2025 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

You are eligible for benefits if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans 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

New Hires: You must complete enrollment within 30 days of your date of hire. If you enroll on time, coverage is effective on the 1st of the month following 30 consecutive days of employment. If you fail to enroll on time, you will NOT have benefits coverage (except for City-paid benefits) until you enroll during our next annual Open Enrollment period.

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

Due to IRS regulations, you cannot change your elections until the next annual Open 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

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 Open Enrollment period to change your elections.

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.

TAKE A LOOK INSIDE

Health

Medical

Preventive Care

Pharmacy

Health Clinics

Virtual Care

Dental

Vision

Wealth

Life Insurance

Voluntary Life

Disability

Accident Insurance

Flex Spending Account

Dependent Care Account

TMRS

457(b) Plan

Wellbeing

Employee Assistance Program

Women's Health

Joint and Musculoskeletal

Diabetes Management

Care Support

Perks

Education Reimbursement Program

Paid Leave

Sick Leave Sharing Program

Resources

Premiums

Care Options

Terminology

WELCOME!

Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of valuable benefits to protect your health, your family and your way of life. This guide answers some of the basic questions you may have about your benefits.

Benefits At-a-Glance

Coverage	Carrier	Phone	Website/Email	Page #
Online Enrollment Platform	Total Benefit Solutions	866-937-3984	https://benselect.com/colbk	10
Medical Plan	Blue Cross Blue Shield of Texas	800-521-2227	www.bcbstx.com	12
Prescriptions	Prime Therapeutics	877-794-3574	www.myprime.com	15
Virtual Care	Teladoc	800-835-2362	teladoc.com/bcbstx	16
Health Clinics	University Medical Center	See Pg. 16	www.umchealthsystem.com	17
Dental	Blue Cross Blue Shield of Texas	800-521-2227	www.bcbstx.com	18
Vision	Davis Vision	800-999-5431	www.davisvision.com	19
Life Insurance	Blue Cross Blue Shield of Texas	800-348-4512	www.bcbstx.com	21
Long-Term Disability	Blue Cross Blue Shield of Texas	800-348-4512	ancillary.bcbstx.com	22
Accident Insurance	Blue Cross Blue Shield of Texas	877-442-4207	www.ancillary.bcbstx.com	23
Flexible Spending Accounts	Optum Financial	866-413-4546	www.optumfinancial.com	24
Retirement	Texas Municipal Retirement System	800-924-8677	www.tmrs.com	26
457(b) Deferred Compensation Plan	Corebridge Financial MissionSquare Voya Financial	806-201-5186 866-886-8023 806-798-7048	www.Corebridgefinancial.com www.missionsq.org www.Voyaretirementplans.com	27
Employee Assistance Program	Texas Tech University Health Science Center	806-743-1327	www.ttuhsc.edu/counseling	29
Women's Health	Ovia Health	888-421-7781	www.oviahealth.com	30
Musculoskeletal Care	Airrosti	800-404-6050	www.airrosti.com	31
Diabetes Management Support	Livongo (Powered by Teladoc Health)	800-945-4355	www.bcbstx.com or membersupport@livongo.com	32
Care Support	2nd.MD	866-854-2575	www.2nd.MD/cityoflubbock	33

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

OPEN ENROLLMENT DETAILS

Remember, Open 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
- Elect your 2025 FSA contributions
- Enroll in the health care and/or dependent care FSAs (**Note:** The IRS requires you to re-enroll in the FSAs each year)

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

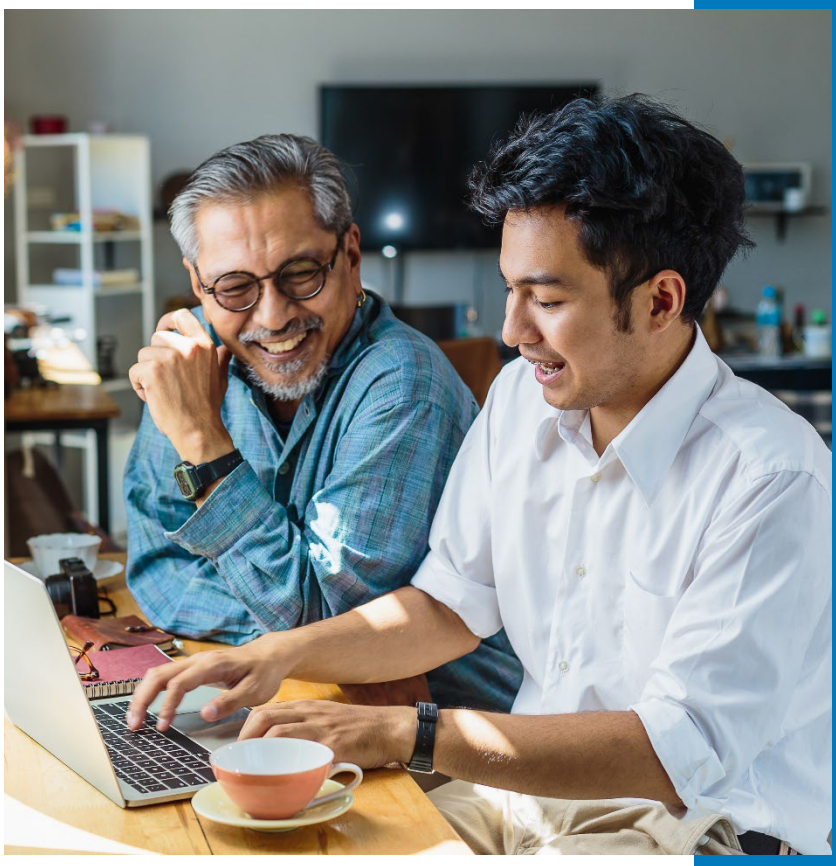
October 17th – 2 PM

October 18th – 10 AM & 2PM

Scan this code to watch a video about Open Enrollment.

