

Acknowledgement of Receipt of Health Plan Notices

Menard County

1. Summary of Benefits & Coverage
2. Grandfathered Health Plan Notice
3. Initial HIPPA notice/ Important Notices
4. Newborns' Act Disclosure Notice
5. WHCR Notice
6. ACA Notice
7. Part D Creditable Coverage Notice
8. CHIP Notice/ Marketplace Coverage Notice
9. COBRA Notice
10. Privacy Notice

Acknowledgement of Receipt

Signature_____

Date_____

Print Your Name_____

Menard County



Employee Benefits

Employee Insurance Benefits

Effective

January 1, 2025 through December 31, 2025

CONTACT INFORMATION

MEDICAL/DENTAL

Blue Cross Blue Shield of Texas

(800) 521-2227 / www.bcbstx.com



TEXAS ASSOCIATION *of* COUNTIES
HEALTH AND EMPLOYEE BENEFITS POOL



BlueCross BlueShield of Texas

PRESCRIPTION DRUGS

Navitus Health Solutions

(866) 33-2757 / www.navitus.com



LIFE

One America

(800) 537-6442 / www.oneamerica.com



VISION

Ameritas

VSP Network

(800) 877-7195 / www.ameritas.com



AMBULANCE BENEFIT

MASA/Medical Transport Solutions

(800) 423-3226 / www.masamts.com



INSURANCE AGENTS

Mindy Seahorn

Seahorn & Herring Insurance Associates, LLP

201 S Chadbourne St

San Angelo, TX 76903

(800) 460-3093 / mindy@martin-herring.com

Bobby Zesch

Zesch & Pickett Insurance, LLP

430 West Beauregard

San Angelo, TX 76903

(800) 259-7302 / Bobbyz@zapins.com

Menard County

Health Renewal - January 1, 2025

TX Association of Counties - BlueCross BlueShield of TX - Blue Choice PPO Network / HMO Blue Essentials Network				
	BASE PLAN: HMO BLUE ESSENTIALS Medical Plan 1475 NGS Rx Option 5B-NG		BUY UP PLAN Medical Plan 1300 NGS - PPO Rx Option 5B-NG	
	In Network Benefits (only ER services covered out-of-network)		In Network Benefits	
	Deductible	\$2,000 / 3x Family		\$1,500 / 3x Family
	Co-Insurance	80/20		80/20
	Out of Pocket Maximum <i>Includes Deductible</i>	\$6,000 / 3x Family		\$5,000 / 3x Family
	Office Visits	\$35 Copay *PCP Required		\$30 Copay
	Specialist Copay	\$45 Copay *Referral Required		\$40 Copay
	Hospital	80% after Ded.		80% after Ded.
	ER Visit - Facility	\$150 Copay then 80% after Ded.		\$150 Copay then 80% after Ded.
	ER Visit - Physician	80% after Ded.		80% after Ded.
	Maternity	Included		Included
	Prescriptions	\$100 Rx Ded then: \$10 Generic / \$30 Brand / \$50 Non-Preferred Brand		\$100 Rx Ded then: \$10 Generic / \$30 Brand / \$50 Non-Preferred Brand
	Lifetime Maximum	Unlimited		Unlimited
Employee Only Cost to Add Spouse Cost to Add Children Cost to Add Family	BASE PLAN RATES		BUY UP PLAN RATES	
	MONTHLY RATES	EMPLOYEE MONTHLY COST FOR BASE PLAN	MONTHLY RATES	EMPLOYEE MONTHLY COST FOR BUY UP PLAN
	\$927.40	\$0.00	\$1,049.00	\$0.00
	\$836.08	\$714.48	\$950.66	\$950.66
	\$505.86	\$384.26	\$575.18	\$575.18
	\$1,272.34	\$1,150.74	\$1,446.72	\$1,446.72

Please note, this is a brief outline of rates and benefits for comparison only. For details, please refer to the proposal.

Menard County

TAC/Blue Cross Blue Shield of TX - DENTAL				Monthly Rates as of January 1, 2025
DENTAL				
Deductible	\$50 / 3x Family	Employee Only		\$0.00
Preventive Care	100%, Ded Waived	Cost to Add Spouse		\$21.40
Basic Care	80% after Ded.	Cost to Add Children		\$32.10
Major Care	50% after Ded.	Cost to Add Family		\$53.48
Annual Benefit Maximum	\$1,500			
Orthodontics	None			


Please note, this is a brief outline of rates and benefits for comparison only. For details, please refer to the proposal.




