2027 Employee Benefits Guide









Scan QR code to begin your enrollment on Employee Navigator

Jefferson County DRAINAGE DISTRICT 3



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Welcome to Your Benefits!

Annual Enrollment is the only opportunity you have to make changes to your 2027 Benefit Plans, unless you have a qualifying event. This guide provides an overview of Drainage District 3's benefits and the changes effective January 1, 2027, so be sure to review all the benefits offered and carefully make your elections to ensure you and/or your family have the coverage you need.

What's New for 2027 Benefits

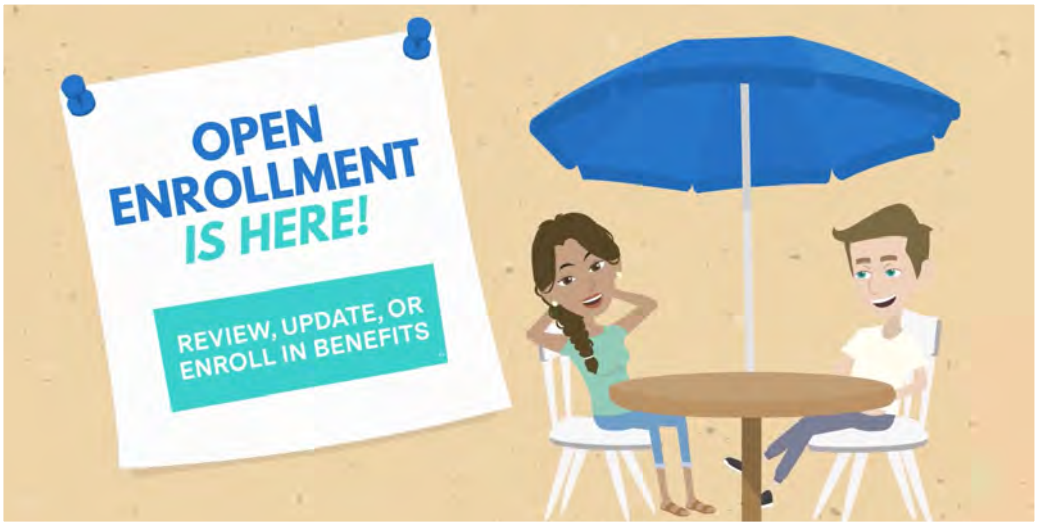
Pharmacy

- MedOne

Enrollment

- Be sure to print a summary of your selections
- Submit your dependent supporting documentation by the enrollment deadline

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see **page 36** for more details.



Eligibility

During Annual Enrollment, if you are not making any changes and not enrolling in the FSA, you do not need to do anything. However, it is important to review your current elections and your eligible dependents and beneficiary information. It is your responsibility to remove a dependent who no longer meets eligibility requirements (divorced spouse, child attained age 26, etc.).



Please note the following:

- If you take no action by October 15, 2026, you and your dependents will receive the same election benefits you had in 2026 except for FSA.
- To make FSA contributions in 2027, you MUST make a new election.
- Your per paycheck deduction must be a whole dollar amount (no cents — example: $100.00) or your enrollment will reject when it uploads to UnitedHealthcare (UHC).
- Adding new dependents will require supporting documentation to show proof of eligibility before enrollment in 2027 plans.
- To make changes, follow the instructions on the next page of this guide. Once you have elected your 2027 benefits, review your elections and print a summary of your selections to verify your enrollment. Be sure to submit your supporting documentation if you are adding dependents.
- Changes made during Annual Enrollment are effective January 1 – December 31, 2027.

Enroll in Benefits

You can log in to review your benefits 24/7

You must enroll or make changes through the Employee Navigator benefits portal. Be prepared to submit supporting documentation for adding dependents, such as marriage license, birth certificate, etc. If documentation is not submitted by the enrollment deadline (Thursday, October 15, 2026), the dependent will not be added to your coverage. You do have the option to upload your documents directly using the portal.

STEP 1 Log In

Go to **www.employeenavigator.com** and click **Login**.
Returning users: Log in with the username and password you selected. Click **Reset a forgotten password**.
First-time users: Create an account, and create your own username and password.

- You will have to click on the **Login** button on the right-hand side of the website.
- From here you will be prompted to log in; however, there is a link at the bottom that says **Register as a New User**, please select that prompt and create a login.
- The Company Identifier is: JefCou2024 — this is case-sensitive so please be sure to use the correct characters.
- You will have to provide: your first and last name, Company Identifier, the last 4 of your Social/ID and your birth date.
- After this you will be able to log in and begin the onboarding process.

STEP 2 Welcome

After you log in, click **Let's Begin** to complete your required tasks.

STEP 3 Onboarding (for first-time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks, click **Start Enrollment** to begin your enrollments.
TIP: If you hit **Dismiss, complete later** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **Start Enrollment**.

STEP 4 Start Enrollments

After clicking **Start Enrollment**, you'll need to complete some personal and dependent information before moving to your benefit elections.
TIP: Have dependent details handy. To enroll a dependent in coverage, you will need their date of birth and Social Security number.

STEP 5 Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?** Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost. Click **Save & Continue** at the bottom of each screen to save your elections. If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

STEP 6 Forms

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

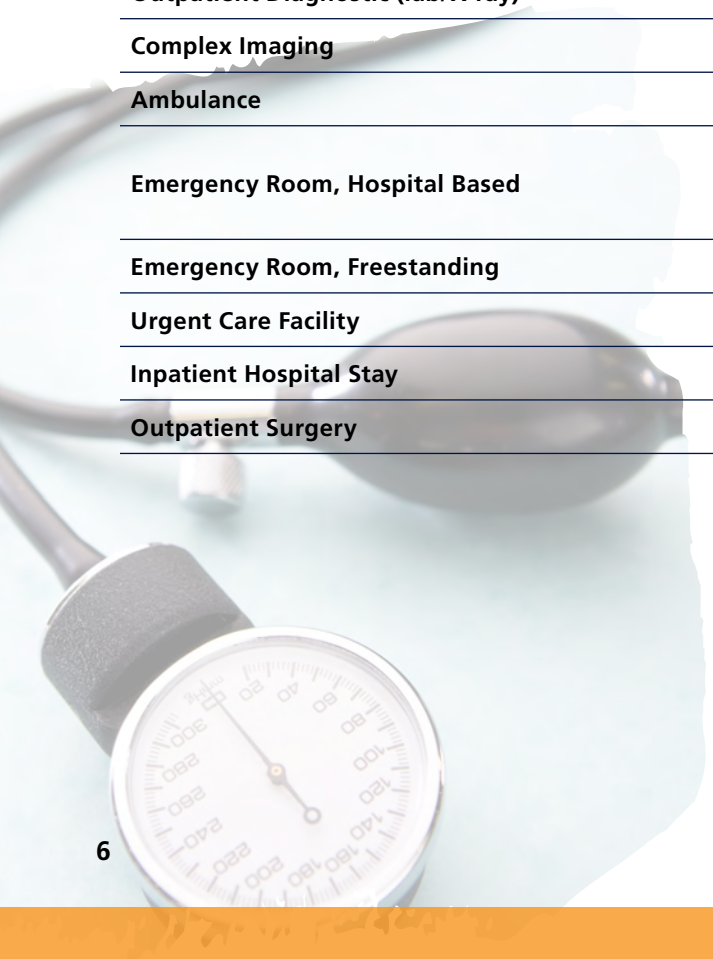
STEP 7 Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct, then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or log in at any point during the year to view your summary online.
TIP: If you miss a step, you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

Medical Plan – UnitedHealthcare

Following is an overview of the coverage available and what you pay. For complete coverage details, please refer to the Summary Plan Description (SPD).

