GATEWAY TO THE BAY

LAGUNA VISTA

TEXAS

2025 - 2026 Benefits Guide

Valley Risk Consulting

Risk Management & Insurance Services

Introduction

As an employee of **Town of Laguna Vista** enjoying your work and making valuable contributions to business are equally vital. The satisfaction and security of you and your family are important, not only to your well-being but ultimately, in terms of achieving the goals of our organization.

For the **2025-2026** plan year, **Town of Laguna Vista** has worked hard to offer a competitive, total rewards package that includes valuable and competitive benefit plans. The programs reflect our commitment to keeping our staff healthy and secure. We understand that your situation is unique, and **Town of Laguna Vista** is offering an overall benefits package that can be shaped and molded by you to fit your needs.

This benefits booklet is a summary description of your **Town of Laguna Vista** benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. The booklet and plan summaries do not constitute a contract of employment. We hope this benefit booklet, along with our additional communication and decision-making tools will help you make the best healthcare choices for you and your family.

Contact Information

Human Resources:
(956) 943-1793

Valley Risk Consulting
(956) 452-1708
www.vrctx.com

Jonathan Sakulenzki - Broker
(956) 452-1708
jsakulenzki@vrctx.com

Krisann Mejia - Office Manager, Customer Service Representative
(956) 452-1708 Ext.103
krisann@vrctx.com

Danielle Rodriguez – Customer Service Representative
(956) 452-1708 Ext. 105
drodriguez@vrctx.com

As a **Town of Laguna Vista** full-time employee (working 40 or more hours per week), you are eligible to enroll in the benefits. ***Effective on the first of the month following your date of employment***.

During **Open Enrollment**, the benefits you elect will be effective from **05/01/2025 – 04/30/2026.**

Qualifying Events

Eligible employees may enroll or make changes to their benefits elections during the annual open enrollment period. As with most benefits, once you elect an option you are bound to that choice for the entire plan year unless you experience a "Qualifying Event". These may include, but are not limited to:

- Changes in employment status
- Changes in legal marital status
- A COBRA-qualifying event
- Taking an unpaid leave of absence
- Family Medical Leave Act (FMLA)
- Entitlement to Medicare or Medicaid
- Change in number of dependents satisfies or ceases to satisfy eligibility requirement
- Change in the place of residence of the employee, resulting in the current carrier not being available

Medical Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 05/01/2025 - 04/30/2026

aetna : AFA CPOSII 500 80/50 CY V24

Coverage for: Employee + Family | **Plan Type:** POS

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, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $500 / Family $1,000. Out-of-Network: Individual $2,000 / Family $6,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain office visits, preventive care, urgent care and prescription drugs in-network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $4,500 / Family $9,000. Out-of-Network: Individual $12,000 / Family $36,000.	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?	Premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services, 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 http://www.aetna.com/docfind or call 1-888-982-3862 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible does not apply	50% coinsurance	No charge for in-network Virtual Primary Care telemedicine provider visits for certain services.
	Specialist visit	$75 copay/visit, deductible does not apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	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)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.com/advancedcontrolaetna	Preferred generic drugs	Tier 1A: $3 copay/ prescription (retail), $6 copay/ prescription (mail order); Tier 1: $10 copay/ prescription (retail), $20 copay/ prescription (mail order), deductible does not apply	50% coinsurance (retail), deductible does not apply	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to out-of-pocket limit. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. No coverage for mail order prescriptions out-of-network. Maintenance drugs- after two retail fills, you are required to fill a 90-day supply at a participating mail service pharmacy or at selected participating retail providers.
	Preferred brand drugs	$45 copay/ prescription (retail), $90 copay/ prescription (mail order), deductible does not apply	50% coinsurance (retail), deductible does not apply	
	Non-preferred generic/brand drugs	$75 copay/ prescription (retail), $150 copay/ prescription (mail order), deductible does not apply	50% coinsurance (retail), deductible does not apply	
	Specialty drugs	Preferred: 20% coinsurance up to a $250 maximum/ prescription for up to a 30 day supply; Non-preferred: 40% coinsurance up to a $500	Not covered	All specialty prescription drug fills on initial fill must be filled at a network specialty pharmacy except for urgent situations. Your plan may include access to selected participating retail pharmacies for certain specialty drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
		maximum/ prescription for up to a 30 day supply, deductible does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance after $300 copay/visit	20% coinsurance after $300 copay/visit	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	$75 copay/visit, deductible does not apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: No charge; All other outpatient services: 20% coinsurance	Office visits and all other outpatient services: 50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Coverage is limited to 60 visits per year. Out-of-network precertification required or $400 penalty applies per occurrence.
	Rehabilitation services	$75 copay/visit	50% coinsurance	Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
	Habilitation services	20% coinsurance	50% coinsurance	None
	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 60 days per year. Out-of-network precertification required or $400 penalty applies per occurrence.
	Durable medical equipment	50% coinsurance	50% coinsurance	Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	Out-of-network precertification required or $400 penalty applies per occurrence.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	Coverage is limited to 1 exam every 12 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

