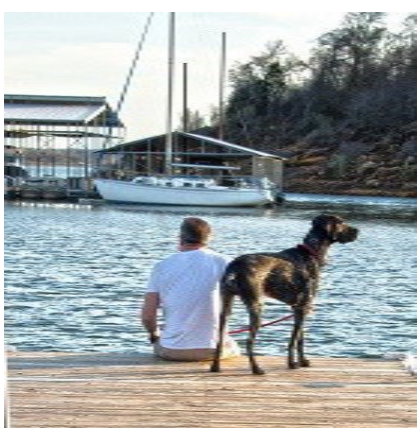
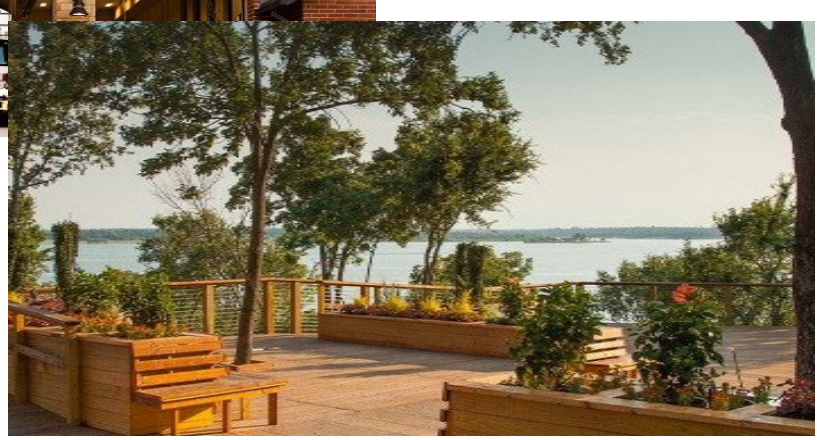
Town of Flower Mound

2024

Employee Benefits Guide
January 1, 2024 – December 31, 2024





THE TOWN OF FLOWER MOUND TEXAS

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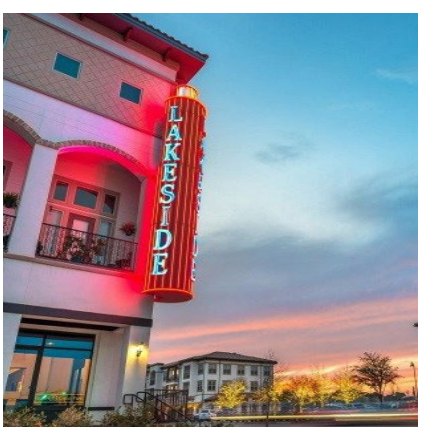
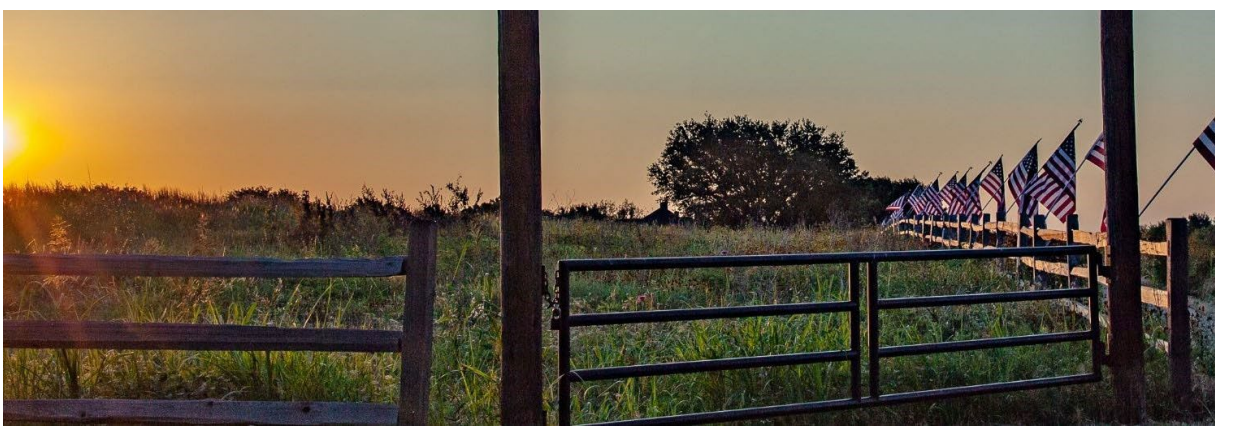
Welcome

We are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation. You have the flexibility to select from a full range of benefits to keep you and your family healthy, provide financial protection in the event of an unforeseen event, and help you build long-term security for retirement. This brochure was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family – then be sure to take action.





Contacts & Resources

Find more details about the benefits offered to you by contacting your insurance carrier. Register on the insurance carrier websites to access plan information, your coverages & claims history, network providers, and more. Search for the carrier apps on Google Play™ or the App Store® to access your benefits information anytime, anywhere from your mobile device.

If you have questions please contact Human Resources at 972.874.6011 or hr@flower-mound.com.

Benefit	Carrier	Phone	Website/Email
Medical, Rx, Dental & Vision	Blue Cross Blue Shield of Texas	800-521-2227	bcbstx.com
Flexible Spending Account	Navia Benefit Solutions	800-669-3539	naviabenefits.com
Life/AD&D and Disability	New York Life	800-644-5567	myNYLGBS.com
Employee Assistance Program	Deer Oaks	866-EAP-2400	deeroaks.com
Retirement	TMRS	800-924-8677	tmrs.com
Pharmacy Mail Order	Express Scripts Pharmacy	833-715-0942	express-scripts.com/rx
Specialty Medications	Accredo Specialty Pharmacy	833-721-1619	accredo.com

Eligibility

All full-time Town of Flower Mound employees who are regularly scheduled to work at least 30 hours per week are eligible to participate in the Town's health insurance program. All benefit coverages for new hires will begin on the first day of the month following date of hire.

Eligible dependents include:

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

Married employees may not cover the spouse as a dependent, and only one employee may cover any dependent children.

