

Tarrant County ESD 1

October 2026 - September 2027

EMPLOYEE BENEFITS



Important Items to Remember

WELCOME TO YOUR BENEFITS

This Benefits Booklet provides a high-level overview of the benefits available to eligible employees and their dependents. Each benefit is outlined in more detail in the corresponding Summary of Benefits. In the event of any discrepancy between the information provided in this booklet and the official plan documents, the terms of the legal plan documents will govern.

We encourage you to review this information carefully and take full advantage of the benefits available to you.

ELIGIBLE EMPLOYEES

To be eligible for company benefits, you must be a full time employee working an average of 30 hours per week during the year.

NEW HIRE WAITING PERIOD

New full-time employees are eligible for company insurance benefits upon date of hire.

DEPENDENT CHILDREN

Children under the age of 26 are eligible to be covered under the benefits. They will be taken off of the plan at the end of the month in which they turn 26.

OPEN ENROLLMENT

You can make changes to your plans (enroll in coverage, waive coverage, add/drop dependents, etc.) during this time period each year. All changes made during this time period will take effect on the renewal date.

MAKING PLAN CHANGES DURING THE YEAR

If you've had a major life event (getting married, having a child, getting divorced, losing coverage, becoming eligible for Medicare, etc.) during the year, you're able to make coverage changes to your plan even though it's outside of the open enrollment window. Please turn in all paperwork within 30 days of your qualifying event to ensure it will be processed timely and any claims incurred will be paid.

PLEASE NOTE: If adding a newborn baby to your plan, the baby's social security number will not be available right away. Please submit the paperwork without it, and provide it once it's available.

PLEASE NOTE

Enrollment will be an online experience through our benefits platform, Employee Navigator. Watch your email for the onboarding and enrollment link!

Medicare Part D Creditable Coverage Notice

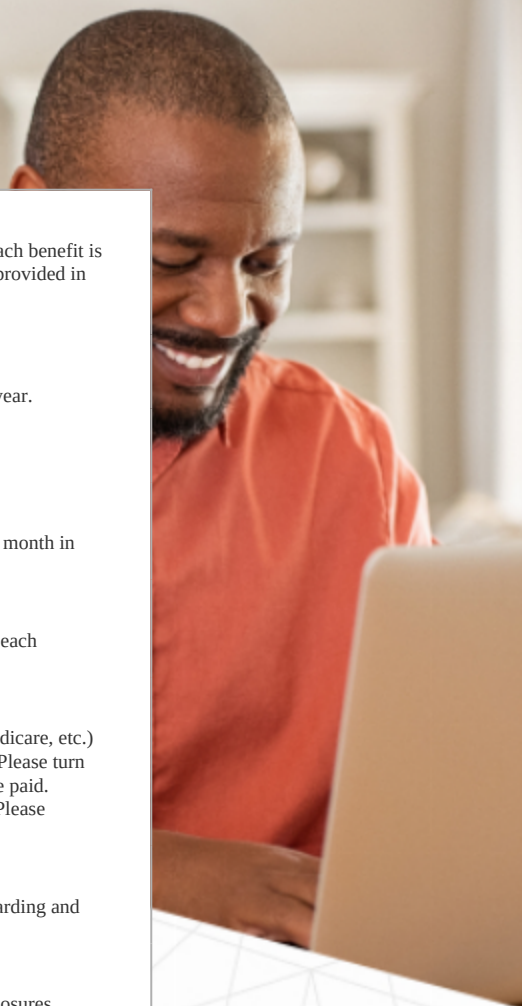
Notices of Medicare Part D creditable and/or non-creditable coverage can be found in this booklet under the Notices & Disclosures section. Additionally, you can request paper copies by contacting 19:21 Consultants at (830) 626-3340.

QUESTIONS?

Call 19:21 Consultants at (830) 626-3340 with questions about:

- Benefits
- Enrolling
- Eligibility
- ID cards
- Assistance finding an in-network provider
- Claims assistance

We are here to serve you!



Insurance Terms and Definitions

PPO (PREFERRED PROVIDER ORGANIZATION)

A PPO is a type of insurance network. In this type of network, you may choose to obtain care in or out of your network. If you choose to visit a "Preferred", or "In-Network", provider, your out of pocket expense will be significantly less than if you visit a provider outside your network. The reason for this is the In-Network provider agrees to accept set, contracted rates as payment in full for their services in return for being part of the insurance carrier's Preferred Provider network.

DEDUCTIBLE

The amount you pay before the insurance carrier starts sharing the expense of your medical care. Major medical expenses apply to the deductible like inpatient/outpatient surgeries, MRI's, CT Scans, etc.

STAY IN NETWORK

To obtain the best benefits, it's important to stay in the insurance carrier's network. Always check online or verify over the phone that a doctor or hospital is in network before your visit. Also, when having a procedure done in a hospital/facility, ask the hospital staff to make sure every doctor, nurse, radiologist, anesthesiologist, etc. is in your network.

CO-INSURANCE

After you've reached your deductible for the year, the insurance carrier will split the balance of the major medical expense with you. They pay a percentage and you pay a percentage of your medical expense until you've reached your Out of Pocket Maximum.