KEY MEDICAL BENEFITS	UHC PPO IN-NETWORK ONLY
Deductible (per calendar year)	
Individual / Family	$750 / $2,250
Out-of-Pocket Maximum (per calendar year)	
Individual / Family	$3,000 / $5,500
Covered Services	
Employee Health Clinic	$0
On-Site Neuromuscular Program (NCS)	$0
Virtual Visit	$0
Office Visits (physician/specialist)	Deductible then 20%
Routine Preventive Care	No charge
Outpatient Diagnostic (lab/X-ray)	Deductible then 20% (Preferred Lab paid at 100%)
Complex Imaging	Deductible then 20%
Ambulance	Deductible then 20%
Emergency Room, Hospital Based	$250 copay then deductible then 20% ($2,000 ER copay maximum)
Emergency Room, Freestanding	$1,000 copay then deductible and 20%
Urgent Care Facility	$50 copay then 20%
Inpatient Hospital Stay	Deductible then 20%
Outpatient Surgery	Deductible then 20%



Prescription Plan – MedOne

Prescription Drug coverage will be offered through MedOne. Visit **www.Liviniti.com** to learn more about the plan.

DRUG TYPE	RETAIL 30-DAY SUPPLY	RETAIL 90-DAY SUPPLY	LIVINITI MAIL ORDER 90-DAY SUPPLY
$0 Copay Generic Drugs	$0 copay for generic statins and generic oral anti-diabetic drugs		
Over-the-Counter Drugs*	$2	$6	$6
Generic	$10	$25	$25
Preferred Brand	$25	$75	$75
Non-Preferred Brand	$50	$160	$160
Specialty Rx – RxCompass	$0 copay 30/90-day supply		
Specialty Rx – Liviniti	$200 copay with a 30-day supply		

*The plan covers **OTC Nasal Sprays:** Flonase Allergy OTC, Nasacort Allergy 24HR and Rhinocort OTC; **Non-Sedating Antihistamines:** Allegra, Claritin, Xyzal Allergy and Zyrtec; **Proton Pump Inhibitors:** Nexium 24HR, Prevacid 24HR, Prilosec OTC and Zegerid OTC. Your prescription must state "OTC" for the drugs to be covered for $2 copay. **Mandatory Generic** — If you or your provider request a brand drug when a generic is available, you will pay the brand copay plus the cost difference between the brand and generic.

Liviniti Programs

RxCompass, which is included in your pharmacy plan, offers 3 unique services that may help you reduce your costs. Their Care Navigators will provide savings opportunities that can lower your copay to $0 for specialty and certain high-cost routine medications.

PATIENT ASSISTANCE PROGRAM
powered by RxCompass

To receive financial assistance from the drug manufacturer, members must qualify and meet financial requirements. If qualified, members will receive their medication at $0 copay.

INTLMAIL

We only include countries that have drug approval processes similar to the FDA in the U.S. Pharmacies from one of four countries — Canada, England, Australia and New Zealand — are used to ship drugs via mail order.

How to Access Your RxCompass

Phone: **(833) 652-8379**
Email: **carenavigator@myrxcompass.com**
Text Messages: **(833) 652-8379**

Important – Freestanding ER Copay Care That Fits Real Life

You will pay a $1,000 copay plus your deductible then 20% coinsurance for a single visit to a freestanding ER. If you need to be admitted to the hospital and have to be transported, you would incur additional costs versus going straight to a hospital-based ER.

Use the ER wisely — Visit the ER for life-threatening emergencies only, such as:

- Heart problems
- Breathing problems
- Heavy bleeding
- Broken bones
- Severe pain

Have a Virtual Visit with a board-certified physician 24/7 — Schedule a Virtual Visit on **myUHC.com** or UHC app for $0 copay.

Use the Employee Health Clinic or Urgent Care — for non-threatening emergencies.

What's a Freestanding ER?

- Freestanding ERs aren't typically in-network. Freestanding ERs usually aren't affiliated with a hospital; they are often owned by independent groups or individuals.
- Because they're not contracted with UHC, you're not protected by a negotiated rate like you are if you use a hospital-affiliated ER that is in-network.
- $1,000 copay per visit to each Freestanding ER to receive service.

How Can You Tell It's a Freestanding ER?

Freestanding ERs aren't attached to hospitals and are required by law to have the word "Emergency" in their signage.





MyUHC.com

MyUHC.com helps you maximize your benefits and easily find many health care answers.

Use it to:

- Check claims and account balances
- Review your benefits and who is covered
- Print a temporary ID card or request a replacement card
- Estimate procedure cost



UHC Virtual Visits

A Virtual Visit lets you see and talk with a doctor from your laptop or mobile device. You have access to a network of Virtual Visit provider groups. Log in to **myUHC.com** or the UnitedHealthcare UHC app. Once you choose a Virtual Visit provider group, you'll be directed to their website or app to access care. **Virtual Visits are $0 copay.**

UHC Advocate4Me

This is a team of people dedicated to helping you. From understanding your claims to estimating costs ahead of time, they're there to help.

How they can support you:

- Help with determining if a treatment is covered
- Help with understanding your claims
- Help with estimating costs for procedures
- Help with understanding your benefits
- Help with finding a doctor or facility



UnitedHealthcare App

Download the UnitedHealthcare app on your smartphone.

With the UnitedHealthcare app, you can:

- Find nearby care and pricing
- Video chat with a doctor 24/7 — without leaving the app
- View and share ID cards
- Estimate procedure cost

Virtual Visits – UnitedHealthcare

If you are enrolled in the District's medical plan, you have access to Virtual Visits, when you need care — anytime, day or night — or when your primary care provider is not available, Virtual Visits can be a convenient option. With Virtual Visits, you don't have to drive to the doctor's office or sit in a waiting room when you're sick — you can see your doctor from the comfort of your own bed or sofa.

