Hunt County
Comprehensive Benefits Summary

October 1, 2026 – September 30, 2027

Presented By:
The Nitsche Group
www.TheNitscheGroup.com
1.800.258.8302

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Benefit Enrollment Center & Vendor Contacts

OCTOBER 1, 2026 – SEPTEMBER 30, 2027

For help with Benefit Enrollment, please contact: The Human Resources Department

Phone: 903-408-4106 Human Resources

Hours: Monday –Friday: 8:00 am – 5:00 pm

MEDICAL/TELEDOC		
UMR, A United Healthcare Company		800-207-3172
MEDICAL	76415594	www.umr.com
TELEDOC	76415594	www.teledoc.com/800-Teladoc (835-2362)
DENTAL/VISION		
Pacific Life Insurance Company		
DENTAL	855-810-3301	Pacificlife.com/dental
VISION	855-810-3301	Pacificlife.com/vision
HOW TO FIND A PROVIDER (DENTAL/VISION)		
Pacific Life Insurance Company	See Dental/Vision	See Dental/Vision
WELLNESS PROGRAM		
UMR, A United Healthcare Company	76415594	800-207-7680
LIFE INSURANCE & DISABILITY		
Colonial Life & Accident Insurance Company	903-646-2463	Stephanie.warner@coloniallifesales.com
Globe Life Liberty National Insurance	469-400-6274	terri-hogan@att.net
Lincoln Financial Group (Disability)	800-423-2765	www.lfg.com
AFLAC	903-886-8657	nevayoung@hotmail.com
RETIREMENT		
AIG Retirement Services	888-569-7055	www.aigrs.com
AIG Retirement Services	Access code: 673410124	
Capital Group/American Funds	903-243-1961	www.envision-fs.com
Security Benefits	800-888-2461	www.securitybenefit.com
Texas County & District Retirement System	800-823-7782	www.tcdrs.org
PRESCRIPTION RX		
Rx Benefits	800-334-8134	www.rxbenefits.com
Optum Rx		www.optumrx.com
LEGAL SERVICES & IDENTITY THEFT		
Legal Shielf/ID Shield	800-654-7757	www.shieldbenefits.com/huntcounty

Benefits Notices

Hunt County

2507 Lee Street, Room #200
Greenville, TX 75401-1097
903-408-4103

Created on: **10/01/2026**

The benefits notices that you have received were prepared from templates which have been drafted with every reasonable effort to be current and compliant with applicable law. However, there are many variables that must be considered in customizing the benefits notices for use by a particular employer or plan. As such, The Nitsche Group makes no warranty or representation, express or implied, regarding these benefits notices and makes no guarantees as to the outcome or results to be obtained from your use of the benefits notices. In addition, the notices attached are not all the required notices that may apply to your company, but rather are the most common notices provided at open enrollment that are not issued by the insurance carrier. You are solely responsible for any failure with respect to distribution of the benefits notices which may be required to comply with applicable law. A qualified attorney or other appropriate professional should be consulted on all legal compliance matters.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2027)

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

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

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 Hunt County		4. Employer Identification Number (EIN) 75-6001017	
5. Employer address 2507 Lee Street, Room #200		6. Employer phone number 903-408-4103	
7. City Greenville	8. State Texas	9. ZIP code 75401-1097	
10. Who can we contact about employee health coverage at this job? Sandy Orange			
11. Phone number (if different from above)	12. Email address sorange@huntcounty.net		

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:

  ☒ Working 30 hours or more a week.

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  As defined by the IRS.

  ☐ 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.

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Notice of Special Enrollment Rights

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

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

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Sandy Orange at 2507 Lee Street, Room #200, Greenville, TX 75401-1097, 903-408-4103, sorange@huntcounty.net

Notice of Privacy Practices

Hunt County
2507 Lee Street, Room #200
Greenville, TX 75401-1097
903-408-4103

Privacy Official:

Sandy Orange
2507 Lee Street, Room #200
Greenville, TX 75401-1097
903-408-4103
sorange@huntcounty.net

Effective Date: 10/01/2026

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan

- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:
  Sandy Orange
  2507 Lee Street, Room #200
- Greenville, TX 75401-1097
  903-408-4103
  sorange@huntcounty.net
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

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

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

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

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

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

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

Run our organization

- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official

- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

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

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: See summary for deductible (in-network) and see summary for coinsurance (in-network). If you would like more information on WHCRA benefits, call your plan administrator at 903-408-4103.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 903-408-4103 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 March 17, 2025. Contact your State for more information on eligibility –

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

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

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

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

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

Newborns' and Mothers' Health Protection Act Notice

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

Medicare Part D Creditable Coverage Notice

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Hunt County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Hunt County has determined that the prescription drug coverage offered by the Hunt County Welfare Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Hunt County coverage will not be affected. United Healthcare Coverage

If you do decide to join a Medicare drug plan and drop your current Hunt County coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information call Sandy Orange at 903-408-4103. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Hunt County changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	10/01/2026
Name of Entity/Sender:	Hunt County
Contact--Position/Office:	Sandy Orange, HR Director
Address:	2507 Lee Street, Room #200, Greenville, TX 75401-1097
Phone Number:	903-408-4103

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

General Notice of COBRA 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."

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 Hunt County, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

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

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

Sandy Orange
HR Director

2507 Lee Street, Room #200
Greenville, TX 75401-1097
903-408-4103
sorange@huntcounty.net

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[2] 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

[2] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Hunt County Welfare Benefit Plan
Sandy Orange
2507 Lee Street, Room #200
Greenville, TX 75401-1097
903-408-4103
sorange@huntcounty.net

General FMLA Notice

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

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

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address:
http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Understanding Plan Resources

MEDICAL

- **TelaDoc Health** – Medical care available by phone or online 24/7 (out-of-pocket cost varies based on your plan). Use this option in order to save a trip to the ER or urgent care for non-emergency needs. Simply make a phone call to reach a certified doctor. The doctor can evaluate your non-emergency health needs like prescription refills, coughs, colds, UTIs, sinus, allergies, and much more.
    - **Contact by phone: 1-800-835-2362**
    - **Contact online: www.teladochealth.com**
    - **Download the app: TelaDoc Health App**
- **CARE a UMR Solution** – With UMR's Live Well Reward$, you can get financial rewards for taking a few simple steps toward living a healthier life. Your participation is completely voluntary, and all resources are available at no cost to you. You can qualify for an incentive up to $100 in a reloadable reward card by completing goal(s). For more detailed information on how to earn your incentive, log into umr.com or call the number below.
    - **Contact by phone: 1-800-207-7680**

PHARMACY

- **RxBenefits, Inc. and OptumRx** – Administers the prescription plan for Hunt County employees.
    - **Contact by phone: 1-800-334-8134**
    - **Contact online: www.optumrx.com**
- **Pharmacy Identification Card (ID Card)** – Your pharmacy ID card enables you to participate in the prescription drug card program. Present your combined medical and pharmacy ID card to the pharmacist when obtaining a prescription to ensure you get the benefits of the prescription drug card program. Please contact your medical insurance carrier for a replacement ID card.

