



2021

# employee benefits guide



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# Take Care of Your Tomorrow!

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Personal needs greatly influence the choices we make every day. Young or old, single or married, our needs differ. That's why we want to provide you with the freedom to select quality benefit options that work best for you.

It is important that you take an opportunity to review all of your plan options in detail. You will need to carefully consider each benefit option, its cost and value to you and whether it is appropriate for your personal needs. By taking the time to examine all of your options, you will ensure that your benefits meet those needs throughout the plan year.

The City of La Porte values our employees and recognizes the importance of offering benefits that enhance people's lives. With that in mind, we have good news for 2021!



## Quick Response (QR) CODES!

You will see these weird looking squares within your benefit guide called QR Codes.



Each of these codes store and transmit data, and you can use them by scanning them with your mobile device if you download a QR Reader from your app store such as the Apple App Store or Android Market.

## *Please Keep This Guide*

*It is a valuable resource for you throughout the year.*

*Your City of La Porte HR Team:*

*Matt Hartleib, HR Manager (281)470-5025*

*Lindsey Campuzano, Benefits Specialist (281) 470-5026*

*Sandra Charles, HR Specialist (281) 470-5024*

*Information Line (281) 470-5028*

# Benefits Resource List



For more information on the wide range of City of La Porte benefits, programs and tools, contact the following resources:

If You Have Questions About	Contact	By Phone	On the Internet
<b>MEDICAL COVERAGE</b> Directories of network providers, claims status or pre-notification	Aetna	800-872-3862	<a href="http://www.aetna.com">www.aetna.com</a>
<b>PRESCRIPTION DRUGS</b>	RxBenefits	800-334-8134	<a href="http://www.rxbenefits.com">www.rxbenefits.com</a>
<b>DENTAL COVERAGE</b>	Cigna	800-244-6224	<a href="http://www.mycigna.com">www.mycigna.com</a>
<b>VISION COVERAGE</b>	Avesis	855-214-6777	<a href="http://www.avesis.com">www.avesis.com</a>
<b>LIFE INSURANCE</b>	Ochs Securian Financial	800-392-7295	<a href="http://www.securian.com">www.securian.com</a>
<b>DISABILITY INSURANCE</b>	Ochs Madison Life	800-392-7295	<a href="http://www.madisonlife.com">www.madisonlife.com</a>
<b>EMPLOYEE ASSISTANCE PROGRAM</b>	UTEAP	800-346-3549	<a href="http://www.uteap.org">www.uteap.org</a>
<b>RETIREMENT</b>	TMRS	512-476-5576	<a href="http://www.tmrs.org">www.tmrs.org</a>

# Eligibility

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If you are a full-time employee who regularly works a minimum of 30 hours per week, you are eligible to participate in The Company's benefit plans.

## Dependent Eligibility

### Who can you cover on your benefit plans?

You may cover your spouse or civil union partner on our medical, dental, vision, and life insurance plans. If your spouse or civil union partner is a benefit eligible employee at the City of La Porte, you may not cover him/her under spouse life insurance. Your domestic partner or partner in common law marriage is eligible for coverage with a signed affidavit. Children's eligibility varies by plan.

**Medical Insurance:** A child may be covered under our medical plan through the end of the month during which he/she reaches age 26. Student status does not affect eligibility for medical coverage.

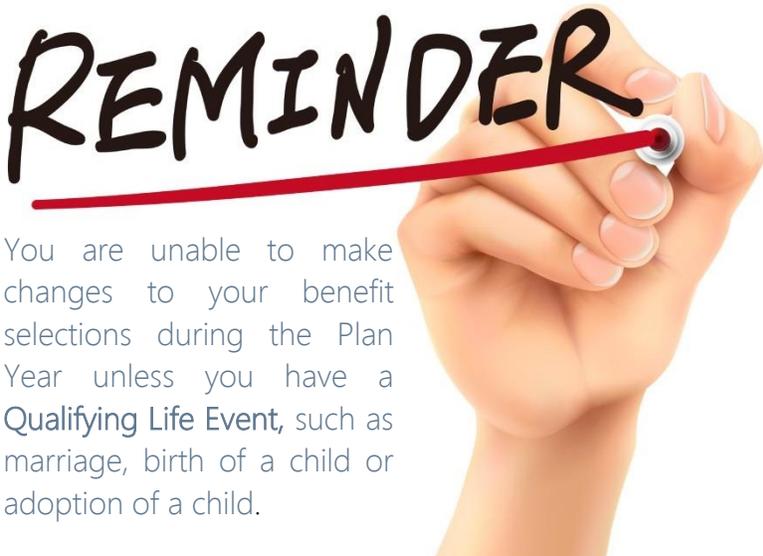
**Dental, Vision, and Life Insurance:** An unmarried, dependent child may be covered through the end of the month during which he/she reaches age 26.

**Flexible Spending Accounts:** Claims incurred by you, your spouse, and qualifying child are reimbursable under an FSA. Per federal tax law, claims incurred by an employee's civil union partner or that partner's children are not eligible for reimbursement through the employee's health care or dependent care flexible spending accounts.

You must cover yourself on any plans that you wish to enroll a dependent(s) in. See the Summary Plan Descriptions for more information about dependents and their eligibility.

## Dependent Verification Required

Documentation will be required to enroll a dependent in medical, dental or vision coverage. Verification of a dependent can range from a copy of a birth certificate, copy of a marriage license, or a copy of your most recent tax return proving the dependent relationship.



# REMINDER

You are unable to make changes to your benefit selections during the Plan Year unless you have a **Qualifying Life Event**, such as marriage, birth of a child or adoption of a child.



