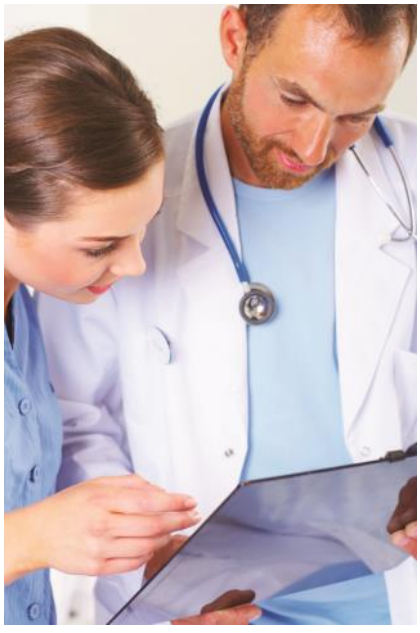
SUNSET VALLEY Texas

EMPLOYEE BENEFITS

2022 Plan Year



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Welcome

We are pleased to offer you a comprehensive benefits package intended to protect your well-being and financial health. This guide is your opportunity to learn more about all of the benefits that are now available to you and your eligible dependents beginning January 1, 2022.

To get the best value from your health care plan, please take the time to evaluate your coverage options and determine which plans best meet your health care and financial needs. By being a wise consumer, you can support your health and maximize your health care dollars.

Each year during Open Enrollment, you have the opportunity to make changes to your benefit plans. The enrollment decisions you make this year will remain in effect through December 31, 2022. You may make changes to your benefit elections only when you have a Qualifying Life Event. After such an event, you can make changes to your health care coverage within 30 days; otherwise, you cannot make changes to your benefits coverage until the next Open Enrollment period.

Availability of Summary Health Information

Our Employee Benefits Program offers one health coverage option. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available, which summarizes important information about your health coverage option in a standard format.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 24 for more details.

Eligibility

You are eligible for benefits if you are a regular, full-time employee working an average of 30 hours per week. Your coverage is effective 1st of the month following the date of hire of employment. You may also enroll eligible dependents for benefits coverage. The cost to you for dependent coverage will vary depending on the number of dependents you enroll in the plan and the particular plans you choose. When covering dependents, you must select the same plans for your dependents as you select for yourself.

Eligible Dependents include:

- Your legal spouse or domestic partner
- Children under the age of 26, regardless of student status, dependency or marital status
- Children who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return; coverage may continue past age 26

How to Enroll

Complete the enrollment form and return to your HR Department:


2022 Benefit Enrollment Form

Qualifying Life Events

Once you elect your benefit options, they will remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event, and you must do so within 30 days of the event.

Qualifying Life Events include:

- Marriage, divorce, legal separation or annulment
- Birth, adoption or placement for adoption of an eligible child
- Death of a spouse or child
- Change in your spouse's employment that affects benefits eligibility
- Change in your child's eligibility for benefits (reaching the age limit)
- Change in residence that affects your eligibility for coverage
- Significant change in coverage or cost in your, your spouse's or child's benefit plans
- FMLA leave, COBRA event, Court Judgment or Decree
- Becoming eligible for Medicare or Medicaid
- Receiving a Qualified Medical Child Support Order

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Medical Coverage: Humana

City of Sunset Valley offers one medical plan provided by Humana. The PPO allows access to both in-network and out-of-network providers, but you will get better discounts and pay less money by remaining in-network. All out-of-network services are subject to Reasonable and Customary (R&C) limitations and you are responsible for all charges over this allowance.

Preferred Provider Organization (PPO)

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the Humana NPOS network, you receive benefits at the discounted network cost. If you use non-PPO providers, you will pay more for services.

Finding an In-network Provider / Specialist / Urgent Care Clinic:

In-network providers and facilities can be found by going to www.humana.com and clicking on "Find a Doctor" located on the bottom of the page in green. From here you can search for Hospitals, Facilities and Physicians. Just follow the prompts:

Search type is Medical, coverage type is "insurance through your employer". Enter your zip code and select your network—National POS—Open Access.

In the Search field—select "All" and a pop up will appear where you can type in Urgent Care clinics, Specialists, etc….

Please note: ER facilities and ER physicians will not provide results as a true emergency is processed in network.

Health Coverage Reminder

The Patient Protection and Affordable Care Act (PPACA) requires most individuals to have minimum essential health coverage. You may obtain coverage through your employer or through the Marketplace.

- Depending on your income and the coverage offered by your employer, you may be able to obtain lower cost private insurance in the Marketplace.
- If you buy insurance through the Marketplace, you may lose any employer contribution to your health benefits.
- Visit **www.HealthCare.gov** for Marketplace information.