Register Today So You Are Ready When You Need Care



Avoid germs in the ER, urgent care clinic or doctor's office.

See a board-certified, licensed, telehealth-trained doctor on your schedule with on-demand virtual visits 24/7, including nights, weekends and holidays.

Get treated for more than 80 common conditions including colds, flu, allergies and more.

Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby in less time than your usual doctor visit.

Avoid costly copays and deductibles of the ER and urgent care clinic.

Virtual Behavioral Health Visits through Amwell, Doctor on Demand or Teladoc. Members can schedule a 45- to 55-minute virtual visit with a licensed mental health provider.

Using Virtual Visits Is as Easy as One, Two, Three

Register Now

Setting up your secure account takes only minutes.

You can visit **myUHC.com** or the UHC app.

Request a Visit

You can have a doctor visit right away or schedule an appointment — all by phone, computer or the app

Feel Better

Get treated by a doctors who can prescribe medication if necessary.

Employee Premiums

Medical

	DISTRICT PAYS MONTHLY	EMPLOYEE PAYS MONTHLY	EMPLOYEE PAYROLL DEDUCTIONS
Employee Only	$1,601.90	$0.00	$0.00
Employee + Spouse	$2,893.62	$791.70	$395.85
Employee + Child(ren)	$2,620.32	$624.19	$312.10
Employee + Family	$3,228.22	$996.78	$498.39

High Dental

	DISTRICT PAYS MONTHLY	EMPLOYEE PAYS MONTHLY	EMPLOYEE PAYROLL DEDUCTIONS
Employee Only	$32.56	$0.00	$0.00
Employee + Spouse	$55.90	$14.30	$7.15
Employee + Child(ren)	$55.90	$14.30	$7.15
Employee + Family	$86.38	$32.98	$16.49

Platinum Dental

	DISTRICT PAYS MONTHLY	EMPLOYEE PAYS MONTHLY	EMPLOYEE PAYROLL DEDUCTIONS
Employee Only	$38.10	$0.00	$0.00
Employee + Spouse	$65.40	$16.73	$8.37
Employee + Child(ren)	$76.56	$23.57	$11.79
Employee + Family	$112.22	$45.43	$22.72





Dental Plans – UnitedHealthcare

You have a choice between two different dental plans with UnitedHealthcare*. Following is an overview of the coverage available and what you pay. You do not have to enroll in medical to elect dental.

KEY DENTAL BENEFITS	HIGH DENTAL	PLATINUM DENTAL
Deductible (per calendar year)		
Individual / Family	$50 / $150	$50 / $150
Benefit Maximum (per calendar year; Preventive, Basic, and Major Services combined)		
Per Individual	$1,500	$3,000
Covered Services		
Preventive Services	No charge	No charge
Basic Services	Deductible then 20%	Deductible then 20%
Major Services	Deductible then 50%	Deductible then 50%
Orthodontia (Adult or Children)	Deductible then 50%; $1,500 Lifetime Benefit	Deductible then 50%; $3,000 Lifetime Benefit

*Neither plan requires you to use an in-network provider; however, If you use an in-network provider, you will receive a greater discount for services.

Vision Plan – VSP

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents, or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect vision coverage or cover the same dependents under medical and vision.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions. Log in to **VSP.com** to retrieve a copy of your ID card.



VSP VISION PLAN		
	IN-NETWORK	OUT-OF-NETWORK
	You Pay	**Reimbursement**
Exam	$10	Up to $45
Single Vision Lenses	$25	Up to $30
Bifocal Lenses	$25	Up to $50
Trifocal Lenses	$25	Up to $60
Frames	80% of balance over $150 allowance	Up to $50
Contacts in lieu of Frames/Lenses	$25 copay + balance over $150 allowance	Up to $100
Benefit Frequency		
Exams	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Contacts	Once every 12 months	

VISION PREMIUMS		
	Employee Pays Monthly	**Employee Payroll Deductions**
Employee Only	$5.00	$2.50
Employee & Spouse	$10.00	$5.00
Employee & Children	$10.70	$5.35
Employee & Family	$17.10	$8.55

Flexible Spending Accounts – UHC

You have an opportunity to participate in up to two different flexible spending accounts (FSAs) administered through UHC. FSAs allow you to set aside a portion of your income, before taxes, to pay for qualified health care and/or dependent care expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security and Medicare taxes. **NOTE: Your payroll deductions for FSA must be a whole dollar amount (no cents) that divides equally between 26 pay periods.**

Health Care FSA

For 2027, you may contribute up to $3,276 to cover qualified health care expenses incurred by you, your spouse and your children up to age 26.

Some qualified expenses include:

- Coinsurance
- Copayments
- Deductibles
- Prescriptions
- Dental treatment
- Orthodontia
- Eye exams/eyeglasses
- LASIK eye surgery
- And more

For a complete list of eligible expenses, visit **www.irs.gov/pub/irs-pdf/p502.pdf**.

Dependent Care FSA

For 2027, you may contribute up to $7,488 (per family) to cover eligible dependent care expenses ($3,750 if you and your spouse file separate tax returns).

Some qualified expenses include:

- Care of a dependent child under the age of 13 by babysitters, nursery schools, preschool or daycare centers
- Care of a household member who is physically or mentally incapable of caring for him/herself and qualifies as your federal tax dependent
- Adult daycare for parents living with you

For a complete list of eligible expenses, visit **www.irs.gov/pub/irs-pdf/p503.pdf**.







FSA – HEALTH CARE EXAMPLES		
Amount per Paycheck	**Annual Pay Periods (26)**	**Total Election Amount**
$10	$10x26 =	$260.00
$30	$30x26 =	$780.00
$50	$50x26 =	$1,300.00
$82	$82x26 =	$2,132.00
$100	$100x26 =	$2,600.00
$126*	$126x26 =	$3,276.00

*This is the highest you can elect per year.

Dependent Care FSA: Unused funds will NOT be returned to you or carried over to the following year.

FSA – DEPENDENT CARE EXAMPLES		
Amount per Paycheck	**Annual Pay Periods (26)**	**Total Election Amount**
$30	$30x26 =	$780.00
$60	$60x26 =	$1,560.00
$94	$94x26 =	$2,444.00
$115	$115x26 =	$2,990.00
$145	$145x26 =	$3,770.00
$288*	$288x26 =	$7,488.00

*This is the highest you can elect per year.

FSA Rules

You Must Enroll Each Year to Participate

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

- **Health Care FSA:** Up to $500 off unused funds from one year can carry over to the following year, but must be used by March 15th. Carryover funds will not count against or offset the amount that you can contribute annually.
- You can incur health care expenses through **March 15, 2028**, and must file claims by **March 31, 2028**.

