City of Sugar Land
Employee Benefits Guide
2025

Contents

CITY OF SUGAR LAND BENEFITS – 2025

The City of Sugar Land offers a comprehensive, cost-effective, and competitive benefits package to help protect you and your family. However, it works only if you take control and make thoughtful decisions about your benefits. In other words, you need to take an active role in choosing your benefits coverage and learning how to access your benefits so that you receive health services that support your needs and goals. This Benefits Guide is intended to help you make benefits choices at hire and throughout the year.

ELIGIBILITY

Employee Eligibility

If you are an active, full-time employee, you are eligible to enroll in the City's benefits program.

Dependent Eligibility

In most cases, you may also cover your eligible dependents, including:

- ✓ Your legal spouse (must provide a copy of your marriage certificate or documentation of common-law marriage).
- ✓ Your children (must provide a copy of the birth certificate). Children up to age 26. Coverage will end the last day of the month your child turns 26. "Children" are defined as your natural children, stepchildren, legally adopted children, and children under your legal guardianship. If your child is no longer eligible, you must notify the City by contacting the People and Culture Department.
- ✓ Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested by the City or Carrier, and the disability must have occurred prior to age 26.

WHAT'S NEW FOR 2025?/PLAN HIGHLIGHTS

- ❖ **Aflac Plans: Enrollment for Aflac will be active on Benefit Connector—everyone with coverage, other than Cancer Indemnity, must re-enroll in the coverages they want.** There will be NO change to Cancer Indemnity. Accident Indemnity will be moved to group plan status with Hospital Indemnity and Critical Illness. All Aflac plans, other than Cancer, will have increased services and price changes.
- ❖ **Employee Assistance Program (EAP):** the City is changing its EAP to Aetna's **Resources for Living**.
- ❖ **Dedicated KelseyCare Appointment Scheduling Line: 713-442-9191**
- ❖ **Employee Benefits Hotline: 877-838-4779** or advocates@HUBinternational.com
- ❖ **Medical premiums on KelseyCare** have increased slightlly, depending on your plan and tier.
- ❖ **Dental premiums** on both plans have increased slightly.
- ❖ **High Deductible Health Plan with HSA:**
  - ✓ No increase to premiums
  - ✓ The City contributes to participant accounts: $500 EE / $1,000 EE+ FAM
  - ✓ HSA Deductible for individuals will increase to $3,300 to comply with IRS Regs
  - ✓ The 2025 annual contribution maximum to an HSA account for employee-only coverage will increase to $4,300. The maximum contribution for family coverage will increase to $8,550.
  - ✓ Coinsurance will be reduced from 30% to 20% after the deductible is met.
  - ✓ Copays will replace coinsurance for pharmacy. After you meet the deductible, then copays will apply: $5 Generic/$40 Preferred brand/$80 non-preferred brand/$200 Specialty medications.
- ❖ **FSA:** The amount you can contribute to your Health Care or Limited Purpose Flexible Spending Account (FSA) will be $3,300 for the 2025 Plan Year. Dependent Care maximum will stay the same at $5,000 per household.
- ❖ **The Airrosti copay** for KelseyCare plan participants is $10/visit.
- ❖ **Behavioral Health copay** for KelseyCare plan participants is $10/visit.
- ❖ **Colonoscopies & Mammograms:** Preventive AND Diagnostic are covered at 100% when you are eligible.
- ❖ **The Cigna Vision Network** changed from VSP to **EyeMed**.
- ❖ **SpotPet** pet insurance is a voluntary benefit to help pay for your fur-baby's illness or injuries.

MAKING ENROLLMENT CHANGES DURING THE YEAR

- ✓ In most cases, your benefits elections remain in effect for the entire year (January 1—December 31). During each annual enrollment period, you have the option to review your benefits elections and make changes for the coming year.
- ✓ You may only make changes to your elections during the year if you have a change in family status ("qualifying event"). Family status changes include, but are not limited to:
  - Marriage or divorce;
  - Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death, marriage, eligibility for other health coverage or reaching the dependent child age limit;
  - Moving outside of Network area;
  - Changes in your spouse's employment affecting benefits eligibility;
  - Loss or gain of eligibility by eligible child under the Medicaid or CHIP program.

You must notify the City by contacting your HR Business Partner and providing (in writing) a revised Benefit Enrollment Worksheet with supporting documentation within 31 days of the Qualifying Event.

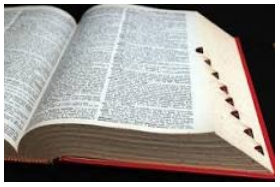
NEWBORNS ARE NOT AUTOMATICALLY ADDED TO YOUR MEDICAL COVERAGE UNDER THE CITY'S BENEFIT PLANS. YOU MUST NOTIFY YOUR PEOPLE SUCCESS PARTNER AND PROVIDE DOCUMENTATION TO ADD THE NEWBORN WITHIN 31 CALENDAR DAYS OF HIS/HER BIRTH.

With a Qualifying Event, you can:

- ✓ Enroll in or drop Medical, Dental and Vision plans
- ✓ Add, change or drop a dependent from your plan
- ✓ Designate contributions to your Health Savings Account
- ✓ Enroll in Flexible Spending Accounts (HealthCare or Limited Purpose HealthCare, and/or Dependent Care)
- ✓ Enroll, increase/decrease, or drop your Supplemental Life/AD&D Insurance (requires Evidence of Insurability form) and Short-Term Disability coverage
- ✓ Enroll in Voluntary Benefit plans
- ✓ Add, change or drop a beneficiary from your Basic and Supplemental Life and AD&D Insurance benefits

Note: Please review the Notices in this Benefits Guide regarding the Special Enrollment Period related to eligibility for or loss of CHIP or Medicaid coverage. If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal Law gives you more choices about your Medicare prescription drug coverage. Please see the Medicare Part D Notice in this Benefits Guide for more details.

HELPFUL DEFINITIONS



- ✓ Premium – Your monthly/biweekly plan payment
- ✓ Deductible – The amount of money you have to spend before health insurance kicks in.
- ✓ Co-pay – A flat fee for doctor visits and prescriptions
- ✓ Co-insurance – The portion of the doctor's bill you're responsible for after you meet your deductible.
- ✓ Out-of-Pocket Maximum (OOPM) – The most you can pay in a year on covered medical costs. The costs of premiums, out-of-network charges and excluded services do not contribute to your out-of-pocket maximum.
- ✓ Network Type – The type of access to doctors, specialists, hospitals, etc. that your health plan offers.
    - Healthcare Maintenance Organization (HMO) – KelseyCare
    - High Deductible Health Plan (HDHP) – Cigna Open Access In-Network
- ✓ Network – Pre-approved doctors and healthcare providers identified by your insurance plan.
- ✓ Health Savings Account (HSA) – A tax-free savings account that can be used towards qualifying care-related services. You can contribute to an HSA if you sign up for a High Deductible Health Plan. Owned by the employee.
- ✓ Flexible Spending Account (FSA) – Health or medical is a tax-free savings account that can be used towards qualifying care-related services. Owned by the employer.
- ✓ Short-Term Disability (STD) – Replaces 70% of your income for a period of 90 days following an illness (including pregnancy) or injury that keeps you out of work. You pay to have this benefit, which is helpful when you don't have sufficient sick or vacation accruals to cover a short-term absence.
- ✓ Long-Term Disability (LTD) – Replaces 60% of your income beginning on the 91st day of disability leave. The City pays for your LTD coverage. You do not have to enroll in STD to receive LTD benefits.
- ✓ Covered Benefits – Medical services and prescriptions your plan covers.
- ✓ Exclusions – Non-covered services such as cosmetic surgery and elective procedures.
- ✓ Preexisting Condition – If you have an illness, disease or injury before your enrollment in a policy. Health insurers cannot deny you coverage or treatment for a pre-existing medical condition, but it may impact your eligibility for life insurance, disability coverage and certain dental services.
- ✓ Supplemental Life Insurance – Term life insurance that you may purchase for you and/or your spouse based on your age rates, or your dependent child(ren). Life insurance is convertible (to Whole life) and portable when you leave your employment with the City.
- ✓ Explanation of Benefits (EOB) – a statement that breaks down a claim, including what the plan paid and how much you may owe.

PAYING FOR YOUR 2025 BENEFITS

The City pays a portion of the overall cost for your benefits. The amount you pay will depend on the selections you make. Below are the **premiums** that will be in effect Jan. 1 – Dec. 31, 2025. Premiums are deducted from the first and second paycheck of each month.