OUT OF POCKET MAXIMUM

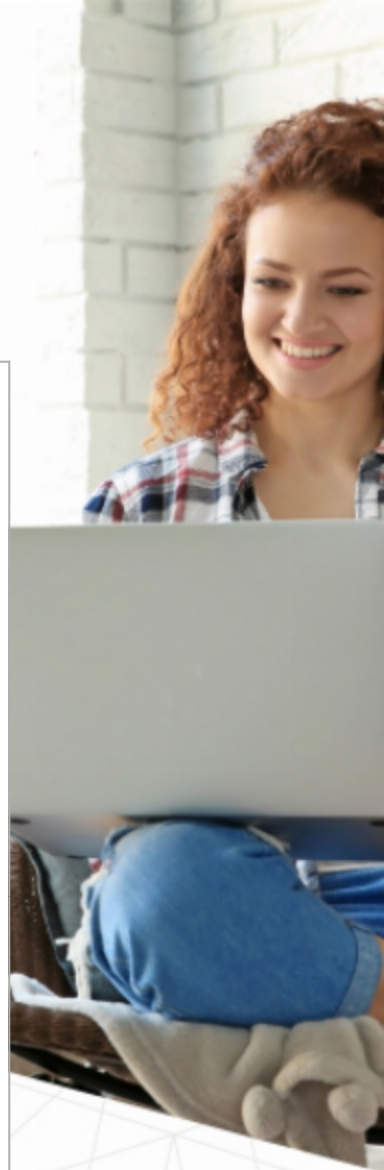
This is the maximum amount you will pay for covered medical expenses during your deductible period.

CO-PAYS

This is a set dollar amount you pay when you receive medical care from a Primary Care Physician, Specialist, Urgent Care, Emergency Room, or Pharmacy. It's called a co-pay, because you pay the set dollar amount and your insurance carrier pays the rest of the actual charge from the doctor/facility. Co-pays do not apply to the deductible.

EXPLANATION OF BENEFITS

Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is (Provider Charge - Network Discount = Negotiated Rate). It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.



Medical Benefits

Gold Plan

DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK
Single	\$1,300	\$2,600
Family	\$3,900	\$7,800
COINSURANCE		
Member %	20%	40%
OUT OF POCKET MAXIMUM		
Single	\$5,250	Unlimited
Family	\$10,500	Unlimited
COMMONLY USED SERVICES		
Primary Care Physician Office Visit	\$35 copay	40% coinsurance
Specialist Office Visit	\$55 copay	40% coinsurance
Urgent Care	\$75 copay	40% coinsurance
Emergency Room	\$600 copay + 20% coinsurance	\$600 copay + 20% coinsurance
PREVENTIVE CARE		
Preventive Services	No Charge	40% coinsurance
MAJOR MEDICAL EXPENSES		
Outpatient Surgery	\$300 copay + 20% coinsurance	\$400 copay + 40% coinsurance (Preauthorization required)
Inpatient Hospitalization / Surgery	\$300 copay + 20% coinsurance	\$400 copay + 40% coinsurance (Preauthorization required)
CT scan, PT scan, MRI	\$150-\$250 copay + 20% coinsurance	40% coinsurance
PRESCRIPTION DRUG COVERAGE		
Generic	\$10 copay	\$10 copay + 50% additional charge
Preferred	\$50 copay	\$20 copay + 50% additional charge
Non-Preferred	\$100 copay	\$70 copay + 50% additional charge
Specialty	\$150 copay	\$120 copay + 50% additional charge
PLAN INFORMATION		
Member Website	www.meritain.com	
Customer Service Phone Number	1.800.566.9311	



**Meritain
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an  aetna company

Plan Explanation

Enrolling in Medical insurance can protect you from paying the full cost of medical services when you're injured or sick.

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Dental Benefits

DEDUCTIBLE			IN-NETWORK		OUT-OF-NETWORK	
Single			\$50		\$50	
Family			\$150		\$150	
MAXIMUM THE CARRIER WILL PAY						
Annual Maximum			\$1,000		\$1,000	
FREQUENCIES						
Cleaning			1 in 6 months			
Exam			1 in 6 months			
DENTAL COVERAGE						
Preventative Services			100%		100%	
Basic Services			80%		80%	
Major Services			50%		50%	
OUT OF NETWORK EXPLANATION						
			The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider.			
PLAN INFORMATION						
Member Website			standard.com			
Customer Service Phone Number			888-937-4783			



Plan Explanation

Dental insurance is a form of health insurance designed to protect you from paying the full cost of routine or emergency dental care.



Vision Benefits

VISION COVERAGE		OUT-OF-NETWORK (REIMBURSEMENT)
Eye Exam	\$10	Up to \$45
Single Vision Lens	\$25	Up to \$30
Lined Bi-Focal Lens	\$25	Up to \$50
Lined Tri-Focal Lens	\$25	Up to \$65
Lenticular Lens	\$25	Up to \$100
Contact Lens Allowance	\$130	Up to \$105
Frame Allowance	\$130	Up to \$70
FREQUENCIES		
Exam Frequency	Every 12 Months	
Lens Frequency	Every 12 Months	
Frame Frequency	Every 24 Months	
OUT OF NETWORK EXPLANATION		
	While you will receive a reimbursement when you go out of network, the out of network provider may not file the claim for you.	
PLAN INFORMATION		
Member Website	standard.com	
Customer Service Phone Number	888-937-4783	



Plan Explanation

Vision insurance is commonly designed as a health and wellness plan to help reduce costs for preventative and prescription eye care.

