EMPLOYEE BENEFITS GUIDE

CITY OF TYLER

EFFECTIVE
01/01/2023 - 12/31/2023

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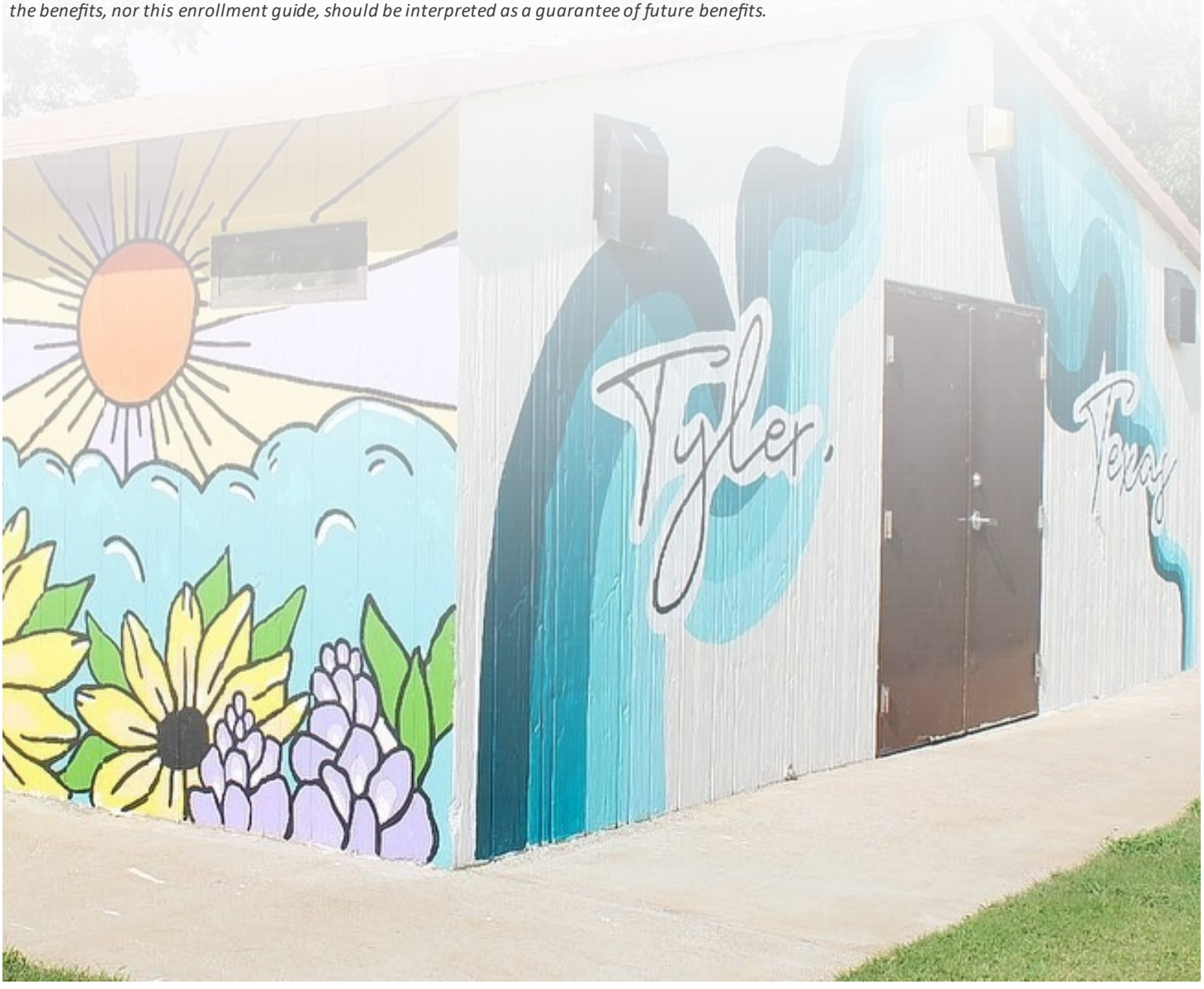
Welcome to your Benefits Enrollment

The City of Tyler is proud to provide you and your family with valuable and significant benefits. The City of Tyler's Benefits Package is designed for your total well-being. This valuable reference guide, is an overview of the services and benefits available to you as an employee of the City of Tyler. Please take the time to carefully review the guide for any changes or updates. Inside you will find the information you need to make informed decisions regarding the selection and continued management of your benefits for the 2023 Plan Year.

The information in this enrollment guide is intended to help you enroll in your 2023 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern. The City of Tyler reserves the right to change or terminate benefits at any time. Neither the benefits, nor this enrollment guide, should be interpreted as a guarantee of future benefits.



Eligibility

If you are a full-time employee regularly scheduled to work 40 hours or more a week you are eligible to enroll in the benefit plans described in this Employee Benefit Guide. Part-time employees scheduled to work 30 hours or more a week are eligible to elect medical coverage. If enrollment is not completed within 30 days, you will have no coverage for the remainder of the plan year for the following voluntary plans:

- Medical, Dental & Vision Plans;
- FSA-Health Account & Dependent Care Account;
- Supplemental Life Insurance Plan / Accidental Death & Dismemberment Plan; and Short Term Disability

Eligible employees are automatically enrolled in the basic term life and accidental death and dismemberment. You must designate your beneficiary for these plans upon your enrollment

Eligible Dependents

Dependents eligible for coverage include:

- Your legal spouse.
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children, regardless of age, provided he or she is 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.

Dependent children are eligible for insurance until age 26. Please keep in mind, you may be required to furnish evidence of dependency during random eligibility audits conducted by an outside consultant.

FAQs

When Does Coverage Begin?

The elections you make during Open Enrollment are effective January 1, 2023- December 31, 2023.

New Hires: The waiting period is 90 days following the date of employment. You are required to enroll no later than 30 days after your first day of regular, full-time or eligible part-time work with the City.

If I am already enrolled and not making any changes, do I have to complete the Open Enrollment process?

Yes, this is an active enrollment. All employees must complete the enrollment process and attend an enrollment meeting.

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.

Can I Drop or Change Plans During the Plan Year?

No, changes can only be made with a qualifying life event.

Things to Consider:

Take the following situations into account before you enroll:

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? Do you need to add or remove any dependent(s) and/or update your beneficiary designation? See Team Resources.