DENTAL INSURANCE

PLAN YEAR DEDUCTIBLES AND MAXIMUMS	IN-NETWORK	OUT-NETWORK
Type A	Waived	Waived
Type B & C Deductible		
Individual	$50	$50
Family	3 times Individual	3 times Individual
Annual Maximum	$3,000	$3,000
Orthodontia Lifetime Maximum	$1,000	$1,000
The same expenses may be used to satisfy both the In-Network and Out-Network deductible.		

COVERED SERVICES	IN-NETWORK	OUT-NETWORK
Type A Services • Examinations/Evaluations • Bitewing X-rays • All Other X-Rays • Fluoride Treatments • Cleaning/Prophylaxis • Sealants • Space Maintainers • Brush Biopsy/Cancer Screening • Full Mouth X-rays, Panoramic Film	100%	100%
Type B Services • Palliative Treatment • Periodontal Maintenance • Fillings • Stainless Steel Crowns • Simple Extractions • Oral Surgery • Endodontics • Surgical Extractions • General Anesthesia or I.V. Sedation • Surgical Periodontics • Non-Surgical Periodontics	90%	90%
Type C Services • Full or Partial Removable Dentures • Repair of Full or Partial Removable Dentures • Adjustments, Tissue Conditioning, Rebasing or Relining of Full or Partial Removable Dentures • Bridges • Repair/Recementation of Bridges • Cast Crowns, Inlays, Onlays, Labial Veneers • Repair/Recementation of Cast Crowns/Inlays/Onlays/Labial Veneers • Implants	60%	60%
Child Orthodontia • Harmful Habit Appliances	50%	50%

VISION INSURANCE

Mutual of Omaha

BENEFITS	MEMBER COST IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT*
Exam with Dilation as Necessary	$10 copay	Up to $37
Exam Options:		
•Retinal Imaging	•Up to $39	
•Standard Contact Lens Fit & Follow-up	•Up to $40	•Not Applicable
•Premium Contact Lens Fit & Follow-up	•10% off retail price	
Frames		
•Any available frame at provider location	• $0 copay, $200 allowance plus 20% off balance over allowance	•Up to $79
Standard Plastic Lenses:		
• Single Vision	• $25 copay	• Up to $20
• Bifocal	• $25 copay	• Up to $36
• Trifocal	• $25 copay	• Up to $64
• Lenticular	• $25 copay	• Up to $64
• Standard Progressive Lenses (add on to bifocal copay)	• $65 copay	• Up to $36
• Premium Progressive Lenses (add on to bifocal copay)		
Tier 1	• $85 copay	• Up to $36
Tier 2	• $95 copay	• Up to $36
Tier 3	• $110 copay	• Up to $36
Tier 4	• $65 copay plus 80% of charge less $120 allowance	• Up to $36
Lens Options:		
• UV Coating	• $15	• Not Applicable
• Tint (Solid and Gradient)	• $15	• Not Applicable
• Standard Scratch Coating	• $15	• Not Applicable
• Standard Polycarbonate (Adults)	• $40	• Not Applicable
• Standard Polycarbonate (Children under 19)	• $40	• Not Applicable
• Standard Anti-Reflective	• $45	• Not Applicable
• Premium Anti-Reflective		
Tier 1	• $57	• Not Applicable
Tier 2	• $68	• Not Applicable
Tier 3	• 20% off retail price	• Not Applicable
• Photochromic – Transitions	• $75	• Not Applicable
• Other Add-ons	• 20% off retail price	• Not Applicable
Contact Lenses: (Contact lens allowance includes materials only)		
• Conventional	• $0 copay, $200 allowance plus 15% off balance over allowance	• Up to $136
• Disposable	• $0 copay, $200 allowance	• Up to $160
• Medically Necessary	• $0 copay, paid in full	• Up to $210
Laser Vision Correction:		
• LASIK or PRK from U.S. Laser Network	• 15% off retail price or 5% off promotional price	
Additional Pair of Glasses or Contacts	40% discount off of complete pair of eyeglasses and 15% off conventional contact lenses once the funded benefit has been used	
FREQUENCY		
Exams	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 12 months	

BASIC TERM LIFE AND AD&D INSURANCE

BENEFITS	
Life Insurance Benefit Amount	For You: $25,000 In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: The Principal Sum amount is equal to the amount of your life insurance benefit.