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbstx.com or by calling 1-855-357-5228. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources> or call 1-800-456-5974 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000 Individual / \$6,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services that charge a copay, prescription drugs, and In-Network diagnostic tests, home health, skilled nursing, and hospice are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes per occurrence: \$100 Individual / \$300 Family prescription drug deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$4,000 Individual / \$7,200 Family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Deductibles, Premiums, preauthorization penalties, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-855-357-5228 for a list of In-Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. This plan does not cover out-of-network providers or services. Check with your provider before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	Your Primary Care Physician (PCP) coordinates your medical care, as appropriate, either by providing treatment or by issuing Referrals to direct you to Participating Providers.
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 All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.				
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	Virtual visits available through MDLive \$0 <u>copay</u> . In-Network.
	<u>Specialist</u> visit	\$45 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge; <u>deductible</u> does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your PCP if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge; <u>deductible</u> does not apply	Not Covered	Office visit <u>copay</u> may apply.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not Covered	None

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.				
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mybenefits.org	Tier 1	Retail: \$10 <u>copay</u> / prescription Mail: \$20 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	Members must meet a separate prescription drug deductible before copay costs apply: \$100 Individual / \$300 Family. Retail: one copay per 30-day supply Retail -90: two copays up to 90 day supply Mail: two <u>copays</u> up to 90-day supply. Members electing to purchase brand name drugs when a generic is available will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name <u>Copayment</u> . <u>Specialty</u> drug prescriptions must be filled through Lumicera Specialty Pharmacy. One <u>copay</u> per 30-day supply.
	Tier 2	Retail: \$30 <u>copay</u> / prescription Mail: \$60 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
	Tier 3	Retail: \$50 <u>copay</u> / prescription Mail: \$100 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
	<u>Specialty drugs</u>	\$30 / \$50 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	
If you have outpatient surgery	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit	Not Covered*	Copay waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Not Covered*	None

*Out-of-network emergency claims will process with in-network level of benefits if the ER diagnosis verifies visit as a true emergency. However, if it is determined to be a non-emergency, the claim will process as out-of-network and benefits will deny due to your plan not having coverage out-of-network.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	<u>Urgent care</u>	\$35/\$45 <u>copay/visit</u> ; <u>deductible</u> does not apply	Not Covered	None
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not Covered	All services must be preauthorized.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35/\$45 <u>copay</u> / office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> for other outpatient services	Not Covered	Certain services must be preauthorized; refer to benefit booklet for details.
	Inpatient services	20% <u>coinsurance</u>	Not Covered	All services must be preauthorized.
If you are pregnant	Office visits	\$35/\$45 <u>copay</u> / initial visit; <u>deductible</u> does not apply	Not Covered	20% <u>coinsurance</u> applies after initial visit In-Network. <u>Cost sharing</u> does not apply for preventive services. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not Covered	All services must be preauthorized.
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge; <u>deductible</u> does not apply	Not Covered	Limited to 60 visits per <u>plan</u> year. All services must be preauthorized.
	<u>Rehabilitation services</u>	\$35/\$45 <u>copay</u> / visit; <u>deductible</u> does not apply	Not Covered	None
	<u>Habilitation services</u>	\$35/\$45 <u>copay</u> / visit; <u>deductible</u> does not apply	Not Covered	None
	<u>Skilled nursing care</u>	No Charge; <u>deductible</u> does not apply	Not Covered	Limited to 25 days per plan year. All services must be preauthorized.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	None
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	Not Covered	All services must be preauthorized.
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)			
• Acupuncture	• Infertility treatment	• Private-duty nursing	
• Bariatric surgery	• Long-term care	• Routine foot care	
• Cosmetic surgery		• Weight loss programs	
• Dental care (Adult)			
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
• Chiropractic care	• Non-emergency care when traveling Outside the U.S.	• Routine eye care (Adult)	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-855-357-5228, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace). For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a [claim](#). This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross Blue Shield of Texas at 1-855-357-5228 or visit www.bcbstx.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Contact the Texas Department of Insurance at 1-800-252-3439 or visit www.texashealthoptions.com.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a plan through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-357-5228.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-357-5228.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-357-5228.]

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-357-5228.]

To see examples of how the plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$2,000
- Specialist copayment \$45
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

→ Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$70
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,830

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,000
- Specialist copayment \$45
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$2,560

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,000
- Specialist copayment \$45
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,100
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600


The plan would be responsible for the other costs of these EXAMPLE covered services.




