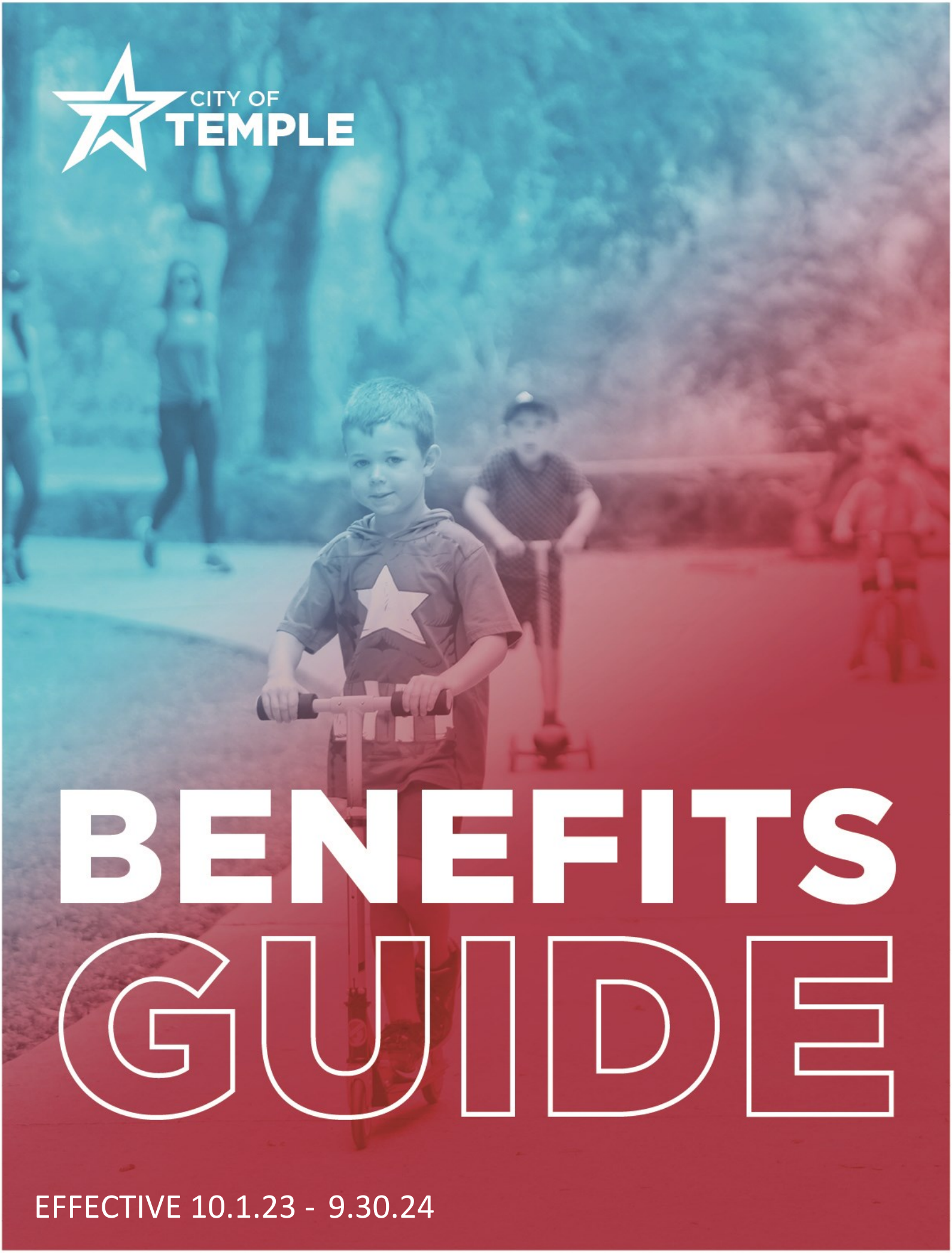

CITY OF
TEMPLE
BENEFITS
GUIDE
EFFECTIVE 10.1.23 - 9.30.24

Welcome

The City of Temple is proud to provide you and your family with valuable and significant benefits. This Employee Benefits Guide was designed with you and your family in mind. This valuable reference guide, is an overview of the services and benefits available to you as an employee of the City of Temple. Please take the time to carefully review the guide for any changes or updates. Inside you will find the information you need to make informed decisions regarding the selection and continued management of your benefits for the 2023-2024 Plan Year.

Table of Contents

Getting Started

Helpful Tips and Reminders

- Be sure to choose the right coverage level, such as individual or family.
- Gather the correct information for your dependents such as social security numbers, birth dates, and smoking status for spouse.
- Make sure your address and personal information is current. If your information is not up-to-date, you may miss out on important information such as insurance cards, plan documents, health notices, etc.
- Need to change your beneficiary? Open Enrollment is an excellent time to ensure that the person designated as your beneficiary is correct regarding your insurance and retirement benefits.
- Visit each vendor's website for additional information. Don't forget to review each plan's provider directory. If your physician or doctor's office is not considered In-network, you cannot change or drop plans mid-year without a qualifying life event.
- You may select any combination of Medical, Dental and / or Vision plan coverage categories. For example, you could select Medical coverage for you and your entire family, but select Dental and Vision coverage only for yourself.
- Some Benefits premiums are deducted on a pre-tax basis, which lessens your tax liability.
- Avoid making quick decisions — **enroll early!**

FAQs

When Does Coverage Begin?

The elections you make are effective October 1, 2023 - September 30, 2024.

New Hires: Coverage starts 1st day of the month following 30 days from your date of hire. Employees who do not elect benefits 15 days from their date of hire will not be able to elect benefits until the next open enrollment unless they experience a qualified life event.

If I Am Already Enrolled and Not Making Any Changes, Do I Have to Complete the Open Enrollment Process?

Yes, this is an **ACTIVE** enrollment. You must re-submit your benefit elections, as previous elections will not roll over into the new plan year. It is important that you review any rate or plan changes to your current plan.

Note: If you do not make any selections, you will not be covered for the 2023-2024 Plan Year.

If I Want to Decline Coverage, Do I still Need to Complete the Open Enrollment Process?

Yes. It is important that People Operations has a record of your decision. Keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a qualifying event as defined on page 8.

Can I Enroll My Spouse or Dependent on One Plan and Myself on Another?

No. All covered dependents, including spouse, must be on the same plan as the employee.

Can I Drop or Change Plans During the Plan Year?

No. Changes can only be made if there has been a qualifying life event as defined on page 6.

Eligibility

Who is Eligible?

If you are a full-time employee of The City of Temple who is regularly scheduled to work 30 hours a week or more, you are eligible to participate in the Medical, Dental, Vision, Life, Disability, and various other benefits as listed in this guide.

Eligible Dependents

Dependents eligible for coverage include:

- Your legal spouse
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26.

Verification of dependent eligibility will be required upon enrollment.

New Hire Coverage

All benefit coverages will begin on the first of the month following the first 30 days of full-time employment for all enrolled full-time employees.

Things to Consider

Take the following situations into account before you enroll to make sure you have the right coverage.

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? If so, do you need to add or remove any dependent(s) and/or update your beneficiary designation?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria.

Qualifying Life Events

Due to IRS regulations, once you have made your choices for the 2023-2024 Plan Year, you won't be able change your benefits until the next open enrollment period unless you experience a Qualifying Life Event.

When one of the following events occurs, you have 31 days from the date of the event to notify People Operations through the online benefits portal.

- Change in your legal marital status (marriage, divorce, annulment, legal separation or death)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your dependent or spouse's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of coverage
- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace
- Change in your address or location that may affect the coverage for which you are eligible

Your change in coverage must be consistent with your change in status. Please direct questions regarding specific life events and your ability to request changes to People Operations.