VOLUNTARY TERM LIFE AND AD&D INSURANCE

COVERAGE GUIDELINES			
	Minimum	**Guarantee Issue**	**Maximum**
For You	$10,000	5 times annual salary, up to $50,000	$300,000, in increments of $10,000, but no more than 5 times annual salary
Spouse	$5,000	100% of employee's benefit, up to $25,000	100% of employee's benefit, in increments of $5,000, up to $150,000
Child(ren)	$2,000	100% of employee's benefit	100% of employee's benefit, in increments of $1,000, up to $10,000

VOLUNTARY SHORT-TERM DISABILITY INSURANCE

Mutual of Omaha

BENEFITS

Elimination Period	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: • On the 8th day of your disabling injury. • On the 8th day of your disabling illness.
Weekly Benefit	Your benefit is equivalent to 60% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources. The premium for your short-term disability coverage is waived while you are receiving benefits.
Maximum Benefit Period	Up to 12 weeks
Maximum Weekly Benefit	$1,000
Minimum Weekly Benefit	$15

To file a claim you can gather forms at: https://www.mutualofomaha.com/support/forms

Group Accident Insurance

Basic Plan

Colonial Life

Injury benefits

- **Burns (based on size and degree)** ..... $375–$12,000
- **Concussion** $275
- **Connective tissue damage** ..... $100–$200
- **Eye injury** $200
- **Hearing loss injuries** $120
  (Maximum once per lifetime per ear per insured)

Fracture benefits

- **Injury** ..... $200–$2,250
  Examples: finger: $200 | wrist: $1,020 | hip: $2,100
- **Surgical repair of fracture** 100%
  (Payable as an additional % of the applicable fractures benefit)
- **Chip fracture** 25%
  (Payable as a % of the applicable fractures benefit)

Dislocation benefits

- **Injury** ..... $140–$2,000
  Examples: elbow: $330 | ankle: $960 | hip: $2,000
- **Surgical repair of dislocation** 100%
  (Payable as an additional % of the applicable dislocations benefit)
- **Incomplete dislocation** 25%
  (Payable as a % of the applicable dislocations benefit)

Treatment benefits

- **Air ambulance** $1,000
- **Ambulance (ground or water)** $200
- **Durable medical equipment** ..... $35–$150
- **Emergency dental repair** ..... $50–$150
- **Emergency department** $150
  (Maximum 4 per year)
- **Family care** ..... $25 per day
  (Maximum of one benefit per day for all Insureds combined, up to a maximum of three days per covered accident, regardless of the number of children)
- **Injections to prevent or limit infection** $50
- **Lodging** ..... $150 per day
  (Maximum 30 days)
- **Medical imaging** $150
- **Pain management injections** $50
- **Pet boarding** ..... $20 per day
  (Maximum of one benefit per day for all insureds combined, up to a maximum of three days per covered accident, regardless of the number of pets that are boarded)
- **Injury due to auto accident** $250
- **Internal injuries** $200
- **Knee cartilage (meniscus) injury** $100
- **Lacerations** ..... $50–$600
- **Loss of a digit – partial** ..... $200–$400
- **Loss of a digit** ..... $500–$1,500
- **Ruptured or herniated disc** ..... $125–$250

- **Prosthetic device or artificial limb** ..... $750–$1,500
- **Skin grafts (due to burns)** 50%
  (Payable as a % of the applicable burn benefit)
- **Skin grafts (not due to burns)** ..... $125–$250
- **Transfusions** $300
- **Transportation** ..... $100 per trip
  (Maximum 6 one-way trips)
- **Treatment in a physician's office or urgent care facility** $75
  (Maximum 4 per year)
- **X-ray or ultrasound** $50

Surgery benefits

- **Anesthesia** ..... $50–$150
- **Connective tissue surgery** ..... $100–$1,000
- **Eye surgery** $200
- **General surgery**
  - **Abdominal, thoracic, or cranial** $1,000
  - **Exploratory surgery** $150
- **Hernia surgery** $250
- **Knee cartilage (meniscus) surgery** ..... $75–$400
- **Outpatient surgical facility** $200
- **Ruptured or herniated disc surgery** ..... $100–$900

Recovery care benefits

- **At-home care** ..... $75 per day
  (Maximum 5 days)
- **Benefit Booster** $500
- **Physician follow-up visits** $50
  (Maximum 3 days per covered accident and 12 days per calendar year)
- **Rehabilitation or sub-acute rehabilitation unit confinement** ..... $100 per day
  (Maximum 15 days per covered accident and 30 days per calendar year)
- **Therapy services (speech, physical therapy, occupational therapy)** ..... $35 per day
  (Maximum 15 days)

