



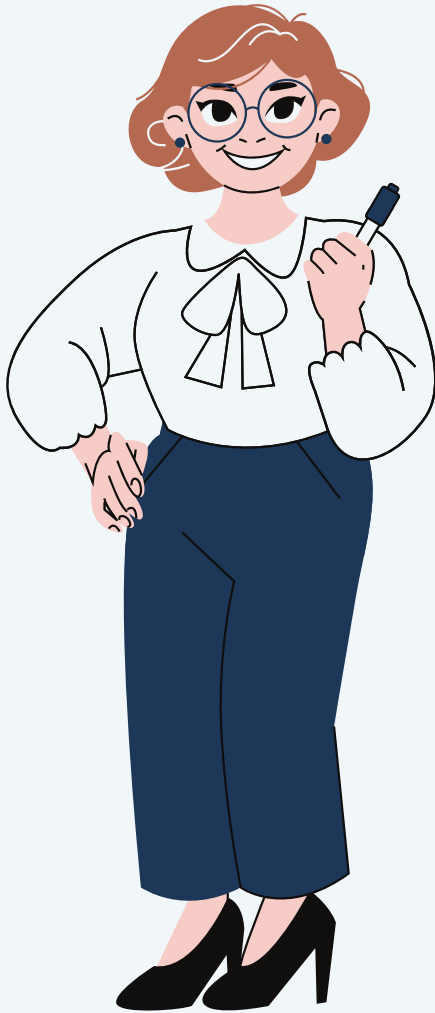
# Webb County Benefit Guide



*A Guideline to your benefits at Webb County*



# Welcome Message



At Webb County, we recognize that our employees are the foundation of our success. Your dedication and service to our community deserve the highest level of support, both at work and in your personal life. That is why we are proud to offer a comprehensive benefits package designed to protect your health, financial well-being, and future.

This guide was created to help you understand the benefits available to you and your family for the 2025 plan year. Inside, you will find details about medical, dental, and vision coverage, life and disability protection, voluntary plans that help you prepare for life's unexpected events, and valuable county-paid resources to keep you and your family thriving.

We encourage you to review this guide carefully, explore your options, and take full advantage of the benefits Webb County provides. Together, we can build a stronger, healthier community that continues to thrive and serve with pride.



***"Our commitment to you extends beyond your workday. It is about helping you live well, plan confidently, and protect what matters most."***



*Please review all sections carefully, and use the QR codes provided throughout the guide for quick access to detailed plan documents and resources.*

# Your Benefit terms.



## **1** Deductible

The amount you must pay out-of-pocket for covered healthcare services before your insurance begins contributing. For example, if you have the Core and it has a \$1,500 deductible, you are responsible for paying the first \$1,500 of eligible expenses. Once this amount is met, you generally pay only co-pays or coinsurance, and your insurance covers the remaining costs.

## **3** Coinsurance

The percentage of costs you are responsible for after meeting your deductible. For example, if your plan covers 80% of a service, you will pay the remaining 20%.

## **2** Co - Pay

A flat fee you pay for certain covered services at the time you receive care. The amount depends on the type of service, such as an office visit, urgent care visit, or prescription medication.

## **4** Out-of-pocket Maximum

The highest total amount you will pay in a plan year for covered healthcare services. This includes deductibles, co-pays, and coinsurance for in-network care. Once you reach this limit, your plan pays 100% of covered expenses for the rest of the year.



# Aetna Medical Plans

Your health is important. Webb County partners with Aetna to provide affordable and flexible medical options that fit your needs and your family's lifestyle. All plans include nationwide access to providers, preventive care at no cost, and prescription drug coverage.