Helpful Tips and Reminders

- Take the time to carefully review the guide for any changes and updates. Choose the right coverage level, such as individual or family.
- Gather the correct information for your dependents such as social security numbers and birth dates and Make sure your address and personal information is current. If your information is not current you may miss out on important information such as insurance cards, plan documents, etc. Notify Team Resources if any of your information needs to be updated. You will need to fill out an address change form to update your address.
- Visit each vendor's website for additional information. Don't forget to review each provider directory. Make sure your physician is In-Network.
- Avoid making quick decisions — **enroll early!**

How to Enroll

First Login and Account Setup:

For best results, please use Chrome to view the enrollment

Your Company Login address is: http://boss.employeenavigator.com

1. When you first arrive, please click the link toward the bottom of the page for **"Register as new user".**

2. You will need to Create Your Account by completing the fields on the next page.

3. Please make certain your answers are the same as on file with Team Resources (try to use the spelling of your name from your paycheck)

-Your "Company Identifier" is **CitofTyl2022**

-For your username, please enter your email address

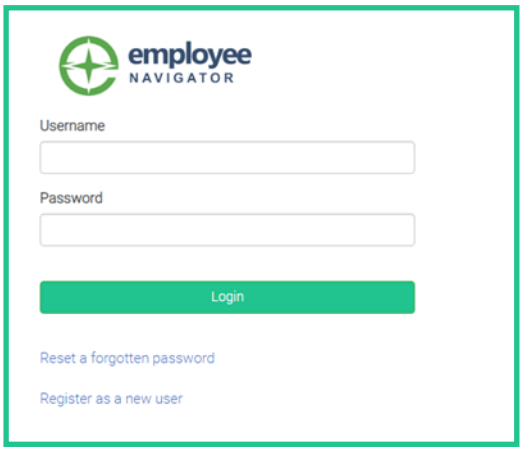
-The password must be 6 digits long and must include both a number and a symbol

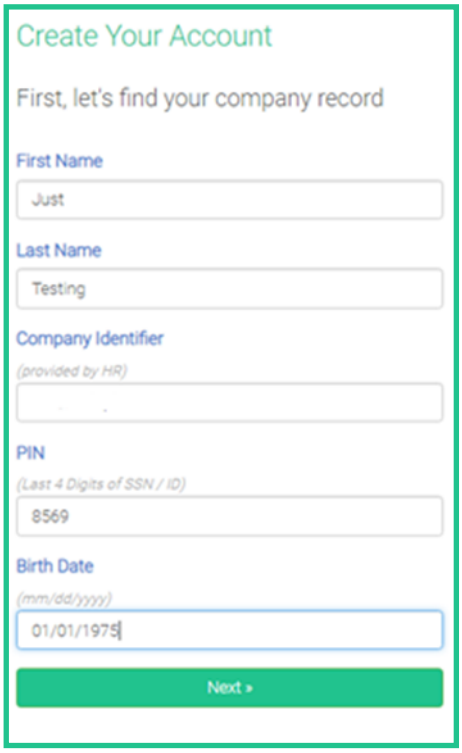
You can click on "show it" to verify what you have typed

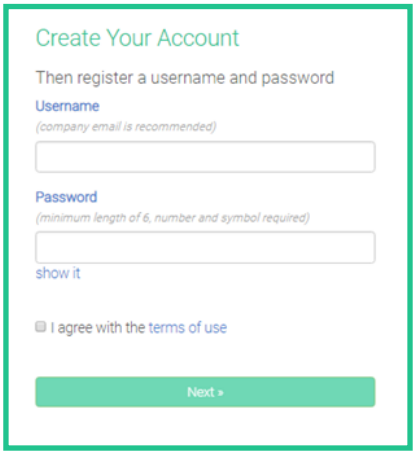
4. Click on the box next to "I agree with the terms of use" before proceeding.

Once you have created your account you will see a welcome message.

5. You can now re-login at the same login address: http://boss.employeenavigator.com by entering your new username (email) and you new password.







Qualifying Life Events

Due to IRS regulations, once you have made your choices for the 2023 Plan Year, you won't be able to change your benefits until the next enrollment period unless you experience a Qualifying Life Event. Benefits that can be changed include: Medical, Dental, Visio n, Supplemental Life, Dependent Life or Voluntary Accidental Death and Dismemberment plans, or the Flexible Spending Account and Dependent Care Spe nding Accounts **only** if you have any of the life changes that affect your eligibility or coverage outlined below.

When one of the following events occurs, you have **30 days** from the date of the event to request changes to your coverage. **Any changes must be submitted to Team Resources for approval.**

- Marriage, divorce, annulment, legal separation or death
- Birth, adoption, or if your dependent loses eligibility for coverage due to age.
- Change in your dependent or spouse's employment status or your spouse's employer offers benefit plans with a different plan year that affects your coverage.
- You or your eligible dependent take or return from an unpaid leave of absence that affects coverage.
- Entitlement to Medicare or Medicaid (or loss of).

Your change in coverage must be consistent with your change in status. The change must result in the gain/loss of coverage by you, your spouse, or any of your dependents and the new election must reflect that gain/loss. Please direct questions regarding specific life events to Team Resources.

Required Information	
Add / Delete Spouse	• Marriage License • Divorce Decree
Adding Dependent	**ONE or more of the following:** • Birth Certificate • Qualified Child Support Order • Adoption Papers • Court Documentation for Foster Child • Proof of Income Tax Deduction

They are referred to as life changes, qualifying events, family status changes, IRS changes. Regardless of the terminology, your new election must be consistent with your status change. Consistent means the change must result in the gain or loss of coverage by you, your spouse, or any of your dependents and the new election must reflect that gain or loss. An employee with current coverage may add or delete dependents to or from that coverage.

TIP: Having existing family coverage DOES NOT enroll the new dependent

In the case of a qualifying event allowing you to add or delete dependents from your coverage, that includes current coverage only. Changing plan types is not allowed under the Plan.

Medical, Dental and Vision Plan Premiums

MEDICAL PLANS

UMR
A UnitedHealthcare Company

	Rose Plan		Azalea Plan		Bluebonnet	
	Employee Per Pay Period Contribution	Employee Monthly Contribution ($)	Employee Per Pay Period Contribution	Employee Monthly Contribution ($)	Employee Per Pay Period Contribution	Employee Monthly Contribution ($)
CONTRIBUTIONS						
Employee Only	$53.57	$107.13	$25.00	$50.00	$7.75	$15.50
Employee +Spouse	$178.62	$357.23	$122.86	$245.71	$88.37	$176.73
Employee + Child(ren)	$138.79	$277.58	$108.57	$217.14	$77.53	$155.05
Employee + Child(ren) (4+)	$155.68	$311.35	$112.50	$225.00	$80.60	$161.19
Employee + Family	$242.03	$484.05	$170.00	$339.99	$121.71	$243.41

DENTAL PLAN

DELTA DENTAL®

	Employee Per Pay Period Contribution	Employee Monthly Contribution ($)
CONTRIBUTIONS		
Employee Only	$4.91	$9.82
Employee +Spouse	$18.05	$36.10
Employee + Child(ren)	$17.48	$34.96
Employee + Family	$27.17	$54.34

VISION PLANS

SuperiorVision

	GOLD $150 PLAN 1		GOLD $100 PLAN 2	
	Employee Per Pay Period Contribution	Employee Monthly Contribution ($)	Employee Per Pay Period Contribution	Employee Monthly Contribution ($)
CONTRIBUTIONS				
Employee Only	$3.07	$6.15	$2.75	$5.50
Employee +Spouse	$5.25	$10.50	$4.65	$9.30
Employee + Child(ren)	$5.57	$11.15	$4.95	$9.90
Employee + Family	$8.35	$16.70	$7.40	$14.80