COST OF COVERAGE (PREMIUMS PER PAY PERIOD)				
MEDICAL PLAN	**KelseyCare Blue HMO**		**KelseyCare Gold HMO**	**Cigna HDHP w/HSA**
Employee Only	$ 0		$ 20.47	$ 103.44
Employee + Spouse	$ 100.95		$ 151.26	$ 353.46
Employee + Child(ren)	$ 69.89		$ 111.01	$ 262.60
Employee + Family	$ 147.54		$ 211.61	$ 463.38
DENTAL PLAN	**Cigna DHMO**		**Cigna DPPO**	
Employee Only	$ 3.30		$ 7.85	
Employee + Spouse	$ 6.19		$ 19.76	
Employee + Child(ren)	$ 8.88		$ 19.13	
Employee + Family	$ 10.86		$ 33.56	
VISION PLAN	**Cigna Vision (EyeMed Network)**			
Employee Only	$ 2.63			
Employee + Spouse	$ 5.25			
Employee + Child(ren)	$ 5.31			
Employee + Family	$ 8.47			
AFLAC ACCIDENT, HOSPITAL & CRITICAL ILLNESS PLANS				
Accident Indemnity	EE Only $5.83	EE+ Spouse $9.61	EE + Child(ren) $12.65	Family $16.42
Hospital Indemnity	EE Only $6.55	EE+ Spouse $12.92	EE + Child(ren) $10.29	Family $16.66
Critical Illness	Premiums vary by coverage level and age. See Aflac Group Summary on SLIC.			
FLEX SPENDING				
Healthcare FSA	Annual Amounts – Annual Minimum $100 / Maximum $3,300			
Limited Purpose FSA				
Dependent Care FSA	Annual Amounts – Annual Minimum $100/ Maximum $5,000			
LIFE & DISABILITY PRODUCTS				
Basic Employee Life/ AD&D	Provided by the City			
Supplemental Employee Life	Age-Banded Rates			
Supplemental Spouse Life	Age-Banded Rates			
Supplemental Child Life w/ AD&D	$.11 or $.165 per $1,000 per month			
Supplemental Employee AD&D	$0.03 per $1,000			
Supplemental Family AD&D	$0.03 per $1,000			
Long-Term Disability	Provided by the City			
Short-Term Disability	Option A: $0.197 per $10 coverage Option B: $0.288 per $10 coverage			
PREPAID LEGAL ACCESS	**LegalShield**			
IDShield	EE Only $4.48		Family $9.48	
LegalShield	EE Only $7.88		Family $7.88	

EMPLOYEE CONTRIBUTIONS

Benefit Plan	Automatic Enrollment	Your Choice	Who Pays	How You Pay
Employee Assistance Plan; Basic Life and AD&D; and Long-Term Disability	✓		The City	No cost
H.S.A. and H.M.O. Medical Plans with Prescription Drug Plan, DHMO and DPPO Plans		✓	You and The City	Before tax*
Vision Plan; contributions to Health Savings Account and/or Flexible Spending Account		✓	You	Before tax*
Supplemental Life and AD&D and Short-Term Disability; Aflac Plans; LegalShield		✓	You	After tax

** 'Before tax' means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions; the IRS has established guidelines on when changes to these 'before tax' benefits can be made.*

MEDICAL BENEFITS

The City offers three medical plans administered by CIGNA HealthCare: KelseyCare HMO Blue, KelseyCare HMO Gold and High Deductible Health Plan (HDHP). The KelseyCare HMO plans offer comprehensive benefits coverage from providers in the KelseyCare network. The HDHP gives you the protection of a traditional health insurance plan utilizing the Cigna Open Access Plus (OAP) In-network, plus, if you qualify, a tax-advantaged Health Savings Account (HSA). Please utilize your network providers for covered benefits because neither plan offers out-of-network benefits.

Convenient Services

Guesting Services: If you or a covered dependent will be in a different Cigna service area for 60 days or more, Guest Privileges lets you enroll as a "guest" in the Cigna network in that location. Cigna Networks depend on zip code. Once you've enrolled in Guest Privileges, only emergency or urgent care will be covered at your home location. College students should consider carefully whether they want to receive their primary care at home or school. You must notify Cigna by 25th day of prior month for 1st of month coverage.

Transition of Care/Continuity of Care: You may apply to continue services for specified medical conditions with health care providers who are not in network at in-network coverage levels for a defined period-of-time. You must apply within 30 days after the effective date of your coverage.

Cancer Care Support Program

The Cigna Cancer Support Program is a resource for employees and their covered dependents who are currently going through, or have just finished, cancer treatment. The free and confidential program can help provide support for every step in the process—from diagnosis to treatment to remission.

Here are the highlights of what you'll get with the Cigna Cancer Support Program:

- A personalized care and support plan
- Access to specially trained oncology nurses who are knowledgeable about your treatment plan and benefits coverage and can answer questions, respond to your concerns, and help you understand your medications and treatment options.
- A care team that will facilitate authorizations, help you manage claims and coordinate care across multiple doctors, and identify and connect you with other caregivers and support.

COST OF SERVICE

Benefits – Cigna	KelseyCare Blue Plan	KelseyCare Gold Plan	Cigna HDHP w/ HSA Plan
MAX HSA Contribution – Individual	-	-	$4,300
MAX HSA Contribution – Family	-	-	$8,550
Deductible - Individual	$0	$0	$3,300
Deductible - Family	$0	$0	$6,000
OOPM* - Individual	$5,000	$3,500	$5,000
OOPM* - Family	$10,000	$7,000	$10,000
Co-Insurance	20%	10%	20%
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Service	**You Pay**	**You Pay**	**You Pay**
Office Visit	$35 PCP / $60 Specialist Copay	$25 PCP / $50 Specialist Copay	Deductible / 20%
Behavioral Health	$10 Specialist Copay	$10 Specialist Copay	Deductible / 20%
Wellness Visit	$0	$0	$0
In-Patient Hospital	20%	10%	Deductible / 20%
Out-Patient Hospital	20%	10%	Deductible / 20%
Urgent Care	$75	$75	Deductible / 20%
Emergency Room	$250	$250	Deductible / 20%
High Tech Radiology	$350	$200	Deductible / 20%
Ambulance	$0	$0	Deductible / 20%
Airrosti	$35	$25	Deductible / 20%
Chiropractic	$35 or $60	$25 or $50	Deductible / 20%
Outpatient Therapy	$60	$50	Deductible / 20%
Durable Medical Equipment	No charge	No charge	Deductible / 20%
Diagnostic Colonoscopy / Mammogram	No charge	No charge	Deductible / 20%
Home Healthcare/ Hospice	No charge	No charge	Deductible / 20%
Pharmacy Coverage	**You Pay**	**You Pay**	**You Pay**
Deductible - Individual	$200	$200	Same as Medical
Deductible – Family	$400	$400	Same as Medical
Preventive Drugs	$0 No Deductible	$0 No Deductible	$0 No Deductible
Generic Rx	Deductible / $5	Deductible / $5	Deductible / $5
Brand – Formulary	Deductible / $40	Deductible / $35	Deductible / $40
Brand – Non-formulary	Deductible / $80	Deductible / $70	Deductible / $80
Specialty Drugs	Deductible / $200	Deductible / $150	Deductible / $200
90-day supply by Mail	2 copays	2 copays	Deductible / 2 copays
90-day supply at Retail	3 copays	3 copays	Deductible / 3 copays

*OOPM = Out of Pocket Maximum before plan pays 100%

USING KELSEYCARE BENEFITS

KelseyCare Healthcare Maintenance Organization (HMO) offers participants convenience, flexibility and a surprise free payment structure:

- You are required to choose a primary care provider (PCP) from the Kelsey facility network.
- You must use an in-network provider for all covered services.
- You have coverage for emergency (any hospital emergency room) and urgent care facilities (in-network).
- No annual deductible for medical; however, there is a prescription deductible of $200/$400.
- Many Kelsey facilities offer different services, including a facility for lab work, on-site pharmacy, radiology, and so on.
- You have the freedom to see most Kelsey-Seybold physician without a referral.
- Schedule an appointment 24 hours a day/7 days a week by calling 713-442-9191 or via www.kelsey-seybold.com.
- Visit www.mykelseyonline.com to email doctors, check your medical records, request prescriptions, request and schedule both in-person and virtual appointments and much more.

What is Co-insurance on the KelseyCare HMO?

Co-insurance is the cost-share between employee (10/20%) and plan (90/80%), and on the KelseyCare plans, applies to in-patient and out-patient hospitalization.

Out-Patient Hospital Procedures			
Blue Plan	**Amount**	**Gold Plan**	**Amount**
Negotiated Bill/EOB	$8,000	Negotiated Bill/EOB	$8,000
Facility Visit Copay	N/A	Facility Visit Copay	N/A
Employee 20% Co-insurance	$1,600	Employee 10% Co-insurance	$800
Medical Plan 80% Co-insurance	$6,400	Medical Plan 90% Co-insurance	$7,200
Employee would still be responsible for 20% co-insurance until out-of-pocket maximum is met. In this example, OOPM is $5,000; thus employee is responsible for remaining $3,400 in out-of-pocket expenses (copays and coinsurance).		*Employee would still be responsible for 10% co-insurance until out-of-pocket maximum is met. In this example, OOPM is $3,500; thus employee is responsible for remaining $2,700 in out-of-pocket expenses (copays and coinsurance).*	
In-Patient Hospitalization			
Blue Plan	**Amount**	**Gold Plan**	**Amount**
Negotiated Bill/EOB	$30,000	Negotiated Bill/EOB	$30,000
Facility Visit Copay	N/A	Facility Visit Copay	N/A
Employee 20% Co-insurance	$6,000	Employee 10% Co-insurance	$3,000
Employee responsibility	$5,000	Medical Plan 90% Co-insurance	$27,000
Medical Plan 80% Co-insurance, *Employee has met OOPM*	$25,000	*Employee would still be responsible for 10% coinsurance until out-of-pocket maximum is met. In this example, OOPM is $3,500; thus employee is responsible for remaining $500 in out-of-pocket expenses (co-pays and coinsurance).*	

USING CIGNA'S HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Cigna HDHP offers participants a broad choice of physicians and facilities, and coverage for current medical expenses and the opportunity to save for the future.