## 2026 AETNA MEDICAL INSURANCE

AETNA HEALTH PLANS	AETNA Choice POS II / Base Plan Plan B	Consumer Driven Health Plan (CDHP)
Annual Deductible	\$1,250 per Individual / \$2,500 per Family In-Network \$4,000 per Individual / \$8,000 per Family Out-of-Network	\$3,500 per Individual / \$7,000 per Family In-Network \$7,000 per Individual / \$14,000 per Family Out-of-Network
<b>Coinsurance</b>	20% In-Network 50% Out-of-Network	You pay 100% In-Network You pay 30% Out-of-Network
Annual Max Out of Pocket: Individual/Fam Cap (MOOP) MOOP = Med Services Max + Deductible + Rx Max	\$7,000 per Individual / \$17,500 In-Network \$30,000 per Individual / \$60,000 Out-of-Network	\$3,500 per Individual / \$7,000 In-Network \$30,000 per Individual / \$60,000 Out-of-Network
<b>MEDICAL SERVICES</b>		
<b>Hospital Services</b>		
In-Patient	20% after deductible In-Network 50% after deductible Out-of-Network	100% after deductible In-Network 30% after deductible Out-of-Network
Out-Patient	20% after deductible In-Network 50% after deductible Out-of-Network	100% after deductible In-Network 30% after deductible Out-of-Network
<b>Physician Office Visit</b>		
Office Visit Copay (PCP/Specialist/Urgent)	<b>\$25/\$35/\$35</b>	Covered 100% after deductible In-Network 30% after deductible Out-of-Network
Allergy Injections	Your cost sharing amount depends on the type of service and where you receive it for In-Network 50% after deductible Out-of-Network	100% when an office visit charge is not applicable In-Network 30% after deductible Out-of-Network
Diagnostic Laboratory	Covered 100%; deductible waived In-Network 50%; no deductible Out-of-Network	Covered 100% after deductible In-Network 30% after deductible Out-of-Network
X-Rays	20%; no deductible, no co-pay In-Network 50%; no deductible Out-of-Network	Covered 100% after deductible In-Network 30% after deductible Out-of-Network
Diagnostic Outpatient Complex Imaging	20%; no deductible, no co-pay In-Network 50%; no deductible Out-of-Network	Covered 100% after deductible In-Network 30% after deductible Out-of-Network
Preventive Care	Covered 100%; no deductible In-Network 30% after deductible Out-of-Network	Covered 100% after deductible In-Network 30% after deductible Out-of-Network
ER Visit * Copay Waived if Admitted <i>Non-Emergency Care in ER - NOT covered</i>	20%: after deductible; \$500 copay Not Covered - Out-of-Network	Covered 100% after deductible In-Network Same as in-network care Out-of-Network
Home Health Care	20%; after deductible In-Network 50%; after deductible Out-of-Network	Covered 100% after deductible In-Network 30% after deductible Out-of-Network

# Aetna Medical Plans

Other Medical Services	100%: no deductible In-Network 30%: after deductible Out-of-Network	Covered 100% after deductible In-Network 30% after deductible Out-of-Network		
<b>PRESCRIPTION DRUGS</b>				
Retail Pharmacy-30 day supply Generic/ Preferred Brand / Non-Preferred Brand / Specialty	<b>\$10 / \$30 / \$60 / \$40</b>	\$0 after deductible In-Network, 30% of submitted cost; after applicable in-network cost share / Out-of-Network  Prescription drug expenses apply to your medical deductible. Affordable Care Act mandated female contraceptive and preventative medications covered 100% in-network.		
Retail or Mail Order 31-90 day supply Generic/ Preferred Brand / Non-Preferred Brand / Specialty	<b>\$30 / \$60 / \$100 / \$60</b>			
<b>Employee Contribution</b>				
<b>AETNA RATES EFFECTIVE 01/01/2026</b>	<b>Monthly Premium</b>	<b>Bi-Weekly Premium</b>	<b>Monthly Premium</b>	<b>Bi-Weekly Premium</b>
Employee only	\$71.32	\$32.92	\$6.57	\$3.03
Employee & Spouse	\$557.00	\$257.08	\$405.59	\$187.20
Employee & Children	\$270.97	\$125.06	\$143.30	\$66.14
Family	\$615.86	\$284.24	\$452.51	\$208.85
*This is a brief outline for comparison only. *Note: Bi-weekly premiums are for 26 pp only. Please consult with Employee Benefits Department for different variations.				

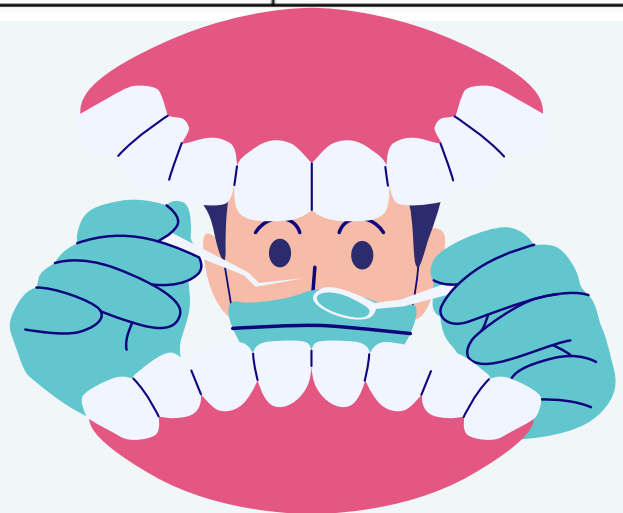


# Aetna Dental - Base Plan

Keeping your smile healthy is an important part of your overall well-being. Webb County offers two Aetna Dental PPO plans that make it easy to access preventive and restorative care. Both plans allow you to visit any licensed dentist, but you'll save more when you choose one in the Aetna network.