Things to Consider

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

Helpful Tips and Reminders

- Be sure to choose the right coverage level, such as individual or family and gather the correct information for your dependents, such as social security numbers and birth dates.
- Make sure your address and personal information is current.
- Open Enrollment is a good time to ensure the person designated as your beneficiary is correct in regard to your insurance and retirement benefits.
- Visit each vendor's website for additional information. Don't forget to review each plan's provider directory. If your physician/ doctor's office is not considered in-network, you cannot change or drop plans mid-year without a qualifying life event.
- Several benefits premiums are deducted on a pre-tax basis, which decreases your tax liability.
- Avoid making quick decisions — **enroll early!**

Don't forget to turn in your enrollment forms by the deadline!

Frequently Asked Questions

When Does Coverage Begin?

Open Enrollment: The elections you make are effective January 1, 2024 - December 31, 2024.

New Hires: Coverage starts the first day of month following date of hire.

Can I Drop or Change Plans During the Plan Year?

No. Changes can only be made if there has been a qualifying life event or personal life change. See page 6 for examples.

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

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

What Happens if I Fail to Enroll?

If a full-time employee fails to enroll in the Town of Flower Mound's health insurance plan within the time specified at new hire orientation or during open enrollment, the employee is automatically enrolled in the PPO Plan - Employee Only, with current optional benefit elections rolling over, minus any Flexible Spending Account elections.

Qualifying Life Events

Due to IRS regulations, once you have made your choices for the 2024 Plan Year, you will not be able change your benefits until the next enrollment period unless you experience a Qualifying Life Event.

Personal Life and Status Changes

When one of the following events occurs, you have 31 days from the date of the event to notify Human Resources and/or request changes to your coverage. Make sure your address and personal information is current. Open Enrollment is a good time to ensure the person designated as your beneficiary is correct in regard to your insurance and retirement benefits.

- Change in your legal marital status (marriage, divorce, annulment, legal separation, or death).
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent).
- Change in your dependent or spouse's employment status (resulting in a loss or gain of coverage).
- Change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of coverage.
- Entitlement to Medicare or Medicaid (Medicare eligibility only impacts your ability to receive and make contributions to your HSA).
    - Once enrolled in Medicare, the employee is no longer eligible to receive any contributions into their HSA, including contributions from the Town.
- Eligibility for coverage through the Marketplace (applies to dependents only).

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

Qualifying Event	Dependent Verification Documentation
Marriage	Government-issued Marriage Certificate; recent tax return showing dependent or bill within last 60 days
Birth	Government-issued Birth Certificate naming you as parent **OR** (if under six months of age only) Hospital documentation reflecting the child's birth, naming you as parent
Adoption	Legal documentation of the adoption
Loss of Other Coverage	Letter indicating the loss of coverage from the prior plan sponsor, including name(s) of the insured, specific coverages that were lost, and date that coverage (s) were lost
Divorce	Government-issued divorce decree showing date of divorce
Gain of Other Coverage	Letter indicating the gain of coverage from the new plan sponsor, including name(s) of the insured, specific coverages that were elected, and date that coverage(s) are effective
Death	Government-issued death certificate

NOTE: Having existing family coverage DOES NOT automatically enroll the new dependent. The change in coverage must be consistent with the change in status.

Taxes and Your Benefits

Your cost for many coverages will be paid on a before-tax basis through payroll deductions. This means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions.

Qualifying Event	Who Pays the Cost?	Is Your Cost Before- Tax or After-Tax?
PPO Plan **Medical / Dental / Vision / RX**		
Employee Only	You / TOFM	Before - Tax
Employee + 1	You / TOFM	Before - Tax
Employee + 2 or More	You / TOFM	Before - Tax
High Deductible Health Plan		
Employee Only	TOFM	Before - Tax
Employee +1	TOFM	Before - Tax
Employee + 2 or more	TOFM	Before - Tax
Basic Life/AD&D Insurance		
Employee	TOFM	N/A
Long Term Disability		
Employee	TOFM	N/A
TMRS		
Employee	You/TOFM	Before - Tax

IRS Rules

The IRS has issued regulations that limit the amount of tax-free group term life insurance to $50,000.

This means that if the amount of Basic Life Insurance is greater than $50,000, that value of your Life Insurance (as determined by the IRS based upon your age) over $50,000 will be considered taxable income (the IRS calls this imputed income). A minimal tax will be assessed and appear on your W-2.

Payroll Deductions for Health Insurance

PPO Plan	Per Pay Period Deductions
Medical, Dental, Vision, Rx	
Employee Only	$35.00
Employee + 1	$120.00
Employee + 2 or more	$130.00
High Deductible Health Plan (HDHP)/Health Savings Account (HSA)	**Per Pay Period Deductions**
Medical, Dental, Vision, Rx	
Employee Only	$30.00
Employee + 1	$67.50
Employee + 2 or more	$77.50

Deductions are taken from 24 paychecks.
Note: Both the Employee and the Town are eligible to make contributions to the health savings account.

ANNUAL TOWN HSA CONTRIBUTION		
New Hires and Employees who have never participated in the HDHP	Employee Only Employee +1 Employee + 2 or More	$750 $1,500 $1,500
ANNUAL TOWN HSA CONTRIBUTION		
Employees participating in HDHP or have participated previously	Employee Only Employee +1 Employee + 2 or More	$375 $750 $750

2024 HSA Contributions

The Contributions for Plan Year 2024 will be made as follows:

- 1st pay period in January 2024 - 50%
- 1st pay period in February 2024 -25%
- 1st pay period in March 2024 - 25%

Medical Plan Comparison

	BCBSTX PPO Plan		BCBSTX HDHP Plan	
Plan Highlights	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible • Individual • Family	 $500 $1,500	 $500 $1,500	 $2,500 $5,000	 $5,000 $10,000
Coinsurance *(plan pays)*	70%	50%	100%	80%
Out-of-Pocket Max • Individual • Family	 $3,000 $9,000	 $4,000 $12,000	 $2,500 $5,000	 $10,000 $20,000
Preventive Care	100% deductible waived	50% after deductible	100% deductible waived	80% after deductible
Physician Office	$25 copay	50% after deductible	100% after deductible	80% after deductible
Specialist Office	$50 copay	50% after deductible	100% after deductible	80% after deductible
Virtual Visit	$20 copay	50% after deductible	100% after deductible	80% after deductible
Urgent Care	$75 copay	50% after deductible	100% after deductible	80% after deductible
Emergency Room	$500 copay		100% after deductible	
Hospital - Inpatient	70% after deductible	50% after deductible	100% after deductible	70% after deductible
Hospital - Outpatient	70% after deductible	50% after deductible	100% after deductible	70% after deductible
Prescription Drugs	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Rx Deductible	$50 per member	$50 per member	N/A	N/A
Rx Out-of-Pocket Max • Individual • Family	 $3,600 $4,200	 $3,600 $4,200	N/A	N/A
Retail *(30-day supply)* • Generic • Preferred[1] • Non-Preferred[1] • Specialty[2]	 $10 copay $35 copay $70 copay 25% to $100 max	 80% of allowable[3] 80% of allowable 80% of allowable Not covered	100% after deductible	100% after deductible
Mail Order *(90-day supply)* • Generic • Preferred[1] • Non-Preferred[1] • Specialty[2]	 $20 copay $70 copay $140 copay 25% to $100 max	Not covered	100% after deductible	Not covered