REMINDER: You may only purchase insurance through the Marketplace if you experience a qualifying event OR during Open Enrollment. The Federal Marketplace Open Enrollment dates are November 1 through December 15.

Medical Coverage: Humana

	Humana	
	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual	$5,000	$15,000
Family	$10,000	$30,000
Coinsurance		
Carrier	100%	70%
Member	0%	30%
Calendar Year Out-of-Pocket Maximum (Includes Deductible)		
Individual	$5,000	$24,000
Family	$10,000	$48,000
Lifetime Maximum	Unlimited	
	You pay	
Coinsurance / Copays		
Preventive Care	Covered at 100%	100% maximum Allowable Fee
Primary Care Physician	$20 copay	Deductible then coinsurance
Specialist	$45 copay	Deductible then coinsurance
Urgent Care	$55 Copay	Deductible then coinsurance
Emergency Room	100% after $250 Copay *(copay waived if admitted)*	
Hospital Services	Deductible then coinsurance	Deductible then coinsurance
Pharmacy		
Retail RX (up to 31 day supply)		
Tier 1	$10 Copay	
Tier 2	$30 Copay	
Tier 3	$50 Copay	
Tier 4	25%	
Mail Order RX (up to 90 day supply)	2.5x Copay	

Health Reimbursement Arrangement

A Health Reimbursement Arrangement (HRA) is a personal health care account that you can use to pay for qualified medical expenses.

When you elect medical coverage, City of Sunset Valley will automatically establish an HRA in your name. The HRA helps you cover out-of-pocket costs that you would pay before meeting your annual deductible.

Eligible Medical Expenses

- You can use your HRA to pay for medical care expenses covered by the health plan
- Any combination of deductible, coinsurance or copayment expenses

Meeting the Deductible and Using the HRA

- The money in your HRA can be used to help you pay your deductible. You must pay the first portion of your deductible and the HRA will reimburse up to the last $2,250 of the $5,000 Employee Only deductible.
- Preventive Care services are covered by the plan at 100%, so you will not use HRA dollars for these visits/services.

Submitting a Claim

Your HRA can be used to pay for qualified medical expenses under your health plan. Any time you have a qualified medical expense, you may submit your claim to your HR Department .

Where to go for Care

When you need medical attention, you should go to your primary care doctor whenever you can. Your doctor knows you best and has quick access to your medical records. However, there are times when you might need to go to a facility other than your doctor's office. This list shows examples of various care providers and the services they generally provide. The cost of medical care can vary widely. Your cost depends on where and how you receive care. Knowing the facts can help you manage your health and your health care dollars.

Virtual Visits - Teladoc		Symptoms	Average Cost	Average Wait
	Access to care via phone, online video or mobile app whether you are home, work or traveling; medications can be prescribed **24 hours a day, 7 days a week**	• Allergies • Cough/cold/flu • Rash • Stomachache	$	2-5 minutes

Doctor's Office		Symptoms	Average Cost	Average Wait
	Generally, the best place for routine preventive care; established relationship; able to treat based on medical history **Office hours vary**	• Infections • Sore and strep throat • Vaccinations • Minor injuries, sprains and strains	$	15-20 minutes

Retail Clinic		Symptoms	Average Cost	Average Wait
	Usually lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies **Hours vary based on store hours**	• Common infections • Minor injuries • Pregnancy tests • Vaccinations	$	15 minutes

Urgent Care		Symptoms	Average Cost	Average Wait
	When you need immediate attention; walk-in basis is usually accepted **Generally includes evening, weekend and holiday hours**	• Sprains and strains • Minor broken bones • Small cuts that may require stitches • Minor burns and infections	$$	15-30 minutes

Hospital ER		Symptoms	Average Cost	Average Wait
	Life-threatening or critical conditions; trauma assist; multiple bills for doctor and facility **24 hours a day, 7 days a week**	• Chest pain • Difficulty breathing • Severe bleeding • Blurred or sudden loss of vision • Major broken bones	$$$$	4+ hours

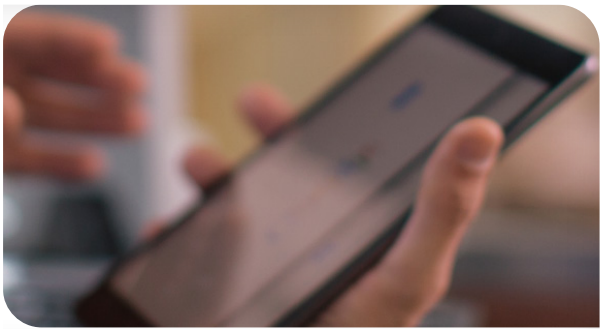
Freestanding ER		Symptoms	Average Cost	Average Wait
	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher **24 hours a day, 7 days a week**	• Most major injuries except trauma • Severe pain	$$$$$$	Minimal

Feeling under the weather? Talk to a doctor within minutes.