	Base Plan	Buy up Plan
Individual	\$75	\$50
Family	\$150	\$150
Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Annual Benefit Maximum	\$750	\$1,000
Office Visit Copay	N/A	N/A
Orthodontic Services ( Child Only)	50%	50%
Orthodontic Deductible	None	None
Orthodontic Lifetime Maximum	\$750	\$1,000

Dental Insurance Employee Bi-weekly Deductions		
	Base Plan	Buy-up Plan
Employee Only	\$5.00	\$13.29
Employee & Spouse	\$14.39	\$22.89
Employee & Children	\$10.80	\$22.89
Employee, Spouse & Children	\$22.89	\$36.33



# Aetna Vision Plan - Premiums

Frequency (Exam/Frame/Lens): 12/12/12 Standard Plan AVP 888657 - Package A	In Network Member Cost Aetna Vision Network	Out of Network Member Reimbursement*
<b>Exam</b>		
<b>Use your Exam Coverage once every Calendar Year</b>		
Eye Exam with Dilation as Necessary	\$10 Copay	\$20 Reimbursement
Retinal Imaging	Member pays discounted fee of \$39	Not Covered
Standard Contact Lens Fit /Follow Up <sup>1</sup>	Member pays discounted fee of \$40	Not Covered
Premium Contact Lens Fit /Follow Up <sup>1</sup>	10% off Retail Price	Not Covered
<b>Frames</b>		
<b>Use your Frame Coverage once every Calendar Year</b>		
Any Frame available, including frames for prescription sunglasses	\$0 Copay; \$150 Allowance**, 20% off balance over allowance	\$80 Reimbursement
<b>Standard Plastic Lenses</b>		
<b>Use your Lens/Lens Option Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses</b>		
Single Vision	\$25 Copay	\$35 Reimbursement
Bifocal	\$25 Copay	\$55 Reimbursement
Trifocal	\$25 Copay	\$90 Reimbursement
Lenticular	\$25 Copay	\$90 Reimbursement
Standard Progressive Lens (copay includes bifocal cost)	\$90 Copay	\$55 Reimbursement
Premium Progressive Lens (copay includes bifocal cost) <sup>2</sup>	\$90 Copay; 80% of Charge less \$120 allowance**	\$55 Reimbursement
<b>Lens Options</b>		
UV Treatment	Member pays discounted fee of \$15	Not Covered
Tint (Solid And Gradient)	Member pays discounted fee of \$15	Not Covered
Standard Plastic Scratch Coating	Member pays discounted fee of \$15	Not Covered
Polycarbonate Lenses - Adult	Member pays discounted fee of \$40	Not Covered
Polycarbonate Lenses - Children to age 19	Member pays discounted fee of \$40	Not Covered
Standard Anti-Reflective Coating	Member pays discounted fee of \$45	Not Covered
Photochromic/Transitions Plastic - Adult	20% off Retail	Not Covered
Photochromic/Transitions Plastic - Child to age 19	20% off Retail	Not Covered
Other Add-Ons	20% off Retail Price	Not Covered
<b>Contact Lenses</b>		
<b>Use your Contact Lens Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses</b>		
Conventional	\$0 Copay; \$150 Allowance**, 15% off balance over allowance	\$120 Reimbursement
Disposable	\$0 Copay; \$150 Allowance	\$120 Reimbursement
Medically Necessary	Covered in Full	\$205 Reimbursement



# HSA vs FSA

## HSA

A Health Savings Account (HSA) is a personal savings account that allows you to set aside pre-tax dollars to pay for qualified medical, dental, and vision expenses. You must be enrolled in a High Deductible Health Plan (HDHP) to participate. Funds roll over from year to year and remain yours even if you change jobs or retire.

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## FSA

A Flexible Spending Account (FSA) also lets you use pre-tax dollars for eligible medical, dental, and vision expenses. However, unlike an HSA, an FSA is upfoted and must be used by the end of the plan year.

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## Note

Both **HSAs** and **FSAs** help you pay for qualified health care expenses with pre-tax dollars, but they differ in flexibility, ownership, and long-term benefits.



# HSA - Inspira

## Key Benefits

- **Portability** – You own the account; funds remain yours even if you leave employment or retire.
- **Rollover** – Unused funds roll over each year with no expiration.
- **Online Access** – Inspira’s online portal allows you to manage contributions, view balances, and set up auto-investment features.

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## Contribution Information

IRS Annual Contribution Limit: **\$4,400**  
Employer One-Time Lump Sum: **\$900**

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## Eligible Expenses

Funds can be used for qualified medical, dental, and vision expenses such as:

- Doctor visits, copayments, and prescriptions
- Dental care, orthodontia, and crowns
- Vision exams, eyeglasses, and contact lenses
- Medical equipment and supplies

Generally not eligible: personal hygiene products, cosmetic procedures, vitamins, or fitness memberships unless prescribed by a medical professional.