Disclaimer

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Employer-Paid Basic Life Insurance

EMPLOYER-PAID LIFE INSURANCE

BENEFITS

Life Insurance Coverage	Flat amount of \$50,000
Accidental Death & Dismemberment	Matches Life Benefit
Age Reduction Schedule	To 65% at age 65 To 50% at age 70 To 35% at age 75



Plan Explanation

All full-time employees receive a Basic Life benefit at no cost. The basic life program will also provide accidental death and dismemberment (AD&D) coverage.

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Accident Insurance

INJURY	SCHEDULED BENEFIT
Coma	\$20,000
Concussion	\$200
Fracture - Hip	\$6,000
Fracture - Skull	\$2,800 - \$6,000
Fracture - Arm	\$1,750
Fracture - Hand	\$2,000
Accidental Death & Dismemberment	\$750 - \$150,000
PLAN INFORMATION	
Member Website	www.manhattanlife.com
Customer Service Phone Number	(855) 448-6982



ManhattanLife[™]

Plan Explanation

An Accident insurance plan helps you pay for medical and out-of-pocket expenses that incur after an accidental injury.

Disclaimer

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Critical Illness Insurance

CRITICAL ILLNESS BENEFIT

Employee Scheduled Benefit	\$30,000
Spouse Scheduled Benefit	\$15,000
Child Scheduled Benefit	\$5,000
Pre-Existing Condition Limitation	If a member has a pre-existing condition that is diagnosed or symptoms occurred in the 12 months prior to the policy effective date, no benefits will be paid for the first 12 months of the policy effective date.

ILLNESS % OF SCHEDULE BENEFIT

Cancer - Invasive	100%
Heart Attack	100%
Major Organ Failure	100%
Stroke	100%

PLAN INFORMATION

Member Website	www.manhattanlife.com
Customer Service Phone Number	(855) 448-6982



Plan Explanation

With a Critical Illness and Cancer plan, you'll receive a benefit after a serious illness or a condition such as a heart attack, stroke, coronary artery disease, or cancer is diagnosed.

Disclaimer

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Hospital Indemnity Insurance

BENEFITS AND FEATURES

Hospital Indemnity Benefit	\$200
Portability	Included
Waiver of Premium	Included
Pre-Existing Condition Limitation	If a member has a pre-existing condition that is diagnosed or symptoms occurred in the 12 months prior to the policy effective date, no benefits will be paid for the first 12 months of the policy effective date.
Maternity Waiting Period	300 days
First Admission	\$1,500

PLAN INFORMATION

Member Website	www.manhattanlife.com
Customer Service Phone Number	(855) 448-6982



Plan Explanation

A Hospital Indemnity plan will help provide you and your family with a lump sum cash benefit to help cover qualified expenses associated with an unexpected hospital stay.

Disclaimer

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Tarrant County Emergency Services District No. 1

Plan Design Summary

Dental Summary

		Plan 1: Dental Plan 12 Mo. RG NC/C
Plan Benefit	Type 1	100%
	Type 2	80%
	Type 3	50%
Deductible		\$50/Calendar Year
		Waived Type 1
		\$150/family
Maximum (per person)		\$1,000/Calendar Year
PPO		Passive PPO
Allowance	Type 1	90th U&C
	Type 2	90th U&C
	Type 3	90th U&C
Waiting Period		None
Annual Open Enrollment		None

Tarrant County Emergency Services District No. 1

Covered Procedure Summary

The following is a sample list of dental procedures payable under the plan. A complete list of procedures is available from your Sales Representative.

Plan 1: Dental Plan 12 Mo. RG NC/C	
Plan Design Summary	100/80/50 \$50/Calendar Year Waived Type 1 \$150/family \$1,000
Type 1 Procedure (Frequency)	• Routine Exam (1 in 6 months) • Bitewing X-rays (1 in 12 months) • Full Mouth/Panoramic X-rays (1 in 5 years) • Periapical X-rays • Cleaning (1 in 6 months) • Fluoride for Children 13 and under (1 in 12 months) • Sealants (age 13 and under) • Space Maintainers
Type 2 Procedure (Frequency)	• Fillings for Cavities • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia
Type 3 Procedure (Frequency)	• Onlays • Crowns (1 in 10 years per tooth) • Crown Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)

Current Dental Terminology © American Dental Association.

Tarrant County Emergency Services District No. 1

Features/Benefits

The Standard's Preferred Care Dental Products

- Employers achieve a balance between cost efficiency and employee choice.
- Plan participants are free to receive care from any dentist they choose. Their out-of-pocket expenses are generally lower when using contracted providers, who have agreed to provide dental care at discounted fees.
- Our plans give participants across the nation over 580,000 contracted provider access points for dental care.
- Contracted network providers must meet credentialing and quality assurance requirements.