If you or someone in your family is not feeling well and doesn't require emergency care, telemedicine, powered by Doctor On Demand, lets you see a U.S. board-certified physician in minutes using your smartphone, tablet, or computer.

With Humana's telemedicine benefit delivered by Doctor On Demand, you can:

- Connect with a physician from one of Doctor On Demand's U.S. board-certified doctors
- Immediately see a doctor 24 hours a day, 7 days a week from any location
- Your primary care physician can access your telemedicine visit at your request
- If medically necessary, the telemedicine doctor can send a prescription to a preferred pharmacy



Go to Doctor On Demand's website for more information on telemedicine and promotional offers

Humana.

Humana.com

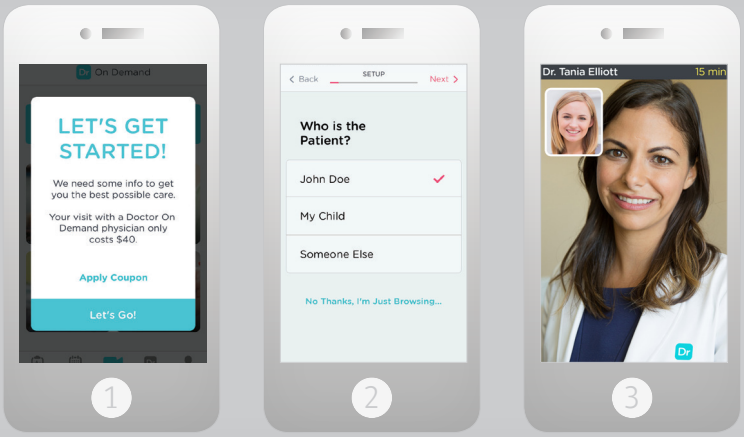
Talk to a telemedicine doctor for $40 or less.

Based on your plan, your co-payment or retail clinic benefit cost may be less.

1 Download the app

2 Enter your Humana information

3 See an MD within minutes



No appointments required

There are many ways to sign up and start seeing a doctor:

- Visit **www.doctorondemand.com/humana**
- Download the Doctor On Demand mobile app, available on the App Store and Google Play

ANDROID APP ON Google play

Download on the App Store

What can be treated by telemedicine

Telemedicine should be considered when your primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with telemedicine, such as:

- Colds, sore throat, and flu symptoms
- Upper respiratory infections
- Allergies and sinus infections
- Ear and eye problems
- Skin conditions

Telemedicine is not for emergency situations such as chest pain, abdominal pain or shortness of breath.

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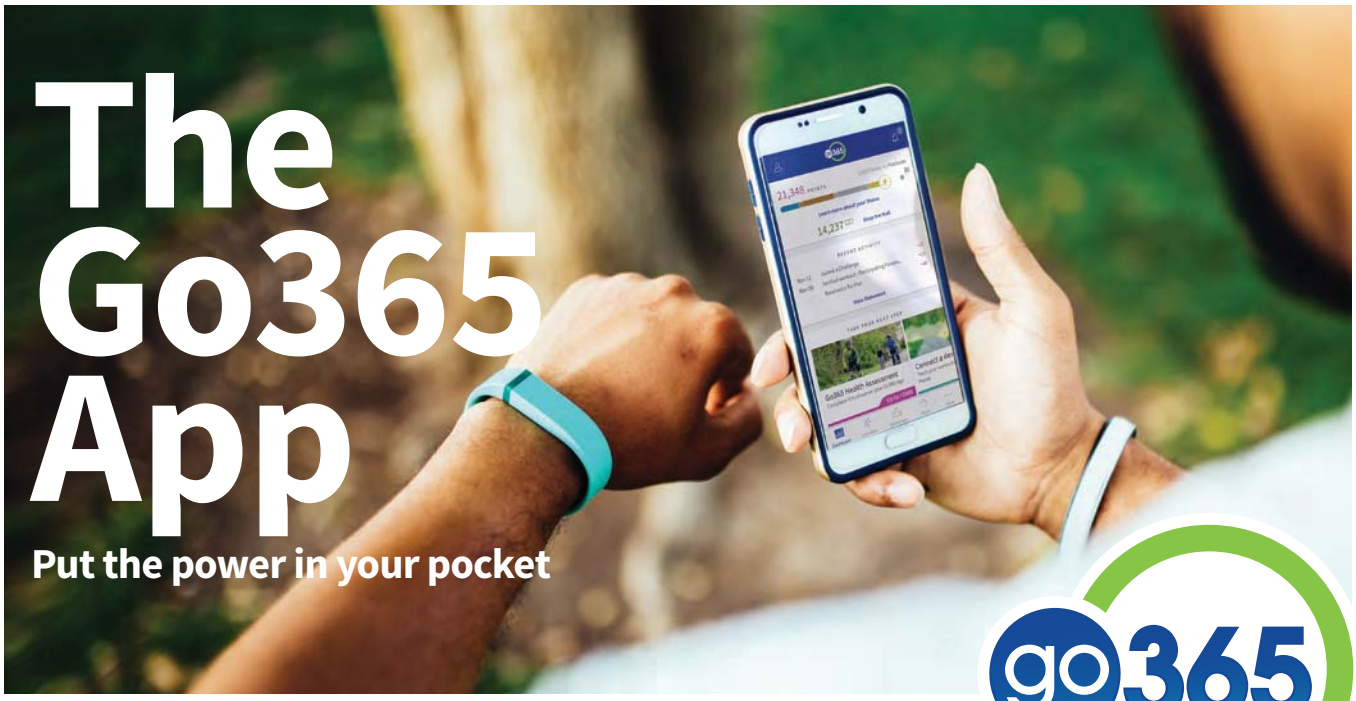
PERSONAL, VERSATILE, SIMPLE