**inspira**  
FINANCIAL

# FSA - NBS

## Key Benefits

- **Tax Savings** - Contributions are made before taxes, reducing your taxable income.
- **Immediate Access** - Your full annual election amount is available on the first day of the plan year.
- **Convenient Spending** - Access your funds using your NBS benefits card or reimbursement portal.
- **Wide Coverage** - Eligible expenses include most out-of-pocket medical, dental, and vision costs.

## Important Details

- Funds must generally be used within the plan year (“use it or lose it” rule).
- 90 day grace period
- Accounts are not portable and do not transfer if you change employers.

## Contribution Information (2026)

IRS Annual Contribution Limit: **\$3,400**  
Employer Contribution: May vary based on plan design.  
Unused Funds: Amounts not rolled over or used by year-end are forfeited.



# **Basic Life and AD&D Insurance**

*The Standard*

## **Basic Life and AD&D - Employer Paid**

Life insurance is an important part of your financial security. Webb County provides eligible employees with Basic Life and Accidental Death & Dismemberment (AD&D) coverage through The Standard at no cost to you. This coverage helps protect your loved ones in the event of your death or a serious injury.

Coverage Type	Benefit Amount
Employee	\$40,000
Accidental Death & Dismemberment (AD&D)	\$40,000

## **Key Features**

- 100 percent County-paid coverage for all eligible employees
- Guaranteed coverage - no medical questions or exams required
- Conversion and portability options available if your employment ends
- Additional payouts for certain accidental losses such as dismemberment, loss of sight, or paralysis.

## **Eligibility**

- All active, full-time employees working 40 or more hours per week are automatically covered on the first day of the month following their date of hire.

## **Beneficiary Designation**

- You may choose one or more beneficiaries to receive your life insurance benefit. Be sure to review and update your beneficiary information after major life events such as marriage, divorce, or the birth of a child.



# Additional Life Insurance

## The Standard

### ? About This Coverage

If you take no action you'll be covered under Basic Life insurance provided you meet the eligibility requirements. Consider whether that would be enough to help your family meet daily expenses, maintain their standard of living, pay off debt and fund your children's education. If not, you may want to apply for additional coverage now.

<p><b>How Much Can I Apply For?</b></p> <p>Your combined Basic Life and Additional Life amounts cannot exceed a maximum of 8 times your annual earnings. The coverage amount for your spouse cannot exceed 50 percent of your Additional Life coverage. The coverage amount for your child(ren) cannot exceed 100 percent of your Additional Life coverage.</p>	<p>For You: <b>\$10,000 – \$300,000</b> in increments of <b>\$10,000</b></p> <p>For Your Spouse: <b>\$5,000 – \$150,000</b> in increments of <b>\$5,000</b></p> <p>For Your Child(ren): <b>\$5,000 or \$10,000</b></p>
<p><b>What is the Guarantee Issue Maximum?</b></p> <p>Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions.</p> <p>To apply for an amount over the guarantee issue, visit <a href="https://myeoi.standard.com/170802">https://myeoi.standard.com/170802</a> to complete and submit a medical history statement online.</p>	<p>For You: Up to <b>\$200,000</b></p> <p>For Your Spouse: Up to <b>\$10,000</b></p>

See the Important Details section for more information, including requirements, exclusions, limitations, age reductions and definitions.

<p><b>Accelerated Benefit</b></p>	<p>If you become terminally ill, you may be eligible to receive up to 75 percent of your combined Basic and Additional Life benefit to a maximum of \$500,000.</p>
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Your Age (as of January 1)	Your Rate (Per \$1,000 of Total Coverage)	Your Spouse's Age (as of January 1)	Your Spouse's Rate (Per \$1,000 of Total Coverage)
<30	\$0.05	<30	\$0.05
30–34	\$0.06	30–34	\$0.06
35–39	\$0.07	35–39	\$0.07
40–44	\$0.09	40–44	\$0.09
45–49	\$0.15	45–49	\$0.15
50–54	\$0.23	50–54	\$0.23
55–59	\$0.38	55–59	\$0.38
60–64	\$0.52	60–64	\$0.52
65–69	\$0.88	65–69	\$0.88
70+	\$1.68	70+	\$1.68



# Hospital Indemnity

*The Hartford*

A Hospital Indemnity plan will help provide you and your family with a lump sum cash benefit to help cover qualified expenses associated with an unexpected hospital stay. Select a plan below to help safeguard your financial security in the event of an extended hospitalization.