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbstx.com or by calling 1-855-357-5228. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources> or call 1-800-456-5974 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$1,500 Individual / \$4,500 Family Out-of-Network: \$4,500 Individual / \$13,500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services that charge a copay, prescription drugs, and In-Network diagnostic tests, home health, skilled nursing, and hospice are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes per occurrence: \$100 Individual / \$300 Family prescription drug deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: \$3,500 Individual / \$8,700 Family Out-of-Network: \$7,000 Individual / \$21,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Deductibles, premiums, preauthorization penalties, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-855-357-5228 for a list of In-Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.				
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Virtual visits available through MDLive \$0 <u>copay</u> . In-Network.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for. No Charge for child immunizations <u>Out-of-Network</u> through the 6 th birthday.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Office visit <u>copay</u> may apply.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.				
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mybenefits.org	Tier 1	Retail: \$10 <u>copay</u> / prescription Mail: \$20 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	Members must meet a separate prescription drug deductible before copay costs apply: \$100 Individual / \$300 Family Retail: one copay per 30-day supply Retail -90: two copays up to 90 day supply Mail: two <u>copays</u> up to 90-day supply. Members electing to purchase brand name drugs when a generic is available will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name Copayment. <u>Specialty drug</u> prescriptions must be filled through Lumicera Specialty Pharmacy. One <u>copay</u> per 30-day supply.
	Tier 2	Retail: \$30 <u>copay</u> / prescription Mail: \$60 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
	Tier 3	Retail: \$50 copay / prescription Mail: \$100 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
	<u>Specialty drugs</u>	\$30 / \$50 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you have outpatient surgery	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit	Copay waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	<u>Urgent care</u>	\$30/\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	All services must be preauthorized; \$250 penalty applies. <u>Out-of-Network</u> for failure to preauthorize.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30/\$40 <u>copay</u> / office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> for other outpatient services	30% <u>coinsurance</u> office visit 40% <u>coinsurance</u> for other outpatient services	Certain services must be preauthorized; refer to benefit booklet for details.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	All services must be preauthorized; \$250 penalty applies <u>Out-of-Network</u> for failure to preauthorize.
If you are pregnant	Office visits	\$30/\$40 <u>copay</u> / initial visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	20% <u>coinsurance</u> applies after initial visit In-Network. <u>Cost sharing</u> does not apply for preventive services. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	All services must be preauthorized; \$250 penalty applies <u>Out-of-Network</u> for failure to preauthorize.
	<u>Home health care</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Limited to 60 visits per <u>plan</u> year. All services must be preauthorized.
	<u>Rehabilitation services</u>	\$30/\$40 <u>copay</u> / visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$30/\$40 <u>copay</u> / visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Limited to 25 days per plan year. All services must be preauthorized.
If your child needs dental or eye care	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	All services must be preauthorized.
	Children's eye exam	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|--|---|---|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Hearing Aids• Infertility treatment• Long-term care | <ul style="list-style-type: none">• Private-duty nursing• Routine foot care• Weight loss programs |
|--|---|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | |
|---|---|
| <ul style="list-style-type: none">• Chiropractic care | <ul style="list-style-type: none">• Non-emergency care when traveling Outside the U.S.• Routine eye care (Adult) |
|---|---|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-855-357-5228, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a [claim](#). This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross Blue Shield of Texas at 1-855-357-5228 or visit www.bcbstx.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Contact the Texas Department of Insurance at 1-800-252-3439 or visit www.texashealthoptions.com.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a plan through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-357-5228.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-357-5228.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-357-5228.]

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-357-5228.]

To see examples of how the plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
--------------------	----------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$70
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,330

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
--------------------	---------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,960

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
--------------------	---------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,100
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200

The plan would be responsible for the other costs of these EXAMPLE covered services.

<p style="text-align: center;">Health care coverage is important for everyone.</p> <p>We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.</p>	<p>To receive language or communication assistance free of charge, please call at 855-710-6984.</p>	<p>If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.</p> <p>Office of Civil Rights Coordinator 300 E. Randolph St. 35th Floor Chicago, Illinois 60601</p> <p>Phone: 855-664-7270 (voicemail) TTY/TDD: 855-661-6965 Fax: 855-661-6960 Email: CivilRightsCoordinator@hcsc.net</p>	<p>You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:</p> <p>U.S. Dept. of Health & Human Services Phone: 800-368-1019 200 Independence Avenue SW TTY/TDD: 800-537-7697 Room 509F, HHH Building 1019 Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf Washington, DC 20201 Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html</p>
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TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

