

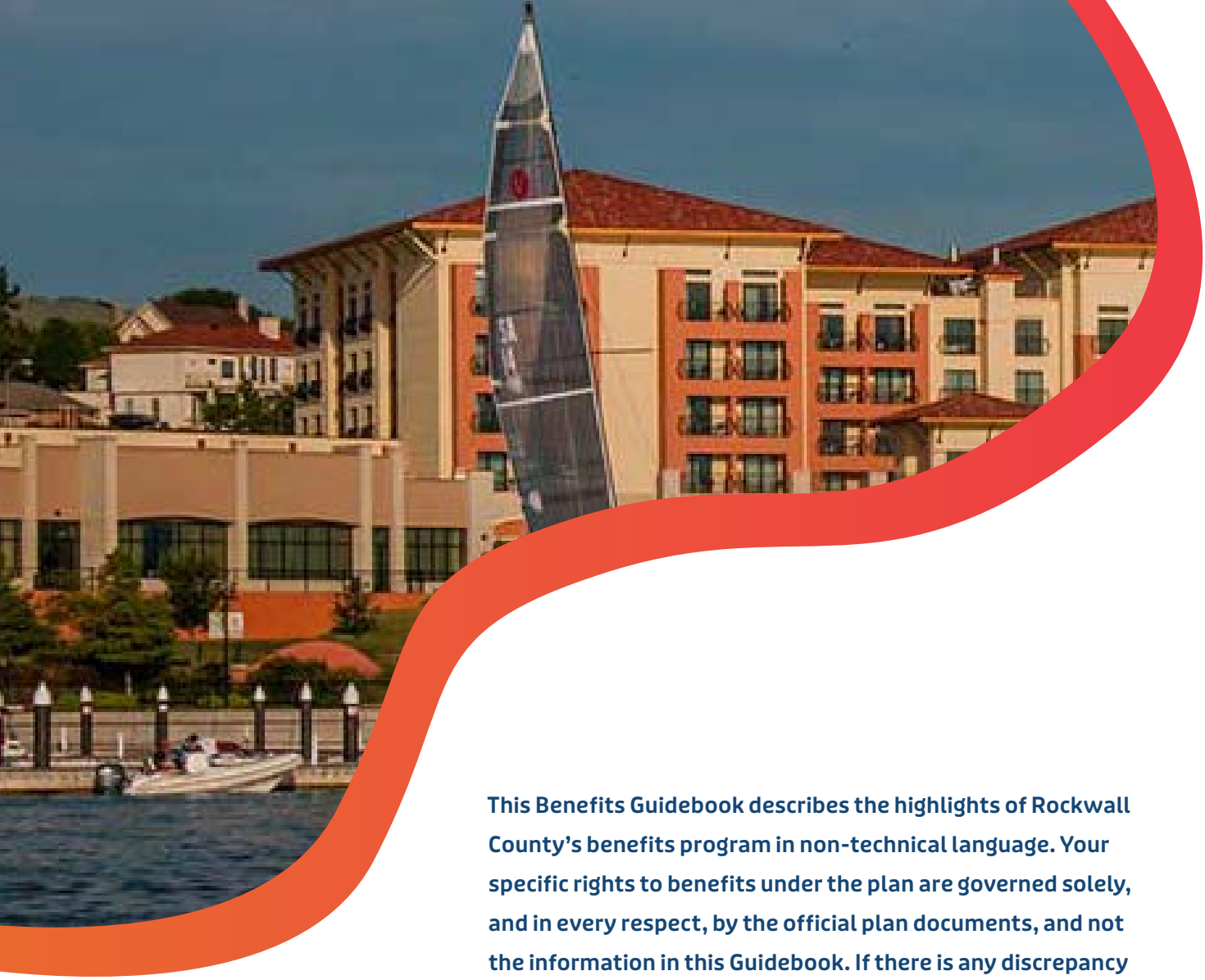


2027

Benefits Guide

ESTABLISHED 1873
ROCKWALL COUNTY
IN GOD WE TRUST

Annual Enrollment:
October 15, 2027



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

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Welcome to Your 2027 Benefits Guide

Each year, we strive to offer comprehensive and competitive benefit plans to our employees. In the following pages, you will find a summary of our benefit plans for the **January 1, 2027 to December 31, 2027** Plan Year. Please read this Guidebook carefully as you prepare to make your elections for the upcoming Plan Year.

TO ENROLL:

To enroll in your 2027 benefits:

Schedule an appointment with an Enrollment Counselor using link: **https://a.flexbooker.com/reserve/RockwallCountyOE2025** OR scan QR code with your phone's camera app.

Before you speak with an Enrollment Counselor, please have the following information ready:

- Dependents' Names
- Birth Dates
- Social Security Numbers
- Addresses
- Phone Numbers

Eligible for Medicare?

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see **page 29** for more details.

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Eligibility

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

EMPLOYEE ELIGIBILITY

Full-Time employees who are at least 18 years of age are eligible to participate in the benefits program, with an effective date of first of the month following a 30-day waiting period. Elected Officials become eligible for coverage on their hire date.

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



DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Lawful Spouse who is not eligible for group benefits through his/her own employment.
- Your eligible children up to age 26 for medical, dental and vision coverage.
- "Children" are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

QUALIFYING LIFE EVENTS

If you experience a Qualifying Life Event (for instance: getting married or having a baby), please contact HR; Proof of the Qualifying Life Event must be submitted to your HR within 31 days in order to change current benefit elections.

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

Health Management



The medical program, administered by UnitedHealthcare, provides the framework for your good health and well-being. In order to better meet the varying needs of our employees, Rockwall County is offering three medical plans described below.

How will Rockwall County know I received my annual physical?

Rockwall County's medical plan administrator, United Healthcare, will provide us a list of those employees who have completed a an annual physical. You do not have to provide certification as proof of completion.

Will Rockwall County be provided details about my physical?

No personal information will be shared with Rockwall County regarding your test results, only that the physical was completed.

Does this surcharge apply to dependents?

Yes, the surcharge does apply to the employee and spouse for the 2028 plan year.

What happens if my spouse or I do not receive an annual physical?

Employees who are enrolled in the County's medical plan and whom have NOT had an annual physical between October 1, 2026 and September 30, 2027 will be charged an additional $50 per person, per paycheck for medical insurance beginning in January 2028. If you and your spouse are both enrolled in the County's medical plan and both do NOT complete an annual physical, you will be charged $100 per paycheck ($50 per enrolled per paycheck). The requirement does not apply to children.

Action Required!

The County of Rockwall believes in the benefit of preventive health for you and your family members. The County's Go To Doctor Campaign encourages employees and covered spouses to take advantage of preventive healthcare services through an annual physical exam. To avoid a premium increase in 2028, employees and spouses enrolled in the County's medical plan must complete an annual physical between October 1, 2026 and September 30, 2027. Beginning January 1, 2028, employees who are enrolled in the County's medical plan and who have not completed an annual physical during that period will be charged an additional $50 per person, per paycheck (employee and spouse only) for medical insurance coverage. If both the employee and spouse are enrolled in the County's medical plan and both fail to complete an annual physical, the additional premium will be $100 per paycheck ($50 per enrolled person, per paycheck). The requirement does not apply to children.