2025 Updates At-a-Glance

- You must take action and confirm your current benefit elections for next year.
- You must actively re-enroll in the health care and dependent care FSAs to participate in 2025.
- There will be a modest increase in how much you pay out of your paycheck for health insurance, also known as your premiums.



BENEFIT ELIGIBILITY

Who is Eligible

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

- Active, full-time employees on the first of the month following 30 consecutive days of employment
- Part-time and seasonal employees are not eligible for medical benefits
- 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 an employee, 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 employee'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 employee 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

BENEFIT ENROLLMENT

Scan this code to watch a video about QLEs.

Enrollment Periods

Annual Open 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.

New Hire and Newly Eligible Employee Enrollment

Newly hired or newly eligible employees must complete their online enrollment within 30 days of their date of hire/within 30 days of the date they become eligible.

Between Enrollment Periods

Generally, once you enroll, you cannot make changes to your enrollment selections until the next Open Enrollment period. You may make changes to your benefit elections outside of the annual Open 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	30 days from date of event (marriage license, informal marriage license, common law certificate)	Date of event
Birth/Adoption	60 days from date of event (birth certificate, adoption agreement)	Date of event
Change in Spouse employment or work hours affecting health insurance eligibility, increases in spouse's employer's rates or decreases in coverage	30 days from effective date of coverage (certificate of coverage from last employer or insurance company)	Effective date of coverage
Termination of employment by spouse or change in hours affecting health insurance eligibility (loss of coverage)	30 days from effective date of loss of coverage (certificate of coverage from last employer or insurance company)	Effective date of loss of coverage
Death	30 days from date of death (death certificate)	Date of death
Divorce	30 days from date of event (final divorce decree)	Date of event
CHIP/Medicare Enrollment	60 days from date of event (notice from CHIPS or Medicare)	Date of event/notice

BENEFIT ENROLLMENT

When Coverage Begins

New Hires: You must complete the enrollment process within 30 days of your date of hire. If you enroll on time, Medical, Dental, Vision, Life Insurance, Long-Term Disability, and Voluntary plans begin on the first of the month following 30 days of continuous service. TMRS contributions begin day one and 457(b) Deferred Compensation Plan contributions become effective the first payroll following your election.

If you fail to enroll on time, you will not have benefits coverage (except for City-paid benefits) until you enroll during our next annual Open Enrollment period.

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

When Coverage Ends

Medical, Dental, Vision, Life Insurance, Long-Term Disability, and Voluntary plans coverage for you and your family will end on the last day of the month in which your employment with the City ends or you lose full-time eligibility status. The FSA benefit will end on your last day.

When Coverage Ends for Your Children

Your children are eligible for medical, dental and vision 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 26 unless the child is disabled and meets certain requirements.

COBRA

If your health care coverage ends, you and your family may have coverage continuation rights under the federal law known as COBRA. If your coverage terminates, you will be notified of your COBRA rights.

BENEFIT ENROLLMENT

Enroll Online

Enrolling in benefits is easy. Our benefit 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 Open Enrollment or within 30 days of experiencing a Qualifying Life Event.

Benefits 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 Open 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.

HEALTH

MEDICAL COVERAGE

EPO

The Exclusive Provider Organization (EPO) plan, provided through Blue Cross 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

