2025 RETIREE BENEFITS GUIDE

January 1 – December 31, 2025

City of Lubbock TEXAS

WELCOME

We are pleased to offer a comprehensive array of valuable benefits to protect your health, family and way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

Qualified retirees are eligible for benefits. You may also enroll your eligible family members under the medical and dental plans that you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

Coverage Begins

Annual Enrollment: Changes made during Annual Enrollment are effective January 1, 2025.

When Coverage Ends for Your Children

Your children are eligible for medical, and dental coverage until the end of the month in which they turn 26. Life insurance will end at date of marriage or when your child reaches age 25 unless the child is disabled and meets certain requirements.

Making Changes

To change your benefit elections, you must contact Human Resources within 30 days of the qualifying life event (60 days for Birth/Adoption). Be prepared to show documentation of the event, such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Annual Enrollment period to change your elections.

Choose Carefully

Due to IRS regulations, you cannot change your elections until the next Annual Enrollment period, unless you have a qualifying life event during the year. Following are examples of the most common qualifying life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse or child
- Lost coverage under your spouse's plan
- You gain access to state coverage under Medicaid or The Children's Health Insurance Program

INSIDE

ENROLLMENT

Scan QR Code to Enroll

www.benselect.com/colbk
There you will find detailed information about the plans available to you and instructions for enrolling.

Required Information—You will be required to enter a Social Security number (SSN) for all covered dependents when you enroll. The Affordable Care Act (ACA) requires the City to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

ANNUAL ENROLLMENT DETAILS

Remember, Annual Enrollment is an opportunity to make changes to your benefits without a qualifying life event. During this time, you can:

- Add, cancel or change your coverage
- Add or remove eligible family members
- Update Beneficiaries
- For life insurance changes or cancellations, contact the benefits team.

MARK YOUR CALENDARS

Open Enrollment Begins:

October 21

Deadline to Enroll:

November 1

Benefits in Effect:

January 1, 2025

In person/online benefits information sessions at Citizens Tower Council Chamber:

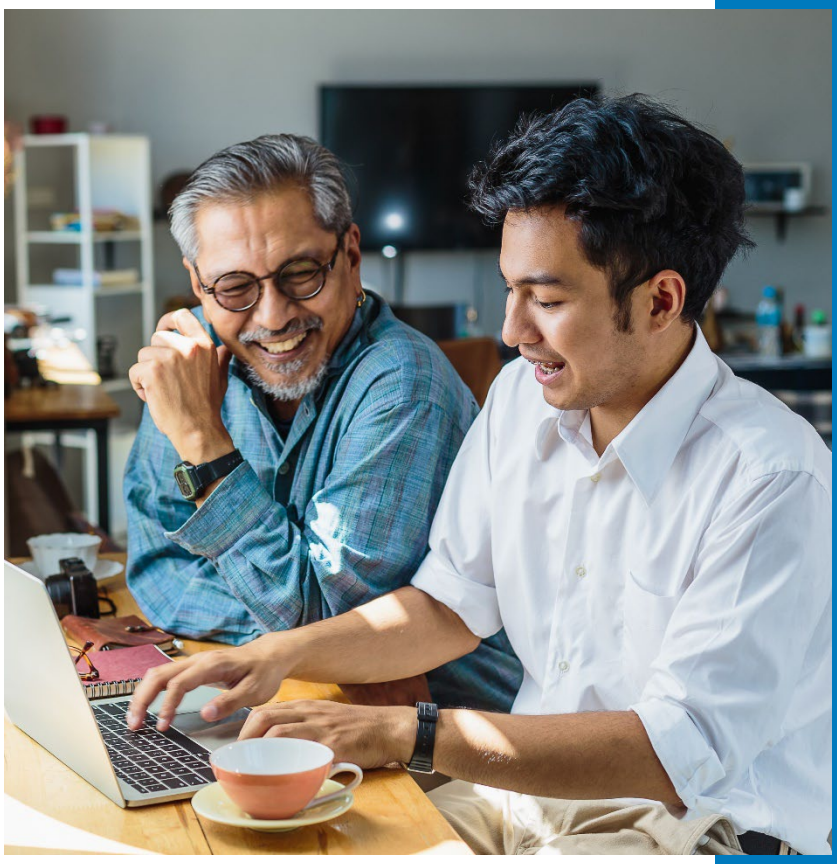
October 16th – 10 AM & 2 PM

October 17th – 2 PM

October 18th – 10 AM & 2PM

2025 Updates At-a-Glance

- You must take action and confirm your current benefit elections for next year.
- There will be a modest increase.



Scan this code to watch a video about Open Enrollment.

BENEFIT ENROLLMENT

Additional enrollment options next page

Enroll Online (Option 1)

Enrolling in benefits is easy. Our benefits enrollment platform, Selerix, is available online 24 hours a day, seven days a week during your enrollment period, so you can visit the site anytime and anywhere you have computer access.

Step 1:
Visit www.benselect.com/colbk

- Username: Social Security Number
- PIN/Password: Last four digits of Social Security Number + last two digits of your year of birth
- Example: Social Security Number is 489-99-1655 & Date of birth 11-21-1987
    - Username: 489991655
    - Password: 165587

Step 2:

- Review your personal and dependent information for accuracy.
- Be sure to gather names, birth dates and Social Security numbers (and addresses if different from you).
- To add a dependent: Click "+Add Dependent" link, then enter the requested information.
- Please add an email address so you can receive valuable information.

Step 3:
Follow the instruction prompts on each page to enroll or decline your benefit elections. Review each product offered then elect your coverage. Make sure you add beneficiaries.
Remember: You will need names, addresses, birth dates and Social Security numbers.

Step 4:
Complete your enrollment by signing the enrollment confirmation using your PIN (last four digits of your Social Security number and last two digits of your year of birth – as noted in Step 1).

After You Enroll

Save Your Summary
Save or print a copy of your Enrollment Summary after making your coverage selections. Review it thoroughly to ensure that your benefit elections have been recorded correctly.
If there are any errors, contact the HR Department immediately at benefits@mylubbock.us, so the necessary corrections can be made. Errors that are not reported by the communicated deadline cannot be corrected. Your next opportunity to correct any errors will be during the next Annual Enrollment or within 30 days of experiencing a Qualifying Life Event.

Benefits Enrollment Website
Our benefits website www.benselect.com/colbk can be accessed anytime you want additional information on our benefit programs.

Scan QR Code to Enroll

QUESTIONS?