Medical Plans At A Glance

	CHOICE PLUS PPO	HDHP / HSA	PPO II
	In-Network	In-Network	In-Network
Employer HSA Contribution Individual Family	N/A	$600 $1,200	N/A
Coinsurance	20%	20%	20%
Calendar Year Deductible Individual Family	$1,250 $2,500[1]	$3,500 $7,000	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$5,500 $11,000	$5,500 $11,000	$6,500 $13,000
Preventive Care	$0	$0	$0
Physician Office Visit Copay	$30	20% after deductible	$30
Specialist Office Visit Copay	$60		$60
Telehealth Doctor on Demand, Teladoc, Amwell	$20-$30		$20
24/7 Virtual Care	$54		
Urgent Care	$60		$60
Emergency Room Visit	$350 copay		$350 copay
Facility Hospital Inpatient	20% after deductible		20% after deductible
Facility Hospital Outpatient	20% after deductible		20% after deductible
Chiropractic	20 visits		20 visits
Phys/Occ/Speech Therapy	$25 - 20 visits		$25 - 20 visits
Major Diagnostics* (CT, PET, MRI, MRA & Nuclear Medicine)	20% after deductible		20% after deductible

EMPLOYEE BIWEEKLY CONTRIBUTIONS			
	In-Network	In-Network	In-Network
Employee	$27.56	$7.36	$13.25
Employee + Spouse	$145.48	$107.92	$116.60
Employee + Child(ren)	$109.11	$70.64	$76.32
Family	$211.61	$156.98	$169.59

Compare Your Options

Getting care at the place that may best fit your condition or situation may save you up to $2,500 compared to an emergency room (ER) visit.

- Visit **myuhc.com/quickcare** to find the best provider for your situation.

Virtual Visits

Visit with a doctor 24/7—whenever, wherever.

With a Virtual Visit, you can talk — by phone or video — to a doctor who can diagnose common medical conditions and even prescribe medications, if needed.*

Whether using myuhc.com® or the UnitedHealthcare® app, Virtual Visits let you video chat with a doctor 24/7 — without setting up additional accounts or apps. But, if you'd rather just speak with a doctor, you can simply do a Virtual Visit over the phone at **855.615.8335**.

	PHYSICAL WELL-BEING	MENTAL WELL-BEING*
Symptoms Treated	• Allergies • Cold or flu • Fever • Minor skin conditions • Nausea • Sinus infections • Stomachache • UTI • And more	• Anxiety • Depression • Parenting concerns • Relationship issues • Substance use concerns • Trauma and PTSD
Eligibility	• Adults • Children aged 18 months+	• Adults • Children aged 10+
Cost: PPO	• PPO: $0	• Psychiatrist: $0 • Therapist: $0
Cost: HDHP	• HDHP: $50, then $0 after deductible	• Psychiatrist: $75 to $200, $0 after deductible • Therapist: $45 to $90, $0 after deductible

GET ON-THE-GO ACCESS

The UnitedHealthcare® app puts your plan at your fingertips.

When you're out and about, you can do everything from managing your plan to getting convenient care. Just download the app to:

- Find nearby care options in your network.
- Estimate costs.
- Video chat with a doctor 24/7.*
- Access to virtual therapy
- View and share your health plan ID card.
- See your claim details and view progress toward your deductible.



*Data rates may apply.
Get the app and log on with Touch ID®.
The UnitedHealthcare app is available for download for iPhone® or Android®.

Prescriptions

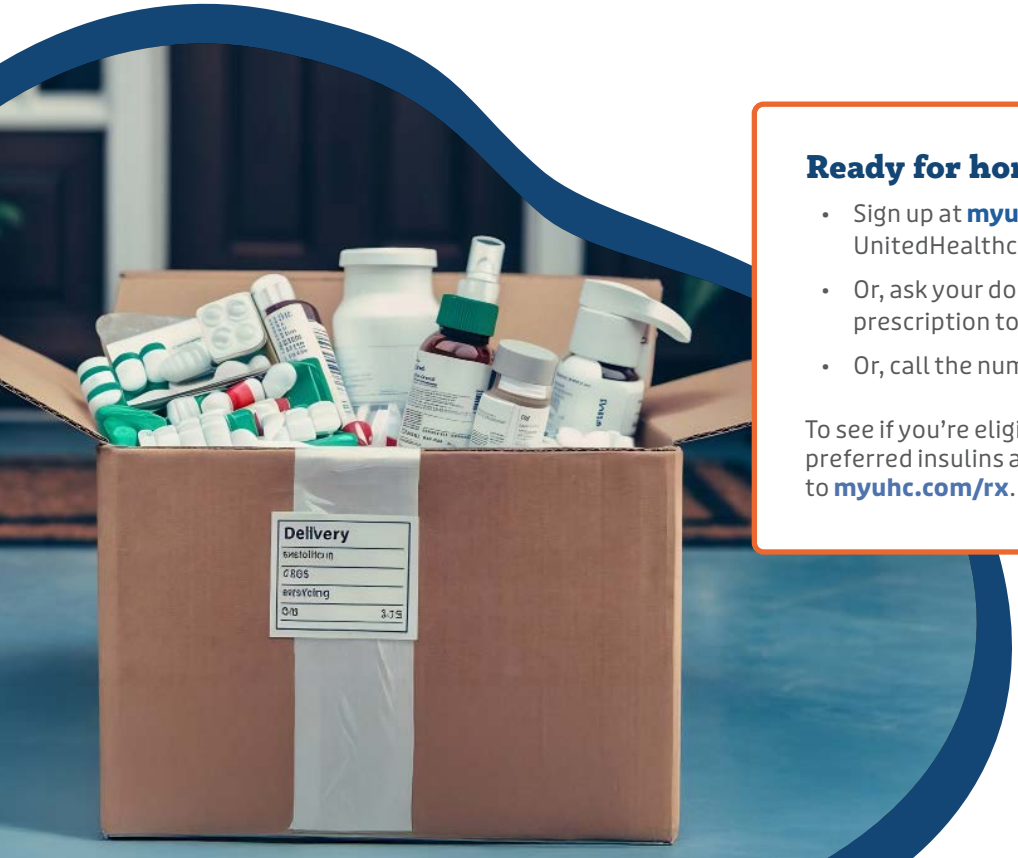
The new UnitedHealthare Vital Medication Program offers certain drugs at no additional cost.* This means there may be no out-of-pocket costs for preferred medications.

	PHARMACY Retail (30-day supply) | Mail Order (90-day supply)		
Tier 1 – Generic	$0 | $25	20% after deductible	$0 | $25
Tier 2 – Preferred Brand	$30 | $75		$30 | $75
Tier 3 – Non-Preferred Brand	$50 | $125		$50 | $125
Specialty Rx	$75 | $187.50		$75 | $187.50
OUT-OF-NETWORK BENEFITS			
OON Calendar Year Deductible	$1,250 ind / $2,500 family	$3,500 ind / $7,000 family	$2,500 ind / $5,000 family
OON Out-of-Pocket Maximum	Unlimited / Unlimited	Unlimited / Unlimited	Unlimited / Unlimited
OON Coinsurance	40%	40%	40%

MEDICATION HOME DELIVERY

With Optum® Home Delivery, you can get a 3-month supply of your long-term medications. Plus, they are mailed to you with free standard shipping.

- Your medications can be delivered to your door. You don't even have to leave home or wait in the pharmacy line.
- You may pay less than what you do at in-store pharmacies. And, standard shipping is free.
- With a 3-month supply, you may be less likely to miss a dose. You can even sign up for automatic refills.
- Make 1 payment upfront or split it up into 3 equal monthly payments with the Easy Payment Plan.