Medical Benefits

	Rose Plan		Azalea Plan		Bluebonnet Plan (HDHP)	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Coinsurance	20%	Not Covered	20%	Not Covered	20%	Not Covered
Individual Deductible	$1,000	Not Covered	$3,000	Not Covered	$3,000	Not Covered
Family Deductible	$3,000	Not Covered	$6,000	Not Covered	$6,000	Not Covered
Individual Out - of - Pocket Max	$6,350	Not Covered	$7,350	Not Covered	$7,350	Not Covered
Family Out - of - Pocket Max	$12,700	Not Covered	$13,700	Not Covered	$13,700	Not Covered
Physician Office Copay	$30 copay	Not Covered	$40 copay	Not Covered	20% after deductible	Not Covered
Specialist Office Copay	$30 copay	Not Covered	$40 copay	Not Covered	20% after deductible	Not Covered
Preventive Care	Covered at 100%	Not Covered	Covered at 100%	Not Covered	Covered at 100%	Not Covered
Emergency Room Copay	$250 copay		$350 copay		20% after deductible	
Urgent Care Copay	$30 copay per visit	Not Covered	$40 copay per visit	Not Covered	20% after deductible	Not Covered
Hospital Inpatient	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Hospital Outpatient	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Home Health Care	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Skilled Nursing Facility	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Mental Illness / Substance Use Inpatient	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Mental Illness / Substance Use Outpatient	$30 copay per visit	Not Covered	$40 copay per visit	Not Covered	20% after deductible	Not Covered
Telemedicine	$0 copay when using Teladoc	Not Covered	$0 copay when using Teladoc	Not Covered	$49 if through Teladoc	Not Covered

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

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A UnitedHealthcare Company

Prescription Drug Benefits

Prescription drug coverage provided by CerpassRX is included for employees enrolled in the City's medical plans.

	Rose Plan			Azalea Plan			HSA Plan		
	30 Day Supply	90 Day Supply	Mail order	30 Day Supply	90 Day Supply	Mail order	30 Day Supply	90 Day Supply	Mail order
Specialty:	$125 copay	Not Covered	Not Covered	80% coinsurance (min $125/ max $250)	Not Covered	Not Covered	80% after deductible (min $125/ max $250)	Not Covered	Not Covered
Non-Preferred Brand:	$100 copay	$250 copay	$300 copay	$125 copay	$312.50 copay	$375 copay	$125 copay after deductible	$312.50 copay after deductible	$375 copay after deductible
Preferred Brand:	$60 copay	$150 copay	$180 copay	$75 copay	$187.50 copay	$225 copay	$75 copay after deductible	$187.50 copay after deductible	$225 copay after deductible
Generic:	$15 copay	$37.50 copay	$45 copay	$25 copay	$62.50 copay	$75 copay	$25 copay after deductible	$62.50 copay after deductible	$75 copay after deductible

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

CERPASSRX®

Access your private, secure member portal today. Visit www.cerpassrx.com - Member Portal

Get the app by searching for CerpassRx at the Apple App Store or Google Play.

Member Portal

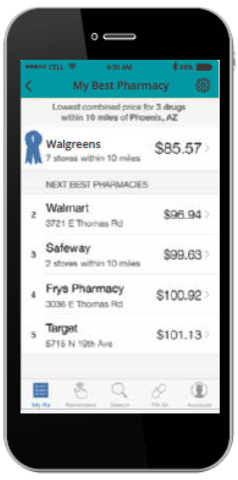
This private, secure website is designed just for you. Your pharmacy plan information is available and kept up-to-date in real time.

Easy Access Allows You To:

- Manage all your prescriptions on a single dashboard
- Keep track of your health history
- Learn more about your prescription drugs
- Compare prices at local pharmacies
- Find your lowest prescription cost
- Transfer your prescription to a different pharmacy
- Locate your pharmacy and get driving directions
- Track your individual and family spend
- Take it all with you through the mobile app

With the Mobile App in your Pocket:

- Stay on top of medication refills. See when refills are due, get refill reminders and quickly contact your pharmacy.
- Pull up your medication history anytime to show your doctor what medications you are taking.
- Learn about medication side effects and interactions.
- Find network pharmacies by ZIP code or location, then check and compare current prescription prices.
- Learn ways to save on your prescription by switching from brand name to generic or splitting a higher dosage pill.
- Track individual and family spend.



HOW TO REGISTER

Visit http://www.cerpassrx.com/members-page/ and click on the member portal button. With your CerpassRx ID card handy, click"activate your account". From there, enter your member ID (as shown on your ID card) and proceed with completing your personal information to activate your account.

Need Help? Just Call Us!

We are here to assist plan members day and night! We are available to our members 24 hours/day, 7 days/week. Please contact us at 844-636-7506 for any questions regarding your pharmacy benefits.

Find an In-Network Provider

- Step 1: Go to www.umr.com.
- Step 2: Click "Find a Provider".
- Step 3: Search for "**UnitedHealthcare Choice Plus Network"** using the alphabet navigation or type "**UnitedHealthcare Choice Plus**" into the search box.
- Step 4: For medical providers, choose **View Providers**. For behavioral health providers (including counseling and substance use), select **Behavioral health directory.**

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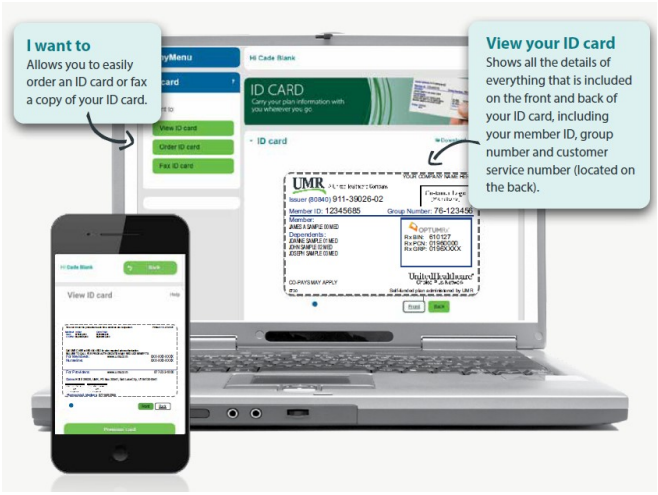
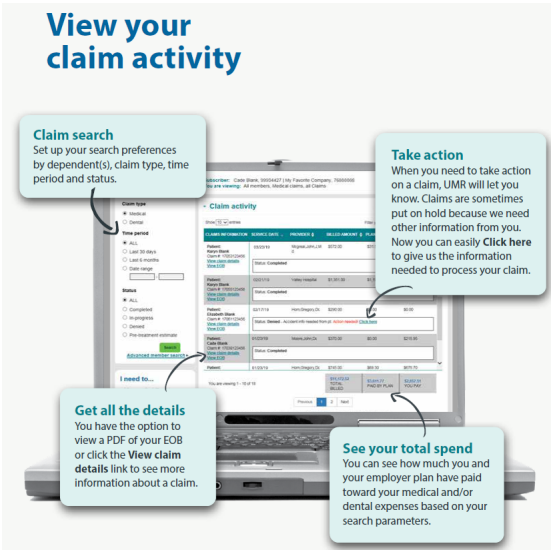
UMR Online

Go to www.umr.com and select **LOGIN/REGISTER.**





As a UMR member, you can access your benefits and claims information anytime, anywhere using your mobile device. There's no app to download - simply login to www.umr.com.