The Go365 App

Put the power in your pocket

Download the Go365® App today to your smartphone.
Use it to help you stay on track in reaching your health and well-being goals.

The App has it all

Look what you can do:

- Go head-to-head against other Go365 members and compete in Challenges*
- Submit proof of eligibile activities for Points
- Connect compatible devices and tracking apps
- Personalize experiences with photos
- Complete or update your Health Assessment in quick, two-minute sections
- Explore ways to increase your Points total
- Complete activities that focus on areas such as food and sleep tracking for Points**
- Check on your Go365 Age and Status
- Enroll and interact with a health coach
- See your Points history
- Spend your Bucks in the Go365 Mall

Look how the Go365 App can make your life easier. Sign in today.

ANDROID APP ON Google play | Download on the App Store

Download the Go365 App

Go365 is not an insurance product. Not available with all Humana health plans.

*Members earn 50 Points for joining a Challenge and 50 more for joining a Challenge team, up to a maximum of 100 combined Points per month no matter how many Challenges and Challenge teams a member may join.

**Depending on the activity, activities can be worth 2 Points a day or may have a weekly or monthly cap. Refer to the App for Points limits.

It's simple to get started with Go365™. Here's how to get rewarded for your healthy behaviors.

1. Register now

Download the Go365 App or visit **Go365.com** to access your secure, password-protected Go365 account and program.

2. Take the next step

Three easy ways to start earning Points and get to Bronze Status:

- Complete at least one section of your Health Assessment
- Log a verified workout
- Get your biometric screening

Adult children are not eligible to earn Points or Bucks for Health Assessment completion or bonuses, biometric screening completion or for having in-range results.

3. Enjoy the rewards

Keep earning Points by completing healthy activities. The more Points you earn, the more Bucks you will have to spend in the Go365 Mall. Reward yourself with brands including:

amazon.com TARGET Spafinder Wellness 365 fitbit

Join the Go365 support community
community.Go365.com

Register or sign in at **Go365.com** or on the App

Go365 is not an insurance product. Not available with all Humana health plans.

Adult children can only move a family into Bronze Status by completing a verified workout.

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INDIVIDUAL

GETTING TO **SILVER STATUS**

You're off to a great start. Now it's time to earn Points so you can move up to Silver Status. Earn Points in Go365™ by completing activities online or using the Go365 App.

Here are all the ways you can earn Points in Go365:

- **Activities** - Things you can do every day to get healthier
- **Recommended Activities** - Created just for you based on your Heath Assessment responses
- **Go365 Kids** - Points for activities that are good for kids' health
- **Challenges** - Compete against friends and co-workers

While you can choose any qualified activity, here are popular activities you may complete to reach Silver Status in the first 12 weeks of your Go365 program year.