- You have the option of choosing a primary care provider (PCP) to guide your care.
- You can see a specialist without a referral.
- You are limited to doctors and health care facilities in the Cigna OAP network (no out-of-network coverage).
- Nationwide in-network coverage for emergency care.
- You pay an annual amount – a deductible – before your health plan begins to pay for covered health care costs. Only services covered by the health plan count toward the deductible.
- Once you meet your deductible, you will pay a portion of covered health care costs (20%) and the plan pays the rest.
- Once you meet the annual out-of-pocket maximum, your plan pays 100% of covered costs.
- In-network preventive care is covered by the plan at 100%.
- You have the option to contribute funds to a health savings account (HSA).

What is Co-insurance on the HDHP?

- Co-insurance is the cost-share between employee (20%) and plan (80%).

Out-Patient Surgical Procedure			In-Patient Hospitalization	
HDHP	Amount		HDHP	Amount
Negotiated Bill/EOB	$8,000		Negotiated Bill/EOB	$30,000
Deductible	$3,300		Deductible	$3,300
Remaining Balance	$4,700		Remaining Balance	$26,700
Employee 20% Co-insurance	$940		Employee 20% Co-insurance to OOPM	$1,700
Medical Plan 80% Co-insurance	$3,760		Medical Plan 80% Co-insurance + bill balance	$25,000
Employee would still be responsible for 20% co-insurance until out-of-pocket maximum is met. In this example, OOPM is $5,000; employee is responsible for remaining $760 in co-insurance.			*Employee pays $5,000; Plan pays $25,000. In this example, OOPM ($5,000) is met. Full "20%" would be $5,340, but capped at $1,700 because of OOPM.*	

Health Savings Account (HSA)

The CIGNA HDHP gives you the protection of a traditional health benefits and insurance plan, plus if you qualify, a tax-advantaged health savings account (HSA), a savings product that offers a different way for consumers to pay for their health care.

What is an HSA?

An HSA is a savings account that enables you to pay for current health expenses and save for future qualified medical (retiree) expenses on a tax-free basis. To be eligible to contribute to an HSA, you must be enrolled in a High Deductible Health Plan (HDHP) by the first of the month, and cannot be enrolled in any other medical plan:

- Must not be enrolled in Medicare (A, B or D) or TRICARE
- Must not be enrolled in a Full Purpose FSA (including a spouse's Full Purpose FSA)
- Must not be covered by spouse's medical or pharmacy plan
- Cannot be claimed as a dependent on another person's tax return

Decisions on how to spend the money in your HSA are made by you. Unused HSA contributions **carry over** from year to year and remain in the HSA for future medical expenses. There is no "use it or lose it" penalty like there is with Flexible Savings Accounts (FSAs). You have investment options when your HSA balance hits a $2,000 balance; you decide what types of investments to make with the money in the account in order to make it grow.

How Does an HSA Work?

The City will contribute up to **$500** to an employee's HSA if the employee elected employee-only coverage in the HDHP, and up to **$1,000** to an employee's HSA if they elected Employee & Spouse/Child(ren) or Family coverage in the HDHP. At hire, during Open Enrollment or following a qualifying event, you may choose to make an additional contribution to your HSA which would be taken out of your paycheck on a pre-tax basis. That money is available to pay for any qualifying medical expenses throughout the year.

If you choose to enroll in the HDHP, a bank account will automatically be opened for you at HSA Bank. Your HSA will be set-up the first of the month following your enrollment. HSA Bank will assign you an account number and provide a Welcome Brochure and debit card(s). HSA Bank places accounts in open status and will post contributions even if you have not completed the Customer Identification Process (CIP). If you do not provide required information within 60 days, HSA Bank will close your account and return the funds to you.

If you need medical care and visit a doctor, hospital, or emergency room, you will be responsible for the cost of the visit (minus network discounts). You can use funds in your HSA account to pay for that visit; you can reimburse yourself at the end of the year; or you can pay for the visit out of pocket and let your HSA funds grow.

You may contribute to a *Limited Purposed* Flexible Spending Account if you have an HSA account; however, the covered expenses are limited to those related to dental and vision care.

2025 Annual Contribution Limit Maximums

The total amount of City and employee contributions to an HSA may not exceed the annual limits established by the IRS, and will be pro-rated if you are not enrolled in the HDHP for the full plan year.

The IRS sets contribution limits each year.

- Employee-only coverage is $4,300; family coverage is $8,550.
- Catch up contribution for HSA accountholders who are 55 and older is $1,000.
- In order to make the maximum contribution in a calendar year you must meet all requirements to be eligible for HSA contributions on January 1 and remain qualified through December 1. If these criteria are not met, the maximum contribution is prorated for each month the individual is qualified.

Investment Options

- You must have $2,000 minimum in your HSA to invest (even if it dips below this in the future).
- Mutual Fund selection option managed by DEVENIR; self-directed brokerage option powered by TD Ameritrade. (trading fees may apply)
- Tax-free growth of interest or investment earnings.
- Investment options, balance information and much more are available on the HSA Bank website via **myCigna.com.**

VIRTUAL CARE

Both HSA and KelseyCare participants are eligible for TeleHealth through Cigna. Cigna provides covered employees with access to MDLive for immediate medical, dental and behavioral care.

You can connect with a board-certified doctor when, where and how it works best for you, via video or phone, without having to leave home or work, day or night, weekdays, weekends and holidays 24/7/365.

Medical Virtual Care

MDLive Telehealth visits can be a cost-effective alternative to an urgent care center, and cost less than going to the emergency room. With Cigna TeleHealth options, you can get the care you need, including most prescriptions, for a wide range of minor medical conditions. Examples include:

General Health				Pediatric
Acne	Diarrhea	Insect Bites	Respiratory Infections	Cold and Flu
Allergies	Earaches	Joint Aches	Sinus Infections	Constipation
Asthma	Fever	Nausea	Skin Infections	Earaches
Bronchitis	Headache	Pinkeye	Sore Throat	Nausea
Cold and Flu	Infections	Rashes	Urinary Tract Infections	Pinkeye

Behavioral Health Virtual Care

Licensed counselors and psychiatrists can diagnose, treat and prescribe medications for non-emergency behavioral/mental health conditions, including:

Behavioral Health				
Addiction	Depression	Life Changes	Parenting Issues	Stress
Bipolar Disorder	Eating Issues	Men's Issues	Postpartum Depression	Trauma/PTSD
Child/Adolescent Issues	Grief/Loss	Panic Disorders	Relationship Issues	Women's Issues

Costs and Access to Cigna TeleHealth

Costs will be based on what plan you are enrolled in:

- HSA participants will pay 30% coinsurance after meeting your deductible for Medical Care and Behavioral Health.
- KelseyCare participants will pay $40 for Immediate Medical Care and $10 for Behavioral Health.

You can access virtual services by calling MDLive directly at (888) 726-3171, or go to myCigna.com and follow these steps:

1. Log into myCigna.com
2. Go to Find Care & Costs
3. Scroll down to Talk to a Doctor, then click 'Learn More'
4. Select your type of service by clicking 'Continue' for Medical, Counseling or Dental
5. Next you will see the cost of the consultation/visit; click 'Connect' to make your selection
6. You will be connected to MDLive for Cigna
7. Select who the services are for
8. Select what type of service is needed: medical visit, wellness visit, therapist, psychiatrist (remember, these are for short term, immediate needs and not a long term service)

KelseyCare TeleMedicine

In addition to being able to participate in Cigna's TeleHealth program for medical and behavioral health virtual visits, KelseyCare provides convenient Video and E-visits directly to plan participants through myKelseyOnline.com. Kelsey-Seybold Telemedicine Services means you, or your child, can get convenient medical care for a number of conditions. Adult (18 years+) Video Visits can be conducted for 50 medical conditions. Pediatric Video Visits can be conducted for 24 medical conditions.

Please remember that KelseyCare participants must utilize Cigna's TeleHealth provider, MDLive, for virtual Behavioral Health services, and will pay $10 for a virtual visit (please see previous page).

Video Visits

Have a real-time conversation with a board-certified provider from your smartphone or iPad using the MyChart app or by logging in to your MyKelseyOnline account. Video Visits are available for primary care and a growing number of specialties including Endocrinology.

- Hours: 365 days a year - days, evening, and weekend hours
- Gold Plan Cost: $25 (primary care) or $50 (specialty) co-pay
- Blue Plan Cost: $35 (primary care) or $60 (specialty) co-pay

E-visits

Start an adult or pediatric E-visit by logging into your MyKelseyOnline account. You'll get a response in an hour or less.

- Hours:
  - Monday – Friday 8 am to 9 pm
  - Saturday & Sunday 10 am to 4 pm
- Cost: $15 fee (charges for E-visits don't accumulate towards the out of pocket maximum).

Access to KelseyCare TeleMedicine

You can access KelseyCare TeleMedicine services by calling 713.442.0427, or go to myKelseyOnline.com and follow these steps:

- Log into your MyKelseyOnline.com account and select Appointments/Schedule an Appointment. Select the Appointments option and then select the green bar at the bottom: "Schedule an Appointment".
- The next screen will have options for Appointment type: Select "I need a Video Visit – Primary Care"; "I need a Video Visit – Specialty"; or E-Visit.
- Select one of the conditions you need to be seen for and review the Virtual Healthcare consent terms and select "Accept" and Continue to proceed.
- Select a preferred location (the Clinic your physician or physician assistant is located) and click Continue. Note: You can select up to five clinic locations.
- Select a Provider you want to schedule with. Note: You can select up to 10 providers.
- Select a date and time, or select "All Available" to show all available appointment options and select the green "Continue" bar.
- Follow the steps to select an available appointment time for your visit. Add in any additional comments or details for the provider about your condition or symptoms and click "Make Appointment" to schedule the Video Visit.
- You will get an option to go to the Echeck-in page. You must complete the Echeck-in prior to your scheduled Video Visit.