Telemedicine - Teladoc

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits.

It's an affordable option for quality medical care.

Talk to a doctor anytime, anywhere you happen to be

Receive quality care via phone, video or mobile app

Prompt treatment, median call back, in 10 minutes

A network of doctors that can treat every member of the family

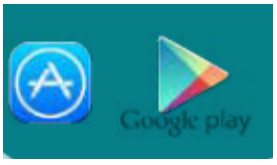
Prescriptions sent to pharmacy of choice if medically necessary

Teladoc is less expensive than the ER or urgent care

Talk to a doctor anytime!

Visit Teladoc.com or call

1.800.Teladoc



Nurseline

An experienced team of registered nurses is standing by to help you make the right decisions. Contact us any time, night or day, seven days a week, for the information you need.

Call NurseLine℠ today at
877-950-5083 or **chat live** with
a nurse on **umr.com**

UMR
A UnitedHealthcare Company

Where to go Guide

The cost for care and time you wait can vary greatly depending on where you go. Below is a simple guide to choosing the right place to go for health care. In addition to clinical settings, you have access to virtual visits.

VIRTUAL VISITS	CONVENIENCE CARE	DOCTOR'S OFFICE	URGENT CARE	ER
Minor medical concerns. Connect with a board certified doctor via video or phone.	Minor medical concerns. Located in retail stores / pharmacies. Often open nights and weekends.	Best place to go for routine / preventive care, and keep track of medications.	Non life - threatening conditions. Usually have extended hours.	Immediate treatment of critical injuries or illness. Open 24/7. If life - threatening, call 911 or go to the nearest ER.
• Colds, flu, fever • Rashes / Allergies • Sore throats • Headaches • Stomachaches • UTIs and more	• Colds, flu, fever • Rashes / Allergies • Sore throats • Headaches • Stomachaches • UTIs and more	• General health issues • Preventive care / Routine checkups • Immunizations / screenings	• Minor cuts, sprains, burns • Headaches • Fever and Flu • Minor respiratory symptoms	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Chest pain / Head trauma

LOWER **Cost & Time** GREATER

*List is not all inclusive. To find a specific health care facility or doctor, go to your medical carrier's website or call the number on your ID card. The listing of a health care professional or facility in the online directory does not guarantee that the services rendered by that professional or facility are covered under your specific medical plan. Check your official plan document for information about the services covered under your plan benefits. The information provided here is for informational purposes only. During a medical emergency, you should always visit the nearest hospital or call 911 for assistance.

Health Savings Account

Eligibility

- You must be enrolled in a high deductible health plan (HDHP).
- You are not covered under another medical plan that is not an HDHP.
- You are not entitled to (eligible for or enrolled in) ANY Medicare benefits. *(While you can still enroll in an HSA plan, you will not be eligible to contribute to, or receive contributions to your HSA account.)*
- You are not eligible to be claimed on another person's tax return.

Contributions

You can contribute on a pretax basis and up to the 2023 IRS maximum of $3,850 if you enroll just yourself, or $7,750 if your enroll in family coverage. Persons age 55+ can contribute an additional $1,000 in catch-up contributions each year. The IRS maximum factors in your contributions and the City's contribution.

Triple Tax Advantage

1. Tax deductions when you contribute to your account
2. Tax free earnings through investment
3. Tax-free withdrawals for qualified medical expenses

The City of Tyler's Contribution

The City will contribute a one-time $500 contribution to an employee's HSA account. The City contribution will be made at the beginning of your enrollment effective date.

Eligible Expenses

You can use your HSA on most medical care that is subject to your deductible/coinsurance, including medical, dental, vision and prescription drug expenses incurred by you and your eligible family members. Should you leave employment, you can also use these funds on select insurance premiums such as COBRA, qualified long-term care insurance, health insurance while receiving unemployment income, and health insurance after you turn age 65, except for Medicare Supplement policies. If you want to enroll in a Health Care FSA, you are eligible to enroll in a Limited Purpose FSA, for more details on the Limited Care FSA, please see **page 22**.

Please note: funds available for reimbursement are limited to the balance in your HSA.

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses. You can also pay providers directly and submit receipts for reimbursement.

Portability

You keep the account even if you change insurance plans/jobs or retire. Use the funds in the account to pay for current expenses or save the money for future needs. Leftover money will rollover from year to year.

OPTUM Bank®

How your HSA can work for you!

Year 1 Example	Year 2 Example
Susan contributes $3,350 to her HSA & receives the City's $500 contribution.	$3,200 rolls over from last year.
	Susan contributes $2,000 to her account.
She uses $650 on eligible expenses.	She uses $1,500 on eligible expenses.
She has $3,200* in her HSA to roll over to next year.	She has $3,700 in her HSA to roll over to next year.

**Optional investment options become available once an account reaches a balance of $3,000.*

Save on out-of-pocket costs head to toe

Your HSA covers you and your family for a wide variety of qualified products and services like:

- Dental care, including extractions and braces
- Eye exams, glasses and contacts
- LASIK surgery
- Prescription medications
- Foot treatment
- Chiropractic services
- Ultrasounds
- Doctor's office visits and procedures

Go to **optumfinancial.com/qualifiedexpenses** to see more eligible expenses.

See how Jake is supersizing his nest egg

Let's meet Jake. He's 27 and considers himself fairly healthy. When he started his new job, he decided to open an HSA and contribute $100 per month. Because he hasn't had many medical expenses, he decided not to touch the balance during his first year. Once he turns 40, he begins using $500 each year after that to cover his health costs. Here's how Jake's balance grows:

Monthly contribution: **$100**

Balance at end of first year: **$1,200**

Balance at age 65: $33,800

Annual income tax savings*: $356

Use the HSA contribution calculator on **optumfinancial.com** to help determine your contributions and see how much you can save on taxes.

Dental Benefits

- ✓ Free to visit a dentist of your choice
- ✓ No balance bill if services provided in-network

Need to locate a network dentist or orthodontist?

Log on to www.deltadentalins.com or Call customer service at 1-800-521-2651.