For questions about any of your benefits during Annual Enrollment contact Total Benefit Solutions at:

866-937-3984

Monday-Friday 8:00 AM – 7:00 PM CST

If you have additional questions, you may also email HR at benefits@mylubbock.us.

BENEFIT ENROLLMENT

Additional Options to Enroll

Option 2

You can mail, email OR fax your completed enrollment packet to the City of Lubbock. All retirees will receive hard copy enrollment forms in the mail. If you choose to manually complete your enrollment, the completed enrollment forms can be sent by mail to Benefits Division, 1314 Avenue K, 6th Floor, Lubbock, Texas 79401 **OR** scanned and emailed to benefits@mylubbock.us OR faxed to (806) 775-3316. On the cover sheet of a fax, please indicate your name and social security number.

Option 3

You can hand-deliver your enrollment papers to the Benefits Office at 1314 Avenue K, Human Resources 6th Floor, Lubbock, Texas 79401.

Reminder: if you enroll online, email or fax, you do not need to mail or bring any forms to the City.

Enrollment Periods

Annual Enrollment

Each calendar year, the City conducts an Open Enrollment. This is the time for you to re-evaluate your needs and elect benefit options for the new plan year.

Between Enrollment Periods

Generally, once you enroll, you cannot make changes to your enrollment selections until the next Annual Enrollment period. You may make changes to your benefit elections outside of the Annual Enrollment ONLY if you experience a Qualifying Life Event (QLE), as defined by the IRS. Benefit changes must also be consistent and made within 30 days of the QLE and 60 days of the QLE for Births/Adoptions. Qualifying life events (QLEs) that may allow you to make benefit changes:

QUALIFYING EVENTS	DEADLINE TO ENROLL OR DISENROLL (documentation required)	CHANGE DATE
Marriage or Divorce	30 days from date of event (marriage license, informal marriage license, common law certificate or formal divorce decree)	Date of event
Birth/Adoption	60 days from date of event (birth certificate, adoption agreement)	Date of event
Change in Spouse employment such as termination, work hours affecting health insurance eligibility, increases in spouse's employer's rates, decreases in coverage, or loss of coverage.	30 days from effective date of coverage (certificate of coverage from last employer or insurance company)	Effective date of coverage
Death	30 days from date of death (death certificate)	Date of death
CHIP/Medicare Enrollment	60 days from date of event (notice from CHIPS or Medicare)	Date of event/notice

BENEFITS AT-A-GLANCE

Your benefits are an important part of your retirement. We are pleased to offer a comprehensive array of valuable benefits to protect your health and eligible family members.

Coverage	Carrier	Phone	Website/Email	Page #
Online Enrollment Platform	Total Benefit Solutions	866-937-3984	https://benselect.com/colbk	4
Medical Plan	Blue Cross and Blue Shield of Texas	800-521-2227	www.bcbstx.com	9
Prescriptions	Prime Therapeutics	877-794-3574	www.myprime.com	12
Virtual Care	Teladoc	800-835-2362	teladoc.com/bcbstx	13
Health Clinics	University Medical Center	See Pg. 16	www.umchealthsystem.com	14
Dental	Blue Cross and Blue Shield of Texas	800-521-2227	www.bcbstx.com	15
Women's Health	Ovia Health	888-421-7781	www.oviahealth.com	16
Musculoskeletal Care	Airrosti	800-404-6050	www.airrosti.com	17
Diabetes Management Support	Livongo (Powered by Teladoc Health)	800-945-4355	www.bcbstx.com or membersupport@livongo.com	18
Care Support	2nd.MD	866-854-2575	www.2nd.MD/cityoflubbock	19
Retirement	Texas Municipal Retirement System	800-924-8677	www.tmrs.com	20
Premiums				21
Fire Retirement	Lubbock Fire Pension Fund	866-952-6329	www.lubbockfirepensionfund.com/	

City of Lubbock Human Resources Contact Information

Address:	1314 Avenue K, 6th Floor, Lubbock, TX 79401
Hours of Operation:	8 a.m. – 5 p.m., Monday – Friday
Questions? Contact:	Benefits@mylubbock.us or 806-775-2303

BENEFIT ELIGIBILITY

Who is Eligible

The following individuals are eligible to participate in the City's benefits program:

- Eligible Retirees
- Your legally married spouse
- Your dependent children up to age 26
- For disabled dependent child(ren) age 26 or over whose disability began prior to age 26
    - A completed dependent eligibility questionnaire verifying an ongoing total disability
    - Written documentation from a physician verifying an ongoing disability is required

Dependent Information

As a retiree, if you elected to keep medical and/or dental coverage you can enroll your spouse, natural child, foster child, stepchild, legally adopted grandchild, or any child under your legal custodianship into a plan.

DEPENDENT VERIFICATION DISCLAIMER

Dependent Verification Required

If you plan to cover any dependents this year, you will need to provide documentation confirming their eligibility within 30 days of coverage. You may be asked to submit proof of dependent status by providing a marriage certificate, birth certificate, tax return, etc. You are responsible for ensuring that any dependents who become ineligible are removed from the City benefits. Dependents covered under the retiree's benefits who are determined to be ineligible, or for whom sufficient proof of eligibility cannot be provided, will be removed immediately. Premiums will not be refunded, and you will be responsible for any claims that may have been paid on their behalf.

Dependent Information for Enrollment

When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA) requires the City to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

Type	Acceptable Forms of Proof Documents
Spouse	• Marriage license • Social Security card with new name • Declaration and Registration of Informal Marriage (This is available through the County Clerk's Office in the county you live.)

Dependent Child(ren)	Birth certificate listing retiree or spouse as parent. For stepchild(ren) when not covering the spouse, a marriage certificate will be requested. Maximum age 26 (except as noted below for disabled child(ren).
	
	If applicable:
	• Adoption agreement
	• Legal guardianship documents
	• Divorce decree documents identifying the dependent child(ren); or
	• Qualified Medical Support Court Order
	• Social Security card
	• For disabled dependent child(ren) age 26 or over whose disability began prior to age 26
	  • A completed dependent eligibility questionnaire verifying an ongoing total disability
	  • Written documentation from a physician verifying an ongoing disability is required

MEDICAL COVERAGE

EPO

The Exclusive Provider Organization (EPO) plan, provided through Blue Cross and Blue Shield of Texas, requires you to use in-network providers for eligible services to be covered under the plan. If you use out-of-network providers, services are not covered – except in some cases where the care is an emergency or there is not an in-network provider available.