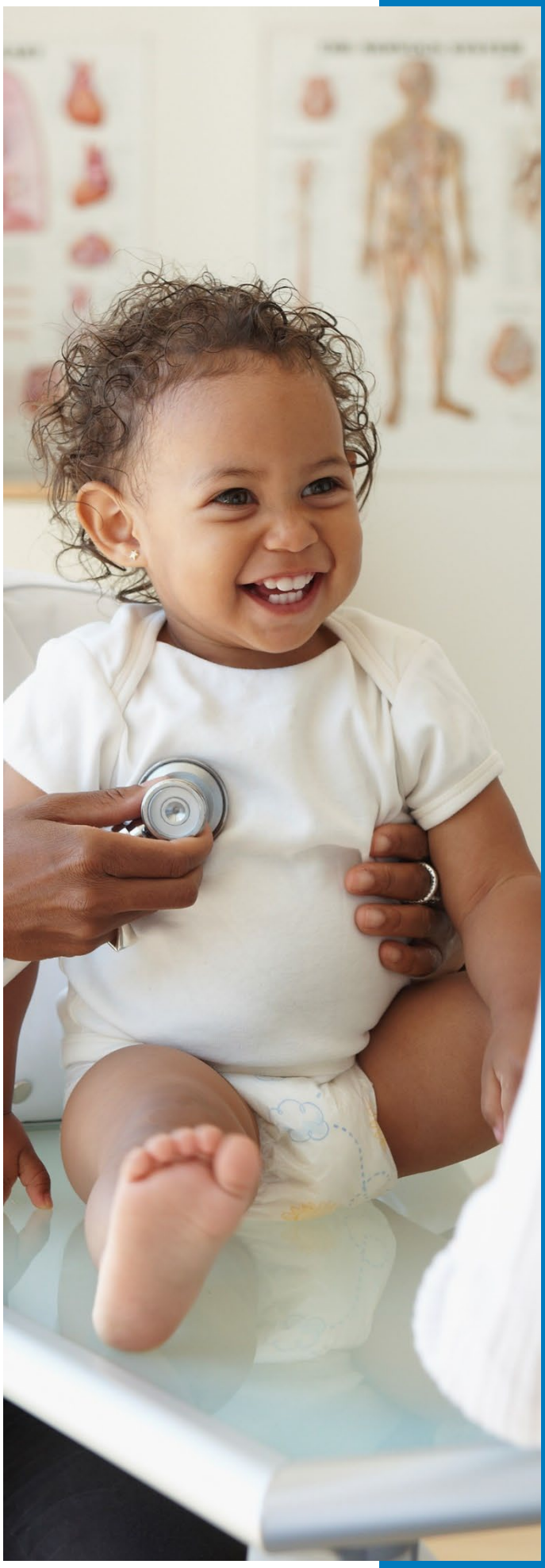
What is Preventive Care?

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 employees on the health plan. Employees 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 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

VISION COVERAGE

Vision Plan

Your eyesight is an integral part of your overall health and a key component of safety. This plan, provided through Davis Vision, gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the Davis Vision network. If you decide to use an out-of-network provider, you will pay the provider in full at the time of your appointment and submit a claim form for reimbursement up to the amount allowed by the plan.

Receiving benefits from a network provider is as easy as making an appointment with the provider of your choice from the list of providers. The provider will coordinate all necessary authorizations you supply in your membership information. To find an in-network provider, go to www.davisvision.com. Special discounts are offered on non-covered services, such as an additional pair of glasses, special lens options and LASIK.

Following is a high-level overview of your vision plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	In-Network Copay	In Network Coverage	
Exam (once every calendar year)	$15	Covered in full, after copay. Includes dilation when professionally indicated.	
Frames (once every calendar year)	$15	Covered in Full Frames: Any Fashion or Designer level frame from Davis Vision's Collection (retail value, up to $160). or Frame Allowance: $130 toward any frame from provider plus 20% off any balance. or Visionworks Frame Allowance: $180 allowance plus 20% off any balance toward any frame from a Visionworks family of store locations.	
Lenses (once every calendar year)		Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full, after copay. (See below for additional lens options and coatings.)	
Contact Lens Fitting	$0	(Specialty contacts allowance $60 plus 15% off balance)	
Contact Lenses (in lieu of glasses; once every calendar Year)	$15	Covered in Full Contacts: Planned Replacement Disposable or Contact Lens Allowance or Visually Required Contacts	From Davis Vision's Collection: Two boxes/multi-packs Four boxes/multi-packs $130 allowance toward any contacts from provider's supply plus 15% off balance. Covered in full with prior approval.

WEALTH

LIFE INSURANCE

BlueCross BlueShield of Texas

Life insurance, provided through Blue Cross Blue Shield of Texas, provides your named beneficiaries with a benefit following your death, while accidental death and dismemberment (AD&D) insurance provides a benefit to you following a covered accident that leads to dismemberment (such as the loss of a hand, foot or eye). Should your death occur due to a covered accident, both the life benefit and the AD&D benefit would be payable.

Basic Life and AD&D (employer-paid)

Coverage Tier	Benefit Amount
Employee	$10,000

Supplemental Life (employee-paid)

If you determine you need more than the basic coverage, you may purchase additional insurance for yourself and your eligible family members.

Supplemental Employee Life*		Spousal Life*	
Age	Biweekly Rate per $1,000 of coverage	Coverage Amount	Biweekly Rate coverage amount
Under 30	.023	$5,000	.37
30-34	.028	$10,000	.74
35-39	.032	$15,000	1.11
40-44	.046	$20,000	1.48
45-49	.069	$25,000	1.85
50-54	.106	$30,000	2.22
55-59	.198	$35,000	2.59
60-64	.305	$40,000	2.96
65-69	.558	$45,000	3.33
70+	.951	$50,000	3.70

Note: During your initial eligibility period, you can secure coverage up to the Guaranteed Issue limits without the need for Evidence of Insurability (EOI, or information about your health). Please note that coverage amounts requiring EOI will only go into effect once the insurance carrier approves them.

Supplemental Employee, Spousal and Dependent Life and AD&D

You can purchase Supplemental Group Term-Life Insurance for yourself and your family. Group Term- Life Insurance provides you with lower rates and the ability to take your coverage with you, if you leave the City or retire. To purchase coverage for your dependents, you MUST purchase supplemental coverage for yourself.

Policies are available in amounts up to three times your annual salary. You may enroll your spouse in increments of $5,000 up to $50,000, and each of your dependent children, under the age of 25 and unmarried, are is eligible for $2,500 increments up to $10,000.