*The Participant will be required to reimburse The City of Temple, if it is determined that a child is or has become ineligible and The City of Temple has paid benefits. The City of Temple reserves the right to audit or request proof of dependent eligibility at any time.

TIP: If you are currently enrolled in family coverage, new dependents are not automatically enrolled or covered.

You must enroll them through the qualifying event process.

Medical Benefits

High Deductible Health Plan Summary

The City of Temple offers one high deductible health plan option through BlueCross BlueShield. The chart below gives a summary of the 2023-2024 Medical coverage. Please refer to your Summary of Benefits & Coverage for full coverage details.

BlueCross BlueShield HDHP HSA

(Employee Pays)

	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE (PLAN YEAR)		
Individual	$3,500	$14,000
Family	$7,000	$28,000
Coinsurance (Plan Pays)	80%	50%
ANNUAL OUT-OF-POCKET MAXIMUM (Includes Deductible)		
Individual	$5,000	$20,000
Family	$10,000	$40,000
Lifetime Maximum	Unlimited	
COPAYS / COINSURANCE		
Preventive Care	No Charge	50% after deductible
Physician Office	20% after deductible	50% after deductible
Specialist Office	20% after deductible	50% after deductible
Virtual Visits (MD Live)	20% after deductible	Not Covered
Urgent Care	20% after deductible	50% after deductible
Emergency Room	20% after deductible	
Hospital - Inpatient	20% after deductible	50% after deductible
Hospital - Outpatient	20% after deductible	50% after deductible
Diagnostic X-Ray	20% after deductible	50% after deductible
Diagnostic Lab	20% after deductible	50% after deductible
Complex Imaging (CT Scans/MRIs)	20% after deductible	50% after deductible

Network: BlueChoice PPO

Find a Provider Select: Blue Choice PPO SM (BCA)

Health Savings Account

What Is a Health Savings Account?

A tax-advantaged personal savings account designed to complement a qualified High Deductible Health Plan (HDHP). You can use a Health Savings Account to pay for medical, prescription drug, dental, vision, and other qualified expenses now or later in life. The funds can even be invested, making it a great addition to your retirement portfolio.

What Are the Tax Advantages of a Health Savings Account?

Funds contributed to a Health Savings Account are triple tax advantaged:

1. **Money goes in tax free:** The contribution is deposited into your account before taxes are applied to your paycheck making your savings immediate.
2. **Money comes out tax free:** Eligible health care purchases can be made tax free when you use your account. Purchases can be made directly either by using your Debit Card provided by Optum or through online bill pay. You can also pay out of pocket and reimburse yourself from the account.
3. **Funds earn interest—tax free:** The interest on your funds grows on a tax free basis. And, unlike most savings accounts, interest earned on your health savings account is not considered taxable income when the funds are used for eligible health care expenses.

What Happens to the Money in My Account If I No Longer Have HDHP Coverage?

Once you discontinue coverage under an HDHP and/or get secondary coverage that disqualifies you, you can no longer make contributions to your account. However, since you still own the account, you can continue to use the remaining funds for future health care expenses.

Can I Rollover or Transfer Funds From Another Health Savings Account into My New Account?

Yes, those monies may be rolled into your new account and will continue their tax free status.

What Expenses Are Eligible for Reimbursement?

- Copays
- Deductibles
- Coinsurance
- Vision
- Dental
- Certain Medical Supplies

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

You are responsible for ensuring the money is spent on qualified purchases only and maintain records to withstand IRS scrutiny. Funds used for non-qualified expenses are subject to income tax and an additional 20% tax.

Am I Eligible to Participate?

In order to contribute you must be:

- Enrolled in a qualified HDHP

In addition you **must not be:**

- Covered under a secondary health plan that is not a qualified HDHP, including a full purpose Flexible Spending Account through your employer, parent or spouse.
- Enrolled in Medicare
- Another person's tax dependent

Can I Change My Contributions Throughout the Year?

Yes, contact People Operations.

How Much Can I Contribute?

Contributions from you and the City cannot exceed $4,150 for individuals or $8,300 for individuals + dependents. Individuals aged 55 and over may make up to an additional $1,000 catch-up contribution annually.

Do I Have to Spend All of My Contributions by the End of the Plan Year?

No, unused money in your account rolls over and continues to grow tax free.

What Happens If My Employment Is Terminated?

Money in your account is yours to keep, the account belongs to you.

Health Savings Account (HSA)

Contributions to the HSA are limited by the amount established by IRS guidelines. The HSA maximum contribution levels for 2023 are $3,850 for employee only and $7,750 for employee + family. For tax year 2024 are $4,150 for employee only and $8,300 for employee + family. Individuals can use tax-free HSA dollars for qualified medical expenses.

Individuals who are 55 years of age or older and not on Medicare can make catch-up contributions up to $1,000.

Your contributions are pre-tax and can be funded:

- Electronically through payroll deduction (this is required to receive any pre-tax benefit).
- Directly to the account by you:
  - At the end of the year.
  - As claims are incurred.
  - On a one time, monthly or quarterly basis.

Note: Deposits will need to be reported on your IRS tax form the following year. Please be careful not to exceed the non-taxable IRS contribution level. Deductions may be adjusted if approaching contribution maximum.

The HSA is administered through Optum. Optum will provide you with tax forms at the end of the year to submit with a 1040. **All medical expense receipts need to be retained by you to document eligible distributions.**

HSA distributions are tax-free for qualified expenses if taken by you, your spouse or dependent(s). Your spouse or dependents do not need to be covered by a high deductible health plan (HSA plans). If the HSA funds are not used for qualified medical expenses, then the amount is included as income and a 20% penalty is applied by the IRS. HSA funds can be withdrawn by using a debit card or a check. (Note: Some reimbursement methods may require additional service fees charged by Optum.)

2023 HSA Maximum Contributions	
Employee Only	$3,850
Employee + Family	$7,750
Catch-Up (55+ Years)	$1,000

2024 HSA Maximum Contributions	
Employee Only	$4,150
Employee + Family	$8,300
Catch-Up (55+ Years)	$1,000

City HSA Contribution	
HDHP HSA	$1,460

Medical Benefits

PPO Health Plan Summary

The City of Temple offers one PPO medical plan option through BlueCross BlueShield. The chart below gives a summary of the 2023-2024 Medical coverage. Please refer to your Summary of Benefits & Coverage for full coverage details.

BlueCross BlueShield PPO PLAN

(Employee Pays)

	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE (PLAN YEAR)		
Individual	$1,500	$6,000
Family	$3,000	$12,000
Coinsurance (Plan Pays)	80%	50%
ANNUAL OUT-OF-POCKET MAXIMUM (Includes Deductible)		
Individual	$2,500	$10,000
Family	$5,000	$20,000
Lifetime Maximum	Unlimited	
COPAYS / COINSURANCE		
Preventive Care	No Charge	50% after deductible
Physician Office	$25 copay	50% after deductible
Specialist Office	$45 copay	50% after deductible
Virtual Visits	$25 copay	Not Covered
Urgent Care	$100 copay	50% after deductible
Emergency Room	Facility: $350 copay then 20% Physician: 20% after deductible	
Hospital - Inpatient	20% after deductible	50% after deductible
Hospital - Outpatient	20% after deductible	50% after deductible
Diagnostic X-Ray/Lab	No Charge	50% after deductible
Complex Imaging (CT Scans/MRIs)	20% after deductible	50% after deductible

Network: BlueChoice PPO
Find a Provider Select: Blue Choice PPO SM (BCA)

Pharmacy Benefits

BlueCross BlueShield PPO PLAN

	In-Network	Out-of-Network
PRESCRIPTION DRUGS (NO DEDUCTIBLE APPLIES)		
RETAIL	Participating Pharmacy	Non-Participating Pharmacy
Preferred Generic	$10 copay	50% after copay
Preferred Brand	$30 copay	50% after copay
Non-Preferred Brand	$60 copay	50% after copay
Specialty	30% to a maximum of $75	50% after copay
MAIL ORDER (90 DAY SUPPLY)		
Preferred Generic	$25 copay	50%
Preferred Brand	$75 copay	50%
Non-Preferred Brand	$150 copay	50%

Note: Please refer to Summary Plan Description for a full outline of your medical coverage.