Group Accident Insurance

Colonial Life

Premier Plan

Injury benefits

- **Burns (based on size and degree)** ..... $750–$21,000
- **Concussion** $500
- **Connective tissue damage** ..... $100–$200
- **Eye injury** $400
- **Hearing loss injuries** $120
  (Maximum once per lifetime per ear per insured)

Fracture benefits

- **Injury** ..... $200–$5,000
  Examples: finger: $200 | wrist: $1,200 | hip: $4,200
- **Surgical repair of fracture** 100%
  (Payable as an additional % of the applicable fractures benefit)
- **Chip fracture** 25%
  (Payable as a % of the applicable fractures benefit)

Dislocation benefits

- **Injury** ..... $260–$4,000
  Examples: elbow: $600 | ankle: $1,600 | hip: $4,000
- **Surgical repair of dislocation** 100%
  (Payable as an additional % of the applicable dislocations benefit)
- **Incomplete dislocation** 25%
  (Payable as a % of the applicable dislocations benefit)

Treatment benefits

- **Air ambulance** $2,000
- **Ambulance (ground or water)** $400
- **Durable medical equipment** ..... $65–$250
- **Emergency dental repair** ..... $200–$600
- **Emergency department** $250
  (Maximum 4 per year)
- **Family care** ..... $50 per day
  (Maximum of one benefit per day for all insureds combined, up to a maximum of three days per covered accident, regardless of the number of children)
- **Injections to prevent or limit infection** $50
- **Lodging** ..... $250 per day
  (Maximum 30 days)
- **Medical imaging** $400
- **Pain management injections** $150
- **Pet boarding** ..... $20 per day
  (Maximum of one benefit per day for all insureds combined, up to a maximum of three days per covered accident, regardless of the number of pets that are boarded)
- **Injury due to auto accident** $250
- **Internal injuries** $200
- **Knee cartilage (meniscus) injury** $200
- **Lacerations** ..... $75–$1,200
- **Loss of a digit – partial** ..... $400–$800
- **Loss of a digit** ..... $1,000–$3,000
- **Ruptured or herniated disc** ..... $200–$400
- **Prosthetic device or artificial limb** ..... $1,750–$3,500
- **Skin grafts (due to burns)** 50%
  (Payable as a % of the applicable burn benefit)
- **Skin grafts (not due to burns)** ..... $375–$750
- **Transfusions** $500
- **Transportation** ..... $200 per trip
  (Maximum 6 one-way trips)
- **Treatment in a physician's office or urgent care facility** ... $150
  (Maximum 4 per year)
- **X-ray or ultrasound** $60

Surgery benefits

- **Anesthesia** ..... $150–$300
- **Connective tissue surgery** ..... $150–$2,200
- **Eye surgery** $400
- **General surgery**
  - **Abdominal, thoracic, or cranial** $2,000
  - **Exploratory surgery** $275
- **Hernia surgery** $400
- **Knee cartilage (meniscus) surgery** ..... $150–$1,050
- **Outpatient surgical facility** $400
- **Ruptured or herniated disc surgery** ..... $150–$2,000

Recovery care benefits

- **At-home care** ..... $125 per day
  (Maximum 5 days)
- **Benefit Booster** $500
- **Physician follow-up visits** $50
  (Maximum 6 days per covered accident and 24 days per calendar year)
- **Rehabilitation or sub-acute rehabilitation unit confinement** ..... $200 per day
  (Maximum 15 days per covered accident and 30 days per calendar year)
- **Therapy services (speech, physical therapy, occupational therapy)** ..... $55 per day
  (Maximum 15 days)

Group Critical Illness Insurance
Plan 1

Colonial Life

Critical illness benefit

COVERED CONDITION[1]	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
Benign brain tumor	100%
Coma	100%
End stage renal (kidney) failure	100%
Heart attack (myocardial infarction)	100%
Loss of hearing	100%
Loss of sight	100%
Loss of speech	100%
Major organ failure requiring transplant	100%
Occupational infectious HIV or occupational infectious hepatitis B, C or D	100%
Stroke	100%
Sudden cardiac arrest	100%
Coronary artery disease	25%

COVERED CONDITION[1]	PERCENTAGE OF APPLICABLE COVERAGE AMOUNT
Cerebral palsy	100%
Cleft lip or palate	100%
Cystic fibrosis	100%
Down syndrome	100%
Spina bifida	100%

Hospital Indemnity

Plan 1 (Monthly Rates)