# Medical Benefits

## Hired Prior to January 1, 2018

Here is a snapshot of the coverage offered through the 2021 medical plans

BENEFITS – Aetna		PPO 500	HF 1000	HF 1500
Deductible	Network	\$500 Individual / \$1,500 Family	\$1,000 Individual / \$3,000 Family	\$1,500 Individual / \$4,500 Family
	Non-Network	N/A	N/A	N/A
Health Fund Allowance		N/A	\$500 Individual/ \$1,000 Family	\$500 Individual/ \$1,000 Family
Out-of-Pocket Maximum	Network	Includes Deductible \$3,500 Individual / \$10,500 Family	Includes Deductible \$3,000 Individual / \$9,000 Family	Includes Deductible \$4,200 Individual / \$12,600 Family
	Non-Network	N/A	N/A	N/A
Co-insurance	Network	80%	80%	80%
	Non-Network	N/A	N/A	N/A
Lifetime Maximum		Unlimited	Unlimited	Unlimited
		You Pay	You Pay	You Pay
Office Visit	Network	\$25 PCP / \$40 Spec	Deductible/ 20%	Deductible/ 20%
	Non-Network	N/A	N/A	N/A
Wellness Visit	Network	\$0 Copay	\$0 Copay	\$0 Copay
	Non-Network	N/A	N/A	N/A
In-Patient & Out-Patient Hosp.	Network	Deductible/ 20%	Deductible/ 20%	Deductible/ 20%
	Non-Network	N/A	N/A	N/A
Urgent Care	Network	\$40 Copay	Deductible/ 20%	Deductible/ 20%
	Non-Network	N/A	N/A	N/A
Emergency Room	Network	\$150 Copay/ Deductible/ 20%	\$150 Copay/ Deductible/ 20%	\$150 Copay/ Deductible/ 20%
	Non-Network	\$150 Copay/ Deductible/ 20%	\$150 Copay/ Deductible/ 20%	\$150 Copay/ Deductible/ 20%
Prescriptions	Generic/Brand/ Non-Formulary	\$10/\$30/\$60 20% Spec <\$100	\$10/\$30/\$60 20% Spec <\$100	\$10/\$30/\$60 20% Spec <\$100
	Mail Order (90 day) – Mandatory Maintenance	\$20/\$60/\$120	\$20/\$60/\$120	\$20/\$60/\$120
Network Website	<a href="http://www.aetna.com">www.aetna.com</a>	Select Open Access	Select Open Access	Select Open Access

*NOTE: This is a brief summary and not intended to be a contract.*

Medical Costs (Bi-Weekly)	PPO 500		HF 1000		HF1500	
	Non - Tobacco	Tobacco	Non - Tobacco	Tobacco	Non - Tobacco	Tobacco
Employee Only	\$23.18	\$46.26	\$10.48	\$33.56	\$6.76	\$29.84
Employee & Spouse	\$127.51	\$150.59	\$85.00	\$108.08	\$48.46	\$71.54
Employee & Children	\$117.74	\$140.82	\$77.89	\$100.97	\$43.96	\$67.04
Employee & Family	\$145.58	\$168.66	\$102.49	\$125.57	\$55.70	\$78.78



# Medical Benefits

## Hired On or After January 1, 2018

Here is a snapshot of the coverage offered through the 2021 medical plans

BENEFITS – Aetna		HF 1500
Deductible	Network	\$1,500 Individual / \$4,500 Family
	Non-Network	N/A
Health Fund Allowance		\$500 Individual / \$1,000 Family
Out-of-Pocket Maximum		Includes Deductible
	Network	\$4,200 Individual / \$12,600 Family
	Non-Network	N/A
Co-insurance	Network	80%
	Non-Network	N/A
Lifetime Maximum		Unlimited
<b>You Pay</b>		
Office Visit	Network	Deductible/ 20%
	Non-Network	N/A
Wellness Visit	Network	\$0 Copay
	Non-Network	N/A
In-Patient & Out-Patient Hosp.	Network	Deductible/ 20%
	Non-Network	N/A
Urgent Care	Network	Deductible/ 20%
	Non-Network	N/A
Emergency Room	Network	\$150 Copay/ Deductible/ 20%
	Non-Network	\$150 Copay/ Deductible/ 20%
Prescriptions	Generic/Brand/ Non-Formulary	\$10/\$30/\$60 20% Spec <\$100
	Mail Order (90 day) – Mandatory Maintenance	\$20/\$60/\$120
Network Website	<a href="http://www.aetna.com">www.aetna.com</a>	Select Open Access

*NOTE: This is a brief summary and not intended to be a contract.*

Medical Costs (Bi-Weekly)	HF1500	
	Non -Tobacco	Tobacco
Employee Only	\$6.76	\$29.84
Employee & Spouse	\$58.30	\$81.38
Employee & Children	\$48.64	\$71.72
Employee & Family	\$74.70	\$97.78

# Aetna – Mobil App

## With the Aetna Mobile app, you can:



Set up touch ID

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).**

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# RxBenefits Member Services



## MEMBER SERVICES

Member Satisfaction is not simply something you measure, it is something you deliver.

*RxBenefits delivering customer service as it was meant to be.*

Member Services can assist you with every aspect of your pharmacy benefit plan, from answering coverage questions and ordering ID cards to resolving complex issues. Unlike an automated call center, our service line is staffed by "live" representatives that are knowledgeable in pharmacy benefits.

During times of high call volume, our Queue Callback solution works seamlessly to offer customers a callback when the next agent becomes available without losing their place in line.

RxBenefits strives to ensure all members can be accommodated and heard through both in-house language resources or via our translation service partners.

Our goal is to understand your needs and to deliver relevant information, ensuring you can fully understand your options.

### HAVE QUESTIONS ABOUT YOUR PHARMACY BENEFITS?

No matter what the issue or need is, members can always expect RxBenefits to:



Act with urgency



Follow all issues to resolution



**Contact Us**

**800.334.8134**

[RxHelp@rxbenefits.com](mailto:RxHelp@rxbenefits.com)

*Member services team members are available from 7:00 a.m. to 8:00 p.m. CST, Monday – Friday. During weekend and after hours/holidays, members are given the option to speak with a PBM representative, or leave a message for us to return their call during business hours.*

## Access in the palm of your hand



**Now you can manage your prescription benefits anytime, anywhere.**

Download the CVS Caremark® app for on-the-go access to helpful tools and resources.



**Easy Refills**—Scan the barcode on your Rx label to refill available prescriptions.



**View ID Card**—No need to carry your benefit ID card. With the app, you always have it on hand.



**Fill New Prescriptions**—Take a photo of the front and back of your new paper prescription and CVS Caremark Mail Service Pharmacy will take it from there.



**Pharmacy Locator**—Find in-network retail pharmacies near you.



**Manage Your Profile**—Set your notifications, update shipping and billing information, and more.

Register today at [Caremark.com/mobile](https://www.caremark.com/mobile) or download the mobile app.



# Generic Drugs: Questions and Answers

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## What are generic drugs?

A generic drug is identical -- or bioequivalent -- to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts from the branded price. According to the Congressional Budget Office, generic drugs save consumers an estimated \$8 to \$10 billion a year at retail pharmacies. Even more billions are saved when hospitals use generics.



For more information about Generic Drugs visit <https://www.accessdata.fda.gov/scripts/cder/daf/> or use your QR Scanner.

## Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used.

FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

Not every brand-name drug has a generic drug. When new drugs are first made they have drug patents. Most drug patents are protected for 20 years. The patent, which protects the company that made the drug first, doesn't allow anyone else to make and sell the drug. When the patent expires, other drug companies can start selling a generic version of the drug. But, first, they must test the drug and the FDA must approve it.

Creating a drug costs lots of money. Since generic drug makers do not develop a drug from scratch, the costs to bring the drug to market are less; therefore, generic drugs are usually less expensive than brand-name drugs. But, generic drug makers must show that their product performs in the same way as the brand-name drug.

## How are generic drugs approved?

Drug companies must submit an abbreviated new drug application (ANDA) for approval to market a generic product. The Drug Price Competition and Patent Term Restoration Act of 1984, more commonly known as the Hatch-Waxman Act, made ANDAs possible by creating a compromise in the drug industry. Generic drug companies gained greater access to the market for prescription drugs, and innovator companies gained restoration of patent life of their products lost during FDA's approval process.

New drugs, like other new products, are developed under patent protection. The patent protects the investment in the drug's development by giving the company the sole right to sell the drug while the patent is in effect. When patents or other periods of exclusivity expire, manufacturers can apply to the FDA to sell generic versions.

The ANDA process does not require the drug sponsor to repeat costly animal and clinical research on ingredients or dosage forms already approved for safety and effectiveness. This applies to drugs first marketed after 1962.

## What standards do generic drugs have to meet?

Health professionals and consumers can be assured that FDA approved generic drugs have met the same rigid standards as the innovator drug. To gain FDA approval, a generic drug must:

- contain the same active ingredients as the innovator drug (inactive ingredients may vary)
- be identical in strength, dosage form, and route of administration
- have the same use indications
- be bioequivalent
- meet the same batch requirements for identity, strength, purity, and quality
- be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products

# OneRx

The OneRx application is a free downloadable app for your smart phone to have instant access to current discounts and coupons for your prescriptions.

## Know out-of-pocket costs in real time

- Employees save money by seeing their personalized out-of-pocket for a drug being prescribed at local pharmacies including any special coupons or discounts you can use.

## Be alerted to insurance restrictions

- Know if step therapy or a prior authorization is required before you try to fill the prescription.

## Stay up to date on coverage and savings

- Track all medications automatically; be kept up to date on the prescription drug list status and all available savings. The average savings for using the OneRx app is \$750!



Visit [www.onerx.com](http://www.onerx.com) or scan the QR Code for additional details about OneRx.

# Urgent Care vs. Emergency Rooms

Healthcare consumers must educate themselves to recognize the differences between an urgent care facility, emergency rooms and freestanding emergency rooms. Understanding their differences could save you as a consumer thousands of dollars.

Whenever you feel bad or have a child who is under the weather all you want is for yourself or them to feel better. You should take into consideration the severity of the situation, the ER wait time and the hefty bill you will receive. Actually, visiting an urgent care may be a better choice as wait times may be shorter and more affordable.

A majority of Urgent Care Clinics accept insurance and are open all week long, including nights, weekends and holidays. Additionally, instead of having to wait in a waiting room to be seen, some Urgent Care Clinics allow you to call in advance and wait in the comfort of your home until a room becomes available.



Urgent care centers are equipped to handle non-life threatening situations, and many have attending doctors and nurses who have access to x-rays and labs onsite. Most urgent care centers are open late and on weekends and holidays.

Choosing an urgent care center over the ER can save you time and money:

- Average time of an ER visit: 4 hours
- Average cost of an ER visit: \$1,757
- Average cost of an urgent care center visit: \$162

## Visit an urgent care center for these common conditions:

- Flu and cold / High fevers
- Broken bones
- Coughs and sore throat
- Vomiting, diarrhea, stomach pain
- Cuts and severe scrapes
- High fevers

## Emergency Rooms

Emergency rooms are meant for true medical emergencies and can handle trauma, x-rays, surgical procedures and other life threatening situations.

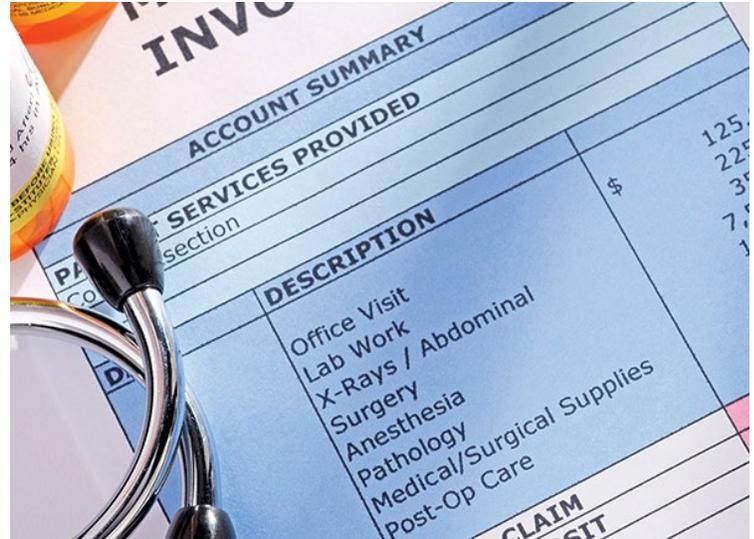
Most hospitals have an emergency room that's open 24 hours a day, 7 days a week. If you have a true emergency, go to your nearest emergency room or call 911.

## Visit an emergency room if you experience:

- Allergic reactions
- Constant vomiting
- Deep wounds
- Broken bones
- Continuous bleeding
- Weakness or pain in a leg or arm
- Chest pain
- Severe shortness of breath
- Head injuries / Unconsciousness

# Surprise Medical Bills

“Surprise medical bill” is a term commonly used to describe charges arising when an insured individual inadvertently receives care from an out-of-network provider. This situation could arise in an emergency when the patient has no ability to select the emergency room, treating physicians, or ambulance providers. Surprise medical bills might also arise when a patient receives planned care from an in-network provider (often, a hospital or ambulatory care facility), but other treating providers brought in to participate in the patient’s care are not in the same network. These can include anesthesiologists, radiologists, pathologists, surgical assistants, and others. In some cases, entire departments within an in-network facility may be operated by subcontractors who don’t participate in the same network. In these non-emergency situations, too, the in-network provider or facility generally arranges for the other treating providers, not the patient.