DENTAL PLAN II WITHOUT ORTHODONTIA

BLUECARE DENTAL PPO

Type of Service	Benefit**
General Provisions	
Plan Year Deductible	\$50 Individual / \$150 Family
Plan Year Maximum per Participant	\$1,500
Diagnostic and Preventive Care Benefits (deductible waived) (Benefits do not apply to Plan Year Maximum)	
Oral Examinations (twice per Plan Year) Problem-Focused and non-routine exams limited to 1 per plan year Consultations Prophylaxis (two cleanings per Plan Year) Dental X-rays -Full Mouth/Panoramic X-rays (once every 60 months) Bitewing X-ray Series (once per Plan Year) Fluoride Treatment (to age 19; twice per Plan Year) Sealants up to age 19, permanent molars, one per tooth every 36 months Space Maintainers up to age 19; 1 per arch per lifetime on posterior teeth only Labs and Tests Periodontal Maintenance 2 per plan year; not combined with Preventive Prophylaxis Full Mouth Debridement once per lifetime	100%
Miscellaneous Services	
Palliative Care	80%
Restorative Services	
Amalgams and Composite (once per surface on the indicated tooth per 24 months) Simple Extractions Pin Retention	80%
General Services	
Diagnostic Casts (once per Plan Year) Prefabricated Stainless Steel Crowns	80%
Endodontic Services	
Root canal therapy Direct pulp cap Apicoectomy/Apexification Retrograde filling Root amputation/hemisection Therapeutic pulpotomy	80%
Periodontal Services	
Periodontal scaling and root planing	80%
Oral Surgery Services	
Surgical tooth extractions Full Bony impacted tooth extractions General Anesthesia/IV Sedation Alveoloplasty, Vestibuloplasty Gingivectomy/gingivoplasty Gingival flap procedure / Osseous surgery and grafts / Soft tissue grafts	50%
Crowns, Inlays/Onlays Services	
Crowns, Inlays, Onlays, Labial Veneers	50%



A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association



TEXAS ASSOCIATION *of* COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

Prosthodontic Services Bridges and dentures Denture relining/rebase, Denture adjustments, Re-cementation and repair of bridges/dentures, Re-cementation and repair of crowns, inlays/onlays, Occlusal Guard Implants	50%
Orthodontia Benefits Orthodontic Diagnostic Procedures and Treatment for Adults	Not Covered

****Each time you need dental care, you can choose to:**

SEE A CONTRACTING DENTIST	SEE A NON-CONTRACTING DENTIST
<ul style="list-style-type: none"> Your out-of-pocket cost will generally be the least amount because BlueCare Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses You are not required to file claim forms You are not balance billed for costs exceeding the BCBSTX Allowable Amount for BlueCare Dentists 	<ul style="list-style-type: none"> Your out-of-pocket cost may be greater because Non-Contracting Dentists have not entered into a contract with BCBSTX to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses You are required to file claim forms You are balance billed for costs exceeding the BCBSTX Allowable Amount

EMPLOYEE INFORMATION

This is a general summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions. The following eligibility provisions apply:

- Dependent children are covered to age 26. Disabled dependent children can be covered beyond age 26.
- Retirees may be eligible, depending on employer contract.
- Employees may enroll dependent children up to age 5, on the first of the month following application with no late enrollment penalty.

When the course of treatment will be in excess of \$300, a predetermination request should be submitted to BCBSTX in advance of treatment.



Menard County
Basic Life Benefit Summary
Class 1 - All Eligible Full Time Employees

Full-time Employee Requirement	An eligible employee is a full-time permanent employee authorized to work and reside in the United States. Eligible employees must work 30 or more hours per week and cannot be considered a part-time, temporary or seasonal employee. If any eligible employee is not actively at work on the individual effective date, group insurance coverage for that employee will not exist until he/she returns to full-time active work.
Life Amount	\$50,000
Accidental Death & Dismemberment (AD&D) Principal Sum Amount	\$50,000
Guaranteed Issue Amount	\$50,000
Dependent Term Life Amount	Plan 1 Employee's Spouse under age 70 \$10,000 Dependent Child* - 6 months to age 19, or 25 if full-time student \$5,000 Dependent Child - Live birth to 6 months \$1,000 *Age and definition of Child(ren) may vary by state.
Reduction Schedule	The Life Amount and AD&D Principal Sum will reduce to 50% of the amount shown above when the Employee reaches age 70. See Certificate for further benefit reductions due to age.
Accelerated Life Benefit	The Employee may request payment of 25%, 50%, or 75% of the Life Amount if the Employee is diagnosed with a terminal condition, as defined in the Certificate.
Waiver of Premium	AUL may waive further premium payments for the Employee's Life Amount if the Employee becomes Totally Disabled before age 60 while insured under the Policy, and remains continuously Totally Disabled for 9 months, and submits proof of Total Disability.