	Delta Dental PPO Plan
NETWORK	**DPO / Premier**
Deductible	$50 Individual $150 Family
Deductible Waived for Preventive	Yes
Diagnostic/Preventive	100%
Restorative/Basic	80%
Major	50%
Endodontics and Periodontics	Basic
Waiting Period	New Hires: 90 days
Calendar Year Maximum	$1,200
R&C Percentage	90%
Orthodontia Coverage	50%
Orthodontia Maximum	$1,000

Additional Discounts:

Hearing Aid

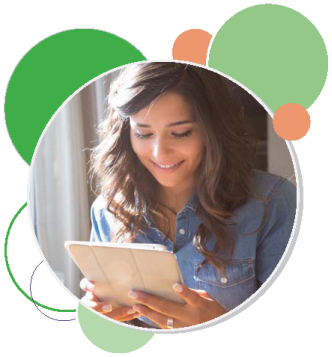
- Discounts on hearing aids and one year of free follow-up care,
- 62% average savings off retail hearing aid pricing, with a best-price guarantee of 5%
- Call Amplifon at 888-779-1429

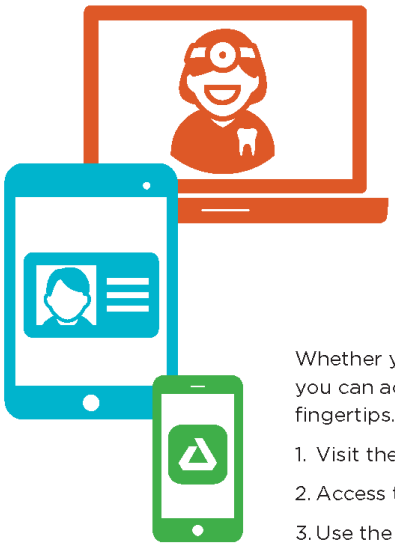
LASIK

- Discount on LASIK eye surgery, including pre- and post-operative visits
- 40-50% off national average price
- Call QualSight at 855-284-2020

DELTA DENTAL

Stay Connected





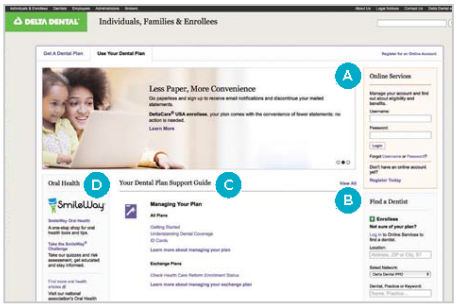
Want information about your dental plan? Take advantage of our web and mobile resources to:

- check your eligibility
- look up coverage details
- check claims
- find a network dentist
- improve your oral wellness
- and more

Whether you're on a computer, tablet or smartphone, you can access all the information you need at your fingertips.

1. Visit the **website**
2. Access the **mobile-optimized site**
3. Use the **free app**

Check the site



1. Enter **deltadentalins.com/enrollees** on your computer's browser.
2. Browse the features listed below. If you haven't already done so, register for Online Services. Already got an account? Log in!

Features:

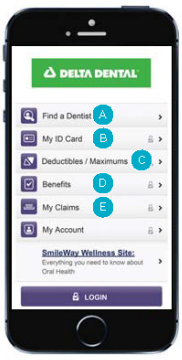
A. **Online Services** (register or log in): See benefits, eligibility, deductibles and maximums; check claims; view or print an ID card

B. **Find a dentist**

C. **Dental Plan Support Guide**

D. **SmileWay® Wellness site**

Go mobile[1]



1. Enter **deltadentalins.com** on your smartphone's browser.
2. Click the **Visit Mobile Site** button.

Features:

A. **Find a dentist**

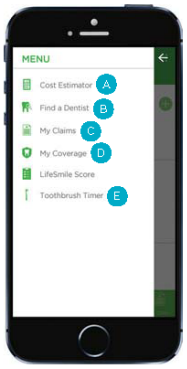
B. **View your electronic ID card**

C. **Check deductibles and maximums**

D. **See your benefits and eligibility**

E. **Check claims**

Get the app[2]



1. Open the **App Store** or **Google Play**.
2. Search for "**Delta Dental**."
3. Download the free app titled **Delta Dental** by Delta Dental Plans Association.

Features:

A. **Get a cost estimate**

B. **Find a dentist**

C. **Check claims**

D. **See your benefits, eligibility, deductibles and maximums**

E. **Use a musical timer to brush for 2 minutes**

¿Habla español?

es.deltadentalins.com

We keep you smiling®
deltadentalins.com/enrollees

Vision Benefits

Vision coverage is provided through Superior Vision. The plan pays benefits for annual exams and corrective lenses. You pay a copayment for exams, and the plan pays benefits for frames and lenses up to certain limits. Under this plan, you may use in-network or out-of-network vision care providers, but you will receive greater benefits when you use in network providers.

	Gold $150 Plan 1		Gold $100 Plan 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam (with dilation)	$10 copay	Up to $35 reimbursed	$10 copay	Up to $35 reimbursed
LENSES: STANDARD	Once every 12 months		Once every 12 months	
Single Vision	After $25 copay	Up to $25 reimbursed	After $25 copay	Up to $25 reimbursed
Bifocal	After $25 copay	Up to $40 reimbursed	After $25 copay	Up to $40 reimbursed
Trifocal	After $25 copay	Up to $45 reimbursed	After $25 copay	Up to $45 reimbursed
FRAMES	Once every 24 months		Once every 24 months	
Standard	Up to $150 Allowance after $25 copay + 20% discount	Up to $70 reimbursed	Up to $100 Allowance after $25 copay + 20% discount	Up to $55 reimbursed
CONTACTS	Once every 12 months		Once every 12 months	
Elective Contact Lenses	$150 allowance after $25 co-pay + 20% discount	Up to $80 reimbursed	$125 allowance after $25 co-pay + 20% discount	Up to $65 reimbursed
Medically Necessary	Covered in Full after $25 copay	Up to $150 reimbursed	Covered in Full after $25 copay	Up to $150 reimbursed
Laser Vision Correction	$200 Allowance		$200 Allowance	

***The frames & contact lens benefit is an either or benefit. For example, contact lens benefit in lieu of frames benefit.**
Note: Please refer to Certificate of Coverage for a full outline of your vision coverage.