Usual and Customary (U&C)

The Usual and Customary (U&C) allowance listed on the plan summary page is determined using information including data from a nationally recognized independent data source. Plan participants are reimbursed based on the appropriate charges in the dentist's ZIP Code area. U&C allowances are reviewed annually.

- 90th U&C means 9 out of 10 dentists in a specific ZIP Code area charge at or below the plan allowance for a procedure.

Deductibles

After the date that \$150 in accumulated deductibles has been met within a family, we will waive the entire deductible or any remaining portion of the deductible amount for any other family members for the rest of that calendar year. At no time can a family member contribute more than the selected deductible amount. (Plan(s): 1, 2)

Tarrant County Emergency Services District No. 1

Plan Design Summary

Eye Exam, Lenses, Frames, Frequencies

	Plan 1: Vision Choice Brochure: Balanced Care Vision I	
	Eye Care Plan NC/C	
	VSP Choice Network + Affiliates	Out of Network
Annual Eye Exam	Covered in full	Up to \$45
Lenses (per pair)		
Single Vision	Covered in full	Up to \$30
Bifocal	Covered in full	Up to \$50
Trifocal	Covered in full	Up to \$65
Lenticular	Covered in full	Up to \$100
Progressive	See lens options	NA
Frame Allowance	\$130**	Up to \$70
Frequencies		
Exam/Lens/Frames	12/12/24	12/12/24
	Based on date of service	Based on date of service

**The Costco and Walmart allowance will be the wholesale equivalent.

Deductible, Maximum

Deductibles	\$10 Exam \$25 Eye Glass Lenses or Frames*	\$10 Exam \$25 Eye Glass Lenses or Frames
Maximum per benefit period	None	None

*Deductible applies to a complete pair of glasses or to frames, whichever is selected.

Contact Lenses

Fit & Follow Up Exams	Participant cost up to \$60	No benefit
Contacts		
Elective	Up to \$130	Up to \$105
Medically Necessary	Covered in full	Up to \$210

Tarrant County Emergency Services District No. 1

Plan Design Summary

Lens Options (participant cost)*

	Plan 1: Vision Choice Brochure: Balanced Care Vision I	
	VSP Choice Network + Affiliates (Other than Costco)	Out of Network
Progressive Lenses		
Standard	\$55	Up to Lined Bifocal allowance.
Premium	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children \$33 adults	No benefit
Scratch Resistant Coating	\$17-\$33	No benefit
Anti-Reflective Coating	\$43-\$85	No benefit
Ultraviolet Coating	\$16	No benefit

*Lens Option participant costs vary by prescription, option chosen and retail locations.

Additional Balanced Care Vision I Choice Network Features (In Network)

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Lens Options (Participant Cost)*	\$15 - Solid Plastic Dye (Except Pink I & II) \$17 - Plastic Gradient Dye \$31-\$82 - Photochromatic Lenses (Glass & Plastic) Lens Option member cost vary by prescription and option chosen.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCareSM	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for participants is \$1,800 for LASIK and \$2,300 for custom LASIK using Wavefront technology, and \$1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to \$1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

Tarrant County Emergency Services District No. 1

Features/Benefits

Balanced Care Vision I Eye Care

Balanced Care Vision I eye care plans from The Standard will help your employees receive and pay for the eye care they need. Balanced Care Vision I plans emphasize eye health and preventive care, and feature the money-saving eye care provider network of VSP. VSP's belief statement is "Passion for People, Vision for Life." VSP provides claims processing and plan participant customer service, as well as the VSP network of independent full-service providers, to Balanced Care Vision I eye care plan participants.

Balanced Care Vision I Plan Participants Use The VSP Network

VSP's network emphasizes experienced, independent private-practice eye doctors. VSP's network philosophy also includes one-stop care. Every doctor in the network provides exam and eyewear services, so there's no need for Balanced Care Vision I plan participants to have a comprehensive exam in one location and then travel to another for their lenses and frames. VSP's statistics indicate 90% of the U.S. population has access to a network doctor within 10 miles, and the average distance to a choice of five doctors is only 7.5 miles.

Policyholders can select the VSP Choice Network, offering 41,000 doctors and 86,000 access points, plus reduced rates. Participants will still save out-of-pocket for typical eye care services, including an average savings of 20-25% on lens options.

Participants may visit any eye doctor. When Balanced Care Vision I plan participants see non-VSP doctors, benefits are reimbursed according to the plan schedule.

No Claim Forms

Making an appointment and receiving claims payment through VSP will be easy for your employees. There is no paperwork or claim to file. The Balanced Care Vision I plan participant simply makes an appointment with a VSP doctor, states that they have coverage that includes the VSP network, and visits the doctor. VSP handles the rest.

Life and AD&D Insurance

Handling a Life insurance claim takes a special touch. All of our Life benefits employees complete annual grief training helping them to empathize with beneficiaries and recognize when they need special attention. And we're focused on settling claims quickly: Our median calculation turnaround time in 2023 was 2 days for clean claims and 3 days for all claims (internal company data as of January 2024).

Covered Members

A regular employee of the Employer working 30 or more hours per week.

