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# 2027 Webb County Benefit Guide

*A Guideline to your benefits at Webb County*





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# 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 2027 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.*

# Company Overview

## Our History

Founded in 1848, Webb County has served as a cornerstone of South Texas heritage, culture, and community service. Over the years, the County has grown into one of the region's leading public institutions, providing essential services that enhance the quality of life for all residents. Through its dedicated employees, Webb County continues to uphold the values of integrity, responsibility, and progress that define our region.

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## Our Mission

To serve the citizens of Webb County with excellence, integrity, and respect by providing essential services and programs that foster safety, health, and prosperity. We are committed to supporting our employees with benefits and resources that reflect our mission of taking care of the people who take care of our community.

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## Our Goals

- Enhance employee well-being through comprehensive benefit programs.
- Promote financial security with County-paid and voluntary insurance options.
- Encourage healthy lifestyles through preventive care, wellness, and supportive 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.

| 2027 AETNA MEDICAL INSURANCE                                                                         |                                                                                                                                        |                                                                                                                       |
|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| AETNA HEALTH PLANS                                                                                   | AETNA Choice POS II / Base Plan Plan B                                                                                                 | Consumer Driven Health Plan (CDHP)                                                                                    |
| Annual Deductible                                                                                    | \$2,000 per Individual / \$4,000 per Family In-Network<br>\$4,000 per Individual / \$8,000 per Family Out-of-Network                   | \$3,500 per Individual / \$7,000 per Family In-Network<br>\$7,000 per Individual / \$14,000 per Family Out-of-Network |
| <b>Coinsurance</b>                                                                                   | 20% In-Network<br>50% Out-of-Network                                                                                                   | You pay 100% In-Network<br>You pay 30% Out-of-Network                                                                 |
| Annual Max Out of Pocket: Individual/Fam Cap (MOOP)<br>MOOP = Med Services Max + Deductible + Rx Max | \$7,000 per Individual / \$17,500 In-Network<br>\$30,000 per Individual / \$60,000 Out-of-Network                                      | \$3,500 per Individual / \$7,000 In-Network<br>\$30,000 per Individual / \$60,000 Out-of-Network                      |
| <b>MEDICAL SERVICES</b>                                                                              |                                                                                                                                        |                                                                                                                       |
| <b>Hospital Services</b>                                                                             |                                                                                                                                        |                                                                                                                       |
| In-Patient                                                                                           | 20% after deductible In-Network<br>50% after deductible Out-of-Network                                                                 | 100% after deductible In-Network<br>30% after deductible Out-of-Network                                               |
| Out-Patient                                                                                          | 20% after deductible In-Network<br>50% after deductible Out-of-Network                                                                 | 100% after deductible In-Network<br>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<br>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<br>50% after deductible Out-of-Network | 100% when an office visit charge is not applicable In-Network<br>30% after deductible Out-of-Network                  |
| Diagnostic Laboratory                                                                                | Covered 100%; deductible waived In-Network<br>50%; no deductible Out-of-Network                                                        | Covered 100% after deductible In-Network<br>30% after deductible Out-of-Network                                       |
| X-Rays                                                                                               | 20%; no deductible, no co-pay In-Network<br>50%; no deductible Out-of-Network                                                          | Covered 100% after deductible In-Network<br>30% after deductible Out-of-Network                                       |
| Diagnostic Outpatient Complex Imaging                                                                | 20% after deductible, no co-pay In-Network<br>50%; no deductible Out-of-Network                                                        | Covered 100% after deductible In-Network<br>30% after deductible Out-of-Network                                       |
| Preventive Care                                                                                      | Covered 100%; no deductible In-Network<br>30% after deductible Out-of-Network                                                          | Covered 100% after deductible In-Network<br>30% after deductible Out-of-Network                                       |
| ER Visit * Copay Waived if Admitted<br><b>Non-Emergency Care in ER - NOT covered</b>                 | 20%: after deductible; \$500 copay<br>Not Covered - Out-of-Network                                                                     | Covered 100% after deductible In-Network<br>Same as in-network care Out-of-Network                                    |
| Home Health Care                                                                                     | 20%; after deductible In-Network<br>50%; after deductible Out-of-Network                                                               | Covered 100% after deductible In-Network<br>30% after deductible Out-of-Network                                       |