Child Life*	
Coverage Amount	Biweekly Rate coverage amount
$2,500	.23
$5,000	.46
$7,500	.69
$10,000	.92

*BCBSTX life insurance includes Beneficiary Resource Services. When a loved one dies, grief and financial counseling, funeral planning, legal support, as well as online will preparation are available.

Supplemental AD&D (employee-paid)

You may also elect Supplemental Accidental Death & Dismemberment (AD&D). Coverage is NOT at the same rate as Supplemental Life and is in the amounts of one, two or three times your salary.

The rate is $.025 per $1000 of coverage for employee only, and $.038 per $1000 of coverage for family AD&D. AD&D insurance pays a death benefit for fatal accidents ON- OR OFF-the- job. It also covers a percentage of the face amount for dismemberment such as the loss of a limb. Plan coverage is reduced after age 65.

Scan this code to watch a video about how life insurance works.

LONG-TERM DISABILITY INSURANCE

Disability insurance, provided through Blue Cross Blue Shield of Texas provides benefits that replace part of your lost income when you cannot work due to a covered illness or injury.

90-day Elimination Period

Benefit	67% of base salary
Maximum Monthly Benefits	$5,000
When it Begins	90-days after you stop working
When benefit ends	After 24 months*

180-day Elimination Period

Benefit	60% of base salary
Maximum Monthly Benefits	$5,000
When it Begins	90-days after you stop working
When benefit ends	After 24 months*

*Refer to plan document for plan coverage after 24 months

LTD is insurance for your paycheck. If you do not currently have this coverage you may enroll online. If you are applying for coverage, or increasing coverage (changing waiting period), you must complete an Evidence of Insurability form.

Pre-existing condition stipulation may apply. Benefits are not payable for a disability caused by a condition that existed on the effective date of coverage or a period of one year.

LTD rates are based on age.

Scan this code to watch a video about how disability insurance works.

Age	90-day Waiting (per $100 of salary)	180-day Waiting (per $100 of salary)
Under 25	.16	.14
25-29	.18	.16
30-34	.20	.17
35-39	.21	.18
40-44	.28	.25
45-49	.36	.31
50-54	.49	.42
55-59	.74	.64
60+	.91	.79

Rate Calculation Sample
$30,000 Annual Salary & Age 40
$30,000/26 pay periods = $1,153.85
$1,153.85 / 100 = $11.54
$11.54 x .28 = $3.23 Premium Per Pay Period

ACCIDENT INSURANCE

BlueCross BlueShield of Texas

Accident insurance, provided through Blue Cross Blue Shield of Texas, can soften the financial impact of an accidental injury by paying a benefit to you to help cover the unexpected out-of-pocket costs related to treating your injuries. Some accidents, like breaking your leg, may seem straightforward: you visit the doctor, take an X-ray, put on a cast and rest up until you're healed. But treating a broken leg can cost thousands of dollars. When your medical bill arrives, you'll be relieved you have accident insurance on your side.

Accident insurance pays a fixed cash benefit directly to you when you have a covered accident-related injury, like a sprain or bone fracture. Examples of covered expenses include:

- Doctor's office visits
- Diagnostic exams
- Broken leg rehab treatment
- Physical therapy sessions

Accident Insurance in Practice	
Situation	Abed broke his leg in a bike accident.
Covered Benefits	• Doctor's office visits • Diagnostic exams • Broken leg rehab treatment • Physical therapy sessions
Total Benefit Paid Directly to Employee	$4,250

Scan this code to watch a video about how an accident plan works.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Optum

The flexible spending accounts (FSAs), provided through Optum Financial, are tax-advantaged accounts that can help you cover certain qualified out-of-pocket expenses. Each account works in much the same way, but has different eligibility requirements, list of qualified expenses and contribution limits. You may choose to enroll in the following accounts:

	Health Care FSA (HCFSA)	Dependent Care FSA (DCFSA)
Eligibility Requirements	You must be benefits eligible; enrollment in an HCFSA disqualifies you from making or receiving HSA contributions	Available to all employees
Examples of Qualified Expenses	• Coinsurance • Copayments • Deductibles • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia • Prescriptions	• Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers • Care of household members who are physically or mentally incapable of caring for themselves, and who qualify as your federal tax dependent
Annual Contribution Limit	$3,200	$5,000 per family (or $2,500 each if you are married and file separate tax returns)

Important FSA Rules

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

- **You must enroll each year to participate.**
- **HCFSA:** Unused funds from 2024 will carry over to the following year. Carryover funds will not count against or offset the amount that you can contribute annually. Carryover funds not used by March 15, 2025 will be forfeited.
- **DCFSA:** Unused funds will NOT be returned to you or carried over to the following year.

Scan this code to watch a video about how an FSA works.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Optum

Advantages of a Flexible Spending (FSA) or Dependent Care Flexible Spending Account (DCFSA)

There are two big advantages to the FSA or DCFSA. First, for the FSA, the total amount of your annual contribution is available to you on January 1. Second, every dollar you set aside for your FSA or DCFSA reduces how much you pay in income taxes.

The maximum FSA annual contribution is $3,200 – the minimum annual contribution is $100.