The EPO utilizes the Blue Choice PPO network of health care clinics, hospitals and professionals who have agreed to provide their services at discounted rates. These preferred providers are considered "in-network."

How You Pay for Services

- You pay a flat dollar amount–or copay–for covered health care treatments and services, such as doctor's office visits and prescription drugs.
- Once you satisfy your annual deductible, you will pay a percentage–or coinsurance–of the cost of the visit, and the plan will cover the rest.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

To find an in-network provider and facilities you will need to setup an account at www.bcbstx.com. Click on the "Find Care" tab, then select "Doctors & Hospitals".

BlueCross BlueShield of Texas

MEDICAL COVERAGE

Following is a high-level overview of your medical and plan options. For complete coverage details, please refer to the Summary of Benefit Coverage (SBC). **Note:** The deductibles and out-of-pocket maximums are per calendar year.

Medical Network Blue Choice PPO	BCBS EPO Plan	
	In Network Only	Out-of-Network
Deductible (Individual/Family)	$1,000 / $2,000	No Coverage
Out-of-Pocket Max (Individual/Family)	$4,000 / $8,000	No Coverage
UMC Health Clinics	$0	No Coverage
Office Visits (physician/specialist)	$50 / $75	No Coverage
Virtual Visits (Teladoc)	$0	No Coverage
Routine Preventive Care	$0	No Coverage
Diagnostics (lab/X-ray)	Office Copay	No Coverage
Mental Health Office Visit	$50	No Coverage
Complex Imaging	20% after Deductible	No Coverage
Chiropractic	$50 Office Visit	No Coverage
Ambulance	20% after Deductible	No Coverage
Emergency Room	$250 + 20% after Deductible	
Urgent Care Facility	$50	No Coverage
Inpatient Hospital Stay	20% after Deductible	No Coverage
Outpatient Surgery	20% after Deductible	No Coverage

blueaccess for Members

Setup a BAM account at www.bcbstx.com to gain all your plan info in one place. After establishing an account, you will also be able to:

- Find Providers
- Review and print your Explanation of Benefits (EOB)
- Order additional replacement insurance cards
- Check your deductible and expenses applied to your out-of-pocket maximum
- Print a Verification of Coverage Letter
- Review Medical & Dental Plan Documents and coverage details

PREVENTIVE CARE

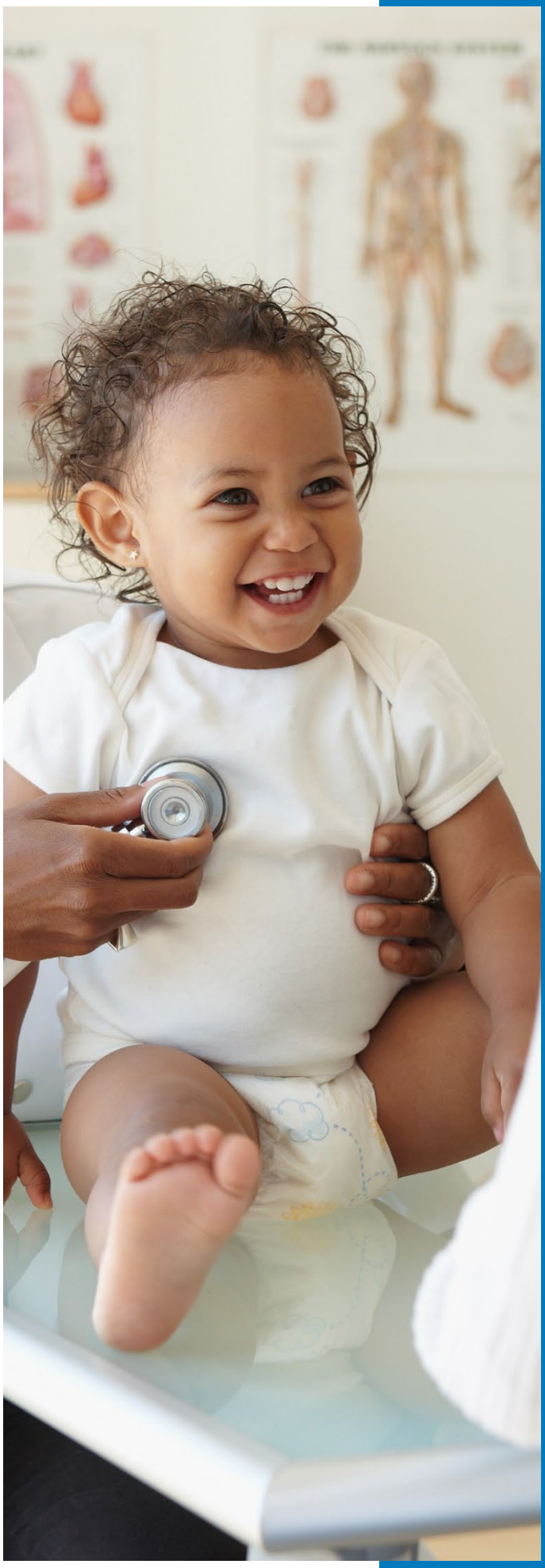
What is Preventive Care?

Regular preventive care can help you stay well, catch problems early and may be potentially lifesaving. The Affordable Care Act (ACA) requires that certain preventive care services are provided for no cost, copayment or coinsurance. All medical plans cover preventive care services like screenings, immunizations and exams. When you visit in-network providers, you don't have to worry about any out-of-pocket costs for preventive care services.

Preventive vs. Diagnostic Care

Preventive care is generally precautionary. For example, if your doctor recommends having a colonoscopy because of your age or family history, this would be considered preventive care. But if your doctor recommends a colonoscopy to investigate symptoms you're having, this would be considered diagnostic care, and your plan cost share will apply.

Scan this code to watch a video about preventive care.



PRESCRIPTION COVERAGE

Prime THERAPEUTICS™

Retail Pharmacy

When you fill a prescription at a participating retail pharmacy, you may purchase up to a 30-day supply. At the participating pharmacy, you will need to present your ID card and an applicable payment. Most major pharmacies are in our plan's pharmacy network. To find a participating pharmacy near you, visit www.myprime.com.

Lower Your Medication Cost

Ask for Generic Drugs
You can save money by asking for generic drugs. The FDA requires that generic drugs have the same quality, strength, purity and stability as brand-name drugs. The next time you need a prescription, ask your doctor to prescribe a generic drug if it is available and appropriate.

Use Mail-Order

If you require regular medication for a long-term or chronic condition, such as arthritis or diabetes, you can save money by using your plan's mail-order service.