	Basic
Benefit Schedule	Flat \$50,000
Guarantee Issue	Full Benefit
AD&D Benefit	Matches Life Benefit
Age Reduction Schedule	To 65% at age 65 To 50% at age 70 To 35% at age 75
Employer Contribution	100%
Minimum Participation	100%

Life Highlights

	Basic
Waiver of Premium	Eligible to age 60 Waived to SSNRA Age reductions apply
Conversion	Included
Portability	Included
Continuity of Coverage	Included
Repatriation Benefit	Included
Travel Assistance	Included
Life Services Toolkit	Included

AD&D Highlights

	Basic
Loss of life	100% (including disappearance and exposure)
Loss of one hand or one foot	50%
Loss of sight of one eye	50%
Loss of speech	50%
Loss of hearing in both ears	50%
Any combination of the above losses	100%
Loss of thumb and index finger of same hand	25%
Quadriplegia	100%
Triplegia	75%
Paraplegia	75%
Hemiplegia	50%
Uniplegia	25%
Seat Belt Benefit	10% of AD&D benefit payable up to \$10,000
Air Bag Benefit	5% of AD&D benefit payable up to \$5,000
Helmet Benefit	10% of AD&D benefit payable up to \$5,000
Family Benefits Package	Included
Portability	Included

Additional Plan Design Details

- An Accelerated Death Benefit is included. Terminally ill members may withdraw up to 80% of their Life benefit to a maximum of \$500,000 (when Basic Life and any Additional Life are combined).
- If Life is sold with Standard's LTD, then the LTD claim will initiate a claim for Standard's Life Waiver of Premium.
- The Family Benefits Package includes:
 - The Higher Education Benefit reimburses tuition expenses up to \$5,000 per child per year towards a 4-year college education for the deceased's children - not to exceed a cumulative total of \$20,000 or 25% of the AD&D benefit per child, whichever is less.
 - Career Adjustment Benefit reimburses tuition expenses up to \$5,000 per year to help a spouse to return to the workforce after the death of their spouse - not to exceed the cumulative total of \$10,000 or 25% of the AD&D benefit, whichever is less.
 - Child Care Benefit reimburses a family's child care expenses up to \$5,000 per year - not to exceed \$10,000 or 25% of the AD&D benefit, whichever is less.
- The Helmet Benefit pays a benefit for a loss of life due to an accident that occurs when riding a bicycle or a motorcycle and wearing a helmet.
- A hand and/or foot that is lost and later surgically reattached will still be considered a loss.
- Travel Assistance is included and provides assistance with pre-trip planning, medical assistance services, emergency transportation services, travel and technical assistance services and legal referral.
- The Life Services Toolkit is included and helps beneficiaries cope with grief and loss, get answers to legal questions, plan a memorial or a funeral, and address financial concerns. Additionally, all covered employees will have access to online will preparation and other estate planning documents as well as articles to help deal with identity theft, improve wellness and more.
- The AD&D Occupational Assistance service is included and provides access to a Workplace Possibilities (SM) Consultant who helps those with a specified accidental dismemberment return to productive work and life.

Designed Especially for:

Tarrant County ESD 1

Accident Indemnity Plus



Receive a Benefit if You Have an Accident

An Accident Indemnity Plan:

- Covers 24 Hour (on and off the job) accidents
- Can cover you, your spouse and your children
- Pays benefits directly to you, in addition to any other coverage you may have, unless otherwise designated
- No limit to the number of accidents covered in a specified time frame*

Why Do I Need Accident Coverage?

"Nearly 40 percent of self-reported episodes of injury leading to hospitalization occurred during leisure activities, and 44 percent occurred in or around the home."

— Source: www.CDC.gov/nchs/fastats/accident-injury.htm; May 8, 2020

INITIAL CARE BENEFITS

Benefit Name and Description	Preferred
Urgent Care Payable for initial treatment within 60 days of a covered accident. Benefit paid once per covered accident and is not payable if Emergency Room Treatment benefit is paid for the same covered accident.	\$200
Doctor's Office Care Payable for initial treatment within 60 days of a covered accident. Benefit paid once per covered accident and is not payable if Emergency Room Treatment benefit is paid for the same covered accident.	\$100
Emergency Room Care* Payable for initial treatment within 72 hours of a covered accident.	\$200
Ground Ambulance Payable when covered person receives transportation in an ambulance by ground for an injury received as a result of a covered accident. Must be to a hospital or from hospital to covered person's home. One trip per accident.	\$300
Air Ambulance Payable when covered person receives transportation in an ambulance by air for an injury received as a result of a covered accident. Must be to a hospital. One trip per accident.	\$1,000

DIAGNOSTIC BENEFITS

Diagnostic Benefits Payable for x-ray, medical imaging (MRI, CT Scan) or EEG performed in a doctor's office or hospital. Pays once per covered accident.	X-rays \$150 MRI/CT Scan/EEG \$100
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*Coverage for ER visits is limited to five per person per calendar year. Benefits and riders may vary by state and may not be available in all states.