1 If you receive a Preferred Brand Name Drug or a Non-Preferred Brand Name Drug when a Generic Drug is available, you may incur additional costs, 2 Filled through Specialty Pharmacy Provider, 3 Minus the copay.

This is meant to be a brief summary only—for full plan details refer to the Certificate of Coverage.

Locate a Network Physician or Hospital: Log on to bcbstx.com or call customer service at 800-521-2227. Access your personal benefit details at bcbstx.com and click the Blue Access for members icon.

Medical Benefits

Prescription Drugs

Prescription drugs are covered under the medical plan if prescribed for the treatment of a covered medical condition. For the highest level of benefits, you must use a participating pharmacy. Mail order service is also available through Express Scripts Pharmacy.

The Town of Flower Mound has a mandatory generic prescription drug program. This means that if there is a generic equivalent available and the participant chooses the brand name prescription, the participant will be required to pay the retail cost difference between the brand name prescription and the generic/generic equivalent, including the copay.

24/7 Nurseline

Health happens—good or bad, 24 hours a day, seven days a week. That is why BCBS has registered nurses waiting to talk to you whenever you call their 24/7 Nurseline.

Nurses can answer your health questions and try to help you decide whether you should go to the emergency room or urgency care center or make an appointment with your doctor. You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions about:

- Asthma
- Dizziness or severe headaches
- Cuts or burns
- Back pain
- High fever
- Sore throat
- Diabetes
- A baby's nonstop crying

Note: When you call, you can access an audio library of more than 1,000 health topics – from allergies to surgeries – with more than 500 topics available in Spanish.

24/7 Nurseline

800-581-0393

Virtual Visits

Speak with a doctor — anytime, anywhere

Getting sick is never convenient, and finding time to get to the doctor can be hard. BCBSTX provides you and your covered dependents access to care for non-emergency medical issues 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.

With virtual visits, you get:

- 24/7 access to an independently contracted, board-certified doctor.
- Access via online video, mobile app or telephone.
- If necessary, e-prescription sent to your local pharmacy.

- Allergies
- Asthma
- Cold/flu
- Ear problems (age 12+)
- Fever (age 3+)
- Nausea
- Pink eye
- Rash
- Sinus infection

Activate your account or schedule a virtual visit

- Go to Blue Access for Members℠ or **MDLIVE.com/bcbstx**
- Download the MDLIVE app from Apple's App Store℠ or Google Play™
- Call MDLIVE at **888-680-8646**
- Text **BCBSTX** to **635-483.** (MDLIVE's online assistant will help you activate your account.)

Talk Therapy

Speak with a licensed counselor, therapist or psychiatrist for support with virtual visits, available by appointment. You can choose who you want to work with for issues such as anxiety, depression, trauma, and loss or relationship problems.

Behavioral Health

With Behavioral Health Virtual Visits, you have access to online counseling, help with child behavior and learning issues and stress management help. These visits are by appointment and are a $20 copay on the PPO and a range between $80 and $175 towards your deductible on the HSA.

Where to Go for Care

	Cost	Appointment Needed?	Wait Time	Severity	Conditions Treated
Nurseline	No cost	No	🕐	⊕	Minor health concerns such as cold and flu symptoms, allergies, sinus and ear infections, family health questions, rashes or skin conditions, minor burns, and vaccinations
Virtual Visit	$	No	🕐	⊕	
Convenience Care Clinic	$$	No	🕐🕐	⊕	
Primary Care Physician	$$	Yes	🕐🕐	⊕	Routine or preventive care, track medications and get refills, or get a referral to see a specialist
Urgent Care	$$$	No	🕐🕐🕐	⊕⊕⊕	Nausea and diarrhea, headaches, minor cuts and broken bones, back and joint pain
Emergency Room	$$$$	No	🕐🕐🕐🕐	⊕⊕⊕⊕	Trouble breathing, heart attack and stroke, sudden illness and serious accidents, and severe bleeding

If you need PRESCRIPTION MEDICATIONS

Choose generic medications whenever possible to keep your medication costs lower.

TAKE THIS NOT THAT

If you need to SEE A DOCTOR

Remember, the bigger the building, the bigger the bill. Where you go makes a big difference.

GO HERE NOT THERE

If you need AFTER HOURS CARE

For after hours care or non-life-threatening emergencies, vist a convenience care clinic or an urgent care center.

GO HERE NOT THERE

If you need OUTPATIENT IMAGING

Visit an outpatient imaging center versus the hospital to save money when you need a CT or MRI.

GO HERE NOT THERE

BCBSTX Extras

Blue Access for Members℠

Blue Access for Members is the secure BlueCross BlueShield of Texas member website.

Using this website, you can:

- Check the status of your claims and your claim history.
- Confirm which family members are covered under your plan.
- View and print Explanation of Benefits (EOB) claims statement.
- Locate an in-network provider.
- Request a new or replacement member ID card or print a temporary member ID card and much more ...

Provider Finder

Go to **bcbstx.com** and log in or create a Blue Access for Members℠ (BAM℠) account.

Click on the Doctors and Hospitals tab in Provider Finder to:

- Find in-network providers, hospitals, laboratories and more.
- Search by specialty, ZIP code, language spoken, gender and more.
- See clinical certifications and recognitions.
- Estimate the out-of-pocket costs of more than 1,600 health care procedures, treatments and tests*.
- Use quality awards such as Blue Distinction Center (BDC), BDC+ or Total Care to inform your choices. See side-by-side provider or facility quality ratings and patient reviews*.