Life, AD&D and Disability Insurance – Ochs

Life insurance provides your named beneficiary(ies) with a benefit in the event of your death. Be sure to review and update your beneficiary designations.

Accidental Death and Dismemberment (AD&D) insurance provides specified benefits to you in the event of a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that your death occurs due to a covered accident, both the Life and the AD&D benefit would be payable to your named beneficiary(ies).

Basic Life/AD&D (Drainage District 3 Paid)

This benefit is provided at NO COST to you and covers 1 times your base salary, up to a $100,000 maximum

Supplemental Life/AD&D (Employee-Paid)

If you determine you need more than the basic coverage, you may purchase additional coverage for yourself and your eligible family members.

BENEFIT OPTION		GUARANTEED ISSUE
Employee	$10,000 increments; minimum of $10,000 up to $750,000	$300,000
Spouse	$5,000 increments; minimum of $5,000 up to $250,000	$25,000
Child(ren)	Live birth to age 26 – $10,000, $15,000, or $20,000	$20,000

The EOI form will prompt online if the elected amount is over the guaranteed issue or elected after initial eligibility.

Long-Term Disability – Ochs

Long-Term Disability (LTD) – Ochs insurance provides benefits that replace a percentage of your lost income when you become unable to work due to a covered injury or illness.

Voluntary Long-Term Disability Rates

LONG-TERM DISABILITY BENEFITS AT A GLANCE	
Coverage	60% of your pre-disability earnings up to a maximum benefit of $7,500 per month until you recover or reach your Social Security Normal Retirement Age, whichever is sooner
When Benefits Begin	Benefits begins after 90 days of disability

RATE PER $100 OF MONTHLY BENEFIT	
Age	**Rate**
0–24	$0.37
25–29	$0.38
30–34	$0.59
35–39	$0.68
40–44	$0.96
45–49	$1.14
50–54	$1.33
55–59	$1.72
60–64	$2.13
65–69	$1.11
70–99	$1.11

- You may elect coverage in $100 increments up to 60% of your base monthly earnings.
- If you are increasing your benefit amount or enrolling for the first time, you must print and complete an Evidence of Insurability form and submit it to Ochs (do NOT submit to Risk Management).

Accident Insurance – The Hartford



Just as it sounds, Accident insurance plans can help you pay for costs you may incur after an accidental injury, illness or hospitalization. These plans are 100% voluntary and are paid by the employee.

Accident insurance pays out a lump sum if you become injured because of an off-the-job accident. It allows you to claim benefits even if the injuries you incur do not keep you out of work. Accident insurance may also complement health insurance if an accident causes you to have medical expenses that your health insurance doesn't cover.

Accident insurance covers qualifying injuries, which might include a broken limb, loss of a limb, burns, lacerations or paralysis. In the event of your accidental death, Accident insurance pays out money to your designated beneficiary. While health insurance companies pay your provider or facility, Accident insurance pays you directly.

How Does Accident Insurance Work?

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of off-the-job accidents, including initial care, surgery, transportation and lodging, and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive.
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit.
- Coverage is available for you, your spouse and eligible dependent children.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Accident insurance covers injuries that happen off the job — unlike workers' compensation, which only covers on-the-job injuries.
- Benefit payments are not reduced by any other insurance you may have with other companies.

	EMPLOYEE PAYS MONTHLY	EMPLOYEE PAYROLL DEDUCTIONS
Employee Only	$5.54	$2.77
Employee & Spouse	$9.97	$4.99
Employee & Child(ren)	$13.25	$6.63
Employee & Family	$19.11	$9.56

Lifetime Benefit Term Life – Chubb

- Minimum Coverage Limit: The greater of $5,000 or the amount of coverage $3/week will purchase
- Issue-Age Benefit: Locks in your age at the time you sign up for coverage

Employee Coverage

- Guaranteed Issue: Issue Age 19–70: $100,000
- For new hires, you will not be required to provide Evidence of Insurability (EOI) unless you elect over 100K.
- For current employees, you can increase up to $25,000 if you are currently enrolled in coverage, not to exceed the Guaranteed Issue amount. Coverage over a $25,000 increase or above the Guaranteed Issue amount will require EOI.
- For late applicants, EOI will be required for any amount of coverage.
- Conditional Guaranteed Issue: Issue Age 19–70: $150,000
- Simplified Issue: Issue Age 19–70: $250,000 / Issue Age 71–79: $50,000

Spouse Coverage

- Modified Guaranteed Issue: Lesser of 50% of employee amount or $25,000 (one qualifying health question)
- Conditional Guaranteed Issue: Issue Age 19–70: $75,000
- Simplified Issue: Issue Age 19–70: $125,000
- Employee must elect coverage to enroll their spouse in coverage

Accelerated Death Benefit: Long-Term Care

Death benefits can be paid early for home health care, assisted living, adult day care and nursing home care equal to 4% of the death benefit per month up to 25 months. Premiums waived while benefit being paid.

Accelerated Death Benefits: Terminal Illness

If the insured is diagnosed with a terminal illness and has a life expectancy of 12 months or less, the policy owner can request up to 50% of the death benefit, to a maximum of $100,000.

Restoration of Death Benefit

This restores the life coverage to 50% of the death benefit, up to $50,000, assuring a death benefit available up to the insured's age 121.

For example, if you elect a $100,000 policy, you'll have a $150,000 pool of dollars.

- $100,000 can be used as a death benefit
- $100,000 can be used toward Long-Term Care services instead of a death benefit
- Upon depletion, Chubb restores 50% of original death benefit