	Named Insured	Named Insured & Spouse	1-Parent Family	2-Parent Family
17-49	$15.26	$28.17	$21.33	$34.25
50-59	$19.80	$38.88	$25.88	$44.96
60-64	$26.60	$54.00	$32.67	$60.08
65+	$40.19	$81.41	$46.26	$87.48

Benefits Included: Hospital Confinement $1000, Waiver of Premium, Daily Hospital Confinement Benefit, Wellbeing Assistance Standard - $50

Plan 2 (Monthly Rates)

	Named Insured	Named Insured & Spouse	1-Parent Family	2-Parent Family
17-49	$23.72	$43.38	$33.39	$53.06
50-59	$30.78	$60.66	$40.46	$70.34
60-64	$41.99	$86.04	$51.66	$95.72
65+	$61.79	$126.32	$71.46	$135.99

Benefits Included: Hospital Confinement $2000, Waiver of Premium, Daily Hospital Confinement Benefit, Wellbeing Assistance Standard - $50

Colonial Life

Whole Life Plus Insurance*

You can't predict your family's future, but you can prepare for it.

Help give your family coverage for final expenses with Colonial Life Individual Whole Life Plus Insurance.

Benefits and features

- Choose the age when your premium payments end — paid-up at age 70 or paid-up at age 100
- Stand-alone spouse policy available even without buying a policy for yourself
- Ability to keep the policy if you change jobs or retire
- Built-in terminal illness accelerated death benefit that provides up to 75% of the policy's death benefit (up to $150,000) if you're diagnosed with a terminal illness[1]
- Advanced claims payment of $3,000 may be available to the designated beneficiary to help pay for funeral costs or other expenses
- Provides cash surrender value at age 100 (when the policy endows)

Additional coverage options

Spouse term rider

Cover your spouse with a death benefit up to $50,000, for 10 or 20 years.

Juvenile Whole Life Plus policy

Purchase a policy (paid-up at age 70) while children are young and premiums are low — whether or not you buy a policy for yourself. You may also increase the coverage when the child is 18, 21 and 24 without proof of good health.

Children's term rider

You may purchase up to $20,000 in term life insurance coverage for all of your eligible dependent children and pay one premium. The children's term rider may be added to either your policy or your spouse's policy — not both.

Advantages of Whole Life Plus Insurance

- Coverage that stays the same through the life of the policy
- Premiums will not increase due to changes in health or age.
- Accumulates cash value based on a nonforfeiture interest rate of 3.75%[2]
- Policy loans are available with sufficient cash value.
- Benefit for the beneficiary that is typically tax-free

Your cost will vary based on the amount of coverage you select.

Benefits worksheet

For use with your benefits counselor

How much coverage do you need?

☐ YOU $_____

Select the option:

☐ Paid-up at age 70

☐ Paid-up at age 100

☐ SPOUSE $ _____

Select the option:

☐ Paid-up at age 70

☐ Paid-up at age 100

☐ DEPENDENT STUDENT

$ _____

Select the option:

☐ Paid-up at age 70

☐ Paid-up at age 100

Select any optional riders:

☐ Spouse term rider
$ _____face amount
for _____-year term period

☐ Children's term rider
$ _____face amount

☐ Accelerated death benefit for long-term care services rider

☐ Restoration of benefits rider

☐ Accidental death benefit rider

☐ Chronic care accelerated death benefit rider

☐ Critical illness accelerated death benefit rider

☐ Guaranteed purchase option rider

☐ Waiver of premium benefit rider

To learn more, talk with your benefits counselor.

Colonial Life®

ColonialLife.com

Additional coverage options (Continued)

Accelerated death benefit for long-term care services and restoration of benefits riders[3]

Talk with your benefits counselor for more details.

Accidental death benefit rider

An additional benefit may be payable if the covered person dies as a result of an accident before age 70 and doubles if the injury occurs while riding as a fare-paying passenger using public transportation. An additional 25% is payable if the injury occurs while driving or riding in a private passenger vehicle and wearing a seatbelt.

Chronic care accelerated death benefit rider

If a licensed health care practitioner certifies that you have a chronic illness, you may receive an advance on all or a portion of the death benefit, available in a one-time lump sum or monthly payments.[1] Talk with your benefits counselor for more details.

Critical illness accelerated death benefit rider

If you suffer a covered heart attack, stroke or end-stage renal (kidney) failure, a $5,000 benefit is payable.[1] A subsequent diagnosis benefit is included.

Guaranteed purchase option rider

This rider allows you to purchase additional whole life coverage — without having to answer health questions — at three different points in the future. The rider may only be added if you are age 50 or younger when you purchase the policy. You may purchase up to your initial face amount, not to exceed a total combined maximum of $100,000 for all options.