BlueCross BlueShield HDHP HSA

	In-Network	Out-of-Network
PRESCRIPTION DRUGS (DECUCTIBLE COMBINED WITH MEDICAL)		
RETAIL	Participating Pharmacy	Non-Participating Pharmacy
Preferred Generic	20% after deductible	50% after deductible
Preferred Brand	20% after deductible	50% after deductible
Non-Preferred Brand	20% after deductible	50% after deductible
Specialty	20% after deductible	50% after deductible
MAIL ORDER (90 DAY SUPPLY)		
Preferred Generic	20% after deductible	50% after deductible
Preferred Brand	20% after deductible	50% after deductible
Non-Preferred Brand	20% after deductible	50% after deductible

Note: Please refer to Summary Plan Description for a full outline of your medical coverage.

Medical Insurance Waiver & Wellness Incentives

PLEASE NOTE FOR THE 2023-2024 PLAN YEAR THE CITY WILL ONLY REQUIRE A TOBACCO ATTESTATION FORM.

TOBACCO FREE

All Employees enrolled in medical coverage are eligible for a medical insurance premium incentive if they and their dependents do not use tobacco or nicotine products in any form.

Tobacco Free Incentive	$40 per month

TOBACCO CESSATION

If you (and any dependent of yours covered by the City's health insurance) successfully complete a tobacco cessation program AND avoid all use of tobacco products for a period of not less than six months, evidence by a sworn statement by you (where applicable) and any of your covered dependents, and by written verification from a physician, the surcharge will be terminated for the remainder of the plan year as long as you and all of your dependents on the City's insurance continue to avoid the use of tobacco products. Documentation upload to the electronic attestation form is required.

WAIVER

All employees who waive medical coverage through the City of Temple are eligible to receive either $125 deposited monthly into their Mission Square Retirement Account OR $100 monthly included in their paycheck. Proof of other qualified insurance coverage is required in order to receive the waiver incentive.

All documentation must be submitted prior to the close of enrollment, every year at time of enrollment. Late submissions will not receive retroactive incentive payment, and the first incentive will be paid on the next paid period following receipt of the documentation.

Medical Benefits

Medical Premiums

Below are the Medical rates for the BlueCross BlueShield medical plans. Premium contributions for Medical will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your semi-monthly contributions, and all below rates assume all wellness incentives.

BCBS HDHP HSA

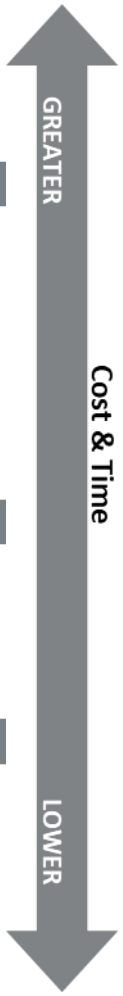
	Monthly Premium	City Base Contribution	Incentive	Total City Contribution	Employee Monthly Contribution	Employee Semi-Monthly Contribution
CONTRIBUTIONS						
Employee Only	$469.57	$429.57	$40.00	$469.57	$0.00	$0.00
Employee + Spouse	$909.31	$669.31	$40.00	$709.31	$200.00	$100.00
Employee + Child(ren)	$646.06	$556.06	$40.00	$596.06	$50.00	$25.00
Employee + Family	$1,131.08	$741.08	$40.00	$781.08	$350.00	$175.00

BCBS PPO

	Monthly Premium	City Base Contribution	Incentive	Total City Contribution	Employee Monthly Contribution	Employee Semi-Monthly Contribution
CONTRIBUTIONS						
Employee Only	$577.31	$477.31	$40.00	$517.31	$60.00	$30.00
Employee + Spouse	$1,117.95	$577.95	$40.00	$617.95	$500.00	$250.00
Employee + Child(ren)	$794.31	$579.31	$40.00	$619.31	$175.00	$87.50
Employee + Family	$1,390.59	$650.59	$40.00	$690.59	$700.00	$350.00

Know Where to Go

Where to Go Guide	Conditions Treated*	Your Cost & Time
Emergency Room		
For the immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room. Open 24/7.	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath; Chest pain • Head injury/major trauma • Blurry or loss of vision • Severe cuts or burns • Overdose	• Costs are highest • No appointment needed • Wait times may be long, averaging over 4 hours
Urgent Care Center		
For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	• Minor cuts, sprains, burns, rashes • Fever and flu symptoms • Headaches • Chronic lower back pain • Joint pain • Minor respiratory symptoms • Urinary tract infections	• Costs are lower than an ER visit • No appointment needed • Wait times vary
Doctor's Office		
The best place to receive routine or preventive care or track medications.	• General health issues • Preventive services • Routine checkups • Immunizations and screenings	• May include coinsurance and/or deductible • Appointment usually needed • May have little wait time
Convenience Care Clinic		
Staffed by nurse practitioners and physician assistants. Treat minor medical concerns that are not life threatening. Located in retail stores and pharmacies, they're often open nights and weekends.	• Common cold/flu • Rashes or skin conditions • Sore throat, earache, sinus pain • Minor cuts or burns • Pregnancy testing • Vaccinations	• Costs are same or lower than an office visit • No appointment needed • Wait times typically 15 minutes or less
Virtual Medicine		
Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or smart phone mobile app.	• Cold and flu symptoms such as a cough, fever and headaches • Allergies; Sinus infections • Family health questions	• Most Convenient • No appointment needed • Immediate, private, and secure visits



Dental Benefits

Dental Plan Summary

The chart below gives a summary of the 2023-2024 Dental coverage provided by BlueCross BlueShield. Employees have the option to choose between two dental plan options. You may see any dentist, however in-network providers have agreed to accept reduced fees for services. All out-of-network services are subject to Usual and Customary (U&C) limitations.

	Base Plan		Buy-Up Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
ANNUAL DEDUCTIBLE				
Individual	$0		$50	
Family	$0		$150	
ANNUAL MAXIMUM BENEFIT				
Per Person	$1,000		$2,000	
COVERED SERVICES				
Preventive Services Oral Exams, X-Rays, Bitewing X-Rays, Routine Cleanings, Fluoride Treatments, Sealants	100%	MAC	100%	100% of U&C
Basic Services* Fillings, Simple extractions, Endodontics, Periodontics, Anesthesia, Complex Oral Surgery	80%	MAC	80%	80% of U&C
Major Services* Implants, Inlays, Onlays, Crowns, Prosthodontics	25%	MAC	50%	50% of U&C
Orthodontia (Child & Adult)	None		50%	
Orthodontia Lifetime Maximum (per individual)	N / A		$1,500 Lifetime Maximum	

*After Deductible

MAC (Maximum Allowable Charge)

Dental Benefits

Dental Premiums

Dental Plan benefits are available to you on a voluntary basis through Blue Cross Blue Shield. Premium contributions for Dental will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your semi-monthly contributions.