# Aetna Medical Plans

|                                                                                                                                                                         |                                                                        |                          |                                                                                                                                                                      |                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Other Medical Services                                                                                                                                                  | 100%: no deductible In-Network<br>30%: after deductible Out-of-Network |                          | Covered 100% after deductible In-Network<br>30% after deductible Out-of-Network                                                                                      |                          |
| <b>PRESCRIPTION DRUGS</b>                                                                                                                                               |                                                                        |                          |                                                                                                                                                                      |                          |
| Retail Pharmacy-30 day supply<br>Generic/ Preferred Brand / Non-Preferred Brand / Specialty                                                                             | \$ 10/ \$40 / \$70 / \$80                                              |                          | \$0 after deductible In-Network, 30% of submitted cost; after applicable in-network cost share / Out-of-Network                                                      |                          |
| Retail or Mail Order 31-90 day supply<br>Generic/ Preferred Brand / Non-Preferred Brand / Specialty                                                                     | \$30/ \$120/ \$210 / \$240                                             |                          | Prescription drug expenses apply to your medical deductible. Affordable Care Act mandated female contraceptive and preventative medications covered 100% in-network. |                          |
| <b>Employee Contribution</b>                                                                                                                                            |                                                                        |                          |                                                                                                                                                                      |                          |
| <b>AETNA RATES EFFECTIVE 01/01/2027</b>                                                                                                                                 | <b>Monthly Premium</b>                                                 | <b>Bi-Weekly Premium</b> | <b>Monthly Premium</b>                                                                                                                                               | <b>Bi-Weekly Premium</b> |
| Employee only                                                                                                                                                           | \$74.89                                                                | \$34.57                  | \$6.90                                                                                                                                                               | \$3.18                   |
| Employee & Spouse                                                                                                                                                       | \$584.85                                                               | \$269.93                 | \$425.87                                                                                                                                                             | \$196.56                 |
| Employee & Children                                                                                                                                                     | \$284.52                                                               | \$131.32                 | \$150.47                                                                                                                                                             | \$69.45                  |
| Family                                                                                                                                                                  | \$646.65                                                               | \$298.45                 | \$475.14                                                                                                                                                             | \$219.29                 |
| *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 & Buy-Up 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

|                                      |                                             |                                      |
|--------------------------------------|---------------------------------------------|--------------------------------------|
| Effective Date: 01/01/2026           | In Network Member Cost Aetna Vision Network | Out of Network Member Reimbursement* |
| Frequency(Exam/Frame/Lens): 12/12/12 |                                             |                                      |
| AVP<br>888657 - Package A            |                                             |                                      |

## Exam

### Use your Exam Coverage once every Calendar Year

|                                                  |                                    |                    |
|--------------------------------------------------|------------------------------------|--------------------|
| 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        |

## Frames

### Use your Frame Coverage once every Calendar Year

|                                                                   |                                                              |                    |
|-------------------------------------------------------------------|--------------------------------------------------------------|--------------------|
| Any Frame available, including frames for prescription sunglasses | \$0 Copay; \$150 Allowance**, 20% off balance over allowance | \$80 Reimbursement |
|-------------------------------------------------------------------|--------------------------------------------------------------|--------------------|

## Standard Plastic Lenses

### Use your Lens/Lens Option Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses

|                                                                     |                                                  |                    |
|---------------------------------------------------------------------|--------------------------------------------------|--------------------|
| 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 |

## Lens Options

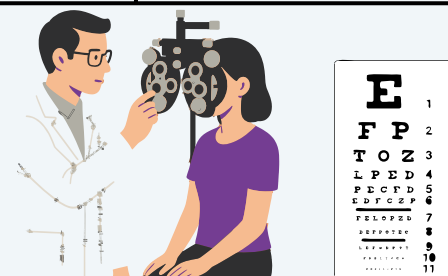
|                                                    |                                    |             |
|----------------------------------------------------|------------------------------------|-------------|
| UV Treatment                                       | Member pays discounted fee of \$15 | 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 |

## Contact Lenses

### Use your Contact Lens Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses

|                     |                                                              |                     |
|---------------------|--------------------------------------------------------------|---------------------|
| 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 |

| Coverage Tier         | PY 2027<br>Bi-Weekly Contribution | Monthly Contribution |
|-----------------------|-----------------------------------|----------------------|
| Employee Only         | \$3.33                            | \$7.21               |
| Employee + Spouse     | \$6.34                            | \$13.73              |
| Employee + Child(ren) | \$6.67                            | \$14.45              |
| Employee + Family     | \$9.80                            | \$21.23              |



# 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: **\$4,500**  
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 – National Benefit Services

## 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.

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## 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.

