2025-2026 EMPLOYEE BENEFITS GUIDE

CONTENTS

WELCOME LETTER

TO: Hill County Employees
FROM: Daniel Anderson
ANCO Insurance, a HUB International Company

We are excited to partner with Hill County as your benefits broker. This Benefits Guide provides the information you'll need when making decisions about your benefit selections for the 2025-2026 plan year (10/01/25 through 09/30/26) from the following providers:

- Curative: Medical
- Guardian: Dental, Vision, Basic Life/AD&D, Short-Term & Long-Term Disability, Critical Illness, Accident, Cancer Insurance
- Texas Republic Life: Whole Life
- MASA: Medical Transportation Services

Please note that certain benefits may require the completion of additional forms, and benefits could be reduced if enrolling for the first time after the initial new hire enrollment period; especially for life and worksite plans.

Should difficulties arise requiring resolution with any carrier, Kelly Coppock can be reached via:

979-774-6214 // kelly.coppock@hubinternational.com

ANCO Insurance, a HUB International Company is happy to assist with any issues or questions concerning the benefit programs. For some claims research, the following items are often requested:

- Member authorization to disclose health information
- Date-of-service, provider information, amount of charges, and explanation of the problem
- Explanation of Benefits (EOB) from carrier and statement from provider's office

Our continuing effort is to provide any assistance and support as needed. Please feel free to contact our team.

Daniel Anderson
Senior Vice President
979-774-6216
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GLOSSARY

BENEFICIARY - The person or entity entitled to receive the claim amount and other benefits upon the death of the benefactor (person covered under the policy) or on the maturity of the policy.

CLAIM - A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

COINSURANCE - The percentage of costs of a covered health care service insurance pays after you've paid your deductible.

COPAYMENT (COPAY) - A fixed dollar amount you pay for a covered health care service.

DEDUCTIBLE - An amount you could owe during a coverage period for covered health care services before your plan begins to pay. An overall deductible applied to all or almost all covered items and services. Copayments do not count towards the deductible.

DEPENDENT - A child or other individual (under the age of 26) for whom a parent, relative, or other person may claim a personal exemption tax deduction.

DISABILITY RESOURCE SERVICES - Provides convenient resources to help address emotional, legal, and financial issues.

ELECTIVE DEFERRAL - A percentage of an employee's salary that's withheld and transferred into a 401(k). Elective-deferrals can be made on a pre-tax or after-tax (Roth) basis.

EVIDENCE OF INSURABILITY (EOI) - An application process through which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage.

FLEXIBLE SPENDING ACCOUNT (FSA) - A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan.

GUARANTEE ISSUE - A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, guarantee issue doesn't limit how much you can be charged if you enroll.

HEALTH SAVINGS ACCOUNT (HSA) - A tax-free financial account where you gain interest and save money while spending on qualified health expenses. Funds in your account roll over from year to year.

HEALTH MAINTENANCE ORGANIZATION (HMO) - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency.

IN-NETWORK - Refers to a health care provider that has a contract with your insurance plan to provide health care services to its plan members at a pre-negotiated rate. Because of this relationship, you pay a lower cost-sharing when you receive services from an in-network doctor.

OPEN ENROLLMENT - The annual period before a new plan year commences that eligible individuals may enroll in or change coverage elections in a job-based insurance plan.

OUT-OF-NETWORK - Refers to a health care provider who does not have a contract with your insurance plan. If you use an out-of-network provider, health care services could cost more since the provider doesn't have a pre-negotiated rate with your health plan. Or, depending on your health plan, the health care services may not be covered at all.

OUT OF POCKET MAXIMUM/LIMIT - The most you must pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

PREFERRED PROVIDER ORGANIZATION (PPO) - A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

PREMIUM - The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.

QUALIFYING EVENT - A change in your situation — like getting married, having a baby, or losing health coverage — that can make you eligible for a Special Enrollment period, allowing you to enroll in health insurance outside of the yearly Open Enrollment period.

WAITING PERIOD - The time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for coverage under a job-based health plan.

ELIGIBILITY

If you are a full-time employee at Hill County, you are eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week. You are eligible for benefits beginning the 1st day of the month following 30 days of employment.

HOW TO ENROLL

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all of your information is up to date, it's time to make your benefit elections. The decisions you make when enrolling for benefits can have a significant impact on your life and finances, so it is important to weigh your options carefully.

WHEN TO ENROLL

Open enrollment begins on July 31, 2025 and runs through August 1, 2025. The benefits you choose during open enrollment will become effective on October 1, 2025. For the initial enrollment you will use Employee Navigator to make benefit elections.

ENROLLMENT CHANGES

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next Open Enrollment period.

Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or coverage under another employer sponsored plan
- Loss of coverage on yourself or dependents during the year

Request for qualifying events must be submitted to the carrier within 30 days of the event.

MEDICAL PPO

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Benefits Summary

PPO Plan Coverage	**Curative In-Network** (Copay deductible, copay insurance when compliant with Baseline Visit)	**Curative In-Network** (Copay deductible, copay insurance when non-compliant with Baseline Visit)	**Curative** Out-of-Network
Annual Deductible	**$0**	$5,000/person and $10,000/family	$10,000/person and $20,000/family
Coinsurance Percentage	**0%**	20% Medical 25% Pharmacy	50%
Annual Out-of-Pocket Maximum (Medical)	**$0**	$7,500/person and $15,000/family	$15,000/person and $30,000/family
Lifetime Maximum Benefit	**No Limit**	No Limit	No Limit
Office/Virtual Visit - Family Practice, Internal Medicine, OB/ GYN, Pediatrics	**$0**	$25 copay after deductible	$50 copay after deductible
Specialist Office/Virtual Visit	**$0**	$50 copay after deductible	$100 copay after deductible
Telemedicine - Urgent Care with a 24/7/365 On Demand Doctor Visit	**$0**	$0 copay	50% coinsurance after deductible
Preferred Drugs - Includes certain Generic, Brand Name, & Specialty drugs	**$0**	$50 copay after deductible	40% coinsurance after deductible
Non-preferred Drugs	**$50 brand and generic $250 specialty**	$100 copay after deductible for brand & generic 25% coinsurance after deductible for specialty drugs	40% coinsurance after deductible
Rx Network	**Mail order and select retail, including: H-E-B, Albertsons, Safeway, Publix (30,000+ pharmacies nationwide)**		
Urgent Care, Hospital / Free Standing Emergency Room	**$0**	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room Physicians	**$0**	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery - Physician	**$0**	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Lab and X-Ray	**$0**	20% coinsurance after deductible	50% coinsurance after deductible
Hospital - Semi-private Room and Board	**$0**	20% coinsurance after deductible	50% coinsurance after deductible
Hospital Inpatient Surgery	**$0**	20% coinsurance after deductible	50% coinsurance after deductible

The company will cover a portion of your cost of coverage for each plan option. You are responsible for the difference in cost.

The amounts shown (your cost) are per pay period.

Curative Health Plans offer no copay, no deductible, no out-of-pocket for in-network, including many preferred medications for members who complete the Baseline Visit in the first 120 days of the plan effective date.

If you don't complete the Baseline Visit, you will still be covered with the same plan benefits, but your copays, coinsurance and annual deductible for care and prescriptions will be significantly higher. See the Benefits Summary for details.

Curative Premium Rates

5 TIER MEDICAL PREMIUM OPTIONS				
COVERAGE	TOTAL MONTHLY	EMPLOYER MONTHLY	EMPLOYEE MONTHLY	EMPLOYEE BI-WEEKLY
Employee Only:	$653.90	$653.90	$0.00	$0.00
Employee + Spouse:	$1,403.46	$1,073.46	$330.00	$165.00
Employee + Child:	$1,098.72	$1,005.72	$93.00	$46.50
Employee + Children:	$1,098.72	$890.72	$208.00	$104.00
Employee + Family:	$1,858.69	$1,443.70	$415.00	$207.50

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Let's check back in

Another year, another Baseline

Complete your annual Baseline to continue with $0 care!

If you completed your Baseline last year, enjoy $0 care and preferred prescriptions straight away!

If you missed last year's Baseline, you have a chance this time around to unlock your $0 perks.

Just remember to complete your Baseline **within 120 days of your plan renewal date** to keep or get these benefits.

As always, your Baseline is confidential and won't impact your premiums.

To schedule:

Log into your Curative account

You likely already have access to the member portal at **health.curative.com**. Log-in with your credentials or check and sign-up for your annual Baseline with the options below!

Part 1

Baseline Onboarding

Learn about your plan's benefits and resources, any updates and changes, find $0 providers, sign up for telehealth, check medication coverage, and get connected to programs to reach your health goals. There are two options for how to onboard:

Option 1: Self-Guided Onboarding
Complete your onboarding on your own by watching videos and completing important tasks. Your Care Navigator will follow up with you after to answer any questions.

Option 2: Live Onboarding
Schedule a Zoom virtual meeting with your Care Navigator. They will explain how Curative works and what your health plan includes. Austin residents can also schedule in-person.

Part 2

Baseline Clinical Check-in

Schedule a Zoom virtual meeting with a Curative Clinician to discuss your medical history and any health questions. They'll help create a plan tailored to you. You can even get labs done before or after for a more complete picture of your health. Austin residents can also schedule in-person.

Clinical Check-ins can be scheduled after the Self-guided Onboarding or at the same appointment time as your Live Onboarding.

Done

Continue to enjoy $0 out-of-pocket costs!

Your Care Navigator will follow-up after the visit and you can always find their contact info on the member portal. For time-sensitive Curative benefit questions, you can call our **24/7 Member Services at 855-428-7284**.

Visit to learn more about the Baseline curative.com/baseline.

Watch to learn more about your Baseline Onboarding options. cur.tv/baseline-preview.

Who has to complete the annual Baseline Visit?

All our members must complete an annual Baseline Visit.
If you've joined us within the last 120 days before your renewal, don't worry – you won't have to go through the Baseline again right away. We've got your back until the next plan renewal.

If you're under 18 when your plan kicks in, you can hold off on the Baseline until the next plan year.

If you were moved to the high-deductible plan, you won't be shifted to the $0 out-of-pocket plan until after your renewal date and once your Baseline within the first 120 days of the renewal year is completed.

Members must complete a Baseline Visit within the first 120 days of the plan's start date to maintain $0 out-of-pocket costs for covered services with in-network providers and preferred prescriptions. See Summary Plan Description and Benefits Booklet for additional requirements for the Baseline Visit.

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Get care when you need it with Curative

Find a provider near you

Use our network search tool to find your go-to care providers and pharmacies near you at curative.com/providers

Provider search tips

- Search using the provider, facility, or pharmacy name.
- Use filters to select a care type to get the most accurate results.
- Enable location services or add your location in the search box to populate providers or pharmacies near you.

Traveling? Simply enter your travel location to find in-network providers in that area (only within the U.S.)

- **When filtering**, be sure to select your language preference and check the box reading "Accepting new patients" when looking for a new provider.
- **When searching** for a primary care provider, note that providers may be found under "family medicine" or "internal medicine."

Don't see a retailer?

*If you are out-of-area for our preferred in-network pharmacies, go to the provider search tool at curative.com/providers or contact Member Services at 855-428-7284.

Free delivery from Curative Pharmacy — no more waiting in line. Overnight and same-day delivery options are available in select locations. Check your local pharmacy retailers for delivery options.

Questions?
Call Member Services at 855-428-7284

Meds made simple.

Transferring prescriptions? Follow these simple steps below or go to health.curative.com/pharmacy

Step 1

Get your Baseline Visit within 120 days of your plan's effective date to unlock $0 coverage for in-network care and preferred prescriptions.

