2024 employee benefits guide

PLAINVIEW, TX
explore the opportunities

Table of Contents

PLAINVIEW, TX
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Take Care of Your Tomorrow!

Take Care of Your Tomorrow!

Personal needs greatly influence the choices we make every day. Young or old, single or married, our needs differ. That's why the City of Plainview wants to provide you with the freedom to select high quality benefit options that work best for you and/or your family.

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

The City of Plainview values our employees and recognizes the importance of offering competitive benefits that enhance people's lives. For the year of 2024, we will continue to provide two plan options for the Medical Insurance plan through BCBS. The City will offer a Standard PPO Plan with a $1,500 deductible. The High Deductible Health Plan ("HDHP") will also to be offered with HSA contributions from the City of up to $1,500 for those with Employee Only coverage and up to $2,000 for those with Employee + dependent coverage. For 2024, there are no changes to the employee cost of the medical plans (at any coverage tier).

The Dental plan will continue to be provided through UnitedHealthcare and the Vision plan through Surency. Voluntary Life AD&D are available through Dearborn National. Also, Alliance Work Partners continues to provide benefits under our Employee Assistance Plan (EAP).

Additional supplemental benefits are available through Aflac – such as accident, critical illness, disability and permanent life.

Please Keep This Guide

It is a valuable resource for you throughout the year.

For more information, visit us at:
www.plainviewtx.org/benefits

or
Contact your HR Team
(806) 296-1139 or (806) 296-1151

Benefits Resource List

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

If You Have Questions About	Contact	By Phone	On the Internet
MEDICAL and PRESCRIPTION (Directories of network providers, claims status or pre-notification)	Blue Cross Blue Shield of Texas	800-521-2227	www.bcbstx.com
DENTAL CARE	UnitedHealthcare	877-816-3596	www.myuhc.com
VISION CARE	Surency	866-818-8805	www.surency.com
GROUP LIFE AND VOLUNTARY SUPPLEMENTAL LIFE and AD&D COVERAGE	Dearborn National	800-348-4512	www.dearbornnational.com
FLEXIBLE SPENDING ACCOUNT	Flores Administrators	704-335-8211	www.flores-associates.com
HEALTH SAVINGS ACCOUNT	Benefit Wallet	877-472-4200	www.mybenefitwallet.com
TEXAS MUNICIPAL RETIREMENT SYSTEM	TMRS	800-924-8677	www.tmrs.com
EMPLOYEE ASSISTANCE PLAN	Alliance Work Partners	800-343-3822	www.awpnow.com
Financial Wellness Program	FinPath	833-777-6545	Finpathwellness.com/register
HUB International	Brooke Spaniol	214-443-2412	www.hubinternational.com

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explore the opportunities

Enrollment Instructions

Enrolling & Making Changes

Open Enrollment is your opportunity to add, cancel, or make changes to your benefits for the 2024 plan year, effective January 1, 2024.

All employees must complete their enrollment in benefits through Benefit Connector. When you complete Open Enrollment, you will need to update your personal e-mail, cell phone and Emergency Contact information. You will also need social security numbers and proof of identity for any dependents you are adding to the plan for the first time.

For enrollment assistance, contact the Human Resources Department at (806) 296-1139 or (806) 296-1151.

Things to Consider…

Open Enrollment is about more than your Health Plan coverage.

Take a moment to consider:

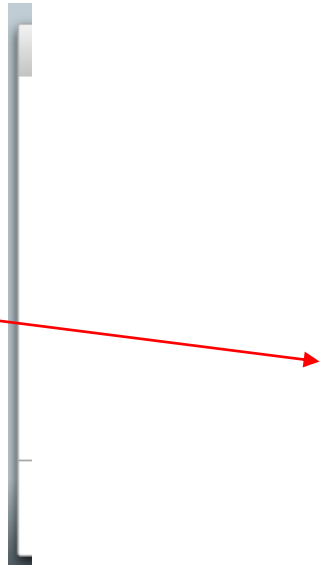
- Do I have enough life insurance coverage to protect my family if something happened to me or my spouse?
- Could I continue to pay my bills if I became disabled?
- How much money would I save if I reduced my taxable earnings and contributed to the Flexible Spending Account?

Read on to learn more about benefit options available to you.

Registering and Enrolling on Benefit Connector

Step 1

Log on to: https://cityofplainview.benefitconnector.com/
or with your mobile device use the following QR Code.



Step 2

If you have never accessed the site, you must **register**.

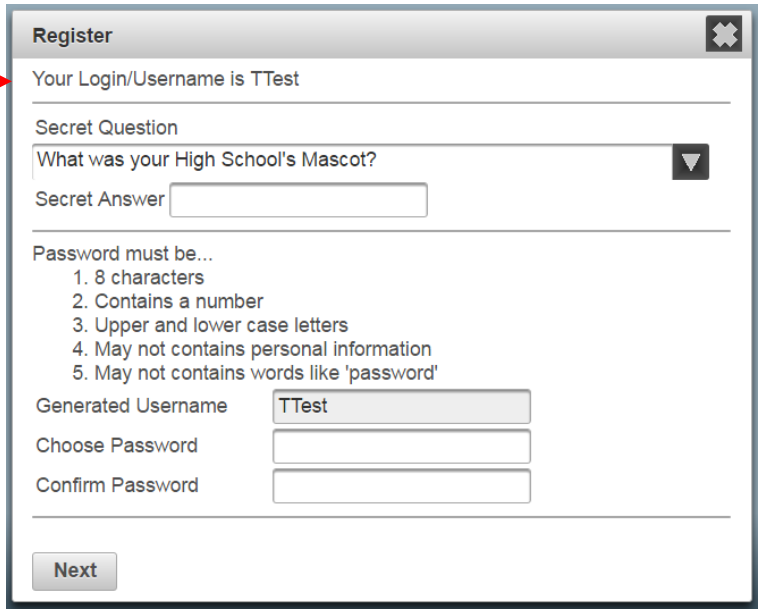
- From the log in screen, click '**register**' to begin registration process.