BCBS BASE PLAN

	Monthly Premium	City Contribution	Employee Monthly Contribution	Employee Semi-Monthly Contribution
CONTRIBUTIONS				
Employee Only	$19.73	$19.73	$0.00	$0.00
Employee + Spouse	$39.03	$19.73	$19.30	$9.65
Employee + Child(ren)	$48.55	$19.73	$28.82	$14.41
Employee + Family	$70.24	$19.74	$50.50	$25.25

BCBS BUY-UP PLAN

	Monthly Premium	City Contribution	Employee Monthly Contribution	Employee Semi-Monthly Contribution
CONTRIBUTIONS				
Employee Only	$35.72	$19.74	$15.98	$7.99
Employee + Spouse	$71.98	$19.74	$52.24	$26.12
Employee + Child(ren)	$97.16	$19.74	$77.42	$38.71
Employee + Family	$133.44	$19.74	$113.70	$56.85

Finding a Dentist

- Visit www.bcbstx.com/find-care/providers-in-your-network/find-a-dentist then click BlueCare Dental..
- You can search by location, county, center or dentist name.

Vision Benefits

Vision Plan Summary

The chart below gives a summary of the 2023-2024 Vision coverage provided by Standard. Periodic eye examinations are an important part of routine preventive healthcare. All out-of-network services are reimbursement levels.

	Vision Plan	
	In-Network	**Out-of-Network (Reimbursement Amount)**
COPAY		
Examination	$10 copay	Up to $45
COVERED MATERIALS		
LENSES		
Single Vision	Covered in Full	Up to $30 allowance
Bifocal	Covered in Full	Up to $50 allowance
Trifocal	Covered in Full	Up to $65 allowance
Lenticular	Covered in Full	Up to $100 allowance
Progressive	Contracted Fee for Bifocals	Up to $50 allowance
Specialty Lenses	20% Discount off Retail +	Standard Lens Reimbursement
FRAMES		
Retail Frame Equivalent	$150 allowance + 20% discount	Up to $70 allowance
CONTACTS		
Elective Contact Lenses	$150 allowance	Up to $120 allowance
Medically Necessary	Covered in full	Up to $210 allowance
FREQUENCY		
Examination	Every 12 Months	
Lenses	Every 12 Months	
Frames	Every 24 Months	
Contacts	Every 12 Months	

Vision Benefits

Vision Premiums

Vision Plan benefits are available to you on a voluntary basis. Premium contributions for Vision will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your semi-monthly contributions.

	VISION PLAN	
	Employee Monthly Contribution	Employee Semi-Monthly Contribution
CONTRIBUTIONS		
Employee Only	$5.74	$2.87
Employee + Spouse	$10.04	$5.02
Employee + Child(ren)	$12.16	$6.08
Employee + Family	$14.92	$7.46

Finding a Doctor

- The Standard Vision Plan utilizes the VSP network. To find a provider online, log into www.standard.com/services and search for a VSP Provider

- For customer service call 1-800-877-7195.

Flexible Spending Account

What is a Flexible Spending Account?

You can pay for eligible health care and dependent care expenses with pre-tax income through a Flexible Spending Account. You do not pay federal income tax on your contribution.

The Flexible Spending Account reimburses you for eligible health care expenses that are not covered by insurance. Expenses may be incurred by you, your spouse, and your dependent children, regardless of whether they are covered by the City's medical, dental or vision plans.

The Flexible Spending Account also reimburses you for certain dependent care expenses incurred while you and/or your spouse work.

How Spending Accounts Work

You choose to contribute part of your earnings into the Medical Flexible Spending Account and/or the Dependent Care Flexible Spending Account. The accounts are maintained separately and you cannot make transfers between them. These accounts will reimburse you for eligible expenses that you submit throughout the year.

Those employees who participate in the High Deductible Health Plan with the Health Savings Account, have the opportunity to contribute pre-tax funds to a Limited Purpose Flexible Spending Account, which can be used for dental and vision expenses only.

- Estimate your annual health care expenditures on items not reimbursed by insurance.
- Decide how much money you want to contribute to the account up to $3,050 per tax year. The money is deducted before taxes, so taxes are withheld on a lower amount of your earnings (pre-tax basis).
- The City offers a debit card that allows eligible expenses to be deducted directly from your account.
- You may also file a paper or online claim when you have eligible health care expenses.
- At the end of the year, you have a 75 day run out period to submit reimbursement for claims from the prior plan year.

What Is the Dependent Care Account?

The Dependent Care Account allows you to put aside up to $5,000 pre-tax for your qualified dependent care expenses for any dependents who live with you and rely on you for more than half of their support as claimed on your taxes. Dependents include:

- Children under the age of 13.
- Persons of any age, if physically or mentally disabled, and claimed on your federal income tax return.
- You may be reimbursed for day care expenses only if this enables you to work. If married, your spouse must also work or be looking for work, be a full-time student, or be disabled.

The City will contribute $200 a month for any employee with a dependent child under the age of 5 as of 9/1/2023 who enrolls in the Dependent Care FSA. This benefit is limited to one per household.

How Much Can I Contribute?

Contributions cannot exceed $3,050 for the Medical and Limited Purpose FSAs and $5,000 for the Dependent Care FSA.

Do I Have to Spend All of My Contributions by the End of the Plan Year?

Yes, employees must spend all contributions in the plan year and will have a 75 day run out period to file for reimbursement.

(FLEXIBLE SPENDING ACCOUNT)

FSA ELIGIBLE EXPENSES

ELIGIBLE EXPENSE EXAMPLES

There are thousands of eligible expenses for tax-free purchase with your account funds, including prescriptions, doctor's office copays, health insurance deductibles, and coinsurance. Many over-the-counter (OTC) treatments are also eligible.

- ✓ Acupuncture
- ✓ Alcoholism treatment
- ✓ Ambulance
- ✓ Artificial limb
- ✓ Birth control pills
- ✓ Blood pressure monitoring device
- ✓ Breast pumps and related supplies
- ✓ Chiropractic care
- ✓ Contact lenses and related materials
- ✓ Dental treatment
- ✓ Dentures
- ✓ Diagnostic services
- ✓ Drug addiction treatment
- ✓ Eye examination, eye glasses, and reading glasses
- ✓ Family planning items
- ✓ Fertility treatment
- ✓ Flu shot
- ✓ Hearing aids
- ✓ Hospital services
- ✓ Immunization
- ✓ Insulin and diabetic supplies
- ✓ Laboratory fees
- ✓ Laser eye surgery
- ✓ Medical testing devices
- ✓ Menstrual care products
- ✓ Nursing services
- ✓ Obstetrical expenses
- ✓ Orthodontia (not for cosmetic reasons)
- ✓ Over-the-counter (OTC) treatments containing medicine–cold treatments, ointments, pain relievers, stomach remedies, etc.
- ✓ Over-the-counter (OTC) treatments without medicine–bandages, wraps, medical testing devices, etc.
- ✓ Oxygen
- ✓ Physical exam
- ✓ Physical therapy
- ✓ Prescription drugs
- ✓ Psychiatric care
- ✓ Smoking cessation program and medications
- ✓ Surgery
- ✓ Sunscreen & sun block (SPF 15+, broad spectrum)
- ✓ Transportation for medical care
- ✓ Weight loss program necessary to treat a specific medical condition
- ✓ Wheelchair, walkers, crutches, and canes

(DEPENDENT CARE ASSISTANCE PROGRAM)

DCAP ELIGIBLE EXPENSES

ELIGIBLE EXPENSE EXAMPLES

Dependent Care Assistance Program funds cover care costs for your eligible dependents to enable you to work.

- ✓ Before school or after school care (other than tuition)
- ✓ Qualifying custodial care for dependent adults
- ✓ Licensed day care centers
- ✓ Nursery schools or pre-schools
- ✓ Placement fees for a dependent care provider, such as an au pair
- ✓ Child care at a day camp, nursery school, or by a private sitter
- ✓ Late pick-up fees
- ✓ Summer or holiday day camps

(LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT)

LPFSA ELIGIBLE EXPENSES

ELIGIBLE EXPENSE EXAMPLES

There are many eligible expenses for your Limited Purpose FSA dental and vision account funds. Funds may even be used for eligible expenses for your spouse or eligible dependents.