Out-of-Network

CVS pharmacies are Out-of-Network and no benefits will be applied.

Specialty Program

With a rare or complex medical condition (e.g., cancer, hepatitis, hemophilia, rheumatoid arthritis or HIV), the appropriate use of specialty medications can be critical to maintaining or improving a patient's health and quality of life. We use the In-Network Specialty Pharmacy Provider program to make these medications accessible and cost effective for plan members. It provides focused, specialized support to individuals with complex medical conditions that often require multiple specialty medication therapies.

Save Money on High-Cost Medications with FlexAccess

FlexAccess is a cost assistance program designed to help you lower your costs if you take certain high-cost medications.

Call FlexAccess at 888-302-3618, M-F, 7 a.m. to 7 p.m. CT, or email **FlexAccess** Member Services at member.services@flexaccessrx.com to ask any question or find out if your prescription drug is part of this program.

Prime Therapeutics	
Retail - 30 Day	
Generic Drugs	$5
Preferred Brand Drugs	$35
Non-Preferred Brand Drugs	$60
Specialty	20% up to $300
Retail - 90 Day	
Generic Drugs	$15
Preferred Brand Drugs	$105
Non-Preferred Brand Drugs	$180
Mail Order - 90 Day	
Generic Drugs	$10
Preferred Brand Drugs	$70
Non-Preferred Brand Drugs	$120

VIRTUAL CARE

Carrier: Teladoc

Our telehealth program is a convenient and cost-effective way to get quick medical advice by phone, online or on your mobile device about many non-emergency conditions. It's just one more way our organization invests in you and your family.

Why Use Telehealth?

It's Affordable

A trip to the ER, urgent care center or doctor's office can easily set you back hundreds of dollars in out-of-pocket costs. A call to our telehealth program will cost you $0.00, regardless of your condition.

It's Convenient

Long wait times at the ER, urgent care center or doctor's office are an unfortunate reality for many. Whether you are at home or work or on the road, a medical professional is available 24/7/365, so you can get the care you need when and where it's convenient for you. Even better: there is no time limit to the consult, giving you plenty of time to ask questions and resolve your issue.

It's Easy to Use

A telehealth medical professional is never more than a phone call, click or tap away. Call 800-835-2362 or visit www.teladoc.com.

Scan this code to watch a video about how telehealth works.

Get Care in Minutes

It takes just a few minutes to set up your medical history online. Once you submit a request, it often takes less than 10 minutes for a doctor to call you back.

Common Reasons to Call

- Allergies
- Anxiety issues
- Back problems
- Bronchitis
- Cold and flu symptoms
- Ear infections
- Diarrhea or constipation
- Headaches and migraines
- Rash and skin problems
- Sore throat and stuffy nose
- Sprains and strains
- Urinary tract infections

UNIVERSITY MEDICAL CENTER (UMC) CLINICS

The City of Lubbock contracts with the UMC physicians' group to provide free primary care services for City of Lubbock retirees on the health plan. Retirees and dependents enrolled in the health plan may visit any of the locations listed below with no co-pay. ONLY listed clinics allow zero co-pay.

Clinic	Address	Phone
UMC Express Care at South Plains Mall	6002 Slide Road	(806) 761-0450
UMC Westwind Primary Health	5520 4th Street	(806)761-0475
UMC Milwaukee Family Medicine	7301 Milwaukee Avenue	(806) 761-0464
UMC Lakeridge Family Medicine	5130 82nd Street	(806) 761-0275
UMC KingsPark Urgent Care	7501 Quaker Avenue	(806) 788-3306
UMC I-27 Medical Center	4105 I-27	(806) 762-2633
UMC Orchard Park Family Medicine	4420 114th Street	(806) 761-0420
98th Drive-thru	9615 Frankford Avenue (98th & Frankford)	(806) 761-0269
98th Family Medicine (2nd Floor)	9615 Frankford Avenue (98th & Frankford)	(806)-761-0267
98th Children's Clinic (1st Floor)	9615 Frankford Avenue (98th & Frankford)	(806) 761-0265

The top-notch physicians and medical experts available at each location are prepared for any primary care patient needs. If necessary, they can refer patients to in-network specialists for specific health care.

COMMITTED TO OUTSTANDING SERVICE

UMC is fully committed to delivering a high level of service for each and every member on the City's health plan. When you become a patient, you'll have access to:

Prompt Appointments
Same or next-day appointments are available at the EIGHT clinics.

Online Access to Resources
After your first visit, you can access a private member portal through www.umchealthsystem.com

UMC HEALTH SYSTEM™

Short Wait Times for Office Visits
For most routine needs, appointments take 30 minutes or less, though lab work or advanced care could take longer. Highly trained staff work with each patient to ensure they are in and out as quickly as possible.

DENTAL COVERAGE

BlueCross BlueShield of Texas

PPO

The dental Preferred Provider Organization (PPO) plan, provided through Blue Cross and Blue Shield of Texas, offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a dentist who participates in the BlueCare and DentaBlue network. To find an in-network provider, go to www.bcbstx.com. Following is a high-level overview of your dental plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and annual benefit maximums are per calendar year.

Key Benefits	DPPO
	In-Network
Deductible (Individual/Family)	$75 / $225
Annual Benefit Maximum (per person)	$1,200
Diagnostic & Preventive Services	100%
Restorative Services	80% of Allowable Amount
General Services	80% of Allowable Amount
Endodontic Services	80% of Allowable Amount
Periodontal Services	80% of Allowable Amount
Oral Surgery Services	80% of Allowable Amount
Crowns, Inlays/Onlays Services	80% of Allowable Amount
Prosthodontic Services	50% of Allowable Amount
Orthodontic Services • All Participants up to age 26 • $1,000 Maximum Lifetime Benefit	50% of Allowable Amount
Dependent Child Age Limit	Age 26

WOMEN'S HEALTH

Ovia Health

Women's and Family Health, Pregnancy, Parenting and Menopause Support.

Wherever you are in your journey, Blue Cross and Blue Shield of Texas (BCBSTX) is here to support you at no extra cost.

- Ovia Health apps are for tracking your cycle, pregnancy, parenting and menopause support. The apps are available in English and Spanish, and provide videos, tips, coaching and more.
    - Ovia: Track your cycle, predict when you are more likely to get pregnant or receive menopause support when the time comes.
    - Ovia Pregnancy: Monitor your pregnancy and baby's growth week by week leading up to your baby's due date.
    - Ovia Parenting: Keep up with your child's growth and milestones.
- Well onTarget® has self-guided courses about pregnancy that you can take online, covering topics such as healthy foods, body changes and labor.