Step 3

- Enter the **Registration Information**
  Last Name, Date of Birth, Last 4-Digits of SS#.
- Click 'Next' to continue.

Step 4

- Make note of your **Login/Username**
- Select and answer a **Secret Question**
- Create and verify a **Password**.(password strength is displayed as developed).
- Click 'Next' to continue.



Be sure to remember your Login/Username and Password for future access to Benefit Connector.
If you forget your Password, it can be reset it by following the instructions for **'Forgot Login/Password'** on the log in screen.

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Eligibility

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

Dependent Eligibility
Who can you cover on your benefit plans?

You may cover your legal spouse on our medical, dental, vision, and life insurance plans. If your legal spouse is a benefit eligible employee at the City of Plainview, you may not cover him/her under spouse life insurance. Children's eligibility varies by plan.

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

Dental, Vision, and Life Insurance: An unmarried, dependent child may be covered through the end of the month during which he/she reaches age 26. Student status does not affect eligibility for medical coverage.

Flexible Spending Accounts: Claims incurred by you, your legal spouse, and qualifying children are reimbursable under an FSA.

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

Dependent Verification Required

Documentation will be required to enroll a dependent in medical, dental or vision coverage. Verification of a dependent can include a copy of a birth certificate, or a copy of a marriage license proving the dependent relationship.

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

Medical Benefits – Blue Cross Blue Shield

Effective January 1, 2024

Here is a snapshot of the coverage options provided under the 2024 Medical plan(s). For a complete summary of medical benefits, please refer to the plans provided.

BENEFITS –BlueCross Blue Shield of Texas		HDHP Plan w/ HSA	Standard Plan
Deductible	Network	$3,200 Individual/ $5,600 Family	$1,500 Individual/ $3,000 Family
	Non-Network	$5,000 Individual/ $10,000 Family	$5,000 Individual/ $10,000 Family
Out-of-Pocket Maximum		Includes Deductible	Includes Deductible
	Network	$3,200 Individual/ $6,000 Family	$4,000 Individual/ $8,000 Family
	Non-Network	$6,000 Individual/ $12,000 Family	Unlimited
Co-insurance	Network	80%	80%
	Non-Network	60%	50%
Lifetime Maximum		Unlimited	Unlimited
		You Pay	You Pay
Office Visit	Network	Deductible/20%	$20 Copay
	Non-Network	Deductible/40%	Deductible/40%
Wellness Visit	Network	Covered at 100%	Covered at 100%
	Non-Network	Deductible/40%	Deductible/50%
In-Patient & Out-Patient Hospital	Network	Deductible/20%	Deductible/20%
	Non-Network	Deductible /40%	Deductible/20%
Urgent Care	Network	Deductible/20%	$60 Copay
	Non-Network	Deductible/40%	Deductible/50%
Emergency Room	Network	Deductible/20%	$150 Copay + 20%
	Non-Network		$150 Copay + 20%
Prescriptions	Generic/Brand/ Non-Formulary	Deductible, then: $10/$35/$75	$10/$35/$75
	Mail Order (90 Days)		$10/$35/$75
	Specialty Drugs (30 Day Supply)	$150	$150

Medical Costs (Monthly)	HDHP Plan w/ HSA	Standard Plan
Employee Only	$0.00	$25.00
Employee & Spouse	$294.64	$389.08
Employee & Children	$241.06	$323.08
Employee & Family	$508.90	$653.04

MDLive

BlueCross BlueShield of Texas

Powered by MDLIVE®

Covered at $20 Copay under the PPO Plan

Getting sick is never convenient, and finding time to get to the doctor can be hard. Blue Cross and Blue Shield of Texas (BCBSTX) provides you and your covered dependents access to care for non-emergency medical issues and behavioral health needs through MDLIVE.

Whether you're at home or traveling, access to a board-certified doctor is available 24 hours a day, seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits can also be a better alternative than going to the emergency room or urgent care center.[1]

MDLIVE doctors or therapists can help treat the following conditions and more:

General Health
- Allergies
- Asthma
- Nausea
- Sinus infections

Pediatric Care
- Cold/flu
- Ear problems
- Pinkeye

Behavioral Health
- Anxiety/depression
- Child behavior/learning issues
- Marriage problems

MDLive (continued)

Connect[2]
Access where mobile app, online video or telephone service is available

Interact
Real-time consultation with a board-certified doctor or therapist

Diagnose
Prescriptions sent electronically to pharmacy of your choice (when appropriate)

Telephone:

- Call MDLIVE (888-680-8646)
- Speak with a health service specialist
- Speak with a doctor

Get connected today!
To register, you'll need to provide your first and last name, date of birth and BCBSTX member ID number.

Blue Care Nurseline

AIRROSTI

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FIX PAIN FAST!

NEW HEALTH PLAN BENEFIT

For all employees and dependents on the BlueCross BlueShield medical plan offered by

City of Plainview

Airrosti is an in-network benefit!

Airrosti providers are experts at diagnosing and rapidly resolving the source of your injury.

Each patient receives one full hour of assessment, diagnosis, treatment, and education designed to eliminate the pain associated with many common conditions, allowing you to quickly and safely return to activity - usually within 3 visits (based on patient-reported outcomes).

Schedule Your Appointment Today!

3.2 visits average to complete injury resolution*

*Based on patient reported outcomes

9,000+ SURGERIES AVOIDED

40% THE AVERAGE COST OF OTHER CARE

(800) 404-6050 | AIRROSTI.COM

Generic Drugs: Questions and Answers

What are generic drugs?

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

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. The FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

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

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

How are generic drugs approved?