## I GOT A SURPRISE BILL. WHAT CAN I DO ABOUT IT?

- Call the doctor or provider that sent the bill and discuss your concerns. In most cases, Texas law requires providers to provide an itemized bill on request, so review the charges carefully. Some providers might accept a lower payment.
- For planned procedures, find out in advance whether your providers are contracted with your health plan. This is especially important in the case of facility-based providers, such as radiologists, anesthesiologists, pathologists, and neonatologists. Even if a hospital is in your health plan's network, some doctors who provide services there might not be.
- Call your health plan to make sure the services you will get are covered under your policy. If the services are not covered, you will have to pay the charges.
- Texas law gives patients the right to request estimates of charges. Doctors and other providers and health plans have 10 days to give you the estimates, so you won't be able to get them in cases of emergencies. Some providers and health plans also have cost information on their websites.
- If there aren't any contracted providers available, your health plan might be able to work out a discounted payment. You also might be able to ask your doctor or provider if they'll accept payment options in advance. In some cases, the health plan may be required to make sure you aren't balance billed.



# Voluntary Dental Benefits

## Effective January 1, 2021

Here is a snapshot of the coverage offered through the 2021 dental plans.

BENEFITS - Cigna	DHMO* You Pay	PPO You Pay
<b>Type I – Preventive Services</b> Oral examinations (2 Per Year) X-rays Cleanings (2 Per Year)	\$5 Copay  See Schedule	No Deductible/ 0%
<b>Type II – Basic Services</b> Fillings Extractions	\$5 Copay  See Schedule	Deductible/ 20%
<b>Type III – Major Services</b> Crowns Removable / fixed bridge-work Partial or complete dentures	\$5 Copay  See Schedule	Deductible/ 50%
<b>Type IV - Orthodontia</b> Child Only to Age 19	See Schedule	50%
<b>Annual Deductible</b>		
Individual	N/A	\$50
Family	N/A	\$150
<b>Annual Maximums</b>		
Dental Annual Maximum	N/A	\$1,250
Orthodontia Lifetime Maximum	N/A	\$1,000
Network Website <a href="http://www.mycigna.com">www.mycigna.com</a>	Cigna DHMO Network	Cigna PPO Network

*NOTE: This is a brief summary and not intended to be a contract.*

Dental Costs – Semi Monthly	Per Pay Period	Per Pay Period
Employee Only	\$5.61	\$15.31
Employee + 1	\$10.66	\$30.51
Employee & Family	\$13.11	\$55.87

\*The DHMO plan requires you to select an in-network primary dentist during enrollment.

For the PPO plan, if you do not enroll when first eligible you will have to be enrolled in the plan for 12 months before Type III and Type IV services will be covered.

# Voluntary Vision Benefits



## Effective January 1, 2021

This is a snapshot of the coverage offered through the 2021 Vision Plans.

BENEFITS		Avesis
Eye Exam	Network	\$10 Copay
	Non-Network	Up to \$45 Reimbursement
<b>Frames/ Lens</b>		
Single Vision	Network	\$25 Copay
	Non-Network	Up to \$40 Reimbursement
Bifocal Lenses	Network	\$25 Copay
	Non-Network	Up to \$60 Reimbursement
Trifocal Lenses	Network	\$25 Copay
	Non-Network	Up to \$80 Reimbursement
Frames	Network	\$65 Wholesale Allowance
	Non-Network	Up to \$65 Reimbursement
<b>Contacts *In Lieu of Glasses</b>		
Network	Medically Necessary	Covered in Full \$175 Allowance
	Elective	
Non-Network	Medically Necessary	Up to \$250 Reimbursement
	Elective	Up to \$150 Reimbursement
Exam Frequency		12 Months
Lens Frequency		12 Months
Frames Frequency		24 Months
Network Website	<a href="http://www.avesis.com">www.avesis.com</a>	Avesis Network

*NOTE: This is a brief summary and not intended to be a contract.*

Vision Costs	Per Pay Period
Employee Only	\$3.16
Employee & Spouse	\$5.59
Employee & Family	\$8.29

# Basic Life & AD&D Benefits



## Effective January 1, 2021

The City of La Porte provides Basic Life and AD&D (Accidental Death and Dismemberment) insurance for you as a full-time employee at no additional cost. If you would like to purchase additional life insurance for yourself and/or your dependents, please see the Voluntary Life Insurance page for more information.

### BENEFICIARY INFORMATION

Remember, it is important to designate beneficiaries for all of your insurance policies that require them. If you don't, laws may cause death benefits to be distributed differently than you had planned resulting in additional taxes and may unnecessarily delay the process of finalizing payment to your loved ones. You should regularly review and, if necessary, update your beneficiary designations. You can update your beneficiary at any time by submitting a new beneficiary form to HR.

BASIC LIFE/AD&D BENEFITS	Securian Financial
Class Description	Class 1: Exempt Employees, Fire, EMS, Police; Class 2: Non-Exempt Employees; Class 3: City Managers and Department Directors
Basic Life & AD&D Schedule	Class 1: \$20,000 Class 2: \$10,000 Class 3: \$70,000
Maximum Amount	Class 1: \$20,000 Class 2: \$10,000 Class 3: \$70,000
Employee Age Reduction Schedule	To 65% @ Age 65, To 45% @ Age 70, To 25% @ Age 75 Terminates at Retirement
Waiver of Premium	Included to age 60
Accelerated Death Benefit	100% of Life Benefit, up to \$1,000,000
Conversion	Included
Portability	Included
AD&D Line of Duty Benefit	AD&D Principal Sum increases by 100%, up to \$100,000

*NOTE: This is a brief summary and not intended to be a contract.*

# How Much Life Insurance Do You Need?

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If you're going to achieve all your goals, such as sending your kids to college, retiring in comfort and leaving a legacy, you will need to save and invest throughout your lifetime. But to really complete your financial picture, you'll also need to add one more element: protection. And that means you'll require adequate life insurance for your situation. However, your need for insurance will vary at different times of your life — so you'll want to recognize these changing needs and be prepared to act.

When you're a young adult, and you're single, life insurance will probably not be that big of a priority. And even married couples without children typically have little need for life insurance; if both spouses contribute equally to household finances, and you don't own a home, the death of one spouse will generally not be financially catastrophic for the other.



But once you buy a home, things change. Even if you and your spouse are both working, the financial burden of a mortgage may be too much for the surviving spouse. So, to enable the survivor to continue living in the home, you might consider purchasing enough life insurance to at least cover the mortgage.