Policy: M-8026

Underwritten by ManhattanLife Insurance and Annuity Company
Preferred-24hr-\$100well-AIP 0826

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IN-PATIENT CARE BENEFITS

Benefit Name and Description	Preferred
Hospital Confinement Payable for each day a covered person is confined as an inpatient in a hospital. A day is defined as a 24-hour period. Confinement is up to 365 days per accident.	\$300
First Hospitalization Payable for the first hospital confinement in a calendar year.	\$1,500
ICU Admission Payable for the first ICU admission if within 48 hours of hospital admission in a calendar year.	\$1,500
ICU Confinement Payable for each day a covered person is confined to a hospital Intensive Care Unit for up to 30 days per accident.	\$600
Rehabilitation Confinement Payable for each day a covered person is confined to a hospital Rehabilitation Unit for up to 30 days. Calendar year maximum 60 days.	\$300

FOLLOW-UP CARE/TREATMENT BENEFITS

Physical Therapy Payable if: started within 90 days; completed within one year; prescribed by a doctor; rendered by a physical therapist; and performed in an office or on an outpatient basis. Benefit is not payable for the same visit the Accident Follow-Up benefit is paid. Pays up to 10 visits per accident.	\$90
Follow-Up Treatment Payable if: initial treatment was received within 72 hours; it is doctor prescribed; and it occurs within 90 days of hospital discharge (if applicable). Maximum of two visits per accident.	\$100
Chiropractic Treatment Available if started within 60 days and completed within 180 days. Pays up to three visits per accident.	\$90

MEDICALLY NECESSARY BENEFITS

Blood and Plasma Payable if received within 90 days.	\$500
Prosthesis - One Payable for a covered device the covered person uses when needed, due to a covered accident. This includes one payment per accident based on the one or multiple prosthesis benefit.	\$750
Prosthesis - Multiple Payable for covered devices the covered person uses when needed, due to a covered accident. This includes one payment per accident based on the one or multiple prosthesis benefit.	\$1,500
Medical Appliances Payable for appliances used for aid in personal locomotion (crutches, wheelchairs, leg braces, back braces and walkers). Max one payment.	\$300

TRANSPORTATION/LODGING BENEFITS

Benefit Name and Description	Preferred
Transportation Payable if the covered person needs care not available locally. The benefit is payable if a covered person is injured and requires a doctor-recommended hospital treatment or diagnostic study that is not available in the covered person's resident city. Use of such transportation must begin within 90 days after the covered accident date. Hospital treatment or diagnostic study must be greater than 50 miles from the covered person's residence. Maximum one trip per accident.	Train or Plane \$200 Bus \$100
Family Member Lodging Payable per night for an adult family member if the covered person is hospitalized more than 100 miles from home for a maximum of 30 nights.	\$100

MAJOR ACCIDENT BENEFITS

Accidental Death Payable to the named beneficiary. The employee is the beneficiary for all covered dependents. Spouse receives 50% of amount shown and child receives 25% of amount shown.	\$75,000
Dismemberment Payable according to a schedule based on the specific loss incurred. Spouse receives 50% of amount shown and child receives 25% of amount shown.	\$750 - \$75,000
Common Carrier Provides an additional benefit if accident occurs while a fare paying passenger is on a commercial airline, passenger train or intercity bus line.	\$150,000

BURN BENEFITS

Burns Payable for second and third degree burns according to a schedule if treatment is received within 72 hours.	2nd Degree \$100 - \$1,000 3rd Degree \$500 - \$10,000
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EMERGENCY DENTAL/VISION BENEFITS

Eye Injuries Payable if surgical repair is performed within 90 days or a foreign body is removed from the eye, by a doctor, with or without anesthesia.	Surgical Repair \$300 Removal of Foreign Body \$100
Emergency Dental Work Payable for injury to sound natural teeth as a result of a covered accident.	Repaired with Crown \$300 Resulting in Extraction \$100

LACERATION BENEFITS

Benefit Name and Description	Preferred
Laceration Benefit Payable according to schedule of length provided that treatment is received within 72 hours.	Over 6 Inches \$200 2 – 6 Inches \$100 Under 2 Inches \$50 Not Requiring Stitches \$50

ORTHOPEDIC BENEFITS

Fracture Payable according to a schedule if diagnosed and treated by a doctor within 90 days. A chipped bone is 25% of scheduled benefit. Open reduction is 200% of closed reduction.	Minimum \$560 Maximum \$6,000
Dislocation Payable according to a schedule if diagnosed and treated by a doctor within 90 days. A partial dislocation is 25% of scheduled benefit. Open reduction is 200% of closed reduction.	Minimum \$80 Maximum \$3,600

SURGICAL BENEFITS

Repaired Ligaments Payable if treatment is received within 60 days and surgical repair is performed within 90 days.	Single \$600 Multiple \$1,200
Repaired Knee Cartilage Payable if treatment is received within 60 days and surgical repair is performed within one year.	Single \$600 Multiple \$1,200
Repaired Tendon Payable if treatment is received within 60 days and surgical repair is performed within 90 days.	Single \$600 Multiple \$1,200
Repaired Rotator Cuff Payable if surgical repair is performed within one year.	Single \$600 Multiple \$1,200
Ruptured Disc Payable if treatment is received within 60 days and surgical repair is performed within one year.	\$1,000
Exploratory Surgery Without Repair Payable if an injury received because of a covered accident requires exploratory surgery that doesn't require surgical repair.	\$400