Waiver of premium benefit rider

Policy and rider premiums are waived if you become totally disabled before the policy anniversary following your 65th birthday and you satisfy the six-month elimination period. Once you are no longer disabled, premiums will resume.

* Whole Life Plus is a marketing name of the insurance policy filed as "Whole Life Insurance" in most states.

1 Accelerated death benefit payments will reduce the amount the policy pays upon the covered person's death, may affect the eligibility for public assistance programs and may be taxable. As with all tax matters, individuals should consult a tax advisor to assess the impact of this benefit.

2 Accessing the accumulated cash value reduces the death benefit by the amount accessed unless the loan is repaid. Cash value will be reduced by any outstanding loans against the policy.

3 These riders are not available in all states.

This life insurance does not specifically cover funeral goods or services and may not cover the entire cost of your funeral at the time of your death. The beneficiary of this life insurance may use the proceeds for any purpose, unless otherwise directed.

EXCLUSIONS AND LIMITATIONS: If the insured dies by suicide, whether sane or insane, within two years (one year in ND) from the coverage effective date or the date of reinstatement, we will not pay the death benefit. We will terminate this policy and return the premiums paid without interest, minus any loans and loan interest to you.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. Applicable to policy forms ICC19-IWL5000-70/IWL5000-70, ICC19-IWL5000-100/IWL5000-100, ICC19-IWL5000J/IWL5000J and rider forms ICC23-IWL5000-LTC/IWL5000-LTC, IWL5000-ROB, ICC19-R-IWL5000-STR/R-IWL5000-STR, ICC19-R-IWL5000-CTR/R-IWL5000-CTR, ICC19-R-IWL5000-WP/R-IWL5000-WP, ICC19-R-IWL5000-ACCD/R-IWL5000-ACCD, ICC19-R-IWL5000-CI/R-IWL5000-CI, ICC19-R-IWL5000-CC/R-IWL5000-CC, ICC19-R-IWL5000-GPO/R-IWL5000-GPO (including state abbreviations where applicable, for example IWL5000-100-FL). For cost and complete details of the coverage, call or write your Colonial Life benefits counselor or the company.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC.

Bi-Weekly Employee Contributions

Coverage Tier	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical - Aetna aetna				
Medical Plan	**$0.00**	**$557.40**	**$369.89**	**$903.83**
Dental - Mutual of Omaha Mutual of Omaha				
Dental Plan	**$0.00**	**$13.22**	**$29.92**	**$43.68**
Vision - Mutual of Omaha Mutual of Omaha				
Vision Plan	**$0.00**	**$3.23**	**$3.59**	**$6.96**
Accident - Colonial Life Colonial Life				
Basic Plan	**$3.82**	**$5.81**	**$7.56**	**$9.61**
Premier Plan	**$7.73**	**$12.37**	**$16.86**	**$21.60**

Critical Illness, Short Term Disability, Long Term Disability & Whole Life rates will need to be calculated on a one-on-one basis.

Important Notices About Your Health Plan & Rights

HEALTH CARE REFORM NOTICE

Non-Grandfathered Plan

This group health plan is a non-grandfathered plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As a non-grandfathered plan, the plan sponsor can make changes that reduce benefits or increase costs to consumers. However, these plans gain additional benefits including:

- Coverage of recommended preventive services with no cost sharing; and
- Patient protections such as guaranteed access to OB-GYNs and pediatricians.

All health plans, whether or not they are grandfathered plans, must provide certain benefits to their employees for plan years starting on or after September 23, 2010 including:

- No lifetime limits on coverage for all plans.
- No rescissions of coverage when people get sick and have previously made a mistake on their application
- Extension of parents' coverage to your adults under 26 years of age.
- No coverage exclusions for children with pre-existing conditions; and
- No "restricted" annual limits (e.g. annual dollar-amount limits on coverage below standards to be set in future regulations).

You should contact your plan administrator at (361) 883-1900 EXT 102 if you have any questions. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

PATIENT PROTECTION AND AFFORDABLE CARE ACT 2010 ("PPACA")

Special Enrollment Notice for Dependent Coverage of Children Up To Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Town of Laguna Vista Employee Benefit Plan. Individuals may request enrollment for such children for 30 days from the date of this notice. Enrollment will be effective retroactively to the Plan Year Effective Date. For more information contact your employer or Aetna Insurance Company at 1-800-872-3862.

Special Enrollment Notice for Individuals Who Have Reached Lifetime Limit

The lifetime limit on the dollar value of benefits under Town of Laguna Vista no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact your employer or Aetna Insurance Company at 1-800-872-3862.