Step 2

Visit an in-network provider who prescribes a preferred medication.

Step 3

Use the preferred in-network pharmacies.

Our in-network pharmacies include all locations across the United States and include: Curative, H-E-B, ACME, Albertsons, Amigos, Carrs, Haggen, Jewel-Osco, Market Street, MedCart, Pavillions, Randalls, Safeway, Sav-on, Tom Thumb, United, Vons, Publix, Brookshire Brothers.

For more information on what's covered, prescription transfers, and updates on Curative Pharmacy's Expansion, visit curative.com/pharmacy

curative cash card

Your Ticket to Hassle-free Care

We guarantee $0 copays and deductibles for any doctor in our search. There are two options to provide payment covered by Curative:

1) insurance billing using the Curative Member ID Card

2) self-pay using our unique Curative Cash Card.

Either way, you don't pay.

What will be approved?

- It can be used for office visits, urgent care, behavioral health, and certain services without hospital stays at approved providers listed in the Curative Provider Search.*

What will not be approved?

- Prescriptions

Questions?

Call Member Services, available 24/7 at 855-428-7284

**To maintain $0 copays and deductibles, a Baseline Visit must be completed within the first 120 days of plan activation.*

Curative Cash Card Visa® Commercial Credit cards are issued by Celtic Bank. Additional Terms & Conditions can be found in your Member Portal Account at health.curative.com.

Here's how you can access your Curative Cash Card:

Step 1

To get started, you'll first need to activate the Curative Cash Card by logging into the member portal at **health.curative.com** and selecting "Cash Card" to follow the activation steps. Once completed, you'll have access to the digital Curative Cash Card instantly.

A physical Cash Card will be delivered soon after your plan start date.

Note: Curative members must be 18 or older to access the card.

Step 2

Before attempting to use the Curative Cash Card, please try using your Curative Member ID Card first. If declined, then proceed with the digital or physical Curative Zero Card.

Step 3

Use the Curative Cash Card for any provider that shows as Cash Card in our search. Tell the front desk you will pay the self-pay price and hand over your Cash Card. Think of it as a payment card with no impact on credit.

Backup: If a provider appears in our search but does not take your Member ID Card for any reason or tries to charge a copay, say you'll self-pay instead and hand over your Curative Cash Card.

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Where mental health support isn't a perk – it's the plan.

While most plans fall short on behavioral health, Curative closes the gap. We combine broad in-network access, leading virtual partnerships, and cash-pay flexibility—so every member can get the care they need, with $0 cost-sharing and no red tape.

Unmatched mental health benefits:

Expansive mental health options: Members get $0 access to therapy, psychiatry, and condition-specific support through partners like Rula and Two Chairs—plus in-network providers across the country. Curative removes waitlists and cost barriers to connect members to the right care, fast.

Substance use management: Curative covers personalized, stigma-free care through Pelago, Recovery Unplugged and in-network providers—with virtual and in-patient options that cost $0 to the member.

Direct pay option: Nearly 1 in 3 mental health professionals don't take insurance. With Curative's payment card, members can see self-pay therapists and counselors—at no cost—bypassing outdated insurance barriers entirely.

Every Curative member can maintain access to **$0 deductibles and copays** for covered services – including therapy, psychaitry and preferred prescriptions—simply by completing a Baseline Visit within the first 120 days of their plan start date.

Members access $0 mental health care via in-network providers, virtual partners, and even self-pay providers using a Curative payment card.

Featured mental health providers

At Curative, we understand that supporting your employees' mental well-being is essential to maintaining a healthy, productive workforce. That's why we're committed to providing seamless access to reliable, supportive, and convenient mental health resources—so your team gets the care they need, when they need it. Members can also use our search tool to find local in-network options or apply their Curative card with eligible self-pay therapists—bypassing the limitations of traditional plans.

Provider	Condition	Ages	Availability	Cost with completion of the Baseline Visit
Rula	Individual, couples, and family therapy sessions (5+); psychiatry (13+)	5+, 13+	Virtual, Nationwide	$0
Two Chairs	Therapy matching & support	18+	Virtual (AZ, CA, CO, FL, IL, MI, MN, NJ, NY, OH, OR, PA, SC, TX, VA, WA); In-Patient in FL, CA, WA	$0
Televero	Virtual therapy, counseling, and psychiatry sessions	All	Virtual (Texas and Florida members)	$0
Pelago	Substance use and mental health disorders	All	Virtual, nationwide	$0
Recovery Unplugged	Substance use and mental health disorders	All	Virtual (TX, FL, VA, TN, SC, NJ); In-Patient in Fort Lauderdale, FL	$0

Why is this important?

Only 44% of employers believe their current plan offers enough in-network behavioral health options to meet the needs of their employees and their families. Curative eliminates financial barriers and expands culturally aligned, in-network access to care, ensuring members get timely, relatable support while helping employers reduce costs and improve workforce well-being.

Source: KFF

Explore our mental health resource options & learn more at curative.com/mental-health.

curative telehealth

Curative Telehealth: Fast, seamless virtual care

Get the care you need, anytime, anywhere.

Curative Telehealth provides 24/7 nationwide virtual care, connecting you with a licensed provider in less than 7 minutes. Whether by phone or video, get fast, hassle-free care—directly through your Curative Member Portal.

Fast, easy access
See a provider **in minutes,** anytime, from home, work, or on the go.

Seamless experience
Access directly through your Curative Member Portal without the hassle of extra apps or logins.

Nationwide coverage
Available **in all 50 states**, so you always have a consistent virtual care option.

Online or phone
Select **video or phone** visits based on your needs and comfort level.

Guided symptom intake
Answer a few quick questions to get connected with the right care provider.

Getting started with Curative Telehealth is easy

1. **Log in or call**
   Start a visit through your Curative member portal or by phone.
   health.curative.com/curative-telehealth
2. **Answer a few questions**
   Our system will match you with the right provider.
3. **See a provider fast**
   Get care via **video or phone,** with visits starting **in less than 7 minutes.**

For more info, go to curative.com/telehealth

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H-E-B: The power of personalized nutrition.

Curative is making it easier for you to elevate your health with personalized nutrition plans brought to you by H-E-B Wellness Nutrition Services* in Texas. H-E-B dietitians are a covered benefit for members who complete a Baseline Visit within 120 days of plan activation.

Through Curative's partnership, H-E-B dietitians create personalized plans that take into account your budget, lifestyle, and specific health requirements. Not only will the team assist you with food selections, they'll also show you exact products that will make a difference in your nutrition plan.

H-E-B Dietitians see the supermarket as a classroom where they can share their knowledge about food and nutrition in ways that are convenient and hassle-free through better-for-you swaps. H-E-B Dietitians make product recommendations that are personalized for you and your journey.

Curative and H-E-B Wellness Nutrition Services believe in providing comprehensive support to help you achieve your nutrition goals while accommodating your preferences and unique circumstances. H-E-B dietitians specialize in the following conditions:

AUTOIMMUNE DISORDERS
Multiple Sclerosis
Celiac Disease
Rheumatoid Arthritis
Crohn's Disease
Ulcerative Colitis

BEHAVIORAL ISSUES
Alzheimer's
Dementia
Eating Disorders:
Anorexia Nervosa, Bulimia Nervosa,
Binge Eating Disorder

CARDIOVASCULAR HEALTH
Coronary Artery Disease
Heart Attack or Stroke
Hypertension

DEVELOPMENTAL DISABILITIES
Autism Spectrum Disorders
Down's Syndrome
Prader-Willi

DIABETES
Type 1
Type 2
Gestational
Pre-Diabetes

DYSPHAGIA

FOOD ALLERGIES & AVERSIONS
Food Allergies
Food Sensitivities
Food Intolerances
Food Aversions (picky eaters)

PULMONARY
COPD
Cystic Fibrosis

MUSCULOSKELETAL CONDITIONS
Arthritis
Gout
Rheumatoid Arthritis
Osteoporosis

GASTROINTESTINAL DISORDERS
Gastroparesis
GERD
Peptic Ulcers
Esophageal
Gastric Surgery
Irritable Bowel Syndrome
Colostomy Ileostomy
Diverticular Conditions
Liver Cirrhosis
Gallbladder
Pancreatitis

NEUROLOGICAL CONDITIONS
Epilepsy
Huntington's Disease
Parkinson's Disease

NUTRIENT DEFICIENCIES
Anemia
Other Nutritional Deficiencies

OBSTETRICS
Prenatal Nutrition
Breastfeeding
RENAL
Kidney Stones
Kidney Disease
Dialysis

ENDOCRINE DISORDERS
Hyperthyroidism
Hypothyroidism
Hashimoto's
Grave's Disease

TRANSPLANT
Transplant of Kidney

WEIGHT MANAGEMENT
Overweight
Obesity
Underweight; BMI < 18.5
Malnutrition
Unintentional Weight Loss
Bariatric Surgery

The program covers:

- ✓ Weight Management
- ✓ Diabetes Management
- ✓ Childhood and Family Nutrition
- ✓ Cancer Nutrition Support
- ✓ Food Allergy Support
- ✓ Digestive Support
- ✓ Sports Nutrition
- ✓ Cardiovascular Health

To sign up, let your **Care Navigator** know you're interested in joining or call Member Services at **855-4-CURATIVE (855)-428-7284.**

curative | NOOM

Noom: Long-term lifestyle change **on your terms.**

Curative members get one-year access to Noom, a psychology-based lifestyle program. With easy and fun lessons on the app, Noom encourages sustainable healthy habits, improved physical activity, and other forms of well-being, including sleep and stress management. Curative will partner with Noom every step of the way to help you achieve the healthiest version of you.

With access to Noom, you get:

Daily lessons on your terms

Gain confidence with practical knowledge you can employ right away. How much time you spend on each lesson is up to you, so you can easily fit Noom into your schedule.

Coaching and support

Optional one-on-one coaching and support groups to get the kind of support you need to keep going.

Ultimate convenience

Noom's tracking tools for food, exercise and more are designed to empower you to hit your goals at a pace that's comfortable for you.

To sign up, let your **Care Navigator** know you're interested in joining or call Member Services at **855-4-CURATIVE (855)-428-7284.**

Galleri® Multi-cancer early detection | curative

Screen for multiple cancers with a single blood draw

Galleri® is the first-of-its-kind—a test that screens for a signal shared by 50+ cancers.

The cancer challenge

Today, only **5 out of 100+** known cancer types have recommended screening tests.

~70%

Around 70% of cancer deaths* are caused by cancers without recommended screening tests.

*Assumes screening is available for all prostate, breast, cervical and colorectal cases and 43% of lung cancer cases (Based on estimated proportion of lung cancers that occur in screen-eligible individuals older than 40 years).

As a Curative member, you can screen for more cancers at no cost to you.†

The Galleri multi-cancer early detection test screens for a signal shared by 50+ types of cancer with a single blood test. Galleri screens your blood sample (two tubes of blood) for cell-free DNA and identifies whether it comes from healthy or cancer cells.

Screening for more cancers

Added to recommended screenings, Galleri looks for many cancers, including those that lack screening tests and fast-spreading cancers that don't show symptoms in early stages.

Testing with ease

Screen with a simple blood draw easily added to your cancer screening plan.

No fasting or preparation required.

Proactive health information

If a cancer signal is found, the results can predict the tissue or organ associated with the signal to help your healthcare provider guide the next steps.

The Galleri test does not detect a signal for all cancers and not all cancers can be detected in the blood. Galleri should be used in addition to healthcare provider recommended screening tests. False positive and false negative results do occur.