Ready for home delivery?

- Sign up at **myuhc.com**® or with the UnitedHealthcare® app.
- Or, ask your doctor to send an electronic prescription to Optum Rx.
- Or, call the number on your member ID card.

To see if you're eligible for no out-of-pocket costs on preferred insulins and other prescription drugs, sign in to **myuhc.com/rx**.

Additional Benefits



2nd.MD - Virtual Second Opinion

Virtual second opinions from doctors for new diagnoses, chronic conditions, surgery considerations, or medication changes. Personalized information and education via video or phone. This service can help with all adult and pediatric sub-specialties.

Visit **uhc.care/programs** or call **866.269.3534**.



AbleTo - Virtual Behavioral Coaching

Program to address being stressed, overwhelmed, or exhausted. Take advantage of an 8-week tailored coaching program with 1-on-1 mental health coaching, digital activities, weekly meetings, in-app messaging, and 24/7 access to resources like breathing exercises and meditations.

Visit **ableto.com/exploremore**.



Bend Health - Child and Family Behavioral Health Coaching

Support for families with children aged 1-17, including up to four 45-minute coaching sessions per month, unlimited in-app messaging, educational resources, and referrals to therapists or psychiatrists if needed.

Visit **bendhealth.com/coaching.**



Kaia Health - Digital Back and Joint Pain Management

Digital back and joint pain management through personalized exercise programs, real-time feedback, mindfulness, relaxation, and educational content.

Visit **uhc.care/getkaia.**



Specialist Management Solutions (SMS)

- Musculoskeletal/Spine (MSK) and Orthopedic Bone, Joint, Ligament, Tendon, or Muscle Conditions
- General Surgery, Hernia Repair, Gallbladder Removal
- Gastrointestinal (GI) Colonoscopy, Endoscopy for GERD, Acid Reflux, Heartburn
- Ear/Nose/Throat (ENT) Sinusitis, Acute Sinusitis, Hearing Loss, Throat Disorders
- Ophthalmology Diabetic Retinopathy, Cataract, Glaucoma, Macular Degeneration
- Women's Health Cervical Cancer Screening, Mammogram

Call **800.379.6898**.



Maven - Virtual Health Companion

Maven is your 24/7 virtual health companion for reproductive, family, and midlife health. Available at no cost to you, Maven bridges the gaps in traditional healthcare by connecting you with top-rated specialists via unlimited video appointments and messaging

- Maternity & Newborn Care: Receive personalized support from preconception through pregnancy, postpartum, and your return to work. Connect with OB-GYNs, doulas, lactation consultants, and mental health specialists.
- Menopause & Midlife Health: Navigate perimenopause, menopause, and midlife health changes with confidence. Access specialized providers, holistic care (nutrition, mental health), and guidance on symptom management or prescriptions like HRT.

Call **800.379.6898**.

Dental

UnitedHealthcare

UnitedHealthcare gives you the freedom to choose whether you would like to visit a participating dentist or an out-of-network dentist. There are considerable cost savings when using a dentist who is in network. The following is a brief summary of the major plan provisions.

For more information about your UnitedHealthcare benefits log-in at **www.myuhc.com.**

	PASSIVE PPO	
	In-Network (% of Negotiated Fee*)	**Out-of-Network** (% of R&C Fee**)
Deductible Individual Family	**Type B and C service only** $50 $150	**Type B and C service only** $50 $150
Annual Maximum Benefit	$2,000	$2,000
Orthodontia Lifetime Maximum	$2,000 per person	$2,000 per person
Type A – Preventive Oral Examinations Bitewing X-rays (Adult / Child) Prophylaxis – Cleanings Topical Fluoride Applications	100%	100%
Type B – Basic Restorative Full Mouth X-rays Sealants Space Maintainers Amalgam and Composite Fillings Periodontal Maintenance Emergency Palliative Treatment	80%	80%
Type C – Major Restorative Crowns / Inlays / Onlays Prefabricated Crowns Repairs Endodontics Root Canal Periodontal Surgery Periodontal Scaling and Root Planing Oral Surgery (Simple / Surgical Extractions) Other Oral Surgery Bridges Dentures General Anesthesia Consultations Implant Services	50%	50%
Type D – Orthodontia (Child only, up to age 19)	50%	50%

***In-Network Benefits** refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.

****Out-of-Network Benefits** are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:

- the dentist's actual charge (the 'Actual Charge'),
- the dentist's usual charge for the same or similar services (the 'Usual Charge') or
- the usual charge of most dentists in the same geographic area for the same or similar services as determined by UnitedHealthcare (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.

DENTAL BIWEEKLY DEDUCTIONS	
Employee	$5.00
Employee + Spouse	$20.63
Employee + Child(ren)	$29.38
Family	$55.63

LEARN MORE ABOUT YOUR DENTAL PLAN BY SCANNING THIS QR CODE OR VISITING UHC.COM

Vision

UnitedHealthcare

UnitedHealthcare is pleased to present to you vision benefits designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health.

For more information about your UnitedHealthcare benefits log-in at **www.myuhc.com.**

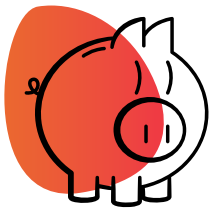
	In-Network	Out-of-Network
Exam Frequency	**12 months**	**12 months**
Exam Benefit	$10 copay	Reimburse up to $40
LENSES		
Materials Copay	$10 copay	
Frequency	12 months	12 months
Single	$10 copay	Reimburse up to $40
Bifocal	$10 copay	Reimburse up to $60
Trifocal	$10 copay	Reimburse up to $80
FRAMES		
Frequency	12 months	12 months
Allowance	$150 allowance	Reimburse up to $45
CONTACT LENSES		
Frequency	12 months	12 months
Allowance	Formulary: Up to 6 boxes; Non-formulary: $150 allowance	Reimburse up to $150
Medically Necessary	Covered in full	Reimburse up to $210
Separate Fitting Allowance	Included in Contact Allowance	N/A

***Contact lenses are in lieu of eyeglasses and frames**

VISION BIWEEKLY DEDUCTIONS	
Employee	$3.44
Employee + Spouse	$6.03
Employee + Child(ren)	$7.23
Family	$8.94

LEARN MORE ABOUT YOUR VISION PLAN BY SCANNING THIS QR CODE OR VISITING UHC.COM





Funding Accounts

Health Savings Account (HSA)

Save for future medical costs and reduce your pre-tax income by making contributions to an HSA. If you are enrolled in the HDHP with HSA, you may be eligible to contribute money to your HSA to pay for eligible health, vision and dental care expenses. Plus, Rockwall County contributes to your HSA as well.

HOW MUCH CAN YOU CONTRIBUTE?	ANNUAL IRS CONTRIBUTION LIMIT	ANNUAL EMPLOYER CONTRIBUTION	YOUR CONTRIBUTION LIMIT
Single coverage	$4,500	$600	$3,900
All other tiers coverage	$9,000	$1,200	$7,800

*Individuals age 55 or older can make an additional $1,000 in "catch up" contributions. Employer contributions are made monthly at 1/12 of the annual amount.