When you have children, your life insurance needs will typically increase greatly. In fact, it's a good idea for both parents to carry enough life insurance to pay off a mortgage and raise and educate the children, because the surviving parent's income may be insufficient for these needs. How much insurance do you need? You might hear of a "formula," such as buying an amount equal to seven to ten times your annual income, but this is a rough guideline, at best. You might want to work with a financial professional to weigh various factors – number and ages of children, size of mortgage, current income of you and your spouse, and so on – to determine both the amount of coverage and the type of insurance ("term" or "permanent") appropriate for your situation.

Once you've reached the "empty nest" stage, and your kids are grown and living on their own, you may need to re-evaluate your insurance needs. You might be able to lower your coverage, but if you still have a mortgage, you probably would want to keep enough insurance to pay it off.

After you retire, you may have either paid off your mortgage or moved into a condominium or apartment, so you may require even less life insurance than before. But it's also possible that your need for life insurance will remain strong. For example, the proceeds of a life insurance policy can be used to pay your final expenses or to replace any income lost to your spouse as a result of your death (e.g., from a pension or Social Security.) Life insurance can also be used in your estate plans to help leave the legacy you desire.

As we've seen, insurance can be important at every stage of your life. You'll help yourself – and your loved ones – by getting the coverage you need when you need it.

# Voluntary Life & AD&D Benefits

VOLUNTARY LIFE & AD&D BENEFITS	Securian Financial	
Employee Life Amount	Increments of \$10,000 – Up to a \$500,000 Maximum Benefit	
Class Description	Class 1: Exempt Employees, Fire, EMS, Police; Class 2: Non-Exempt Employees; Class 3: City Managers and Department Directors	
Employee Guarantee Issue Amount	Open Enrollment allows for a maximum increase of two increments of \$10,000 up to the guarantee issue amount of \$250,000 without Evidence of Insurability	
Employee Maximum Amount	\$500,000	
Employee & Spouse Age Reduction Schedule	None	
Spouse Life Amount (not eligible if already covered as an employee of the City)	Increments of \$5,000 – Up to a \$150,000 Maximum Benefit	
Spouse Guarantee Issue Amount	Open Enrollment allows for a maximum increase of two increments of \$5,000 up to the guarantee issue amount of \$40,000 without Evidence of Insurability	
Spouse Maximum Amount	\$150,000	
Child Life Amount (can only be covered by one parent if both parents employed by the City)	\$10,000 or \$15,000	
Employee Waiver of Premium	Included to Age 60	
Accelerated Death Benefit	100% of Life Amount, up to \$1,000,000	
Conversion	Included	
Portability	Included	
Suicide Clause	24 Months	
MONTHLY AGE RATED PREMIUMS (Rates based on Employee's Age)	Employee (Rate Per \$1,000)	Spouse (Rate Per \$1,000)
AD&D Rate: \$.025	Included	Included
Life Rate: Under 25	\$0.075	\$0.075
25-29	\$0.085	\$0.085
30-34	\$0.105	\$0.105
35-39	\$0.115	\$0.115
40-44	\$0.145	\$0.145
45-49	\$0.235	\$0.235
50-54	\$0.395	\$0.395
55-59	\$0.635	\$0.635
60-64	\$0.775	\$0.775
65-69	\$1.335	\$1.335
70-74	\$2.085	\$2.085
75+	\$2.405	\$2.405
Child Life Rate Per \$1,000	\$.13 per \$1,000 of Coverage	

*NOTE: This is a brief summary and not intended to be a contract.*



# Disability Insurance

## Effective January 1, 2021

The City of La Porte provides full-time employee with the option to purchase short-term disability income benefits on a voluntary basis. The City also provides full-time employees with long-term disability income benefits paid in full by the City. In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income.

VOLUNTARY SHORT TERM DISABILITY BENEFITS	Madison Life – Option 1
Weekly Percentage	60% of Base Weekly Earnings
Weekly Maximum	\$1,000
Benefit Duration	11 Weeks
Accident Benefit Begin	15 <sup>th</sup> Day
Sickness Benefit Begin	15 <sup>th</sup> Day
Pre-existing Condition Limitation	12 / 12
Survivor Benefit	3 Weeks
Monthly Rate per \$10 of Weekly Benefit	\$0.346

VOLUNTARY SHORT TERM DISABILITY BENEFITS	Madison Life – Option 2
Weekly Percentage	60% of Base Weekly Earnings
Weekly Maximum	\$1,000
Benefit Duration	9 Weeks
Accident Benefit Begin	31 <sup>st</sup> Day
Sickness Benefit Begin	31 <sup>st</sup> Day
Pre-existing Condition Limitation	12 / 12
Survivor Benefit	3 Weeks
Monthly Rate per \$10 of Weekly Benefit	\$0.286

LONG TERM DISABILITY BENEFITS	Madison Life
Monthly Percentage	60% of Base Monthly Earnings
Monthly Maximum	\$6,000
Definition of Disability	2 Years Own Occupation
Elimination Period	90 Days
Benefit Duration	Social Security Normal Retirement Age
Definition of Earnings	Base Annual Earnings
Pre-existing Condition Limitation	6 / 12
Mental Nervous Limitations	24 Months per Disability
Drug & Alcohol Limitations	24 Months per Disability
Survivor Benefit	3 Months

*NOTE: This is a brief summary and not intended to be a contract.*

# Employee Assistance Program (EAP)

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**Effective January 1, 2021**

The Employee Assistance Program (EAP) can help you resolve problems that affect your personal life or job performance. The Employee Assistance Program (EAP) is offered to all employees and immediate family members through UTEAP. The EAP is paid for by company (or is offered on a voluntary basis). It is a completely confidential counseling program that covers issues such as:

- Legal / Financial
- Depression / Stress
- Drug / Alcohol Abuse
- Emotional Problems
- Financial Pressures
- Grief Issues
- Family / Relationship Problems
- Other Personal Concerns



EAP staff members are available 24 hours a day, 7 days a week, every day of the year by calling 713-500-3327. Staff members are highly trained professionals with experience in family, personal, work related and substance abuse issues.