Individual (5,000 Points)

Activity	Point Value
Health Assessment (all sections)	**500**
Bonus - Health Assessment 90-day completion (all sections)	**250**
Bonus - First step Health Assessment (once per lifetime) (all sections)	**500**
Biometric screening completion	**2,000**
In healthy range biometric screening results:	
Blood pressure	**400**
Blood glucose	**400**
Dental exam	**200**
Flu shot	**200**
Daily fitness Points (over 12 weeks):	
Two fitness facility workouts per week (10 Points x 24 workouts)	**240**
Complete an organized 5K walk or run	**250**
Calculators (x1)	**75**
Total Points	**5,015**

Bonus Bucks! Earn 500 Bonus Bucks when you reach Silver Status. Earn 1,000 Double Bonus Bucks when you reach Silver Status for the first time or if your prior year highest Status was Silver.

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GETTING TO **SILVER STATUS**

Give the whole family a boost! Get to Silver Status together by earning Points through activities, Challenges and even Go365 Kids.

Family; 2 adults + child (8,000 Points)

5,000 Points for primary Go365 member + 3,000 Points for additional adult family member

Activity	Point Value
Health Assessment (2 adults; 500 Points x 2)	**1,000**
Bonus - Health Assessment 90-day bonus (2 adults; 250 Points x 2)	**500**
Bonus - First step Health Assessment (2 adults; 500 Points x 2)	**1,000**
Biometric screening completion (2 adults; 2,000 Points x 2)	**4,000**
In healthy range biometric screening results (1 adult):	
BMI	**800**
Calculators (1 adult; 75 Points x 4)	**300**
Blood donation (1 adult; 50 Points x 2)	**100**
Sports league participation (1 adult)	**350**
Monthly **Go365.com** visit (1 adult; 10 Points x 12 months)	**120**
Daily fitness Points (1 adult; over 12 weeks):	
8,000 steps per day achieved 5 days per week (8 Points x 60 days)	**480**
First lifetime verified workout (1 adult)	**500**
First verified workout of the new program year (1 adult)	**750**
Kids sports league (100 Points x 2)	**200**
Kids preventive care visit	**200**
Kids dental exam	**100**
Total Points	**8,400**

Adult children are not eligible to earn Points or Bucks for Health Assessment, biometric screening completion or for having in healthy range results.

Bonus Bucks! Earn 500 Bonus Bucks when you reach Silver Status. Earn 1,000 Double Bonus Bucks when you reach Silver Status for the first time or if your prior year highest Status was Silver.

We'll award your adult family members, too! Each adult family member will receive 250 Bonus Bucks for reaching Silver Status. Adult family members will earn 500 Double Bonus Bucks when you reach Silver Status for the first time or if your prior year highest Status was Silver. That's a lot of buying power!

Go365 is not an insurance product. Not available with all Humana health plans.
We are committed to helping you achieve your best health. Rewards for participating in Go365 are available to all members. If you think you might be unable to meet a standard for a Go365 reward, you might qualify for an opportunity to earn the same reward by different means. Sign in to your Go365.com account and visit the Communication center to send us a secure message and we will work with you (and, if you wish, with your health care practitioner) to develop another way to qualify for the reward.
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ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 (TTY: 711).
ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-320-1235 (TTY：711)。

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Dental Coverage: Humana

Our dental plan helps you maintain good dental health through affordable options for preventive care, including regular checkups and other dental work. Premium contributions for dental will be deducted from your paycheck on a pre-tax basis.

DPPO Plan

Two levels of benefits are available with the DPPO dental plan depending on whether or not your dentist is in or out of the PPO network. You have the flexibility to select the provider of your choice, but your level of coverage may vary based on the provider you see for services. Staying in-network and going to a contracted DPPO provider will provide you with the highest level of benefits and the deepest discounts your plan has to offer

How to Find a Dentist

To find an in-network dentist, visit the website at www.humanadental.com or call 1-800-558-4444 to speak with Member Services.

Dental Coverage: Humana

	DENTAL	
	Contracted Dentist	Non Contracted Dentist
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Annual Maximum Benefit		
Individual	Unlimited Per Covered Person	
	You pay	
Services		
Preventive Procedures Exams, Cleanings, X-rays, Fluoride Treatments, Sealants	100% No Deductible	100% No Deductible
Basic Procedures Fillings, Oral Surgery, Routine Extractions Endodontics, Periodontics	80% after Deductible	80% after Deductible
Major Procedures Crowns, Inlays/Outlays, Dentures and Implants	50% after Deductible	50% after Deductible
Usual, Customary & Reasonable	Negotiated Fee Schedule	In-Network Fee Schedule
Orthodontia		
Children up to age 19	50% Up to a $1,500 Lifetime Max	50% Up to a $1,500 Lifetime Max

Vision Coverage: Humana

Vision exams can help to identify certain medical conditions such as diabetes or high cholesterol. To help you manage your health, we offer vision coverage through Humana. Under this plan, you may use the eye care professional of your choice. However, when you use a participating network provider, you receive higher levels of coverage.