HSA ELIGIBILITY

In order to have a Health Savings Account (HSA) and receive contributions from Rockwall County, you MUST enroll in our High Deductible Health Plan (HDHP). The IRS does not permit you to contribute to an HSA if you:

- are enrolled in another non-HDHP medical plan like a Health Care FSA, Medicare Part A or B, or TRICARE
- have received Veterans' Administration benefits in the prior three months, or
- can be claimed as a dependent on someone else's tax return.

In these cases, you may still enroll in the HDHP, but you **MUST** opt out of the HSA.

USING YOUR HSA SAVINGS

You can use your HSA to pay for eligible medical expenses for your spouse and/or tax dependents. Full details of the expenses you can claim can be found in **IRS Publication 502**.

You can also use your HSA to save for your retirement by investing the balance in mutual funds, stocks, bonds and more (subject to a minimum account balance).

There are no use-it-or-lose-it rules, and your HSA funds roll over year to year. If you retire or resign, your account balance goes with you.

We'll Help Fund Your Health Savings Account!

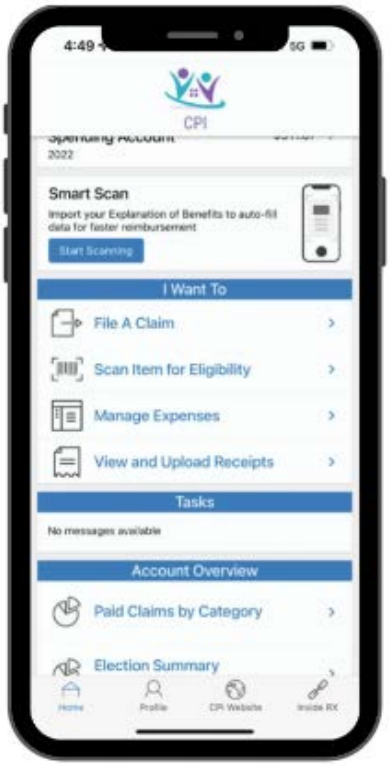
When you enroll in the HDHP with Health Savings Account we are excited to offer funding to help you meet your deductible and qualified medical expenses. Employer funds will be available to you beginning in January and pro-rated throughout the year.

Medical coverage funding:

Individual: $4,500

All Other Tiers: $9,000

LEARN MORE ABOUT YOUR HSA PLAN BY SCANNING THIS QR CODE OR VISITING MYCPITEAM.COM



Flexible Spending Accounts (FSAs)

The Flexible Spending Accounts (FSA) administered by CPI allows you to set aside pre-tax dollars from your paycheck to pay for many healthcare and dependent care expenses. By paying for these expenses with pre-tax dollars, you reduce the amount of your taxable income and increase your take-home pay. You may choose to participate in one or both FSAs – whether you elect any other benefits.

GENERAL RULES AND RESTRICTIONS

In exchange for the tax advantages FSAs offer, the IRS has imposed the following rules and restrictions for both healthcare FSA and dependent care FSA:

- You may only use the money in your FSAs to reimburse expenses that you have incurred during the plan year for which the FSA was established.
- IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the"use it or lose it" rule.
- You cannot transfer monies between Healthcare and Dependent Care FSAs.
- You cannot begin, stop, or change the amount of your FSA contributions during the calendar year unless you experience a Qualified Life Event (such as: marriage,divorce or the birth/adoption of a child). Contact your HR Department.
- You cannot claim expenses that are reimbursed through your FSA as a deduction on your income tax return.
- Reimbursement for dependent care FSA claims is only up to the total amount that is in your account at that time.
- The dependent care provider cannot be anyone considered your dependent for income tax purposes(such as one of your older children). In order to be reimbursed, you are required to provide the tax identification number or Social Security number of the party providing care.

HOW MUCH CAN I CONTRIBUTE?

To participate, decide how much you would like to contribute to one or both accounts for the year. The money you allocate to each account is automatically deducted from your paycheck each pay period before taxes are calculated.

- **For a Healthcare Flexible Spending Account you could contribute up to the maximum of $3,500 for the 2027 plan year.**
- **For a Dependent Care Flexible Spending Account you could contribute up to the maximum of $7,500 for the 2027 plan year.**
  The exceptions are:
  - »If you and your spouse file separate tax returns, you may contribute $3,750 per year.
  - »If your spouse is employed, your maximum contribution is the lesser of your spouse's taxable income (but no more than $7,500)
  - »If your spouse is a full-time student or they are physically or mentally disabled, your maximum contribution is $3,750 a year if you claim expenses for one dependent and $7,500 a year if you claim expenses for two or more dependents.



What happens to any remaining funds at the end of the plan year?

Following the end of the plan year, employees will be given a 90-day run out period during which to submit claims for the prior plan year. Upon the conclusion of the run out period, up to **$700 of funds remaining in an employee's account will be carried over for use in the following plan year** (this does not count against the maximum election you may make for the new plan year). Any funds in excess of $700 will be forfeited.

LEARN MORE ABOUT YOUR FSA PLAN BY SCANNING THIS QR CODE OR VISITING MYCPITEAM.COM

HSA & FSA Comparison

	HEALTH SAVINGS ACCOUNT (HSA)	FLEXIBLE SPENDING ACCOUNT (FSA)
What is it?	An HSA is a savings account that is used in combination with a high-deductible health plan (HDHP) that lets you set aside pre-tax funds. You can use your HSA funds to cover qualified medical expenses	An FSA is an account your employer establishes that allows you to set aside pre-tax funds aside to pay for eligible medical, dental, vision or daycare expenses
Am I eligible?	You must be enrolled in a HDHP in order open and contribute to an HSA If you are covered by a non-HDHP, medical FSA, 213(d) HRA or Medicare, you are not eligible to open or contribute to an HSA	You must be offered a group health plan by your employer, but do not need to participate in their health plan to participate in the FSA
Who owns the account?	Individual/employee	Employer
Who can contribute to the account?	Employee and/or employer	Employee and/or employer
Where are funds held?	Is an employee-owned account-held at a qualified financial institution	By employer
Pre-tax payroll deductions allowed?	Yes, up to the annual IRS limit	Yes, up to the amount you "elect" during open enrollment
Post-tax contributions allowed?	Yes, up to the annual IRS contribution limit.	No
Annual maximums limit on contributions?	Yes	Yes
Entire election available for reimbursement at start of plan year?	No	Yes (except Dependent Care FSAs)
Can funds roll over from year to year?	Yes	Depends on plan design. If the plan includes a carryover, up to **$700** can be rolled over into the next year.
Can funds be invested?	Yes	No
What distributions are allowed?	Debit Card[1] Request for distribution or bill-pay Online/Paper	Debit Card "Claim"- Request for reimbursement or bill pay Online/Mobile/Paper
Documentation (substantiation) required?	Not required for payment[2]	Required for manual claims and if a debit card claim cannot be automatically approved.
Interest earning?	Interest can be accrued on a tax-deferred basis in No qualified HSAs. And if the account balance reaches the minimum balance requirement, the funds can be invested in mutual funds, and those gains are also tax-free.	No
Access to funds after termination?	Since the HSA is an individually owned account, and not owned by your employer, you keep your HSA and all funds regardless of where you are employed.	You will be given a pre-determined number of days after your last day of employment to submit claims. Access to your FSA may be offered through COBRA
What expenses qualify for distribution?	Medical expenses under 213(d) of the Internal Revenue Code including over the counter drugs are eligible medical expenses. HSAs may not be used to pay insurance premiums except for (1) COBRA, (2) qualified long-term care insurance (3) health care coverage while the individual is receiving unemployment compensation; and (4) premiums for Medicare Part A or B, Medicare HMO, and (5) after age 65, the employee's share of employer-sponsored retiree health care.	Eligible expenses are determined by the type of FSA you are enrolled in. • Medical FSA covers 213(d) eligible expenses including over-the-counter medication. • Limited FSAs cover dental, vision and preventative care expenses. • Combination FSAs cover dental, vision and preventative care expenses until you meet your health plan deductible. Then it covers all 213(d) expenses. • Dependent care FSA plans cover eligible dependent care expenses that allow you to work out of the home.