Partnerships with:

1-800 Contacts & Glasses.com

SuperiorVision

Basic Life and AD&D *Paid for you by the City of Tyler*

Benefits	Securian administered by Ochs Employee Coverage
Employee Life Amount	$10,000
Employee AD&D Amount If you are injured or die as a result of an accident, you or your beneficiary will receive a benefit based on the extent of the injury. AD&D pays benefits if death or dismemberment occurs within 180 days following the covered accident.	$10,000
Age Reduction Formula	65th birthday - age 69 - 65% 70th birthday - age 74 - 50% 75th birthday and after - 30%
Line of Duty – *Additional basic AD&D for public safety officers that suffer a loss while he/she is performing his or her customary duties for the City.*	$10,000
Retiree Life and AD&D Amount	$5,000

Voluntary Life and AD&D *100% voluntary, paid for by the employee*

Benefits	Securian administered by Ochs Employee Coverage
Employee Benefit	$10,000 Increments
Employee Voluntary AD&D	Same as Life
Maximum Benefit	$500,000
Guarantee Issue Amount - *benefit amount offered regardless of health. Note: Newly eligible employees only*	$250,000
Conversion - *option which allows the insured to switch to a different type of policy without submitting to a physical examination*	Included
Portability - *allows eligible insureds to continue their insurance coverage when they are leaving employment (voluntarily or involuntarily terminated)*	Included
Accelerated Death Benefit - *enables the policy holder to receive cash advances against the death benefit in the case of being diagnosed with a terminal illness*	24 Months Expectancy 100% to $1,000,000
Waiver of Premium if disabled - *a clause that waives the policyholder's obligation to pay any further premiums should you become seriously ill or disabled*	9 Months Elimination To age 70
Age Reduction Formula	None
Line of Duty – *An additional amount of basic AD&D for public safety officers that suffer a loss while he or she is performing his or her customary duties for the City.*	Principal Sum up to $100,000

You may choose additional coverage for yourself, in $10,000 increments, up to $500,000. Premiums are paid on an after-tax basis, so any insurance benefits paid are not taxable when your beneficiary receives them. Voluntary Rates are on page 20.

Voluntary Dependent Life & AD&D 100% voluntary, paid for by the employee

Benefits	Securian administered by Ochs Dependent Coverage
Spouse Benefit	$5,000 Increments
Spouse Voluntary AD&D	Same as Life
Spouse Maximum	Up to $250,000
Spouse Guarantee Issue - newly eligible only	$50,000
Child Benefit	Choice of $5,000, $10,000, $15,000 or $20,000
Child Maximum and Guaranteed Issue	
Age Reduction Formula	None

securian FINANCIAL® | Ochs

HOW MUCH LIFE INSURANCE DO YOU NEED?

Check out the life insurance calculator at **LifeBenefits.com/Insuranceneeds**.

Insurance helps cover

- Funeral/burial costs
- Medical bills
- Taxes & living expenses (i.e. mortgage, childcare)

All Children Premium Table Monthly Rates (one premium insures all eligible children)			
$5,000	$10,000	$15,000	$20,000
$0.65	$1.30	$1.95	$2.60

Employee and Spouse* Life & AD&D Insurance Monthly Rates

Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate per $1,000	$0.08	$0.09	$0.11	$0.12	$0.15	$0.24	$0.40	$0.64	$0.78	$1.34	$2.09	$4.10
Coverage Amount												
$10,000	0.80	0.90	1.10	1.20	1.50	2.40	4.00	6.40	7.80	13.40	20.90	41.00
$20,000	1.60	1.80	2.20	2.40	3.00	4.80	8.00	12.80	15.60	26.80	41.80	82.00
$30,000	2.40	2.70	3.30	3.60	4.50	7.20	12.00	19.20	23.40	40.20	62.70	123.00
$40,000	3.20	3.60	4.40	4.80	6.00	9.60	16.00	25.60	31.20	53.60	83.60	164.00
$50,000	4.00	4.50	5.50	6.00	7.50	12.00	20.00	32.00	39.00	67.00	104.50	205.00
$60,000	4.80	5.40	6.60	7.20	9.00	14.40	24.00	38.40	46.80	80.40	125.40	246.00
$70,000	5.60	6.30	7.70	8.40	10.50	16.80	28.00	44.80	54.60	93.80	146.30	287.00
$80,000	6.40	7.20	8.80	9.60	12.00	19.20	32.00	51.20	62.40	107.20	167.20	328.00
$90,000	7.20	8.10	9.90	10.80	13.50	21.60	36.00	57.60	70.20	120.60	188.10	369.00
$100,000	8.00	9.00	11.00	12.00	15.00	24.00	40.00	64.00	78.00	134.00	209.00	410.00
$110,000	8.80	9.90	12.10	13.20	16.50	26.40	44.00	70.40	85.80	147.40	229.90	451.00
$120,000	9.60	10.80	13.20	14.40	18.00	28.80	48.00	76.80	93.60	160.80	250.80	492.00
$130,000	10.40	11.70	14.30	15.60	19.50	31.20	52.00	83.20	101.40	174.20	271.70	533.00
$140,000	11.20	12.60	15.40	16.80	21.00	33.60	56.00	89.60	109.20	187.60	292.60	574.00
$150,000	12.00	13.50	16.50	18.00	22.50	36.00	60.00	96.00	117.00	201.00	313.50	615.00
$160,000	12.80	14.40	17.60	19.20	24.00	38.40	64.00	102.40	124.80	214.40	334.40	656.00
$170,000	13.60	15.30	18.70	20.40	25.50	40.80	68.00	108.80	132.60	227.80	355.30	697.00
$180,000	14.40	16.20	19.80	21.60	27.00	43.20	72.00	115.20	140.40	241.20	376.20	738.00
$190,000	15.20	17.10	20.90	22.80	28.50	45.60	76.00	121.60	148.20	254.60	397.10	779.00
$200,000	16.00	18.00	22.00	24.00	30.00	48.00	80.00	128.00	156.00	268.00	418.00	820.00
$210,000	16.80	18.90	23.10	25.20	31.50	50.40	84.00	134.40	163.80	281.40	438.90	861.00
$220,000	17.60	19.80	24.20	26.40	33.00	52.80	88.00	140.80	171.60	294.80	459.80	902.00
$230,000	18.40	20.70	25.30	27.60	34.50	55.20	92.00	147.20	179.40	308.20	480.70	943.00
$240,000	19.20	21.60	26.40	28.80	36.00	57.60	96.00	153.60	187.20	321.60	501.60	984.00
$250,000	20.00	22.50	27.50	30.00	37.50	60.00	100.00	160.00	195.00	335.00	522.50	1,025.00
$260,000	20.80	23.40	28.60	31.20	39.00	62.40	104.00	166.40	202.80	348.40	543.40	1,066.00
$270,000	21.60	24.30	29.70	32.40	40.50	64.80	108.00	172.80	210.60	361.80	564.30	1,107.00
$280,000	22.40	25.20	30.80	33.60	42.00	67.20	112.00	179.20	218.40	375.20	585.20	1,148.00
$290,000	23.20	26.10	31.90	34.80	43.50	69.60	116.00	185.60	226.20	388.60	606.10	1,189.00
$300,000	24.00	27.00	33.00	36.00	45.00	72.00	120.00	192.00	234.00	402.00	627.00	1,230.00
$350,000	28.00	31.50	38.50	42.00	52.50	84.00	140.00	224.00	273.00	469.00	731.50	1,435.00
$400,000	32.00	36.00	44.00	48.00	60.00	96.00	160.00	256.00	312.00	536.00	836.00	1,640.00
$450,000	36.00	40.50	49.50	54.00	67.50	108.00	180.00	288.00	351.00	603.00	940.50	1,845.00
$500,000	40.00	45.00	55.00	60.00	75.00	120.00	200.00	320.00	390.00	670.00	1,045.00	2,050.00