Important Information

- The choices an employee makes now will remain in effect until the next open enrollment period, unless they experience a Qualifying Event.
- This book highlights the main features of the employee benefit program, but does not include all plan rules, features, limitations or exclusions. The terms of the benefit plans are governed by legal documents, including insurance contracts, and the summary of benefits. Should there be any inconsistencies between this book and the legal plan documents, the plan documents are the final authority.
- Hunt County reserves the right to change or discontinue its benefit plans at any time.
- Should an employee wish to review the Summary Plan Description, Summary of Benefits, and/or insurance contracts, they should make their request in writing and provide it to the Human Resources Department (HR). HR will provide you the opportunity to review the requested materials within 30 days of the request. These documents may be found on-line at the Hunt County's website. Employees who wish to have a paper copy should include that in their written request to HR.

Open Enrollment & Qualifying Life Events

Passive Enrollment

If you accepted coverage for the Last Plan Year and choose to do nothing at open enrollment, your election of coverage shall continue as long as you remain employed. Should you have waived coverage Last Plan Year and intend to waive coverage this year, we need you to make that election to confirm that you wish to waive coverage for This Plan Year. Should you have waived coverage last plan year and do nothing at open enrollment this year, we will presume that you have waived this coverage again. As such, you will not be eligible to enroll in the medical plan again until next open enrollment and then only if you have met our eligibility requirements. Of course, if you have a Qualifying Event, which necessitates coverage, please reach out to us

Open Enrollment

- Employees are eligible for Hunt County benefits if they are regularly scheduled to work at least thirty (30) hours a week, or one-hundred and thirty (130) hours a month.
- Employees may make changes or add dependents without having to provide proof of insurability during the open enrollment period; Except for increases to the amount of voluntary life and AD&D, which requires evidence of insurability.
- Open enrollment applies to Medical, Dental, Vision, Life, Flexible Spending Account, and Supplemental Coverages.
- If an employee has been offered the dental plan previously, and is enrolling for the first time, he/she will be subject to late entrant penalties.
- The open enrollment period is the only time employees may enroll in the above listed coverage without the occurrence of a qualifying event (see definition below).
- Upon request, Employees and/or their dependents can receive a HIPAA Certificate of Creditable Coverage at termination from their previous carrier to provide proof of prior coverage.

Enrollment Changes during the Year

In most cases, an employee's benefit elections will remain in effect for the entire plan year (October 1st –September 30). During the open enrollment period, employees have the opportunity to review their benefit elections and make changes for the coming year. Employees may only make changes to their elections during the year if they have one of the following status changes:

- Marriage, divorce, or legal separation;
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death, reaching the dependent child age limit; or
- Significant changes in employment or employer-sponsored benefit coverage that affect the employee's or their spouse's benefit eligibility.
- Termination of Medicaid or CHIP coverage;
- Eligibility for employment assistance under Medicaid or CHIP.

Employee benefit changes must be consistent with the change in family status.

These and other events may require employees to make changes to their benefits (medical, dental, flexible spending accounts, etc.) outside the annual open enrollment periods. Keep in mind that a Qualifying Event does NOT allow a plan change during the plan year.

IRS regulations require that for changes in enrollment due to the qualifying events above, change forms must be submitted to Human Resources within 30 days of the event.

Medical Terminology

COPAY

A fixed amount the participant pays for a covered health care service after having paid his or her deductible.

COINSURANCE

The percentage of costs of a covered health care service the participant pays after having paid his or her deductible.

DEDUCTIBLE

The amount a plan participant pays for covered health care services before his or her insurance plan starts to pay.

DEPENDENT COVERAGE

Dependent children are eligible to their twenty-sixth (26th) birthday, or until the end of the month in which they turn twenty-six (26). A dependent child may also remain covered with no age limitation, provided the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap.

OUT-OF-POCKET COSTS

Expenses for medical care that are not reimbursed by insurance. Out-of-pocket costs include deductibles, co-insurance, and co-pays for covered services plus costs for services that are not covered.

OUT-OF-POCKET LIMIT

The most a plan participant can be required to pay for covered services in a plan year. The out-of-pocket limit does not include monthly premium amounts or spending for services the plan does not cover. An out-of-pocket limit is also called "out-of-pocket maximum."

PRE-TAX DEDUCTIONS

A pre-tax deduction is money withheld from the employee's wages before money or taxes. Pre-tax deductions are used to pay employee premiums of certain benefits. Common pre-tax health benefits include health insurance, accident insurance, dental, and vision insurance. However, not all benefits can be pre-tax deductions.

POST-TAX DEDUCTIONS

Post-tax deductions come out after taxes and do not have any effect on your taxable income.

WAITING PERIOD

The time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for coverage under an employer-sponsored health plan.

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.umr.com or by calling 1-800-207-3172. 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 www.umr.com or call 1-800-207-3172 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$300 person / $900 family In-network $600 person / $1,800 family Out-of-network	Generally, you must pay all 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. Preventive care services 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.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$1,800 person / $5,400 family In-network $4,200 person / $12,600 family Out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance billing 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.umr.com or call 1-800-207-3172 for a list of 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 referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		In-network (You will pay the least)	Out-of-network (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	$25 Copay per visit; Deductible Waived	30% Coinsurance	None
	Specialist visit	$25 Copay per visit; Deductible Waived	30% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	30% Coinsurance; No charge; Deductible Waived to age 7 immunizations only	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; Deductible Waived	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	30% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (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.insurancecompany.com/prescriptions.	Generic drugs (Tier 1)	Benefits are applied by outside vendor	Benefits are applied by outside vendor	None
	Preferred brand drugs (Tier 2)	Benefits are applied by outside vendor	Benefits are applied by outside vendor	
	Non-preferred brand drugs (Tier 3)	Benefits are applied by outside vendor	Benefits are applied by outside vendor	
	Specialty drugs (Tier 4)	Benefits are applied by outside vendor	Benefits are applied by outside vendor	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	None
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	None
If you need immediate medical attention	Emergency room care	$90 Copay per visit; 10% Coinsurance	$90 Copay per visit; 10% Coinsurance	In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	$25 Copay per visit; Deductible Waived	30% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance; Deductible Waived	30% Coinsurance; Deductible Waived	Preauthorization is required.
	Physician/surgeon fees	10% Coinsurance; Deductible Waived	30% Coinsurance; Deductible Waived	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay per visit; Deductible Waived Office visits; 10% Coinsurance other outpatient services	30% Coinsurance	Preauthorization is required for Partial hospitalization.
	Inpatient services	10% Coinsurance; Deductible Waived	30% Coinsurance; Deductible Waived	Preauthorization is required.
If you are pregnant	Office visits	No charge; Deductible Waived	30% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% Coinsurance; Deductible Waived	30% Coinsurance; Deductible Waived	
	Childbirth/delivery facility services	10% Coinsurance; Deductible Waived	30% Coinsurance; Deductible Waived	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge; Deductible Waived	30% Coinsurance	60 Maximum visits per plan year; Preauthorization is required.
	Rehabilitation services	10% Coinsurance	30% Coinsurance	Preauthorization is required to age 3 with development delays; Habilitation services for Learning Disabilities are not covered.
	Habilitation services	10% Coinsurance	30% Coinsurance	
	Skilled nursing care	No charge; Deductible Waived	30% Coinsurance	60 Maximum days per plan year; Preauthorization is required.
	Durable medical equipment	10% Coinsurance	30% Coinsurance	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases.
	Hospice service	No charge; Deductible Waived	30% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Infertility treatment	• Routine eye care (Adult)
• Bariatric surgery	• Long-term care	• Routine foot care
• Cosmetic surgery	• Private-duty nursing	• 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	• Hearing aids - $2,500 per hearing aid every 3 years	• Non-emergency care when traveling outside the U.S.