Confirm your eligibility and request the Galleri test today

Scan the QR code or visit Galleri.com/curative to request the test from an independent telemedicine provider.

Need more information?
Please visit **Galleri.com/curative** for more details about the test, including frequently asked questions.

Who is eligible for the Galleri test?

All Curative members and their dependents must meet the following eligibility requirements for this program. Curative is offering access to the test with $0 out-of-pocket costs once your annual Baseline Visit is completed.†

- Active Curative plan members residing in the United States who have also completed their annual Baseline Visit.
- Aged 50 years old and older.
- Not currently pregnant.
- Not currently undergoing active cancer treatment, though history of cancer* with treatments completed at least 5 years ago is permitted.

* Excludes basal or squamous cell carcinoma of the skin.

† No out-of-pocket costs contingent on completion of your Curative Baseline Visit within 120 days of plan activation date. If the Baseline. Visit is not completed within the first 120 days of plan activation date, members completing the test after that time period will be subject to the full price of the Galleri test ($899).

Our testing process

Request the test

Complete your Baseline Visit, then visit Galleri.com/curative to request the test through an independent telemedicine provider.

Complete your blood draw

At a GRAIL partner laboratory via Galleri.com/schedule.

Receive your results

The ordering provider will share results about 2 weeks after your sample is received at the GRAIL lab.

Galleri must be ordered by the telemedicine provider

Understanding the two possible results

No Cancer Signal Detected

This means the Galleri test did not find a cancer signal in your blood sample. The test does not detect all cancers and not all cancers can be detected in the blood. This result does not rule out cancer.
Next steps: Continue with routine cancer screening your healthcare provider recommends.

Cancer Signal Detected

This means the Galleri test did find a cancer signal in your blood sample. This result includes 1 or 2 predictions of the tissue type or organ associated with the signal, called a **"Cancer Signal Origin."**
Next steps: A "Cancer Signal Detected" result is NOT a diagnosis of cancer. Diagnostic testing by a healthcare provider is needed to confirm if you have cancer.

False positive and false negative results do occur.

Important Safety Information The Galleri test is recommended for use in adults with an elevated risk for cancer, such as those aged 50 or older. The Galleri test does not detect all cancers and should be used in addition to routine cancer screening tests recommended by a healthcare provider. Galleri is intended to detect cancer signals and predict where in the body the cancer signal is located. Use of Galleri is not recommended in individuals who are pregnant, 21 years old or younger, or undergoing active cancer treatment. Results should be interpreted by a healthcare provider in the context of medical history, clinical signs and symptoms. A test result of "No Cancer Signal Detected" does not rule out cancer. A test result of "Cancer Signal Detected" requires confirmatory diagnostic evaluation by medically established procedures (e.g. imaging) to confirm cancer. If cancer is not confirmed with further testing, it could mean that cancer is not present or testing was insufficient to detect cancer, including due to the cancer being located in a different part of the body. False-positive (a cancer signal detected when cancer is not present) and false-negative (a cancer signal not detected when cancer is present) test results do occur. **Rx only**.

Laboratory / Test Information GRAIL's clinical laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and accredited by the College of American Pathologists (CAP). The Galleri test was developed, and its performance characteristics were determined by GRAIL. The Galleri test has not been cleared or approved by the Food and Drug Administration. GRAIL's clinical laboratory is regulated under CLIA to perform high-complexity testing. The Galleri test is intended for clinical purposes.

Confirm your eligibility and request the Galleri test today

Scan the QR code or visit Galleri.com/curative to request the test from an independent telemedicine provider

Need more information?
Please visit **Galleri.com/curative** for more details about the test, including frequently asked questions.

GRAIL

masa Access

$14/month

Stay prepared with MASA® Access℠

Comprehensive coverage and care for emergency transport.

Our Emergent Plus membership plan includes:

Emergency Ground Ambulance Coverage[1]

Your out-of-pocket expenses for your emergency ground transportation to a medical facility are covered with MASA.

Emergency Air Ambulance Coverage[1]

Your out-of-pocket expenses for your emergency air transportation to a medical facility are covered with MASA.

Hospital to Hospital Ambulance Coverage[1]

When specialized care is required but not available at the initial emergency facility, your out-of-pocket expenses for the ground or air ambulance transfer to the nearest appropriate medical facility are covered with MASA.

Repatriation Near Home Coverage[1]

Should you need continued care and your care provider has approved moving you to a hospital nearer to your home, MASA coordinates and covers the expense for ambulance transportation to the approved medical facility.

Did you know?

51.3 million

emergency responses occur each year

MASA protects families against uncovered costs for emergency transportation and provides connections with care services.

Source: NEMSIS, National EMS Data Report, 2023

About MASA

MASA is coverage and care you can count on to protect you from the unexpected. With us, there is no “out-of-network” ambulance. Just send us the bill when it arrives and we’ll work to ensure charges are covered. Plus, we’ll be there for you beyond your initial ride, with expert coordination services on call to manage complex transport needs during or after your emergency — such as transferring you and your loved ones home safely.

Protect yourself, your family, and your family’s financial future with MASA.

Coverage territories

1: United States and Canada.

Disclaimers

This material is for informational purposes only and does not provide any coverage. The benefits listed, and the descriptions thereof, do not guarantee coverage and do not represent the full terms and conditions applicable for usage and may only be offered in some memberships or policies. Premiums, benefits, and coverage vary depending on the plan selected. For a complete list of benefits, premiums, terms, conditions, and restrictions, please refer to the applicable member services agreement or policy for your state. For additional information and disclosures about MASA plans, visit: https://info.masamts.com/masa-mts-disclaimers

masa Access

How to use your MASA benefits

Transportation coordination services

Access transport services for the following benefits:

- Repatriation Near Home Coverage
- Child, Pet, and Vehicle Return Coverages
- Companion Transportation Coverage
- Hospital Visitor Transportation Coverage
- Patient Return Transportation Coverage
- Sick While Away from Home Expense Protection
- Organ Retrieval & Organ Recipient Transport Coverage
- Mortal Remains Transportation Coverage

When to access:
During or immediately following your emergency care treatment.

How to access:
Call 800-643-9023.
The MASA Transport Team is available 24/7/365 to assist you and will begin making the necessary arrangements, including working with your medical team.
Note: *If you are traveling out of the U.S., please submit your dates of travel through the member portal or to travel@masaglobal.com.*

View your benefits online at: masaaccess.com/member or through the MASA app.

Claims

Benefits that you submit claims for include:

- Emergency Ground Ambulance Coverage
- Emergency Air Ambulance Coverage
- Hospital to Hospital Ambulance Coverage
- Post-Admission Continued Care Transportation Coverage

When to file your claim:
When you receive the ambulance bill.
Note: *Be sure to file within 180 days of the transport.*

How to file your claim:

Online: masaaccess.com/member
Email: ambulanceclaims@masaglobal.com
Fax: (877) 681-2399

Mail: MASA Global / ATTN: Claims
1250 S. Pine Island Road, Suite 500
Plantation, FL 33324
Include your member number

Note: *To process your claim, in addition to the invoice we may require your health insurance claim form (HICFA) and explanation of benefits (EOB), the ambulance run notes, and the ambulance provider's W9. MASA claim specialists will advise you on how to obtain these.*

Check the status of your claim at: masaaccess.com/member, through the MASA app, or call (800) 643-9023.

MASA connections

Member services: (800) 643-9023

Member site: masaaccess.com/member

Download on the App Store GET IT ON Google Play

MASA app

Guardian

Watch our video
Learn how dental insurance can protect your long-term health.

Dental insurance

Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health.

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is required.

Who is it for?

Everyone should have access to great dental coverage, which is why we offer comprehensive plans that are available through employers as part of your benefit offerings.

What does it cover?

Dental insurance helps to protect your overall oral care. That includes services like preventive cleanings, x-rays, restorative services like fillings, and other more serious forms of oral surgery if you ever need them.

Why should I consider it?

Poor oral health isn't just aesthetic, it's also been linked to conditions including diabetes, heart disease, and strokes. So, while brushing and flossing every day can help keep your teeth clean, nothing should replace regular visits to the dentist.

You will receive these benefits if you meet the conditions listed in the policy.

Staying healthy

Joe visits his dentist for a routine dental cleaning, to take care of his teeth as well as his overall health.

Oral health is about more than just teeth and gums. It's also essential for a range of other health and wellbeing reasons:

Cardiovascular disease: Some research suggests that heart disease, clogged arteries, and strokes may be linked to inflammation and infections from oral bacteria.

Osteoporosis: Weak and brittle bones may be linked to tooth loss.

Diabetes: Research shows that people with gum disease find it more difficult to control their blood sugar levels.

Alzheimer's disease: Worsening oral health is seen as Alzheimer's disease progresses.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, www.mayoclinic.com. 2021.

DENTAL

Guardian®

NAP plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	**NAP**	
Your Network is	DentalGuard Preferred	
Your Semi-monthly premium	**$12.80**	
You, Spouse/Domestic Partner and Child(ren)	$37.08	
Calendar year deductible	*In-Network*	*Out-of-Network*
Individual	$50	$50
Family limit	3 per family	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*
Preventive Care	100%	100%
Basic Care	80%	80%
Major Care	50%	50%
Orthodontia	50%	50%
Annual Maximum Benefit	$1500	
Maximum Rollover	Yes	
Rollover Threshold	$700	
Rollover Amount	$350	
Rollover Account Limit	$1250	
Lifetime Orthodontia Maximum	$1500	
Dependent Age Limits	26	

DENTAL PREMIUM BREAKDOWN				
COVERAGE	**TOTAL MONTHLY**	**EMPLOYER MONTHLY**	**EMPLOYEE MONTHLY**	**EMPLOYEE BI-WEEKLY**
Employee Only:	$25.60	$25.60	$0.00	$0.00
Employee + Family:	$74.15	$33.77	$40.38	$20.19

DENTAL

Guardian®

A Sample of Services Covered by Your Plan:

		NAP *Plan pays (on average)*	
		In-network	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	2 in 12 Months	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 19	
	Oral Exams	100%	100%
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Anesthesia*	80%	80%
	Fillings‡	80%	80%
	Perio Surgery	80%	80%
	Periodontal Maintenance	80%	80%
	Frequency:	2 in 12 months	
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%
	Root Canal	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%
	Simple Extractions	80%	80%
	Surgical Extractions	80%	80%
Major Care	Bridges and Dentures	50%	50%
	Dental Implants	50%	50%
	Inlays, Onlays, Veneers**	50%	50%
	Single Crowns	50%	50%
Orthodontia	Orthodontia	50%	50%
	Limits:	Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

Guardian®

Oral Health Rewards Program

Regular visits to the dentist can help prevent and detect the early signs of serious diseases.

That's why Guardian's Maximum Rollover Oral Health Rewards Program encourages and rewards members who visit the dentist, by rolling over part of your unused annual maximum into a Maximum Rollover Account (MRA). This can be used in future years if your plan's annual maximum is reached.

Automatic rollover

Submit a claim (without exceeding the paid claims threshold of a benefit year), and Guardian will roll over a portion of your unused annual dental maximum.

How maximum rollover works*

Depending on a plan's annual maximum, if claims made for a certain year don't reach a specified threshold, then the set maximum rollover amount can be rolled over.

Plan annual maximum**	Threshold	Maximum rollover amount	Maximum rollover account limit
$1,500 Maximum claims reimburesment	**$700** Claims amount that determines rollover eligibility	**$350** Additional dollars added to a plan's annual maximum for future years	**$1,250** The limit that cannot be exceeded within the maximum rollover account

Guardian®

Guardian Choice

With dental insurance from Guardian, you have the flexibility to choose a plan that works for you, and helps you save.