PLAN INFORMATION		PLAN 1	PLAN 2
Coverage Type		On and off-job (24 hour)	On and off-job (24 hour)
Covered Events		Illness and injury	Illness and injury
HSA Compatible		Yes	Yes
BENEFITS		PLAN 1	PLAN 2
HOSPITAL CARE <sup>2</sup>		PLAN 1	PLAN 2
First Day Hospital Confinement	Up to 5 days per year	\$750	\$1,250
Daily Hospital Confinement (Day 2+)	Up to 15 days per year	\$100	\$150
First Day ICU Confinement	Up to 5 days per year	\$1,500	\$2,500
Daily ICU Confinement (Day 2+)	Up to 15 days per year	\$200	\$300
FAMILY CARE		PLAN 1	PLAN 2
Health Screening	Up to 1 day per year	\$75	\$75
ADDITIONAL CARE		PLAN 1	PLAN 2
Newborn Routine Hospital Care	Once per newborn Dependent Child	\$250	\$500
FEATURES		PLAN 1	PLAN 2
Ability Assist® EAP <sup>3</sup> – 24/7/365 access to help for financial, legal or emotional issues		Included	Included
HealthChampion <sup>SM4</sup> – Administrative & clinical support following serious illness or injury		Included	Included

COVERAGE TIER	PLAN 1	PLAN 2
Employee Only	\$8.92	\$14.05
Employee & Spouse/Partner	\$18.24	\$28.68
Employee & Child(ren)	\$15.34	\$24.10
Employee & Family	\$25.72	\$40.40



# Short-Term Disability (STD)

## 🔗 About This Coverage

See the Important Details section for more information, including requirements, exclusions and definitions.

### What Your Benefit Provides

This is the benefit you'd receive if you were to suffer a qualifying disability. Eligible earnings are your weekly insured predisability earnings, as defined by the group policy. Your benefit amount will be reduced by deductible income; see the Important Details section for a list of deductible income sources.

**60%** of your eligible earnings, up to a maximum benefit of **\$1,000** per week. Plan minimum **\$15** per week.

### Benefit Waiting Period

If you suffer a qualifying disability, your benefit waiting period is the length of time you must be continuously disabled before you can begin receiving your weekly benefit.

14 days for accidental injury  
14 days for physical disease, pregnancy or mental disorder

### Extended Benefit Waiting Period

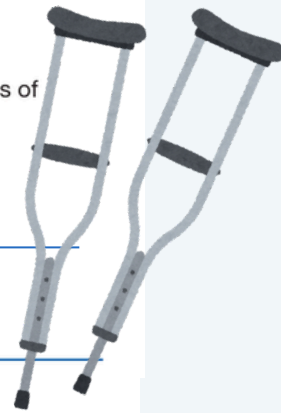
This applies if you do not apply for this coverage within 31 days of becoming eligible, were eligible for coverage under a prior plan for more than 31 days but were not insured, or if your insurance ends because you failed to pay your premium and is later reinstated.

60 days for any qualifying disability caused by physical disease, pregnancy or mental disorder occurring during the first 12 months of coverage.

### How Long Your Benefits Last

This is the maximum length of time you could be eligible to receive a weekly disability benefit.

90 days



## 💰 How Much Your Coverage Costs

Because this insurance is offered through Webb County, you'll have access to competitive group rates that may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and benefit amount.

Use this formula to calculate your premium payment:

$$\underline{\hspace{2cm}} \times 0.60 \times \underline{\hspace{2cm}} \div 10 = \underline{\hspace{2cm}}$$

Enter your weekly earnings (cannot be more than \$1,667).      Enter your rate from the rate table.      This amount is an estimate of how much you'd pay each month.

Your Age (as of January 1)	Rate per \$10 of weekly benefit
<25	\$0.476
25-29	\$0.523
30-34	\$0.441
35-49	\$0.371
50-54	\$0.441
55-59	\$0.566
60-64	\$0.687
65+	\$0.761

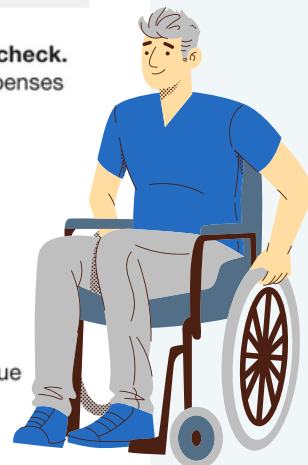
### Not being able to work also means not being able to earn a paycheck.

As you consider Short Term Disability insurance, think about the expenses you would need to cover if you were to become disabled:

- Mortgage or rent
- Utilities
- Groceries
- Medical bills
- Car insurance
- Childcare costs

To estimate your insurance needs, you'll need to consider your unique circumstances.

Use our online calculator at [www.standard.com/disability/needs](http://www.standard.com/disability/needs).