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 U.S. 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 to submit a claim, appeal or a grievance for any reason to your plan. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 Standard? 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 1-800-207-3172.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-207-3172.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-207-3172.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-800-207-3172.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-207-3172.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-207-3172.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-207-3172.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-207-3172.

To see examples of how this 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	$300
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$470**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$300
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$300
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$610**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-207-3172.

RxBenefits

Prescription Benefit Coverage

Hunt County | **Administered by RxBenefits, Inc. and OptumRx, Effective October 1, 2026**

Note: *Members may contact RxBenefits Member Services at 1.800.334.8134 or visit optumrx.com. If there are any additional questions, please contact your Human Resource Department.*

Prescription Drug Plan

Retail Pharmacy Coverage (01-30 Day Supply)	In Network Pharmacy
Generic	$10.00
Preferred Brand	$25.00
Non-Preferred Brand	$40.00

Retail Pharmacy Coverage (31-90 Day Supply)	In Network Pharmacy
Generic	$30.00
Preferred Brand	$75.00
Non-Preferred Brand	$120.00

Mail Order Extended Supply (01-90 Day Supply)	In Network Pharmacy
Generic	$20.00
Preferred Brand	$50.00
Non-Preferred Brand	$80.00

Accumulations

Maximum Out of Pocket (MOOP) Embedded	$1,800.00 Individual/ $3,600.00 Employee +1/ $5,400.00 Family

The plan year MOOP applies to pharmacy and medical claims. Each individual family member must meet the individual MOOP unless the family MOOP has been met by any two or more covered family members. Once met, your covered prescriptions are paid at 100%. Generic Dispense as Written policy does not apply to the MOOP.

Specialty Medications

Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through OptumRX specialty pharmacy by calling OptumRX at 1.855.427.4682. Some exceptions apply. These medications are limited to a 30 day supply. Specialty medications largely fall into the formulary brand category but could also fall into the biosimilar or generic specialty drug category. These medications are subject to the appropriate copay as listed below. OptumRX Specialty Pharmacy also offers pharmaceutical care management services designed to provide you with assistance throughout your treatment.

Specialty Medication	
Specialty Generic	$10.00
Specialty Preferred Brand	$25.00
Specialty Non-Preferred Brand	$40.00

Retail and Mail Order Pharmacies

Hunt County participates in the OptumRx pharmacy network. Contact RxBenefits Member Services at 1.800.334.8134 to inquire about a specific pharmacy.

Manufacturer Copay Assistance Program (MCAP)

Some specialty medications may qualify for third-party copayment assistance programs which could lower your out-of-pocket costs for those products. For any such specialty medication where third party copayment assistance is used, you will not receive credit toward your maximum out of pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate. Your employer has elected to enroll in Optum's CCAA & Variable Copay Solution program.

Generic Policy - Dispense As Written (DAW)

If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand copay/coinsurance plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if your doctor requires a brand name medication.

Maintenance Drug

A medication that is used for chronic health conditions on an ongoing or long-term basis (e.g., antihypertensive medication taken daily to control high blood pressure). Your plan allows maintenance medications to be filled in 90-day supplies by mail order pharmacy or at a retail pharmacy location.

Compound Drugs

For compound drugs to be covered, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. Any denial of coverage of a compound drug may be appealed in the same manner as any other drug claim denial under this coverage. Compounded medications equal to or exceeding $300 per script will require prior authorization.

High Dollar Claim Review, Prior Authorization and Appeals Program (HDCR)

Members on high-cost specialty medications for a complex condition may be subject to a more detailed clinical review of treatment guidelines, medical standards, and FDA approved indication and dosing to ensure clinical efficacy. This detailed review includes inappropriately dosed medications, weight based dosed medications, parity priced medications and those specialty medications that do not have a Prior Authorization (PA) in place today.

Low Clinical Value Drug List (LCV)

Separate formulary exclusion list including low clinical value drugs, me too drugs, new to market drugs, and non-essential.

Step Therapy Program

Certain medications may be subject to step therapy. You could be asked to try one of the first or second level options before certain drugs are covered by the plan.

Formulary

A list of Federal Drug Administration (FDA) approved Prescription Drugs and supplies developed by a Pharmacy and Therapeutics Committee, and/or customized by OptumRx or RxBenefits. This list reflects the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. In your prescription drug coverage, the Formulary Drug list is used as a guide for determining your costs for each prescription. Drugs not listed on the Premium Formulary may not be covered. Your formulary is Premium.

The following lists are not all-inclusive, but rather are lists of the most commonly used prescription drugs. These lists are subject to change. The OptumRx formulary provides an up-to-date list of medications that may be covered by the program. The OptumRx formulary may be found online at optumrx.com. You may also contact RxBenefits Member Services at 1.800.334.8134 to learn whether a specific drug is covered.

Covered Drugs and Supplies

The following examples of Covered Drugs and supplies may be available with your prescription benefit coverage. FDA-approved pharmaceuticals requiring a written prescription, issued by a licensed physician, dentist, osteopath, podiatrist, optometrist (licensed professionals) or licensed advance practice certified nurse and dispensed by a licensed pharmacist. Please contact RxBenefits Member Services at 1.800.334.8134 if you have specific drug questions or register at *optumrx.com* to check coverage.

- ACA Preventative Services List
- ADHD/ADD
- Androgen
- Continuous Blood Glucose Monitors
- Contraceptive (Implant & IUD)
- Contraceptive (oral, cycle, inject, ring)
- DEA Schedule V Products
- Diabetic Medications (Non-Insulin)
- Diabetic Supplies(Lancet, Strips, Swabs)
- Diabetic Supplies (Pumps & Supplies)
- Diabetic Supplies (Syringes & Needles)
- Erectile Dysfunction
- Growth Hormones
- Hemophilia/Blood Disorder Products
- Hereditary Angioedema (HAE) Drugs
- Insomnia / Sedatives / Hypnotics
- Legend Drug Compounds
- Legend Vitamins (Rx)
- Migraine Medications
- Narcolepsy
- Pain / Narcotics / Opioids
- Respiratory Supplies
- Smoking Cessation Products
- Specialty Medications

- Topical Acne Medications

Covered Drug Limitations

Certain Prescription Drugs are covered up to preset limits. These limits are based upon standard FDA approved dosing for the medications. If you request that a prescription be filled for a drug that is subject to quantity limitations, the prescription will be filled up to the preset limits. In some cases, it may be medically necessary for you to exceed the preset limits. In those instances, Prior Authorization is required. In such cases your doctor may initiate Prior Authorization by calling RxBenefits toll-free at 1.800.334.8134. Many drugs are subject to quantity limitations for patient safety based on FDA guidelines. Your plan has identified the following drug categories for Quantity Limits.