# Flexible Spending Account

## Effective January 1, 2021

A Flexible Spending Account, or FSA, lets you set aside pre-tax money from your paychecks to spend on out-of-pocket healthcare expenses (i.e. co-pays, deductibles, over-the-counter items, etc.). Money that goes into an FSA is pre-tax, so by anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

### Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses not covered by their insurance plan with pre-tax dollars. The annual maximum amount you may contribute to the **Health Care Reimbursement FSA** is **\$2,750**. Some examples include:

- Deductible, Prescriptions & Doctor Visit Co-Payments
- Over-the-Counter Medicines with a Prescription
- Vision services, including Lasik Eye Surgery, Glasses & Contacts
- Hearing services, including hearing aids and batteries
- Orthodontics, Dental deductibles and coinsurance
- Acupuncture

### Dependent Care FSA

The Dependent Care FSA allows employees to use pre-tax dollars towards qualified dependent care for children under the age of 13 or caring for elders. The annual maximum amount you may contribute to the **Dependent Care FSA** is **\$5,000**, (or \$2,500 if married and filing separately).

Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

#### FSA Smart Tips

Cover any significant medical expenses early in the year using your FSA. You'll spend the remainder of the year paying yourself back with the regular payroll deductions.

Save your receipts as proof of purchase in order to be reimbursed for your health care expenses from your FSA. So if you are making purchases that are eligible for reimbursement, you'll want to keep them separate from other items.

Take advantage of the pre-tax savings and use your FSA dollars. Remember, unused money in an FSA at the end of the year is lost.

# Medical Eligible Expenses for FSA

<p>Acupuncture</p> <p>Alcoholism</p> <p>Ambulance</p> <p>Artificial Limb</p> <p>Artificial Teeth</p> <p>Bandages</p> <p>Breast Reconstruction Surgery</p> <p>Birth Control Pills</p> <p>Braille Books and Magazines</p> <p>Capital Expenses - ramps, rails, etc.</p> <p>Car - special design</p> <p>Chiropractor</p> <p>Christian Science Practitioner</p> <p>Contact Lenses</p> <p>Crutches</p> <p>Dental Treatment (not teeth whitening)</p> <p>Diagnostic Devices</p> <p>Disabled Dependent Care Expenses</p> <p>Drug Addiction - inpatient treatment</p> <p>Drugs (excluding over-the-counter)</p> <p>Eyeglasses</p> <p>Eye Surgery</p> <p>Fertility Enhancement</p> <p>Founder's Fee - care at retirement home</p> <p>Guide Dog or Other Animal</p> <p>Health Institute</p> <p>Health Maint. Org. (HMO)</p> <p>Hearing Aids</p> <p>Home Improvements - ramps, lifts, etc.</p> <p>Hospital Services</p> <p>Insurance Premiums - see IRS list</p> <p>Laboratory Fees</p> <p>Lead-Based Paint Removal</p> <p>Learning Disability</p>	<p>Lifetime Care—Advance Payments</p> <p>Lodging - for medical care</p> <p>Long-Term Care</p> <p>Meals - for medical care</p> <p>Medical Conferences</p> <p>Medical Information Plan</p> <p>Medical Services</p> <p>Medicines (excluding over-the-counter without an Rx)</p> <p>Nursing Home</p> <p>Nursing Services &amp; Home Care</p> <p>Operations</p> <p>Optometrist</p> <p>Organ Donors</p> <p>Osteopath</p> <p>Oxygen</p> <p>Pregnancy Test kit</p> <p>Prosthesis</p> <p>Psychiatric Care</p> <p>Psychoanalysis</p> <p>Psychologist</p> <p>Special Education</p> <p>Sterilization</p> <p>Stop-Smoking Programs</p> <p>Surgery</p> <p>Telephone for hearing-impaired</p> <p>Television for hearing impaired</p> <p>Therapy</p> <p>Transplants</p> <p>Transportation - for medical care</p> <p>Trips - for medical care</p> <p>Vasectomy</p> <p>Vision Correction Surgery</p> <p>Weight-Loss Program</p> <p>Wheelchair</p>
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Using your mobile device scan the QR Code to get more information about HSA and FSA eligible expenses.



# What Constitutes a Qualifying Life Event?

Qualifying Life Event	Benefits Allowed to Change									Documentation
	Medical	Dental	Vision	Supp. EE Life	Vol. Sp. Life	Vol. Child Life	Dep. Care	Health Care	Beneficiaries	
Change in marital status: · Marriage · Divorce or Annulment · Legal Separation · Domestic Partner Dissolution · Death of Spouse	✓	✓	✓		✓		✓	✓	✓	Marriage Certificate Divorce Decree Final Court Document Notarized Statement of Disenrollment Death Certificate
Change in the number of dependents: · Birth · Adoption · Guardianship of a Child · Death of a Dependent	✓	✓	✓			✓	✓	✓	✓	Birth Certificate, Hospital Announcement Adoption Agreement Court Decree for Guardianship Death Certificate
Dependent Becomes Eligible	✓	✓	✓	✓	✓	✓	✓	✓	✓	Provide Name, Social Security Number, and Date of Birth for dependents
Dependent Loses Other Coverage	✓	✓	✓				✓	✓	✓	Proof of Loss of Coverage, such as termination letter; Certificate of Creditable Coverage
Dependent Gains Other Coverage	✓	✓	✓				✓	✓	✓	Proof of Coverage with start date of benefits and name(s) of covered dependents
A change in Employee's, spouse's, or dependent's work hours (including a switch between full and part-time status)	✓	✓	✓				✓	✓	✓	Proof of loss of Coverage due to employment status change, such as a Certificate of Creditable Coverage or letter from the company
Change in Dependent Care Costs							✓			Letter from your Day Care Provider
Court Ordered Dependent, add or drop from coverage	✓	✓	✓			✓	✓	✓	✓	Contact your Benefits Team Directly

For more information on Qualifying Events scan the QR code with your mobile device.



# Glossary of Health Coverage & Medical Terms

This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)



For a digital version of the Glossary of Health Coverage & Medical Terms scan the QR code with your mobile device.

## Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

## Appeal

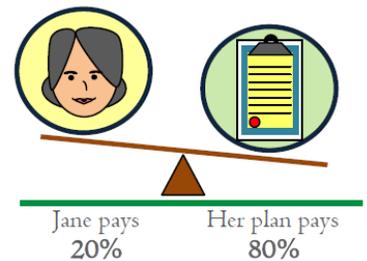
A request for your health insurer or plan to review a decision or a grievance again.

## Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you for covered services.

## Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance *plus* any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



## Complications of Pregnancy

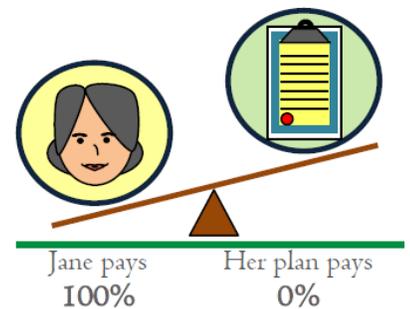
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

## Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

## Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



## Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

## Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

## Emergency Medical Transportation

Ambulance services for an emergency medical condition.