Dependent Term Life Insurance
Family

Monthly Premium Rate
\$8.46

Conversion

If the Employee's Life Insurance or a portion of it ceases, the Employee may be entitled to convert his / her life amount. The Employee can refer to his or her Certificate for specific details of this provision.

Accidental Death & Dismemberment

While insured under the Policy, if the Employee has an accident which results in a loss or condition specified in the chart below, AUL will pay the amount shown. The loss or condition must occur within 365 days from the date of the accident and AUL must receive acceptable proof of loss or condition.

Loss Schedule**Loss**

Life [AD&D Principal Sum]

Both hands or both feet or sight of both eyes [AD&D Principal Sum]

Speech and hearing [AD&D Principal Sum]

One hand and one foot [AD&D Principal Sum]

One hand and sight of one eye [AD&D Principal Sum]

One foot and sight of one eye [AD&D Principal Sum]

Sight of one eye [Half of AD&D Principal Sum]

One hand or one foot [Half of AD&D Principal Sum]

Speech or hearing [Half of AD&D Principal Sum]

Thumb and index finger [Quarter of AD&D Principal Sum]

Conditions

Quadriplegia or Loss of Use of Upper and Lower Limbs of the Body [AD&D Principal Sum]

Paraplegia or Loss of Use of Both Lower Limbs of the Body [Half of AD&D Principal Sum]

Hemiplegia or Loss of Use of Upper and Lower Limbs on the Same Side of the Body [Half of AD&D Principal]

Monoplegia or Loss of Use of One Limb of the Body [Quarter of AD&D Principal]

Severe Burns [AD&D Principal Sum]

The total amount payable will never exceed the AD&D Principal Sum for all losses or conditions sustained by the Employee.

Benefit Features Offered for Basic Term Life and AD&D

Seat Belt

Air Bag

Exposure

Disappearance

Repatriation

Child Higher Education

Child Care

This information is provided as a Benefit Outline. It is not a part of the insurance policy and does not change or extend American United Life Insurance Company's® liability under the group Policy. Employers may receive either a group Policy or a Certificate of Insurance containing a detailed description of the insurance coverage under the group Policy. If there are any discrepancies between this information and the group Policy, the Policy will prevail.

Vision Plan Benefits

	VSP Choice Network	Out-of-Network
Annual Eye Exam	Covered in full	Up to \$45
Single Vision Lenses	Covered in full	Up to \$30
Bifocal Lenses	Covered in full	Up to \$50
Trifocal Lenses	Covered in full	Up to \$65
Lenticular Lenses	Covered in full	Up to \$100
Progressive Lenses	See lens options	NA
Frames	\$130	\$70
Contacts (standard) fit & follow up exam	Member cost up to \$55	\$0
Contacts (elective)	Up to \$130	Up to \$105
Contacts (medically necessary)	Covered in full	Up to \$ 210

Deductible

Annual Eye Exam	\$10	\$10
Eyeglass Lenses or Frames	\$25	\$25

Benefit Frequencies (months)

Based on Date of Service

Exam/Lens/Frame	12/12/24
-----------------	----------

Member cost for lens options (May vary by prescription, options chosen and retail location)

Progressive Lenses	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
Solid Plastic Dye	\$15 (except Pink I & II)	No benefit
Plastic Gradient Dye	\$17	No benefit
Scratch Resistant Coating	\$17-\$33	No benefit
Anti-Reflective Coating	\$43-\$85	No benefit
Ultraviolet Coating	\$16	No benefit

Monthly Rates

Employee only	\$7.96
Employee & Spouse	\$17.16
Employee & Child(ren)	\$13.88
Employee & Spouse & Child(ren)	\$23.08

Rates are effective from 1/1/2021 to 1/1/2022.