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

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

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

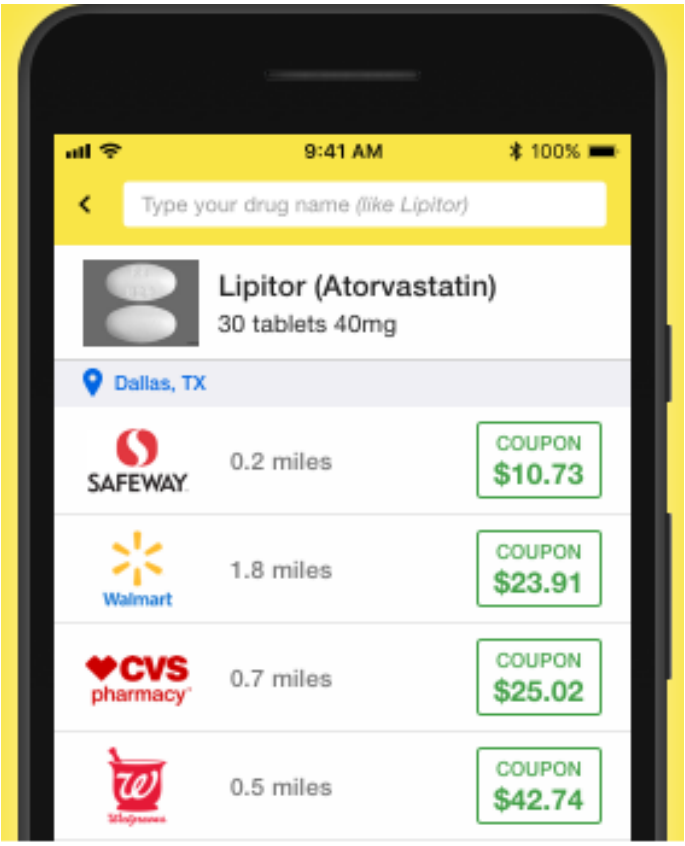
What standards do generic drugs have to meet?

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

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

GoodRX

Access Good Rx at www.goodrx.com or download the free app for your smart phone to have instant access to current discounts and coupons for your prescriptions.



- Know out-of-pocket costs in real time

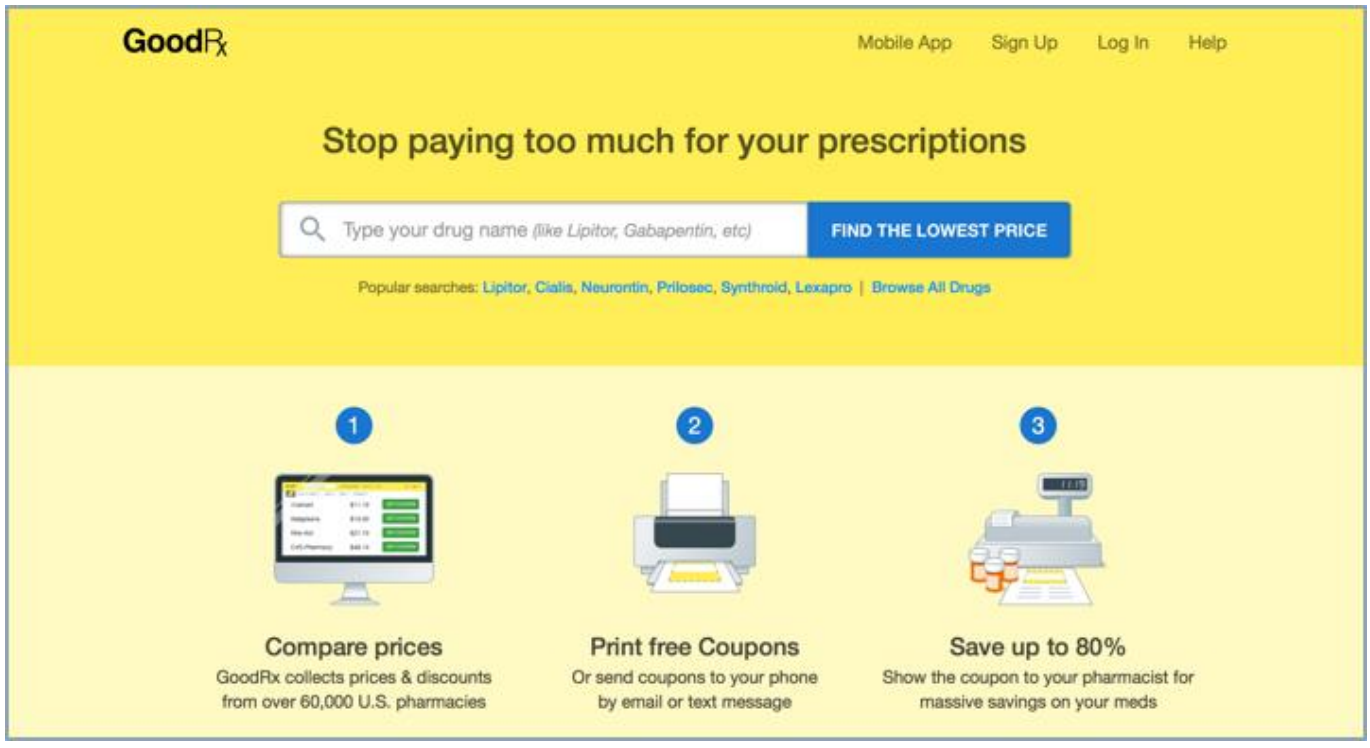
Employees save money by seeing their personalized out-of-pocket for a drug being prescribed at local pharmacies including any special coupons or discounts you can use. The cost of a prescription can differ by more than $100 between pharmacies!