[1]HSA, HRA, and FSA debit cards are automatically restricted for use with medical, dental and vision service providers and for items purchased at retail that are identified as qualified medical expenses based on merchant category codes..

[2]HSA distributions subject to IRS audit to prove they do not exceed out-of-pocket qualified medical expenses since HSA opened.

This Plan Comparison Chart is a summary of differences between plan types, and it does not describe all of the rules and limitations that apply to these arrangements. It is not legal or tax advice. See IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans, for more information on HSAs, HRAs, and FSAs.

Security & Legal Protection

Life and AD&D Insurance

UnitedHealthcare®

GROUP BASIC LIFE INSURANCE & AD&D - EMPLOYER PAID

Rockwall County provides $50,000 of Basic Life Insurance and Accidental Death and Dismemberment (AD&D) insurance through UnitedHealthcare. Rockwall County provides a guaranteed issue amount of Basic Life insurance at no cost to you during your employment. Please call the Benefits Service Center to designate or update beneficiary information.

The AD&D insurance provides a monetary benefit to an employee or beneficiary when the employee experiences certain bodily injuries or death resulting from a covered accident while insured. Rockwall County provides a guaranteed issue amount equal to the basic life insurance amount.

Note: Life and AD&D benefit reduces by 35% at age 65 and 50% at age 70.

Guaranteed Issue

- **Employees** – $150,000
- **Spouse** – $20,000
- **Child** – $10,000

Note: Employees may elect additional coverage with the submission and approval of an Evidence of Insurability (EOI) form.

Voluntary Life Insurance

Rockwall County gives you the opportunity to elect additional life insurance through UnitedHealthcare. The AD&D amount will reflect Voluntary Life insurance amount.

- **Employees** may elect up to 5 times annual salary in increments of $10,000 (not to exceed $300,000).
- **Spouse** coverage may be elected up to 50% of employee amount in increments of $5,000 (not to exceed $150,000).
- **Child** coverage may be elected in a flat amount of $10,000 (not to exceed 50% of employee amount).

Note: Voluntary Life and AD&D benefit reduces by 35% at age 65 and 50% at age 70.

Please speak to a licensed Benefits Counselor for personalized rates.

LEARN MORE ABOUT YOUR LIFE INSURANCE PLAN BY SCANNING THIS QR CODE OR VISITING UHC.COM



Permanent Life

Permanent Life Insurance offers you and your family long-term financial security with coverage that lasts a lifetime. In addition to providing lifelong protection, this plan also includes living benefits, ensuring financial support in the event of a long-term care stay.

LIFE INSURANCE	LONG-TERM CARE	PROVISIONS
Employee Guaranteed Issue up to $100,000	Benefit Trigger: 2 of 6 Activities of Daily Living (Bathing, Dressing, Toileting, Transferring, Feeding, Continence)	Guarantee Issue (only available for new hires)
Spouse Modified Guaranteed Issue up to $15,000	90-day Elimination Period	Rates based on employee age, spouse age, and tobacco status
Child(ren) Coverage Available	4% of Life Insurance Volume payable for 25 months, for licensed care	Terminal Illness Benefit: Less than 24 months of life expectancy, up to 75% of benefit is payable
Permanent Rate: Your rate will never increase due to age	Restoration of Benefit: Restores 100% of the benefit amount accelerated	Portable at the same rate even if you change jobs or retire
Universal Life Events (ULE) Issue Age is 18-64		
Universal Life (UL) Issue Age is 65-75		

HOW UNIVERSAL LIFE EVENTS WORKS

- Higher living benefits during working years.
- Long-term care (LTC) benefits stay the same throughout your life.

	UNIVERSAL LIFE EVENTS		UNIVERSAL LIFE
Example: $50,000 Policy	**Ages 18-64**	**After Age 70**	Ages 65-75
Life Insurance Benefit	$50,000	$16,667	$50,000
LTC Benefit	$50,000	$50,000	$50,000

Universal Life Events benefit is reduced to one-third at the later age of 70 or the beginning of the 15th policy year.



Disability Insurance

UnitedHealthcare

VOLUNTARY SHORT-TERM DISABILITY (STD)

UnitedHealthcare's Short-Term Disability plan provides income replacement benefits for you and your family in the unfortunate event you are unable to work due to injury or illness. This covers injuries and illnesses from both on or off the job.

WHY IS THIS COVERAGE SO VALUABLE?

It's flexible: You can use the money how ever you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

Please speak to a licensed Enrollment Counselor for personalized rates.

HOW DOES IT WORK?

If you become sick or injured and can't work, this insurance can replace part of your income while you recover. As long as you remain disabled, you can receive payments. You're generally considered disabled if you're unable to do important parts of your job and your income suffers as a result.

SHORT-TERM DISABILITY	
Monthly Benefit	60%; up to $2,000 per week
Elimination Period	Benefits begin after 14 days following injury/illness
Benefit Duration	Benefits continue for 13 weeks
Pre-Existing Limitation	None

EMPLOYER-PAID LONG-TERM DISABILITY (LTD)

UnitedHealthcare's Long-Term Disability plan provides income replacement benefits for you and your family in the unfortunate event you are unable to work due to injury or illness. This covers injuries and illnesses from both on or off the job. Rockwall County provides this benefit to you at no cost.

WHY IS THIS COVERAGE SO VALUABLE?

- **It's flexible:** You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

HOW DOES IT WORK?

If you become sick or injured and can't work, this insurance can replace part of your income while you recover. As long as you remain disabled, you can receive payments. You're generally considered disabled if you're unable to do important parts of your job and your income suffers as a result.

LONG-TERM DISABILITY	
Monthly Benefit	60% of gross monthly benefit, to a maximum of $6,000
Elimination Period	90 days following injury/illness
Benefit Duration	Disabled before age 63 as long as you are disabled to maximum of the greater of your Social Security Normal Retirement Age or 4 years
Pre-Existing Limitation	3/12

THREE WAYS TO FILE A CLAIM

If you have any questions about this process, please call our claim service team at 888.299.2070 between 8 a.m. and 8 p.m. ET.

1. MEMBER CLAIMS PORTAL:
Log in to **myuhcfp.com** and click the "Start a Claim" icon to complete and submit a claim online.

2. HARD COPY CLAIM FORM:
Request the claim form from your HR representative. Complete, sign, date and send the forms via fax or mail to the contact details listed on the claim form. You may also email the completed forms to **fpcustomersupport@uhc.com**. Please note, this is an unsecured email address.

3. PHONE:
Confirm telephonic access with your HR representative. Then, call us toll-free at **866.556.8298**. Hours of operation are Monday through Friday, 8 a.m. to 8 p.m. ET.