PRESCRIPTION DRUG COVERAGE

Prescription drug benefits are provided by CIGNA. You have the choice of purchasing your prescriptions through retail pharmacies for a one-time prescription, 30-day or 90-day supply. You also have the option of the mail order program for a 90-day supply. Generic Maintenance Medications filled through mail order may not be subject to your annual deductible.

Retail Prescription Program

Members can now get up to 90-day supplies at participating pharmacies! Cost is 3x 30-day supply co-pay or cost. The retail prescription program utilizes a network of participating pharmacies; to receive the benefit, you must visit a CIGNA HealthCare Provider Network Pharmacy. Prescriptions filled at non-participating CIGNA HealthCare pharmacies, except in cases of Medical Emergency, are not covered.

Mail Order Prescription Program

Express Scripts Pharmacy is Cigna's home delivery pharmacy. The mail order drug program can be used to receive up to a 90-day supply of medication that you take on a regular basis (maintenance medication). Through mail order, a member can receive a 90-day supply for the cost of a 60-day. If you are interested in using the mail order drug program, you may log onto www.mycigna.com and you will be connected to the Express Scripts website.

Deductible on the KelseyCare Plan

You must meet an annual $200 (individual) or $400 (family) before the discounted copay schedule applies. The deductible will not apply to preventive drugs.

Your Prescription Drug Benefits under the HDHP

When you fill prescriptions, you pay the full discounted cost until your annual deductible ($3,300 individual; $6,000 family) is met. We have special rates with the pharmacies in our network, so you may save when you visit a participating pharmacy.

Step Therapy Requirement

Step therapy requires prior authorization requirement for all new brand-name prescriptions. In most cases, you must first try a less expensive drug on the plan's prescription formulary that has been proven effective for most people with the condition before you can move up a "step" to a more expensive drug.

A SaveOnSP (specialty medications savings program) is available to KelseyCare plan participants who have a medical condition, such as Hepatitis C, MS, Psoriasis, IBD, RA and cancer, and who use qualifying specialty medications to treat their conditions. You must enroll in the program to pay $0 for your medication. If you choose not to participate you will pay a higher copay when your fill your medication.

Planning for Prescription Costs

		OAP-HDHP w/HSA		KelseyCare Powered by Cigna	
In-network	**Retail (30/90-day supply)**	**Home delivery* (90-day supply)**	**Retail (30-day supply)**	**Retail (90-day supply)**	**Home delivery* (90-day supply)**
Tier 1 (Generics)	30 days - You pay $5 90 days – You pay $15	You pay $10	Gold: You pay $5 Blue: You pay $5	Gold: You pay $15 Blue: You pay $15	Gold: You pay $10 Blue: You pay $10
Tier 2 Preferred brand)	30 days - You pay $40 90 days – You pay $120	You pay $80	Gold: You pay $35 Blue: You pay $40	Gold: You pay $105 Blue: You pay $120	Gold: You pay $70 Blue: You pay $80
Tier 3 (Non-preferred brand)	30 days - You pay $80 90 days – You pay $240	You pay $160	Gold: You pay $70 Blue: You pay $80	Gold: You pay $210 Blue: You pay $240	Gold: You pay $140 Blue: You pay $160
Tier 4 (Specialty)	30 days - You pay $200 Ltd to 30-day supply	Limited to 30-day supply	Gold: You pay $150 Blue: You pay $200	Limited to 30-day supply	Limited to 30-day supply
Deductible**		$3,300 Individual / $6,000 Family Combined medical/pharmacy		$200 Individual / $400 Family Pharmacy only	
If you go out-of-network to fill your prescription medications, you'll pay 100% of the cost.					

How Does a Prescription Deductible Work?

The following example illustrates how the prescription deductible is applied.

Meet Karen: she is single, has heart disease, and is controlling her health through medication. She is on the KelseyCare Gold plan, and must meet her $200 prescription deductible before her copays kick in. This example assumes she is paying for a 30-day retail supply:

Medications Per Month	
January	
Medications	**Cost**
(2) Tier 1	$101
(1) Tier 3	$90
(1) Preventive	$35
100% of Cost	$226
What Karen Pays	
Deductible to be met	**$200**
(2) Tier 1	$101
(1) Tier 3	$90
(1) Preventive	$0
Deductible applied (to Tier 1 & 3)	$191
Total Due	**$191**

Medications Per Month	
February	
Medications	**Cost**
(2) Tier 1	$101
(1) Tier 3	$90
(1) Preventive	$35
100% of Cost	$226
What Karen Pays	
Deductible balance	**$9**
Deductible applied	$9
(2) Tier 1	$10
(1) Tier 3	$90
(1) Preventive	$0
Total Due	**$89**

Medications Per Month	
March	
Medications	**Cost**
(2) Tier 1	$101
(1) Tier 3	$90
(1) Preventive	$35
100% of Cost	$226
What Karen Pays	
Deductible balance	**$0**
(2) Tier 1 copays	$10
(1) Tier 3 copay	$70
(1) Preventive	$0
Total Due	**$80**

FLEXIBLE SPENDING ACCOUNTS (FSA)

Administered by WEX

Flexible Spending Accounts (FSAs) let you save taxes on the money you spend for eligible out-of-pocket health, dental and vision care, as well as dependent care expenses per IRS guidelines. If you enroll, you choose an annual amount you want to contribute. Your contributions are taken from your first and second paychecks each month throughout the plan year and deposited in your account. Since this money is taken out of your check before you pay taxes, you pay fewer taxes. There are three types of FSAs: Health Care or Limited-Purpose (if participating in an HSA), and Dependent Care.

To be eligible, you must incur the expense during the plan year (January 1, 2025 through December 31, 2025). You will have a 90-day grace period after the end of the plan year to submit claims for reimbursement. Money remaining in your FSAs after the 90-day grace will be forfeited. If you are separated from the City during the plan year, the date of separation then becomes the effective end of the plan year date.

The elections you make to your FSAs will remain in effect until December 31, 2025. You cannot change or stop your deductions during the year unless you have a Qualifying Event or Family Status change.

Health Care FSA **-** The maximum amount you can contribute to this account is $3,300 per year.

The Health Care FSA is used to pay for eligible out-of-pocket expenses, such as:

- ✓ Deductibles, coinsurance and copays for medical, dental and vision coverage
- ✓ Retail and mail-order prescription copays
- ✓ Any IRS deductible expense not covered by a health plan
- ✓ Certain over-the counter medicines

Limited Purpose FSA **-** The maximum amount you can contribute to this account is $3,300 per year.

If you are contributing to an HSA you can also be enrolled in a FSA with specific limitations on reimbursement. This is called a Limited Purpose FSA. Eligible expenses for a Limited Purpose FSA are limited to dental and vision care:

- ✓ Deductibles, coinsurance and copays for dental and vision coverage
- ✓ Contact Lenses and Prescription Glasses
- ✓ Eye Exams
- ✓ Lasik Eye Surgery
- ✓ Vision Screenings
- ✓ Eye Drops
- ✓ Fillings and Crowns
- ✓ Dentures
- ✓ Orthodontics

Dependent Care FSA **-** The maximum amount you can contribute to the Dependent Care FSA is $5,000 per household (individual or married filing a joint tax return) or $2,500 (if you are married filing separate tax returns).

Dependent Care FSA can reimburse your eligible day care expenses for a dependent who lives with you, and who is under age 13 (or any age if disabled). You must claim this person as a dependent for Federal income tax purposes. Also, you may be reimbursed only for care that enables you to work or look for work on a full-time basis. You can't be reimbursed for care provided by your spouse, your child under age 19, or someone you claim as a dependent.

Filing Claims for Reimbursement

When you file a Dependent Care claim, you are only reimbursed up to the amount in your account at the time you file your claim. For instance, if you have incurred $300 in expenses, but you have only $200 in your account, you will be reimbursed only $200 at the time. Once other deposits are made, you will then receive the remaining $100.

FSA or Tax Credit?

A child-care tax credit is available on your federal income tax return. Expenses you pay through the Dependent Care FSA reduce the tax credit you may claim. Ask a tax advisor which is better for you.

MEDICAL ELIGIBLE EXPENSES (HSA AND FSA)

Acid Controller / Antacids	Learning Disability
Acupuncture	Long-Term Care
Alcoholism	Medical Records Charge
Ambulance	Medical Services
Artificial Limb	Medications (Prescription and OTC)
Bandages	Nursing Services & Home Care
Breast Reconstruction Surgery	Operations
Birth Control Pills	Optometrist
Braille Books and Magazines	Organ Donors
Capital Expenses - ramps, rails, etc.	Osteopath Fees
Car - special design	Oxygen
Chiropractor	Pain Relievers
Christian Science Practitioner	Pregnancy Test kit
Coinsurance / Copays	Prosthesis
Contact Lenses	Psychiatric Care
Counseling	Psychoanalysis
Crutches	Psychologist
Deductibles	Special Education
Dental Treatment (not teeth whitening)	Sterilization
Diagnostic Devices	Stop-Smoking Programs
Disabled Dependent Care Expenses	Surgery
Drug Addiction - inpatient treatment	Telephone for hearing-impaired
Eyeglasses	Therapy
Eye Surgery	Transplants
Fertility Treatment	Transportation - for medical care
Guide Dog or Other Animal	Vasectomy
Hearing Aids	Virtual Care
Home Improvements - ramps, lifts, etc.	Vision Correction Surgery
Hospital Services	Weight-Loss Program
Laboratory Fees	Wheelchair

PLEASE VISIT
https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/
FOR A COMPLETE DETAILED LIST OF QUALIFIED MEDICAL EXPENSES.