Plus, if your pregnancy is high-risk, BCBSTX will provide support from maternity specialists to help you care for yourself and your baby. Having a baby changes everything, so use these tools to help you get ready.

ovia health™

JOINT AND MUSCULOSKELETAL

Airrosti

Airrosti provides a unique approach to reduce the prevalence and incidence of musculoskeletal conditions. Most often, clients obtain relief in about three visits. Care from Airrosti will be copay FREE to retirees and dependents on the City's health plan.

When you sign up for the therapy program, you'll get:

- A personalized therapy program with unlimited exercises and stretches developed for you by physical therapists.
- Your own care team, which includes a qualified health coach and physical therapist you can turn to for questions and help setting goals. Get in touch with them via text, email, phone or video chat.

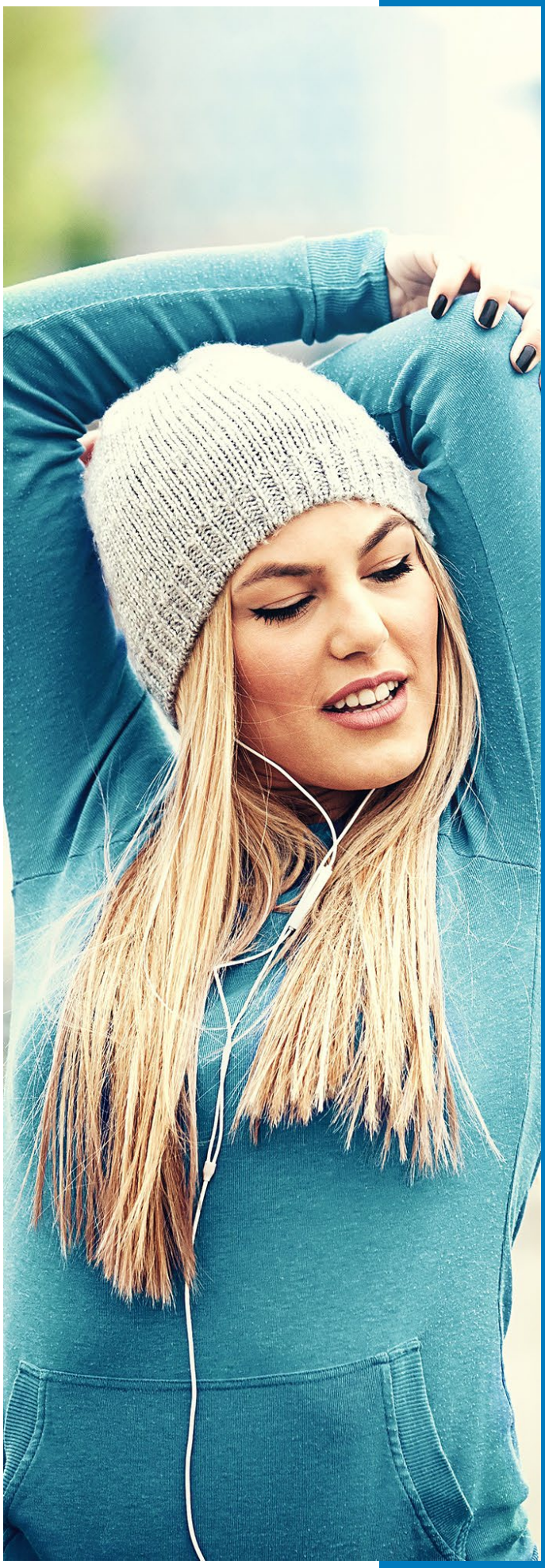
Conditions treated include:

- Acute injuries/musculoskeletal conditions
- Chronic joint and soft tissue injuries
- Patients seeking an alternative to surgery
- Patients not receiving lasting relief from steroid injections and other pain management interventions
- Unresolved rehab patients
- Postsurgical patients with persistent symptoms

Common injuries treated include:

- Back pain
- Neck pain
- Headaches
- Triceps injuries
- Tendonitis
- Disc injuries
- Hip pain
- Sciatic-like pain
- Achilles tendonitis
- Carpal tunnel syndrome
- Knee pain
- Shin splints
- Plantar fasciitis

AIRROSTI®



DIABETES MANAGEMENT

Livongo

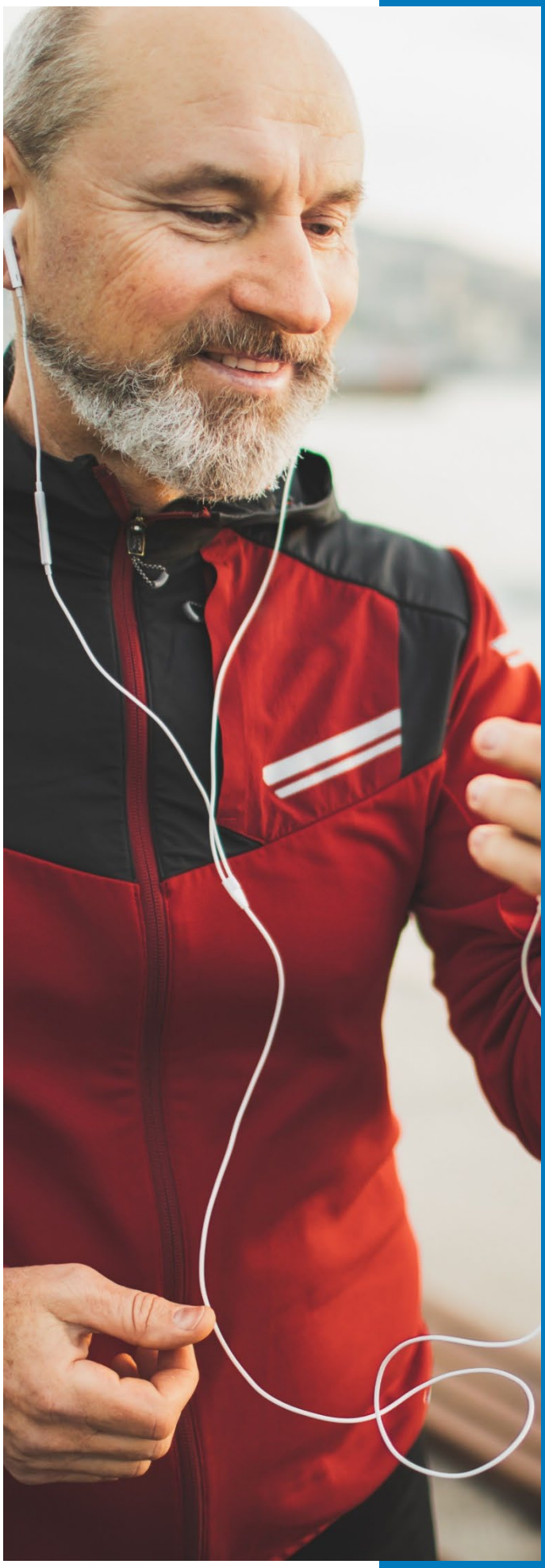
This program is available to retirees enrolled in the BCBS EPO medical plan. Livongo supports people diagnosed with type 1 or type 2 diabetes, people at risk for getting type 2 diabetes, people with high blood pressure and more. These programs are available at no cost to you.