# Long-Term Disability (LTD)

## The Standard

### ? About This Coverage

See the Important Details section for more information, including requirements, exclusions and definitions.

#### What Your Benefit Provides

This is the amount per month you would receive if you were to suffer a qualifying disability. Eligible earnings are your monthly insured predisability earnings, as defined by the group policy. Your monthly benefit will be reduced by deductible income. Please see the Important Details section for a list of deductible income sources.

**60%** of your eligible earnings, up to a maximum benefit of **\$10,000** per month.  
Plan minimum per month: **\$100.**

#### Benefit Waiting Period

If you experience a qualifying disability, your benefit waiting period is the length of time you must be continuously disabled before you become eligible to receive your monthly benefit

90 days

#### How Long Your Benefits Last

This is the maximum length of time you could be eligible to receive disability benefits for a continuous disability.

**Option 1:** For five years

Depending on your age at the time of disability, your benefits may be subject to a different schedule. Refer to the "Maximum Benefit Period" table in the Important Details section for specifics.

**Option 2:** Until your Social Security Normal Retirement Age (SSNRA)

Depending on your age at the time of disability, your benefits may be subject to a different schedule. Refer to the "Maximum Benefit Period" table in the Important Details section for specifics.



### ≡ Additional Features

Your coverage comes with some added features:

#### Help with Returning to Work

This plan provides incentives to help you get back to work. For instance, you'll get help paying for some of the expenses associated with participating in an approved rehabilitation plan.

If a worksite modification would enable you to return to work, the coverage can help your employer make approved modifications.

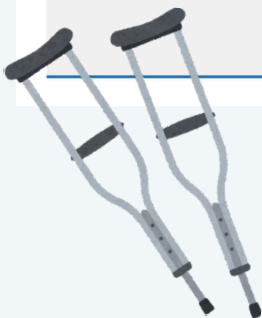
You may also be eligible to receive an additional benefit of 10 percent of your predisability earnings for participating in an approved rehabilitation plan, subject to the plan maximum.

#### Survivors Benefit

If you die while receiving benefits, your survivor may be eligible to receive a one-time additional payment.

#### Support When You Need It

You'll have access to an Employee Assistance Program, a valuable confidential counseling resource if you're experiencing personal or work-related issues. This service is provided through an arrangement with a service provider who is not affiliated with The Standard.



# Long-Term Disability (LTD)

*Continued*

## How Much Your Coverage Costs

Because this insurance is offered through Webb County, you'll have access to competitive group rates that may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and benefit amount.

Use this formula to calculate your premium payment:

$$\text{_____} \times \text{_____} \div 100 = \text{_____}$$

Enter your monthly earnings (cannot be more than \$16,667).      Enter your rate from the rate table.      This amount is an estimate of how much you'd pay each month.

Your Age (as of January 1)	Rate Percentage Option 1 / Option 2
<25	0.168 / 0.217
25-29	0.196 / 0.245
30-34	0.273 / 0.364
35-39	0.420 / 0.630
40-44	0.567 / 0.896
45-49	0.679 / 1.043
50-54	1.001 / 1.386
55-59	1.386 / 1.638
60-64	1.519 / 2.079
65-69	0.812 / 1.386
70+	0.581 / 0.539

As you consider Long Term Disability insurance, evaluate what makes sense for you.

Getting by without a paycheck isn't easy, especially for an extended period of time. Make sure you have enough financial protection to help you cover your housing costs, utilities and other bills.

To estimate your insurance needs, you'll need to consider your unique circumstances.

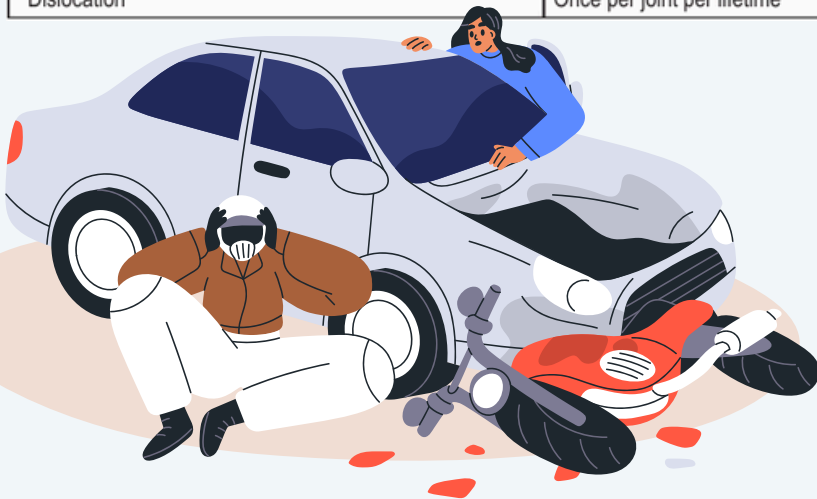
Use our online calculator at [www.standard.com/disability/needs](http://www.standard.com/disability/needs).