Both of the dental plans available are designed to keep you healthy, with identical premiums. The differences between them are summarized below, and you can change plans each year at your annual enrollment time.

It's easy to save

Find a participating doctor near you by visiting **guardiananytime.com/fpapp/FPWeb/search** or by downloading the **Guardian Anytime mobile app.**

Pick the plan that best suits your needs

Choose from:

	Value Plan	Network Access Plan
Description	In-network and out-of-network benefits are paid at the same coinsurance percentages. Both plans allow you to retain the freedom of choice to see any dentist, in-network or out of network.	
Coinsurance	Preventive services covered at 100%. Coinsurance for other services is higher than the Network Access Plan (increased coverage).	Preventive services covered at 100%. Coinsurance for other services is lower than the Value Plan (decreased coverage).
In-network	Member benefits are based on discounted (negotiated) rates.	
Out-of-network	Member pays the difference over network negotiated rates.	Member costs are based on usual and customary (UCR) rates.

Guardian

Watch our video
How vision insurance can help you see clearly as you get older.

Vision insurance

Vision insurance helps protect the health of your eyes by providing coverage for benefits that often aren't covered by regular medical insurance.

Protecting your eyesight means allowing for routine visits to the optometrist for eye exams, as well as coverage for glasses and contacts. Make sure your eyes remain in great shape at any age – no matter how much time you spend staring at digital screens.

Who is it for?

Even if you have perfect eyesight, it's important to have regular eye exams to make sure you're still seeing clearly. Most of us may eventually need vision correction, which is why we offer vision insurance to cover some of the costs.

What does it cover?

Vision insurance covers benefits not typically included in medical insurance plans. It covers things like routine eye exams, allowances towards the purchase of eyeglasses and contact lenses, as well as discounts on corrective Lasik surgery.

Why should I consider it?

Regular eye exams can detect more than failing eyesight, they can also pick up diseases like glaucoma and diabetes. Vision problems are one of the most prevalent disabilities in the United States, making vision insurance especially useful for anyone who regularly needs to purchase eyeglasses or contacts, or anyone who simply wants to help protect their eyesight and general health.

You will receive these benefits if you meet the conditions listed in the policy.

20/20 coverage

David notices that his vision is deteriorating. He goes in for an eye exam, and is diagnosed with myopia, which means he needs glasses.

Average cost of vision exam: **$171**

Average cost of frames and lenses: **$350**

Total cost: **$521**

With a Vision policy from Guardian, David pays just **$10** for his eye exam. After **$25** in copay, his lenses are fully covered, and he pays **$96** for his frames.

David's total out-of-pocket expense is **$131**, saving him **$390**.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

VISION

Guardian

Your vision coverage

Option 1: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of VSP's network locations, including one of the largest private practice provider networks, Visionworks and contracted Pearle Vision locations.

Your Vision Plan	**Full Feature**	
Your Network is	VSP Choice Network	
Your Semi-monthly premium	**$ 3.10**	
You and Spouse/Domestic partner	$ 5.90	
You and Child(ren)	$ 6.22	
You, Spouse/Domestic partner and Child(ren)	$ 9.14	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 25	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $39
Single Vision Lenses	$0	Amount over $23
Lined Bifocal Lenses	$0	Amount over $37
Lined Trifocal Lenses	$0	Amount over $49
Lenticular Lenses	$0	Amount over $64
Frames	80% of amount over $130[1]	Amount over $46
Costco, Walmart and Sam's Club Frame Allowance	Amount over $70	
Contact Lenses *(Elective)*	Amount over $130	Amount over $100
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts
Cosmetic Extras	Avg. 20-25% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price**	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	
Frames	Every two calendar years‡‡‡	
Network discounts *(glasses and contact lens professional service)*	Limitless within 12 months of exam.	
Dependent Age Limits	26	
To Find a Provider:	Register at VSP.com to find a participating provider.	

VISION PREMIUM BREAKDOWN				
COVERAGE	**TOTAL MONTHLY**	**EMPLOYER MONTHLY**	**EMPLOYEE MONTHLY**	**EMPLOYEE BI-WEEKLY**
Employee Only:	$6.20	$0.00	$6.20	$3.10
Employee + Family:	$11.80	$0.00	$11.80	$5.90
Employee + Child:	$12.44	$0.00	$12.44	$6.22
Employee + Family:	$18.28	$0.00	$18.28	$9.14

Guardian

Watch our video
How life insurance protects families and covers critical costs.

Life insurance

If something happens to you, life insurance can help your family reduce financial stress.

Life insurance helps protect your family's finances by providing a cash benefit if you pass away. This ensures that they'll be financially supported, and can cover important things from bills to funeral costs. With life policies, you can get affordable life insurance protection for a set period of time.

Who is it for?

Everyone's life insurance needs are different, depending on their family situation. That's why group life insurance through an employer is an easier and more affordable option than individual life insurance.

What does it cover?

Life insurance protects your loved ones by providing a benefit (which is usually tax-exempt) if you pass away.

Why should I consider it?

Life insurance is about more than just covering expenses. Depending on your circumstances, it could take your family years to recover from the loss of your income.

With a life insurance benefit, your family will have extra money to cover mortgage and rent payments, legal or medical fees, childcare, tuition, and any outstanding debts.

Guardian, its subsidiaries, agents, and employees do not provide tax, legal, or accounting advice. Consult your tax, legal, or accounting professional regarding your individual situation.

You will receive these benefits if you meet the conditions listed in the policy.

Preparing and planning

Jorge's never considered purchasing life insurance, but after being offered it through work, he decides it's a smart way to protect his family.

Jorge has a mortgage, and because his wife is helping to take care of her mother, she only works part-time. In addition, his daughter is about to start college.

Jorge looks at how his family would be affected by losing him.

Average funeral cost: **$9,000**

Average mortgage debt: **$202,000**

Average cost of college: **$17,000 - $44,000**

Average household credit card debt: **$8,500**

With life insurance, Jorge can make sure that part of these costs are covered if something happens to him.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

LIFE/AD&D BASIC

Your life coverage

	BASIC LIFE
Employee Benefit	Your employer provides $10,000 Basic Term Life coverage for all full time employees.
Accidental Death and Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	Guarantee Issue coverage up to $10,000 per employee
Premiums	Covered by your company if you meet eligibility requirements
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions, including evidence of insurability
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Subject to coverage limits
The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

LIFE WHOLE

TEXAS REPUBLIC LIFE INSURANCE COMPANY

While Hill County offers basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage through Texas Republic Life.

TEXAS REPUBLIC TRUEFLEX UNIVERSAL LIFE

Texas Republic Life Insurance was founded by a group of industry leaders with one goal in mind, Texans helping Texans. With over 200 years of industry experience consulting together the TrueFlex Universal Life product was developed for the Texas work space.

BENEFITS OF TRUEFLEX

The market today demands efficiency and accuracy. Texas Republic Life accomplishes both with the TrueFlex product. Using state of the art technology, TrueFlex enrollments are both easy and accurate.

When you take a best of class product, add cutting edge technology, years of experience in the worksite space, and a personal Texas touch, you have the ingredients needed for success.

HIGHLIGHTS FOR THE EMPLOYEE

- Permanent Life Insurance coverage to age 121 with no reduction of benefit.
- Available for the whole family; employee, spouse, and children.
- Easy qualification with Express Issue Underwriting (only three questions and **NO MEDICAL EXAM!!!**)
- Convenient to enroll in. Offered through your employer as part of your benefits package.
- Funded through the convenience of payroll deduction.
- Portable and easy, TrueFlex transitions from payroll deduction to a bank draft or direct bill when you retire or change jobs.
- Guaranteed premium rate for a significant number of years (average of 30 years across all ages).
- Provides Accelerated Death Benefit, that can be used as a living benefit.
- Flexible options! Including Accidental Death Rider and Accelerated Death Benefit.
- Individual issue policies allows the employee to purchase a policy on family members even if the employee does not participate in the life insurance program.
- Perfect complement to Group Term and Voluntary Term. In your working years you want max protection (Term and Permanent Life). House payment, car payments, kids, college, that is a lot of responsibility. When you retire your exposure to risk can be greatly diminished.

LIFE WHOLE

TEXAS REPUBLIC LIFE INSURANCE COMPANY

PERMANENT PROTECTION

TrueFlex is permanent life insurance protection. Texas Republic Life can never cancel or reduce coverage if the required premiums are paid, even if your health status changes. Coverage extends to age 121. At age 121 the policy matures, and the cash surrender value shall be paid to the owner of the policy and the coverage terminated.

LOWER PREMIUMS

TrueFlex is designed to have a minimal cash value. It is to be purchased for life insurance protection. Payment of table premium produces a small cash value, used to keep the policy enforce and premiums level. Making loans can affect the performance of the policy.

PORTABLE POLICY

TrueFlex is portable. Continuance of employment is not a condition of continued coverage. When your employment status changes due to retirement or termination you may port your TrueFlex policy. When you retire or terminate employment, you may port your TrueFlex policy by making your premium payment by bank draft or direct bill. Texas Republic Life reserves the right to charge a monthly fee for a direct bill not to exceed $2.00.

LONG GUARANTEED PERIODS

TrueFlex has long guaranteed periods (an average of over 30 years across all age groups). Texas Republic Life cannot legally predict the premium required to keep the policy in force after the guaranteed period. The premium could go down, stay the same, or go up after the guaranteed period.

INDIVIDUAL POLICIES

TrueFlex individual policies are available for the employee, spouse, children and grandchildren. Please see the underwriting offer for Minimum and Maximum offers for family coverage. TrueFlex policies are individual so the employee does not have to participate to purchase coverage on other family members. Most policies are issued based on three work and health related questions on the application.

UNIVERSAL LIFE CONTRACT

TrueFlex is a Universal Life Contract. The premium has a flexible mechanism but if the table premiums are not paid the policy could laps before the guaranteed period. The Trueflex life product has a 4% guaranteed credited interest rate and charges an 8% loan interest rate.

ACCIDENTAL DEATH RIDER

The TrueFlex Accidental Death Rider is used to protect policy owners against an untimely death caused by an accident. The Accidental Death Rider doubles the face amount when the insured is killed in an accident before the insured's 70th birthday. The accident must be the cause of death and the death occurring within 180 days of the accident. Please see form TRLIC-ADB.

ACCELERATED DEATH BENEFIT

The Accelerated Death Benefit Rider is included with every TrueFlex policy at no additional cost. You can Accelerate 50% of your death benefit if you are diagnosed as Terminally Ill. Terminally Ill is defined as having 12 months or less to live by a licensed physician. This benefit is paid in a lump sum and there is a $100.00 administration charge. (Please see form TRLIC-Chron for full explanation of benefit). You can also Accelerate 45% of your death benefit with a Chronic Care Rider if you are unable to preform 2 of the 6 activities of daily living or have severe cognitive impairment. This benefit is paid out over a 24-month period. There is a $100.00 administration charge for this acceleration of the death benefit. (Please see form TRLIC-Chron for a full explanation of benefits). These benefits may have tax consequences so please consult your tax advisor. The Accelerated Death Benefit may also affect your eligibility for medical assistance. Please consult your advisor before you make application for the Accelerated Death Benefit.