- Stay up to date on coverage and savings

Good RX gathers information on current prices and discounts to help you find the lowest cost pharmacy for your prescriptions. The average Good RX customer saves $276 a year on their prescriptions!

- How to use?

Go to www.goodrx.com or the free app and type in your drug's name and click the "Find the Lowest Price" button. Print the coupon or show the coupon on your phone to your pharmacist. Your pharmacist will input the coupon code and pull up the lowest discount available.



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explore the opportunities

Health Savings Account – Benefit Wallet

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

An HSA is an individually-owned, personal health care savings account that you can use to pay out-of-pocket health care expenses with pre-tax dollars. Your contributions are tax-free, and the money remains in the account for you to spend on eligible expenses no matter where you work or how long it stays in the account.

An HDHP generally costs less than what traditional health care coverage costs, so the money that you save on insurance premiums can therefore be put into the Health Savings Account.

2024 IRS CONTRIBUTION MAXIMUMS COVERAGE LEVEL	
Employee Only	$4,150
Employee + Spouse Employee + Child(ren) Family	$8,300
Catch-Up Contribution (Individuals 55 or Older)	$1,000

YOUR HSA IS AN INDIVIDUALLY OWNED ACCOUNT

- You own and administer your HSA.
- You determine how much you will contribute to your account and when to use the money to pay for eligible health care expenses.
- You can change your contribution during the plan year without a qualifying event (allowed one time per month).
- Like a bank account, you must maintain a balance in order to pay for eligible healthcare expenses.
- Keep all receipts for tax documentation.
- An HSA allows you to save and "roll over" money from year to year.
- The money in the account is always yours, even if you change health plans or jobs.
- There are no vesting requirements or forfeiture provisions.

For more information on HSA Accounts visit https://www.irs.gov/pub/irs-pd/p969.pdf

YOU ARE ELIGIBLE TO OPEN AND FUND AN HSA IF YOU MEET ALL OF THE CRITERIA BELOW:

- You are enrolled in a HDHP/HSA plan.
- You are not covered by another health plan (unless it is an HSA-qualified plan), healthcare FSA (including a spouse's healthcare FSA), or health reimbursement arrangement.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE for Life.

WHAT IS A HIGH DEDUCTIBLE HEALTH PLAN (HDHP)?

You must have an HDHP if you want to open an HSA or keep contributing to an existing HSA. The HDHP is usually a less expensive health insurance plan that generally doesn't pay for the first several thousand dollars of health care expenses (i.e., your "deductible") but will generally cover you after that. Preventive Care services including physician services, lab and routine x-rays are covered at 100%. Of course, your HSA is available to help you pay for the expenses your plan does not cover.

Health Savings Account (HSA) *continued*

HSA ADVANTAGES AND HOW DOES THE HSA PLAN WORK?

1. Contributions are made to the HSA by the City of Plainview. **The City of Plainview's 2024 contribution is $1,500 for single coverage for the year and $2,000 for Employee & Spouse or Child(ren), or Family coverage. If you are a newly hired employee after January 1st, your contribution amount will be pro-rated accordingly.** You can also elect to make your own additional contribution to the HSA at Open Enrollment which would be taken out of your paycheck on a pre-tax basis. That money is available to pay for the qualifying medical expenses throughout the year.

2. When you need medical care and visit the doctor, emergency room or hospital, you will be responsible for the full cost of the visit (minus any network discounts). You can use the HSA account funds to pay for that visit at the time of the service, you can reimburse yourself at the end of the year or you can choose to pay for the visit out of pocket and let the HSA funds grow.

3. Unused HSA contributions carry over from year to year and remain in the HSA for the following year's medical expenses.

CHANGES TO YOUR HSA WHEN YOU REACH 65

At age 65, you can take penalty-free distributions from the HSA for any reason. However, in order to be both tax-free and penalty-free the distribution must be for a qualified medical expense. Withdrawals made for other purposes will be subject to ordinary income taxes.

HEALTH INSURANCE PREMIUMS

At age 65, you can use your HSA to pay for Medicare parts A, B, D and Medicare HMO premiums tax-free and penalty-free. You cannot use your HSA to pay for Medigap insurance premiums.

If your Medicare premium is automatically deducted from your Social Security check, you simply reimburse yourself directly from your HSA for the Medicare premiums paid from your Social Security payment.

CONTINUED ELIGIBILITY FOR AN HSA

Most Americans become eligible for Medicare at age 65. Americans that begin receiving Social Security benefits prior to age 65 are automatically enrolled in Medicare at age 65. Participation in any type of Medicare (Part A, Part B, Part C - Medicare Advantage Plans, Part D, and Medicare Supplement Insurance -Medigap), makes you ineligible to contribute to an HSA. However, you can continue to use your HSA for qualified medical expenses and for other expenses for as long as you have funds in your HSA.

LOSS OF ELIGIBILITY IN MONTH YOU TURN 65. You lose eligibility as of the first day of the month you turn 65 and enroll in Medicare.

STOPPING MEDICARE TO RECLAIM HSA ELIGIBILITY

If you signed up for Medicare Part A and now want to decline it, you can do so by contacting the Social Security Administration. Assuming you have not begun receiving Social Security checks this will reestablish your eligibility for an HSA. If you have applied for or have begun receiving Social Security, you cannot opt out of Medicare Part A without paying the government back all the money you received from Social Security payments plus paying the government back for any money Medicare spent on your medical claims. This action will also stop future Social Security payments (until you reapply and start this cycle over again).

SPOUSE UNDER AGE 65

If your spouse is under age 65, that may provide an avenue for continued HSA contributions. An employee however, cannot make HSA contributions into the HSA of an employee's spouse.

BenefitWallet®
A Xerox Solution

My Health Savings Account

Overview

A Health Savings Account (HSA) enables you to save, invest and spend funds for qualified medical expenses on a tax-advantaged basis. Unused HSA dollars roll over from year to year, making HSAs a convenient and easy way to save for future medical expenses.