HEAD AND SPINE BENEFITS

Benefit Name and Description	Preferred
Concussion Payable if diagnosed within 72 hours using medical imaging (such as x-ray, CT Scan or MRI).	\$200

ADDITIONAL BENEFITS

Coma Payable if the comatose state lasts more than 30 days and diagnosis indicates that permanent neurological deficit is present.	\$20,000
Paralysis (Paraplegia/Quadriplegia) Payable if paralysis lasts more than 90 days and is diagnosed by a doctor within those 90 days.	Paraplegia \$12,500 Quadriplegia \$25,000
Ambulatory Surgical Pays a benefit for the day surgery is performed in an ambulatory surgical center facility or outpatient hospital facility on an insured person because of a covered accident. This benefit is payable only once per covered accident. Two or more surgeries performed during the same ambulatory surgery session are considered one surgery.	\$300
Total Disability Premium Waiver Waives premiums after 30 th day of total disability lasting for at least three consecutive months and disability starts before the Certificate anniversary prior to the 65th birthday. Limit of 12 months per disability.	Included
Portability Portable if you leave the company prior to age 70, not totally disabled and as long as the Master Policy remains in force. Not available in NJ, VT.	Included

RIDERS

On-the-Job (24 Hour Insurance) Benefit Pays a benefit for injuries, due to an accident, that are covered by Worker's Compensation or occupational disease law.	Included
Wellness Screening Pays a cash benefit when a member has one or more of the 21 covered screening tests. This screening benefit is payable once per covered person per calendar year.	\$100

Benefits and riders may vary by state and may not be available in all states.

This document is provided for reference only and does not supersede your proposal offer.

IMPORTANT NOTICE: The Insurance coverage provided under the policy does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and it does not satisfy the requirement of minimum essential coverage under the Patient Protection and Affordable Act. This is not a complete disclosure of plan qualifications and limitations. For a complete list of limitations and exclusions, please refer to www.ManhattanLife.com/Disclosure. Please review this information before applying for coverage. The benefits provided depend on the plan selected. Premiums will vary according to the selection made.

THIS POLICY PROVIDES LIMITED BENEFITS.

Critical Illness



A Critical Illness and Cancer Plan:

- Pays a lump sum benefit directly to you if diagnosed with a serious illness, unless otherwise designated
- Provides a benefit that can be used as you wish
- Pays in addition to any other coverage you may have
- Can cover you, your spouse and your children
- You or a covered member of your family are diagnosed with a covered critical illness, such as a heart attack, stroke or cancer

Did you know?

The 5-year relative survival rate for all cancers combined that were diagnosed during 2009 through 2015 was 67%.

<https://www.cancer.org/latest-news/facts-and-figures-2020.html>

BENEFITS & FEATURES

Benefit Amount

Employee:
• \$10,000 - \$30,000

Dependents:
• Spouse: \$5,000 - \$15,000. Equal to 50% of the employee's coverage amount
• Child: \$5,000. Equal to 50% of the employee's coverage amount to a max of \$5,000

Guarantee Issue for Employee, Spouse and Child(ren) coverage.

Cardiac Conditions

100% of benefit amount paid upon treatment period or proof of loss for Myocardial Infarction or Sudden Cardiac Arrest.
25% of benefit amount paid at diagnosis for Coronary Heart Disease.

Cerebral Vascular Disease

100% of the benefit amount paid upon treatment or proof of loss for a Stroke.
10% of the benefit amount paid upon treatment or proof of loss for a Ruptured Brain Aneurysm.
10% of the benefit amount paid upon treatment or proof of loss for a Transient Ischemic Attack.

Cancer

100% of the benefit amount paid upon treatment or proof of loss for Invasive Cancer.
25% of the benefit paid upon treatment or proof of loss for a Non-Invasive Cancer.
30 Day waiting period for Cancer - Waived

Other Specified Illnesses

100% of the benefit amount paid for one of the following illnesses or conditions: Benign Brain Tumor, Major Organ Failure, End- Stage Renal Failure*, Coma, Severe Burns, Permanent Paralysis*, Occupational HIV/Hepatitis*, Functional Loss of Sight*, Speech* or Hearing* as defined in the policy (certificate).

**not eligible for recurrence benefit.*

Policy: M-8021

Underwritten by ManhattanLife Insurance and Annuity Company

TARCESD1-CI_0826

www.manhattanlife.com

BENEFITS & FEATURES

Additional Occurrence	Once benefits have been paid for a Critical Illness, a benefit is paid for an additional different Critical Illness when; 1) the Date of Diagnosis for the new Critical Illness is separated from the prior Critical Illness by at least six (6) consecutive months, and 2) the new Critical Illness is not caused by a Critical Illness for which benefits have been paid, and 3) a benefit is not paid for more than one Critical Illness within a six (6) month period.
Portability	Portable after six months of continuous coverage if group master policy remains in force and the insured is less than age 70, not Totally Disabled, and no longer Actively at work for the Employer. Insured's policy terminates at age 70, dependents on ported certificates terminate when the spouse attained age is 70 or the child attained age is 25. If the policy terminates the ported Certificate terminates.
Recurrence Benefit	This provides a one-time additional benefit for the same condition if a covered participant is treatment-free for at least 12 months.
Pre-Existing Condition Limitation	12/12
Benefit Reduction	Waived
Waiver of Premium	Issue ages 18-55. Premiums will be waived for the insured if he or she is totally disabled as a result of a confirmed critical illness for at least 180 consecutive days.