DENTAL BENEFITS

The City offers comprehensive dental coverage through both a Dental HMO (DHMO) plan and a Dental PPO (DPPO) plan. The plans are offered by CIGNA HealthCare.

- On the DPPO plan, you can visit any dentist. When you choose a CIGNA network dentist, you will receive services at discounted rates. Plus, the network dentist agrees to accept CIGNA's contracted fees – so you won't receive any surprise charges above reasonable and customary rates.
- On the DHMO plan, you can only visit dentists in the DHMO network. You will be responsible for the applicable copay at the time of service.

Below is a summary list of DPPO and DHMO benefits.

Benefits	Cigna DHMO	Cigna DPPO (your plan pays)
Type I – Preventive Services • Oral examinations (2 Per Year) • X-rays • Cleanings (2 Per Year)	$5 Office Visit Copay See Patient Charge Schedule*	No Deductible / 100%
Type II – Basic Services • Fillings • Extractions • Root Canal	See Patient Charge Schedule	80% after Deductible
Type III – Major Services • Crowns • Removable / fixed bridge-work • Partial or complete dentures	See Patient Charge Schedule	50% after Deductible
Type IV – Orthodontia • Evaluation • Adult Braces • Children Braces	$67 $2,376 for 24-mo. treatment $2,040 for 24-mo. treatment	50% up to $2,000
Annual Deductible		
Individual	N/A	$100
Family	N/A	$300
Annual Maximums		
Dental Annual Maximum	N/A	$2,000
Orthodontia Lifetime Maximum	N/A	$2,000
Network Website www.mycigna.com	DHMO Network	DPPO Network

**The DHMO Patient Charge Schedule can be found on SLIC.*

Cigna Virtual Dental Care

If you need dental care and are unable to reach your regular provider, you now have the option to consult with a licensed dentist through a video call, 24 hours a day, seven days a week, 365 days a year. A dentist will help you address urgent dental situations like toothaches, infection, swelling, bleeding and more. Identifies whether more involved procedures are needed, and helps guide care. If necessary, a dentist will prescribe medication to be filled at your local pharmacy.

Claims are processed as in-network claim on your plan, with no copay or coinsurance costs (but does apply to your plan's annual maximum, if applicable). To access Cigna Dental Virtual Care, just log on to your **myCigna.com** account and follow the prompts to the virtual care portal.

Cigna Dental Oral Health Integration Program

If you're living with a certain chronic condition or if you are pregnant, the Cigna Dental Oral Health Integration Program provides reimbursement for certain dental services that help combat gum disease and tooth decay. The program is for people with certain medical conditions with a higher risk of oral health issues. There's no additional cost for the Oral Health Integration Program – if you qualify, you get reimbursed.

Who qualifies?

If you have a Cigna dental plan, you're eligible for the program. You do NOT have to be enrolled in a Cigna medical plan to be eligible for this program. You must be treated by a doctor for any of the following conditions:

- Heart Disease
- Diabetes
- Chronic kidney disease
- Radiation for head or neck cancers
- Sjogren's syndrome
- Parkinson's disease
- Huntington's disease
- Stroke
- Pregnancy
- Organ transplants
- Rheumatoid arthritis
- Lupus
- Amyotrophic lateral sclerosis (ALS)
- Opioid misuse and addiction

If you have Cigna medical and dental coverage, have a diagnosis for a certain chronic health condition and have not seen a dentist in over seven months, Cigna will reach out and remind you to make an appointment.

How to enroll?

To be reimbursed, you first have to enroll in the Cigna Dental Oral Health Integration Program by either:

- Going to **myCigna.com**, selecting Coverage > Dental and filling out the registration form online
- Requesting a registration form from your HRBP and returning the completed form to Cigna
- Calling the number on the back of your Cigna ID card and asking for a mailed registration form

What is the reimbursement process?

1. Go to your dentist and pay the copay or coinsurance for the covered treatment.
2. If your dentist is in the Cigna network, they'll send us a claim for reimbursement. If your dentist isn't in the Cigna network, you might need to submit the claim.
3. Cigna will review the claim and mail reimbursements for eligible dental services in about 30 days.

VOLUNTARY VISION COVERAGE

The City offers a voluntary Vision plan to all eligible employees administered by CIGNA HealthCare. The Vision plan offers access to a large network (EyeMed) of participating eye care providers and offers discounts on lenses, frames and contact lenses. Effective January 1, 2024, Cigna replaced their previous network, VSP, with EyeMed.

You can choose your own eye doctor, but you will get the most savings when you stay in the Cigna Vision network. If you choose to see an eye doctor who is out-of-network, you will pay the full cost of the service at the time of the appointment, then submit a claim form to get reimbursed for covered charges.

There is no claim paperwork necessary when you receive care in-network. You pay your plan copay(s) and any amount over the plan allowances and costs for non-covered services. You may have to pay extra if you choose certain cosmetic or elective eyewear options. Before selecting your eyewear, ask your provider what items are fully covered by the plan.

Cigna Vision Benefits	In-Network	Out-of-Network
Vision Exam (once every calendar year)	Covered in Full after $10 copay	$45 Allowance
Lenses (once every calendar year)		
• Single Vision	Covered in Full after $20 copay	$32 Allowance
• Bifocal Lenses	Covered in Full after $20 copay	$55 Allowance
• Trifocal Lenses	Covered in Full after $20 copay	$65 Allowance
• Lenticular Lenses	Covered in Full after $20 copay	$80 Allowance
Frames Allowance (once every 24 months)	$130 Wholesale	$71 Retail
Contact Lenses (once every calendar year)*		
• Necessary	Covered in Full	Up to $210
• Elective	$130 Allowance	$105 Allowance

**Copays do not apply to contact lenses and contact lens exams.*

BASIC LIFE AND AD&D BENEFITS

The City of Sugar Land provides Basic Life and AD&D (Accidental Death and Dismemberment) insurance for you as a full-time employee. If you would like to purchase additional life insurance for yourself and your dependents, please see the Supplemental Life Insurance page for more information. The life plan includes additional benefits such as travel resources, will preparation, and legal, financial and grief counseling. Please contact your HR Business Partner or OCHs for additional information.

Beneficiary Designation

- ✓ You MUST designate a beneficiary for your basic life and AD&D insurance when you become eligible for coverage. Your "beneficiary" is the person (or people, estate, trust, etc.) who will receive your life insurance benefits if you die.
- ✓ If you do not name a beneficiary, or if your beneficiary dies before you, benefits will be paid to your estate.
- ✓ Remember, you can update your beneficiary at any time by submitting a new beneficiary form to HR.

BASIC LIFE/AD&D BENEFITS	OCHs
Basic Life & AD&D Schedule	1 X Annual Salary ($50,000 Minimum)
Guarantee Issue Amount	1 X Annual Salary ($50,000 Minimum)
Minimum Amount	$50,000
Employee Age Reduction Schedule	50% @ Age 70
Waiver of Premium	Included
Conversion	Included
Portability	Included

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

SUPPLEMENTAL LIFE AND AD&D INSURANCE

Not everyone's personal situation is the same; your family needs may be different from the needs of your coworkers. In recognition of these differences, the City of Sugar Land offers supplemental, voluntary benefits, which you can purchase at group rates.

When you elect supplemental life insurance coverage, you are also electing accidental death and dismemberment insurance (AD&D) in the same amount. New elections and increases (outside of the one-time special enrollment period) to coverage are subject to Evidence of Insurability (EOI) – see below.

You may purchase supplemental term life insurance coverage for yourself, your spouse and/or children, even if you do not have supplemental life yourself.

Coverage Amounts

You may buy supplemental life and AD&D insurance for you and your eligible dependents, as follows:

- ✓ Employee: You can elect in $5,000 increments up to maximum coverage level of $750,000. Any coverage over the $250,000 guaranteed issue amount (when you are newly eligible) will require EOI.
- ✓ Spouse: You can elect in $5,000 increments up to maximum coverage level of $250,000. Any coverage over the $50,000 guaranteed issue amount (when newly eligible) will require EOI.
- ✓ Child: You can elect $10,000 or $15,000 for eligible dependent child(ren) from birth up to age 26. EOI is not required for children.

If you and your spouse are both employed by the City, only one of you can elect dependent life insurance coverage for any eligible dependent children. Also in this situation, spouse dependent life insurance coverage is not available to you or your spouse.

When is Evidence of Insurability (EOI) Required?

- ✓ Employees and/or their spouses wishing to newly elect or increase coverage during open enrollments (eg., November 1-15, 2024 for the 2025 plan year) require EOI.
- ✓ If you previously waived coverage and wish to enroll or increase your coverage following a qualifying event, any amount you elect requires EOI.

Supplemental Life and AD&D Insurance Rates

Supplemental Child Life and AD&D is $1.10/month for $10,000 coverage; $1.65/month for $15,000 coverage.

The monthly rates for both employee and spouse – per $1,000 of supplemental life coverage – are listed below. Please note that for current employees, rates depend on age as of January 1st of the plan year; for newly hired employees and/or qualifying event changes, rates depend on age at the time of the qualifying event.