You won't pay taxes (in most states) on deposits, earnings or payments for qualified medical expenses.

It's your choice to save for future health expenses or pay for current health care expenses.

Your HSA funds are yours even if you change health plans, change employers or retire.

Deposit and Invest

Contribute to your HSA by:

- Payroll contribution
- Online account-to-account transfer
- Mailing a check with a deposit slip

Invest your accumulated funds:

- Funds over $1,000 can be invested
- Over 25 mutual funds to choose from
- Investment selections can be made on the BenefitWallet website

Pay for Qualified Medical Expenses

Pay for your expenses using your:

- Health care payment card
- Online bill pay
- Checkbook

Reimburse yourself for out-of-pocket expenses by:

- Online account-to-account transfer
- Writing an HSA check to yourself

There aren't any claim forms to submit, but be sure to keep your receipts in case the IRS asks for proof of your expenses.

HSA Resources

Available resources on www.mybenefitwallet.com include:

- Modeling tools
- Frequently asked questions
- Educational materials
- Educational video library

Call the **BenefitWallet Service Center at** 1 877.472.4200

HSAs: How They Work

The idea is simple: you choose to set up an HSA as you enroll in an HSA-compatible health plan. As you build up a balance in your account, you can use your tax-free HSA dollars to pay for your eligible health care costs, such as doctor and hospital visits ("qualified medical expenses").

Even better, most qualified medical expenses paid from your HSA are credited toward meeting the deductible of your new health plan.

If your total expenses reach your health plan deductible, an out-of-pocket maximum kicks in, capping your cost and activating insurance coverage for all additional covered expenses for the plan year.

Even if you don't meet your deductible, you can use your tax-advantaged HSA dollars to pay for qualified medical expenses covered under your health plan, such as for chiropractic care, eyeglasses or other vision expenses, or alternative medical expenses.

Growing your HSA

Each year you may make HSA contributions up to an annual limit specified by the IRS:

- For 2015, that annual contribution limit is $3,350 for individual coverage and $6,650 for family coverage.
- For 2016, that annual contribution limit is $3,350 for individual coverage and $6,750 for family coverage.

Signing Up: Easy as 1, 2, 3!

1. After you enroll in the High Deductible Health Plan (HDHP) coverage, you'll receive a Welcome Kit in the mail that will provide you with more information and ask you to name an account beneficiary.
2. Return the paperwork to receive an HSA checkbook and health care payment card (in separate mailings, for your protection) to use to pay for your health care expenses.
3. You'll have access to all of your account activity online. If you have questions, you can call the BenefitWallet Service Center toll free at 1.877.635.5472.

More Opportunities to Save

Have you ever compared prices as you shopped for a car or planned a trip? With your HSA, you decide where to spend your health care dollars, and you keep the savings as you make smart health care decisions. Simple steps to keep more money in your account include:

- Using the discounted health care provider network
- Asking for generic prescriptions when they're available
- Asking your physician questions about treatments and tests

If you are age 55 or older, you may make additional "catch-up" contributions of up to $1,000 for 2015 and 2016. (Some additional rules apply if you enroll after January 1. Visit our website at www.mybenefitwallet.com for more information.)

If your employer puts money in your account, those contributions count toward your contribution maximum for the year. The good news, though: you own that money, regardless of whether you leave your current job or retire.

You can choose to fund your HSA to meet your expected health care costs for the next year, or fund up to the contribution limit to build up tax-advantaged savings for the future.

At the end of the year, any funds you have not used remain in your account, "rolling over" for future expenses. As your account grows, you can elect to transfer funds into an investment account.

BenefitWallet offers an integrated investment platform with over 25 investment options from a variety of fund families.

You can open investments online once your HSA checking balance reaches $1,000.

If or when you need those investment dollars for health care expenses, they can be returned to your original account without penalty.

BenefitWallet

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Flexible Spending Account – Flores Assoc.

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

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses not covered by their insurance plan with pre-tax dollars. The annual maximum amount you may contribute to the Health Care Reimbursement FSA for 2024 is $3,050. Some examples include:

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

Dependent Care FSA

The Dependent Care FSA allows employees to use pre-tax dollars towards qualified dependent care for children under age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 for 2024, (or $2,500 if married and filing separately).

Examples include:

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

FSA Smart Tips

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

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

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

Limited Flexible Spending Account – Flores Assoc.

**For HSA participant use only*

If you participate in the City of Plainview High Deductible Health Plan and participate in a health savings account, you can only enroll in the limited purpose health care FSA, not the standard health care FSA.

The limited purpose health care FSA allows you to reimburse yourself for eligible dental and vision expenses.

Dental and vision expenses are also eligible under your health savings account, but you cannot claim the same expenses on both accounts.

You cannot submit medical, prescription drug, or over-the-counter medication expenses to your limited purpose health care FSA for reimbursement — those expenses are eligible only for reimbursement from your health savings account.

If you have both an HSA and a limited purpose healthcare FSA…	Can you use your HSA?	Can you use your limited purpose health care FSA?
Medical expenses you incur, such as your deductible and coinsurance costs	Yes	No
Prescription drug expenses you incur	Yes	No
Over-the-counter (OTC) medication expenses	Yes, with doctor's prescription	No. Some over-the-counter medications for dental care and vision may be eligible for reimbursement.
Dental expenses, such as visits to the dentist and orthodontia (unreimbursed expenses only)	Yes	Yes
Vision expenses, such as eyeglasses and contact lenses. If enrolled in the Vision Benefits, these would be expenses remaining out of your pocket after the Vision benefit is paid.	Yes	Yes

IRS limitations on flexible spending accounts

- Expenses reimbursed from an FSA cannot be claimed as a medical expense on your tax return.
- Only expenses actually incurred during the calendar year are eligible for reimbursement. Expenses incurred before or after the eligibility period are not eligible, regardless of when you paid for the expenses. FSAs may not reimburse for future or projected expenses.
- If you do not use all the pre-tax dollars in your flexible spending account, you forfeit the amount left over. That's an Internal Revenue Service requirement.