Eligibility:

Employee: Ages 17-65
Spouse: Ages 17-60
Child(ren): 14 days - 26 years

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

LIFE NON-TOBACCO

TEXAS REPUBLIC LIFE INSURANCE COMPANY

TrueFlex

Class: Non-Tobacco

TEXAS REPUBLIC LIFE INSURANCE COMPANY

Issue Age (ALB)	Semi-Monthly Premium with ADB (24 Pay Periods per Year)								Age to Which Coverage is Guaranteed at Table Premium
	25,000	30,000	40,000	50,000	75,000	100,000	125,000	150,000	
17-20	5.15	5.96	7.56	9.17	13.19	17.21	21.23	25.25	66
21	5.27	6.09	7.75	9.40	13.54	17.67	21.81	25.94	66
22	5.27	6.09	7.75	9.40	13.54	17.67	21.81	25.94	65
23	5.38	6.23	7.93	9.63	13.88	18.13	22.38	26.63	63
24	5.38	6.23	7.93	9.63	13.88	18.13	22.38	26.63	63
25	5.38	6.23	7.93	9.63	13.88	18.13	22.38	26.63	63
26	5.50	6.38	8.13	9.88	14.25	18.63	23.00	27.38	63
27	5.62	6.52	8.31	10.11	14.60	19.09	23.58	28.06	63
28	5.62	6.52	8.31	10.11	14.60	19.09	23.58	28.06	62
29	5.73	6.65	8.50	10.34	14.94	19.55	24.15	28.75	62
30	5.85	6.79	8.68	10.57	15.29	20.00	24.72	29.44	60
31	5.85	6.79	8.68	10.57	15.29	20.00	24.72	29.44	60
32	6.08	7.07	9.05	11.03	15.97	20.92	25.87	30.81	61
33	6.32	7.35	9.43	11.50	16.69	21.88	27.07	32.25	62
34	6.55	7.63	9.80	11.96	17.38	22.80	28.21	33.62	62
35	6.90	8.06	10.36	12.67	18.44	24.21	29.98	35.75	64
36	7.13	8.33	10.73	13.13	19.13	25.13	31.13	37.13	64
37	7.36	8.60	11.10	13.59	19.82	26.05	32.28	38.50	64
38	7.71	9.03	11.66	14.30	20.88	27.46	34.05	40.63	65
39	8.17	9.58	12.40	15.21	22.25	29.30	36.34	43.37	66
40	8.64	10.14	13.15	16.15	23.66	31.17	38.68	46.19	67
41	9.22	10.84	14.08	17.32	25.41	33.50	41.60	49.69	68
42	10.04	11.82	15.38	18.94	27.85	36.75	45.66	54.56	70
43	10.85	12.79	16.68	20.57	30.29	40.00	49.72	59.44	72
44	11.66	13.77	17.98	22.19	32.72	43.25	53.79	64.31	73
45	12.59	14.88	19.46	24.05	35.51	46.96	58.42	69.88	74
46	13.53	16.01	20.96	25.92	38.32	50.71	63.11	75.50	75
47	14.34	16.98	22.26	27.55	40.76	53.96	67.17	80.38	76
48	15.27	18.09	23.75	29.40	43.54	57.67	71.81	85.94	77
49	16.32	19.35	25.43	31.50	46.69	61.88	77.07	92.25	78
50	17.59	20.88	27.46	34.05	50.51	66.96	83.42		79
51	19.10	22.69	29.88	37.07	55.04	73.00	90.97		80
52	20.96	24.93	32.86	40.80	60.63	80.46	100.30		82
53	22.82	27.15	35.83	44.50	66.19	87.88	109.57		83
54	24.68	29.39	38.81	48.23	71.79	95.34	118.89		85
55	26.31	31.34	41.41	51.48	76.66	101.84	127.02		86
56	27.47	32.74	43.28	53.82	80.16	106.50	132.85		85
57	28.29	33.72	44.58	55.44	82.60	109.75	136.91		84
58	29.21	34.83	46.06	57.30	85.38	113.46	141.55		84
59	30.38	36.23	47.93	59.63	88.88	118.13	147.38		84
60	31.12	37.12	49.11	61.11	91.10	121.09	151.08		84
61	33.80	40.33	53.40	66.46	99.13	131.80	164.46		85
62	37.05	44.23	58.60	72.96	108.88	144.80	180.71		87
63	39.25	46.88	62.13	77.38	115.50	153.63	191.75		89
64	41.50	49.58	65.73	81.88	122.25	162.63	203.00		93
65	43.88	52.43	69.53	86.63	129.38	172.13	214.88		94

Spouse Permanent Life Policy: Based on Spouse Age: Ages (17-60): Max of $50,000

Child(ren) Permanent Life Policies: $25,000 for $4.50 per (24 pay), per covered child.

LIFE TOBACCO

TEXAS REPUBLIC LIFE INSURANCE COMPANY

TrueFlex
Class: Tobacco

TEXAS REPUBLIC LIFE INSURANCE COMPANY

Issue Age (ALB)	Semi-Monthly Premium with ADB (24 Pay Periods per Year)								Age to Which Coverage is Guaranteed at Table Premium
	25,000	30,000	40,000	50,000	75,000	100,000	125,000	150,000	
17-20	7.13	8.33	10.73	13.13	19.13	25.13	31.13	37.13	66
21	7.36	8.60	11.10	13.59	19.82	26.05	32.28	38.50	66
22	7.36	8.60	11.10	13.59	19.82	26.05	32.28	38.50	65
23	7.71	9.03	11.66	14.30	20.88	27.46	34.05	40.63	63
24	7.71	9.03	11.66	14.30	20.88	27.46	34.05	40.63	63
25	7.71	9.03	11.66	14.30	20.88	27.46	34.05	40.63	63
26	7.83	9.17	11.85	14.53	21.22	27.92	34.62	41.31	63
27	7.94	9.30	12.03	14.75	21.57	28.38	35.19	42.00	63
28	8.06	9.44	12.21	14.98	21.91	28.84	35.77	42.69	62
29	8.17	9.58	12.40	15.21	22.25	29.30	36.34	43.37	62
30	9.11	10.70	13.90	17.09	25.07	33.05	41.03	49.00	60
31	9.11	10.70	13.90	17.09	25.07	33.05	41.03	49.00	60
32	9.34	10.98	14.26	17.55	25.76	33.96	42.17	50.38	61
33	9.45	11.12	14.45	17.78	26.10	34.42	42.74	51.06	62
34	9.57	11.25	14.63	18.00	26.44	34.88	43.32	51.75	62
35	10.15	11.96	15.56	19.17	28.19	37.21	46.23	55.25	64
36	10.50	12.38	16.13	19.88	29.25	38.63	48.00	57.38	64
37	11.08	13.07	17.05	21.03	30.97	40.92	50.87	60.81	64
38	11.43	13.49	17.61	21.73	32.04	42.34	52.64	62.94	65
39	12.13	14.33	18.73	23.13	34.13	45.13	56.13	67.13	66
40	13.17	15.58	20.40	25.21	37.25	49.30	61.34	73.37	67
41	13.98	16.55	21.70	26.84	39.69	52.55	65.40	78.25	68
42	15.04	17.82	23.38	28.94	42.85	56.75	70.66	84.56	70
43	16.66	19.77	25.98	32.19	47.72	63.25	78.79	94.31	72
44	17.59	20.88	27.46	34.05	50.51	66.96	83.42	99.88	73
45	18.87	22.42	29.51	36.61	54.35	72.09	89.83	107.56	74
46	20.04	23.82	31.38	38.94	57.85	76.75	95.66	114.56	75
47	21.19	25.20	33.23	41.25	61.32	81.38	101.44	121.50	76
48	22.36	26.60	35.10	43.59	64.82	86.05	107.28	128.50	77
49	24.21	28.83	38.06	47.30	70.38	93.46	116.55	139.63	78
50	25.49	30.37	40.11	49.86	74.22	98.59	122.95		79
51	27.47	32.74	43.28	53.82	80.16	106.50	132.85		80
52	29.91	35.67	47.18	58.69	87.47	116.25	145.04		82
53	31.89	38.04	50.35	62.65	93.41	124.17	154.93		83
54	34.33	40.97	54.25	67.53	100.72	133.92	167.12		85
55	36.08	43.07	57.05	71.03	105.97	140.92	175.87		86
56	37.59	44.88	59.46	74.05	110.51	146.96	183.42		85
57	38.74	46.27	61.31	76.36	113.97	151.59	189.20		84
58	40.84	48.78	64.66	80.55	120.26	159.96	199.67		84
59	42.59	50.88	67.46	84.05	125.51	166.96	208.42		84
60	43.68	52.19	69.21	86.23	128.79	171.34	213.89		84
61	46.70	55.82	74.05	92.28	137.85	183.42	228.99		85
62	50.54	60.42	80.18	99.94	149.35	198.75	248.16		87
63	54.48	65.15	86.50	107.84	161.19	214.55	267.90		89
64	58.79	70.32	93.38	116.44	174.10	231.75	289.41		93
65	61.69	73.80	98.03	122.25	182.82	243.38	303.94		94

Spouse Permanent Life Policy: Based on Spouse Age: Ages (17-60): Max of $50,000

Child(ren) Permanent Life Policies: $25,000 for $4.50 per (24 pay), per covered child.

Guardian®

Watch our video
How short term disability insurance can supplement your income.

Disability insurance

Short term disability

Disability insurance covers a part of your income, so you can pay your bills if you're injured or sick and can't work.

Disability may be more common than you might realize, and people can be unable to work for all sorts of different reasons. There are times when many disabilities can be caused by Illness, including common conditions like heart disease and arthritis. However, many disabilities aren't covered by workers' compensation.

Who is it for?

If you rely on your income to pay for everyday expenses, then you should probably consider disability insurance. It helps ensure that you'll receive a partial income if you're injured or too sick to work.

What does it cover?

Many disability insurance plans pay out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

Why should I consider it?

Accidents happen, and you can't always anticipate if or when you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills in the event of being unable to collect your normal paycheck.

You will receive these benefits if you meet the conditions listed in the policy.

Partial income replacement

Mike injures his back in a bicycle accident and can't work for 13 weeks.

Unpaid time off work: **13 weeks**

Elimination period: **1 week**

After a 1-week elimination period following his accident, Mike's Guardian Short Term Disability policy kicks in and replaces **$400** of his weekly income for the remaining **12 weeks** of his rehabilitation.

This gives him a total of **$4,800** to cover his expenses while he's unable to work.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Guardian

Watch our video
How long term disability insurance can supplement your income.

Disability insurance

Long term disability

Disability insurance covers a part of your income, so you can pay your bills if you're injured or sick and can't work.

Disability may be more common than you might realize, and people can be unable to work for all sorts of different reasons. There are times when many disabilities can be caused by Illness, including common conditions like heart disease and arthritis. However, many disabilities aren't covered by workers' compensation.

Who is it for?

If you rely on your income to pay for everyday expenses, then you should probably consider disability insurance. It helps ensure that you'll receive a partial income if you're injured or too sick to work.

What does it cover?

Many disability insurance plans pay out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

Why should I consider it?

Accidents happen, and you can't always anticipate if or when you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills in the event of being unable to collect your normal paycheck.

You will receive these benefits if you meet the conditions listed in the policy.

Partial income replacement

Jim suffers a heart attack that leaves him unable to work for two years.

Unpaid time off work: **24 months**

Elimination period: **6 months**

After a 6 month elimination period, Jim's Guardian Long Term Disability policy kicks in and replaces **$2,000** of his monthly income for the remaining **18 months** of his disability or illness.