- Anti-Anxiety Medications
- Anticoagulants
- Anticonvulsants
- Anti-Diabetic Agents
- Antidepressants
- Anti-Inflammatory Eye Agents
- Anti-nausea Agents
- Antipsychotic Agents
- Asthma and COPD Agents
- Contraceptives
- Erectile Dysfunction (ED) Agents
- Glaucoma Agents
- Irritable Bowel Syndrome(IBS) Agents
- Nasal Steroids
- Non-opioid Analgesics
- Opioid Analgesics
- Osteoporosis Agents
- Proton Pump Inhibitors
- Sleep Agents
- Smoking Cessation Agents
- Specialty Medications

For more information about specific drugs subject to coverage limitations, please call RxBenefits Member Services at 1.800.334.8134 or visit optumrx.com.

Prior Authorization and Appeals

If a prescription drug claim is wholly or partially denied, you or your authorized representative has the right to appeal the decision. You or your authorized representative may appeal the denial no later than 180 days after receiving notice of an adverse claim decision. Appeals of prescription drug claims are handled by RxBenefits and are decided in accordance with the terms of the plan document. Following a clinical review, one of four actions will occur: the medication is approved, the medication claim is denied, the doctor may decide to withdraw and prescribe a different medication, or the reviewer can dismiss the claim due to lack of communication from the prescriber. If denied, the appeal process is available. Your prior authorizations are handled by RxBenefits.

The following medications may require a prior authorization under your plan:

- Acne Topical Agents
- Acne Oral Medications
- ADHD Medications
- Opioid Analgesics
- Anticonvulsants
- Anti-Infective Agents
- Asthma and COPD Agents
- Diabetic Agents
- Dry Eye Syndrome Agents
- Drug Devices
- Irritable Bowel Syndrome (IBS) Agents
- Non ADHD Stimulant
- Specialty Medications
- Testosterone

The Appeal Process

If denied, the member may appeal the decision. Upon appeal, a second pharmacist reviewer will evaluate the prior authorization and make a decision (approved/denied). If denied a second time, a final appeal may be made, which is forwarded to an outside medical reviewer. If denied, there are no further appeals.

Your doctor may initiate the Prior Authorization, quantity limit, high dollar claim review or any other rejection process by calling RxBenefits at 1.800.334.8134.

Exclusions

Coverage is not provided for:

- Abortifacients
- Allergy Serums (Injectable & Oral)
- Anabolic Steroids
- Anti-Obs/Anorexiants/Appetite Suppressant
- Blood Products / Blood Serum
- Bulk Powder Compounds
- Cosmetics
- DESI Drugs (DESI 5 & 6 Only)
- Diabetic Supplies (Blood Glucose Meters)
- Dietary Management
- Digital Therapy
- Electrolyte Replacement
- Experimental Medications
- Fertility Medications (Injectable & Oral)
- Fluoride (Topical with Prescription)
- Homeopathics
- HSDD (i.e., Addyi)
- Medical / Therapeutic Devices
- Non-ACA Vaccines
- Nutritional Supplements
- Standard RX/OTC Equivalents
- Multi-Vitamin w/ Iron
- Multi-Vitamin w/ Fluoride

Pharmacy Identification Card (ID Card)

Your pharmacy ID card enables you to participate in the prescription drug card program. Present your combined medical and pharmacy ID card to the pharmacist when obtaining a prescription to ensure you get the benefit of the prescription drug card program. Please contact your medical insurance carrier for a replacement ID card.

Definitions:

Co-Insurance

The percentage of charges a Participant is required to pay for covered prescription drugs.

Copayment (Copay)

The specified charge you are required to pay for a Covered Drug.

Brand-Name

A Prescription Drug that is protected by a patent, supplied by a single company and marketed under the manufacturer's brand name.

Generic Drug

A generic drug is identical to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. Although a generic drug is chemically identical to its branded counterpart, it is typically sold at substantial discounts from the branded drug's price.

Over-the-Counter Drug (OTC)

Any medical substance that can be purchased without a prescription. OTC medications are not covered by your plan unless otherwise stated.

Non-Preferred Brand
Non-Preferred Brand is a Brand Name prescription drug that does not appear on the formulary of Brand Name Drugs designated by OptumRx as Preferred. Members may pay a higher cost for Non-Preferred Brand-Name Prescription Drugs than for Preferred Brand-Name prescription Drugs.

Preferred Brand Drug
Preferred Brand Drug is a prescription drug that appears on the formulary of Brand-Name Prescription Drugs designated by OptumRx Preferred. This list is subject to periodic review and modifications by OptumRx. Members may obtain a copy of this list by contacting RxBenefits Member Services at 1.800.334.8134 or by registering on *optumrx.com*. Members pay a lower copay/co-insurance for Preferred Brand-Name Prescription Drugs than for Non-Preferred Brand-Name Prescription Drugs.

For More Information About the Prescription Benefit Coverage
Hunt County has partnered with OptumRx and RxBenefits to provide prescription drug benefits. OptumRx serves as the pharmacy benefit manager and RxBenefits administers the prescription drug program.

The website, *optumrx.com*, is designed to help you explore ways to track your prescription benefits. You may use the site to locate pharmacies and compare prescription drug costs.

Questions?
Contact RxBenefits Member Services for information regarding the prescription drug program at 1.800.334.8134.

RxBenefits, Inc. does not provide legal advice. Nothing herein or in any other documents provided by RxBenefits, Inc. should be construed, or relied upon, as legal advice. It is the responsibility of the employer/plan sponsor and not RxBenefits, Inc. to determine the contents of its group health plan document and related summary plan description. The employer/plan sponsor should consult with its legal counsel regarding the contents of its group health plan and summary plan description, and the legal requirements that may be applicable thereto. For plan members with questions about plan coverage, please consult your HR Department.

Know where to go when you need care.

When you need care quick, your first impulse may be to go to an emergency room (ER). But did you know that there are alternative options to treat your immediate care needs that could save you up to $1,800 or more compared to an ER?*

Before you wait for hours in the ER, call your primary care provider (PCP) or family doctor. Many doctors offer same-day appointments, but if that's not possible, you may be able to receive fast, professional care for much less at an urgent care center, convenience care clinic or an online doctor visit.

CHECK
your options for care

CHOOSE
your care provider

GO
for better health

continued

*Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. The information provided is for general informational purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 9-1-1 or go to the nearest emergency room.

