with no medical questions or health exams, up to the guaranteed issue amount of $200,000.

Dependent Life Insurance

This coverage will pay benefits to you in the event your covered spouse or children die.

You may elect coverage for your spouse with a minimum coverage amount of $5,000, up to 100 percent of your Employee Supplemental coverage, but no more than $250,000. If you are a new hire, you can elect voluntary spouse life up to $25,000 without answering a health questionnaire.

You may also elect up to $10,000 in $2,000 increments for each child. If you elect coverage for your children, all of your eligible children are covered from birth to age 26. You pay the same premium amount regardless of the number of children.

Accidental Death & Dismemberment (AD&D)

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.

You may choose this additional coverage for yourself at the same time you purchase your voluntary life policy. You can elect in $10,000 increments, up to $500,000. Premiums are paid on an after tax basis, so any insurance benefits paid are not taxable when your beneficiary receives them.

Rates on page 15.

You must elect employee coverage to have Dependent Life Insurance. Increases in your voluntary life insurance policy or first time coverage will require a health questionnaire and underwriting approval.

Voluntary Short Term Disability

Eligibility: All active employees working 30+ hours per week

Benefit Amount: 60% of your monthly earnings, to max of $1,000 per week

Elimination Period: 14 days

Duration: 24 weeks

Pre-Existing Condition: 3/6

Use the disability worksheet provided below to calculate your premium for voluntary short-term disability coverage.

Disability worksheet

1 Calculate your weekly disability benefit.

$________ ÷ 52 =	$________ x	60% =	$__________
Your annual earnings	Your weekly earnings	(Max % of income covered)	Max weekly benefit available (if the amount exceeds the plan max of $1,000, enter $1,000.

2 Calculate your cost per paycheck.

$________ ÷ 10 =	$________ x	$0.705 =	$________ x 12 =	$_______ ÷	24 =	$__________
Your weekly benefit amount		Your rate	Your monthly cost	Your annual cost	Number of paychecks per year	Your cost per paycheck

Voluntary Life and AD&D Premiums

Employee - 24 payroll deductions per year

Age Band	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$100,000	$130,000	$150,000
0-29	$0.275	$0.550	$0.825	$1.100	$1.375	$1.650	$2.750	$3.575	$4.125
30-34	$0.325	$0.650	$0.975	$1.300	$1.625	$1.950	$3.250	$4.225	$4.875
35-39	$0.375	$0.750	$1.125	$1.500	$1.875	$2.250	$3.750	$4.875	$5.625
40-44	$0.590	$1.180	$1.770	$2.360	$2.950	$3.540	$5.900	$7.670	$8.850
45-49	$1.045	$2.090	$3.135	$4.180	$5.225	$6.270	$10.450	$13.585	$15.675
50-54	$1.675	$3.350	$5.025	$6.700	$8.375	$10.050	$16.750	$21.775	$25.125
55-59	$2.650	$5.300	$7.950	$10.600	$13.250	$15.900	$26.500	$34.450	$39.750
60-64	$4.150	$8.300	$12.450	$16.600	$20.750	$24.900	$41.500	$53.950	$62.250
65-69	$7.400	$14.800	$22.200	$29.600	$37.000	$44.400	$74.000	$96.200	$111.000
70-74	$13.250	$26.500	$39.750	$53.000	$66.250	$79.50	$132.500	$172.250	$198.750
75+	$21.850	$43.700	$65.550	$87.400	$109.250	$131.100	$218.500	$284.050	$327.750
AD&D	$0.165	$0.330	$0.495	$0.660	$0.825	$0.990	$1.650	$2.145	$2.475

Spouse - 24 payroll deductions per year

Age Band*	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$50,000	$55,000	$60,000
0-29	$0.138	$0.275	$0.413	$0.550	$0.688	$0.825	$1.375	$1.513	$1.650
30-34	$0.163	$0.325	$0.488	$0.650	$0.813	$0.975	$1.625	$1.788	$1.950
35-39	$0.188	$0.375	$0.563	$0.750	$0.938	$1.125	$1.875	$2.063	$2.250
40-44	$0.295	$0.590	$0.885	$1.180	$1.475	$1.770	$2.950	$3.245	$3.540
45-49	$0.523	$1.045	$1.568	$2.090	$2.613	$3.135	$5.225	$5.748	$6.270
50-54	$0.838	$1.675	$2.513	$3.350	$4.188	$5.025	$8.375	$9.213	$10.050
55-59	$1.325	$2.650	$3.975	$5.300	$6.625	$7.950	$13.250	$14.575	$15.900
60-64	$2.075	$4.150	$6.225	$8.300	$10.375	$12.450	$20.750	$22.825	$24.900
65-69	$3.700	$7.400	$11.100	$14.800	$18.500	$22.200	$37.000	$40.700	$44.400
70-74	$6.625	$13.250	$19.875	$26.500	$33.125	$39.750	$66.250	$72.875	$79.500
75+	$10.925	$21.850	$32.775	$43.700	$54.625	$65.550	$109.250	$120.175	$131.100
AD&D	$0.083	$0.165	$0.248	$0.330	$0.413	$0.495	$0.825	$0.908	$0.990