Resources and support will depend on which program(s) you are enrolled in:

- **Diabetes:** Enrollees get an advanced blood glucose meter, unlimited strips, personalized tips, 24/7 support for out-of-range readings and shareable reports. Talk to a certified diabetes educator to discuss blood sugar, nutrition, meal planning and more.
- **Hypertension:** Take charge of your health with a connected blood pressure monitor, personalized tips after every reading, shareable reports and coaching that's tailored to you.
- **Weight and a Healthy Lifestyle:** Enrollees get a connected scale that automatically sends data to your Livongo app. Build healthy habits with in-app challenges and interactive digital lessons. Connect with a coach to discuss healthy eating, weight loss and more.

Getting registered for Livongo is easy and only takes a few minutes. You can call 800-945-4355 or visit the website at www.livongo.com. To start the process, simply answer a few questions about your health to see if you qualify for the program. If you do qualify, you will be mailed a Livongo welcome kit with instructions on how to get started.

Livongo® by Teladoc Health



CARE SUPPORT

2nd.MD

2nd.MD is a second opinion virtual expert medical consultation and navigation service.

City of Lubbock retirees and family members enrolled in the City's health plan now have access to 2nd.MD, a virtual expert medical consultation and navigation service. With 2nd.MD you can connect with board-certified, elite specialists about your diagnosis or treatment plan all within a matter of days at NO cost to you.

Retirees and eligible family members on the health plan can get expert advice about:

- A new or existing diagnosis
- A treatment plan
- Possible surgery
- Your medications
- A chronic condition

2nd.MD takes on the burden of finding the right specialist, collecting medical records and navigating the health care system so employees and their families can focus on getting the best care possible, as soon as possible.

2nd.MD
Specializing in Medical Certainty

TEXAS MUNICIPAL RETIREMENT SYSTEM

The City of Lubbock employees enjoy the benefits of participating in a state-wide retirement system with other municipalities in Texas.

Program Highlights:

Participating, non-firefighter, employees contribute 7% of their pay and the City matches those contributions on a 2 to 1 basis upon retirement. You are guaranteed a minimum 5% annual return and, are considered vested in just five years. Retirement eligibility is based on 20-years of service or age 60 with 5-years of service.

Eligibility:

Employees who work at least 1,000 hours per year are eligible for the TMRS plan and enrollment is automatic beginning with your first payroll check. The amount you contribute to TMRS is based on your payroll earnings and withheld from each payroll check at a pre-tax rate of 7%. Enrollment in TMRS is mandatory.

You are eligible to retire after 20 years of service at any age or after 5 years of service and age 60.

Your TMRS Account:

Register your online TMRS account and you will have 24/7 access to review your account balance (the amount you contribute only), run retirement scenarios, change your home address, and see the beneficiary on record for your account. Register your account at my.tmrs.com.

Earning Service Credits:

While employed by the City, you will receive a service credit for every month in which there is a contribution. If you were employed as a full-time employee of any United States agency, government, military, or another branch of the United States, you may be able to apply for restricted prior service credit. See the Application for Restricted Prior Service Credit form at www.tmrs.com below for more information and a list of eligibility entity types.

Schedule a Counseling Session:

TMRS allows you to schedule a counseling session with a TMRS representative to help answer your TMRS benefit questions, estimate your monthly retirement benefit, or discuss your retirement options. They offer both in- person counseling at their offices or online counseling. For online counseling, you will need a mobile device or computer. A webcam or camera phone is not required, but will allow you to see the representative and any documentation they share with you. Family members and financial advisors are welcome to attend. To schedule your Counseling session go to www.tmrs.com.

PREMIUMS & CONTRIBUTIONS

Your contributions toward the cost of benefits are drafted from your bank or credit union. The amount will depend on the plan you select and if you choose to cover eligible family members.

Medical

Coverage	2024 Rates			2025 Rates		
	Retiree Rate	City Rate	% City Paid	Retiree Rate	City Rate	% City Paid
Employee Only	$442.25	$913.98	67%	$462.15	$977.96	68%
Employee + Spouse	$840.79	$2,079.19	71%	$878.63	$2,224.73	72%
Employee + Child(ren)	$742.01	$1,512.60	67%	$775.40	$1,618.48	68%
Employee + Family	$1,009.49	$3,054.25	75%	$1,054.92	$3,268.05	76%
Pre-65 Retiree Medicare Eligible Only	$228.27	$196.12	46%	$238.54	$209.85	47%
Pre-65 Retiree & Spouse Medicare Eligible	$468.98	$406.25	46%	$490.08	$434.69	47%
Pre-65 Retiree Medicare Eligible + Spouse	$670.51	$1,110.11	62%	$700.68	$1,187.82	63%
Pre-65 Retiree Medicare Eligible + Child(ren)	$670.51	$1,110.11	62%	$700.68	$1,187.82	63%
Pre-65 Retiree Medicare Eligible + Family	$970.28	$1,708.73	64%	$1,013.94	$1,828.34	64%

Dental

Coverage	2024 Rates			2025 Rates		
	Retiree Rate	City Rate	% City Paid	Retiree Rate	City Rate	% City Paid
Employee Only	$23.31	$21.63	48%	$24.59	$22.82	48%
Employee + Spouse	$39.13	$20.91	35%	$41.28	$22.06	35%
Employee + Child(ren)	$35.94	$21.06	37%	$37.92	$22.22	37%
Employee + Family	$51.15	$20.33	28%	$53.96	$21.45	28%

BEST OPTIONS FOR CARE

Choosing the best option provides faster care at a lower cost

Symptoms	Primary Care Doctor	UMC Clinic	Teladoc	Urgent Care	Emergency Room or 911
Annual Physical	☑	☑	☒	☒	☒
Routine Care	☑	☑	☒	☒	☒
Cold/Flu	☑	☑	☑	☒	☒
Sore Throat	☑	☑	☑	☒	☒
Ear Aches/Infection	☑	☑	☑	☒	☒
Seasonal Allergies	☑	☑	☑	☒	☒
Minor Cuts/Burns				☑	☒
Minor Sprains/Strains				☑	☒
Mild Asthma				☑	☒
Severe Asthma & Breathing Issues					☑
Severe Cut/Bleeding					☑
Severe Allergic Reaction					☑
Heart Attack					☑
Stroke					☑

BENEFIT TERMINOLOGY

Allowed amount
This is the amount agreed upon between the provider and the insurance company for the service provided. It is almost always less than the billed amount, which is why enrollees see different amounts on their Explanation of Benefit statements (EOBs). For example, a provider may charge $120 per hour of psychotherapy, but the insurance company pays them $95—the allowed amount for that service.