Quick care options:

When seeing your physician is not possible, it's important to know your quick care options to find the place that's right for you and help avoid financial surprises. If you're not sure where to go, UMR's benefits specialists can help you decide.

	Teladoc Consults	Convenience Care Clinics	Urgent Care Facility	Emergency Room
Reason for Visit	• Urinary tract infections • Mild colds and flu • Mild vomiting or diarrhea • Mild fevers or headaches • Pink eye • Rashes • Sinus or ear infections • Sore throat	• Minor injuries • Mild vomiting or diarrhea • Allergies • Urinary tract infections • Rashes • Pink eye • Sinus or ear infections • Sore throat • Preventive care	• Animal and insect bites • More-severe-than-usual asthma • Mild vomiting or diarrhea • Minor burns or cuts that may need stitches • Sprains, strains and minor fractures	• Severe pain, especially in the chest or upper abdomen • Uncontrollable bleeding • Difficulty breathing, speaking or walking • Fainting or dizziness • Severe trauma or serious injuries
Average Cost	**$**	**$$**	**$$$**	**$$$$**

Call the member services number listed on the back of your ID card or visit **umr.com** to learn more about your care options and find a network provider near you.

UMR
A UnitedHealthcare Company

Administrative services provided by UMR or their affiliates.

24/7 doctor visits via phone or mobile app

TELADOC

Teladoc gives you round-the-clock access to U.S. board-certified doctors, from home or on the go. Call or connect online or using the Teladoc mobile app for affordable medical care, when you need it.

Talk to a doctor anytime, anywhere you happen to be

Receive quality care via phone, video or mobile app

Prompt treatment, median call back, in 10 minutes

A network of doctors that can treat every member of the family

Prescriptions sent to pharmacy of choice if medically necessary

Teladoc is less expensive than the ER or urgent care

Talk to a doctor anytime!

visit **Teladoc.com**
or call
1-800-Teladoc

Google play

Get the care you need

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infections
- Sinus problems
- Skin problems
- And more

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician.

UMR
A UnitedHealthcare Company

Get all your answers **quick** and **easy** @ **umr.com**

Make **umr.com** your first stop

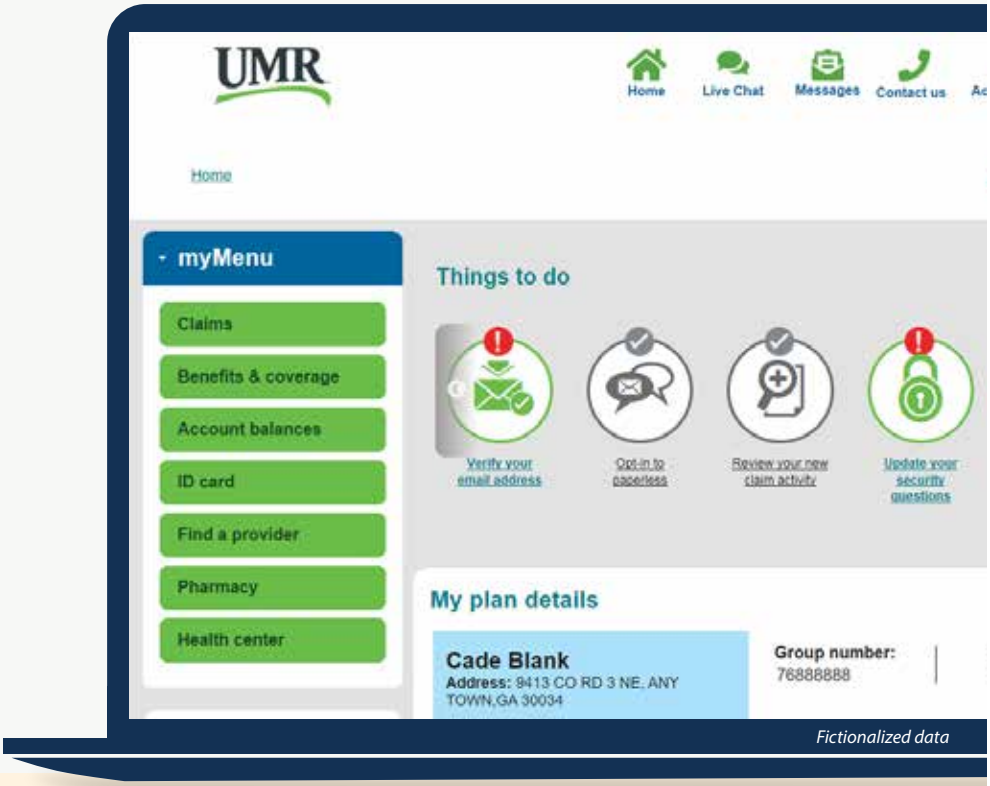
You want managing your health care to be fast and easy, right? You got it. At **umr.com**, you'll find everything you want to know – and need to do – as soon as you log in.

No hassles. No waiting. Just the answers you're looking for anytime, night or day!

Log in now to:

- View **Things to do**, your personalized benefits to-do list
- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life

Note: *The images shown reflect available features within our desktop site. These features may or may not be available to all users, depending on your individual and/or company benefits.*



The **UMR app** is another way we're reimagining health care to work for you.

We have a smarter, simpler, faster way to manage your health care benefits, right from the palm of your hand.

With just a tap, you can:

- Access your digital ID card
- View your plan details on-demand – anytime, anywhere
- Find out if there is a co-pay for your upcoming appointment
- Chat, call or message UMR's member support team

Stay connected to your health care and download the UMR app today!

Simply scan the QR code to the left or visit your app store to get started.

Preventive care services

Preventive care services

UMR is dedicated to helping people live healthier lives. We encourage you to obtain preventive care services and health screenings, as appropriate for your age, to help maintain or improve your health and achieve your health and wellness goals.

Regular preventive care visits and health screenings may help to identify potential health risks for early diagnosis and treatment.

Most health plans typically cover preventive services, as specified in the health care reform law[1], at 100 percent without charging a co-payment, co-insurance or deductible, as long as they are received in your health plan's network. Most also cover other routine services, which may require a co-payment, co-insurance or deductible.

Always refer to your plan documents for your specific coverage.

» Continue on next page

TALK TO YOUR DOCTOR

Consult your doctor for your specific preventive recommendations, as he or she is your most important source of information about your health.

1 Preventive services that are covered with no cost share are those services described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the CDC, and HRSA Guidelines for women, as well as children, including the American Academy of Pediatrics Bright Futures periodicity guidelines. Your plan may cover additional items as preventive. Refer to your plan documents for your specific coverage.