VSP Network

With access to the largest network of independent doctors, VSP members receive services at rates well below walk-in prices at more than 36,000 doctors nation wide. Find a provider at <https://www.vsp.com>



4,500

retail chain affiliates such as



The largest network of independent doctors



94% of VSP doctors offer early morning or evening appointments and access to 24-hour emergency care



No claim forms to complete when you see a VSP doctor



Out-of-network benefits can be used at



Online In-network Options

[Eyeconic.com](https://www.vsp.com) is in-network online eyewear store - which means you won't have to pay the full price now, then wait to be reimbursed later. Your vision benefits will be applied directly to your online order. Eyeconic FAQ:

<https://www.vsp.com/eyewear-question.html>

Customer Service

VSP 800-877-7195 www.vsp.com

Mon-Fri 5am-8am, Sat 7am-8pm, Sun 7am-7pm (PST)

Additional Savings

Find More VSP exclusive member savings offers at <https://www.vsp.com/optical-discounts.html>

When you visit a VSP network provider you'll save:



20% off remaining frame balance



20-25% off non-covered lens options such as UV coating & polycarbonate



20% off non-covered complete prescription glasses



15% off LASIK and PRK laser surgery retail price or



5% off promotion price

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

Laser Vision Surgery

Your vision plan provides an average discount of 15% on LASIK and PRK. Your maximum out-of-pocket per eye is \$1,800 for LASIK, \$2,300 for custom LASIK using Wavefront technology, and \$1,500 for PRK. In order to receive the benefit, a VSP Provide must coordinate the procedure. Getting started is simple; just follow the steps at <https://www.vsp.com/lasik.html>

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

Rx Savings

Save on Prescription medications at 60,000 Pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. Just Present your Rx savings card. To access and print your Rx savings cards, visit [ameritas.com](https://www.ameritas.com), register/sign in to your secure member account and select member savings. This discount is offered at no additional cost and is not insurance.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

Ameritas Vision Providers
VSP Choice Network
www.ameritas.com
as of November 14, 2024

Brady

Brasher, Warren
Gold, Jamie
Henson, Karen

Brownwood/Early

Boren, Carol
Cavett, Stanley
Hills, Stephen
Jacob, Tony
Ness, Peter
Moffatt, Travis
Wood, Larry

Fredericksberg

Alaquinez, Jacklyn
Aneregg, Heather
Blaker, Brandon
Blaker, Shelly
Henson, Karen
Kroeger, Steve
Oosterbaan, Hans
Pena, Benito
Thomas, Gladdis
Trevino, Christopher
Williamson, Amanda

Junction

No Providers

Kerrville

Alaquinez, Jacklyn
Blaker, Brandon
Blaker, Shelly
Ford, Bret
Henson, Karen
Kroeger, W Steve
Nguyen, Huong
Thomas, Gladdis
Tilley, Tobin
Trevino, Christopher
Whitehead, Phillip

Llano

Dang, Dana
Danson, Jeremy

Mason

No Providers

Menard

No Providers

San Angelo

Brasher, Warren
David, Ashley
Gold, Jaime
Hejny, Whitney
Holle, Douglas
Holle-Garcia, Laura
Jefferies, John
Larsen, Alan
Matthews, John

	\$14	\$19	\$39
	Emergent Plus plan	Emergent Premier	Platinum plan
Emergency Ground Ambulance Coverage	● ²	● ²	● ²
Emergency Air Ambulance Coverage	● ²	● ²	● ²
Hospital to Hospital Ambulance Coverage	● ²	● ²	● ²
Repatriation to Hospital Near Home Coverage	● ²	● ³	● ⁴
Post Admission Continued Care Transportation Coverage (\$500 max per calendar year per Member)		● ¹	
Sick While Away From Home Expense Protection (Limited to 2 claims per calendar year, up to \$5,000 per claim)		● ⁴	
Minor Return Transportation Coverage		● ³	● ³
Pet Return Transportation Coverage		● ³	● ³
Patient Return Transportation Coverage			● ⁴
Companion Transportation Coverage			● ³
Companion Return Transportation Coverage			● ³
Hospital Visitor Transportation Coverage			● ³
Mortal Remains Transportation Coverage			● ⁴
Vehicle & RV Return Coverage			● ³
Organ Retrieval Transportation Coverage			● ¹

Coverage territories

1: United States only.

2: United States, Canada.

3: United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas and Bermuda.

4: Worldwide coverage to include any region with the exclusion of Antarctica and not prohibited by U.S. law or under certain U.S. travel advisories as long as the member has provided ten (10) day notice.

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

masaAccess

Stay prepared with MASA[®] AccessSM

Comprehensive coverage and care for emergency transport.

Emergency Ground Ambulance Coverage²

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

Emergency Air Ambulance Coverage²

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

Hospital to Hospital Ambulance Coverage²

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

Repatriation to Hospital Near Home Coverage⁴

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

Patient Return Transportation Coverage⁴

Once you're discharged from medical care and able to travel without medical transport, MASA coordinates and covers the costs associated with your commercial airline transport home.