IMPORTANT INFORMATION CONCERNING PRE-EXISTING

HIPAA regulations allow an individual to obtain new health coverage regardless of any pre-existing medical conditions, upon "proof of creditable coverage".

Creditable coverage for HIPAA purposes means an individual's coverage under a previous group health plan, individual coverage, Medicare, Medicaid, a public health plan, a medical or dental plan for members of the uniformed services and their dependents, an Indian or tribal organization medical program, a state health risk pool, the Federal Employees Health Benefits program or a Peace

Corps health benefits plan. A college plan is considered creditable coverage, and colleges must provide certification of health insurance coverage to students losing coverage, even temporarily.

Creditable coverage from a previous health plan or policy is used to shorten or waive the pre-existing condition limitation when an individual leaves one plan and joins another. An individual's pre-existing condition exclusion period is reduced or eliminated by such individual's days of creditable coverage if there was not a break in coverage of 63 or more consecutive days. Any waiting period for benefit coverage from an employer must run concurrently with any pre-existing limitation.

HIPAA reduces or eliminates pre-existing condition exclusions depending on the circumstances under which the new employee enters the plan. Group health plans and/or their insurers will not be able to deny employee coverage or apply pre-existing conditions exclusions to individuals who had prior health coverage for at least 12 months.

When enrolling, an individual should present a letter of Creditable Coverage to Aetna Insurance Company in order to satisfy pre-existing requirements of prior coverage. Without this letter of Creditable Coverage, Aetna Insurance Company may assume that there was no prior coverage and initiate an investigation of possible pre-existing claims.

IMPORTANT NOTE: According to the Patient Protection and the Affordable Care Act of 2010 ("PPACA"), pre-existing condition exclusions do not apply for any enrollee under the age of 19 for plan years beginning on or after September 23, 2010.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Your Group Health Plan (the "Plan"), and its selected Third-Party Administrator, Aetna Insurance Company, understands the importance of keeping your personal health information private and is committed to maintaining and protecting the confidentiality of this sensitive information. We are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information and to send you this Notice about our policies, safeguards and practices. When we use or disclose your confidential information, we are bound by the terms of this Notice or our revised notice, if we revise it.

How your personal health information is protected

The Plan is required by law to take reasonable steps to ensure the privacy of your personal health information and to inform you about:

- The Plan's uses and disclosures of Protected Health Information (PHI);
- Your privacy rights with respect to your PHI including;
- Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- The Plan's duties with respect to your PHI;
- The person or office to contact for further information about the Plan's privacy practices.
- The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Uses and disclosures of your PHI

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it. The Plan and its Business Associates will not use your PHI or disclose it to others without your authorization, except for the following purposes:

- **Treatment.** The Plan may disclose your PHI for its provision, coordination or management of your health care and related services. It also includes, but is not limited to, consultations or referrals to one or more of your providers.

Example: The Plan may disclose to a treating orthodontist the name of the participant's treating dentist so that the orthodontist may ask for the dental x-rays from the treating dentist.

- **Payment**. The Plan may disclose your PHI for the payment of your benefits under the Plan. This includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

  Example: The Plan may tell a doctor whether the plan participant is eligible or what percentage of the bill will be paid by the Plan.

- **Health Care Operations.** The Plan may use or disclose your PHI for the health care operations of the Plan. This includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

  Example: The Plan may use information about the participant's claim to refer the participant to a disease management program, project future costs, or audit the accuracy of its claims processing functions.

- **Required by Law.** The Plan must disclose your PHI when required by law.

Individual Rights

- *Right to Request Restrictions on PHI Uses and Disclosures*
  You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

  The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Privacy Officer as identified below.

- *Right to Inspect and Copy PHI*
  You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

  PHI includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

  "*Designated Record Set"* includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analysis and not used to make decisions about individuals is not the designated record set.
  The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.
  You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Privacy Officer as identified below.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the secretary of the U.S. Department of Health and Human Services.

- *Right to Amend PHI*
  You have the right to request the Plan to amend your PHI or request a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

  The plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

  Requests for amendment of PHI in a designated record set should be made to the Privacy Officer as identified below.

- *The Right to Receive an Accounting of PHI Disclosures*
  At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; (4) based on your written authorization.

  If accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

  If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

- *The Right to Receive a Paper Copy of This Notice Upon Request*
  To obtain a paper copy of this Notice contact the Privacy Officer as identified below.

- *A Note About Personal Representatives*
  You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:
    - A power of attorney for health care purposes, notarized by a notary public.
    - A court order of appointment of the person as the conservator or guardian of the individual; or
    - An individual who is the parent of a minor child.

The Plan Duties

The Plan and its Business Associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations.