**not eligible for recurrence benefit.*

Benefits and riders may vary by state and may not be available in all states.

IMPORTANT NOTICE: The Insurance coverage provided under the policy does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and it does not satisfy the requirement of minimum essential coverage under the Patient Protection and Affordable Act. This is not a complete disclosure of plan qualifications and limitations. For a complete list of limitations and exclusions, please refer to www.ManhattanLife.com/Disclosure. Please review this information before applying for coverage. The benefits provided depend on the plan selected. Premiums will vary according to the selection made.

THIS POLICY PROVIDES LIMITED BENEFITS

Policy: M-8021

Underwritten by ManhattanLife Insurance and Annuity Company

TARCESD1-CI_0826



www.manhattanlife.com

Hospital Indemnity



Provides Cash Benefits When You or Your Family Are Hospitalized

A Hospital Indemnity Plan:

- Can help reduce the financial strain of the high out-of-pocket expenses associated with hospital stays
- Benefits are paid directly to you, in addition to any other insurance coverage you may have
- Can cover you, your spouse and your children

Did You Know?

The national average length of a hospital stay is 4.5 days.

– Source: “Decreasing the Patient Length of Stay (LOS) to Lower HAIs Centrak.” Centrak, Web

Benefits of your Hospital Indemnity plan:

- Can cover you, your spouse and your children

Your Offer:

Guarantee Issue Coverage

Hospital Indemnity Benefit - \$200 per day for up to 30 days

Waives premium after primary insured has been totally disabled for 90 consecutive days and is 55 or younger

First Hospitalization Admission Benefit - \$1,500

ICU Daily Confinement - \$200 per day for up to 15 days

Pre-Existing Condition Limitation - 12/12

Maternity Waiting Period - 300 day Waiting Period

Benefits and riders may vary by state and may not be available in all states.

IMPORTANT NOTICE: The Insurance coverage provided under the policy does not constitute comprehensive health insurance coverage (often referred to as “major medical coverage”) and it does not satisfy the requirement of minimum essential coverage under the Patient Protection and Affordable Act. This is not a complete disclosure of plan qualifications and limitations. For a complete list of limitations and exclusions, please refer to www.ManhattanLife.com/Disclosure. Please review this information before applying for coverage. The benefits provided depend on the plan selected. Premiums will vary according to the selection made.

THIS POLICY PROVIDES LIMITED BENEFITS

Policy: M-8019

Underwritten by ManhattanLife Insurance and Annuity Company

TARCESD1-HI_0826

www.manhattanlife.com

Notices & Disclosures

The background of the page is a dark green color with a subtle, wavy, wood-grain-like texture. Overlaid on the right side of the page are several large, abstract, light green geometric shapes. These shapes include rounded rectangles and curved lines that overlap each other, creating a modern, layered design. The shapes are positioned primarily in the lower right quadrant, extending towards the center of the page.

Medicare Part D Creditable Coverage Notice

Important Notice About Your Prescription Drug Coverage and Medicare

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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 employer-sponsored group health plan coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current employer-sponsored group health plan coverage, be aware that you and your dependents may not be able to get this coverage back until the plan's next open enrollment period.

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 your employer 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% per month of the Medicare base beneficiary premium 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 your Human Resources representative for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage 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 our 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).

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

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Please review your plan materials regarding deductibles and coinsurance or contact your Human Resources representative for more information on WHCRA benefits.

Notice for Newborns' and Mothers' Health Protection Act (Newborns' Act)

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

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

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

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI) and includes all individually identifiable health information held by a health plan; whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (Plan), sponsored by your employer (plan sponsor). The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer. You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management.

Your employer is committed to the privacy of your health information. The administrators of the employer-sponsored group health plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting your Human Resources representative.

HIPAA Special Enrollment Rights

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, **you must request enrollment within 30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

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

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy

from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, **you must request enrollment within 60 days** after your or your dependents' determination of eligibility for such assistance. To request special enrollment or to obtain more information about the plan's special enrollment provisions, please contact your Human Resources representative.

Important Warning

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

No Surprise Billing Notice

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

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

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

For Patients and Plans that have protections under the State Law by the Texas Department of Insurance, please visit <https://www.tdi.texas.gov/medical-billing/index.html> for more information.

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 January 31, 2026. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfir/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

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

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

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 2/28/2026)

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

**** 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."

RETIREE COVERAGE ONLY:

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 Tarrant County ESD No. 1, 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;
- Retiree coverage only: 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 after the qualifying event occurs. You must provide this notice to: Tarrant County ESD No. 1.

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, 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>.

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

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

Jennifer Hilburn, 682-463-7206, jennifer.hilburn@tarrantesd1.org



This Benefit Booklet

Is Presented By:



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