Beneficiary
A person who is designated as the recipient of proceeds from an insurance policy.

Coinsurance
Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Consider an example in which the medical plan's allowed amount for a medical service is $100 and you've met your deductible. If your plan pays 70%, then you are responsible for the remaining 30%, which is $30.

Copay Assistance
Copay assistance programs help patients pay for medical expenses, such as copays, deductibles, and coinsurance. These programs are offered by drug manufacturers and other organizations generally available to patients with commercial or private insurance. See "Specialty Drug Copay Assistance" for more information on assistance with high-cost medications.

Copayment
Oftentimes referred to as a "copay," this is the amount you are responsible for paying when seeing a doctor, picking up a prescription, or visiting an urgent care facility or emergency room.

Deductible
The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. For example, if your individual deductible is $1,500, your plan will not pay anything for certain medical services until you have paid $1,500. The deductible may not apply to all services, such as services that are covered by a copay.

Dependent
Dependents are usually an immediate relative, such as a spouse or child up to age 26, as per the Affordable Care Act (ACA), who is eligible to be included on your health insurance policy.

Diagnostic test
Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

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 or crutches.

Excluded services
Medical services that your medical plan doesn't pay for or cover.

BENEFIT TERMINOLOGY

Explanation of benefits
Every time you use your health insurance, your health plan sends you a record called an "explanation of benefits" (EOB) or "member health statement" that explains how much you may owe. The EOB also shows the total cost of care, how much your plan paid, and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount"). An EOB is generated for every single health claim. It is not a bill, but rather a tool members can use to make sure they're not paying more than their insurer expects them to for services rendered.

Generic drugs
Medications that are comparable to brand-name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand-name counterparts. (These are typically "Tier 1" drugs in the medical plans.)

In-network coinsurance
The percentage you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network coinsurance costs you less than out-of-network coinsurance payments.

In-network provider
The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Mail order Rx
The City's medical carrier offers this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can obtain a 90-day supply at one time versus a 30-day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your copay is cheaper through mail order.

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

Member health statement
Every time you use your health insurance, your health plan sends you a record called a "member health statement" or an "explanation of benefits" (EOB) that explains how much you may owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount").

Negotiated rate
Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "eligible expense."

Network
The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at a pre-negotiated discount. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

BENEFIT TERMINOLOGY

Non-preferred brand-name drugs
Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand-name drug or a generic. (These are typically "Tier 3" drugs in the City's medical plans.)

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.

Out-of-network 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 an out-of-network provider.

Over-the-counter drug
A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment allowance
Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "negotiated rate" or "eligible expense."

Preauthorization
A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preferred/brand-name drug
These are medications for which generic equivalents are not available. They have been on the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs. (These are typically "Tier 2" drugs in the City's medical plans.)

Prescription drugs
Medications you can only obtain with a prescription from your doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicodin and Albuterol can only be obtained with a prescription. The opposite of an over-the-counter drug.

Prescription drug coverage
Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA-approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the copayment you will pay for the drug. These tiers typically, but not always, are: Generic (Tier 1), Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty.
Your cost will depend on the level of drug specified by your doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand-name drugs generally do not have a generic equivalent, while those listed as non-preferred brand-name drugs generally do have a generic or preferred brand-name equivalent.
Your copay for preferred brand-name drugs is less than the copay for non-preferred brand-name drugs because you don't have the generic option available to you.

BENEFIT TERMINOLOGY

Premium (Insurance)
The fees paid to an insurance carrier to provide coverage. These fees are usually shared between you and the City, though there are insurance benefits the City pays for entirely, while there are others that you pay for yourself.

Premium (Medical)
The amount that is paid for your medical coverage. You and the City share this cost, which is paid monthly to the insurance carrier.

Prior approval/authorization
A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preventive care
Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

Primary care physician (PCP)
A physician who directly provides or coordinates a wide range of medical services for a patient. Primary care physicians include medical doctors, doctors of osteopathic medicine, internists, family practitioners, general practitioners, OB/GYNs and pediatricians. The opposite of a specialist.

Provider
A physician, health care professional or health care facility, certified or accredited as required by state law.

Qualifying life event (QLE)
QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an Annual Enrollment period. This usually includes the birth or adoption of a child, marriage, divorce, death of a spouse or change in the spouse's employment or insurance status. These changes must typically be made within 30 days of the QLE.

Special enrollment period
Special enrollment periods allow you to make changes to your insurance plan or sign up for a new policy outside of Annual Enrollment. They're almost always triggered by QLEs.

Specialist
A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a primary care physician. For example, a dermatologist is considered a specialist.

Specialty drugs
Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

Specialty drugs copay assistance
FlexAccess is a cost assistance program designed to help you lower your costs if you take certain high-cost medications. Call FlexAccess at 888-302-3618, M-F, 7 a.m. to 7 p.m. CT, or email FlexAccess Member Services at member.services@flexaccessrx.com to ask any question or find out if your prescription drug is part of this program.

BENEFIT TERMINOLOGY

Telehealth

Telehealth is the use of telecommunication technologies through which you and your personal physician, who is treating you and knows your health history, can talk live over the phone or video chat, by appointment, during regular office hours. Services such as medication management, regular visits and online counseling are particularly well suited to Telehealth, since consistent and regular visits with your physician typically improve outcomes.

Telemedicine

Telemedicine is the use of telecommunication technologies where you and an on-call physician can talk live (24/7/365) over the phone or video chat. Services that are particularly well-suited to telemedicine include the discussion of symptoms, receiving a diagnosis, learning your treatment options and minor health issues such as pink eye or sore throat. Prescriptions can also be facilitated through telemedicine. Please note that each time you reach out for telemedicine services, you might speak with a different physician.