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning April 14, 2004 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior that

date. If a privacy practice is changed, a revised version of this notice will be provided [to all past and present participants and beneficiaries] for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

- *Minimum Necessary Standard*
  When using or disclosing PHI or when requesting PHI for another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount or PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

  However, the minimum necessary standard will not apply in the following situations:
  - Disclosures to or request by a health care provider for treatment.
  - Uses or disclosures made to individual.
  - Disclosures made to the Secretary of the U.S. Department of Health and Human Services.
  - Uses or disclosures that are required by law.
  - Uses or disclosures that are required for the Plan's compliance with legal regulations

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. De-identifiable information is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summaries the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

If you want more information about your privacy rights, do not understand your privacy rights, are concerned that the Plan has violated your privacy rights or disagree with a decision that the Plan has made about access to your confidential information, you may contact the Plan's Privacy Officer Privacy Officer. You may also file written complaints with the Secretary of the U.S. Department of Health and Human Services. Please call the Plan's Privacy Officer to obtain the correct address for the Secretary. The Plan will not take any action against you if you file a complaint with the Secretary against the Plan.

You may contact the Plan's Privacy Officer at:
Town of Laguna Vista
122 Fernandez Street
Laguna Vista, TX | 78578
956-943-1793

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 codes of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

GENERAL NOTICE OF SPECIAL ENROLLMENT RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your group health plan is required to provide you this notice explaining your group health plan's procedures for your special enrollment rights

Your 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 towards 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).

In addition, 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.

You or your spouse or dependents may also have special enrollment rights in another group health plan at the time a claim is denied as a result of a lifetime limit on all benefits, if you request enrollment within 30 days after the claim has been denied.

Contact your plan administrator to request a special enrollment.

CONTINUATION COVERAGE RIGHTS UNDER COBRA (General Notice)
Introduction:

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

Town of Laguna Vista
122 Fernandez Street
Laguna Vista, TX | 78578
956-943-1793

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep 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.

IMPORTANT NOTICE FROM TOWN OF LAGUNA VISTA TECHNOLOGIES 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 Town of Laguna Vista Employee Health Plan and 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. Aetna Insurance Company has determined that the prescription drug coverage offered by Town of Laguna Vista 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 Aetna Insurance Company coverage may be affected. Town of Laguna Vista Employee Benefit Plans provide prescription coverage for certain covered medications. The prescription coverage for the adopted Aetna Insurance Company Plans is considered creditable. Further details of your prescription coverage can be found in your Summary of Benefits and Coverage document. If you do decide to join a Medicare drug plan and drop your current Town of Laguna Vista coverage, be aware that you and your dependents may be able to get this coverage back at our next open enrollment or upon a qualifying event.

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 Town of Laguna Vista 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) if and for 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 human resources for further information or call Aetna (1-800-872-3862) (. **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 Town of Laguna Vista 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).

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Federal law (Newborns' and Mothers' Health Protection Act of 1966) prohibits the plan from limiting a mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery for from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

NOTICE OF THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

On October 21, 1998 the federal government passed the Women's Health and Cancer Rights Act of 1998 (WHCRA). As part of the Plan's compliance with the WHCRA, the Plan is required to provide you with this notice outlining the coverage that this law requires the Plan to provide.

The Plan provides coverage for medically necessary mastectomies. This coverage includes procedures to reconstruct the breast, on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. As a result of WHCRA, the Plan also provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance and any complications that could result from that surgery.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed;
3. Prostheses; and
4. Treatment of physical complications resulting from any stage of the mastectomy, including lymphedema.

These benefits are subject to the same deductible, co-pays and coinsurance that apply to other medical and surgical benefits provided under this plan.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –

<table>
<tr><td>ALABAMA – Medicaid</td><td>COLORADO – Medicaid</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov

Phone: 1-855-692-5447</td><td rowspan="2">Medicaid Website: http://www.colorado.gov/

Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/

Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529</td><td></td></tr>
<tr><td>ARIZONA – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/

Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid

Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)

Phone: 1-800-869-1150</td></tr>
<tr><td>IDAHO – Medicaid and CHIP</td><td>MONTANA – Medicaid</td></tr>
<tr><td>Medicaid Website: www.accesstohealthinsurance.idaho.gov

Medicaid Phone: 1-800-926-2588</td><td>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml

Phone: 1-800-694-3084</td></tr>
</table>

CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone:1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

After key parts of the health care law took effect in 2014, there became a new 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 new 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 new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November and continues through February of each year.

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 9.5% 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.[1]

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 Human Resources. For more information on the Marketplace, please visit www.healthcare.gov.

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

[1] 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.

Notes


Valley Risk
Consulting
Risk Management & Insurance Services