Medical Eligible Expenses for HSA or FSA

Acupuncture	Lifetime Care—Advance Payments
Alcoholism	Lodging - for medical care
Ambulance	Long-Term Care
Artificial Limb	Meals - for medical care
Artificial Teeth	Medical Conferences
Bandages	Medical Information Plan
Breast Reconstruction Surgery	Medical Services
Birth Control Pills	Medicines
Braille Books and Magazines	Nursing Home
Capital Expenses - ramps, rails, etc.	Nursing Services & Home Care
Car - special design	Operations
Chiropractor	Optometrist
Christian Science Practitioner	Organ Donors
Contact Lenses	Osteopath
Crutches	Oxygen
Dental Treatment (not teeth whitening)	Pregnancy Test kit
Diagnostic Devices	Prosthesis
Disabled Dependent Care Expenses	Psychiatric Care
Drug Addiction - inpatient treatment	Psychoanalysis
Drugs (excluding over-the-counter)	Psychologist
Eyeglasses	Special Education
Eye Surgery	Sterilization
Fertility Enhancement	Stop-Smoking Programs
Founder's Fee - care at retirement home	Surgery
Guide Dog or Other Animal	Telephone for hearing-impaired
Health Institute	Television for hearing impaired
Health Maint. Org. (HMO)	Therapy
Hearing Aids	Transplants
Home Improvements - ramps, lifts, etc.	Transportation - for medical care
Hospital Services	Trips - for medical care
Insurance Premiums - see IRS list	Vasectomy
Laboratory Fees	Vision Correction Surgery
Lead-Based Paint Removal	Weight-Loss Program
Learning Disability	Wheelchair

Urgent Care vs. Emergency Rooms

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

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

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

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

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

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

Visit an urgent care center for these common conditions:

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

Emergency Rooms

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

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

Visit an emergency room if you experience:

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

Dental – UnitedHealthcare

Effective January 1, 2024

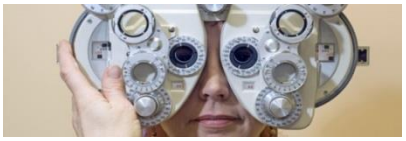
Here is a snapshot of the coverage provided under the 2024 Dental plan. For a complete summary of dental benefits, please refer to the plans provided.

BENEFITS	UnitedHealthcare
Type I – Preventive Services Oral examinations (2 Per Year) X-rays Cleanings (2 Per Year)	No Waiting Period 100%
Type II – Basic Services Fillings Extractions Root Canal	No Waiting Period 80%
Type III – Major Services Crowns Removable / fixed bridge-work Partial or complete dentures	No Waiting Period 50%
Type IV - Orthodontia Adult & Child / Child Only	No Waiting Period 50%
Annual Deductible	
Individual	$50
Family	$150
Annual Maximums	
Dental Annual Maximum	$1,500
Orthodontia Lifetime Maximum	$1,500
Network Website - Options PPO 30 Network	www.myuhc.com

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

Dental Costs	Monthly
Employee Only	$29.20
Employee & Spouse	$60.40
Employee & Children	$77.88
Employee & Family	$107.32

Vision – Surency



Effective January 1, 2024

Here is a snapshot of the coverage provided under the 2024 vision plan. For a complete summary of vision benefits, please refer to the plans provided.

BENEFITS		Surency
Eye Exam	Network Non-Network	$10 Copay Up to $35 Reimbursement
Frames/ Lens		
Single Vision	Network Non-Network	$25 Copay Up to $25 Reimbursement
Bifocal Lenses	Network Non-Network	$25 Copay Up to $40 Reimbursement
Trifocal Lenses	Network Non-Network	$25 Copay Up to $55 Reimbursement
Frames	Network Non-Network	$130 Allowance Up to $65 Reimbursement
Contacts In Lieu of Glasses		
Network	Medically Necessary Elective	Covered in Full $130 Allowance, 15% discount on balance
Non-Network	Medically Necessary Elective	Up to $200 Reimbursement Up to $90 Reimbursement
Exam Frequency		12 Months
Lens Frequency		12 Months
Frames Frequency		24 Months
Network Website - EyeMed Insight Network		www.surency.com

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

Vision Costs	Monthly
Employee Only	$4.65
Employee & Spouse	$9.91
Employee & Children	$10.42
Employee & Family	$16.78

Life & AD&D Benefits – Dearborn National

Effective January 1, 2024

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

BENEFICIARY INFORMATION

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

BASIC LIFE/AD&D BENEFITS	Dearborn National
Basic Life & AD&D Schedule	$25,000
Guarantee Issue Amount	$25,000
Maximum Amount	$25,000
Conversion	Included

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

How Much Life Insurance Do You Need?