Medical FSA Annual Election	Pay Period Deduction	Tax Bracket	Annual Savings	Saving Per Paycheck
$1,000	$38.46	25%	$250	$9.62
$1,500	$57.70	25%	$375	$14.42
$2,000	$76.92	25%	$500	$19.23

Dependent Care FSA Annual Election	Pay Period Deduction	Tax Bracket	Annual Savings	Saving Per Paycheck
$3,500	$134.62	25%	$875	$33.65
$5,000	$192.31	25%	$1,250	$104.16

Optum Financial App

Visit www.optumfinancial.com to learn more and get the app!

Remember to always keep your receipts in case you have to verify that it is an eligible expense - receipts can be uploaded to your account on the website (credit card receipts, non-itemized cash register receipts and cancelled checks are NOT acceptable forms of documentation).

Scan this code to watch a video about how an FSA works.

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 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.

457(B) DEFERRED COMPENSATION PLAN

Our 457(b) plan has three different providers to choose from:

- Corebridge Financial
- MissionSquare Retirement
- Voya Financial

Choose one provider to invest in your retirement to supplement the City's TMRS retirement benefit. You may elect:

- "Pre-Tax" contributions allowing you to defer paying taxes until your assets are withdrawn, or
- "Roth" (post-tax) contributions are made with money that's already been taxed, so you won't have to pay taxes on qualified withdrawals, including earnings.

The following highlights key features of the plan:

- Contributions are immediately vested, meaning you own them outright.
- The plan offers a variety of funds to which you may contribute.
- You may contribute up to $23,000 in 2024, or up to $46,000 if you include the Special Pre-retirement Catch-up Provision.
- You may contribute up to $30,500 in 2024 if you are age 50 or older.
- You can enroll in the 457(b) Deferred Compensation Plan or change your contribution at any time.
- The 10% federal excise penalty on unforeseeable withdrawals does not apply, regardless of your age.

The 457(b) Deferred Compensation Oversight Committee monitors the performance of the plan. The committee meets quarterly.

To setup an account and begin investing in your future, contact a plan representative for more information:

Provider	Representative	Contact Number
Corebridge Financial	Erin Kennedy	806-201-5186
MissionSquare Retirement	Omar Guevara	866-886-8023
Voya Financial	Keith Leonard	806-798-7048

WELLBEING

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The City of Lubbock has adopted an Employee Assistance Program as a tool for dealing with employees' personal problems that can affect their work situations. It is also an aid to employees and their family members who voluntarily use the program as a means of resolving personal problems. Any employee receiving help under this program will be given careful consideration and confidential assistance. The Employee Assistance Program (EAP) is provided at NO COST.

The EAP can help with the following issues, among many others:

- Depression
- Excessive stress or anxiety
- Healing from trauma
- Workplace issues
- Grief and loss
- Better couple communication
- Managing family conflict
- Alcohol and drug abuse

TTU HSC

EAP Benefits

- Assistance for you and your dependents up to age 18
- Up to 8 in-person or virtual sessions with a counselor per event, per year, per individual

SCHEDULE AN APPOINTMENT

806-743-1EAP (1327)

Scan this code to watch a video about how an EAP works.

WOMEN'S HEALTH

Ovia Health

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

Wherever you are in your journey, Blue Cross 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 employees 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.

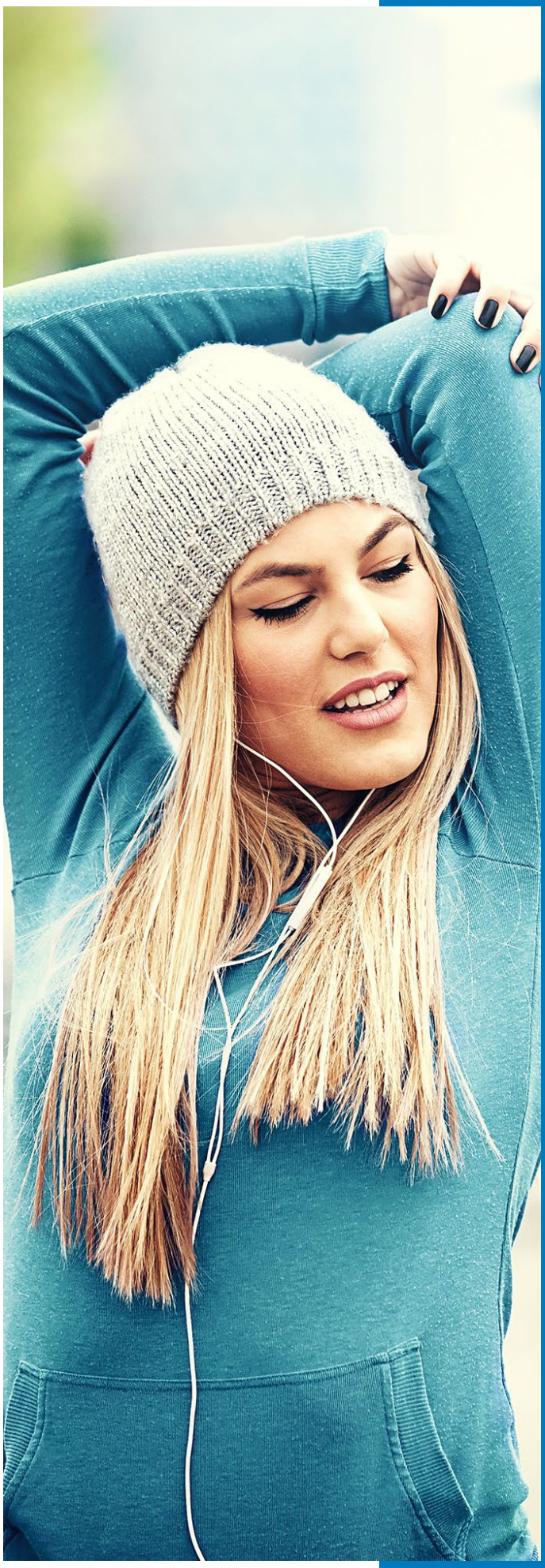
Conditions treated include:

- 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

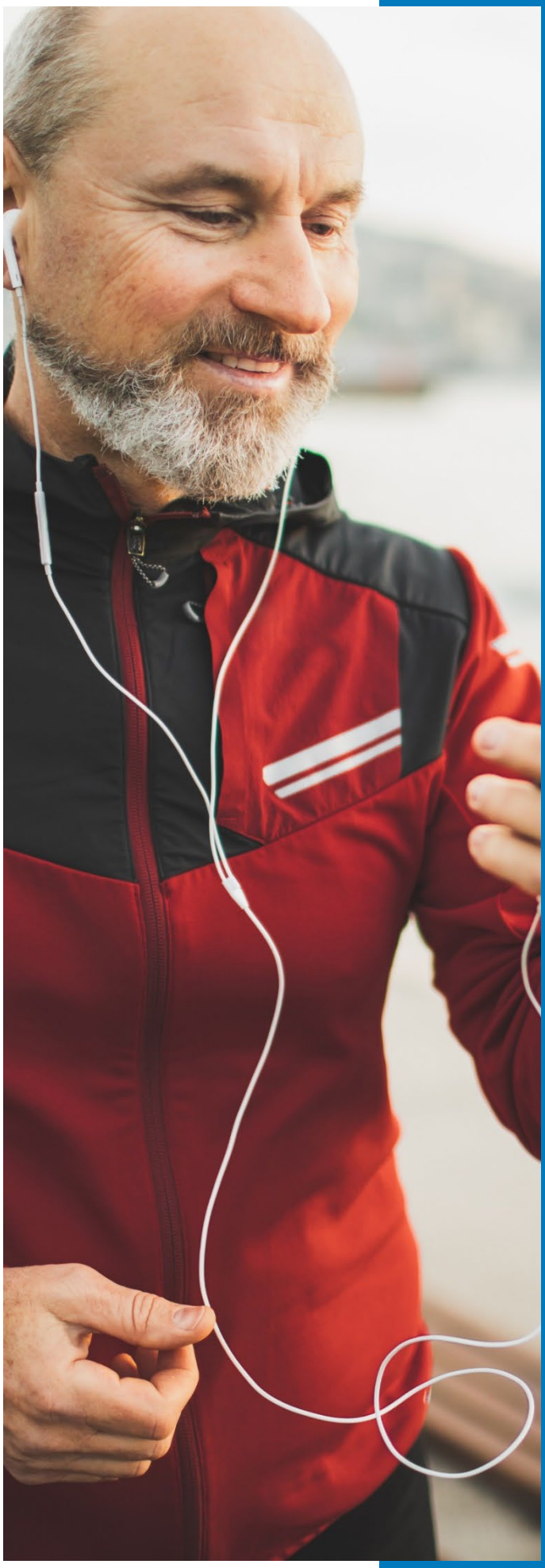
This program is available to employees enrolled in the BCBS EPO medical plan. Livongo supports people diagnosed with type 1 or type 2 diabetes, people at risk for getting type 2 diabetes, people with high blood pressure and more. These programs are available at no cost to you.

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 employees 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.

Employees 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

PERKS

EDUCATION REIMBURSEMENT PROGRAM

After completing the initial probationary period, regular, full-time employees who plan to attend college or receive training in a business or technical field that is related to a City career field may be able to receive financial assistance through the Education Reimbursement Program.

The program is designed to meet organization goals by assisting employees who elect to improve job performance or increase skills through education.

Participation should be mutually beneficial to both the employee and the City of Lubbock.

Every employee participating in the program and receiving assistance must have approval from their department.

TUITION REIMBURSEMENT

The maximum amount the City will reimburse per year is $8,000 for certifications or undergraduate programs and $10,000 for graduate programs. You can use that all in one semester or spread that out over several semesters in a year.

Tuition is paid directly to the school by the employee, but reimbursement of fees will be included in the employee's paycheck when grades and receipts are submitted.

Only grades of C and higher or "pass" in ungraded courses are eligible for reimbursement.

If an employee voluntarily leaves the City after receiving education reimbursement, they must pay back 100 percent of the amount reimbursed in the 12 months prior to leaving and 50 percent of fees reimbursed 13 to 24 months prior to leaving. If an employee works at least 2 years after receiving an education reimbursement, no repayment is required.