Semi-Monthly Life Non-Smoker Rates

AGE	10,000	25,000	50,000	75,000	100,000	150,000	200,000	250,000
19	N/A	N/A	$10.96	$16.44	$21.92	$32.88	$43.83	$54.79
20	N/A	N/A	$10.96	$16.44	$21.92	$32.88	$43.83	$54.79
21	N/A	N/A	$11.15	$16.72	$22.29	$33.44	$44.58	$55.73
22	N/A	N/A	$11.38	$17.06	$22.75	$34.13	$45.50	$56.88
23	N/A	N/A	$11.65	$17.47	$23.29	$34.94	$46.58	$58.23
24	N/A	N/A	$11.86	$17.78	$23.71	$35.56	$47.42	$59.27
25	N/A	N/A	$12.15	$18.22	$24.29	$36.44	$48.58	$60.73
26	N/A	N/A	$12.54	$18.80	$25.07	$37.60	$50.13	$62.67
27	N/A	N/A	$12.96	$19.45	$25.93	$38.89	$51.85	$64.81
28	N/A	$6.72	$13.44	$20.15	$26.87	$40.30	$53.73	$67.17
29	N/A	$6.95	$13.91	$20.86	$27.81	$41.71	$55.62	$69.52
30	N/A	$7.18	$14.36	$21.53	$28.71	$43.06	$57.42	$71.77
31	N/A	$7.49	$14.97	$22.45	$29.93	$44.90	$59.87	$74.83
32	N/A	$7.82	$15.64	$23.46	$31.28	$46.93	$62.57	$78.21
33	N/A	$8.15	$16.30	$24.45	$32.59	$48.89	$65.18	$81.48
34	N/A	$8.53	$17.06	$25.58	$34.11	$51.16	$68.22	$85.27
35	N/A	$8.93	$17.86	$26.78	$35.71	$53.56	$71.42	$89.27
36	N/A	$9.43	$18.85	$28.27	$37.69	$56.54	$75.38	$94.23
37	N/A	$9.93	$19.86	$29.79	$39.72	$59.58	$79.43	$99.29
38	N/A	$10.48	$20.96	$31.43	$41.91	$62.86	$83.82	$104.77
39	N/A	$11.06	$22.11	$33.17	$44.23	$66.34	$88.45	$110.56
40	N/A	$11.66	$23.31	$34.97	$46.63	$69.94	$93.25	$116.56
41	N/A	$12.29	$24.58	$36.88	$49.17	$73.75	$98.33	$122.91
42	N/A	$12.96	$25.92	$38.88	$51.83	$77.75	$103.67	$129.58
43	N/A	$13.65	$27.29	$40.94	$54.58	$81.87	$109.16	$136.46
44	N/A	$14.39	$28.77	$43.16	$57.54	$86.31	$115.08	$143.85
45	N/A	$15.18	$30.36	$45.53	$60.71	$91.06	$121.41	$151.77
46	N/A	$16.24	$32.48	$48.72	$64.96	$97.44	$129.91	$162.39
47	$6.96	$17.40	$34.79	$52.19	$69.58	$104.37	$139.16	$173.95
48	$7.46	$18.66	$37.31	$55.97	$74.62	$111.94	$149.25	$186.56
49	$7.99	$19.98	$39.96	$59.94	$79.92	$119.87	$159.83	$199.79
50	$8.59	$21.46	$42.92	$64.37	$85.83	$128.75	$171.66	$214.58
51	$9.13	$22.81	$45.62	$68.43	$91.24	$136.86	$182.48	$228.10
52	$9.72	$24.29	$48.58	$72.86	$97.15	$145.72	$194.29	$242.87
53	$10.33	$25.82	$51.63	$77.45	$103.27	$154.90	$206.53	$258.16
54	$10.99	$27.46	$54.92	$82.38	$109.84	$164.76	$219.68	$274.60
55	$11.69	$29.21	$58.42	$87.62	$116.83	$175.25	$233.66	$292.07
56	$12.63	$31.58	$63.15	$94.73	$126.31	$189.46	$252.61	$315.76
57	$13.66	$34.13	$68.27	$102.40	$136.53	$204.79	$273.06	$341.32
58	$14.74	$36.86	$73.71	$110.57	$147.42	$221.13	$294.84	$368.55
59	$15.90	$39.75	$79.49	$119.24	$158.98	$238.47	$317.96	$397.44
60	$17.12	$42.80	$85.60	$128.40	$171.20	$256.80	$342.41	$428.01
61	$18.68	$46.69	$93.38	$140.07	$186.76	$280.14	$373.52	$466.90
62	$20.30	$50.74	$101.47	$152.21	$202.94	$304.42	$405.89	$507.36
63	$22.01	$55.03	$110.06	$165.10	$220.13	$330.19	$440.25	$550.31
64	$23.80	$59.50	$118.99	$178.48	$237.98	$356.96	$475.95	$594.94

Semi-Monthly Life Non-Smoker Rates

AGE	10,000	25,000	50,000	75,000	100,000	150,000	200,000	250,000
65	$25.68	$64.21	$128.41	$192.62	$256.83	$385.24	$513.65	$642.06
66	$28.58	$71.46	$142.91	$214.36	$285.82	$428.72	$571.63	$714.54
67	$31.65	$79.12	$158.24	$237.36	$316.47	$474.71	$632.94	$791.18
68	$34.90	$87.25	$174.50	$261.75	$349.01	$523.51	$698.01	$872.51
69	$38.36	$95.89	$191.77	$287.65	$383.54	$575.30	$767.07	$958.84
70	$42.05	$105.12	$210.24	$315.36	$420.49	$630.73	$840.97	$1,051.21

Semi-Monthly Life Non-Smoker Rates Over 70

AGE	10,000	25,000	30,000	40,000	50,000
71	$46.89	$117.21	$140.65	$187.54	$234.42
72	$52.01	$130.01	$156.01	$208.01	$260.02
73	$57.45	$143.63	$172.36	$229.81	$287.26
74	$63.23	$158.07	$189.69	$252.92	$316.14
75	$69.40	$173.50	$208.19	$277.59	$346.99
76	$77.91	$194.77	$233.72	$311.63	$389.53
77	$86.88	$217.19	$260.62	$347.50	$434.37
78	$96.35	$240.87	$289.05	$385.40	$481.75
79	$106.36	$265.90	$319.07	$425.43	$531.79

Semi-Monthly Life Smoker Rates

AGE	10,000	25,000	50,000	75,000	100,000	150,000	200,000	250,000
19	N/A	$7.20	$14.40	$21.60	$28.79	$43.19	$57.58	$71.98
20	N/A	$7.20	$14.40	$21.60	$28.79	$43.19	$57.58	$71.98
21	N/A	$7.39	$14.77	$22.16	$29.54	$44.31	$59.08	$73.85
22	N/A	$7.58	$15.15	$22.72	$30.29	$45.44	$60.58	$75.73
23	N/A	$7.78	$15.56	$23.35	$31.13	$46.69	$62.25	$77.81
24	N/A	$7.99	$15.98	$23.97	$31.96	$47.94	$63.92	$79.90
25	N/A	$8.22	$16.44	$24.66	$32.88	$49.31	$65.75	$82.19
26	N/A	$8.50	$17.00	$25.50	$33.99	$50.99	$67.98	$84.98
27	N/A	$8.79	$17.58	$26.36	$35.15	$52.73	$70.30	$87.87
28	N/A	$9.09	$18.18	$27.26	$36.35	$54.53	$72.70	$90.87
29	N/A	$9.38	$18.76	$28.13	$37.51	$56.26	$75.02	$93.77
30	N/A	$9.69	$19.38	$29.06	$38.75	$58.13	$77.50	$96.87
31	N/A	$10.10	$20.19	$30.29	$40.38	$60.58	$80.77	$100.96
32	N/A	$10.55	$21.09	$31.64	$42.18	$63.27	$84.37	$105.46
33	N/A	$10.97	$21.93	$32.89	$43.86	$65.79	$87.72	$109.64
34	N/A	$11.44	$22.87	$34.31	$45.74	$68.61	$91.48	$114.35
35	N/A	$11.92	$23.83	$35.75	$47.67	$71.50	$95.33	$119.16
36	N/A	$12.55	$25.09	$37.64	$50.18	$75.27	$100.37	$125.46
37	N/A	$13.22	$26.43	$39.65	$52.87	$79.30	$105.73	$132.16
38	N/A	$13.91	$27.82	$41.73	$55.63	$83.45	$111.26	$139.08