It's easy to get started!

1. Go to **bcbstx.com/member**
2. Click Log in to My Account
3. Use the information on your BCBSTX ID card to sign up, or text **BCBSTXAPP** to **33633** to get the BCBSTX App that lets you use BAM while you're on the go

Get 90-Day Fills With Your Traditional Select Extended Supply Network Benefits

Filling prescriptions can be time consuming. But, with your health plan's Traditional Select Extended Supply Network, you can get convenient 90-day supplies of your medicine. This may mean fewer trips to the pharmacy — and fewer missed doses.

Over 65,000+ participating pharmacy locations nationwide. To see if your pharmacy is in the Traditional Select Extended Supply Network, or to find a new pharmacy, log in to **MyPrime.com** and click on "Pharmacies."

90-day fills help make it easier to take your medicine as prescribed, which is especially important for chronic conditions like:

- Diabetes
- Asthma
- High cholesterol
- Mental health

BCBSTX Mobile App

You can go to your mobile device's App Store and download the BCBSTX mobile app. This app can help you stay organized and in control of your health – anytime/anywhere. You can log in to:

- Track your account balances and deductibles
- View, fax or email ID card information
- Find doctors, dentists or pharmacies
- Refill your BCBSTX home delivery prescriptions and view order history
- View medication costs based on your plan and search for lower, cost-saving alternatives.

BCBSTX Extras

Blue365® – Discounts to Make Health and Wellness More Affordable

With this program, you may save money on health and wellness products and services not covered by insurance. There are no claims to file and no referral or preauthorization is needed.

Once you sign up for Blue365 at **www.blue365deals.com/BCBSTX**, weekly "Featured Deals" will be emailed to you.

Some of the discounts available are:

- Davis Vision℠ | TruVision® – Eyewear & lasik
- TruHearing® | Beltone™ – Hearing test & hearing aids.
- Procter & Gamble Dental Products – Oral B® and Crest products.
- Dental Solutions℠ – a dental discount card
- Jenny Craig & Nutrisystem® – Weight loss
- Reebok | Sketchers.

Well onTarget®

Well onTarget is a program designed to give you the support you need to make healthy choices. With Well onTarget, you have access to a secure website with personalized tools and resources.

- Onmytime™ self-directed courses
- Health and wellness libraries
- Tools and Trackers
- Onmyway™ Health Assessment
- Fitness Program

To access the Well onTarget member portal, go to **www.wellontarget.com**. If you have already registered on **BCBSTX.com**, you will use the same login information. If not, you can register on this site. Customer Service is available at **877-806-9380** to answer any questions you may have.

BCBSTX MEMBER REWARDS

Same Procedure, Different Cost and Potential Cash in Your Pocket!

Did you know that prices for the same quality medical services can differ by thousands of dollars within the same region and health plan network? BCBSTX provides.

Member Rewards – a program administered by Sapphire Digital that offers cash rewards when a lower-cost, quality provider is selected from several options.

- Compare it to where you park your car – the $30 lot or the $15 one just a few blocks away.
- Member Rewards allows you to shop for your health care services in a similar way, and as the following examples show, you can save money depending on where you go for care.
- Best of all – shopping with Member Rewards could help lower your out-of-pocket costs and help get you a cash reward.

Reward Eligible Procedure	Provider A Cost	Provider B Cost
Lab/Blood Draw (New!)	$30	$85
MRI of the Brain	$682	$2,723
Knee Replacement	$17,003	$47,617

What Is the Member Rewards Program?

Member Rewards – combined with Provider Finder, our nationwide database of independently contracted health care providers – can help you:

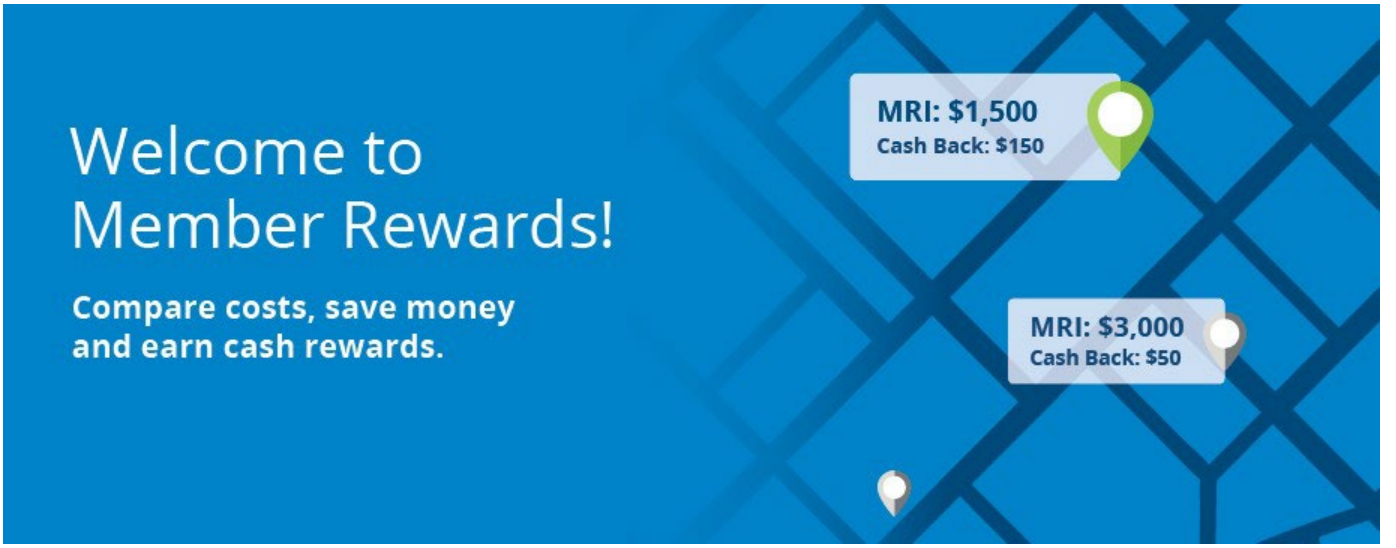
- Compare costs and quality for numerous. procedures Estimate out-of-pocket costs.
- Earn cash while shopping for care.
- Save money and make the most efficient use of your health care benefits.
- Consider treatment decisions with your doctors.