This gives him a total of **$36,000** to cover his expenses while he's unable to work.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

DISABILITY

Guardian®

Your disability coverage

	Short-Term Disability	Long-Term Disability
Coverage amount	Choose weekly benefit amount from $200 to $1500. See cost illustration page for weekly benefit offerings.	60% of salary to maximum $6000/month
Maximum payment period: Maximum length of time you can receive disability benefits.	13 weeks	Social Security Normal Retirement Age
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 8	Day 91
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 8	Day 91
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required	Health Statement may be required
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue $1500 in coverage	We Guarantee Issue $6000 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines	Planholder Determines
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months look back; 12 months after 2 week limitation	12 months look back; 12 months after exclusion
Premium waived if disabled: Premium will not need to be paid when you are receiving benefits.	Yes	Yes
Survivor benefit: Additional benefit payable to your family if you die while disabled.	No	3 months

UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

- **Disability (long-term):** For first two years of disability, you will receive benefit payments while you are unable to work in your own occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.
- **Earnings definition:** Your covered salary excludes bonuses and commissions.
- **Special limitations:** Provides a 24-month benefit limit for specific conditions including mental health and substance abuse. Other conditions such as chronic fatigue are also included in this limitation. Refer to contract for details.
- **Work incentive:** Plan benefit will not be reduced for a specified amount of months so that you have part-time earnings while you remain disabled, unless the combined benefit and earnings exceed 100% of your previous earnings.

DISABILITY

Guardian®

Short-Term Disability Plan Cost Illustration:

	Election Cost Per Age Bracket								
	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*60+*
$17,333 Minimum Annual Salary $200 Weekly Benefit	$6.43	$6.43	$8.71	$6.21	$4.48	$4.40	$4.95	$5.70	$8.62
$21,667 Minimum Annual Salary $250	$8.04	$8.04	$10.89	$7.76	$5.60	$5.50	$6.19	$7.13	$10.78
$26,000 Minimum Annual Salary $300	$9.65	$9.65	$13.07	$9.32	$6.72	$6.60	$7.43	$8.55	$12.93
$30,333 Minimum Annual Salary $350	$11.25	$11.25	$15.24	$10.87	$7.84	$7.70	$8.66	$9.98	$15.09
$34,667 Minimum Annual Salary $400	$12.86	$12.86	$17.42	$12.42	$8.96	$8.80	$9.90	$11.40	$17.24
$39,000 Minimum Annual Salary $450	$14.47	$14.47	$19.60	$13.97	$10.08	$9.90	$11.14	$12.83	$19.40
$43,333 Minimum Annual Salary $500	$16.08	$16.08	$21.78	$15.53	$11.20	$11.00	$12.38	$14.25	$21.55
$47,667 Minimum Annual Salary $550	$17.68	$17.68	$23.95	$17.08	$12.32	$12.10	$13.61	$15.68	$23.71
$52,000 Minimum Annual Salary $600	$19.29	$19.29	$26.13	$18.63	$13.44	$13.20	$14.85	$17.10	$25.86
$65,000 Minimum Annual Salary $750	$24.11	$24.11	$32.66	$23.29	$16.80	$16.50	$18.56	$21.38	$32.33
$73,667 Minimum Annual Salary $850	$27.33	$27.33	$37.02	$26.39	$19.04	$18.70	$21.04	$24.23	$36.64
$86,667 Minimum Annual Salary $1,000	$32.15	$32.15	$43.55	$31.05	$22.40	$22.00	$24.75	$28.50	$43.10
$108,333 Minimum Annual Salary $1,250	$40.19	$40.19	$54.44	$38.81	$28.00	$27.50	$30.94	$35.63	$53.88
$130,000 Minimum Annual Salary $1,500	$48.23	$48.23	$65.33	$46.58	$33.60	$33.00	$37.13	$42.75	$64.65

*This benefit may not exceed 60% of your weekly salary.

Long-Term Disability Plan Cost Illustration:

Policy amounts shown based on sample salary amounts only.

	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*60+*
Your premium rate	$0.080	$0.090	$0.180	$0.310	$0.470	$0.680	$0.890	$1.100	$1.020

DISABILITY

Guardian®

	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+
	Election Cost Per Age Bracket								
	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+
$20,000 Annual Salary $1,000 Monthly Benefit	$0.67	$0.75	$1.50	$2.58	$3.92	$5.67	$7.42	$9.17	$8.50
$30,000 Annual Salary $1,500 Monthly Benefit	$1.00	$1.13	$2.25	$3.88	$5.88	$8.50	$11.13	$13.75	$12.75
$40,000 Annual Salary $2,000 Monthly Benefit	$1.33	$1.50	$3.00	$5.17	$7.83	$11.33	$14.83	$18.33	$17.00
$50,000 Annual Salary $2,500 Monthly Benefit	$1.67	$1.88	$3.75	$6.46	$9.79	$14.17	$18.54	$22.92	$21.25
$60,000 Annual Salary $3,000 Monthly Benefit	$2.00	$2.25	$4.50	$7.75	$11.75	$17.00	$22.25	$27.50	$25.50
$70,000 Annual Salary $3,500 Monthly Benefit	$2.33	$2.63	$5.25	$9.04	$13.71	$19.83	$25.96	$32.08	$29.75
$80,000 Annual Salary $4,000 Monthly Benefit	$2.67	$3.00	$6.00	$10.33	$15.67	$22.67	$29.67	$36.67	$34.00
$90,000 Annual Salary $4,500 Monthly Benefit	$3.00	$3.38	$6.75	$11.63	$17.63	$25.50	$33.38	$41.25	$38.25
$100,000 Annual Salary $5,000 Monthly Benefit	$3.33	$3.75	$7.50	$12.92	$19.58	$28.33	$37.08	$45.83	$42.50
$110,000 Annual Salary $5,500 Monthly Benefit	$3.67	$4.13	$8.25	$14.21	$21.54	$31.17	$40.79	$50.42	$46.75
$120,000 Annual Salary $6,000 Monthly Benefit	$4.00	$4.50	$9.00	$15.50	$23.50	$34.00	$44.50	$55.00	$51.00

Guardian + OSARA HEALTH

Cancer support service

Personalized, empathetic support to help you navigate a cancer diagnosis.

With cancer cases in the United States continuing to rise and remaining a leading cause of long-term disability, employees may be looking for improved benefits that can support them to a better quality of life. That's why Guardian partnered with Osara Health to bring our members facing a cancer diagnosis the support services that can help you focus on your holistic well-being throughout your treatment. Because you have Guardian Long-Term Disability Insurance as a benefit through your employer, you have access to this unique 6 to 12 week program.

A comprehensive solution to help cancer patients navigate their diagnosis

Dedicated health coach

One-on-one coaching for holistic support, education and guidance with scheduled calls over 6-12 weeks that works around your schedule.

Digital resource modules

Weekly resources sent directly to you, covering the key areas of cancer self-management as developed by Osara Health's clinical research team.

Tailored well-being information

Access to the Osara Health app to track symptoms and access tailored and verified well being content.

"My health coach understood exactly what I was going through and provided a wealth of resources on how to manage my stress, as well as other tips on food and exercise that I wouldn't have otherwise." - Osara Health Cancer Coach Program Participant

This service is only available if you have qualifying lines of coverage. See your plan administrator for more details.

Guardian's Group Long Term Disability Insurance are underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs.

Osara Health ("Osara") is a vendor to The Guardian Life Insurance Company of America ("Guardian"). Osara and Guardian are not affiliated entities. Osara provides a personalized support program through certified health coaches to address cancer management issues for the benefit of a member ("Services"). Services are designed for members 18 years+ of age, diagnosed with cancer, regardless of cancer type, stage, or prognosis. Services are not meant to provide medical advice/care. Medical advice/care should be sought from your independent healthcare provider(s). Guardian does not control or provide any part of the Services and does not bear any liability for their provision. This informational resource is not a contract and is for illustrative purposes only. Only the policy contains applicable terms. Guardian and Osara reserve the right to discontinue Services at any time without notice. Services may not be available in all states. Guardian® is a registered trademark of The Guardian Life Insurance Company of America, New York, NY and is used with permission. ©2024 The Guardian Life Insurance Company of America. All rights reserved.

How to access

As part of the Guardian disability claims process, you will be proactively provided with the details on how to access this valuable benefit.

Guardian®

Watch our video
How critical illness insurance helps cover the costs of treatment.

Critical illness insurance

Critical illness insurance may help you cover expenses not covered by your health insurance.

It's a cash payment you receive if you ever experience a serious illness like cancer, a heart attack, or a stroke, giving you the financial support to focus on recovery.

Who is it for?

Critical illness insurance is a supplemental policy for people who already have health insurance. It provides you with an additional payment to cover expenses like deductibles, treatments, and living costs.

What does it cover?

Critical illnesses include strokes, heart attacks, Parkinson's disease and cancer. Our policies can cover over 30 major illnesses, helping you stay financially stable by paying you a lump sum if you're diagnosed with one of them.

Why should I consider it?

Health coverage is becoming more expensive, with higher co-pays, premiums, and deductibles. Critical illness insurance is an affordable way to supplement and pay for additional expenses that your health insurance doesn't cover. Our policies typically provide payments for the first and second time you're diagnosed with a covered illness.

Plus, critical illness insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

Critical costs

John is hospitalized after a heart attack, and has to cover the cost of five days as an inpatient.

Average heart attack hospitalization expense: **$53,000**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20%: **$10,300**.

Total out-of-pocket amount for John (deductible + coinsurance): **$11,800**.

John has a **$10,000** Guardian Critical Illness policy, which covers the majority of these out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

CRITICAL ILLNESS

Guardian

Your critical illness coverage

	CRITICAL ILLNESS	
Benefit Amount(s)	Employee may choose a lump sum benefit of $5,000 to $20,000 in $5,000 increments.	
CONDITIONS		
Vascular	**1st OCCURRENCE**	**2nd OCCURRENCE**
Heart Attack	100%	50%
Stroke	100%	50%
Heart Failure	100%	50%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	50%
Kidney Failure	100%	50%
ADDITIONAL CONDITIONS	**1st OCCURRENCE ONLY**	
Addison's Disease	30%	
ALS (Lou Gehrig's Disease)	100%	
Alzheimer's Disease	50%	
Coma	100%	
Huntington's Disease	30%	
Loss of Hearing	100%	
Loss of Sight	100%	
Loss of Speech	100%	
Multiple Sclerosis	30%	
Parkinson's Disease	100%	
Permanent Paralysis	50% for 1 limb, 100% for 2 limbs	
Severe Burns	100%	
Childhood Conditions	**1st OCCURRENCE ONLY**	
Cerebral Palsy	100%	
Cleft Lip/Palate	100%	
Club Foot	100%	
Cystic Fibrosis	100%	
Down's Syndrome	100%	
Muscular Dystrophy	100%	
Spina Bifida	100%	
Type 1 Diabetes	100%	
Spouse/Domestic Partner Benefit	May choose a lump sum benefit of $5,000 to $20,000 in $5,000 increments up to 100% of the employee's lump sum benefit.	
Child Benefit- children age Birth to 26 years	25% of employee's lump sum benefit	

CRITICAL ILLNESS

Guardian®

Your critical illness coverage

	CRITICAL ILLNESS
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages	50% at age 70
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period or the annual open enrollment period.	We Guarantee Issue up to: Less than age 70 $20,000 For a spouse: Less than age 70 $20,000 For a child: All Amounts **Health questions are required if the elected amount exceeds the Guarantee Issue, as well as for all applicants age 70+ regardless of elected amount.**
Portability: Allows you to take your Critical Illness coverage with you if you terminate employment.	Included
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months prior/6 months treatment free/12 months after
WELLNESS BENEFIT	
Employee Per Year Limit	$50
Spouse Per Year Limit	$50
Child Per Year Limit	$50

Condition Definitions

- Stroke: Stroke must be severe enough to cause neurological deficits at least 30 days after the event.
- Heart Failure: An insured must be placed on an organ transplant list in order to be eligible for the Heart failure benefits.
- Coronary Arteriosclerosis: Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.
- Organ Failure: Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.
- Kidney Failure: An insured must be placed on an organ transplant list in order to be eligible for the Kidney failure benefits.