- ✓ Artificial teeth
- ✓ Contact lenses and related materials
- ✓ Dental examination
- ✓ Dental and vision coinsurance, copayments, and deductibles
- ✓ Dental and vision screening tests
- ✓ Dental crowns (metal / porcelain)
- ✓ Dental x-rays
- ✓ Dentures
- ✓ Eye examination
- ✓ Eye glasses and related materials
- ✓ Laser eye surgery
- ✓ Occlusal guards
- ✓ Optometrist
- ✓ Orthodontia (not for cosmetic reasons)
- ✓ Radial keratotomy
- ✓ Shipping and handling fees on eligible expenses
- ✓ Sunglasses (prescription)

For more information, visit **optumfinancial.com**

Dependent care assistance programs (DCAPs) are administered on behalf of your plan sponsor by Optum Financial, Inc. and are subject to eligibility and restrictions. Please contact a legal or tax professional for advice on eligibility, tax treatment, and restrictions. Please contact your plan administrator with questions about enrollment or plan restrictions. Federal and state laws and regulations and the design of your plan are subject to change.

WF4625008-136941-042021

OPTUM Financial™

How to submit a reimbursement request

If you used personal funds — a personal credit card, cash or check — to pay for an eligible expense, you'll have to submit a request to be reimbursed. Here's how.

Step 1

Getting started

Log into your account online or by using the mobile app.

Step 2

Enter the required information

Select "Make a Payment" and follow the on-screen prompts to fill in the requested information.

Step 3

Check your documentation

Be sure your documentation contains these five pieces of information:

1. Patient name
2. Date of service
3. Doctor's name
4. Description of the service
5. Amount charged

Use technology to your advantage

Save yourself time by downloading our secure mobile app. Use it to:

- View account balances and payments
- Request a payment
- Receive important account alerts
- Take a photo of your receipt and upload it directly to the system
- View FAQs or tap to call Customer Service

Are you an advanced user? Sign up for mobile alerts in your online account for text messaging.

Step 4

Submit your documentation

Follow the on-screen prompts to submit your documentation. If you are on your phone, you can take a picture and upload it directly. If on your computer, you can browse and select your image to upload.

You also have the option to fax your documentation when online, though this method takes longer to receive reimbursement. Fax the form, along with your documentation, to the number on the form. Continue through the on-screen prompts to finalize you're request.

Each fax cover form has a unique barcode at the top; be sure to use the fax cover form for this claim. If you have more than one claim, send each claim as a separate fax.

You're done. If we have all the information we need, we'll process the claim.

**Health savings accounts (HSAs) will not require documentation, but you should always retain your documentation in case it is needed at tax time.*

Online access

Mobile access

24/7 access

Optum Customer Service: 877-292-4040

Income Protection

Short Term Disability (STD)

Short Term Disability (STD) benefits are available to you on a voluntary basis through Standard. STD insurance protects a portion of your income if you become partially or totally disabled for a short period of time. It replaces 60% of your income, up to a maximum weekly benefit of $1,500, depending on your current annual earnings. You have two benefit options, 1) you must be sick or disabled for at least 7 days or 2) you must be sick or disabled for 14 days before you can receive a benefit payment. Payments may last up to 26 weeks, and exhaustion of sick leave is not required prior to receiving benefit payments. Certain exclusions may apply. Please refer to your Summary Plan Description or plan certificate for details or contact People Operations for questions.

Long Term Disability (LTD)

Long Term Disability (LTD) benefits are provided for all full time City employees at no cost to you through Standard. LTD insurance protects a portion of your income if you become partially or totally disabled for an extended period of time. This insurance replaces 60% of your income, up to a maximum of $5,000 per month, depending on your current annual earnings. You must be sick or disabled for at least 180 days before you can receive a benefit payment. Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your Summary Plan Description or plan certificate for details or contact People Operations for questions.

Voluntary STD	
Benefit Percentage	60%
Maximum Weekly Benefit	$1,500
Elimination Period	Option 1: 7/7 Days Option 2: 14/14 Days
Duration of Benefits	Up to 26 weeks
Pre-Existing Condition Limitation	None

Long Term Disability	
Benefit Percentage	60%
Maximum Monthly Benefit	$5,000
Elimination Period	180 Days
Duration of Benefits	To Age 65
Pre-Existing Condition Limitation	3 months / 12 months
Mental Disorder/Self Reported	24 Months

Survivor Benefits

Life Insurance

The City of Temple provides all full time employees with Basic Life / AD&D Insurance at no cost to you through Standard. Employees also have the option to purchase additional voluntary life insurance for themselves, their spouse and their dependent children. In order to purchase coverage for dependents, an employee must elect coverage for themselves.

Basic Group Term Life / AD&D (Paid for by the City)	
Eligibility	All Full Time Employees
Life Benefit Amount	One Times Annual Salary to a Maximum of $100,000
AD&D Benefit Amount	One Times Annual Salary to a Maximum of $100,000

Voluntary Life / AD&D (Paid for by employee)	
Eligibility	All Full Time Employees
Life Benefit Amount	Employee: $10,000 increments to $300,000 maximum Spouse: $5,000 increments to $150,000 maximum Children: $10,000
Guarantee Issue*	Employee: $150,000 Spouse: $50,000 Children: All Guarantee Issue
Conversion	Included

*Guarantee Issue is available at initial eligibility
*Any coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability.

Additional Voluntary Benefits

Premiums are paid by employee and will vary based on plan selected and employee age. Both plans are offered through Standard.

Critical Illness Insurance

Facing a critical illness is difficult. There is so much to think about – from deciding between your treatment options to managing your family's everyday needs to maintaining your financial and emotional stability. City of Temple Critical Illness insurance can provide immediate financial relief from the overwhelming expenses of a serious illness, such as a heart attack, stroke or organ failure. It pays a lump-sum cash benefit when you are diagnosed with a covered illness easing your financial worries. In short, The City of Temple Critical Illness insurance can provide a financial cushion to help you manage your illness, your way. It's that simple.

Accident Insurance

You do everything you can to keep your family safe, but accidents do happen. When they do, it's good to know you have help to manage the unexpected bills that come with them. The City of Temple Accident insurance is designed to cover unexpected expenses that result from all kinds of accidents. Your benefits come directly to you without any restrictions on how you can use them. You can't predict when unexpected accidents will happen, but you can help protect your family from the expenses accidents bring with them. The City of Temple Accident insurance provides a financial cushion to help you take care of bills, so you can take care of each other. It's that simple.

Voluntary Critical Illness	
Benefit	EE: $5,000 increments to $30,000 SP: $5,000 increments to $30,000 CH: 50% of Employee Benefit
Guarantee Issue	Employee: $30,000 Spouse: $30,000 Child: 50% of EE Amount
Heart Attack	100%
Stroke	100%
Heart Failure	100%
Cancer	100%
Kidney Failure	100%
Major Organ Failure	100%
Paralysis	100%
Alzheimer's Disease	100%
Advanced Parkinsons	100%
Coma	100%
Loss of Sight	100%
Loss of Hearing	100%
Pre-Existing Condition	None
Health Screening	$50

Voluntary Accident	
Emergency Care	
Ambulance	$300
Air Ambulance	$800
Accident Physician Office	$50
Accident ER Treatment	$150
Major Diagnostic Exam	$200
X-ray	$50
Treatment Care	
Hospital Admission	$1,000
Hospital Confinement Daily Benefit	$200
Intensive Care Unit Daily Benefit	$200
Transportation for Care (30 days)	$150
Companion Lodging (30 days)	$175
Fractures	Schedule up to $8,000 depending on location and whether open/closed
Dislocations	Schedule up to $5,000 depending on location
Accidental Death & Dismemberment	
Employee	$50,000
Spouse	$25,000
Child	$12,500

Additional Voluntary Benefits

Hospital Indemnity Insurance

Employees have the opportunity to elect Voluntary Hospital Indemnity through Standard. Hospital Indemnity Insurance is a comprehensive plan that provides direct payment to you when hospitalization due to accident or sickness. Below shows an example of the Hospital Indemnity offering.