# The Hartford Accident Insurance

With Accident Insurance, you'll receive payments associated with a covered injury and related services. You can use the payment in way you choose - from expenses not covered by your major medical plan to day-to-day costs of living such as the mortgage or your utility bills.

PLAN INFORMATION		LOW PLAN	HIGH PLAN
Coverage Type		On and off-job (24 hour)	On and off-job (24 hour)
BENEFITS		LOW PLAN	HIGH PLAN
EMERGENCY, HOSPITAL & TREATMENT CARE			
Accident Follow-Up	Up to 3 visits per accident	\$75	\$100
Acupuncture/Chiropractic Care/PT	Up to 10 visits each per accident	\$25	\$50
Ambulance – Air	Once per accident	\$800	\$1,100
Ambulance – Ground	Once per accident	\$250	\$400
Blood/Plasma/Platelets	Once per accident	\$200	\$300
Child Care	Up to 30 days per accident while insured is confined	\$25	\$35
Daily Hospital Confinement	Up to 365 days per lifetime	\$125	\$225
Daily ICU Confinement	Up to 30 days per accident	\$250	\$450
Diagnostic Exam	Once per accident	\$125	\$225
Emergency Dental	Once per accident	Up to \$300	Up to \$450
Emergency Room	Once per accident	\$75	\$125
Health Screening Benefit	Once per year for each covered person	\$50	\$50
Hospital Admission	Once per accident	\$600	\$1,200
Initial Physician Office Visit	Once per accident	\$50	\$75
Lodging	Up to 30 nights per lifetime	\$125	\$225
Medical Appliance	Once per accident	\$250	\$500
Rehabilitation Facility	Up to 15 days per lifetime	\$125	\$225
Transportation	Up to 3 trips per accident	\$400	\$600
Urgent Care	Once per accident	\$50	\$75
X-ray	Once per accident	\$50	\$50
SPECIFIED INJURY & SURGERY		LOW PLAN	HIGH PLAN
Abdominal/Thoracic Surgery	Once per accident	\$1,100	\$2,200
Arthroscopic Surgery	Once per accident	\$250	\$500
Burn	Once per accident	Up to \$6,000	Up to \$11,000
Burn – Skin Graft	Once per accident for third degree burn(s)	50% of burn benefit	50% of burn benefit
Concussion	Up to 3 per year	\$200	\$400
Dislocation	Once per joint per lifetime	Up to \$3,500	Up to \$6,500



# The Hartford Accident Insurance

You have a choice of two accident plans, which allows you the flexibility to enroll for the coverage that best meets your needs. This insurance provides benefits when injuries, medical treatment and/or services occur as the result of a covered accident. Unless otherwise noted, the benefit amounts payable under each plan are the same for you and your dependent(s).

Eye Injury	Once per accident	Up to \$300	Up to \$400
Fracture	Once per bone per accident	Up to \$3,500	Up to \$6,500
Hernia Repair	Once per accident	\$200	\$400
Joint Replacement	Once per accident	\$500	\$1,000
Knee Cartilage	Once per accident	Up to \$600	Up to \$800
Laceration	Once per accident	Up to \$225	Up to \$450
Ruptured Disc	Once per accident	\$600	\$800
Tendon/Ligament/Rotator Cuff	Once per accident	Up to \$1,200	Up to \$1,500
<b>CATASTROPHIC</b>		<b>LOW PLAN</b>	<b>HIGH PLAN</b>
Accidental Death	Within 90 days; Spouse @ 50% and child @ 25%	\$30,000	\$60,000
Common Carrier Death	Within 90 days	3 times death benefit	3 times death benefit
Coma	Once per accident	\$10,000	\$15,000
Dismemberment	Once per accident	Up to \$30,000	Up to \$60,000
Home Health Care	Up to 30 days per accident	\$50	\$75
Paralysis	Once per accident	Up to \$12,000	Up to \$52,000
Prosthesis	Once per accident	Up to \$1,200	Up to \$2,400
<b>FEATURES</b>		<b>LOW PLAN</b>	<b>HIGH PLAN</b>
Ability Assist® EAP <sup>2</sup> – 24/7/365 access to help for financial, legal or emotional issues		Included	Included
HealthChampion <sup>SM3</sup> – Administrative & clinical support following serious illness or injury		Included	Included

## PREMIUMS

The amounts shown are monthly amounts (12 payments/deductions per year):<sup>4</sup>

COVERAGE TIER	LOW PLAN	HIGH PLAN
Employee Only	\$3.26 (\$0.11 per day)	\$5.47 (\$0.18 per day)
Employee & Spouse/Partner	\$5.14 (\$0.17 per day)	\$8.61 (\$0.28 per day)
Employee & Child(ren)	\$5.58 (\$0.18 per day)	\$9.45 (\$0.31 per day)
Employee & Family	\$8.72 (\$0.29 per day)	\$14.73 (\$0.48 per day)



# Critical Illness Insurance

Critical Illness coverage from The Hartford provides a lump-sum cash payment if you are diagnosed with a covered condition such as cancer, heart attack, or stroke.