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

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

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

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

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

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

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

Voluntary Life and AD&D – Dearborn National

Effective January 1, 2024

VOLUNTARY LIFE BENEFITS	Dearborn National
Class Description	All Full Time Employees
Definition of Earnings	Base Annual Earnings
Employee Life Schedule	$10,000- $500,000, Increments of $10,000
Employee Maximum Benefit	$500,000
Employee Guarantee Issue Amount	$100,000
Age Reduction Schedule	to 65% at age 70-74 to 45% at age 75-79 to 30% at age 80-84 to 15% at age 85+
Waiver of Premium	Disabled Prior to age 60, 6 month Elimination Period, to age 65
Accelerated Death Benefit	50% of benefit to a max $150,000
Spouse Life Schedule	Increments of $10,000
Spouse Maximum Benefit	$10,000
Spouse Guarantee Issue Amount	$10,000
Child(ren) Life Schedule	6 months to age 26- $10,000
Conversion	Included
Portability	Included
Suicide Clause	1 year
FINANCIALS (per $1,000)	
Age of Employee	Employee
Up to 24	$0.08
25 –29	$0.08
30 – 34	$0.08
35 – 39	$0.12
40 – 44	$0.19
45 – 49	$0.28
50 – 54	$0.48
55 – 59	$0.82
60 – 64	$1.29
65 – 69	$2.03
70 – 74	$3.23
75+	$5.72
Employee AD&D Rate (per $1,000)	$0.05
Spouse Life Rate (per $10,000)	$2.00
Child(ren) Rate (per $10,000)	Life - $2.00

*During your initial eligibility period only, you can receive coverage up to the Guaranteed Issue amounts without having to provide Evidence of Insurability (EOI, or information about your health). Coverage amounts that require EOI will not be effective unless approved by the insurance carrier.

TMRS Retirement Plan

To help you prepare for the future, the City of Plainview participates in the TMRS Plan as part of its benefits package. Here are some of the plan highlights.

- Mandatory Employee contribution 7%
- Contribution matched by the City 2:1
- Vesting after 5 years
- Retirement after 25 years or Age 60 with 5- years of service
- Coverage becomes effective on Date of Hire.

For additional personal account information or to add other eligible service credit, please contact TMRS at:

Contact: 1-800-924-8677
Website: www.tmrs.com

PLAINVIEW, TX
explore the opportunities

Employee Assistance Plan – Alliance Work Partners

City of Plainview

Employee Assistance Program (EAP)

Alliance Work Partners is
here for you as life happens.

AWP is proud to serve as your EAP, offering you and your household valuable, *confidential* services at no cost to you.

Your benefits are designed to help you manage daily responsibilities, major events, work stresses, or any issue affecting your quality of life.

All benefits can be accessed by calling:

toll free
1-800-343-3822

TDD
1-800-448-1823

teen line
1-800-334-TEEN (8336)

We are available to take your call 24 hours a day, 7 days a week.

Visit your EAP website at
awpnow.com

and create a customized account.

Go to
https://www.awpnow.com
Select "Access Your Benefits"

Registration Code:
AWP-COPV-4508

Your EAP Benefits:

LawAccess
Legal and Financial services provided by a lawyer or financial professional specializing in your area of concern. Available online or by telephone.

HelpNet
Customized EAP website featuring resources, skill-building tools, online assessments and referrals.

WorkLife
Resources and referrals for everyday needs. Available by telephone.

PlanWell
Online tools and resources to help improve your finances and track financial goals.

SafeRide
Reimbursement for emergency cab fare for eligible employees and dependents that opt to use a cab service instead of driving while impaired.

1 to 6 Counseling Sessions
Per problem, per year. Short-term counseling sessions which include assessment, referral, and crisis services. *(Same day appointments available for urgent/crisis callers, or facilitation of immediate hospitalization)*

Newsletters
Webinar Training Series
Tips for Everyday Living

Here for you as life happens ...

City of Plainview

Employee Assistance Program (EAP)

Criteria for Benefits Eligibility

Full Benefits:

- Employee, retiree, married/divorced spouse, partner, significant other
- Any household member, regardless of age or relationship, residing in employee's home, including significant other and their children
- All covered employees may bring anyone with them to their authorized/covered sessions regardless of relationship to employee.
- Children and grandchildren, **age 26 or under**, residing in US or Puerto Rico. This includes children and grandchildren of significant other or partner.
- Any person meeting benefit eligibility prior to lay-off or termination of an employee will continue to be eligible for benefits up to 6 months from the date of employee's lay-off or termination. Benefits are extended for 6 months from date of employee's call within this timeframe.

Assessment & Referral:

- Children and grandchildren **age 27 and over** of employee, married/divorced spouse, partner, or significant other living outside employee's home
- Employee instructed by law to receive court-ordered counseling
- All crisis cases (suicidal/homicidal, domestic violence, chemical dependence, substance abuse, child/elderly abuse) not otherwise covered
- Any person meeting benefit eligibility prior to lay-off or termination of an employee will continue to be eligible for assessment and referral after 6 months and up to 1 year from the date of employee's lay-off or termination. Benefits are extended 1 year from date of employee's call within this timeframe.

Information & Referral:

- Anyone contacting Alliance Work Partners regardless of contract status

PLAINVIEW, TX
explore the opportunities

Financial Wellness Program - FinPath

finpath

Empowering the shift from surviving to thriving

In the United States, 7 in 10 Americans report high levels of financial stress. We're here to change that.

If you've ever felt like you're living paycheck to paycheck or like your dollar can go farther, we have just the tools to make a difference. And it's all available at **no cost to you**.

Meet FinPath

FinPath is a financial education program paid for by your employer to help you take control of your finances and reduce your financial stress. With FinPath, focusing on your financial goals and getting answers to your questions is easy.

Here's what you get:

Unlimited 1:1 Coaching
Personalized, confidential coaching sessions tailored to your financial needs

Financial Health Tools
Over 30+ tools to help you budget, reduce debt, plan for emergencies, and more!

FinPath University
Participate in live and self-paced courses accessible anytime, anywhere

FinPath Perks
Get rewarded by building better financial habits through monthly gift card raffles, including a $1,000 giveaway

Activate your free account in 3 easy steps!

1. Head to **finpathwellness.com/register**
2. Enter your **work email address**
3. Check your email for your unique **activation link**

Have Questions? Get Answers.