Accident Insurance

UnitedHealthcare®

Accident insurance pairs well with those who have active lifestyles or children involved in sports/other extracurricular activities. This plan is designed to pay benefits directly to you based on treatment received and injuries sustained from a covered accident.

	ACCIDENT PROTECTION PLAN CLASS 1 - VOLUNTARY PRIMARY
Eligibility	All Active Full Time Employees working a minimum of 30 hours per week
PLAN PROVISIONS	
Coverage Type	24 Hours
Portability	Included; no termination age
Telephonic Claim Submission	Included

CATEGORIES OF BENEFITS

BENEFITS PAYABLE*	MAXIMUM AMOUNT PAYABLE PER INSURED	
	Option A	Option B
ACCIDENTAL DEATH & DISMEMBERMENT *(Spouse Benefit is 100% of EE; Child benefit 50% of EE)*		
Death & Dismemberment	$5,000-$50,000	$5,000-$50,000
Common Carrier		
Life	$100,000	$100,000
INITIAL CARE		
Ground or Water Ambulance *(1 per accident)*	$200	$400
Air Ambulance *(1 per accident)*	$600	$1,200
Emergency Room Treatment *(1 per covered accident)*	$150	$200
Physician Office/Telemedicine/Urgent Care *(1 per covered accident)*	$100	$100
HOSPITAL CARE		
Hospital Admission *(1 per covered accident)*	$750	$1,000
Hospital Confinement *(up to 365 days per accident; starting Day 2 of Confinement)*	$150	$300
Hospital ICU Admission *(1 per covered accident)*	$1,500	$2,000
Hospital ICU Confinement *(up to 30 days per accident; starting Day 2)*	$350	$600
FOLLOW UP CARE		
Chiropractic Care *(5 per accident)*	$25	$35
Follow up Physician Visit *(5 per accident)*	$50	$75
Major Diagnostic Exam *(1 per accident)*		
MRI; CT; PET; EEG; ImPACT; or SPECT scan	$150	$250
Minor Diagnostic Exam *(1 per accident)*		
X-ray; or a laboratory test	$50	$75

BENEFITS PAYABLE*	MAXIMUM AMOUNT PAYABLE PER INSURED	
	Option A	Option B
COMMON INJURIES		
Burns *(2nd or 3rd degree)*	$250-$10,000	$500-$15,000
Coma	$5,000	$7,500
Concussion	$250	$500
Dislocations *(highest 2 dislocations per accident)* *Surgically Corrected/Non-Surgically Corrected* *Partial Dislocations: 25% of the Non-Surgically Corrected Amount*	$250-$4,500	$375-$6,000
Fractures *(highest 2 fractures per accident)* *Surgically Corrected/Non-Surgically Corrected* *Chip Fractures: 25% of the Non-Surgically Corrected Amount*	$200-$6,000	$265-$8,000
Lacerations	$30-$400	$50-$400
Paralysis	$2,500-$10,000	$3,750-$15,000
Traumatic Brain Injury	$2,000	$2,000
Surgery	$100-$1,000	$150-$1,500
ORGANIZED SPORTING ACTIVITY INJURY		
Payable for all covered persons	Increases benefits by 25%	
ADDITIONAL BENEFITS		
Lodging *(per day up to 30 days)*	$100	$200
Transportation *(per day up to 3 days)*	$250	$500
WELLNESS BENEFIT		
Wellness See Wellness Details below for covered exams	$50 Benefit payable upon completion of a covered Wellness exam or health screening test. One covered test per calendar year per covered employee, spouse and child.	

*All Benefits are payable once per covered accident unless otherwise noted

ACCIDENT INSURANCE BI-WEEKLY RATES *(24 of 26 pay periods)*		
	Option A	Option B
Employee	$4.23	$5.51
Employee & Spouse	$6.89	$8.84
Employee & Children	$8.59	$11.44
Family	$12.43	$15.88



Critical Illness Insurance

When a major illness is diagnosed, there can be several expenses that aren't covered by major medical insurance. Critical Illness insurance pays a lump sum benefit when a covered illness is diagnosed. This benefit would be paid directly to you to help cover out-of-pocket expenses.

	CRITICAL ILLNESS PROTECTION PLAN (CIPP) CLASS 1 – VOLUNTARY PRIMARY		
Eligibility	All Active Full-Time Employees working a minimum of 30 hours per week		
PLAN PROVISIONS			
Portability	Included; ported coverage terms at age 75.		
Re occurrence Benefit	100% of maximum benefit amount payable upon the subsequent diagnosis of a Covered Condition for which we have paid a benefit.		
Re occurrence Benefit – Separation Period	Diagnosis dates must be separated by at least 180 Days		
Re occurrence Benefits Payable per Condition	No Limit		
BENEFITS PAYABLE	Employee Paid Benefits		
	Option A	Option B	Option C
Employee Guarantee Issue	$10,000	$20,000	$30,000
Spouse Guarantee Issue	$10,000	$20,000	$30,000
Child(ren) Guarantee Issue	$5,000	$10,000	$15,000
Employee must purchase coverage in order to purchase dependent coverage. Dependent benefits cannot exceed the Employee benefit amount.			
ADDITIONAL BENEFITS			
Wellness	$50 per calendar year per insured		

See Summary Plan Documents for covered conditions.

HOW TO FILE A CLAIM FOR CRITICAL ILLNESS AND HOSPITAL INDEMNITY

If you have any questions about this process, please call our claim service team at 888.299.2070 between 8 a.m. and 8 p.m. ET.

1. **GATHER YOUR DOCUMENTATION:** Have a copy of your diagnosis and supporting medical records, such as a pathology report, MRI report, CT scan results or procedure/operative report.
2. **LOG INTO MYUHCFP:** Sign in to your account at myuhcfp.com and select Claims Submission from the Claims menu. First-time users will need to register using their Group ID and Group Name.
3. **COMPLETE THE CLAIM FORM:** Provide the requested information, including details about your diagnosis and treating physician.
4. **UPLOAD YOUR DOCUMENTATION AND SUBMIT:** Attach the required medical documentation and submit your claim for review.

WHAT HAPPENS NEXT?

UnitedHealthcare will confirm receipt of your claim within five business days. If approved, your benefit will be paid according to your selected payment method.

EMPLOYEE PAID BI-WEEKLY RATES *(24 of 26 pay periods)*	OPTION 1: EE $10,000/ SP $10,000/ CH $5,000*			
AGE RANGE	**EE Only**	**EE + SP**	**EE + CH**	**EE + SP + CH**
Under 25	$2.30	$5.10	$2.30	$5.10
25-29	$2.30	$5.10	$2.30	$5.10
30-34	$3.40	$7.50	$3.40	$7.50
35-39	$3.40	$7.50	$3.40	$7.50
40-44	$6.80	$14.20	$6.80	$14.20
45-49	$6.80	$14.20	$6.80	$14.20
50-54	$14.80	$29.25	$14.80	$29.25
55-59	$14.80	$29.25	$14.80	$29.25
60-64	$29.40	$57.05	$29.40	$57.05
65-69	$29.40	$57.05	$29.40	$57.05
70-74	$34.80	$69.80	$34.80	$69.80
75+	$34.80	$69.80	$34.80	$69.80