Semi-Monthly Life Smoker Rates

AGE	10,000	25,000	50,000	75,000	100,000	150,000	200,000	250,000
39	N/A	$14.71	$29.41	$44.11	$58.82	$88.22	$117.63	$147.04
40	N/A	$15.47	$30.94	$46.41	$61.88	$92.81	$123.75	$154.68
41	$6.58	$16.46	$32.91	$49.36	$65.82	$98.72	$131.63	$164.54
42	$6.99	$17.47	$34.94	$52.41	$69.88	$104.82	$139.76	$174.70
43	$7.41	$18.53	$37.06	$55.59	$74.12	$111.17	$148.23	$185.29
44	$7.85	$19.63	$39.26	$58.89	$78.52	$117.77	$157.03	$196.29
45	$8.34	$20.86	$41.71	$62.56	$83.42	$125.12	$166.83	$208.54
46	$8.90	$22.25	$44.49	$66.73	$88.97	$133.46	$177.95	$222.43
47	$9.51	$23.76	$47.52	$71.27	$95.03	$142.55	$190.06	$237.58
48	$10.16	$25.40	$50.80	$76.19	$101.59	$152.38	$203.18	$253.97
49	$10.85	$27.11	$54.22	$81.33	$108.44	$162.66	$216.88	$271.10
50	$11.59	$28.98	$57.96	$86.94	$115.91	$173.87	$231.83	$289.78
51	$12.38	$30.94	$61.88	$92.81	$123.75	$185.62	$247.49	$309.37
52	$13.22	$33.05	$66.10	$99.15	$132.21	$198.31	$264.41	$330.51
53	$14.10	$35.24	$70.48	$105.72	$140.96	$211.43	$281.91	$352.38
54	$15.03	$37.57	$75.15	$112.72	$150.29	$225.43	$300.57	$375.72
55	$16.00	$40.00	$80.00	$120.00	$160.00	$239.99	$319.99	$399.99
56	$17.25	$43.13	$86.25	$129.38	$172.50	$258.75	$345.01	$431.26
57	$18.60	$46.48	$92.97	$139.45	$185.93	$278.89	$371.85	$464.82
58	$20.00	$50.00	$99.99	$149.98	$199.98	$299.97	$399.95	$499.94
59	$21.49	$53.73	$107.45	$161.18	$214.90	$322.35	$429.80	$537.25
60	$23.06	$57.66	$115.31	$172.96	$230.62	$345.93	$461.23	$576.54
61	$25.11	$62.78	$125.56	$188.33	$251.11	$376.66	$502.22	$627.77
62	$27.22	$68.06	$136.11	$204.17	$272.22	$408.34	$544.45	$680.56
63	$29.48	$73.69	$147.38	$221.07	$294.76	$442.13	$589.51	$736.89
64	$31.77	$79.43	$158.85	$238.28	$317.71	$476.56	$635.41	$794.26
65	$34.21	$85.52	$171.04	$256.55	$342.07	$513.11	$684.14	$855.18
66	$38.02	$95.05	$190.10	$285.15	$380.20	$570.29	$760.39	$950.49
67	$42.05	$105.12	$210.24	$315.36	$420.49	$630.73	$840.97	$1,051.21
68	$46.33	$115.81	$231.62	$347.43	$463.23	$694.85	$926.47	$1,158.08
69	$50.88	$127.18	$254.37	$381.55	$508.73	$763.10	$1,017.46	$1,271.83
70	$55.73	$139.33	$278.66	$417.99	$557.31	$835.97	$1,114.62	$1,393.28

Semi-Monthly Life Smoker Rates Over 70

AGE	10,000	25,000	30,000	40,000	50,000
71	$62.72	$156.80	$188.15	$250.87	$313.59
72	$70.13	$175.31	$210.38	$280.50	$350.63
73	$78.03	$195.08	$234.10	$312.13	$390.16
74	$86.45	$216.13	$259.36	$345.81	$432.26
75	$95.49	$238.73	$286.48	$381.97	$477.46
76	$107.52	$268.80	$322.56	$430.08	$537.60
77	$120.27	$300.66	$360.79	$481.05	$601.32
78	$133.79	$334.47	$401.36	$535.14	$668.93
79	$148.16	$370.40	$444.48	$592.64	$740.79





Critical Illness with Cancer – The Hartford

While medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, stroke or a heart attack, medical insurance may not provide the coverage you need. Critical Illness insurance will ease the financial strain and help you focus on your recovery.

How Will a Critical Illness Claim Get Paid?

After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used for many things including:

- Child care costs
- Medical expenses
- Travel expenses for you and your family
- Lost wages from missed time at work
- Living expenses

Benefits and Amounts

INITIAL CRITICAL ILLNESS BENEFITS: BENEFITS PAID ONCE PER COVERED PERSON	
Heart Attack	100%
Cancer (Invasive)	100%
Stroke – Without Impairment (Including Transient Ischemic Attack)	10%
Stroke – Mild	25%
Stroke – Moderate	50%
Stroke – Severe	100%
End Stage of Renal Failure	100%
Major Organ Transplant	100%
Coronary Artery Disease – Minor	10%
Coronary Artery Disease – Major	100%
REOCCURRENCE OF CRITICAL ILLNESS BENEFITS	
Initial Critical Illness	100%
RIDER BENEFITS	
Advanced Alzheimer's Disease	100%
Advanced Parkinson's Disease	100%
Benign Brain or Spinal Cord Tumor – Early Diagnosis	25%
Benign Brain or Spinal Cord Tumor – Advanced Diagnosis	100%
Coma	100%
Complete Loss of Hearing	100%
Complete Loss of Sight	100%
Complete Loss of Speech	100%
Paralysis	100%
Fixed Wellness Rider	100%

The coverage contains exclusions and limitations; please refer to plan documents for details.
The Pre-Existing Condition Limitation is excluded in your plan design.
Benefits paid once per person. When all benefits have been used, the coverage terminates.
Covered dependents receive 50% of the benefit amount.
Limit of $5,000 in a calendar year. Limit of $1,000 in a calendar year. Maximum of 1,000 miles.