## Emergency Room Care

Emergency services you get in an emergency room.

## Emergency Services

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

# Glossary of Health Coverage & Medical Terms (continued)

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## **Excluded Services**

Health care services that your health insurance or plan doesn't pay for or cover.

## **Grievance**

A complaint that you communicate to your health insurer or plan.

## **Habilitation Services**

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

## **Health Insurance**

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

## **Home Health Care**

Health care services a person receives at home.

## **Hospice Services**

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

## **Hospitalization**

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

## **Hospital Outpatient Care**

Care in a hospital that usually doesn't require an overnight stay.

## **In-network Co-insurance**

The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

## **In-network Co-payment**

A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

## **Medically Necessary**

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

## **Network**

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

## **Non-Preferred Provider**

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

## **Out-of-network Co-insurance**

The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

## **Out-of-network Co-payment**

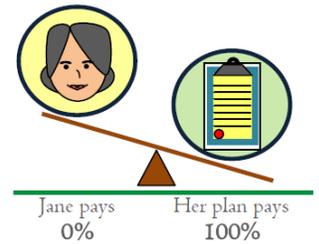
A fixed amount (for example, \$30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

# Glossary of Health Coverage & Medical Terms (continued)

## Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health

insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.



## Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

## Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

## Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

## Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

## Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

## Prescription Drug Coverage

Health insurance or plan that helps pay for prescription drugs and medications.

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

## Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

## Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

## Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

# Glossary of Health Coverage & Medical Terms (continued)

## Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

## Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

## UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

## Urgent Care

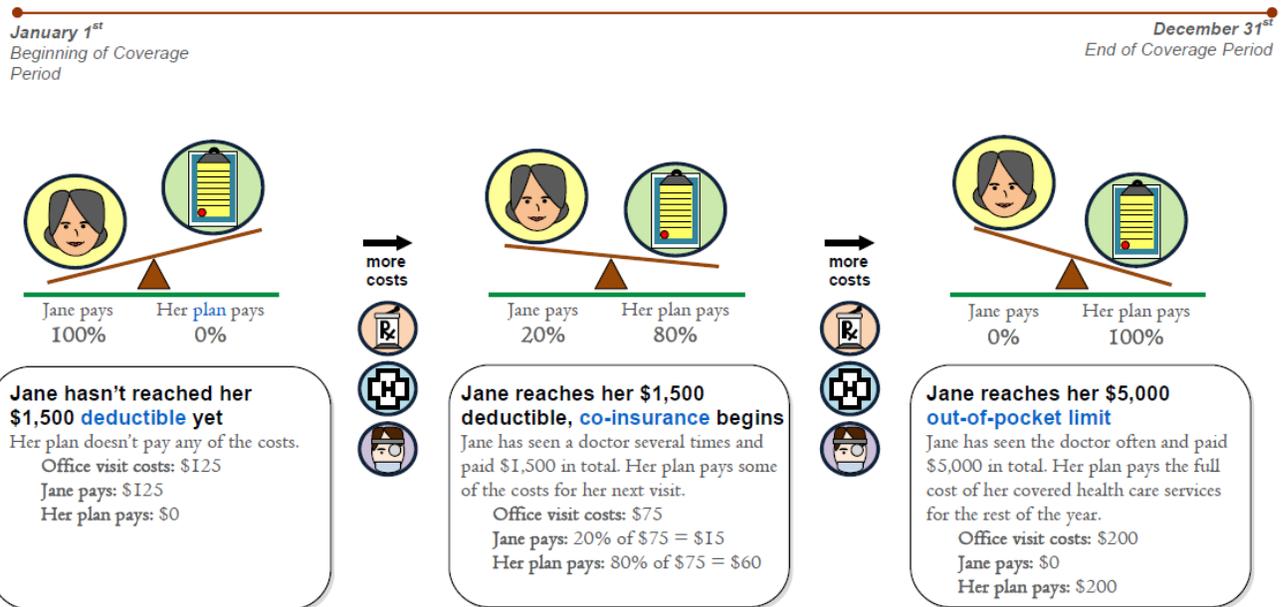
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

## How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500

Co-insurance: 20%

Out-of-Pocket Limit: \$5,000



# Annual Notices

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## **Important Notice from City of La Porte About Your Prescription Drug Coverage and Medicare**

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

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

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

### **When Can You Join A Medicare Drug Plan?**

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

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

### **What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current Plan Sponsor coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the person listed at the end of this notice for more information about what happens to your coverage if you enroll in a Medicare Part D prescription Drug Plan.

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

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

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

**For More Information about This Notice or Your Current Prescription Drug Coverage...**

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan Sponsor changes. You also may request a copy of this notice at any time.

**For More Information about Your Options under Medicare Prescription Drug Coverage...**

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 1/1/2021  
Name of Entity/Sender: City of La Porte  
Contact-Position/Office: Human Resources  
Address: 604 W. Fairmont Pkwy, La Porte, TX 77571  
Phone Number: (281) 471-5020

## Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020 Contact your State for more information on eligibility –**

<b>ALABAMA – Medicaid</b>	<b>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</b>
Website: <a href="http://myalhipp.com">http://myalhipp.com</a> Phone: 1-855-692-5447	Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a> HIBI Customer Service: 1-855-692-6442
<b>ALASKA – Medicaid</b>	<b>FLORIDA – Medicaid</b>
The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a>	Website: <a href="https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html">https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html</a> Phone: 1-877-357-3268
<b>ARKANSAS – Medicaid</b>	<b>GEORGIA – Medicaid</b>
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162 ext 2131
<b>CALIFORNIA – Medicaid</b>	<b>INDIANA – Medicaid</b>