***Spouse's rate is based on employee age.**

Child(ren)*- 24 payroll deductions per year

	$2,000	$4,000	$6,000	$8,000	$10,000
Life	$0.900	$0.180	$0.270	$0.360	$0.450
AD&D	$0.033	$0.066	$0.099	$0.132	$0.165

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed above.

Voluntary Critical Illness

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

If you're diagnosed with a covered illness, 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 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.

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.

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%)

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

Voluntary Accident Insurance

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

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.

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	Plan 1
You	$9.94
You and your spouse	$17.65
You and your children	$30.44
Family	$38.15

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

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

Injury

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

Voluntary Accident Insurance Cont.

Accident Insurance – Schedule of Benefits cont.

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

Surgery

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 maximum payable multiplier for multiple bones	2 Times
General Surgery	
Abdominal, Thoracic, or Cranial	$1,500
Incidence per covered accident	1 Per Insured
Exploratory	$150
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

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
Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	$550
Kneecap (patella)	$550

Treatment

Ambulance	
Air	$1,500
Ground	$300
Durable Medical Equipment	
Tier 1 (arm sling, cane, medical ring cushion)	$25
Tier 2 (bedside commode, cold therapy system, crutches)	$50
Tier 3 (back brace, body jacket, continuous passive movement, electric scooter)	$100
Emergency Dental Repair	
Dental Crown	$150
Dental Extraction	$50
Filling or Chip Repair	$40
Imaging	
Tier 1: X-rays or Ultrasound	$50

Recovery

At-Home Care	$50
Physician Follow-Up Visits	$75
Physician Follow-Up Maximum Visits	2 Visits
Prescription Drug	None
Prescription Benefit Incidence per covered accident	1 Per Insured
Rehabilitation or Subacute Rehabilitation Unit	$50
Therapy Services (chiro, speech, PT, occ)	$25
Therapy Services Maximum Days	15 Days

Surgery

Dislocations	
Dislocation, Surgical Repair - Payable as a % of the applicable injury benefit	100%
Anesthesia	
Epidural or Regional Anesthesia	$100
General Anesthesia	$250

Treatment

Tier 2: Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	$100
Medical Imaging Incidence allowance covered accident per Tier	1 Per Insured Per Tier
Lodging	
Lodging (per night)	$50
Prosthetic Device	
One Device or Limb	$250
Two or more Devices or Limbs	$500
Skin Grafts	
For Burns - Payable as a % of the applicable Burn benefit	50%
Not Burns - Less than 20% of skin surface	$125
Not Burns - 20% or greater of skin surface	$250
Treatment	
Emergency Room Treatment	$200
Injections to Prevent or Limit Infection (tetanus, rabies, antivenom, immune globulin)	$50
Pain Management Injections (epidural, cortisone, steroid)	$25
Transfusions	$200
Transportation (per trip)	$50
Treatment in a Physician's Office or Urgent Care Facility (Initial)	$125

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 $2,750 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 14th, 2021. (75 days after plan year ends)
- √ The Rollout period allows you to submit claims for reimbursement until February 12th, 2022. (60 days after grace period ends)

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

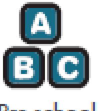
Custodial care for dependent adults

Nursery school

Before and after school programs

Private sitter

Nanny service



Pre-school

Required Notices

Women's Health and Cancer Rights Act: 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 stages 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. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

Newborn's and Mother's Health Protection Act (NMHPA): 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).