Critical Illness Age Rates[1]

MONTHLY RATES PER $1,000 OF COVERAGE					
Non-Tobacco			Tobacco[4]		
Issue Age[2]	Employee[3]	Spouse	Issue Age[2]	Employee[3]	Spouse
<30	$0.36	$0.27	<30	$0.39	$0.29
30–39	$0.49	$0.40	30–39	$0.66	$0.57
40–49	$0.85	$0.76	40–49	$1.34	$1.25
50–59	$1.54	$1.46	50–59	$2.78	$2.71
60–69	$2.84	$2.79	60–69	$5.60	$5.58
70–79	$4.89	$4.85	70–79	$9.68	$9.70
80+	$6.73	$6.70	80+	$13.37	$13.40

[1]Rates/benefits may change on a class or plan basis. For any premium paid by employees, actual per pay period premium deductions may vary slightly from monthly billed amounts due to rounding. The Hartford offers a billing tolerance to help account for this difference.
[2]Employee and spouse premiums are calculated with the employee's age as of the effective date of the policy or as of the most recent policy anniversary. Rates are adjusted once each year on the policy anniversary date that coincides with or follows the day an employee reaches the starting age of the next band.
[3]Child insurance is automatic with employee enrollment/participation. A separate premium is not required.
[4]Tobacco rates apply for **any** use of tobacco or nicotine replacement by the employee within the past 12 months.



Hospital Indemnity – The Hartford

Hospital Indemnity insurance is a plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. The plan covers employees who are admitted to a hospital or ICU for a covered sickness or injury. Even if your medical insurance covers most of your hospitalization, you can still receive payments from your Hospital Indemnity insurance plan to cover extra expenses while you recover.

How Does Hospital Indemnity Insurance Work?

You pay monthly premiums for your Hospital Indemnity insurance plan. If you are admitted to the hospital for an injury or illness, your Hospital Indemnity plan makes cash payments to you. With the payments going directly to you, you can use these emergency funds to pay for costs not covered by your medical insurance. Medical insurance deductibles, copays and coinsurance, child care expenses while you are in the hospital or cost-of-living expenses as you recover.

HOSPITALIZATION BENEFITS	
First Day Hospital Confinement	$1,000; Once/year
Daily Hospital Confinement	$200; Up to 30 days/year
First Day ICU Confinement	$2,000; Once/year
Daily ICU Confinement	$400; Up to 30 days/year
Health Screening	$50; Once/year
Continuous Care Confinement (Rehab, Skilled Nursing & Hospice)	$200; Up to 30 days/year
Hospital Observation/Short Stay	$100; Up to 5 days/year
Newborn Routine Hospital Care	$300; Once/live birth

	EMPLOYEE PAYS MONTHLY	EMPLOYEE PAYROLL DEDUCTIONS
Employee	$15.60	$7.80
Employee + Spouse	$35.23	$17.62
Employee + Child	$20.80	$10.40
Family	$43.16	$21.58

Lantern

Lighting Your Path to the Right Surgical Care

What Is Lantern?

Lantern can help you get the best care when you need planned, nonemergency surgery. This money-saving benefit is available at no additional cost to you as part of your benefits.

Here's What's Covered

In partnership with Southeast Texas Government Employee Benefits Pool (Drainage District 3), we cover the most expensive costs associated with surgery, so you'll pay less for your procedure when you use your Lantern benefit. Your coverage includes:*

- Dedicated support and guidance
- Personalized matching with the best surgeon for your unique needs
- Consults and appointments with your Lantern surgeon
- Anesthesia, procedure and facility (hospital) fees

*Testing, scans, imaging, durable medical equipment and physical therapy expenses may not be included. However, coverage may be available through your medical plan.

In the event of a medical emergency, call 911 or visit your nearest emergency room.

Let Us Guide You Back to Health: 3 Steps to the Best Care

Step 1

Call a Care Advocate to get started. They'll share more information about your benefits and ask about the care you're looking for.

Step 2

Based on your needs, your Care Advocate will match you with a handpicked list of excellent surgeons.

Step 3

After you choose a surgeon, your Care Advocate will help set up appointments and guide you through every step of the experience.

Learn More

Call (888) 726-1353 to see how Lantern can help you.

SETGEBP
SOUTHEAST TEXAS GOVERNMENT EMPLOYEE BENEFITS POOL

LANTERN

NCS Musculoskeletal Program

NCS can resolve most problems in less than 4 treatment sessions (sessions are 15 minutes). Treatment is done by a board certified chiropractor, at an on-site County location, and is free to employees and their dependents (MUST be enrolled in the UHC medical plan in order to participate).

NCS can treat the following:

- Sciatica
- Back pain
- Knee pain
- Hip pain
- Foot pain
- Neck pain
- Elbow pain
- Shoulder pain
- Wrist pain
- Leg pain
- Ankle pain
- Other pain

Risk Management Conference Room

215 Franklin Street, Suite 202
Beaumont, TX 77701

Mid-County

7933 Viterbo Rd.
Beaumont, TX 77705

Make an Appointment at:

- **www.nmcsonline.com/SETGEBP**
- Select **Create New Account** and complete the on-screen form
- Select **Appointment** and choose your preferred location/date/time and make a minimum of 4 appointments (appointments cannot be on consecutive days)
- Questions? Contact NCS at **(817) 380-4183**

AngioScreen

AngioScreen®

AngioScreen takes only 6 minutes and you'll leave with an instant color ultrasound picture printout with data showing your risk of heart disease and stroke.

AngioScreen measures Ankle Brachial Index, a screening for blockages in the leg arteries that is normally not performed by doctors unless patients are symptomatic. Blood pressure, pulse and body mass index are also measured.

AngioScreen is:

- Painless, non-invasive screening for the risk of heart disease and stroke
- No needles
- No radiation
- Instant results and consultation

Provided by Southeast Texas Government Employee Benefits Pool.

Visit **www.AngioScreen.com** for more information.

Be on the lookout for upcoming emails announcing dates, locations and instructions on how to schedule your appointments.

Special Enrollment

After Declining Health Coverage

If you are declining enrollment for yourself or your dependents (including spouses) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if 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 you or your dependent's coverage ends (or after the employer stops contributing to the other coverage).

New Dependents

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.

Government Programs

You may be able to enroll yourself or your dependents in this plan if:

- You or your dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage terminated as a result of loss of eligibility; **or**
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.
- You must request enrollment within **60 days** of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined.

If you have a special enrollment event and want to enroll in health coverage, contact Risk Management at **(409) 835-8672**.