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## 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.





# 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:

|                                                                                                               |             |       |   |                                      |   |                                                                  |
|---------------------------------------------------------------------------------------------------------------|-------------|-------|---|--------------------------------------|---|------------------------------------------------------------------|
| _____                                                                                                         | ÷ \$1,000 = | _____ | × | _____                                | = | _____                                                            |
| Enter the amount of AD&D coverage you're requesting (see benefit amounts in the About This Coverage section). |             |       |   | Enter your rate from the rate table. |   | 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.

# 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.

|                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>How Much Can I Apply For?</b><br>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.                                                            | For You: <b>\$10,000 – \$300,000</b> in increments of <b>\$10,000</b><br><br>For Your Spouse: <b>\$5,000 – \$150,000</b> in increments of <b>\$5,000</b><br><br>For Your Child(ren): <b>\$5,000 or \$10,000</b> |
| <b>What is the Guarantee Issue Maximum?</b><br>Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions.<br><br>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. | For You: Up to <b>\$200,000</b><br><br>For Your Spouse: Up to <b>\$10,000</b>                                                                                                                                   |

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

|                            |                                                                                                                                                             |
|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Accelerated Benefit</b> | 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. |
|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|



| Your Age<br>(as of January 1) | Your Rate<br>(Per \$1,000 of Total Coverage) | Your Spouse's Age<br>(as of January 1) | Your Spouse's Rate<br>(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                                                |



# Short-Term Disability (STD)

## ② 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

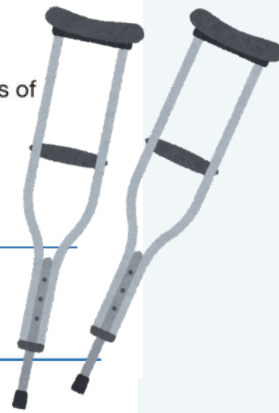
This applies if you do not apply for this coverage within 31 days of becoming eligible, were eligible for coverage under a prior plan for more than 31 days but were not insured, or if your insurance ends because you failed to pay your premium and is later reinstated.

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:

\_\_\_\_\_ x 0.60 x \_\_\_\_\_ ÷ 10 = \_\_\_\_\_  
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<br>(as of January 1) | Rate per \$10 of weekly<br>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                            |

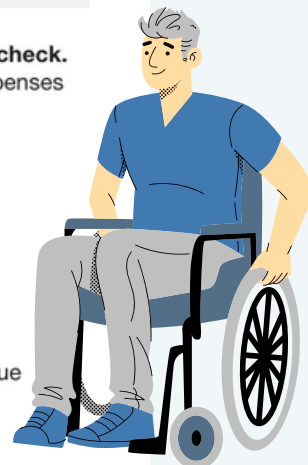
### Not being able to work also means not being able to earn a paycheck.

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.

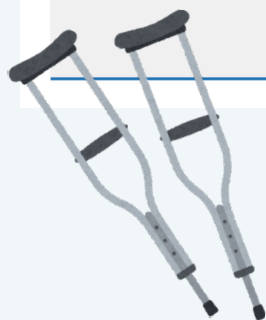
You may also be eligible to receive an additional benefit of 10 percent of your predisability earnings for participating in an approved rehabilitation plan, subject to the plan maximum.

#### 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:

$$\text{Enter your monthly earnings (cannot be more than \$16,667).} \times \text{Enter your rate from the rate table.} \div 100 = \text{This amount is an estimate of how much you'd pay each month.}$$

| Your Age<br>(as of January 1) | Rate Percentage<br>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).