	Vision Plan	
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	You pay	Reimbursement
Cost		
Exam (dilation as necessary)	$10 Copay	Up to $35
Covered Services - Lenses		
Single Lenses	$15 Copay	Up to $25
Bifocals	$15 Copay	Up to $40
Trifocals	$15 Copay	Up to $60
Frames	Up to $50	Up to $40
Covered Services - Contacts in lieu of Frames/Lenses		
Contacts - Elective	Up to $130	Up to $104
Benefit Frequency		
Exams	Once every 12 Months	Once every 12 Months
Lenses / Contact Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 24 Months	Once every 24 Months

Flexible Spending Accounts

A great way to plan ahead and save money over the course of a year is to participate in our Flexible Spending Account (FSA) programs.

These accounts allow you to put a portion of your salary, on a pre-tax basis, into reimbursement accounts. Pre-tax means the dollars you use for eligible expenses are not subject to Social Security tax, federal income tax and, in most cases, state and local income taxes. When you enroll, you must decide how much to set aside from your paycheck for each account. Be sure to estimate your expenses conservatively, as the IRS requires that you use the money in your account during the plan year and the applicable grace period or it will be forfeited (the "use it or lose it" rule).

Health Care Spending Account

The Health Care Spending Account enables you to take control of your out-of-pocket health care spending by contributing pre-tax money to your account to pay for everyday eligible expenses. The result can be substantial savings on products and services not covered by your plan such as copayments, coinsurance, deductibles, prescription expenses, lab exams and tests, contact lenses, eyeglasses and more. A complete list of qualified expenses can be found in publication 502 on the IRS website. When you incur the expense, you will be reimbursed the full amount at that time. You can contribute up to $2,750 annually to the Health Care Spending Account.

Dependent Care Spending Account

The Dependent Care Spending Account helps pay for dependent/elder care expenses associated with caring for elder or child dependents in order for you or your spouse to work or attend school full-time. The dependent child must be under age 13 and claimed as a dependent on your federal income tax return, or a disabled dependent of any age incapable of caring for him- or herself, and who spends at least eight hours a day in your home. You can contribute up to $5,000 annually to the Dependent Care Spending Account.

Unlike the Health Care Spending Account, reimbursement from your Dependent Care Spending Account is limited to the total amount that is deposited in your account at that time. In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care and that provider cannot be anyone considered your dependent for income tax purposes.

How FSAs Work

Estimate the amount you will need for eligible out-of-pocket health care and/or dependent care expenses for the calendar year or portion thereof, depending upon your effective date of coverage. Estimate carefully and contribute only as much as you think you will need, subject to the plan limit.

Divide your total estimated expenses by the number of paychecks you receive yearly, or portion thereof, depending on your effective date of coverage. This is the amount that will be deducted from each paycheck and deposited into your non-interest-bearing account(s).

Whenever you have an eligible expense, submit your receipt to Higginbotham at flexclaims@higginbotham.net or fax to 866-419-3516, along with a Reimbursement Request Form, or use your FSA debit card. You will then be reimbursed with funds from your account.

Your debit card cannot be used for dependent care expenses.

Account Type	Eligible Expenses	Annual Contribution Limits	Benefit
Health Care Spending Account	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over-the-counter medications	Maximum contribution is $2,750 per year	Saves on eligible expenses not covered by insurance, reduces your taxable income
Dependent Care Spending Account	Dependent care expenses such as day care, after-school programs or elder care programs	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income

New! ClaimsFlow™

ClaimsFlow makes it easy for you to request reimbursement from your Health Care FSA by connecting your insurance plan to your medical Explanation of Benefits (EOBs) so that they are organized for future reference.

- When you access the portal, you will have a single view of all medical EOBs
- Your claims feed into the portal as they occur.
- Click on *Request Reimbursement*, choose the applicable EOB, then click *Submit* to begin the reimbursement process

Once you register for ClaimsFlow at **https://higginbotham.wealthcareportal.com,** your and your eligible dependents' (EOBs) will automatically load into the portal. When they have been loaded, you may submit them for reimbursement from your Health Care FSA.

If this is your first time logging in to the system, enter your Social Security number and **HIGCITYO45** as your Employer ID. After registering and selecting the ClaimsFlow widget, you will be prompted to provide your Humana login information.