Required Notices

Health Coverage Notices

FOR YOUR FILES

This guide contains legal notices for participants in group health plan(s) sponsored by Drainage District 3. The notices included in this guide are:

- **CHIP Notice that details coverage for children using premium assistance from Medicaid or CHIP. Health Insurance Marketplace Coverage Options and Your Health Coverage** that describes the Health Insurance Marketplace and eligibility and tax credit information.
- **Notice of Privacy Practices** that explains how the health care plan(s) protect your personal medical information.
- **Medicare Part D Notice** that provides information about how your current prescription drug coverage under the health care plan(s) is affected—and your options for coverage—when you become eligible for Medicare.
- **COBRA Rights Notice** that explains when you and your family may be able to temporarily continue coverage under the health care plan(s) if coverage would otherwise end for you.
- **Newborn & Mothers Health Protection Notice** that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.
- **Women's Health and Cancer Rights Act** that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.
- **Expanded Coverage for Women's Preventive Care** that explains how the health care plan(s) cover(s) women's preventive care, including contraceptives, under the Affordable Care Act.
- **Notice of Special Enrollment Rights** that explains when you can enroll in the health care plan(s) due to special circumstances.
- **60-Day Special Enrollment Period** that describes a special 60-day timeframe to elect or discontinue coverage.

CHIP NOTICE

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 Drainage District 3, 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 on the following page, 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, dial 1-877-KIDS NOW, or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

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

Nevada Medicaid	Medicaid: **dhcfp.nv.gov**	800-992-0900
New Hampshire Medicaid	**dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program** Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**	603-271-5218 or 800-852-3345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: **state.nj.gov/humanservices/dmahs/clients/medicaid** CHIP: **njfamilycare.org/index.html**	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York Medicaid	**health.ny.gov/health_care/medicaid**	800-541-2831
North Carolina Medicaid	**medicaid.ncdhhs.gov**	919-855-4100
North Dakota Medicaid	**hhs.nd.gov/healthcare**	844-854-4825
Oklahoma Medicaid and CHIP	**insureoklahoma.org**	888-365-3742
Oregon Medicaid	**healthcare.oregon.gov/Pages/index.aspx**	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: **pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html** CHIP: **dhs.pa.gov/CHIP/Pages/CHIP.aspx**	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	**eohhs.ri.gov**	855-697-4347 or 401-462-0311 (Direct RIte Share Line)
South Carolina Medicaid	**scdhhs.gov**	888-549-0820
South Dakota Medicaid	**dss.sd.gov**	888-828-0059
Texas Medicaid	**hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**	800-440-0493
Utah Medicaid and CHIP	UPP: **medicaid.utah.gov/upp/** UPP Email: **upp@utah.gov** Adult Expansion: **medicaid.utah.gov/expansion/** Utah Medicaid Buyout Program: **medicaid.utah.gov/buyout-program/** CHIP: **chip.utah.gov**	UPP: 877-222-2542
Vermont Medicaid	**dvha.vermont.gov/members/medicaid/hipp-program**	800-250-8427
Virginia Medicaid and CHIP	**coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** **coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs**	Medicaid/CHIP: 800-432-5924
Washington Medicaid	**hca.wa.gov**	800-562-3022
West Virginia Medicaid and CHIP	**dhhr.wv.gov/bms/** **mywvhipp.com/**	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid and CHIP	**dhs.wisconsin.gov/badgercareplus/p-10095.htm**	800-362-3002
Wyoming Medicaid	**health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility**	800-251-1269

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

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

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 10.22% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Drainage District 3 at 409-243-3495.

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: Drainage District 3	4. Employer Identification Number (EIN): 74-600029	
5. Employer address: 24460 Hwy 124	6. Employer phone number: 409-243-3495	
7. City: Hampshire	8. State: TX	9. ZIP code: 77622
10. Who can we contact about employee health coverage at this job? Shanna Verret		
11. Phone number (if different from above)	12. E-mail address: **SVerret@jcdd3.org**	

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

- As your employer, we offer a health plan to eligible employees (employees working at least 30 hours per week)
- With respect to dependents, we offer coverage to eligible dependents (legal spouse, dependent children under 26 who is your dependent for federal income tax purposes at the time application for coverage of the child is made.)

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

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

If you decide to shop for coverage in the Marketplace, **www.healthcare.gov** will guide you through the process

Special Enrollment Notice

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

LOSS OF OTHER COVERAGE

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

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

MARRIAGE, BIRTH OR ADOPTION

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

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

MEDICAID OR CHIP

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

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

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact:

Drainage District 3 at 409-243-3495.

Drainage District 3 Notice of Privacy Practices

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.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the Drainage District 3 (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 1/1/2027.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Drainage District 3 requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Drainage District 3 for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Drainage District 3
24460 Hwy 124
Hampshire, TX 77622
409-243-3495

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit **www.hhs.gov/ocr** for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Important Notice from Drainage District 3 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 Drainage District 3 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. Drainage District 3 has determined that the prescription drug coverage offered by Drainage District 3 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 Drainage District 3 coverage will be affected. If you do decide to join a Medicare drug plan and drop your current Drainage District 3 coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Drainage District 3 and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Drainage District 3 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 "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: 1/1/2027
Drainage District 3
24460 Hwy 124
Hampshire, TX 77622
409-243-3495

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 Public Sector COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Drainage District 3

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

Disability Extension of 18-month Period of COBRA Continuation Coverage

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

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

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

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

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

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

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

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Date: 1/1/2027
Drainage District 3
24460 Hwy 124
Hampshire, TX 77622
409-243-3495

Women's Health and Cancer Rights Act

ENROLLMENT NOTICE

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

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

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

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 medical plan administrator for more information.

Newborns' and Mothers' Health Protection Act

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

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

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

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

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

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

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

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

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

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

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

Important Contacts

Shanna Verret

(409) 243-3495
sverret@jcdd3.org

COVERAGE	CARRIER	PHONE #	WEBSITE/EMAIL
Medical	UnitedHealthcare Group No. 912677	(888) 567-4659	www.myUHC.com
Dental	UnitedHealthcare Group No. 1182424	(877) 816-3596	www.myUHC.com
Vision	VSP Group No. 40164693	(800) 877-7195	www.VSP.com
Prescriptions	MedOne	(800) 710-9341	Support@Liviniti.com
International Prescriptions	MyRxCompass	(833) 652-8379	carenavigator@myrxcompass.com
FSA	UnitedHealthcare (Optum Bank)	(866) 755-2648	www.myUHC.com
Advocate 4 Me	UnitedHealthcare Group No. 912677	(888) 567-4659	www.myUHC.com
Cancer, Critical Illness, Hospital Indemnity	The Hartford	(866) 547-4205	TheHartford.com/benefits/myclaim
Basic Life, Supplemental Life, LTD	Ochs	(800) 392-7295	ochs@ochsinc.com
Lifetime Benefit Term Life	Chubb	(855) 241-9891	csmail@gotoservice.chubb.com
Lantern (Formerly known as Surgery Plus)	Lantern	(888) 726-1353	my.lanterncare.com

Drainage District 3
24460 Hwy 124
Hampshire, TX 77622

Jefferson County DRAINAGE DISTRICT 3









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