AGE RATED PREMIUMS (Rates based on Employee/Spouse)	Employee & Spouse Rates (Per $1,000)	AGE RATED PREMIUMS (Rates based on Employee/Spouse)	Employee & Spouse Rates (Per $1,000)
Up to Age 29	$0.081	50-54	$0.319
30-34	$0.084	55-59	$0.519
35-39	$0.101	60-64	$0.585
40-44	$0.141	65-69	$1.069
45-49	$0.221	Age 70 & older	$1.754

Note: There is no age reduction for supplemental life.

Beneficiary Designation

- ✓ You are automatically the beneficiary for any supplemental life insurance and AD&D you elect for your spouse and/or children.
- ✓ You MUST designate a beneficiary for **your** life insurance and AD&D insurance when you elect coverage. Your "beneficiary" is the person (or people, estate, trust, etc.) who will receive your life insurance benefits if you die while coverage is in effect.
- ✓ If you do not name a beneficiary, or if your beneficiary dies before you, benefits will be paid to your estate.
- ✓ Remember, you can update your beneficiary anytime by submitting a new beneficiary form to HR.

Calculating Your Supplemental Life and AD&D Costs

To calculate your monthly cost for Supplemental life and AD&D insurance, use the following formula: Your Supplemental Coverage Amount/$1,000 x Your Monthly Rate. Follow these steps to calculate your monthly Supplemental life and AD&D insurance coverage cost:

EMPLOYEE SUPPLEMENTAL LIFE AND AD&D	
1. Enter the amount of coverage you want to elect	$
2. Divide above amount by $1,000	$
3. Enter your monthly rate per $1,000 of coverage from the age rated premiums chart	$
4. Multiply the amount in (2) by the amount in (3) This is your **monthly** cost for supplemental life and AD&D coverage.	$
REPEAT 1-4 FOR SPOUSE RATE	

SHORT-TERM DISABILITY

Short-Term Disability coverage is available for you – you will pay a premium based on your weekly salary and the option you select. In the event you become disabled from a non-work-related injury or sickness, the plan will pay 70% of your base weekly salary.

SHORT TERM DISABILITY BENEFITS	SYMETRA
Percentage of Base Weekly Salary	70%
Weekly Maximum	$1,500
Maximum Benefit Duration	Up to 90 Days
Accident/Illness Benefit Begins (Option A)	Day 31
Accident/Illness Benefit Begins (Option B)	Day 8/Day 15

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

Option A has a 30-day elimination period following the onset of a disabling illness or injury before benefits will be begin.

Option B has a 14-day elimination period following the onset of a disabling illness, and a 7-day elimination period following the onset of a disabling injury, before benefit will begin.

Calculating Your Short-Term Disability

To calculate your monthly cost for STD insurance, use the following formula:

Option A: Your Weekly Salary Amount x 70% / $10 x $0.197 = monthly rate

Option B: Your Weekly Salary Amount x 70% / $10 x $0.288 = monthly rate

LONG-TERM DISABILITY (LTD)

The City provides eligible full-time employees with Long-Term disability (LTD) coverage. In the event you become disabled, the plan will pay 60% of your monthly base earnings. The City provides this benefit at no cost to you.

How LTD Coverage Works

Benefits begin after 90 calendar days of continuous disability (your "elimination period"). LTD benefits replace 60% or 66 ²/₃% of your basic monthly earnings (depending on your employment category) to a maximum monthly benefit of $12,000.

To qualify for benefits, you must provide satisfactory proof that you are totally disabled due to an injury or illness. Benefit payments will continue provided you continue to meet the criteria set forth by the insurance City.

Your disability payments will be combined with, and offset by, other disability income you receive (social security, worker's compensation, state disability, etc.) so that your monthly payments total your eligible percentage of your "basic earnings."

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program (EAP) is available to all employees and household members through Aetna's Resources for Living. **EAP staff members are available 24 hours a day, 7 days a week, every day of the year.** The EAP is paid for by the City of Sugar Land. It is a **completely confidential** counseling program that covers issues such as:

- Depression / Stress
- Drug / Alcohol Abuse
- Emotional Problems
- Family/Relationship Problems
- Financial Pressures
- Grief Issues
- Legal Consultation
- Financial Services & Referral
- Other Personal Concerns

Aetna's **Resources for Living** - Call 1-888-238-6232 (TTY: 711) to speak with a live person 24/7 with little to no wait time. Access to Aetna's network of experienced counselors in your area, and all members of the household are covered. Staff members are highly trained professionals with experience in family, personal, work-related and substance abuse issues, and they can direct you to the resources within your community and online tools. You and your household members have up to **12 free counseling sessions** available to you per incident, per year.

Resources for Living also partners with Talkspace to offer text/chat therapy session options for members 5 days/week. Common reasons clients seek help include anxiety, depression, stress, grief, relationships, PTSD and management of physical health issues. To get started, visit **Talkspace.com/rfl** and select "Get Started."

If you have questions, please contact your People Success Partner. **Website:** resourcesforliving.com **Password: TBA**

RETIREMENT PROGRAMS

TEXAS MUNICIPAL RETIREMENT SYSTEM (TMRS)

All eligible full-time employees contribute 7% of gross pretax earnings to TMRS. The City matches your contribution 2 to 1. After 5 years of service, you are considered to be vested. At that point, you are eligible to retire at age 60 or with 20 years of service, any age.

Texas Municipal Retirement System
1.800.924.8677
www.tmrs.org

457 DEFERRED COMPENSATION PLANS

The 457 plans, managed by MissionSquare Retirement (formerly ICMA-RC) and Dearborn & Creggs, allow you to contribute additional monies to a tax deferred retirement plan, as well as an after-tax ROTH 457 plan, up to $23,500 (plus an additional $7,500 if you will be age 50 or older) in 2025. You can contribute a flat amount per pay period.

Dearborn & Creggs
281.277.6400
www.dearborncreggs.com

MissionSquare
1.800.669.7400
www.missionsquare.org

You select the funds in which you want to invest. You can also join a plan and change your contribution level at any time during the course of your employment.

VOLUNTARY LEGAL ACCESS PLAN

The City offers voluntary prepaid legal benefits through LegalShield. This plan is designed to meet the most common legal needs encountered by employees and their families. Plan benefits include preventive legal services, moving violation representation, pretrial and trial assistance, identity theft protection and IRS legal services. You must contact your Legal Shield representative, Alicia Ward, to enroll or make changes: Alicia@aliciaward.com or call: 817-607-8868

VOLUNTARY ACCIDENT, CRITICAL ILLNESS & HOSPITAL INDEMNITY PLANS

Employees can voluntarily elect to purchase (through post-tax payroll deduction) Accident, Critical Illness (including Cancer) & Hospital policies for themselves and their eligible dependents through AFLAC. AFLAC is different from health insurance; it's insurance for daily living. While major medical insurance pays doctors and hospitals, Aflac pays cash benefits directly to you. Benefits are paid regardless of any other coverage you may have - even workers' compensation. Most claims are paid within four days and with One Day Pay, eligible claims can be paid in just a day when you submit them online. You can use the money however you see fit. For more information about the AFLAC policies available, please contact your People Success Partner or review the plans on the People & Culture Benefits page on SLIC. You can now enroll in Accident, Critical Illness and Hospitalization coverage through Benefit Connector. Questions regarding these group Aflac plans can be directed to Michelle Baxter at 864-733-1527 or email mbaxter@aflac.com.

To make changes to your existing individual Cancer plan, you should reach out to Nicole Hutchinson at 409-200-4862 or email nicole_franklin@aflac.com.

PET INSURANCE

Pet Insurance is a financial safety net for your furry family. It permits you to get reimbursed for accidents and illness, so you don't have to worry about cost, and can focus on care.

What Spot Pet Covers*: Emergency Visits, Lab Fees, Behavioral Problems, X-rays and Tests, Surgeries, Cancer and Much More
**Note: preexisting conditions are NOT covered—see website for all exclusions.*

How Spot Pet Works:

1. Visit any licensed vet in the US or Canada
2. Submit your claim online, in the app or via fax
3. Get paid back for eligible vet bills for covered conditions

Contact Spot Pet Insurance to Select your Plan, Get a Quote, Enroll and Pay for Insurance:

Visit: https://spotpet.link/sugarland

Or call: 1-800-905-1595

Use Priority Code: 0101SUGARLAND

CONTACT INFORMATION

For questions about your City of Sugar Land benefits, please contact your People Success Partner:

For Benefits Questions, Contact:			
Nina Stephens	SR People Success Partner	281-275-2152	nstephens@sugarlandtx.gov
Kim Dzierzanowski	People Success Partner	281-275-2735	kdzierzanowski@sugarlandtx.gov
Janet Lawrie	Deputy Director of P&C	281-275-2211	jlawrie@sugarlandtx.gov
Mary Aleman	Leave Solutions Partner	Teams	maleman@sugarlandtx.gov

If you have specific questions about a City of Sugar Land benefit plan, please contact the Benefits Administrator listed below:

BENEFIT	ADMINISTRATOR/ PROVIDER	PHONE	WEBSITE/EMAIL
Medical & Prescription Drugs	CIGNA	1-800-244-6224	www.mycigna.com
KelseyCare HMO **Dedicated Scheduling Line**	Kelsey Seybold	713-442-0000 Scheduling: 713-442-9191	www.mykelseyonline.com
Mail-Order Pharmacy	Express Scripts	1-800-835-3784	www.mycigna.com
Dental – DHMO & DPPO	CIGNA	1-800-244-6224	www.mycigna.com
Vision Plan	CIGNA	1-877-478-7557	www.mycigna.com
Life, AD&D & Supplemental Life Claims	OCHs/Securian	Claim number: 1-888-658-0193 Port/Conversion: 1-866-365-2374	www.ochsinc.com
Short Term and Long Term Disability	Symetra	Questions: 1-877-377-6773	www.symetra.com LADCLA@symetra.com
Flexible Spending Accounts	WEX	1-877-765-8810	www.WEX.com
Employee Assistance Program (EAP)	Resources for Living	1-888-238-6232	resourcesforliving.com
Legal Access Plan	LegalShield Rep: Alicia Ward	1-800-972-9272 1-817-607-8868	www.legalshield.com Alicia@aliciaward.com
Group Accident, Critical Illness & Hospital Indemnity Plans	Aflac Rep: Michelle Baxter	1-800-433-3036 864-733-1527	cscmail@aflac.com groupclaimfiling@aflac.com
Individual Cancer Plan	Aflac Rep: Nicole Hutchinson	409-200-4862	Nicole_franklin@usaflac.com
Pension Plan	Texas Municipal Retirement System	1-800-924-8677	www.TMRS.org
Retirement Savings Programs (457 Plans)	Dearborn and Creggs Mission Square	281-277-6400 1-800-669-7400	www.dearborncreggs.com www.missionsq.org

REQUIRED HEALTH COVERAGE NOTICES

For Your Files

This brochure contains legal notices that are required to be distributed to participants in group health plans sponsored by the City of Sugar Land. The notices included in this brochure are:

- Notice of Availability of HIPAA Notice of Privacy Practices
- Notice of Privacy Practices that provides you with notice of the City of Sugar Land's legal duties and privacy practices with regard to your protected health information.
- Medicare Part D Notice that provides information about how your current prescription drug coverage under the City of Sugar Land health care plans is affected—and your options for coverage—when you become eligible for Medicare.
- COBRA Rights Notice that explains when you and your family may be able to temporarily continue coverage under the City of Sugar Land health plans if coverage would otherwise end for you.
- Newborn & Mothers Health Protection Notice that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.
- Women's Health and Cancer Rights Act that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.
- Expanded Coverage for Women's Preventive Care that explains how the City covers women's preventive care, including contraceptives, under the Affordable Care Act.
- Patient Protection Disclosure that explains who you and your family can designate as a primary care provider under the health plans and rules around access to obstetrical/gynecological care.
- Paperwork Reduction Act Notice
- Tax Forms for 2025 related to medical plan participation and coverage.
- CHIP Notice that explains premium assistance under Medicaid and the Children's Health Insurance Program.
- Notice of Special Enrollment Rights that explains when you can enroll in the plan due to special circumstances.
- Health Insurance Marketplace Coverage Options
- Your rights under Genetic Information Nondiscrimination Act (GINA)
- Nondiscrimination Notice explains that the City of Sugar Land complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- Wellness Program Disclosure (HIPAA & EEOC) which explains what the City of Sugar Land Wellness plan entails and how your health information will be used and protected.

Notice of Availability of HIPAA Notice of Privacy Practices

City of Sugar Land
2700 Town Center Blvd. North
Sugar Land, TX 77479

1/1/2025
To: Participants in the City of Sugar Land Health Plan
From: People and Culture
Re: Availability of Notice of Privacy Practices

The City of Sugar Land Health Plan (each a "Plan") maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact People and Culture, at: 2700 Town Center Blvd. North, Sugar Land, TX 77479, (281) 275-2735, pkutchka@sugarlandtx.gov.

Notice of Privacy Practices

The City of Sugar Land is required by law to maintain the privacy of your protected health information and to provide you with notice of its legal duties and privacy practices with regard to your protected health information. As your group health plan, the City of Sugar Land must use and disclose protected health information in order to pay benefits to you and your health care providers. The City of Sugar Land uses physical, electronic, and procedural safeguards to protect your personal information from being used or disclosed inappropriately. This notice describes how medical information about you may be used, disclosed and how you can get access to this information. Please review it carefully.

Frequently Asked Questions

1. What is protected health information? -- Protected health information is individually identifiable health information that is transmitted or maintained in writing, electronically, orally, or by any other means. It includes information created or received by the City of Sugar Land that identifies a person and relates to the person's participation in the plan, the person's physical or mental health, the provision of health care services to that person, or the payment of health care services received by the person.

2. How does City of Sugar Land use and disclose protected health information? -- The most common use of protected health information by the City of Sugar Land is for treatment, payment, and health care operations. The City of Sugar Land also may disclose protected health information to health care providers, other health plans, and health care clearinghouses for treatment, payment, and health care operations. (Health care clearinghouses are organizations that assist in electronic claims transactions.) The City of Sugar Land may also disclose protected health information to a business associate if the business associate needs the information to perform treatment, payment, or health care operations on the City of Sugar Land's behalf. Health care providers, other health plans, health care clearinghouses, and the City of Sugar Land's business associates are all required to maintain the privacy and confidentiality of the protected health information they receive from the City of Sugar Land. All uses and disclosures of protected health information made by the City of Sugar Land for treatment, payment, and health care operations are kept to the minimum necessary to accomplish the intended purpose.

3. What are treatment, payment, and health care operations? -- Treatment is the provision, coordination, or management of health care and related services. An example of a disclosure of protected health information for treatment is when your family doctor refers you to a specialist.

Payment includes City of Sugar Land activities such as billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review, and pre-certification of health care services. For example, the City of Sugar Land may tell a doctor whether you are eligible for coverage and what percentage of the bill the City of Sugar Land will pay.

Health care operations include quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, and other activities necessary to create or renew health plans. It also includes disease management, case management, conducting or arranging for medical review, legal services, auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, City of Sugar Land may use information from your claims to contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

4. How else does the City of Sugar Land use and disclose protected health information? -- The City of Sugar Land may use or disclose protected health information, when permitted or required by law, as follows:

- Directly to you or your personal representative. A personal representative is a person who has legal authority to make health care decisions on your behalf. In the case of a child under 18 years of age, your personal representative may be a parent, guardian, or conservator. In the case of an adult, a personal representative may be a person who has a durable power of attorney to make health care decisions in the event you are incapacitated.
- To the Secretary of the U.S. Department of Health and Human Services to investigate or determine the City of Sugar Land's compliance with privacy regulations.
- To your family member, other relative, close personal friend, or other person identified by you that is directly involved in your care. Such disclosures will be limited to information relevant to the person's involvement in your care and, except in the case of an emergency or your incapacity, you will be given an opportunity to agree or to object to the disclosure.
- For public health activities.
- To report suspected abuse, neglect, or domestic violence to public authorities.
- To a public oversight agency.
- When required for judicial or administrative proceedings.
- When required for law enforcement purposes.
- To organ procurement organizations or other organizations to facilitate organ, eye, or tissue donation or transplantation.
- To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties required by law.
- To a funeral director when permitted by law and when necessary for the funeral director to carry out his/her duties with respect to the deceased person.
- To avert a serious threat to health or safety.
- For specialized government functions, as required by law.
- When otherwise required by law.
- Information that has been de-identified. This means that all individual identifiers have been removed and it is reasonable to believe that the organization receiving the information will not be able to identify the person to whom the information belongs.

5. Can I keep the City of Sugar Land from using or disclosing my protected health information for any of these purposes? -- You have the right to make a written request that the City of Sugar Land not use or disclose your protected health information for certain purposes, unless the use or disclosure is required by law. However, since most of the uses and disclosures made by the City of Sugar Land are necessary to administer your health plan, the City of Sugar Land does not have to agree to your request.

6. Are there any other circumstances when the City of Sugar Land may use or disclose protected health information? -- The City of Sugar Land may not use or disclose your protected health information for any purpose not included in this notice, unless the City of Sugar Land first receives your written authorization. To be valid, an authorization must include: the name of the person or organization making the disclosure, the name of the person or organization receiving the disclosure, specifics on the information that may be disclosed, the purpose of the disclosure, and an end date or end event. You may revoke any authorization that you make. A revocation must be made in writing and will not apply to any information disclosed before the City of Sugar Land receives the revocation.

7. Will Group & Pension Administrators (GPA) disclose my protected health information to my employer? -- The City of Sugar Land health plan is administered by GPA. However, the City of Sugar Land is prohibited from using or disclosing any protected health information for employment-related activities, if the protected health information was received or created while the City of Sugar Land was acting as your group health plan.

8. Can I find out if my protected health information has been disclosed to anyone? -- You may make a written request to the City of Sugar Land's Privacy Officer for an accounting of any disclosures of your protected health information made during the six years prior to receipt of your request. The accounting will not include any disclosures made for treatment, payment, or health care operations; any disclosures made directly to you; any disclosures made based upon your written authorization; any disclosures reported on a previous accounting; or any disclosures made before April 14, 2004.

Generally, the accounting will be provided within 60 days of the date the City of Sugar Land receives your written request. However, the City of Sugar Land is allowed an additional 30 days if the City of Sugar Land notifies you, in writing, of the reason for the delay and notifies you of the date by which you can expect the accounting.

If you request more than one accounting within a 12-month period, the City of Sugar Land may charge a reasonable, cost-based fee for each additional accounting.