Voluntary Hospital Indemnity	
	HOSPITAL INDEMNITY PAID TO EMPLOYEE
Hospital Admission	$1,000
Critical Care Admission*	$500
Hospital Confinement Non-ICU Critical Care Unit*	 $100/day (15 days) $50/day (15 days)*
Health Screening	$50
Pre-Existing Condition	None

*Critical Care Unit Benefit Pays In addition to Non-ICU Confinement Benefit

Employee Assistance Program

DEER OAKS EAP SERVICES

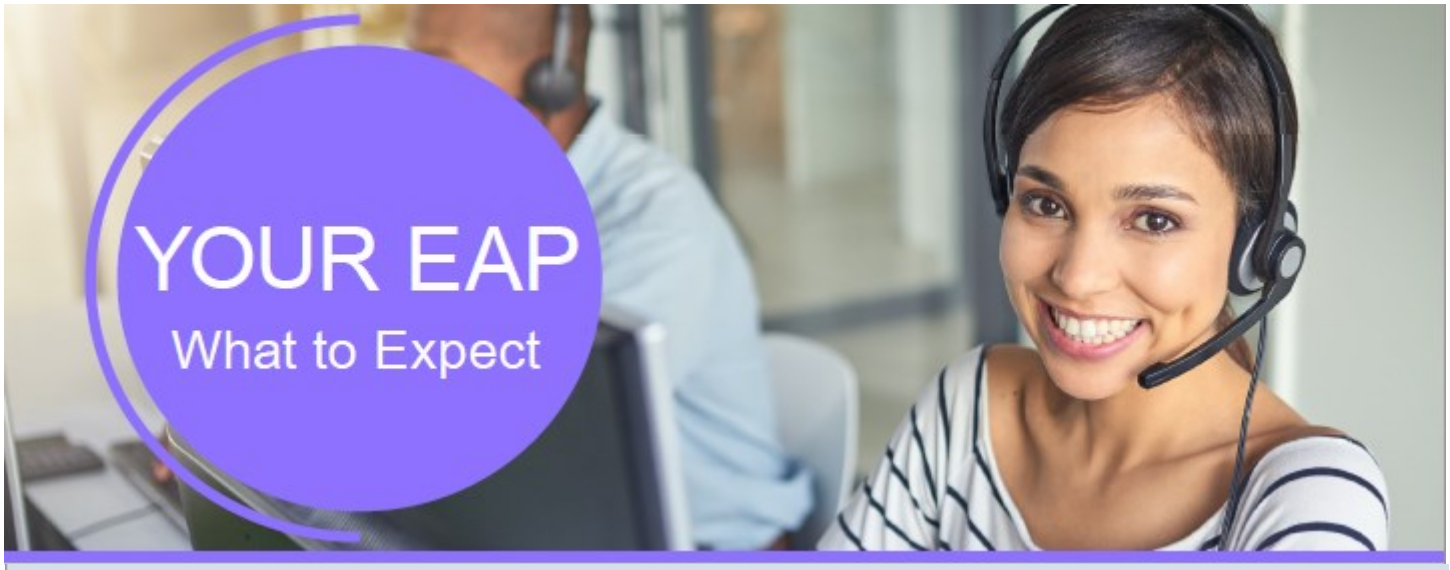
Employee Assistance Program

The Deer Oaks Employee Assistance Program (EAP) is a free service provided for you, your dependents, and household members by your employer. This program offers a wide variety of counseling, referral, and consultation services, which are all designed to assist you and your family in resolving work and life issues in order to live happier, healthier, more balanced lives. From stress, addiction, and change management, to locating child care facilities, legal assistance, and financial challenges, our qualified professionals are here to help. These services are completely confidential and can be easily accessed 24/7, offering you around-the-clock assistance for all of life's challenges.

- Program Access: You may access the EAP by calling the toll-free Helpline number, using our iConnectYou App, or instant messaging with a work-life consultant through our online instant messaging system.
- Telephonic Assessments & Support: In-the-moment telephonic support and crisis intervention are available 24/7 along with intake and clinical assessments.
- Short-term Counseling: Counseling sessions with a qualified counselor to assist with issues such as stress, anxiety, grief, marital/family challenges, relationship issues, addiction, etc. Counseling is available via structured telephonic sessions, video, and in-person at local provider offices.
- Referrals & Community Resources: Our team provides referrals to local community resources, member health plans, support groups, legal resources, and child/elder care/daily living resources.
- Advantage Legal Assist: Free 30 minute telephonic or in-person consultation with a plan attorney; 25% discount on hourly attorney fees if representation is required; unlimited online access to a wealth of educational legal resources, links, tools and forms; and interactive online Simple Will preparation.
- Advantage Financial Assist: Unlimited telephonic consultation with an Accredited Financial Counselor qualified to advise on a range of financial issues such as bankruptcy prevention, debt reduction, financial planning, and identity theft; supporting educational materials available; unlimited online access to a wealth of educational financial resources, links, tools and forms (i.e. tax guides, financial calculators, etc.).
- Alternate Modes of Support: Your EAP offers support alternatives in addition to traditional short-term counseling including telephonic life coaching, AWARE stress reduction sessions, and virtual group counseling. During your call with one of our counselors, ask if these programs would be right for you.
- Work-life Services: Our work-life consultants are available to assist you with a wide range of daily living resources such as locating pet sitters, event planners, home repair, tutors, travel planning, and moving services. Simply call the Helpline for resource and referral information.
- Child & Elder Care Referrals: Our child and elder care specialists can help you with your search for licensed child and elder care facilities in your area. They will discuss your needs, provide guidance, resources, and qualified referral packets. Searchable databases and other resources are also available on the Deer Oaks member website.
- Take the High Road Ride Reimbursement Program: Deer Oaks reimburses members for their cab, Lyft and Uber fares in the event that they are incapacitated due to impairment by a substance or extreme emotional condition. This service is available once per year per participant, with a maximum reimbursement of $45.00 (excludes tips).

CONTACT US:
Toll-Free: (888) 993-7650
Website: www.deeroakseap.com
Email: eap@deeroaks.com

Employee Assistance Program



Who can use the EAP?
Employees, their dependents, and household members are eligible to access services. Coverage continues for six (6) months post-employment.

How can I access services?
By calling the toll-free Helpline, by downloading our iConnectYou Smartphone App, or through our website. A counselor is always available to help.

Who do I speak with when I call the EAP?
All calls into the EAP are answered by Master's level counselors who will conduct intake to gather demographic information and to understand the challenges that prompted you to call the EAP. If a clinical referral is needed, the intake counselor will conduct a telephonic clinical assessment during the call.

How long is the initial call with the intake counselor?
Although each call varies, the average call length including clinical assessment is around 20 minutes.

What Kinds of Problems Do You Help With?
Counseling can be provided for most issues that are affecting your work, family or personal well-being. Some examples include: interpersonal, familial, or marital conflicts; anxiety and depression; loss and grief; substance abuse; and crisis management/trauma.

Are there issues that can not be addressed through the EAP?
Yes. Not every issue is appropriate for short-term counseling through the EAP. For example, the EAP does not cover issues that require physician/psychiatric evaluation, psychological testing, chronic mental health illness, long-term psychotherapy treatment, or inpatient or residential treatment services. In these cases, we will provide you with an appropriate referral to either your health plan or to other community resources.