Mental Health Parity Act (1996) (MHPA) and Mental Health Parity and Addiction Equity Act (2008) (MHPAEA): The Cameron County medical plan complies with the Mental Health Parity Act of 1996 ("MHPA"). Pursuant to such compliance, the annual and lifetime limits on Mental Health Benefits, if any, will not be less than the annual and lifetime plan limits on other types of medical and surgical services (if any limits apply). The plan does utilize cost containment methods, applicable for Mental Health Benefits, including cost-sharing, limits on the number of visits or days of coverage, and other terms and conditions that relate to the amount, duration and scope of Mental Health Benefits.

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). To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefit Security Administration
www.dol.gov/agencies/ebsa - 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services—www.cms.hhs.gov
1-877-267-2323, menu Option 4, Ext. 61565

Notice of Opportunity to Enroll in Connection with Extension of Dependent Coverage to Age 26 Notice: Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in **Cameron County** insurance plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to 10/1/20. If you would like more information, contact your Plan Administrator.

Notice Lifetime Limit No Longer Applies & Enrollment Opportunity: The lifetime limit on the dollar value of benefits under **Cameron County** benefit Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. If you would like 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 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. **Cameron County** has determined that the prescription drug coverage offered by the **Cameron County** Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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? If you decide to join a Medicare drug plan, your current coverage with Cameron County will not be affected. You and/or your dependents can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Cameron 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 Cameron 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).

Coverage After Termination (COBRA) - Health Coverage: You're getting this notice because you recently gained coverage under a group health plan **(Cameron County Group Health Plan).** This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage. If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events: Your hours of employment are reduced, or Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events: Your spouse dies; Your spouse's hours of employment are reduced; Your spouse's employment ends for any reason other than his or her gross misconduct; Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events: The parent-employee dies; The parent-employee's hours of employment are reduced; The parent-employee's employment ends for any reason other than his or her gross misconduct; The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); The parents become divorced or legally separated; or The child stops being eligible for coverage under the Plan as a "dependent child."

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Phone: 956-983-5098

How is COBRA continuation coverage provided? Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage: If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of: The month after your employment ends; or The month after group health plan coverage based on current employment ends. If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions: Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes: To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Cameron County
1100 Monroe St. STE. 118
Brownsville, Texas, 78520
Phone: 956-983-5098

HIPAA) Employee Health Plan Summary Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Your Rights: You have the right to: Get a copy of your health and claims records; Correct your health and claims records; Request confidential communication; Ask us to limit the information we share; Get a list of those with whom we've shared your information; Get a copy of this privacy notice; Choose someone to act for you; and File a complaint if you believe your privacy rights have been violated.

(Your Choices: You have some choices in the way that we use and share information as we: Answer coverage questions from your family and friends; Provide disaster relief; and Market our services and sell your information

Our Uses and Disclosures: We may use and share your information as we: Help manage the health care treatment you receive; Run our organization; Pay for your health services; Administer your health plan; Help with public health and safety issues; Do research; Comply with the law; Respond to organ and tissue donation requests and work with a medical

examiner or funeral director; Address workers' compensation, law enforcement, and other government requests; Respond to lawsuits and legal actions

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records: You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records: You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us at 806.441.7122. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in payment for your care; Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* In these cases we never share your information unless you give us written permission: Marketing purposes or Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive: We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization: We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. *Example: We use health information about you to develop better services for you.*

Pay for your health services: We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan: We may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director: We can share health information about you with organ procurement organizations; We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date: 10/1/2020

Privacy Contact: Cameron County
1100 Monroe St. STE. 118
Brownsville, Texas, 78520
Phone: 956-983-5098

Health Insurance Marketplace Coverage Options and Your Health Coverage

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 2020 for coverage starting as early as January 1, 2021.

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.*

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. *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.

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

- Eligible employees are Full time employees who work 30 hours per week and have completed the newly eligible 30 day waiting period. Coverage begins the first day of the month following the first 30 days of employment.
- Eligible dependents include the employee's spouse and eligible dependent children up 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 employee wages.

** 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 premiums.

3. Employer name		4. Employer Identification Number (EIN)
Cameron County		74-6000420
5. Employer address		6. Employer phone number
1100 E. Monroe St. Ste.118		956-983-5098
7. City	8. State	9. ZIP code
Brownsville	TX	78520
10. Who can we contact about employee health coverage at this job?		
Human Resources		

Special Enrollment Notice: 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 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 request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

To request special enrollment or obtain more information, contact the plan administrator listed below:

Phone: 956-983-5098

The information in this benefits guide is intended to help you enroll in your 2020 - 2021 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern.

Cameron County reserves the right to change or terminate benefits at any time. Neither the benefits, nor this enrollment guide, should be interpreted as a guarantee of future benefits.