# 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                                                                                             |                                  |                          |                          |
| 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>SM</sup> – Administrative & clinical support following serious illness or injury |                                  | Included                 | Included                 |

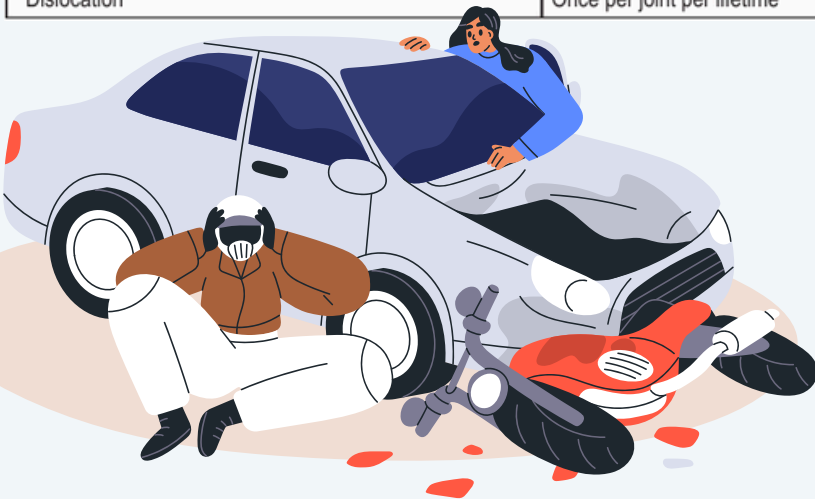
| COVERAGE TIER             | PLAN 1  | PLAN 2  |
|---------------------------|---------|---------|
| Employee Only             | \$8.92  | \$14.05 |
| Employee & Spouse/Partner | \$18.24 | \$28.68 |
| Employee & Child(ren)     | \$15.34 | \$24.10 |
| Employee & Family         | \$25.72 | \$40.40 |



# 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 |                                       |





# Cancer Insurance - MetLife

When cancer affects your family, Cancer Insurance may support your needs when it matters most.

## Why is it important?

Even if you have medical and disability insurance, you still may have expenses not covered by insurance. Following a verified cancer diagnosis, your first priority should be getting better - not worrying about lost income or everyday living expenses. Cancer Insurance can help pay for anything you may need, such as:

- Mortgage or rent payments
- Credit card bills or other debts
- Utilities
- Groceries
- Car payments
- Childcare expenses

## How it works

Cancer Insurance is coverage that can help pay for expenses. Upon an initial cancer diagnosis or a recurrence of cancer, you'll receive a lump-sum payment to spend as you see fit. The extra cash can help you focus on getting back on track, without worrying about how to pay for the cost of treatment.

Best of all, the payment is made directly to you, regardless of any other insurance you may have.

You have the option of choosing a \$15K Benefit Plan or a \$30K Benefit Plan.

## Why should I enroll?

- Group rates
- Guaranteed acceptance<sup>1</sup>
- Payment through payroll deductions
- Portable coverage so you can take it with you<sup>2</sup>

1. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents are not subject to medical restrictions set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the Armed Forces or living overseas. For CA situated cases, coverage is guaranteed provided (1) the employee is performing all of the usual and customary duties of the employee's job at the employer's place of business or at an alternate place approved by the employer and (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate.

2. Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.



# Retirement Benefits - Nationwide

Start Saving for retirement **today**.

## Why join now?

The more time you give your savings to potentially grow, the easier it is to contribute enough per pay period to potentially meet your future needs. Many experts say you may need 80% to 90% of your current income just to maintain your standard of living in retirement. Your three major sources of income through retirement will probably be:

- Pension Benefits
- Social Security Benefits
- Your Savings & Investments

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## Expenses to Consider

- Increases in medical costs
- Keeping up with inflation
- Not qualifying for a full pension
- Outliving your resources
- Planning for major trips and other activities

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## For more information contact:

Sarita Null

512.497.1666

[nulls4@nationwide.com](mailto:nulls4@nationwide.com)

Sarita can assist you in establishing a 457(b) Tax Deferred Compensation Account with Nationwide, roll overs/transfers or in changing allocations on existing accounts.



Nationwide®

# **AirEvac Benefits**

When seconds count™, emergency Air Ambulance membership protects your family and your finances.

## **What is an Air Ambulance membership?**

AirMedCare Network membership provides affordable air medical transport coverage, helping families get to the right hospital with added financial protection.

A 911 dispatcher may request air transport in an emergency. If an AirMedCare Network (AMCN) provider flies you, your Air Ambulance membership covers the cost.

## **Plan includes:**

- Entire household included
- No exclusions for preexisting conditions
- No hidden costs
- Only **\$3.23** per paycheck deduction



 **AirMedCare**  
NETWORK®  
A Global Medical Response Solution



**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://enrollatweb.com/webbcounty>