CRITICAL ILLNESS

Guardian®

Critical Illness Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Critical Illness.

Your premium will not increase as you age.

Spouse/DP coverage premium is based on Employee age

Child cost is included with employee election.

	Semi-monthly Premiums Displayed *Election Cost Per Age Bracket*					
Issue Age	*< 30*	*30-39*	*40-49*	*50-59*	*60-69*	*70+†*
Employee						
$5,000	$1.76	$2.06	$3.11	$4.91	$7.01	$14.41
$10,000	$2.94	$3.54	$5.64	$9.24	$13.44	$28.24
$15,000	$4.11	$5.01	$8.16	$13.56	$19.86	$42.06
$20,000	$5.29	$6.49	$10.69	$17.89	$26.29	$55.89
Benefit Amount Up To 100% of Employee Amount to a Maximum of $20,000						
Spouse						
$5,000	$1.76	$2.06	$3.11	$4.91	$7.01	$14.41
$10,000	$2.94	$3.54	$5.64	$9.24	$13.44	$28.24
$15,000	$4.11	$5.01	$8.16	$13.56	$19.86	$42.06
$20,000	$5.29	$6.49	$10.69	$17.89	$26.29	$55.89

†Benefit reductions may apply. See plan details.

Guardian®

Watch our video
How accident insurance can get you back on your feet.

Accident insurance

Accidents happen. With accident insurance, you can help them hurt a bit less.

Accident insurance is an extra layer of protection that gives you a cash payment to help cover out-of-pocket expenses when you suffer an unexpected, qualifying accident.

Who is it for?

Nobody can predict when an accident might happen. That's why accident insurance is an important add-on policy for people who want to supplement the health and disability insurance coverage they already have individually or through an employer.

What does it cover?

Accident Insurance pays you lump sum of benefits after you suffer an accident. This could be more than 40 different circumstances, including: emergency treatment, ambulance, burns, dislocations, fractures, hospital confinement, and surgery.

Why should I consider it?

Health coverage may become more expensive, with higher co-pays, premiums, and deductibles. Accident insurance can be a simple, affordable way to help supplement and cover additional expenses your health and disability insurance may not cover, including x-rays, ambulance services, deductibles, and even things like rent or groceries.

Plus, accident insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

Added support during recovery

Amanda breaks her leg falling off her bike and needs emergency treatment.

Average non-surgical broken leg treatment expense: **$2,500**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the surgical cost after the deductible is met, but Amanda's still responsible for 20%: **$200**

Total out-of-pocket amount for Amanda (deductible + coinsurance): **$1,700**

Amanda's Guardian Accident policy pays her a benefit of **$1,700,** which covers all of her out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

ACCIDENT

Guardian

Your accident coverage

	ACCIDENT
COVERAGE - DETAILS	
Your Semi-monthly premium	$12.30
You and Spouse	$18.51
You and Child(ren)	$20.35
You, Spouse and Child(ren)	$26.56
Accident Coverage Type	On and Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment.	Included
ACCIDENTAL DEATH AND DISMEMBERMENT	
Benefit Amount(s)	Employee $50,000 Spouse $50,000 Child $5,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: $10,000 & Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500
WELLNESS BENEFIT - Per Year Limit	$50
Child(ren) Age Limits	Children age birth to 26 years
FEATURES	
Accident Emergency Room Treatment	$200
Accident Follow-Up Visit - Doctor	$75 up to 6 treatments
Air Ambulance	$1,500
Ambulance	$200
Appliance - Wheelchair, leg or back brace, crutches, walker, walking boot that extends above the ankle or brace for the neck.	$125
Blood/Plasma/Platelets	$300
Burns (2nd Degree/3rd Degree)	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
Burn - Skin Graft	50% of burn benefit
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child is participating in an organized sport that is governed by an organization and requires formal registration to participate.	20% increase to child benefits

ACCIDENT

Guardian®

FEATURES (Cont.)	
Chiropractic Visits	$50 per visit up to 6 visits
Coma	$12,500
Concussions	$100
Dislocations	Schedule up to $4,800
Diagnostic Exam (Major)	$200
Emergency Dental Work	$400/Crown, $100/Extraction
Epidural pain management	$100, 2 times per accident
Eye Injury	$300
Family Care	$20/day up to 30 days
Fracture	Schedule up to $6,000
Hospital Admission	$1,500
Hospital Confinement	$300/day - up to 1 year
Hospital ICU Admission	$2,500
Hospital ICU Confinement	$500/day - up to 15 days
Initial Physician's office/Urgent Care Facility Treatment	$200
Joint Replacement (hip/knee/shoulder)	$3,500/$1,750/$1,750
Knee Cartilage	$750
Laceration	Schedule up to $500
Lodging - The hospital must be more than 50 miles from the insured's residence.	$150/day, up to 30 days for companion hotel stay
Occupational or Physical Therapy	$35/day up to 10 days
Prosthetic Device/Artificial Limb	1: $750 2 or more: $1,500
Rehabilitation Unit Confinement	$150/day up to 15 days
Ruptured Disc With Surgical Repair	$750
Surgery	Schedule up to $1,500 Hernia: $200
Surgery - Exploratory or Arthroscopic	$350
Tendon/Ligament/Rotator Cuff	1: $750 2 or more: $1,500
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	$600, 3 times per accident
X - Ray	$40

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passenger in a public conveyance. If this is paid, we do not pay the Accidental Death benefit.

ACCIDENT PREMIUM BREAKDOWN				
COVERAGE	TOTAL MONTHLY	EMPLOYER MONTHLY	EMPLOYEE MONTHLY	EMPLOYEE BI-WEEKLY
Employee Only:	$24.59	$0.00	$24.59	$12.30
Employee + Family:	$37.02	$0.00	$37.02	$18.51
Employee + Child:	$40.70	$0.00	$40.70	$20.35
Employee + Family:	$53.12	$0.00	$53.12	$26.56

Guardian

Watch our video
How cancer insurance can ease the financial burden of a cancer diagnosis.

Cancer insurance

If you're diagnosed with cancer, the last thing you need to think about is the cost. Cancer insurance helps ease the financial burden.

Every year, more and more people are diagnosed with cancer. Unfortunately, in addition to bearing the physical and emotional toll of this disease, patients are often saddled with added financial expenses.

Who is it for?

Cancer insurance is for people who want added financial protection, in addition to their regular health insurance. It comes into play if you are diagnosed with cancer—providing additional financial support to help keep the focus on your cancer treatment and recovery.

What does it cover?

Cancer insurance benefits can help you handle medical plan deductibles, co-pays and other out-of-pocket costs by providing benefits when you receive radiation or chemotherapy treatment, or are hospitalized for surgery to treat cancer. These benefits can be used for non-medical expenses such as transportation to treatment facilities, and even everyday living expenses like groceries, rent, and mortgage payments.

Why should I consider it?

Health coverage may become more expensive, with higher co-pays, premiums, and deductibles. The unexpected out-of-pocket expenses of cancer recovery, including transportation, co-pays, and deductibles, can add up fast. What's more, some of the costs you may incur during recovery are non-medical, such as covering a mortgage, childcare, and household expenses. Cancer insurance can help you pay for all of them.

Plus, cancer insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

Extra support

Sarah's diagnosed with kidney cancer after a screening test and decides to undergo kidney removal surgery.

Average surgical expense: **$25,000**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the surgical cost after the deductible is met, but Sarah's still responsible for 20%: **$4,700**

Total out-of-pocket amount for Sarah (deductible + coinsurance): **$6,200**

Sarah has Guardian's Cancer Advantage policy, which pays her **$2,500** as an initial diagnosis benefit and **$2,100** for a 7-day hospital stay.

This gives her a total of **$4,600** to help cover a portion of her out-of-pocket amount.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

CANCER

Guardian®

Your cancer coverage

	CANCER
COVERAGE - DETAILS	
Your Semi-monthly premium	$19.21
You and Spouse	$32.00
You and Child(ren)	$21.41
You, Spouse and Child(ren)	$34.20
INITIAL DIAGNOSIS BENEFIT - Paid when you are diagnosed with internal invasive cancer for the first time while insured under this Plan.	
Benefit Amount(s)	Employee $7,500 Spouse $7,500 Child $7,500
Benefit Waiting Period - A specified period of time after your effective date during which the Initial Diagnosis benefits will not be payable.	30 Days
CANCER SCREENING	
Benefit Amount	$100; $100 for Follow-Up screening
RADIATION THERAPY OR CHEMOTHERAPY	
Benefit	Schedule amounts up to a $15,000 benefit year maximum.
Pre-Existing Conditions Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months prior/ 6 months treatment free/ 12 months after.
Portability: Allows you to take your Cancer coverage with you if you terminate employment. Ported Cancer plan terminates at age 70.	Included
Child(ren) Age Limits	Children age birth to 26 years
FEATURES	
Air Ambulance	$2,000/trip, limit 2 trips per hospital confinement
Alternative Care	$50/visit up to 20 visits
Ambulance	$250/trip, limit 2 trips per hospital confinement
Anesthesia	25% of surgery benefit
Anti-Nausea	$50/day up to $250 per month
Attending Physician	$25/day while hospital confined. Limit 75 visits.
Blood/Plasma/Platelets	$200/day up to $10,000 per year
Bone Marrow/Stem Cell	Bone Marrow: $10,000 Stem Cell: $2,500 50% benefit for 2nd transplant. $1,500 benefit if a donor
Experimental Treatment	$200/day up to $2,400/month
Extended Care Facility/Skilled Nursing care	$150/day up to 90 days per year
Government or Charity Hospital	$400 per day in lieu of all other benefits
Home Health Care	$100/visit up to 30 visits per year
Hormone Therapy	$50/treatment up to 12 treatments per year

CANCER

Guardian

Your cancer coverage

FEATURES (Cont.)	
Hospice	$100/day up to 100 days/lifetime
Hospital Confinement	$400/day for first 30 days; $800/day for 31st day thereafter per confinement
ICU Confinement	$600/day for first 30 days; $800/day for 31st day thereafter per confinement
Immunotherapy	$500 per month, $2500 lifetime max
Inpatient Special Nursing	$150/day up to 30 days per year
Medical Imaging	$200/image up to 2 per year
Outpatient and family member lodging - Lodging must be more than 50 miles from your home.	$100/day, up to 90 days per year
Outpatient or Ambulatory Surgical Center	$350/day, 3 days per procedure
Physical or Speech Therapy	$50/visit up to 4 visits per month, $1,000 lifetime max
Prosthetic	Surgically Implanted: $3,000/device, $6,000 lifetime max Non-Surgically: $300/device, $600 lifetime max
Reconstructive Surgery	Breast TRAM $3,000 Breast reconstruction $700 Breast Symmetry $350 Facial reconstruction $700
Reproductive Benefit	$1,500 egg harvesting, $500 egg or sperm storage, $2,000 lifetime max
Second Surgical Opinion	$300/surgery procedure
Skin Cancer	Biopsy Only: $100 Reconstructive Surgery: $250 Excision of a skin cancer: $375 Excision of a skin cancer with flap or graft: $600
Surgical Benefit	Schedule amount up to $5,500
Transportation/Companion Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive treatment for internal cancer.	$0.50/mile up to $1,500 per round trip/equal benefit for companion
Waiver of Premium - If you become disabled due to cancer that is diagnosed after the employee's effective date, and you remain disabled for 90 days, we will waive the premium due after such 90 days for as long as you remain disabled.	Included

CANCER PREMIUM BREAKDOWN				
COVERAGE	TOTAL MONTHLY	EMPLOYER MONTHLY	EMPLOYEE MONTHLY	EMPLOYEE BI-WEEKLY
Employee Only:	$38.42	$0.00	$38.42	$19.21
Employee + Family:	$64.00	$0.00	$64.00	$32.00
Employee + Child:	$42.82	$0.00	$42.82	$21.41
Employee + Family:	$68.40	$0.00	$68.40	$34.20

Guardian®

Electronic Evidence of Insurability (EOI)

Our online EOI forms are an easier, quicker alternative to traditional paper forms, helping you get covered when you need to provide additional information.