***Spouse rates are based off of employee age.**

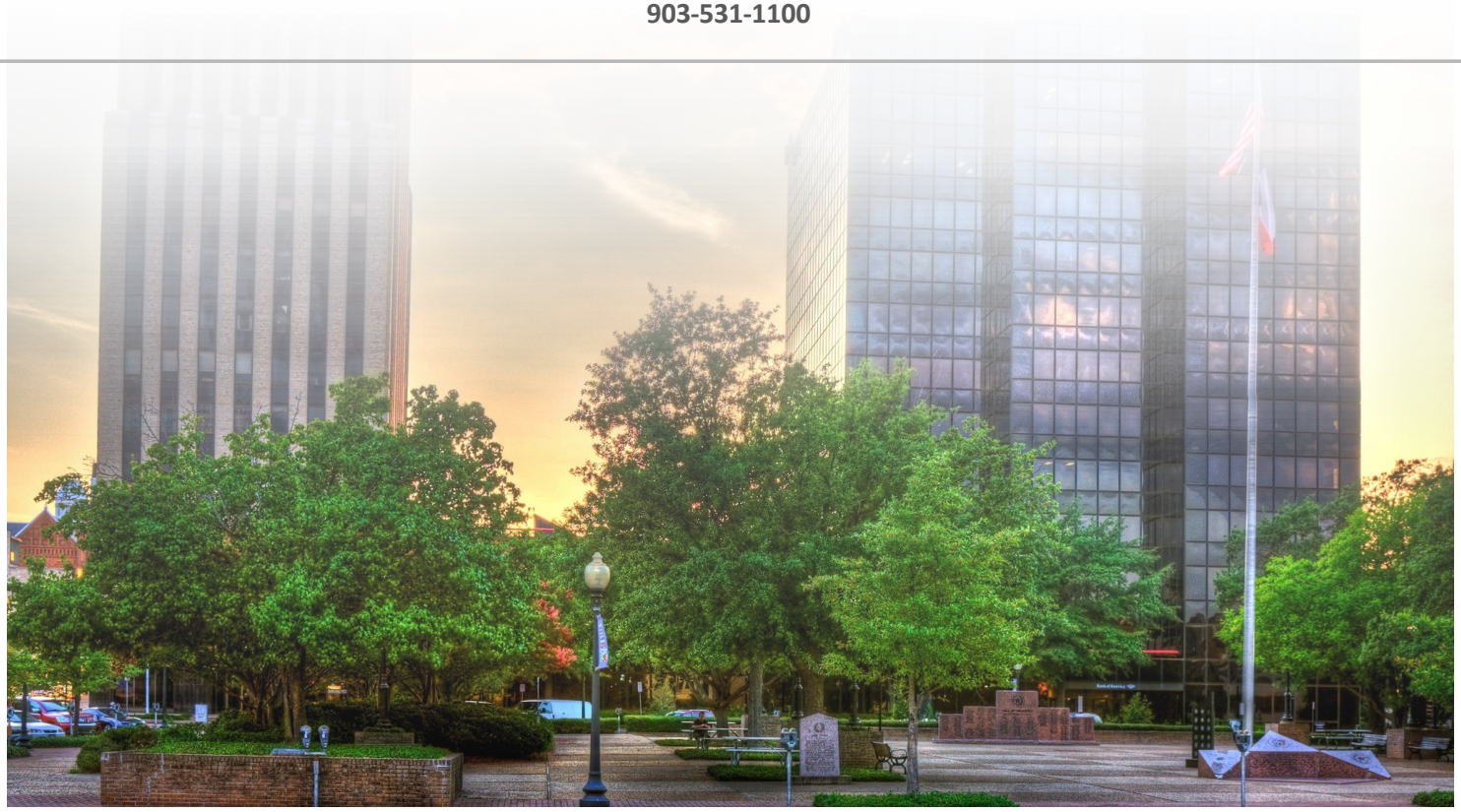
Voluntary Short Term Disability Insurance Benefits Paid for by the employee

All active regular non-civil service full-time employees are eligible to participate in this plan at a cost of $7.50 per pay period. (24 pay periods per year)

Basic Monthly Earnings– *gross rate of pay used to determine benefit dollar amount*	Average monthly base salary or hourly pay before taxes. Does not include commissions, bonuses, overtime pay, or any other extra compensation.
Benefit Percentage	60% of weekly salary
Maximum Weekly Benefit	$1,200
Elimination Period - *period of continuous disability which must be satisfied before you are eligible to receive short term disability benefit payments*	7th Day Sickness/7th Day Accident
Definition of Disability	Unable to perform all the material duties of your regular occupation, and unable to earn 80% or more of your covered earnings.
Maternity Benefit	6 weeks – Normal Delivery 8 weeks - C-section
Benefit Duration	Up to 26 weeks

To File a Disability Claim Contact Team Resources:

903-531-1100



Flexible Spending Account

- Employees are eligible to open a Flexible Spending Account (FSA) each year. Deductions are pre-tax.

- **A max of $3,050 for 2023 may be contributed to your Healthcare FSA. Up to $610 can be rolled over at the end of the plan year, all other funds will be forfeited.**

- Accounts are pre-loaded with the annual election. You have access to all of your funds the first day of the new plan year.

- If participating in an HSA, you can enroll in a limited FSA to be used on vision and dental services only.

- **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).

- Participants receive a debit card that can be used for qualified expenses, or you can also file a claim online for reimbursement. For dependent care expenses, you will be reimbursed for eligible claims up to the current contributed amount available in your account.

- ***Money may not be transferred between medical and dependent care accounts.***

- Employees have up to 60 days following the end of the plan year or termination of employment to apply for reimbursement. Expenses must be incurred during the plan year (January 1, 2023 to December 31, 2023).

FSA Eligible Expenses For a full list of eligible expenses please see IRS Publication 502.
Glasses/Contact Lenses/Solutions*
Co-Payments / Prescriptions
Medical Supplies / Equipment
Dental / Orthodontic Fees*

*Limited Care FSA eligible expenses

Non-Qualified FSA Expenses
Cosmetic Surgery
Teeth Whitening
Marriage/Family Debt Counseling
Weight Loss Programs for General Health/ Appearance
Premiums

UMR
A UnitedHealthcare Company

2023 FSA Maximum Contributions	2023 Dependent Care Maximum Contributions
$3,050	$5,000

Dependent Care Eligible Expenses
Incurred for services outside your home provided they are: for the care of a qualifying person under the age of 13 when care was provided or for custodial care of a spouse/dependent who is physically or mentally unable to care for themselves. Persons who cannot dress/clean/feed themselves because of physical or mental limitations. Persons who must have constant attention to prevent injury to self or others.
Nanny expenses, for services provided inside your home if they are attributable to dependent care expenses and incidental household services.
Employees (and spouses if married) must have earned income during the year and you must pay for dependent care expenses so you can work or can look for work.
Payments must be made for a child and dependent care to someone you (or your spouse) cannot claim as a dependent. If you make payments to your child, they cannot be your dependent and must be 19 or older by the end of the tax year.
Registration fees to a daycare facility if allocated to actual care and not described as materials or other fees.
Nursery school expenses if the school also furnishes lunch and education services and food and incidental expenses (diapers, activities, etc.) may be eligible if part of dependent care charge.