EMPLOYEE PAID BI-WEEKLY RATES *(24 of 26 pay periods)*	OPTION 2: EE $20,000/ SP $20,000/ CH $10,000*			
AGE RANGE	**EE Only**	**EE + SP**	**EE + CH**	**EE + SP + CH**
Under 25	$4.60	$10.20	$4.60	$10.20
25-29	$4.60	$10.20	$4.60	$10.20
30-34	$6.80	$15.00	$6.80	$15.00
35-39	$6.80	$15.00	$6.80	$15.00
40-44	$13.60	$28.40	$13.60	$28.40
45-49	$13.60	$28.40	$13.60	$28.40
50-54	$29.60	$58.50	$29.60	$58.50
55-59	$29.60	$58.50	$29.60	$58.50
60-64	$58.80	$114.10	$58.80	$114.10
65-69	$58.80	$114.10	$58.80	$114.10
70-74	$69.60	$139.60	$69.60	$139.60
75+	$69.60	$139.60	$69.60	$139.60

EMPLOYEE PAID BI-WEEKLY RATES *(24 of 26 pay periods)*	OPTION 3: EE $30,000/ SP $30,000/ CH $15,000*			
AGE RANGE	**EE Only**	**EE + SP**	**EE + CH**	**EE + SP + CH**
Under 25	$6.90	$15.30	$6.90	$15.30
25-29	$6.90	$15.30	$6.90	$15.30
30-34	$10.20	$22.50	$10.20	$22.50
35-39	$10.20	$22.50	$10.20	$22.50
40-44	$20.40	$42.60	$20.40	$42.60
45-49	$20.40	$42.60	$20.40	$42.60
50-54	$44.40	$87.75	$44.40	$87.75
55-59	$44.40	$87.75	$44.40	$87.75
60-64	$88.20	$171.15	$88.20	$171.15
65-69	$88.20	$171.15	$88.20	$171.15
70-74	$104.40	$209.40	$104.40	$209.40
75+	$104.40	$209.40	$104.40	$209.40

*Cost includes Wellness Benefit.

Hospital Indemnity Insurance

UnitedHealthcare®

The cost of a hospital stay can be financially difficult if money is tight, and you're not prepared. Having the right coverage in place before you experience an unexpected sickness or injury can help eliminate the stress of financial concerns and provide support when needed most. See page 18 for instructions on how to file a claim.

BENEFIT NAME	HOSPITAL INDEMNITY PROTECTION PLAN (HIPP) CLASS 1 – VOLUNTARY PRIMARY	
Eligibility	All Active Full Time Employees working a minimum of 30 hours per week	
PLAN PROVISIONS		
Pre-existing Conditions Exclusion	Waived	
Portability	Included; must be ported before age 70 and ported coverage terms at age 75.	
Maternity	Included without a waiting period	
PLAN BENEFITS	Option A	Option B
Hospital Admission Payable for Injury or sickness, on the day of admission *(up to 2 times per plan year)*	$500	$1,000
Hospital Confinement Payable once per day of confinement for an injury or sickness, beginning on day 2 *(up to 29 Days per plan year)*	$100	$150
ICU Confinement Payable once per day of confinement for an injury or sickness, beginning on day 2 *(up to 29 Days per plan year)* Payable in addition to Hospital Confinement	$100	$150
ICU Admission Payable for Injury or sickness, on the day of admission *(up to 2 times per plan year)* Payable in addition to Hospital Admission	$500	$1,000

HOSPITAL INDEMNITY INSURANCE BI-WEEKLY RATES *(24 of 26 pay periods)*		
	Option A	Option B
Employee	$4.25	$7.62
Employee & Spouse	$8.68	$15.67
Employee & Children	$6.59	$11.75
Family	$11.59	$20.79



Additional Benefits

WILL AND TRUST PREPARATION

Creating a will and trust may help give you more control over future events and helps your family follow your wishes. Your life insurance plan includes online will and trust services to help you:

- Create and prepare a will — registration required
- Locate nearby attorneys, search legal forms, find helpful articles by legal experts and more
- Access financial planning help and cost calculators

PREPARE YOUR WILL TODAY

1. Go to **Liveandworkwell.com**
2. **Select Browse as guest with a company access code**
3. **Enter access code: LIFEBENSVS**
4. **From the Financial & Legal tab, select Estate Planning**
5. **Scroll to the Legal consultation box and select Learn More**
6. **Select Explore Tools and Legal Information**
7. **Select Legal Forms**
8. **Select Personal Documents**
9. **Select State**
10. **Select Document**

BENEFICIARY SERVICES

It's nice to know your beneficiary will have a team of professionals — included in your plan — ready to help provide emotional, financial and legal guidance. All services are confidential and specialists are available 24/7.

- Grief Support
- Financial and Legal Support
- Wealth Management Account

BENEFICIARY COMPANION

The Beneficiary Companion program provides 24/7 guidance for your beneficiary on closing your estate and protecting your identity.

- Guidance Services
- Social Media Shutdown
- Fraud Resolution

REQUEST THE GUIDEBOOK

Get assistance or request your complimentary guidebook by calling **1-866-643-4241**



TRAVEL ASSISTANCE

If you or your beneficiaries need to travel 100 miles or more away from home or outside the country, call 1-800-527-0218to access travel assistance services 24 hours a day, anywhere in the world. Here are just a few of the travel services UnitedHealthcare Global provides:

TRAVEL ASSISTANCE SERVICES

- Emergency travel arrangements
- Assistance in replacing lost or stolen travel documents
- Emergency translation services

MEDICAL ASSISTANCE SERVICES

- Worldwide medical and dental referrals
- Relay of insurance and medical information
- Assistance in replacing corrective lenses, medical devices and much more

GET TRAVEL HELP ANYTIME

Log in to uhcglobal.com to print your Global Assistance ID card, get up-to-date travel alerts and tips, and much more.

1. **Create Your Account**
2. **Select Sign In > Member Login**
3. **Go to Visit Global IIntelligence Center**

RETURN-TO-WORK AND ABSENCE SUPPORT

With your plan, you have access to specialists who are trained to help you return to work more quickly and safely. They can also assist with:

- Resume preparation
- Skills training
- Job placement/search support
- Interview preparation
- Relocation services and more

VOCATIONAL REHABILITATION

Specialists will work with your care team to create a plan to evaluate any need for equipment, retraining or job placement.

WORKPLACE MODIFICATION

A benefit payment of up to $5,000 may be paid to your employer for any approved workplace modifications needed for you to return to work.

LUMP-SUM SURVIVOR BENEFIT

If you pass away and meet the eligibility requirements, we will pay a lump-sum benefit that is equal to 3 months of your monthly disability payment to your spouse or children.

SOCIAL SECURITY ASSISTANCE

If you qualify for Social Security assistance, we can connect you with our Social Security advocates who can assist you with the application process. They can also help you:

- Find appropriate legal representation or other assistance
- Obtain any medical and vocational evidence, if required
- Get reimbursed for any pre-approved case management expenses

MEMBER ASSISTANCE PROGRAM (MAP)

Our MAP from Optum® offers you and your family personal and confidential support available 24 hours a day, 7 days a week.*The program includes:

- Counseling services
- Legal and financial consultation
- Referrals to community resources

Call **1-877-660-3806, TTY 711**, for personal and confidential assistance. Translators are available for non-English speakers.