GETTING STARTED

Prior to the beginning of class each semester, complete and submit the Education Approval application. Once approved, study hard and enjoy your class. Within 45 business days of class ending, complete and submit an Education Reimbursement form along with a transcript of your final grade and an itemized receipt to receive reimbursement.

CHOOSING A DEGREE

Several degrees are generally allowed in the Education Reimbursement Program, but others may qualify. Check with the Training Division of Human Resources prior to selecting a degree plan. The following are examples of acceptable degrees:

- Associates or Arts (Business, Communication)
- Associate of Science (Accounting , Business, Geographical Information Systems, Information Technology, Management, Office Administration)
- Bachelor of Arts, Bachelor of Science (Accounting, Business, Criminal Justice, Environmental Science & Engineering)
- Master in Business Administration
- Master of Public Administration
- Master in City & Regional Planning
- Master of Library Science

PAID LEAVE

Sick Leave

Employees in full-time positions are eligible for sick leave with full pay for fifteen (15) working days per year. Sick leave accrues at 4.62 hours per pay period.

Vacation Leave

During the first five years of employment, full-time (Non-Civil Service) employees accrue vacation leave hours at 3.08 hours per pay period (10 vacation days per year). After an employee's 5th year, the vacation leave accrual rate increases every year for an additional vacation day through the 15th year of service for a maximum of 20 vacation days per year.

Holidays

The City designates the eleven (11) following dates as holidays to be observed by all City employees occupying full-time positions:

- New Year's Day
- Martin Luther King, Jr. Day
- Good Friday - Friday before Easter
- Memorial Day
- Independence Day
- Labor Day
- Veterans Day (Floating Holiday)
- Thanksgiving and Friday After Thanksgiving
- Christmas Eve and Christmas Day

Funeral Leave

City employees are immediately eligible for funeral leave. You may receive up to three (3) working days per occurrence for the death of a member in the employee's family.

Jury Duty

Any full-time employee who is summoned to serve on a jury or appear as a witness on behalf of the City shall be permitted to be absent from work with pay by the department head for the time actually required by such duty or appearance.

SICK LEAVE SHARING PROGRAM

The Sick Leave Sharing Program provides income for full-time employees unable to work due to a non-job-related illness or injury after their paid leave is exhausted.

Important:
You can only use Sick Leave Share hours in 2025 if you contribute during open enrollment. Even if you don't expect to need it, contributing ensures you're eligible if things change.

How it works:

- You'll need at least 8 hours of accrued sick leave (or 8 vacation leave hours if fewer than 8 sick leave hours are accrued) by **February 8, 2025**
- Your contribution will be deducted on **February 14, 2025**
- You must elect to participate during **Open Enrollment**

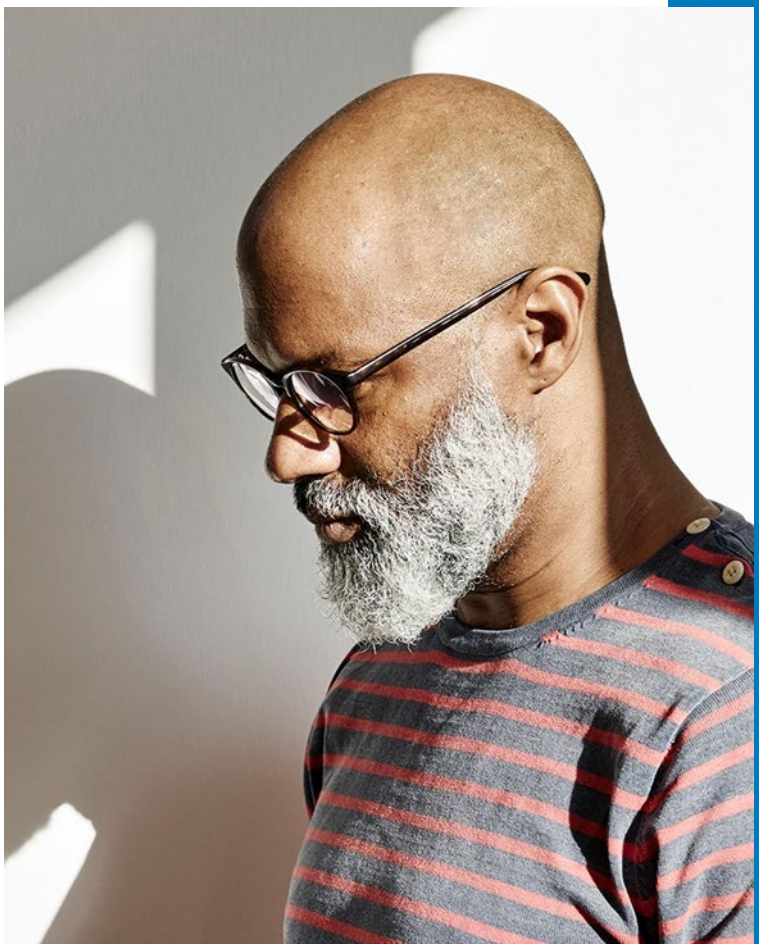
If you typically use leave as it accrues, plan ahead to ensure you have 8 hours available for donation. Also, note there will be no lump sum vacation hours distribution in January 2025—vacation accrues per pay period.

For employees with less than a year of service: Eligibility for Sick Leave Sharing requires one full-year of employment, but you must elect to participate during Open Enrollment.