What happens after I complete the intake call?
Following the initial intake call, our team will search for a local affiliate counselor that has appropriate availability for your case. The counselor referral will be emailed to you within three business days. Some referrals with specific criteria such as an evening appointment or a counselor that speaks a specific language may take longer to identify and confirm. Once you receive the referral, you will need to call the referred counselor directly to schedule an appointment.

What should I do if I don't receive the referral?
We recommend first checking your spam/junk folder as referrals are typically provided via email. If the referral is not in your inbox or spam/junk mail, you may call the Helpline to inquire about the status of your referral.

Is the EAP only for counseling?
No. We offer unlimited telephonic consultation with financial counselors, 30-minute consultations with attorneys, and can assist with locating nearly endless resources such as finding care for pets, personal care, travel, contractors, education, and managing day-to-day responsibilities at home, and work.

Is It Really Confidential?
Yes! All information, assessments, and referrals through the EAP are held highly confidential and protected by the HIPAA Privacy Rule. The EAP will not release information to anyone, including your employer or family member, without your written consent. However, in situations where there is a danger to the individual or others, the Deer Oaks counselor is obligated by law to make appropriate notification.

What Does It Cost?
There is no charge to you or your household members to access the EAP. This benefit is paid for by your employer.

Helpline: (888) 993-7650 Website: www.deeroakseap.com E-mail: eap@deeroaks.com

Retiree Benefits

THE CITY OF TEMPLE IS PLEASED TO ANNOUNCE YOUR 2023-2024 BENEFIT PLANS. PLEASE REVIEW YOUR PLAN OPTIONS BEFORE MAKING YOUR FINAL PLAN ELECTIONS. FURTHER DETAILS ABOUT ALL OF YOUR PLANS ARE INCLUDED IN THIS ENROLLMENT GUIDE. PLEASE REVIEW YOUR CHOICES CLOSELY, AS YOU WON'T BE ABLE TO MAKE CHANGES TO YOUR ELECTIONS UNTIL NEXT OPEN ENROLLMENT.

WHEN CAN I ENROLL?

At Retirement: You must enroll within thirty (30) days of your retirement effective date. If you do not enroll or you reject coverage for any benefit, you will not be eligible to enroll in that benefit in the future.

Initial Enrollment Eligibility: An employee is eligible to enroll in retiree benefits if they meet the full retirement eligibility requirements as established by TMRS. Proof of retirement eligibility must be provided at time of enrollment.

Medical

The City of Temple offers retirees a choice of two medical plans through BlueCross Blue Shield of Texas. One plan has copayments for services provided in a doctor's office and for most prescription drugs. For services in a hospital or outpatient setting, there will be a deductible that you will be responsible to pay. The remaining plan is a High Deductible Health Plan, and members will be responsible for the contracted rate until applicable deductibles have been met. The City contributes $200 per month for all retirees with 25+ years of service.

Dental

Retirees may choose to enroll in one of two dental plans offered through BlueCross BlueShield of Texas. Both offer benefits for contracted and non-contracted dentists.

Please see the following two pages for retiree rates for medical and dental.

Reminder: Retirees may change health plan and dental plan elections during open enrollment or due to a qualifying life event, however retirees are not eligible to enroll in a plan they are not currently enrolled in. In addition, retirees are not eligible to add dependents to their plan if the dependent is not currently enrolled.

Retirees are eligible for coverage until the age of 65.Upon attaining age 65, retirees are eligible to enroll in the Medicare Supplement Plan (Senior Care) and are no longer eligible for the current group coverage.

Retiree Medical Rates

BCBS HDHP HSA

	Monthly Premium (Retirees with less than 25 years of Service)	City Contribution (Retirees with 25+ Years of Service)	Retiree Monthly Contribution (Retirees with 25+ Years of Service)
CONTRIBUTIONS			
Retiree Only	$646.20	$200	$446.20
Retiree + Spouse	$1,251.32	$200	$1,051.32
Retiree + Child(ren)	$889.06	$200	$689.06
Retiree + Family	$1,556.48	$200	$1,356.48
Retiree Spouse Only	$646.20	$0.00	$646.20

BCBS PPO

	Monthly Premium (Retirees with less than 25 years of Service)	City Contribution (Retirees with 25+ Years of Service)	Retiree Monthly Contribution (Retirees with 25+ Years of Service)
CONTRIBUTIONS			
Retiree Only	$850.71	$200	$650.71
Retiree + Spouse	$1,647.37	$200	$1,447.37
Retiree + Child(ren)	$1,170.43	$200	$970.43
Retiree + Family	$2,049.11	$200	$1,849.11
Retiree Spouse Only	$850.71	$0.00	$850.71

Retiree Dental Rates

BCBS BASE PLAN

	Monthly Premium (Retirees with less than 25 years of Service)	City Contribution (Retirees with 25+ Years of Service)	Retiree Monthly Contribution (Retirees with 25+ Years of Service)
CONTRIBUTIONS			
Retiree Only	$19.73	$5.89	$13.84
Retiree + Spouse	$39.03	$5.89	$33.14
Retiree + Child(ren)	$48.55	$5.89	$42.66
Retiree + Family	$70.24	$5.89	$64.35

BCBS BUY-UP PLAN

	Monthly Premium (Retirees with less than 25 years of Service)	City Contribution (Retirees with 25+ Years of Service)	Retiree Monthly Contribution (Retirees with 25+ Years of Service)
CONTRIBUTIONS			
Retiree Only	$35.72	$5.89	$29.83
Retiree + Spouse	$71.98	$5.89	$66.09
Retiree + Child(ren)	$97.16	$5.89	$91.27
Retiree + Family	$133.44	$5.89	$127.55

Glossary

Allowed Fees

Term used by some dental plans for their participating dentist fees and / or maximum payable for a non-participating dentist.

Calendar Year

January 1st through December 31st of each year.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985. This Act requires that continuation of group insurance be offered to covered persons who lose health, dental or vision coverage due to a qualifying life event as defined in the Act.

Coinsurance

The portion of covered health care costs for which the covered person is financially responsible, usually according to a fixed percentage. Co-insurance may be applied after a deductible requirement is met.

Copay

The charge you are required to pay for certain covered health services, such as a prescription or office visit.

Deductible

The amount you must pay for covered health services based on contracted rates (also referred to as eligible charges/expenses) in a year before the plan will begin paying certain benefits in that year.

Explanation of Benefits (EOB)

A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Flexible Spending Accounts (FSAs)

An option that allows participants to set aside pre-tax dollars to pay for certain qualified expenses during a specific time period (usually a 12-month period). There are two types of FSAs: the Health Care FSA and the Dependent Care FSA.

Guarantee Issue

The amount of coverage pre-approved by the Life Insurance Company regardless of health status.

Health Savings Account (HSA)

A personal health care bank account funded by your or your employer's tax-free dollars to pay for qualified Medical expenses. You must be enrolled in a CDHP / HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, meaning if you change jobs your account goes with you.

Incurred Expense

An expense is considered incurred on the date services were rendered or supplies were received.

Initial Enrollment Period

The first 15 days of fulltime employment or 30 days from a covered life event.

In-Network

In-network providers are doctors, hospitals and other providers that contract with your insurance company to provide health care services at discounted rates.

Medical Emergency

A sudden, serious, unexpected and acute onset of an illness or injury where a delay in treatment would cause irreversible deterioration resulting in a threat to the patient's life or body part.

Out-of-Network

Out-of-network providers are doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.

Out-of-Pocket Maximum

The maximum amount of co-insurance you pay every year. Once you reach the out-of-pocket maximum, as an individual or family, benefits for those covered health services that apply to the out-of-pocket maximum are paid at a percent of eligible charges during the rest of that year. Deductibles and copays apply to the out-of-pocket maximum.

Plan Year

October 1, 2023 through September 30, 2024.

Portability

You keep the account even if you change Insurance plans / jobs or retire.