How Does It Work?

1. When a doctor recommends treatment, call a Benefits Value Advisor (see following page) at the number on the back of your member ID card, or log into Blue Access for Members at bcbstx.com and click the Doctors and Hospitals tab – then on Find a Doctor or Hospital.

2. Choose a Member Rewards eligible location, and you may earn a cash reward.

3. Complete your procedure and, once verified, you will receive a check within 4 to 6 weeks. Questions? Call the number on the back of your member ID card.



BENEFIT VALUE ADVISORS

BVAs can help you bring down your overall health care costs. If you are enrolled in one of the medical plans, BVAs can help answer your health care questions and guide you through the complexities of your medical plans – at no cost to you.

How BVAs Can Take Care of You

Understand Insurance Benefits
Receive guidance in understanding your benefits throughout the year.

Coordinate Care
Receive help scheduling appointments and coordinating care. BVAs give you back all the time you spent on hold and help you get the services you need.

Find a Great Doctor
Find highly-rated doctors in your area who meet your personal preferences and health care needs.

Save Money on Medical Care
Get price comparisons before receiving care. Depending on the doctor, hospital or facility, costs can vary by hundreds or thousands of dollars – even in-network.

Pay Less for Prescriptions
BVAs can compare medication prices and explore lower-cost options for you.

Get Help With Medical Bills
Have your medical bills reviewed to make sure you are not overcharged.

Health Care Support for You and Your Family

Simply visit **bcbstx.com,** register or log in to Blue Access for Members℠ and click on the "Doctors & Hospitals" tab – then click on the "Find a Doctor or Hospital" link.

Health Care Help on the Go
Whether you need help finding a great doctor or lowering health care costs, you can make smarter, in-the-moment health care decisions with BVAs. Get instant answers to health care questions 24/7.

Testimonials

James – Savings of $800
"When I hurt my shoulder, my doctor told me I needed a CT Scan. Luckily, I talked to a BVA to check prices first because the hospital was going to charge me $1,500. My BVA found an imaging center near my home that only charged $700."

Sarah – Savings of $600
"After my surgery, I wanted to check my various bills and charges to make sure I wasn't being overcharged. I had absolutely no time to do this, so I called a BVA and they found several mistakes. They worked everything out between the hospital and the insurance company and it saved me $600."

Health Savings Account

When you elect to enroll in the HDHP medical plan, you are eligible to open a Health Savings Account (HSA). An HSA allows you to save money on a tax-free basis to use for your out-of-pocket health care expenses. You are the owner of this bank account, and unlike a traditional Flexible Spending Account, your funds can roll over from year-to-year and build over time.

- Employees can contribute funds through pre-tax payroll deduction from 24 pay periods. See maximum contributions chart.
- Unused funds stay in your bank account and roll over year to the next year.
- The plan year runs from January 1, 2024 - December 31, 2024.
- HSAs serve as a pre-tax and pre-FICA fund that can be used to save for the day medical expenses are actually incurred. Funds compound tax free. The account is owned and controlled by you.
- In addition, individuals can use tax-free HSA dollars for qualified medical expenses not covered by the high deductible health plan, along with dental and vision expense. If HSA funds are not used for qualified medical expenses, the amount is included as income and a 20% penalty is applied by the IRS.
- Your spouse and/or dependents do not need to be covered by an HDHP. Funds can only be used on qualified dependents. See eligible dependent chart.
- Members will be responsible for the up-front deductible amount and then BCBS coverage pays at 100% once deductible and out-of-pocket is met.

IRS Definition of Qualifying Dependent
Qualifying Child: daughter, son, stepchild, sibling, or step-sibling or any descendant of these who: • Has the same principal place or abode as the covered employee for more than one-half of the taxable year. • Has not provided more than one-half of his or her own support during the taxable year. • If not age 19, (or if a student, not yet 24) at the end of the tax year. • Or is permanently and totally disabled.
If an HSA Account holder cannot claim a child as a dependent on their tax return, they cannot spend HSA dollars on services provided to that child. This applies to all children, including those mentioned above.

2024 HSA Maximum Contributions*	
Employee Only	$4,150
Employee + 1	$8,300
Employee + 2 or more	$8,300
Catch-Up (age 55+)	$1,000

**Maximum contributions include Flower Mound and Employee Contributions, combined.*

Flexible Spending Accounts

Flexible Spending Account

$3,050 Maximum Contribution

- Employees enrolled in the PPO plan are eligible to open a Flexible Spending Account (FSA) each year, which allows tax free payroll deductions from 24 pay periods for certain types of unreimbursed medical and/or dependent care expenses. Employees enrolled in the HDHP/HSA are eligible to open a Limited FSA. The Limited FSA can only be used on qualified dental and vision expenses.
- The annual contribution amount is available on the effective date.
- Funds can be used to reimburse all qualified expenses for the employee and IRS eligible dependents regardless of whether they are enrolled in the Town's Group Health Plan.
- Employees have until March 31, 2025, to apply for reimbursement for incurred medical expenses that were incurred during the 2024 plan year.
- Participants will receive debit cards which can be used at the point of service.

Dependent Care Spending Account

$5,000 Maximum Contribution

- A maximum of $5,000 per calendar year may be contributed to the dependent care account ($2,500 if an employee's spouse also participates in a dependent care plan).
- Dependent care funds must be used in the plan year in which they are contributed.
- Funds are only available as money is put into the account via payroll deduction.
- Funds can be used to reimburse qualified expenses for your eligible dependents.

Setting Your Contributions

Outside of open enrollment, you are only able to make a change to your elections if you experience certain qualified life events. It is advised that you think wisely about the amount you choose to contribute and seek advice from your tax preparer.

FSA Reminders

- **"Use-it-or-lose-it" unused Health Care amounts over $610** or any unused Dependent Care funds will be forfeited, so estimate wisely.
- You cannot mix funds from one account to another: you may only use Health Care FSA money for health care expenses and Dependent Care FSA for funds for dependent care (day care) expenses.
- Save your receipts - No matter how you access your FSA funds, be sure to keep your receipts to validate your reimbursements.
- You can incur expenses only during the plan year you are enrolled.
- Your entire Health Care FSA balance – even money you have not yet contributed – is available as of January 1, 2024.
- Dependent care funds are only available as you contribute to them through payroll deductions.
- You must re-enroll each year if you wish to continue funding the account(s).
- Employees enrolled in the HDHP w/HSA Medical plan may use FSA funds for dental and/or vision expenses only.