You can participate with a prorated contribution based on your hire date in 2024:

- January: 8 hours
- February: 7.37 hours
- March: 6.70 hours
- April: 6.03 hours
- May: 5.36 hours
- June: 4.69 hours
- July: 4.02 hours
- August: 3.35 hours
- September: 2.68 hours
- October: 2.01 hours
- November: 1.34 hours
- December: 0.67 hours

This program has been a valuable resource for many employees, and your participation strengthens our ability to support one another in times of need.



RESOURCES

PREMIUMS & CONTRIBUTIONS

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Medical

Coverage	2025 Bi-Weekly Rates		% City Paid
	Employee Bi-Weekly Premium	City Bi-Weekly Contribution	
Employee Only	$11.22	$306.72	96%
Employee + Spouse	$185.72	$479.95	72%
Employee + Child(ren)	$145.56	$369.89	72%
Employee + Family	$254.23	$669.72	72%

Dental

Coverage	2025 Bi-Weekly Rates		% City Paid
	Employee Bi-Weekly Premium	City Bi-Weekly Contribution	
Employee Only	$5.48	$16.40	75%
Employee + Spouse	$13.18	$16.06	55%
Employee + Child(ren)	$11.63	$16.13	58%
Employee + Family	$19.00	$15.81	45%

Vision

Coverage	2025 Bi-Weekly Rates		% City Paid
	Employee Bi-Weekly Premium	City Bi-Weekly Contribution	
Employee Only	$2.86	$0.00	0%
Employee + One	$5.16	$0.00	0%
Employee + Family	$8.02	$0.00	0%

PREMIUMS & CONTRIBUTIONS

Your contributions toward the cost of voluntary benefits are automatically deducted from your paycheck. The amounts will depend upon the plan you select, your age (in some cases) and if you choose to cover your spouse and/or unmarried dependents under the age of 25.

Voluntary Life Insurance

Age	Employee Life	Spousal Life		Child Life	
	Biweekly Rate per $1,000 of coverage	Coverage Amount	Biweekly Rate coverage amount	Coverage Amount	Biweekly Rate coverage amount
Under 30	.023	$5,000	.37	$2,500	.23
30-34	.028	$10,000	.74	$5,000	.46
35-39	.032	$15,000	1.11	$7,500	.69
40-44	.046	$20,000	1.48	$10,000	.92
45-49	.069	$25,000	1.85	*BCBSTX life insurance includes Beneficiary Resource Services. When a loved one dies, grief and financial counseling, funeral planning, legal support, as well as online will preparation are available.	
50-54	.106	$30,000	2.22		
55-59	.198	$35,000	2.59		
60-64	.305	$40,000	2.96		
65-69	.558	$45,000	3.33		
70+	.951	$50,000	3.70		

Voluntary Accidental Death & Dismemberment (AD&D)

Employee AD&D	Family AD&D
Biweekly Rate per $1,000 of coverage	Biweekly Rate per $1,000 of coverage
.0115	.0175

PREMIUMS & CONTRIBUTIONS

Your contributions toward the cost of voluntary benefits are automatically deducted from your paycheck after taxes. The amounts will depend upon the plan you select and your age.

Long-Term Disability

Age	90-day Waiting (per $100 of salary)	180-day Waiting (per $100 of salary)
Under 25	.16	.14
25-29	.18	.16
30-34	.20	.17
35-39	.21	.18
40-44	.28	.25
45-49	.36	.31
50-54	.49	.42
55-59	.74	.64
60+	.91	.79

Rate Calculation Sample
$30,000 Annual Salary & Age 40
$30,000/26 pay periods = $1,153.85
$1,153.85 /100 = $11.54
$11.54 x .28 = $3.23 Premium Per Pay Period

Accident Insurance

Coverage	Employee Bi-Weekly Premiums
Employee Only	$2.14
Employee + Spouse	$3.62
Employee + Child(ren)	$3.93
Employee + Family	$6.26

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.

Dependent Care FSA
A dependent care flexible spending account (DCFSA) is designed to provide tax-exempt funds that can be used to offset qualifying expenses for children and elderly dependents. Eligible dependent care expenses include daycare, before- and after-school care, summer day camps and eldercare for dependents claimed on your income taxes. Funds deposited in an FSA must be spent in the same year in which they are set aside, or they are forfeited. This rule is often referred to as "use it or lose it." Funds are not available for use until they have been deducted and deposited into your DCFSA.

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.

BENEFIT TERMINOLOGY

Employee contribution
The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

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

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.

Health care FSA
Funded through pre-tax payroll deductions, a health care flexible spending account (FSA) is a cost-savings tool that allows you to pay for qualified health care-related expenses with pre-tax dollars.

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.

Open Enrollment
A period during which a health insurance company is required to accept applicants without regard to health history.

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.

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.

BENEFIT TERMINOLOGY

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.

Pre-tax deduction
Payments deducted from your gross pay before Medicare, federal, and state taxes are calculated, thus reducing your taxable wages and tax liability.

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.

Post-tax deduction
Payments deducted from your net pay after Medicare, federal and state taxes are calculated, thereby having no impact on your taxable wages and tax liability.

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 Open 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 Open 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.

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