<p>Website:  <a href="https://www.dhcs.ca.gov/services/Pages/TPLRD_CA_U_cont.aspx">https://www.dhcs.ca.gov/services/Pages/TPLRD_CA_U_cont.aspx</a>  Phone: 1-800-541-5555</p>	<p>Healthy Indiana Plan for low-income adults 19-64  Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a>  Phone: 1-877-438-4479  All other Medicaid  Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a>  Phone 1-800-457-4584</p>
<p><b>IOWA – Medicaid and CHIP (Hawki)</b></p>	<p><b>MONTANA – Medicaid</b></p>
<p>Medicaid Website:  <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a>  Medicaid Phone: 1-800-338-8366  Hawki Website:  <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a>  Hawki Phone: 1-800-257-8563</p>	<p>Website:  <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a>  Phone: 1-800-694-3084</p>
<p><b>KANSAS – Medicaid</b></p>	<p><b>NEBRASKA – Medicaid</b></p>
<p>Website: <a href="http://www.kdheks.gov/hcf/default.htm">http://www.kdheks.gov/hcf/default.htm</a>  Phone: 1-800-792-4884</p>	<p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>  Phone: 1-855-632-7633  Lincoln: 402-473-7000  Omaha: 402-595-1178</p>
<p><b>KENTUCKY – Medicaid</b></p>	<p><b>NEVADA – Medicaid</b></p>
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>  Phone: 1-855-459-6328  Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a></p> <p>KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a>  Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a></p>	<p>Medicaid Website: <a href="http://dhcfnv.gov">http://dhcfnv.gov</a>  Medicaid Phone: 1-800-992-0900</p>
<p><b>LOUISIANA – Medicaid</b></p>	<p><b>NEW HAMPSHIRE – Medicaid</b></p>
<p>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>  Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>Website: <a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a>  Phone: 603-271-5218  Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
<p><b>MAINE – Medicaid</b></p>	<p><b>NEW JERSEY – Medicaid and CHIP</b></p>
<p>Enrollment Website:  <a href="https://www.maine.gov/dhhs/ofl/applications-forms">https://www.maine.gov/dhhs/ofl/applications-forms</a>  Phone: 1-800-442-6003  TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage:  <a href="https://www.maine.gov/dhhs/ofl/applications-forms">https://www.maine.gov/dhhs/ofl/applications-forms</a>  Phone: -800-977-6740.  TTY: Maine relay 711</p>	<p>Medicaid Website:  <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>  Medicaid Phone: 609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>  CHIP Phone: 1-800-701-0710</p>
<p><b>MASSACHUSETTS – Medicaid and CHIP</b></p>	<p><b>NEW YORK – Medicaid</b></p>
<p>Website:  <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a>  Phone: 1-800-862-4840</p>	<p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>  Phone: 1-800-541-2831</p>

<b>MINNESOTA – Medicaid</b>	<b>NORTH CAROLINA – Medicaid</b>
Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a> Phone: 1-800-657-3739	Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a> Phone: 919-855-4100
<b>MISSOURI – Medicaid</b>	<b>NORTH DAKOTA – Medicaid</b>
Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005	Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825
<b>OKLAHOMA – Medicaid and CHIP</b>	<b>UTAH – Medicaid and CHIP</b>
Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742	Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669
<b>OREGON – Medicaid</b>	<b>VERMONT– Medicaid</b>
Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone: 1-800-699-9075	Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427
<b>PENNSYLVANIA – Medicaid</b>	<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</a> Phone: 1-800-692-7462	Website: <a href="https://www.coverva.org/hipp/">https://www.coverva.org/hipp/</a> Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
<b>RHODE ISLAND – Medicaid and CHIP</b>	<b>WASHINGTON – Medicaid</b>
Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022
<b>SOUTH CAROLINA – Medicaid</b>	<b>WEST VIRGINIA – Medicaid</b>
Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820	Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>SOUTH DAKOTA - Medicaid</b>	<b>WISCONSIN – Medicaid and CHIP</b>
Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059	Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002
<b>TEXAS – Medicaid</b>	<b>WYOMING – Medicaid</b>
Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a> Phone: 1-800-440-0493	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

**Employee Benefits Security Administration**

U.S. Department of Labor  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)

**Centers for Medicare & Medicaid Services**

U.S. Department of Health and Human Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)

## **Women's Health and Cancer Rights Act**

Do you know that your plan, as required by the Women's Health and Cancer Right Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment for complications resulting from a mastectomy, including lymphedema? Call your plan administrator at **(281) 471-5020** for more information.

## **Notice of Availability of HIPAA Notice of Privacy Practices**

City of La Porte  
604 W. Fairmont Pkwy  
La Porte, TX 77571

1/1/2021

To: Participants in the City of La Porte Health Plan

From: Human Resources

Re: Availability of Notice of Privacy Practices

The City of La Porte Health Plan (each a "Plan") maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources at 604 W. Fairmont Pkwy, La Porte, TX 77571, (281) 471-5020, [HR@laportetx.gov](mailto:HR@laportetx.gov).

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

## PART A: General Information

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

### **What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2020 for coverage starting January 1, 2021.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% (as adjusted annually) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

### **How Can I Get More Information?**

For more information about your coverage offered by your employer, please check your summary plan description or contact **Human Resources at 604 W. Fairmont Pkwy, La Porte, TX 77571, (281) 471-5020, [HR@laportetx.gov](mailto:HR@laportetx.gov)**.

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

## Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

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

- As your employer, we offer a health plan to:
  - All full-time active eligible employees.
  - We do offer coverage to all eligible dependents.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to

3. Employer name City of La Porte	4. Employer Identification Number (EIN) 74-6001552
5. Employer address, 7. City, 8. State, 9. Zip Code 604 W. Fairmont Pkwy, La Porte, TX 77571	6. Employer phone number (281) 471-5020
10. Who can we contact about employee health coverage at this job? Human Resources	
11. Phone number (if different from above) (281) 471-5020	12. Email address HR@laportetx.gov

be affordable, based on employee wages.

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

### Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no later than 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have 60 days after the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event and provide the employer plan with timely notice of the event and your enrollment request. .

To request special enrollment or obtain more information, contact **City of La Porte, Human Resources at (281) 471-5020.**

# General Notice of COBRA Continuation Coverage Rights

## Continuation Coverage Rights Under COBRA

### Introduction

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

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

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

### What is COBRA continuation coverage?

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

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to City of Conroe, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### **When is COBRA continuation coverage available?**

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

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

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

### **How is COBRA continuation coverage provided?**

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

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

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

#### ***Disability extension of 18-month period of COBRA continuation coverage***

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

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

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

### **Are there other coverage options besides COBRA Continuation Coverage?**

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

## **Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period<sup>1</sup> to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

### **If you have questions**

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

### **Keep your Plan informed of address changes**

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

### **Plan contact information**

Human Resources at 604 W. Fairmont Pkwy, La Porte, TX 77571, (281) 471-5020, [HR@laportetx.gov](mailto:HR@laportetx.gov).

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<sup>1</sup> <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.



604 W. Fairmont Pkwy.  
La Porte, TX 77571  
(281) 470-5028