Dental Benefits

Taking care of your oral health is not a luxury, it is a necessity for long-term optimal health. With a focus on prevention, early diagnosis and treatment, Dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. Our dental benefits are offered through MetLife. Preventive services are covered at no cost to you and include routine exams and cleanings. You will only pay a small deductible and coinsurance for basic and major services.

When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill.

Plan Highlights	In-Network
Deductible	$50 Individual / $150 Family max
Annual Maximum	$1,500 per person
Preventive Services Oral Exams, X-Rays, Routine Cleanings, Fluoride Treatments, Sealants	100%; deductible waived
Basic Services Fillings, Extractions, Periodontics, Endodontics, Basic Oral Surgery, Root Canals	80% after deductible
Major Services Repairs to Inlays, Onlays, Crowns, Dentures, Bridges, Complex Oral Surgery	50% after deductible
Orthodontia Services » Benefit » Lifetime maximum	 50% $1,500
This is meant to be a brief summary only—for full plan details refer to the Certificate of Coverage.	

Each time you need dental care, you can choose to:

See a Contracting Dentist		See a Non-Contracting Dentist
BlueCare Dentist	**DentalBlue Dentist**	
• Your out-of-pocket maximum will generally be the least amount because BlueCare Dentists have contracted to accept a lower allowable amount as payment in full for Eligible Dental Expenses. • You **are not** required to file claim forms. • You **are not** balance billed for costs exceeding the BCBSTX Allowable Amount for BlueCare Dentists.	• Your out-of-pocket maximum may be greater because DentalBlue Dentists have contracted to accept a higher allowable amount as payment in full for Eligible Dental Expenses. • You **are not** required to file claim forms. • You **are not** balance billed for costs exceeding the BCBSTX allowable amount for DentalBlue Dentists.	• Your out-of-pocket maximum may be greater because non-contracting Dentists have not entered into a contract with BCBSTX to accept any allowable amount determined as payment in full for your Eligible Dental Expenses. • You **are** required to file claim forms. • You **are** balance billed for costs exceeding the BCBSTX allowable amount.

Vision Benefits

Healthy eyes and clear vision are an important part of your overall health and quality of life. Vision benefits are provided by BlueCross BlueShield of Texas as part of your medical benefits when you enroll in one of the BCBSTX medical plans. However, you can also elect solely Dental or Vision benefits or decline if that fits your needs best.

Plan Highlights	Vision Benefits
Vision Exam	Covered 100% One per calendar year
Lenses and Frames	Covered 85% after $25 copay $325 per Calendar Year Maximum (applies to lenses, contacts and frames)

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

Life and Disability

Basic Life Insurance

Life doesn't always bring us what we expect. It helps to know that financial security is available for your family, even if you aren't. Life Insurance coverage will help protect your family's security. The Town of Flower Mound automatically provides all eligible, regular full-time employees with a Basic Life Insurance and Accidental Death and Dismemberment Policy at no cost.

Basic Life/AD&D (Town of Flower Mound Provides)	
Life Benefit Amount	2 X Base Annual Earnings up to a maximum of $100,000
AD&D Benefit Amount	Matches Life Benefit
Age Reduction	65% at age 65 50% at age 70 Conversion privileges apply at termination/ retirement

Basic Accidental Death & Dismemberment

Benefits are payable to your beneficiary, in addition to your Life Insurance benefit, if you die within 365 days after a covered accident and the cause of your death can be attributed to the covered accident. Accidental Dismemberment benefits are payable to you if you suffer a loss that is covered under the plan. The loss must have occurred within 365 days of the covered accident.

Basic Accidental Death & Dismemberment	
Loss of Life	100% of benefit
Loss of Both Hands, Feet or Eyes	100% of benefit
Loss of One Hand, Foot or an Eye	50% of benefit

Please refer to policy certificates for a full outline of your basic life and AD&D coverage.

Dependent Life Insurance

Dependent Life coverage is available to purchase for those that want a greater level of protection. Contact the Human Resources Division for more information. You may purchase dependent life insurance for your Spouse and Dependent Children (up to age 26).