Patient Return Transportation Coverage⁴

Once you're discharged from medical care and able to travel without medical transport, MASA coordinates and covers the costs associated with your commercial airline transport home.

Companion Transportation Coverage³

MASA coordinates services and covers the cost for a companion to accompany you during your emergency air ambulance transport.

Hospital Visitor Transportation Coverage³

Should you be hospitalized more than 100 miles from home, MASA coordinates and covers the cost of round-trip air transportation for a companion to join you.

Minor Return Transportation Coverage³

In the event your minor child traveling with you is left unattended due to your emergency transport, MASA coordinates services and covers expenses to return your child safely home.

Pet Return Transportation Coverage³

If you are traveling with your pets and an emergency occurs requiring your medical transport, MASA coordinates services and covers expenses for returning up to two pets to your home.

Mortal Remains Transportation Coverage⁴

In the event that you pass away more than 100 miles from home, MASA coordinates services and covers the cost of air transport for your remains to be returned home.

Vehicle & RV Return Coverage³

Should a travel emergency occur requiring you to leave your vehicle or RV by ambulance, MASA provides services and covers expenses associated with returning your vehicle or RV to your home.

Organ Retrieval & Organ Recipient Transportation Coverage¹

Should you need an organ transplant, MASA coordinates and covers the cost of getting you or the organ to the transplant location.

Coverage Only under Emergent Premier Membership

Sick While Away From Home Expense Protection⁴

Should you contract a communicable disease while traveling away from home, your out-of-pocket expenses are eased with MASA.

Post Admission Continued Care Transportation Coverage¹

Should you need care in a rehabilitation facility, skilled nursing facility, long-term care facility, hospice, or at home after an emergency, your out-of-pocket expenses for transport are eased with MASA.

Coverage territories

1: United States only.

2: United States and Canada.

3: United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas and Bermuda.

4: Worldwide coverage to include any region with the exclusion of Antarctica and not prohibited by U.S. law or under certain U.S. travel advisories as long as the member has provided ten (10) day notice.



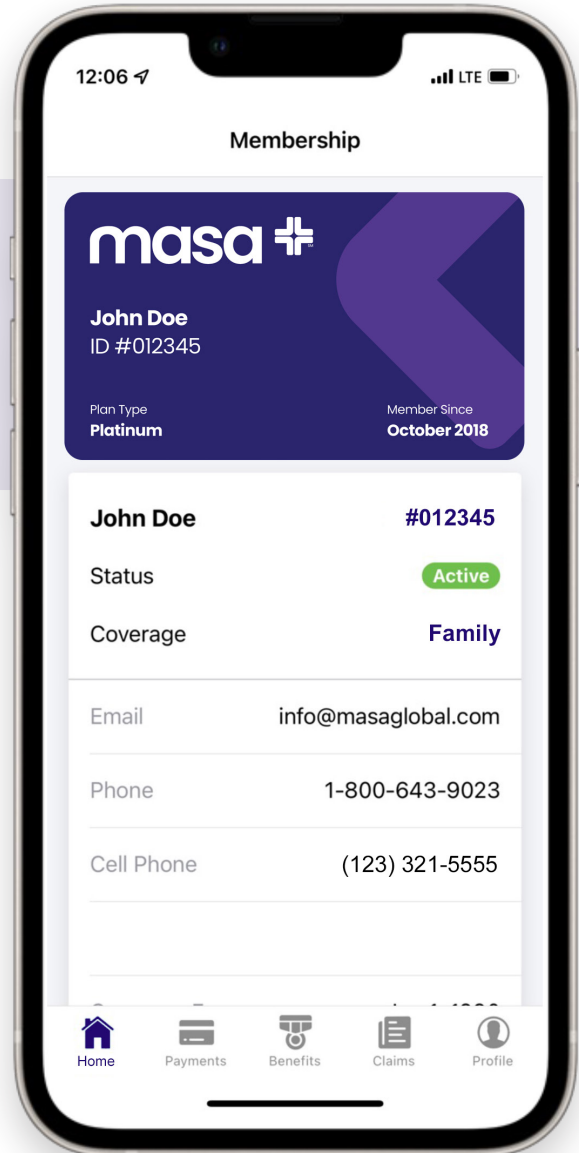
Download the MASA mobile app today!

Registration is easy with your member ID.