UMR
A UnitedHealthcare Company

Summary of preventive care services benefit

ALL MEMBERS

Preventive medicine for adults[2], all standard immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)

ALL MEMBERS AT AN APPROPRIATE AGE AND/OR RISK STATUS

- Screening for:
- Obesity
- Cholesterol level and lipids
- Colorectal cancer[2] for ages 45-plus
- Certain sexually transmitted diseases, including HIV
- Behavioral counseling to prevent skin cancer for young adults up to age 24.
- Lung cancer with low-dose computer tomography
- Latent tuberculosis infection
- Cardiovascular disease aspirin use counseling for ages 45-plus
- High blood pressure (Clinical and ambulatory measurement)
- Pre-diabetes and diabetes for certain populations
- Tobacco use
- Diet and nutrition
- Alcohol abuse
- Hepatitis C screening
- Depression
- Well exam

MEN'S HEALTH SERVICES

Screening for:

- Abdominal aortic aneurysm for men 65-75 years old who have ever smoked

Please talk with your doctor and make the health care decisions that may be right for you in managing your own health today.

[2] Certain preventive care services are not currently required to be covered by the health reform law; however, various additional services may be covered under your preventive care services benefit.

WOMEN'S HEALTH SERVICES

- Screening mammography (film and digital) for all adult women[2]
- Cervical cancer screening, including Pap smears
- Breast cancer genetic test evaluation and counseling (BRCA)
- Counseling for cancer prevention strategies for women at high risk for breast cancer
- Screening for certain sexually transmitted diseases, including HIV, chlamydia and gonorrhea
- Osteoporosis for certain populations[2]
- Yearly well-women visits
- Pregnant women screenings for:
  - Bacteria in urine
  - Hepatitis B virus
  - Rh incompatibility
- Sexually transmitted infections counseling
- Contraception methods and counseling
- Domestic violence screening
- Gestational diabetes screening
- HIV screening and counseling
- Human papillomavirus testing (beginning at age 30)
- Breast-feeding support and supplies, including renting or purchase of specified breast-feeding equipment from an approved vendor and counseling
- Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression
- Screening for urinary incontinence
- Screening for anxiety
- Behavioral counseling interventions for healthy weight and weight gain during pregnancy

CHILDREN'S HEALTH SERVICES

Services at each of these preventive visits will vary based on age, but will include some of the following:

- Measurement of your child's head size
- Measurement of length/height and weight
- Screening blood tests, if appropriate
- Metabolic screening panel for newborns – age 0-90 days old
- Providing age appropriate immunizations
- Vision screening
- Hearing screening
- Counseling on oral health
- Psychological and behavioral development assessment
- Counseling on the harmful effects of smoking and illicit use of drugs (for older children and adolescents)
- Counseling for children and their parents on nutrition and exercise
- Screening certain children at high risk for high cholesterol, sexually transmitted diseases, lead poisoning, tuberculosis and more
- Fluoride application in primary care
- Behavioral counseling to prevent skin cancer at each wellness examination

Let's get into **being well**

Finding ways to stay healthy doesn't have to be difficult. Healthy choices are all around us every day.

Hunt County has teamed up with **UMR Wellness CARE** to offer a program to help you recognize and make the most of your health care opportunities. Here, you'll find details about how to earn rewards when you meet specific goals. Additional wellness resources are available on **umr.com**, including a library of health information, videos and interactive "action plan" tutorials to help you get and stay healthy.

EARN YOUR LIVE WELL REWARD$

With UMR's Live Well Reward$, you can get financial rewards for taking a few simple steps toward living a healthier life. Your participation is completely voluntary, and all resources are available at no cost to you.

You can qualify for an incentive up to $100 in a reloadable reward card by completing the **GOAL(S)** below. For more detailed information on how to earn your incentive, log in to **umr.com** and from the **Health center,** select **Wellness Activities.**

GOAL: COMPLETE YOUR CHRA BETWEEN ($25)

October 1, 2026 - September 30, 2027

Filling out an online clinical health risk assessment (CHRA) will help you see how healthy you are right now and what areas you can improve. It will only take 20 minutes to complete. To take the CHRA, log in to **umr.com** and select **Take CHRA.**

GOAL: RECEIVE YOUR BIOMETRIC SCREENING

($25) October 1, 2026 - September 30, 2027

Certain numbers can tell you a lot about your odds for developing health problems in the future. To find out where you stand, we use the results from a basic screening to measure your height and weight and check for conditions such as high blood pressure, high cholesterol and diabetes.

Step 1 - Create an account on umr.com

To get started, visit **umr.com** and select **Log in/Register**. Choose **Member** from the dropdown menu. Enter your **username** and **password**, or if it's your first time visiting us, click **Register now** to open an account.

Helpful hints:

- When you register for the first time, make sure you have your UMR member ID card handy. You will need your **member ID number** and **group number** (**76415594**) to enroll, and you can find this information on the front of your ID card.
- You will need to provide a valid email address when you register.
- Make sure you select a username and password you can remember. You will need these when you log in again in the future. If you can't remember your username and password, you can use the links provided to recover your username or password.

Step 2 - Complete your CHRA

To begin your CHRA:

1. Select **Take a CHRA** from your member home page.
2. Select the **Get started!** button from the Wellness activity center landing page; if you are not redirected, please check to see if a new tab or page has opened.
3. Under **Clinical health risk assessment (CHRA)**, press the **Start** button.
4. After answering all the questions in the CHRA, make sure to hit **Submit**. Your CHRA is considered incomplete until it is submitted, and we will be unable to process your results.

Note: You can also complete your CHRA on your mobile device. Simply log in to **umr.com**, select **Health center** from the main menu and choose the **Wellness activity center** button.

When you are done, it's time to view your report. Your results will tell you your personal wellness score, health status and risk for developing a disease in the future.

DOWNLOAD YOUR PHYSICIAN LAB FORM FOR YOUR BIOMETRIC SCREENING:

1. Log in to your online services on **umr.com**.
2. Select **Health center** from **myMenu** on your home page.
3. Choose **Wellness activities** to get started.
4. Look for **Physician Lab Forms** in the resources area and click the **Download** button.

GOAL: COMPLETE AN ACTION PLAN(S) ($25)

October 1, 2026 - September 30, 2027

If you're ready to quit smoking, get more active, or eat better to lose weight and feel your best, there are free resources waiting for you at **umr.com**. Our interactive action plans guide you in building healthy habits. To get started, go to **Action Plans** within **Wellness Activities** and select **Enroll.**

LOOKING FOR HELP?

For questions related to login issues or rewards, call UMR at **800-826-9781**.

For questions related to the CHRA or coaching call **800-207-7680.**

If you think you might be unable to meet a standard for a reward under this program, you might qualify for an opportunity to earn the same reward by different means. Contact us and we will work with you to establish an alternative goal with the same reward.

PACIFIC LIFE

DENTAL

Pacific Life & Annuity Company

Benefit Highlight Sheet

Coverage effective date: October 1, 2025

Hunt County #OC0000006948

Welcome to Pacific Life Dental Insurance

Pacific Life Dental promotes good dental health by providing you with high-quality dental benefits that offer coverage for routine exams and other services at reduced costs.

Coverage available for:

- Employee Only
- Employee + Family

Large National Network

Your plan gives you the flexibility to choose any dentist or a dentist in our extensive, national network.