COVERAGE AMOUNT	
Employee Coverage Amount	\$15,000 or \$30,000
Spouse Coverage Amount	100% of your coverage amount
Child(ren) Coverage Amount	100% of your coverage amount
COVERED ILLNESSES	BENEFIT AMOUNTS
CANCER CONDITIONS	
Invasive Cancer*	100% of coverage amount
Non-invasive Cancer	25% of coverage amount
VASCULAR CONDITIONS	
Heart Attack (Myocardial Infarction)*; Heart Failure/Transplant*; Stroke*	100% of coverage amount
Coronary Artery Bypass Graft	100% of coverage amount
OTHER SPECIFIED CONDITIONS	
End Stage Renal Failure; Major Organ Failure Transplant*	100% of coverage amount
Other Dread Diseases†	25% of coverage amount
NEUROLOGICAL CONDITIONS	
Advanced Multiple Sclerosis	50% of coverage amount
Advanced Parkinson's	50% of coverage amount
Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's)	50% of coverage amount
Alzheimer's Disease	100% of coverage amount
CHILD CONDITIONS	
Cerebral Palsy; Congenital Heart Disease; Cystic Fibrosis; Muscular Dystrophy; Spina Bifida;	100% of coverage amount
ADDITIONAL BENEFITS	
BENEFIT AMOUNTS	
Recurrence – Pays a benefit for a subsequent diagnosis of conditions marked with an asterisk (*)	100% of original benefit amount
Health Screening Benefit	\$75 once per year per covered person
FEATURES	DETAILS
Coverage Maximum – Primary Insured & Spouse	500% of coverage amount
Coverage Maximum – Child(ren)	300% of coverage amount
Ability Assist® EAP <sup>3</sup> – 24/7/365 access to help for financial, legal or emotional issues	



# Accidental Death & Dismemberment

Accidental Death & Dismemberment insurance helps protect against the sudden financial loss often brought on by an accidental death. It can also help you pay for unexpected expenses associated with surviving an accident that results in a severe physical loss. You can elect to cover your eligible spouse and children as well.

## ? About This Coverage

### How Much Can I Apply For?

Note: You can't buy more coverage for your spouse and child(ren) than you buy for yourself.

For You: **\$5,000 – \$300,000** in increments of **\$5,000**

### For Your Family:

Spouse Only: 60% of your AD&D coverage amount

Child only: 15% of your AD&D coverage amount for each child

Spouse and Children: 50% of your AD&D coverage amount  
10% of your AD&D coverage amount for each child

See the Important Details section for more information, including requirements, exclusions, age reductions and definitions.

Your coverage comes with some added features:

### Seat Belt and Air Bag Benefits

The Standard may pay an additional benefit if you die while wearing a seat belt, provided certain conditions are met. If the car's air bags deploy during an accident, an air bag benefit may also be payable.

### Family Benefits Package

This package is designed to help surviving family members maintain their standard of living and pursue their dreams. Included in the package are benefits to help with child care, career adjustment for your spouse and higher education for your children.

## \$ How Much Your Coverage Costs

Because this insurance is offered through Webb County, you'll have access to competitive group rates. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on the benefit amount you elect.

### Use this formula to calculate your premium payment:

$$\frac{\text{Enter the amount of AD\&D coverage you're requesting (see benefit amounts in the About This Coverage section).}}{\text{\$1,000}} = \text{_____} \times \text{Enter your rate from the rate table.} = \text{_____}$$

This amount is an estimate of how much you would pay each month.

If you buy coverage for your family (spouse and children), your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use the appropriate rate for the premium you are calculating.





# **Accidental Death & Dismemberment**



**If you have any questions about your benefits, please don't hesitate to reach out.**

**Address:  
1110 Washington St. Suite 305  
Laredo, Texas 78040**

**Phone: 956-523-4143  
Fax: 956-523-5012  
Mon-Fri 8am - 5pm**



 **Thank you!**



If you need any help regarding your benefits our Employee Navigator contact us!

**Address:** 702 Wyoming Ave El Paso TX, 79902

**Phone:** (855) 687-9887

Mon-Fri 8am - 5pm

Closed Weekends and Holiday

**Enroll Now!** 

<https://enrollatzeb.com/webbcounty>