Rollover Rule

The IRS allows you to carry-over up to $550 of unused dollars in your Health Care Spending Account into the next plan year. [Grace Period **OR** Rollover Rule]

How to Use the Debit Card

The FSA debit card allows you to pay for eligible health care expenses at the point of service and deducts funds directly from your Health Care Spending Account. This allows you to avoid waiting for reimbursement. You may use your FSA debit card at locations such as doctor and dentist offices, pharmacies and vision service providers. The card cannot be used at locations that do not offer services under the plan, unless the provider has complied with IRS regulations. Should you attempt to use the card at an ineligible location, the swipe transaction will be denied. Should you need to submit a receipt for substantiation, you will receive an email or be mailed a Receipt Notification. Always retain receipts for your records.

The debit card is automatically sent to new participants. If you are already a participant, keep your current card.

Your debit card can not be used for dependent care expenses.

Flexible Spending Accounts

FSA Eligible Expenses

Your Health Care Spending Account dollars can be used for a variety of out-of-pocket health care expenses. The following is based on a list of eligible expenses created by the IRS. It is not an all-inclusive list, but provides many examples of eligible expenses. Some eligible expenses require a Note of Medical Necessity from your health care provider to qualify for reimbursement.

Over-the-Counter Item Rule Reminder

Health care reform legislation requires that certain over-the-counter (OTC) items require a "prescription" in order to be considered an eligible Health Care Spending Account expense. You will only need to obtain a one-time prescription per OTC item for the 2021 plan year.

Dental

- Dental x-rays
- Dentures and bridges
- Exams and teeth cleaning
- Extractions and fillings
- Oral surgery
- Orthodontia
- Periodontal services

Eyes

- Eye exams
- Eyeglasses and contact lenses
- Laser eye surgeries
- Prescription sunglasses
- Radial keratotomy

Hearing

- Hearing aids and batteries
- Hearing exams

Lab Exams/Tests

- Blood and metabolism tests
- Body scans
- Cardiograms
- Laboratory fees
- X-rays

Medications

- Insulin
- Prescription drugs

Medical equipment/supplies

- Air purification equipment
- Arches and orthotic inserts
- Contraceptive devices
- Crutches, walkers, wheel chairs
- Exercise equipment
- Hospital beds
- Mattresses
- Medic alert bracelet or necklace
- Nebulizers
- Orthopedic shoes
- Oxygen
- Post-mastectomy clothing
- Prosthetics
- Syringes

Medical Procedures/Services

- Acupuncture
- Alcohol and drug/ substance abuse
- Ambulance
- Fertility enhancement and treatment
- Hair loss treatment
- Hospital services
- Immunization
- In vitro fertilization
- Physical examination
- Service animals
- Sterilization/sterilization reversal
- Transplants (to include donor)
- Transportation

Obstetrics

- Lamaze class
- OB/GYN exams
- OB/GYN maternity fees
- Pre- and postnatal

Practitioners

- Allergist
- Chiropractor
- Christian Science practitioner
- Dermatologist
- Homeopath
- Naturopath
- Optometrist
- Osteopath
- Physician
- Psychiatrist or psychologist

Therapy

- Alcohol and drug addiction
- Counseling
- Exercise programs
- Hypnosis
- Massage (medically necessary)
- Occupational
- Physical
- Smoking cessation programs
- Speech

Weight Loss Programs

Life and AD&D Insurance: Unum

Life insurance is an important part of your financial security, especially if others depend on you for support. Even if you are single, your beneficiary can use your Life insurance to pay off your debts, such as credit cards, mortgages, and other final expenses.

Basic Life insurance and Accidental Death and Dismemberment (AD&D) coverage are provided at no cost to you. Employees are automatically covered up to $15,000 through Unum .

AD&D coverage helps protect you and your family from the unforeseen financial hardship of a serious accident that causes death or dismemberment. AD&D insurance provides you specified benefits for a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that death occurs from an accident, 100% of the AD&D benefit would be payable to your beneficiary(ies).

Designating a Beneficiary

A beneficiary is the person or entity you designate to receive the death benefits of your life insurance policy. You can name more than one beneficiary and you can change beneficiaries at any time. If you name more than one beneficiary, identify the share for each.

Disability Insurance: Unum

If you suddenly become ill or are involved in an accident and are unable to work, it is easy to fall behind on your rent or mortgage, car payment, and other expenses. That is why a salary replacement plan is an important benefit for you and your family.

Short Term Disability Insurance

If you become sick or injured and are unable to work, including pregnancy, would you have enough savings to cover your living expenses during that time? If not, you may want to consider Short Term Disability (STD) insurance as a piece of your overall financial plan. City of Sunset Valley provides STD coverage at no cost to you.