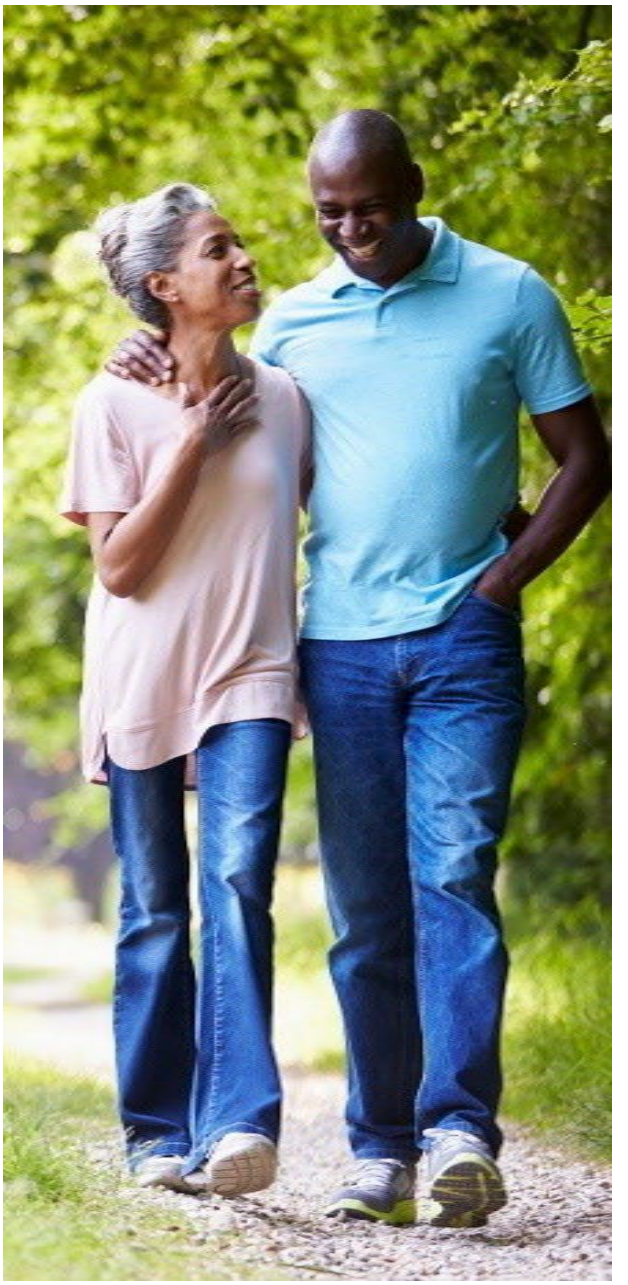
Long-Term Disability

The Town of Flower Mound is pleased to provide all eligible employees with long-term disability coverage at no cost. Financial Planning includes taking steps to protect yourself and your family when the unthinkable happens. Having adequate insurance coverage in the event of a disabling condition is the foundation of a solid financial plan. Long-Term Disability provides the protection you need to ensure that your way of life is protected in case of a serious injury or illness.

Long-Term Disability (Town Provided)	
Basic Benefit	60% of salary
Maximum Monthly Benefit	$5,000
Benefit Waiting Period	120 days

Please refer to policy certificates for a full outline of your LTD coverage.

Workers' Compensation



The Town of Flower Mound provides Workers' Compensation. The Town contracts with a third party administrator to administer Workers' Compensation claims. If you are injured in the scope and course of your employment with the Town, you may be eligible to receive Workers' Compensation.

Workers' Compensation is required under State Law and covers the cost of hospitalization, physician fees, drugs, treatment, and other related expenses.
Employers are required by State Law to report a Workers' Compensation injury as soon as they are aware the injury may be work related. Town policy requires notification to be made immediately; but no later than 24 hours after the injury.

Employees who are unable to report to work as a result of a work-related injury and whose inability to work extends beyond eight calendar days will begin to accrue temporary income benefit (TIBs) on the 8th day of the lost time following the injury. TIBs are equal to a percentage of the previous 13 weeks of the employee's pre-injury wage and are capped at a maximum amount set by Texas Workers' Compensation.

The Town will supplement the employee's pay for the first 12 weeks of Worker's Compensation leave. Upon expiration of the first 12 weeks, the employee will supplement their own pay to obtain approximately up to 100% of the pre-injury wages via use of accrued leave balances and Workers' Compensation TIBS payment combined. The employee retains the weekly temporary income benefit check that is received from the Workers' Compensation administrator. Employees may receive both a TIBs check and a Town check; however, all TIBs payments received will be deducted from future employee paychecks if the TIBs payments are cashed by the employee.

Please contact the Human Resources Division for detailed information regarding Workers' Compensation.

Employee Assistance Program

All regular full-time employees, part-time employees and dependents have access to the Deer Oaks Employee Assistance Program provided by the Town of Flower Mound at no cost. Participants can access the EAP helpline at 866.EAP.2400, 24 hours per day, 7 days a week, 365 days per year.

Employees also have access to EAP services for six months after separation of employment. Deer Oaks provides up to 6 counseling sessions per incident per year. Referrals to the program are typically sought for the following issues:

- Stress, tension, and anxiety
- Anger management
- Depression and grief
- Marital/family problems
- Work-related difficulties
- Legal/financial concerns
- Health and wellness issues
- Trauma recovery
- Substance abuse
- Childcare and elder care services
- Adolescent and teen concerns
- Crisis Intervention

Visit deeroaks.com for an interactive website that gives you free access to resources and tools for improving health and enhancing life.

Additional Benefits

Fitness Opportunities

All regular full-time Town employees and their immediate family members are eligible for a free membership at the Community Activity Center (CAC). Membership requires a completed CAC enrollment form submitted to the CAC. All members will need to have ID card pictures taken at the CAC before or on the first day of center access.

Retirement

The Town of Flower Mound is a member of the Texas Municipal Retirement System (TMRS). The purpose of the retirement system is to provide adequate and dependable retirement benefits for employees retiring from participating Texas Municipalities.

Participation is mandatory for all regular full-time employees. There is no maximum age for participation in TMRS. As a TMRS participant, you receive an additional life insurance benefit of 1X your annual salary.

Vesting

Employees are vested after 5 years of service. Vesting means you have worked enough years and established enough service credit to meet the minimum length of service requirement. Once vested, if you leave the Town of Flower Mound, you may leave your member deposits with TMRS until you reach retirement eligibility.

Retirement Eligibility

You can retire under TMRS when you have at least 5 years of service and are at least 60 years of age. You may also retire at any age if you have at least 20 years of service. Upon retirement, you will choose a monthly payment option to receive your benefit. All options pay you a monthly benefit for the rest of your life.

TMRS Plan Contributions

Employees contribute 7% of gross income, on a pre-tax basis, each pay period and the Town matches the employee's contribution at a 2-to-1 ratio. Contributions to the system are not taxable until withdrawn.

Deferred Compensation/457 Plan

The Town of Flower Mound's deferred compensation option is an investment for your future, designed to provide an additional source of income to help you financially in your retirement years.

Participation in the deferred compensation plan is voluntary. Full-time employees are eligible to join and make changes at any time. The Town does not contribute to 457 Plans.

Providers

You have a variety of investment options to achieve a maximum return on your savings by working with the following providers:

- Nationwide Retirement System
- Mission Square Retirement (Formerly known as International City Management Association)
- FT Jones Fund Choice
- Aflac

Glossary

Allowed Amount: Means the maximum amount determined by the Claims Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply, or procedure.

Calendar Year: January 1 - December 31 of each year. The TOFM plan year corresponds with the calendar year.

Claims Administrator: Blue Cross and Blue Shield of Texas.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985. Requires continuation of group insurance to covered persons who lose health, dental or vision coverage due to a qualifying life event as defined in the Act.

Coinsurance: The percent of eligible charges the plan pays.

Copay: The charge you are required to pay for certain covered health services at the time of service. Copays for covered services do not apply to your deductible.

Deductible: The amount you must pay for covered health services each calendar year before the plan will begin paying certain benefits.

Eligibility: Eligibility for benefits is the first of the month following regular full-time employment. The effective date is the date the coverage actually begins.