The benefits of going in-network include:

- **Reduced out-of-pocket costs**
  In-network dentists have accepted negotiated fees that will save you money
- **No claims to fill out**
  In-network dentists will file claims on your behalf
- **Quality assurance**
  In-network dentists are credentialed and regularly reviewed assuring strict network standards

Search for providers at pacificlife.com/dental

Plan Services - Premier

PPO Plan	In-Network	Out-of-Network
Benefit Year Maximum	**Applies to Class A, B & C Services** $3,000 per person	**Applies to Class A, B & C Services** $3,000 per person
COINSURANCE		
Class A: Preventive	100%	100%
Class B: Basic	80%	80%
Class C: Major	50%	50%
Class D: Orthodontics	50%	50%
Deductible	**Applies to Class B & C Services** $50 per person (Maximum 3 per family)	**Applies to Class A, B & C Services** $50 per person (Maximum 3 per family)

Dental Covered Services	
Class A - Preventive **No waiting period**	• Oral evaluations (2 in 12 Months) • Prophylaxis (2 in 12 Months , additional cleaning for verified health conditions) • Bitewing x-rays (maximum of 4 films per 12 months) • Full mouth x-rays (1 per 36 months) • Fluoride (children up to age 16) • Sealants (children up to age 16) • Oral cancer screening for ages 40+
Class B - Basic **No waiting period**	• Fillings • Posterior composite restorations • Simple extractions • Surgical extractions • Non surgical periodontics • Surgical periodontics • Periodontal maintenance (in combination with prophylaxis) • Oral surgery • Endodontics • Emergency pain • Space maintainers • Crown, denture and bridge repairs
Class C - Major **No waiting period**	• Inlays and onlays • General anesthesia (Covered) • Crowns, Bridges, Dentures and Implants
Class D - Orthodontics **No waiting period**	• Separate lifetime maximum: $1,500 • This benefit is available for adults and children

Plan Benefits and Information

Search for providers online:

pacificlife.com/dental

Log in for access to:

- Our large dental network
- Network discounts
- Provider ratings

You can also:

- Access benefit information
- View claims
- Access ID cards
- Leverage dental cost estimator
- Review oral health library

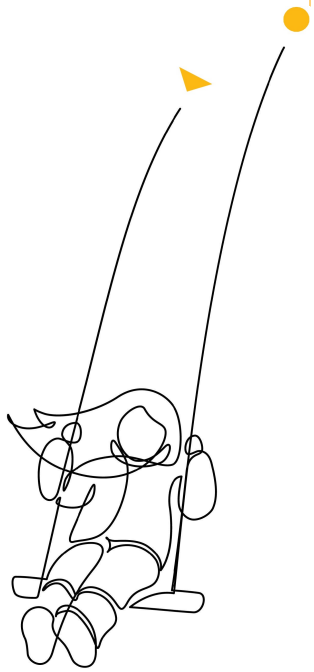
Maximum Rollover Benefit

Your plan includes a Maximum Rollover Benefit, which allows you to rollover a portion of your unused Annual Maximum Benefit to the following plan year and help offset costs for more expensive services such as implants or crowns.

- To be eligible for the Rollover Benefit, you must have had at least one cleaning in the benefit year and paid a total claims amount for Preventive, Basic, and Major services under the Rollover Threshold limit.
- The Rollover Amount shown below (up to the Rollover Maximum) is the amount that can be added to your following year's Annual Maximum Benefit.*

Rollover Threshold	Rollover Amount	Rollover Maximum
$800	$375	$1,500

* The maximum rollover benefit is not available to pay for orthodontics services.



Exclusions and Limitations

We encourage members to request a pre-treatment estimate for major services or services that are expected to exceed $300.

The Policy contains exclusions and limitations, and unless identified in the Schedule of Covered Procedures, no benefits will be paid for the following:

- Any service that doesn't meet professionally recognized standards of dental practice or is considered to be experimental.
- Any service on a tooth with a guarded, questionable, or poor prognosis.
- Any service used solely to alter occlusal vertical dimensions, restore or maintain occlusion, treat a condition resulting from attrition, abrasion, erosion, or abfraction, or splint or stabilize teeth for periodontal reasons.
- Any service provided solely for cosmetic reasons, such as teeth whitening, characterization, or personalization of a dental prosthesis, or odontoplasty.
- Replacement of a lost, missing, or stolen appliance or dental prosthesis, or the fabrication of a spare appliance or dental prosthesis.
- Upgrading from one appliance or dental prosthesis to another appliance or dental prosthesis, such as replacing a bridge with a dental implant or replacing a denture with a bridge.
- A temporary or provisional appliance or dental prosthesis, unless it is an interim partial denture that replaces anterior teeth extracted while this coverage was in place. These are the incisor and cuspid teeth located in the front of the mouth.
- Overdentures and related services, including root canal therapy on teeth supporting the overdenture.
- Any educational or instructional service such as oral hygiene instruction, tobacco counseling or nutritional counseling.
- Bite registration, bite analysis or occlusion analysis - mounted case.
- Maxillofacial prosthetics to repair facial or skeletal anomalies, maxillofacial surgery, orthognathic surgery, or any oral surgery requiring the setting of a fracture or dislocation that results from or is incidental to a medical condition.
- Any service intended to treat or diagnose disorders of the temporomandibular joint (TMJ).
- Charges for implants unless specified in the Covered Procedures, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures, and any associated surgery, or other customized services or attachments.
- Treatment of malignancies, cysts, and neoplasms.
- Replacement of 3rd molars.
- Restorations used to restore teeth with micro fractures or fracture lines, undermined cusps, or large existing restorations without over pathology.

Other exclusions may apply, refer to the Schedule of Covered Procedures for a complete list.

Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations. During a single visit, multiple periapical and bitewing x-rays may be paid as a full-mouth x-ray.

Alternate Benefit:

There are multiple options for dental treatment, all of which provide acceptable results. An alternate benefit may be applied if there is a less expensive Covered Procedure appropriate for the course of treatment, capable of producing acceptable results. When an Alternate Benefit is applied, the less expensive Alternate Benefit is used to determine the amount payable under the certificate.

Network:

Network access plan available.

Termination of Coverage:

If applicable, child coverage terminates at age 26.

Questions? Give us a call at (855) 810-3301

The Insured has a right to receive, free of charge, a paper copy of the certificate of coverage and any amendments at any time. The Insured can exercise the right to receive a paper copy at no cost to the Insured by calling us at (855) 810-3301.

Policy Form Series: PLADNPOL22 and PLADNCERT22. Form numbers, provisions and availability may vary by state. The state approved form is the governing document. Dental policy forms issued in Idaho include PLADNPOL22-ID and PLADNCERT22-ID.

Dental insurance plans are underwritten by Pacific Life & Annuity Company (Pacific Life).

Pacific Life refers to Pacific Life Insurance Company and its subsidiary Pacific Life & Annuity Company. Insurance products can be issued in all states, except New York, by Pacific Life Insurance Company and in all states by Pacific Life & Annuity Company. Product/material availability and features may vary by state. Each insurance company is solely responsible for the financial obligations accruing under the products it issues.