Urgent care

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

Wellness

Wellness refers to a healthy state of being.

Scan this code to watch a video about benefit terms.

NOTES

DISCLAIMER: The material in this benefits brochure is for informational purposes only and is neither an offer of coverage or medical or legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. Please refer to the Summary Plan Description (SPD) for complete plan details. In case of a conflict between your plan documents and this information, the plan documents will always govern.
Annual Notices: Various state and federal laws require that employers provide disclosure and annual notices to their plan participants. The company will distribute all required notices annually.

HUB

CITY OF LUBBOCK

Benefits Disclosures

Please note: HUB is providing these notices as a courtesy to its client, HUB does not provide legal or tax advice.

Medicare Part D Creditable Coverage Notice

Important Notice from City of Lubbock 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 Lubbock (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 City of Lubbock 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:

- 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).

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:	October 10, 2024
Name of Entity/Sender:	City of Lubbock
Contact-Position/Office:	Donna Price-English
Address:	1314 Avenue K Lubbock, TX 79401
Phone Number:	(806) 775-3262

CHIPRA/CHIP Notice

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**.

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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access (https://dvha.vermont.gov/members/medicaid/hipp-program) Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
OREGON – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

PENNSYLVANIA – Medicaid and CHIP	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Annual Notice of 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 **(806) 775-3262** for more information.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1, 2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through November 30, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and November 30, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and November 30, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact **Donna Price-English** at **(806) 775-3262**, **dprice@mylubbock.us**.

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

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.

3. Employer name City of Lubbock	4. Employer Identification Number (EIN) 75-6000590
5. Employer address, 7. City, 8. State, 9. Zip Code 1314 Avenue K Lubbock, TX 79401	6. Employer phone number (806) 775-3262
10. Who can we contact about employee health coverage at this job? Donna Price-English	
11. Phone number (if different from above) (806) 775-3262	12. Email address dprice@mylubbock.us

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

- As your employer, we offer a health plan to:

  ☒ All employees. Eligible employees are:

  Work 30 or more hours per week.

  ☐ Some employees. Eligible employees are:

  .

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  Legally married spouse, biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

  ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to 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 Lubbock**, Benefits Dept. at **(806) 775-3262**.

General Notice of COBRA Continuation Coverage Rights

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 **[Q34- must pay *OR* aren't required to 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."

[Q36 - 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 Lubbock, 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;
- [Q36 - 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 [Q37 - 60 days] after the qualifying event occurs. You must provide this notice to: [*PN2*]. [Q38 - *Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

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. [Q39 - Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]

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.**

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[1] 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.** (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.

Plan contact information

City of Lubbock-Benefits Department
Donna Price-English
1314 Avenue K
Lubbock, TX 79401
(806) 775-3262

[1] **https://www.medicare.gov/basics/get-started-with-medicare/sign-up/how-do-i-sign-up-for-medicare.**

Notice of Availability of HIPAA Notice of Privacy Practices

To: Participants in the City of Lubbock Benefits Program

From: Benefits Department

Re: Availability of Notice of Privacy Practices

The Medical, Dental, Vision, Life Insurance, Long-Term Disability, and Accident 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:

City of Lubbock-Benefits Department
Donna Price-English
1314 Avenue K
Lubbock, TX 79401
(806) 775-3262

Dear Retiree:

If you complete your open enrollment manually, you must return the 2025 Acknowledgement Form and indicate any changes. If you do not have any changes, please indicate this on the acknowledgement form.

The 2025 acknowledgement form along with any changes must be mailed to the to the Benefits Division at 1314 Avenue K, 6th Floor, Lubbock, Texas 79401, by Friday, November 1, 2024. You can also fax your information to (806) 775-3316 or email your completed information to benefits@mylubbock.us.

Reminder: If you completed your enrollment online you do not need to return any paperwork to the City.

2025 Acknowledgement Form

1. I acknowledge that I have received the 2025 Annual Benefits Enrollment Packet and I have until Friday, November 1, 2024 to confirm my Benefits election for 2025.

2. I acknowledge and understand that I have three options to complete my open enrollment.

   - I can visit www.benselect.com/colbk, or
   - Mail, email or fax my completed enrollment forms to the Benefits Department, 1314 Avenue K, 6th floor, Lubbock, Texas 79401,
   - or I can hand-deliver my enrollment papers to the Benefits office listed above.

   Reminder: If you enroll online, email or fax, you do not need to mail or bring any forms to the City.

3. I acknowledge that with this packet I received the following notices and that these notices are required to be distributed annually by federal law:

   - ✓ Medicare Part D Creditable Coverage Notice
   - ✓ Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
   - ✓ Health Insurance Marketplace Coverage Options and Your Health Coverage
   - ✓ Notice of Special Enrollment Rights
   - ✓ General Notice of COBRA Continuation Coverage Rights
   - ✓ Notice of Availability of HIPAA Notice of Privacy Practices

My enrollment Selection

Please acknowledge the following one of the following by marking an **(X)**:

☐ I do not wish to make any changes to my benefits for the year 2025.

☐ I wish to cancel my benefits for 2025.

☐ I wish to make the following changes to my benefits.

I. Add Dependent to my Medical Benefits:

To add a dependent the person must be an eligible spouse or an eligible child under 26 years of age or a disabled child. List the Name of the Dependent, Date of Birth, and Social Security Number of the Dependent.

Name	Address	Social Security Number	Relationship	Date of Birth

Note: You must attach a copy of a Marriage License, Birth Certificate, and Social Security Card for each dependent you are adding to your medical benefits.

II. Add Dependent to my Dental Benefits:

Must be an eligible spouse of an eligible child under 26 years of age or a disabled child. List the Name of the Dependent, Date of Birth, and Social Security Number of the Dependent.

Name	Address	Social Security Number	Relationship	Date of Birth

Note: You must attach a copy of a Marriage License, Birth Certificate, and Social Security Card for each dependent you are adding to your medical benefits.

III. I wish to cancel life insurance for the following person(s): Note: You cannot add life insurance during open enrollment for your dependents.

Name	Address	Social Security Number	Relationship	Date of Birth

IV. Other person authorized to discuss my Personal Health Information:

Name	Address	Phone Number	Relationship	Date of Birth

I have completed my open enrollment for my benefits for 2025.

_____ _____

Print Name Social Security Number

_____ _____

Signature Date

_____ _____

Email Address Telephone Number/ Contact Number