Long Term Disability Insurance

Long Term Disability (LTD) insurance provides long term income protection in the event of sickness or injury. A qualifying disability can occur on or off the job. City of Sunset Valley provides LTD coverage at no cost to you.

Coverage	Benefit
Short Term Disability	Covers 60% of your base annual earnings, to a $1,500 maximum per week for 11 weeks. Benefit begins after 14 days of injury or sickness.
Long Term Disability	Covers 60% of your base annual earnings to a $6,000 maximum per month. Benefit begins after 90 days of disability and continues to age 65 SSNRA.

Rates

This worksheet helps you calculate your semi monthly benefit costs and is not an enrollment form.

Medical Coverage		Medical
	Semi-Monthly Wellness / Non Wellness	
Employee Only	$0.00 / $47.73	$
Employee + Spouse	$309.12 / $330.76	
Employee + Child(ren)	$206.84 / $221.32	
Employee + Family	$650.06 / $695.56	

Dental Coverage		Dental
	Semi-Monthly	
Employee Only	$0.00	$
Employee + Spouse	$16.30	
Employee + Child(ren)	$29.88	
Employee + Family	$47.18	

Vision Coverage		Vision
	Semi-Monthly	
Employee Only	$0.00	$
Employee + Spouse	$3.64	
Employee + Child(ren)	$3.28	
Employee + Family	$7.23	

Life and Disability		
	Paid at 100% by City of Sunset Valley	$0

Subtotal	→	$

Important Contacts

Coverage	Provider	Contact	Website
Medical	Humana	1-800-558-4444	www.humana.com
Dental	Humana	1-800-558-4444	www.humanadental.com
Vision	Humana	1-800-558-4444	www.humanavisioncare.com
FSA	Higginbotham	1-866-419-3516	www.higginbothamwealthcareportal.com
Life / Disability	Unum	1-866-679-3054	www.unum.com

Required Notices

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

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

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

City of Sunset Valley

Human Resources

3205 Jones Rd

Sunset Valley, TX 78745

512-892-1383

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 Sunset Valley and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription 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. City of Sunset Valley has determined that the prescription drug coverage offered by the City of Sunset Valley medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a

Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting City of Sunset Valley at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current City of Sunset Valley prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at 512-892-1383.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription 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 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 800-772-1213. TTY users should call 800-325-0778.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, 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 whether or not you are required to pay a higher premium (a penalty).

Date: 1/1/2022

Name of Entity/Sender: City of Sunset Valley

Contact Office: OR Human Resources

Address: 3205 Jones Rd

Sunset Valley, Texas 78745

Phone Number: 512-892-1383

Notice of HIPAA Privacy Practices

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan - whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan), sponsored by City of Sunset Valley, hereinafter referred to as the plan sponsor.

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer.

You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask the Human Resources Department to amend the information. For a full copy of the Notice of Privacy Practices describing how protected health information about you may be used and disclosed and how you can get access to the information, contact the Human Resources Department.

Complaints: If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, please contact the Privacy Officer.

City of Sunset Valley

Human Resources

3205 Jones Rd

Sunset Valley, TX 78745

512-892-1383

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 are 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 and CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual 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, you can 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, you can ask the 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 are not 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, 2019. Contact your State for further information on eligibility.

ALABAMA – Medicaid
Website: http://www.myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (1-855-692-7447)

COLORADO– Medicaid and CHP+
Medicaid Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+ Website: www.colorado.gov/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 1-678-564-4462 Ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0864

IOWA – Medicaid
Website: http://www.dhs.iowa.gov/hawki
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http:/dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: http://www.mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for HIPP program: 1-800-852-3345 Ext.5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid and CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll Free Phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: http://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com
Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, you can contact either:

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

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

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your eligible dependents are entitled to continue your group health benefits coverage (medical, dental, vision and HCRA) under the Company Name plan after you have left employment with the agency. If you wish to elect COBRA coverage, you have 60 days from the date you receive your election notice to make an election. You have 45 days after electing coverage to pay the initial premium.

Notice Regarding Wellness Program

The employee wellness program is a voluntary program administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which could include a blood test for certain medical conditions such as diabetes, heart disease, etc. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may qualify for an incentive. Although you are not required to complete a HRA or biometric screening, the wellness program may specify that only employees who do so will qualify for the incentive. Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources.

If you choose to participate in a HRA and/or biometric screening, information from your HRA and results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

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SUNSET VALLEY Texas

This brochure highlights the main features of the employee benefits program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are final authority. The rights are reserved to change or discontinue the employee benefits plans at any time.