There are a few situations where you need to answer health questions, enroll for higher amounts of coverage, or request coverage after the initial eligibility period. In all of these situations, our online EOI form keeps things simple.

Electronic EOI keeps things simple

With Guardian's electronic EOI forms, your data is kept secure at every stage of the process. And with fewer errors than hand-written forms, and faster submission digitally, it's easier than ever to complete it and get covered.

Electronic EOI can be used for*:

- Basic life
- Voluntary life
- Short term disability
- Long term disability

How it works

You will receive a letter or email from your employer or Guardian with instructions and a unique link to submit your EOI form online.

First register and create an account on Guardian Anytime. Then simply fill out the form, electronically sign it, and click 'Submit.'

Once we receive the form, we'll contact you with any questions, before notifying you (and your employer if the coverage amount changes).

Guardian

Employee Assistance Program

We all need a little support every now and then.

Guardian's Employee Assistance Program gives you and your family members access to confidential personal support, across everything from stress management and nutrition to handling legal or financial issues.

The services available include consultations with experienced professionals, as well as access to resources and discounts designed to help you in a variety of different ways.

How it can help

Consultative services are available to provide direct support and assistance

Work/life assistance that can help you save money and balance commitments

Access legal and financial assistance and resources – including WillPrep Services

How to access

Visit
worklife.uprisehealth.com

Access Code
worklife

Call
1 800 386 7055

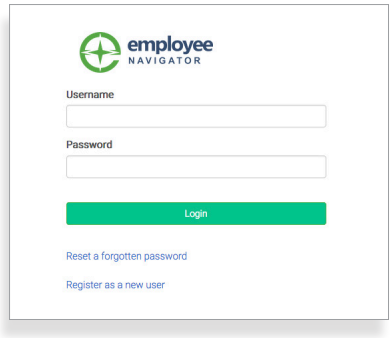
24 hour crisis help available.
Regular office hours:
Monday-Friday 6am-5pm PST.

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

Legal/financial assistance and resources services are not available in the state of New York.

The Employee Assistance Program is a suite of services solely created and offered by Integrated Behavioral Health, Inc. (IBH), doing business as Uprise Health. Guardian is not responsible or liable for care or advice given by any provider or any service offering within the Employee Assistance Program. This information is for informational purposes only. It is not a contract. Only the plan service agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the Employee Assistance Program at any time without notice. Legal services provided through the Employee Assistance Program will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer. The Employee Assistance Program, or any individual service offering within the Program, is not an insurance benefit and may not be available in all states.

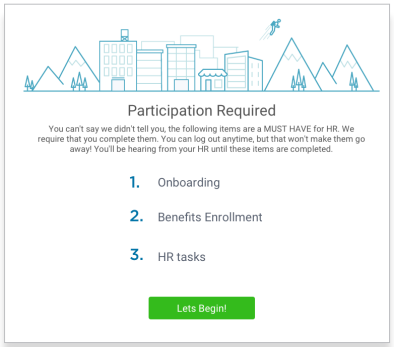
ENROLL IN YOUR BENEFITS: One step at a time



Step 1: Log In

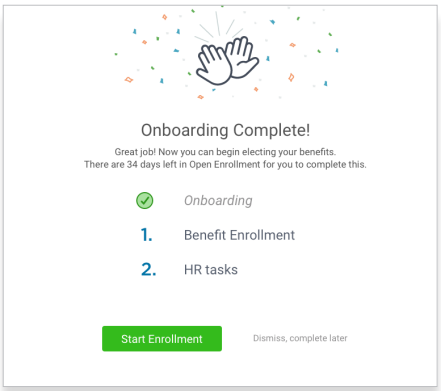
Go to www.employeenavigator.com and click **Login**

- **Returning users:** Log in with the username and password you selected. Click **Reset a forgotten password**.
- **First time users**: Click on your Registration Link in the email sent to you by your admin or **Register as a new user.** Create an account, and create your own username and password.



Step 2: Welcome!

After you login click **Let's Begin** to complete your required tasks.

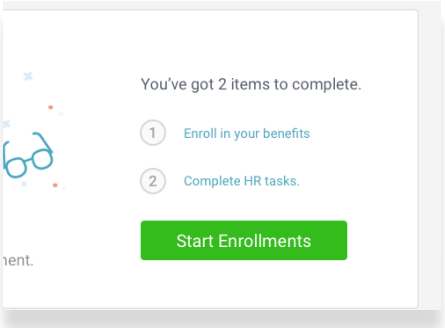


Step 3: Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click **Start Enrollment** to begin your enrollments.

TIP

if you hit "**Dismiss, complete later"** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **"Start Enrollments"**



Step 4: Start Enrollments

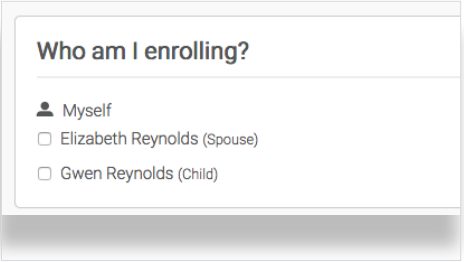
After clicking **Start Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.

TIP

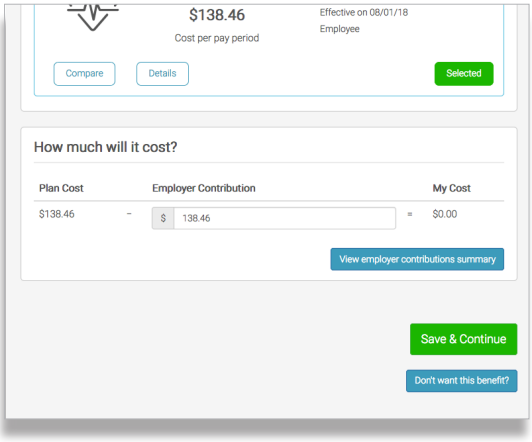
Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**



Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

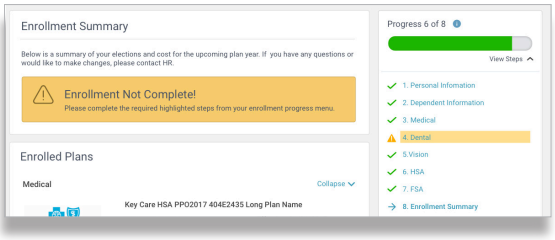


Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

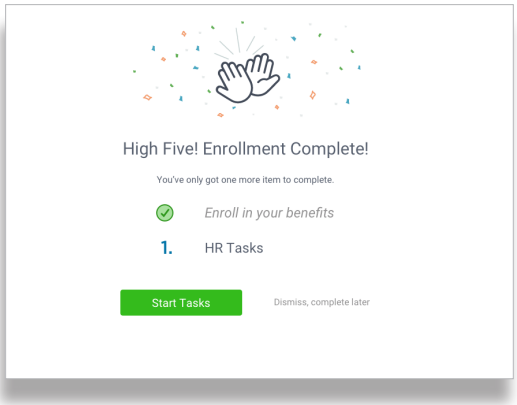


Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.



Step 8: HR Tasks (if applicable)

To complete any required HR tasks, click **Start Tasks**. If your HR department has not assigned any tasks, you're finished!

You can login to review your benefits 24/7

CONTACTS

THE STATE OF TEXAS HILL COUNTY	Rachel Parker County Treasurer	254-582-4050 rparker@co.hill.tx.us
ANCO INSURANCE A HUB International Company	Kelly Coppock Account Manager	979-774-6214 kelly.coppock@hubinternational.com
curative	Medical Network: PPO Group Number: Hill County	1-855-428-7284 www.curative.com
masa	MASA Medical Transportation Solutions	1-877-503-0585 www.masamts.com
Guardian	Dental/Vision/Life/Disability/ Critical Illness/Accident/Cancer Dental Network: DentalGuard Preferred Vision Network: VSP Choice Group Number: 530422	General: www.guardiananytime.com, Life: www.guardianlife.com; Vision: www.vsp.com”
TEXAS REPUBLIC LIFE INSURANCE COMPANY	Whole Life	1-512-330-0099 www.texasrepubliclife.com

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

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 is known as protected health information (PHI) and includes 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 (Plan), sponsored by your employer (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 duties 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 protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management.

Hill County is committed to the privacy of your health information. The administrators of **Curative** (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting: **Rachel Parker | rparker@co.hill.tx.us | 254-582-4050**

HIPAA Special Enrollment Rights

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (*Excluding* Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, **you must request enrollment within 60 days** after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, **you must request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, **you must request enrollment within 60 days** after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, please contact:

Rachel Parker
rparker@co.hill.tx.us | 254-582-4050

Important Warning
If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Women's Health and Cancer Act of 1998 (WHCRA)

Under Women's Health and Cancer Rights Act of 1998 (WHCRA), group health plans are required to provide benefits for mastectomy-related services. If you have had or are going to have a mastectomy, you may be entitled to certain benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation withthe 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 resulting from a mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefitsprovided under the plan. Please review your plan materials regarding any deductibles and/or coinsurance or call your Plan Administrator/benefits contact representative with any questions, concerns and/or more information on WHCRA benefits.

Notice for Newborns' and Mothers' Health Protection Act (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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)

USERRA Notice

HEALTH INSURANCE PROTECTION ☆☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. ☆☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

For your full Uniformed Service Employment and Reemployment Rights Act protections, please visit:

https://www.dol.gov/agencies/vets/programs/userra

Summary of Material Modifications Disclosure

This Employee Benefits Communication serves as notice of material changes to your employer sponsored health benefits plan(s). It describes the changes that affect your benefits plans and updates the Summary Plan Description (SPD). Please read this information thoroughly and keep it with your group health plan SPD. You can request a copy of your SPD by contacting your group health plan administrator.

No Surprise Billing Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact Federal No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services at 1-800-985-3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

Medicare Part D – Notice of CREDITABLE Coverage
Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Hill 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. **Hill County** has determined that the prescription drug coverage offered by Curative is, on average for all plan participants on all Plans offered, 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 **Hill County** coverage will or will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription coverage. If they select Medicare Part D prescription drug coverage, the group health plan drug coverage *may or may not* coordinate with Medicare Part D prescription coverage.

If you do decide to join a Medicare drug plan and drop your current **Hill County** coverage, be aware that you and your dependents *may or may not* 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 [Insert Name of Entity] 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 **Hill 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).

CONTACT INFORMATION:

Hill County
Plan Effective Date: October 1, 2025
Plan Administrator Contact: Rachel Parker
rparker@co.hill.tx.us | 254-582-4050

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the **2025 Plan Year** with respect to mental health or substance use disorder benefits, please contact your plan administrator:

Rachel Parker
rparker@co.hill.tx.us | 254-582-4050

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact **Rachel Parker**
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.

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