Explanation of Benefits (EOB): A statement sent by your insurance carrier explaining which procedures and services were provided, the cost, the portion of the claim that was paid by the plan, and the portion that is your liability, in addition to how you can appeal the insurer's decision. EOBs are also posted on the carrier's website.

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

Guarantee Issue: Amount of coverage pre-approved by the Life Insurance Company regardless of health status.

Health Savings Account (HSA): A personal health care bank account funded by you and/or your employer's tax-free dollars to pay for qualified health expenses. You must be enrolled in a CDHP/HDHP to open an HSA.

Identification Card: The card issued to the employee by the Claims Administrator, indicating pertinent information applicable to coverage. Cards can be accessed on the Claim Administrator's website.

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

Network/Non-Network Benefits: The benefits applicable for the covered services of a network provider. Non-Network benefits are the benefits applicable for the covered services of a non-network provider.

Out-of-Pocket Maximum: The most a covered person can pay in coinsurance in a calendar year for covered health care expenses (excluding reductions for provider contracts and usual and customary guidelines and copays).

Open Enrollment: The period during which existing employees and their dependents are given the opportunity to enroll in or change their current elections.

Plan Administrator: The named administrator of the Plan, having fiduciary responsibility for its operation. The Town of Flower Mound is the Plan Administrator.

Preferred Provider Organization (PPO): A network of health care providers contracted to provide medical services to covered employees and dependents at negotiated rates. You may seek care from either a network or non-network provider, but network care is covered at a higher benefit level while the employee is responsible for a greater portion of the cost when using a non-network provider.

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Women's Health and Cancer Rights Act: If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

Newborns and Mother's Health Protection Act (NMHPA): Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0702**. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP): If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer- sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

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

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

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 Town of Flower Mound and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Town of Flower Mound has determined that the prescription drug coverage offered by the Town of Flower Mound Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current coverage with Town of Flower Mound will not be affected. You and/or your dependents can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Town of Flower Mound and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage. Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Town of Flower Mound changes. You also may request a copy of this notice at any time. For More Information About Your Options Under Medicare Prescription Drug Coverage. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage: Visit www.medicare.gov. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone

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number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213
(TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Coverage After Termination (COBRA) - Health Coverage: You're getting this notice because you recently gained coverage under a group health plan (Town of Flower Mound Group Health Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events: Your hours of employment are reduced, or Your employment ends for any reason other than your gross misconduct.
If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events: Your spouse dies; Your spouse's hours of employment are reduced; Your spouse's employment ends for any reason other than his or her gross misconduct; Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or You become divorced or legally separated from your spouse. Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events: The parent-employee dies; The parent-employee's hours of employment are reduced; The parent-employee's employment ends for any reason other than his or her gross misconduct; The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); The parents become divorced or legally separated; or The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events: The end of employment or reduction of hours of employment; Death of the employee; Commencement of a proceeding in bankruptcy with respect to the employer; or The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

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

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of: The month after your employment ends; or The month after group health plan coverage based on current employment ends. If you don't enroll in Medicare and elect COBRA

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continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/ medicare-and-you.

If you have questions: Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including. COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov. **Keep your Plan informed of address changes:** To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:
Town of Flower Mound
2121 Cross Timbers Road Flower Mound, TX 75028

(**HIPAA) Employee Health Plan Summary Notice of Privacy Practices:** This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Your Rights: You have the right to:
Get a copy of your health and claims records; Correct your health and claims records; Request confidential communication; Ask us to limit the information we share; Get a list of those with whom we've shared your information; Get a copy of this privacy notice; Choose someone to act for you; and file a complaint if you believe your privacy rights have been violated.

Your Choices: You have some choices in the way that we use and share information as we: Answer coverage questions from your family and friends; Provide disaster relief; and Market our services and sell your information.

Our Uses and Disclosures: We may use and share your information as we: Help manage the health care treatment you receive; Run our organization; Pay for your health services; Administer your health plan; Help with public health and safety issues; Do research; Comply with the law; Respond to organ and tissue donation requests and work with a medical examiner or funeral director; Address workers' compensation, law enforcement, and other government requests; Respond to lawsuits and legal actions.

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records: You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records: You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost- based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us at 806.441.7122. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in payment for your care; Share information in a disaster relief situation If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases, we never share your information unless you give us written permission: Marketing purposes or Sale of your information.

Our Uses and Disclosures: How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive: We typically use or share your health information in the following ways. Help manage the health care treatment you receive: We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization: We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. Example: We use health information about you to develop better services for you. Pay for your health services: We can

Important Notices

use and disclose your health information as we pay for your health services. Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan: We may disclose your health information to your health plan sponsor for plan administration. Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/ understanding/consumers/index.html.

Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety.

Do research: We can use or share your information for health research. Information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may. change your mind at any time. Let us know in writing if you change your mind. **For more information see:** www.hhs.gov/ocr/privacy/hipaa/ understanding/consumers/noticepp.html. Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you. Effective Date: 1/1/2024

Health Insurance Marketplace Coverage Options and Your Health Coverage PART A: General Information: When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2020 for coverage starting as early as January 1, 2024.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover, you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

*Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. An employer- sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer: This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

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

Eligible employees are Full time employees who work 30 hours per week and have completed the newly eligible 30-day waiting period. Coverage begins the first day of the month following the first 30 days of employment.

Eligible dependents include the employee's spouse and eligible dependent children up to age 26. This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Important Notices

Special Enrollment Notice: If you are declining enrollment for yourself or your dependents including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within

30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

To request special enrollment or obtain more information, contact the plan administrator.

3. Employer name Town of Flower Mound		4. Employer Identification Number (EIN) 75-1366210
5. Employer address 2121 Cross Timbers Road		6. Employer phone number 972-874-6015
7. City Flower Mound	8. State TX	9. ZIP code 75028
10. Who can we contact about employee health coverage at this job? Lynda Bolitho		
11. Phone number (if different from above)	12. Email address lynda.bolitho@flower-mound.com	

Consolidated Appropriations Act (CAA) No Surprises Act

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

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

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

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

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

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

Visit www.tdi.texas.gov for more information about your rights under state law.

Notes

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by your employer. The text contained in this Summary was taken from various summary plan descriptions and benefits information. While every effort was taken to report your benefits, discrepancies or errors accurately are always possible. In case of a discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this Summary, contact Human Resources.

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THE TOWN OF FLOWER MOUND TEXAS