833-777-6545

finpathwellness.com/support

Optional Supplemental Benefits

Effective January 1, 2024

For complete details please refer to the brochures provided or contact the Agents below:

Aflac Customer Service
Office: 800-433-3036
Aflacgroupinsurance.com

Aero-Lifestar-AirMedCareNetwork
Phone: 800-793-0010
www.airmedcarenetwork.com

Corebridge/VALIC Financial Advisors, Inc.
Erin Kennedy
2745 Dallas Parkway, Ste 480, Plano, TX 75093
C: 806-201-5186
Client Care Center: 800-448-2542
Fax: 806-589-1927

Plainview Country Club
Phone: 806-293-2445

Karen Crim
CFO
YMCA of Plainview
313 Ennis St
Plainview, TX 79072
806-293-8319

What Constitutes a Qualifying Life Event?

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

Glossary of Health Coverage & Medical Terms

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

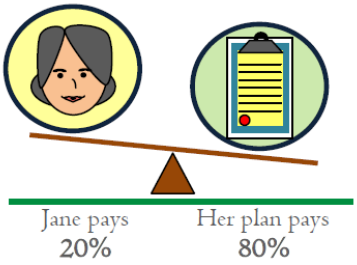
For a digital version of the Glossary of Health Coverage & Medical Terms scan the QR code with your mobile device.

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

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

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

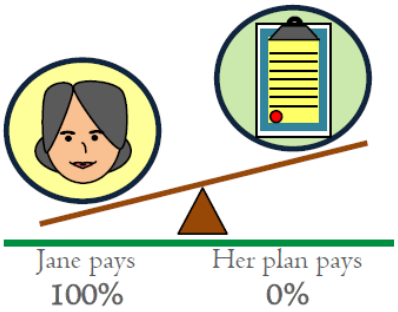
Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance *plus* any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've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



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

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

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



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

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

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

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

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

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

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

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

Home Health Care
Health care services a person receives at home.

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

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

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

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

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

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

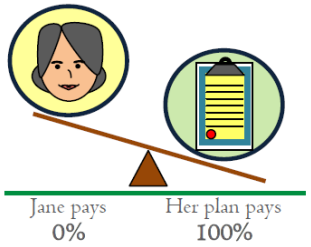
Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

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

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

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

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health
insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.



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

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

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

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

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

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

Prescription Drugs
Drugs and medications that by law require a prescription.

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

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

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

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

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

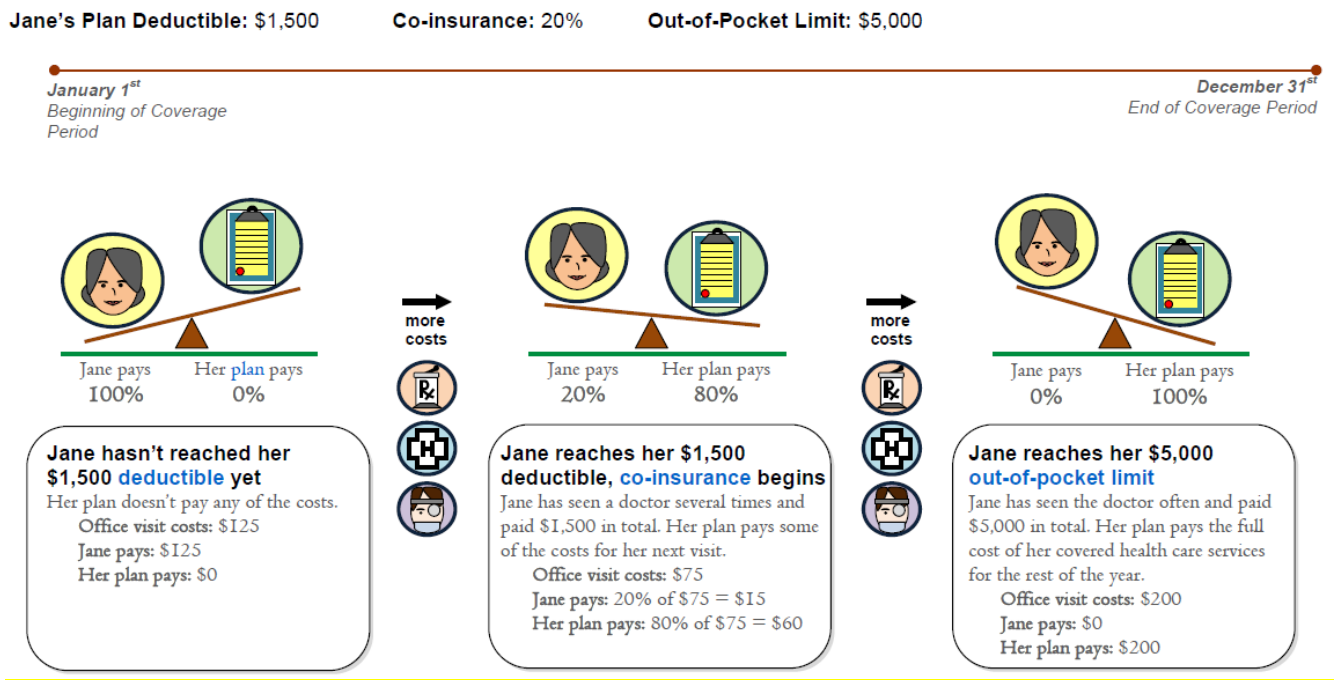
Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

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

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

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

How You and Your Insurer Share Costs - Example



The benefits described in this booklet are represented for employees only.

The City of Plainview expects to continue these plans indefinitely but reserve the right to modify, amend, suspend or terminate any plan at any time and for any reason without prior notification.

You will be notified of any changes to these plans and how they affect your benefits, if at all. The plans described in this booklet are governed by insurance contracts and self-insured plan documents, which are available for examination by request of your HR Department. We have attempted to make the explanation of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of the plans, since the written descriptions in the insurance contracts or plan documents will always govern.

2024 Plan Year