ACCESS THE MAP ONLINE

1. **Visit liveandworkwell.com**
2. **Access code: FP3EAP**
3. **Select the Benefits tab at the top**
4. **Select EAP or Legal & Financial**

Contacts

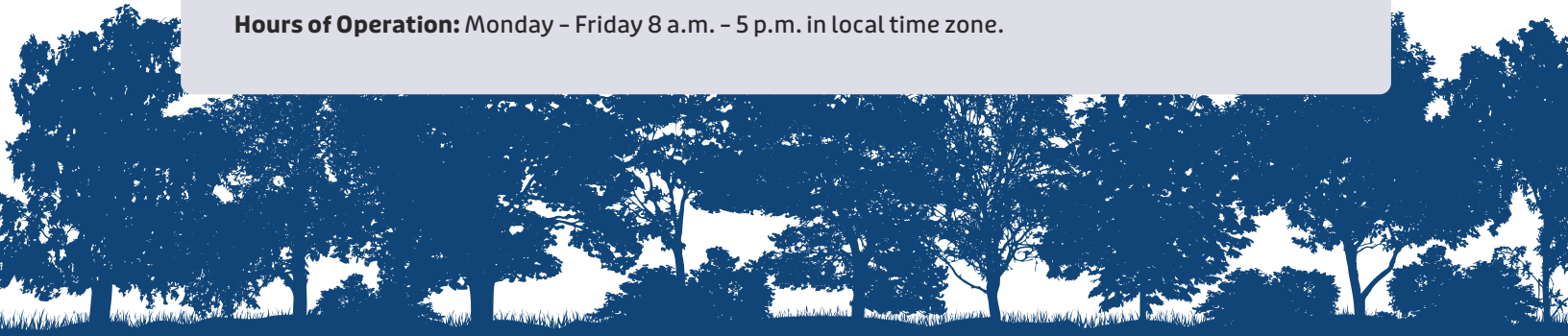
BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL	POLICY #
Medical	UnitedHealthcare	866.314.0335	www.myuhc.com	922107
Dental	UnitedHealthcare	866.314.0335	www.myuhc.com	5973471
Vision	UnitedHealthcare	866.314.0335	www.myuhc.com	10771-480
Flexible Spending Account and Health Savings Account	CPI	866.241.0237	cpisupport@mycpiteam.com www.mycpiteam.com	N/A
Basic Life and AD&D, Voluntary Life and AD&D, Long-Term Disability	UnitedHealthcare	866.293.1794	www.myuhc.com	370432
Voluntary Accident, Critical Illness, Hospital Indemnity	UnitedHealthcare	866.293.1794	www.myuhc.com	370432
Universal Life	Trustmark	800.918.8877	www.trustmarkbenefits.com	532600000
Benefit Advocate Center	Holmes Murphy	??	??	N/A

ASK YOUR ADVOCATE TEAM

Holmes Murphy is ready to help you get the most from your benefits program by providing support from an advocate at no cost to you. Get assistance with:

- Insurance Cards
- Benefits Questions
- Eligibility Rules
- Provider Search
- Prescription/Pharmacy Issues
- Claims

Hours of Operation: Monday – Friday 8 a.m. – 5 p.m. in local time zone.



Notes

Required Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

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.

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

1. Indexed annually; see 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% 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.

Special Enrollment Notice

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

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

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

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact: Kami Webb - kwebb@rockwallcountytexas.com.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

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

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

Get a list of those with whom we've shared information

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.

- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

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

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

Other Instructions for Notice

- Effective 01/01/2027
- Kami Webb kwebb@rockwallcountytexas.com
- 915 Whitmore Drive, Suite D
- Rockwall, TX 75087
- O: 972-204-6188

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Rockwall 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. **Rockwall County has determined that the prescription drug coverage offered by United HealthCare is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. If you decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

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

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

Contact the person listed below for further information Kami Webb at 972-204-6188 **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 Rockwall County changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 01/01/2027
Name of Entity/Sender: Rockwall County
Contact--Position/Office: Kami Webb; Human Resources Director
Address: 915 Whitmore Drive, Suite D Rockwall, TX 75087
Phone Number: 972-204-6188

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Rockwall County, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

- Name of Entity/Sender: Rockwall County
- Contact--Position/Office: Kami Webb; Human Resources Director
- Address: 915 Whitmore Drive, Suite D Rockwall, TX 75087
- Phone Number: 972-204-6188

https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

Women's Health and Cancer Rights Act

Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator at:

Name of Entity/Sender: Rockwall County
Contact--Position/Office: Kami Webb; Human Resources Director
Address: 915 Whitmore Drive, Suite D Rockwall, TX 75087
Phone Number: 972-204-6188

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides 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? Call your plan administrator at 972-204-6188 for more information.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the Frequently Asked Questions (FAQs) About the Newborns' and Mothers' Health Protection Act.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other 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" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

You are 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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 may 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 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 care out-of-network. You can choose a provider or facility in your plan's network.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact

· UHC Member Services: Call the phone number printed directly on the back of your UHC insurance card.

· Federal Help Desk: Call 1-800-985-3059 (CMS No Surprises) if you believe you have been wrongly billed under federal law.

· Texas Department of Insurance (TDI): Call 1-800-252-3439 or visit the TDI Surprise Balance Billing page for state-regulated plan assistance

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, 2025. Contact your State for more information on eligibility –

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	Premium Payment Program: myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myakhipp.com	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/child-health-plan-plus HIBI: mycohibi.com	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida Medicaid	flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	877-357-3268
Georgia Medicaid	HIPP: medicaid.georgia.gov/health-insurance-premium-payment- program-hipp CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana Medicaid	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	800-403-0864 800-457-4584
Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KIHIPP.PROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	ldh.la.gov/healthy-louisiana or www.ldh.la.gov/lahipp	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY/Relay: 711
Minnesota Medicaid	mn.gov/dhs/health-care-coverage	800-657-3672
Missouri Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana Medicaid	HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HIPP Email: HHSHIPPProgram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcfp.nv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 800-852-3345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York Medicaid	health.ny.gov/health_care/medicaid	800-541-2831

North Carolina Medicaid	medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	insureoklahoma.org	888-365-3742
Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina Medicaid	scdhhs.gov	888-549-0820
South Dakota Medicaid	dss.sd.gov	888-828-0059
Texas Medicaid	hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	dhhr.wv.gov/bms/ mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid and CHIP	dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Wellness Program Notices

The County's Go To Doctor Campaign is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary annual physical that includes a series of questions about your health-related activities, behaviors, and whether you currently have or have had certain medical conditions, such as cancer, diabetes, or heart disease. You may also be asked to complete lab work, which may include blood testing. The specific tests required will be determined as part of your annual physical. You are not required to participate in the blood test or other medical examinations.

However, employees who choose not to participate in the wellness program will be charged an additional $50 per person, per paycheck, for medical insurance coverage (employee and spouse only). If both the employee and spouse are enrolled in the County's medical plan and neither completes an annual physical, the additional premium will be $100 per paycheck. This requirement does not apply to dependent children.

While completion of the Go To Doctor Campaign is not required, employees and spouses who do not complete the annual physical will be subject to the additional premium differential.
If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Kami Webb - kwebb@rockwallcountytexas.com.

The information from physician will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the health plan.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personal identifiable health information. Although the wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, the Go To Doctor Campaign will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is your selected Physician.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Kami Webb - kwebb@rockwallcountytexas.com.

Accommodations

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Kami Webb - kwebb@rockwallcountytexas.com and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.


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