- ✓ Access your digital ID cards.
- ✓ View plan documents and benefits.
- ✓ View your claims history.

You now have access to emergency transportation solutions in the palm of your hand. The MASA App allows you to check and update your membership information, view payment history, immediately access benefits and to view up-to-the minute claims processing information, along with many more exciting features to come.

This one stop shop is a must have app for all MASA Global members, while at home or traveling.



Important Notice MENARD COUNTY

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 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. Menard County has determined that the prescription drug coverage offered by Blue Cross Blue Shield is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
-

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Menard County coverage will be affected. If you decide to elect a Part D plan, you can keep your current coverage with Menard County but it will not coordinate with Part D coverage. Your Part D coverage will become your primary prescription drug benefit.

If you decide to join a Medicare drug plan and drop your current Menard County coverage, be aware that you and your dependents will be able to get this coverage back only during the specific Open Enrollment period for Menard County coverage.

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 Menard 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 in a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes Menard County. 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:	1/1/2025
Name of Entity/Sender:	Menard County
Contact-Position/Office:	
Address:	PO Box 1038, Menard, TX 76859
Phone Number:	325-396-2748



Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

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

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

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name MENARD COUNTY		4. Employer Identification Number (EIN)	
5. Employer address PO BOX 1038		6. Employer phone number 325-396-2748	
7. City MENARD	8. State TX	9. ZIP code 76859	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)		12. Email address	

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

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

- ☒ Some employees. Eligible employees are:

ALL FULL TIME EMPLOYEES

- With respect to dependents:
☒ We do offer coverage. Eligible dependents are:

SPOUSES AND DEPENDENTS. PLEASE REFER TO BENEFIT BOOKLET FOR DEFINITION OF ELIGIBLE SPOUSE OR DEPENDENT

- ☐ We do not offer coverage.

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

****** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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."

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;
- 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 your employer.

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, 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.

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 you 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

Menard County
PO Box 1038
Menard, TX 76859-1038
325-396-2748



TEXAS ASSOCIATION *of* COUNTIES

HEALTH AND EMPLOYEE BENEFITS POOL



BlueCross BlueShield
of Texas

EMERGENCY EVACUATION MEDICAL INFORMATION



Please keep the following information where it can be referred to in the event of an emergency evacuation.

Special arrangements have been made to assist our members of the Health and Employee Benefits Pool (TAC HEBP) in the event of an official evacuation. If your county has officially been declared by the Governor's office to evacuate, we will notify Blue Cross Blue Shield of Texas (BCBSTX) and Navitus Health Solutions so they are ready to assist those that are faced with emergency medical situations. In the event you have to leave your home and need assistance with getting your prescription refilled or medical care in an unfamiliar community, we are here to assist you.

KEEP YOUR TAC HEBP/BCBSTX HEALTH PLAN ID CARD WITH YOU:

The information on this card is necessary to get you the care that you need with minimal disruption. BlueCross Blue Shield of Texas and Navitus are both nationwide networks and customer service can be reached at the number provided on the back of your ID card.

FOR CUSTOMERS OF CHAIN PHARMACIES:

If you have your prescriptions at a large CHAIN pharmacy (i.e.; Wal-Mart, Walgreens, Brookshire Brothers, HEB, CVS, etc.), you should be able to go to the local branch of that chain pharmacy and have your prescription transferred to your current location for filling. Once you return home, you will need to have it transferred back to your regular pharmacy. If there are no local branches accessible to you, please follow the instructions below.

FOR CUSTOMERS OF LOCAL PHARMACIES:

If you have your prescriptions at a local pharmacy that is closed or is not accessible to you due to the evacuation, you will need to have a doctor call in a new prescription to a pharmacy where you are located, or to the Costco mail order facility. If you want to use the Costco mail order pharmacy, please have an address ready where the medicine can be sent. If you cannot reach your local doctor to call in a prescription, you can see a doctor where you are located. BCBSTX has made your health care records electronically available to physicians across the state so that you can continue to receive excellent health care while you are away from home.

FOR SPECIALTY PHARMACY CUSTOMERS:

Cold Pack medicines are shipped via UPS. Please call Lumicera Health Services at 855-847-3553 .

IMPORTANT NUMBERS:

Navitus Customer Care: 866-333-2757

Costco Mail Order Pharmacy: For doctor to fax in a prescription: 800-633-0334
For doctor to call in a prescription: 800-607-6871

BCBSTX Customer Service and MD Live Telemedicine Service: 855-357-5228

Texas Association of Counties Health and Employee Benefits: 800-456-5974