Usual and Customary Rates (U&C)

Out-of-network health plan expenses are considered for reimbursement at usual and customary (U&C) rates. U&C rates are determined to be the prevailing charge made for a service by a similar provider in the same geographic area. Charges above U&C are not covered by the plan and are the responsibility of the participant

Important Notices

Women's Health and Cancer Rights Act

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

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

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

Newborn's and Mother's Health Protection Act (NMHPA)

The Newborn's and Mother's Health Protection Act (NMHPA) restricts limiting the length of a hospital stay in connection with childbirth for a mother or newborn child to less than 48 hours (or 96 hours for a cesarean delivery). The law does not prohibit earlier discharge if the mother and her attending physician are in agreement that an earlier discharge is appropriate. In addition, authorization of the hospital stay cannot be required for stays of 48 hours or less (or 96 hours) nor are early discharge incentives allowed. Hospital stays begin at delivery or upon hospital admission (whichever is later).

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.

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** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefit Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, menu Option 4, Ext. 61565

Notice Informing Individuals About Non Discrimination and Accessibility Requirements Discrimination is against the law: City of Temple complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **City of Temple** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

City of Temple:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
· Qualified sign language interpreters
· Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

· Qualified interpreters
· Information written in other languages

If you need these services, contact People Operations. If you believe that **City of Temple** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Coverage After Termination (COBRA) Continuation of Health Coverage

If you or your dependents have coverage at the time of a qualifying event, you may be eligible to elect continuation of coverage under one or more of the following:

- Medical Plan
- Dental Plan
- Vision Plan

You have a legal right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to purchase a temporary extension of your coverage at group rates. However, you must pay the full cost of the coverage, plus a 2% administrative fee.

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."

COBRA and Retirement

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 the City of Temple, 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 with respect to the bankruptcy. 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 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.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Have Questions?

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

Keep Your Plan Informed of Address Changes

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

(HIPAA) Employee Health Plan Summary Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Uses and Disclosures of Health Information

The City of Temple uses health information about you for treatment, to pay for treatment, and for other allowable healthcare purposes. Health care providers submit claims for payment for treatment that may be covered by the group health plan. Part of payment includes ascertaining the medical necessity of the treatment and the details of the treatment or service to determine if the group health plan is obligated to pay. Information may be shared by paper mail, electronic mail, fax, or other methods. Subject to certain requirements, City of Temple may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. City of Temple provides information when otherwise required by law, such as for law enforcement in specific circumstances. n any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. f you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and distribute the new notice. You can also request a copy of our full notice at any time. For more information about our privacy practices, contact the Office of the Privacy Officer in the People Operations Department listed below.

Consolidated Appropriations Act (CAA) No Surprises Act

Your Rights and Protections Against Surprise Medical Bills When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for: Emergency services If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. Certain services at an in-network hospital or ambulatory surgical center when you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network. When balance billing isn't allowed, you also have the following protections: You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly. Your health plan generally must cover emergency services without requiring you to get approval for services in advance (prior authorization). Cover emergency services by out-of-network providers. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits. Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit. If you believe you've been wrongly billed, you may contact People Operations at City of Temple

If you believe you've been wrongly billed, you may contact your People Operations Department. In addition, if you have questions about a provider's network status or you believe you've been wrongly billed, please contact the BCBS help line.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

Medicare Part D Notice

Important Notice from The City of Temple 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 The City of Temple and about your options under Medicare's prescription drug coverage. 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. This information can help you decide whether or not you want to join a Medicare drug plan. 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 City of Temple** has determined that the prescription drug coverage offered by the City of Temple 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 through December 7th. However, if you lose creditable prescription drug coverage, through no fault of your own, you will 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 coverage through the City of Temple will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health benefits.

If you do decide to join a Medicare drug plan and drop your current The City of Temple coverage, be aware that you and your dependents may not be able to get this coverage back.

Medicare Part D Notice

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 coverage with The City of Temple 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 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 City of Temple** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- ⇒ Visit www.medicare.gov
- ⇒ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- ⇒ Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at **1.800.772.1213 (TTY 1.800.325.0778)**

Date:	**October 1, 2023**
Name of Entity:	**The City of Temple**
Contact:	**Tara Raymore, People Operations**
Address:	**2 North Main Street**
	Temple, Texas 76501
Phone Number:	**254-298-5650**

Marketplace Notice

1. Q What is the "Exchange" or "Marketplace" ?

A The Exchange/Marketplace is a health insurance marketplace in each state. The Marketplaces were established under the Healthcare Reform Act that was passed in 2010. The Marketplace is an on-line site where individuals and smaller employers may go to purchase health insurance coverage.

2. Q Why was the Marketplace established?

A The Marketplace is intended to help individuals by offering another option to purchase coverage, and possibly qualify for federal assistance to do so.

3. Q What are some possible other sources of coverage?

A Your employer, your spouse's employer, Medicare (if eligible in your state), the individual market, etc.

4. Q Can I drop myself or my dependents from my group plan to purchase a plan through the Marketplace or outside of the Marketplace?

A Maybe yes. Maybe no. Employers and Marketplaces have very specific rules around enrollment and disenrollment. In general, both have an annual open enrollment period (which will usually be different) and permit special enrollments during the year based on events such as marriage or birth of a child. Although these rules are similar, they are not identical. In addition, determining when you can change an election outside the annual open enrollment period will be determined by IRS regulations and the terms of the group health plan. Generally, employees may not change an election unless the employee experiences a change in status permitted by the IRS and allowed by the group health plan.

5. Q How do I know if I qualify for assistance to purchase my coverage through the Marketplace?

A Individuals who are not offered qualifying healthcare coverage through their employer may be eligible for government subsidies to help pay for health insurance premiums for plans purchased in the Marketplaces (based on income level and how many dependents you have). Generally, household income must be below 400% of the federal poverty level, in addition to some other rules, in order to qualify. Whether you qualify will depend on what kind of coverage your employer offers. If your job-based coverage is considered affordable and meets minimum value requirements, you won't be able to get lower costs on premiums or out-of-pocket costs in the Marketplace. This is true no matter what your income and family size are.

6. Q Will my employer subsidize my health coverage if I purchase it through the Marketplace?

A Employers are not required to help you pay for coverage that you purchase through the Marketplace. With most employer-provided plans, the employer pays a portion of the premium cost. You should consider this when making decisions about where to obtain your health coverage.

7. Q Will I be able to see my same doctor if I purchase coverage through the Marketplace instead of at work?

A Maybe yes. Maybe no. Insurance purchased through the Marketplace may have different provider networks.

Important Contacts

Coverage	Company	Phone Number	Website
Medical	BlueCross BlueShield	800-521-2227	www.bcbstx.com
Dental	Blue Cross BlueShield	877-442-4207	www.bcbstx.com
Vision	Standard	800-547-9515	www.standard.com
Basic Life/AD&D	Standard	800-628-8600	www.standard.com
Voluntary Life/AD&D	Standard	800-628-8600	www.standard.com
Voluntary Short Term Disability	Standard	800-368-2859	www.standard.com
Long Term Disability	Standard	800-368-1135	www.standard.com
Critical Illness / Accident / Hospital	Standard	866-851-5505	www.standard.com
FSA / HSA	Optum Financial	877-292-4040	www.optumfinancial.com
Employee Assistance Program (EAP)	Deer Oaks	888-993-7650	www.deeroakseap.com
People Operations	City of Temple	254-298-5650	www.templetx.gov

You may contact People Operations with any questions at: 254-298-5650.

Notes

Notes

The information in this benefits guide is intended to help you enroll in your 2023 - 2024 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern.

City of Temple reserves the right to change or terminate benefits at any time. Neither the benefits, nor this enrollment guide, should be interpreted as a guarantee of future benefits.