Non-Qualified Dependent Care Expenses
Tuition fees for grades K-12
Meals / Diapers*
Activity / Late Fees
Overnight Camps / Summer Camp Supplies

*Incidental fees are not eligible if billed separately by your provider.

Note: If you terminate employment or experience a change in status from full-time to part-time, you are eligible to access FSA funds up to your termination or status change date. Any services after the previous mentioned dates are ineligible for reimbursement. You have up to 60 days after your ineligibility date to file claims that were incurred prior to becoming ineligible.

Glossary

Allowed Fees

The maximum amount a health plan will pay for covered medical and dental services. Also referred to as “eligible expenses” or “negotiated rate:.

Deductible

The amount you must pay for covered health services based on contracted rates (also referred to as eligible charges/expenses) in a year before the plan will begin paying certain benefits in that year.

Coinsurance

The portion of covered health care costs for which the covered person is financially responsible, may be applied after a deductible requirement is met.

Copayment

A fixed amount you pay for a covered health care service. Copays can vary for different services within the same plan.

Dependent Care Account

A pre-tax account that can be used for eligible dependent care services, such as preschool, summer day camp, before or after school programs and child or adult daycare.

Eligibility

Eligibility for benefits will begin following a 90 day waiting period after regular full-time employment hire date.

Flexible Spending Account (FSA)

An arrangement that lets you pay for many of your out of pocket medical expenses with tax free dollars. Allowed expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices. A limited FSA can be paired with an HSA, but may only be used for dental and vision expense.

Guarantee Issue

The amount of coverage pre-approved by the Life Insurance Company regardless of health status.

Health Savings Account (HSA)

A type of savings account where you can set aside money on a before-tax basis to use on qualified medical expenses.

High Deductible Health Plan (HDHP)

A health plan with a higher deductible where you pay for first dollar coverage until the deductible is met. Can be paired with a Health Savings Account.

Initial Enrollment Period

The first 31 days of fulltime employment or 30 days from a covered life event.

In-Network / Out-of-Network

In-network providers, doctors, and hospitals that contract with our insurance company to provide services at discounted rates. **Out-of-network** providers are not contracted. If you choose an out-of-network doctor, services will not be provided at a discounted rate and are not covered by your health plan.

Out-of-Pocket Maximum

The maximum amount of co-insurance you pay every year. Deductibles and copays apply to the out-of-pocket maximum.

Plan Year

January 1st through December 31st of each year

Portability

You keep the account even if you change Insurance plans / jobs or retire.

Usual and Customary Rates (U&C)

Out-of-network dental plan expenses are considered for reimbursement at usual and customary (U&C) rates. U&C rates are determined to be the prevailing charge made for a service by a similar provider in the same geographic area. Charges above U&C are not covered by the plan and are the responsibility of the participant.

Required Notices

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.

Newborn's 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).

Mental Health Parity Act (1996) (MHPA) and Mental Health Parity and Addiction Equity Act (2008) (MHPAEA) Opt Out

The Notice to Enrollees in a Self-Funded Nonfederal Governmental Group Health Plan for Plan Years Beginning On or After September 23, 2010 Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. City of Grapevine has elected to exempt the City of Tyler Group Health Plan from the following requirement: Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan. The exemption from these Federal requirements will be in effect for the 2023 plan year beginning 1.1.2023 and ending 12.31.2023. The election may be renewed for subsequent plan years.

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, 2021, 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 Centers 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 City of Tyler 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: 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. City of Tyler has determined that the prescription drug coverage offered by the City's Group 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 City of Tyler will not be affected. (HSA contribution eligibility will 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 the City of Tyler 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 City of Tyler 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. Team Resources: 903.531.1100. For more information about Medicare prescription drug coverage: Visit www.medicare.gov. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY

1-800-325-0778). **Remember:** Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Coverage After Termination (COBRA) - Health Coverage

You're getting this notice because you recently gained coverage under a group health plan (City of Tyler 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. You must provide this notice to: Team Resources: 903.531.1100. **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 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: Team Resources: 903.531.1100.

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 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 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. Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. Respond to organ and tissue donation requests and work with a medical examiner or funeral director: We can share health information about you with organ procurement organizations; We can share health information with a coroner, medical examiner, or funeral director when an individual dies. Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services. Respond to lawsuits and legal actions: We can share health 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:** 1/1/2023 Privacy Contact: City of Tyler Team Resources, 212 N Bonner, Tyler, TX, 75710, 903.531.1100.

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 an 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 using the number listed below: Team Resources: 903.531.1100.

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 plan's 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. 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 Team Resources at The City of Tyler. 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 United Healthcare No Surprises Help Desk: 1-800-985-3059 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.

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 2022 for coverage starting as early as January 1, 2023. **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 9.12% 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 Team 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 90 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.

3. Employer name City of Tyler	4. Employer Identification Number (EIN) 75-6000697	
5. Employer address 212 North Bonner	6. Employer phone number 903.531.1100	
7. City Tyler	8. State TX	9. ZIP code 75710
10. Who can we contact about employee health coverage at this job? Team Resources		
11. Phone number (if different from above)	12. Email address jmcgrew@tylertexas.com	

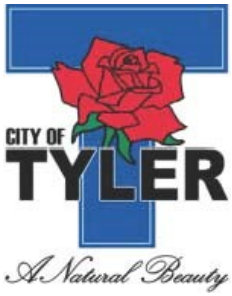
Important Contacts

Coverage	Company	Phone Number	Website
Medical	UMR	855.858.6865	www.umr.com
Flexible Spending Account	UMR	855.858.6865	www.umr.com
Short Term Disability	UMR	855.858.6865	www.umr.com
Pharmacy Benefit Manager	CerpassRX	844.636.7506	www.cerpassrx.com
Nurseline	UMR	877.950.5083	www.umr.com
Telemedicine	Teladoc	800.835.2362	www.teladoc.com
HSA Account	Optum Bank	877.292.4040	www.optumfinancial.com
Dental	Delta Dental	800.521.2651 Plan #18474	www.deltadentalins.com
Vision	Superior Vision	866.265.0517 1.888.494.1272 *(hearing aid discount)*	www.superiorvision.com
Life and Supplemental Life	Securian administered by Ochs	800.392.7295 (Customer Service) Plan #34638 888.658.0193 (Claims)	www.securian.com

You may contact Team Resources with any questions at:
903.531.1100 or at www.cityoftyler.org

Hours of Operation
Monday - Friday, 8 a.m. to 5 p.m.

Notes



The information in this benefits guide is intended to help you enroll in your 2023 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern.

The City of Tyler reserves the right to change or terminate benefits at any time. Neither the benefits, nor this enrollment guide, should be interpreted as a guarantee of future benefits.