The home office for Pacific Life & Annuity Company is located in Phoenix, Arizona. The home office for Pacific Life Insurance Company is located in Omaha, Nebraska.

PACIFIC LIFE

PACIFIC LIFE

Pacific Life & Annuity Company

VISION

POWERED BY eyeMed

Benefit Highlight Sheet

Coverage effective date: October 1, 2025

Hunt County #OC0000006948

Welcome to Pacific Life Vision - Classic-24

Your Pacific Life Vision Plan powered by EyeMed® provides comprehensive vision benefits with an extensive provider network, contributing to good eye health while reducing out-of-pocket costs. With Pacific Life Vision benefits, you can gain access to smart savings, advanced technology, and quality providers.

Coverage available for:

- Employee Only
- Employee + Spouse
- Employee + Children
- Employee + Family

Plan Services

Covered Services	Benefit Frequencies
Exams	Once Every Calendar Year
Diabetic Exam Benefit	Once Every 6 Months
Frames	Once Every Two Calendar Years
Eyeglass Lenses	Once Every Calendar Year
Contact Lenses	Once Every Calendar Year

Visit www.pacificlife.com/vision to locate a provider near you.

Plan Services (continued)

Exams	In-Network	Out-of-Network
Vision exam (includes dilation if necessary)	$10 copay	$35
Retinal Imaging	Up to $39	Not covered
Diabetic Exam (if diagnosed with type 1 or type 2 diabetes)		
Medical follow-up	Covered	$73
Fundus photography	Covered	$61
Extended opthalmoscopy	Covered	$23
Gonioscopy	Covered	$23
Scanning Laser	Covered	$40
EYEGLASSES		
Frames	$150 allowance (20% off balance less allowance)	$66
Eyeglass Lenses		
Single vision	$25 copay	$40
Bifocal	$25 copay	$50
Trifocal	$25 copay	$80
Lenticular	$25 copay	$80
Standard progressive	$90 copay	$50
Premium progressive tier 1	$110 copay	$50
Premium progressive tier 2	$120 copay	$50
Premium progressive tier 3	$135 copay	$50
Premium progressive tier 4	$90 copay, 20% off charge less $120 allowance	$50
Lens Options		
Polycarbonate Lenses (under age 19)	Covered	$32
Scratch resistant coating	Covered	$12
CONTACT LENSES (in lieu of eyeglass lenses)		
Elective contacts	$150 allowance	$120
Non-elective contacts	Covered in Full	$300
Standard contact lens fit + follow up	Up to $40	Not Covered
Premium contact lens fit + follow up	10% discount	Not Covered

Large Vision Network

Pacific Life utilizes the EyeMed Insight Vision Network to ensure that you have choices — lots of them. Be it an independent eye doctor, popular retailer, or online option, with the Insight network, you'll get the latest in advanced vision technology. And with one of the largest provider networks in the nation, you'll have the freedom to find one who fits your unique needs.

- You can see any provider but will save more when you go to an in-network provider

Independent Providers

The Insight network makes it easy to find a trusted neighborhood eye doctor.

Retail Providers

With options including LensCrafters®, Pearle Vision®, Target Optical® and many other favorite regional retailers, you can pick the location and hours that work for you.

Shop Online

Staying in-network can also mean using your vision benefits online at:

- Lenscrafters.com
- Targetoptical.com
- Ray-ban.com
- Glasses.com
- Contactsdirect.com
- Oakley.com

INDEPENDENT PROVIDER NETWORK · LensCrafters · PEARLE VISION EST. 1961 · OPTICAL · more options available

More Savings for You

Receive additional discounts when you visit an in-network provider including:

- 40% off additional complete pair of prescription eyeglasses
- 15% off additional conventional contact lenses after benefit has been used
- 20% off non-covered items including non-prescription sunglasses
- 15% off retail or 5% off promotional price for LASIK or PRK from U.S. Laser Network [1]
- Additional savings of 20-40% on non-covered lens options at in-network providers including fixed costs such as:
  - UV Treatment - $15
  - Tint (solid and gradient) - $15
  - Adult polycarbonate lenses - $40
  - Anti-reflective coating
    - Standard - $45
    - Tier 1 - $57
    - Tier 2 - $68
  - Photochromic/transition plastic lenses - $75

Discounts on hearing care through Amplifon® Hearing Health Care [2]:

- 64% off hearing aids at thousands of locations nationwide
- 60 day hearing aid trial period with no restocking fees
- free batteries for 2 years with initial purchase

[1] Lasik special pricing is not an insured benefit and may not be combined with any other discounts. Laser vision correction is an elective procedure performed by specially trained providers. Discounts may not be available at all locations.

[2] Hearing discounts are not an insured benefit and are subject to change.

Search for providers and schedule appointments online: **pacificlife.com/vision**

Log in for access to:

- View benefit
- Check claims status
- Access ID cards
- Provider search and schedule an appointment online
- Know before you go – You can estimate your cost ahead of time so there are fewer surprises
- Access exclusive member-only special offers on vision-related products and services that may be used above and beyond your vision benefit

Exclusions and Limitations

Limitations: Fees charged by provider for services other than a covered benefit and any local, state or federal taxes must be paid in full by the member to the provider. Such fees, taxes or materials are not covered under the Policy.

Allowances provide no remaining balance for future use within the same benefit frequency.

Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate.

Exclusions: No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; refraction, when not provided as part of a comprehensive eye examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; occupational safety eyewear; non-prescription sunglasses; plano (non-prescription) lenses; two pair of glasses in lieu of bifocals; services rendered after the date an member ceases to be covered under the Policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the member are within 31 days from the date of such order; lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next benefit frequency when vision materials would next become available. Other exclusions may apply, see the Certificate of Coverage for a complete list.

Network:
Network access plan available.

Termination of Coverage: If applicable, child coverage terminates at age 26.

Questions? Give us a call at (855) 810-3301

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Vision Policy Form Series PLAVIPOL22 and PLAVICERT22. Form numbers, provisions and availability may vary by state. The state approved form is the governing document. Vision policy forms issued in Idaho include PLAVIPOL22-ID and PLAVICERT22-ID.

Vision insurance plans are underwritten by Pacific Life & Annuity Company (Pacific Life).

Pacific Life refers to Pacific Life Insurance Company and its subsidiary Pacific Life & Annuity Company. Insurance products can be issued in all states, except New York, by Pacific Life Insurance Company and in all states by Pacific Life & Annuity Company. Product/material availability and features may vary by state. Each insurance company is solely responsible for the financial obligations accruing under the products it issues.

The home office for Pacific Life & Annuity Company is located in Phoenix, Arizona. The home office for Pacific Life Insurance Company is located in Omaha, Nebraska.

EyeMed®, LensCrafters®, Pearle Vision®, Target Optical®, and Amplifon® are not affiliated companies of Pacific Life.

PACIFIC LIFE


HUNTCOUNTY
TEXAS