9. Can I view my protected health information maintained by the City of Sugar Land? -- You may make a written request to inspect, at the City of Sugar Land offices, your enrollment, payment, billing, claims, and case or medical management records maintained by the City of Sugar Land. You also may request paper copies of your records. If you request paper copies, the City of Sugar Land may charge a reasonable, cost-based fee for the copies. Requests to view your protected health information should be made in writing to:

City of Sugar Land	2700 Town Center Blvd. North	
Paula Kutchka, Director of People and Culture	Sugar Land, TX 77479	281-275-2735

10. If I review my protected health information and find errors, how do I get my records corrected? -- You may request that the City of Sugar Land amend any of your protected health information that the City of Sugar Land maintains. All requests for amendment must be made to the City of Sugar Land's Privacy Officer, must be in writing, and must include a reason for the amendment. Please be aware that the City of Sugar Land can amend only the information that it creates. If your request is to amend information that the City of Sugar Land did not create, the City of Sugar Land will need a statement from the individual or organization that created the information explaining an error was made. For example, if you request a claim be amended because the diagnosis is incorrect, the City of Sugar Land will amend the claim if the City of Sugar Land made an error in the data entry of the diagnosis. However, if your health care provider submitted the wrong diagnosis to the City of Sugar Land, the City of Sugar Land cannot amend the claim without a statement from your health care provider that the diagnosis is incorrect.

The City of Sugar Land has 60 days after it receives your request to respond. If the City of Sugar Land is not able to respond, it is allowed one 30-day extension. If the City of Sugar Land denies your request, either in part or in whole, the City of Sugar Land will send you a written explanation for the denial. You may then submit a written statement disagreeing with the City of Sugar Land's denial and have that statement included in any future disclosures.

11. I'm covered as a dependent and do not want anything that includes my protected health information mailed to the covered employee's address. Will you do that? -- If mailing communications to the covered employee's address could place you in danger, the City of Sugar Land will accommodate your request to receive communications of protected health information by alternative means or at alternative locations. Your request must be reasonable, must be in writing, must specify an alternative address or other method of contact, and must include a statement that sending communications to the covered employee's address could place you in danger.

12. If I believe my privacy rights have been violated, how do I make a complaint? -- If you believe your privacy rights have been violated, you may make a complaint to the City of Sugar Land in writing at:

City of Sugar Land	2700 Town Center Blvd. North
Paula Kutchka, Director of People and Culture	Sugar Land, TX 77479
281-275-2735	

Also, you may file a complaint with the U.S. Department of Health and Human Services at:

U.S. Department of Health and Human Services 200 Independence Avenue, S.W.
Hubert H. Humphrey Building Washington, D.C. 20251

The City of Sugar Land will not retaliate against you for filing a complaint.

13. When are the privacy practices described in this notice effective? -- This privacy notice has an effective date of January 1, 2025.

14. Can the City of Sugar Land change its privacy practices? -- The City of Sugar Land is required by law to abide by the terms of the privacy notice currently in effect. The City of Sugar Land reserves the right to change its privacy practices and to apply the changes to any protected health information the City of Sugar Land received or maintained prior to the effective date of the change. The City of Sugar Land will (describe how revised notices will be distributed) any revised notice of privacy practices. The City of Sugar Land will distribute the notice to covered employees before the effective date of any changes. Also, the City of Sugar Land will maintain its current privacy notice on its web site at: www.sugarlandtx.org.

15. What happens to my protected health information when I leave the plan? -- The City of Sugar Land is required to maintain your records for at least six years after you leave the City of Sugar Land's group health plan. However, the City of Sugar Land will continue to maintain the privacy and confidentiality of your protected health information even after you leave the plan.

16. How can I get a paper copy of this notice? -- To request that the City of Sugar Land mail you a paper copy of this notice, call 281-275-2735.

17. Who can I contact for more information on my privacy rights? -- Write to:

City of Sugar Land 2700 Town Center Blvd. North
Paula Kutchka, Director of People and Culture Sugar Land, TX 77479
281-275-2735

Medicare Part D Notice

Important Notice from City of Sugar Land About 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 Sugar Land (the "Plan Sponsor") 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. The Plan Sponsor has determined that the prescription drug coverage offered by the City of Sugar Land Health 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 Plan Sponsor coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the person listed at the end of this notice for more information about what happens to your coverage if you enroll in a Medicare Part D prescription Drug Plan.

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 Plan Sponsor 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 the Plan Sponsor 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 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).

Date: 1/1/*2025*
Name of Entity/Sender: City of Sugar Land
Contact-Position/Office: Paula Kutchka, Director of People and Culture
Address: 2700 Town Center Blvd. North, Sugar Land, TX 77479
Phone Number: (281) 275-2735

COBRA Rights Notice

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to City of Sugar Land, and that bankruptcy results in the loss of coverage

of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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 People and Culture.

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[1] 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

People and Culture at 2700 Town Center Blvd. North, Sugar Land, TX 77479, (281) 275-2735, pkutchka@sugarlandtx.gov.

[1] **https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods**.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not 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 delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

Women's Health and Cancer Rights Act of 1998

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provide benefits for mastectomy-related service, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment for complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles, co-pays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact the City of Sugar Land medical plan administrator at 281-275-2735 for more information.

Expanded Coverage for Women's Preventive Care

Under the Affordable Care Act, the City provides female plan participants with expanded access to recommended in-network preventive services, including contraceptives, without cost sharing.

Additional women's preventive services that will be covered without cost sharing requirements include:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- Contraception and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- STI counseling, and HIV screening and counseling
- Domestic violence screening

For a description of what these items include, visit: https://www.healthcare.gov/what-are-my-preventive-care-benefits/women/.

Patient Protection Disclosure

City of Sugar Land Health Plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Paula Kutchka, Director of People and Culture at 2700 Town Center Blvd N., Sugar Land, TX - 77479, 281 - 275-2735, pkutchka@sugarlandtx.gov.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from City of Sugar Land Health Plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Paula Kutchka, Director of People and Culture at 2700 Town Center Blvd N., Sugar Land, TX 77479, 281-275-2735, pkutchka@sugarlandtx.gov.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20250 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137. OMB Control Number 1210-0137 (expires 12/31/2025)

Tax Forms 2025

You will use form 1095-C in conjunction with your W-2 to file your taxes for 2024. The 1095-C form describes what coverage your employer made available to you, but does not subject you to additional taxes. The form is intended only to report to the IRS the medical coverage offered to you by your employer.

• Effective January 1, 2014, the "individual mandate" provision under Health Care Reform (also known as individual shared responsibility) requires every individual to have minimum essential health coverage for each month, qualify for an exemption, or pay a penalty when filing his or her federal income tax return.

• The employer shared responsibility provisions (also known as "pay or play") require large employers—generally those with at least 50 full-time employees, including full-time equivalent employees (FTEs)—to offer affordable health insurance that provides a minimum level of coverage to full-time employees or pay a penalty tax if any full-time employee is certified to receive a premium tax credit for purchasing individual coverage on the Health Insurance Marketplace (Exchange).

CHIPRA/CHIP Notice

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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024 Contact your State for more information on eligibility:

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672

IOWA – Medicaid and CHIP (Hawki)	MISSOURI – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE - Medicaid**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access (https://dvha.vermont.gov/members/medicaid/hipp-program) Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
OREGON – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid and CHIP	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

Employee Benefits Security Administration

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

Centers for Medicare & Medicaid Services

U.S. Department of Health and Human Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Notice of Special Enrollment Rights

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 no later than 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 no later than 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have 60 days after the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event and provide the employer plan with timely notice of the event and your enrollment request. You must contact People and Culture within 30 days of qualifying life event.

To request special enrollment or obtain more information, contact City of Sugar Land, Department of People and Culture at 281-275-2735.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income. [1, 2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **People and Culture at 2700 Town Center Blvd. North, Sugar Land, TX 77479**, **(281) 275-2735**, pkutchka@sugarlandtx.gov.

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.

[1] *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.

3. Employer name City of Sugar Land	4. Employer Identification Number (EIN) 74-6027491
5. Employer address, 7. City, 8. State, 9. Zip Code 2700 Town Center Blvd. North, Sugar Land, TX 77479	6. Employer phone number (281) 275-2735
9. Who can we contact about employee health coverage at this job? Paula Kutchka, Director of People and Culture	
11. Phone number (if different from above) (281) 275-2735	12. Email address pkutchka@sugarlandtx.gov

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

○ As your employer, we offer a health plan to:

☒ All full-time active eligible employees.

○ With respect to dependents:

☒ We do offer coverage to all eligible dependents. Eligible dependents are:

- ✓ Your legal spouse (must provide a copy of your marriage certificate or documentation of common law marriage).
- ✓ Your children (must provide a copy of the birth certificate). Children up to age 26. Coverage will end the last day of the month your child turns 26. "Children" are defined as your natural children, stepchildren, legally adopted children, and children under your legal guardianship. If your child is no longer eligible, you must notify the City by contacting the People and Culture Department.
- ✓ Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested and disability has to have occurred prior to age 26.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

NOTE: 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.

GINA (Genetic Information Nondiscrimination Act)

The City of Sugar Land is an Equal Opportunity Employer. It is the policy and intent of the City that all qualified persons, regardless of race, color, religion, sex, sexual orientation, age, genetic information, national origin, marital status, physical, or mental disability, or veteran status are entitled to equal employment opportunity. Further, it is the policy of the City to make reasonable accommodations for the employment of disabled persons. Equal Opportunity shall be observed in all aspects of the employment relationship, such as recruitment, hiring, work assignment, termination, salary administration, transfer, promotion, compensation, selection for training, use of facilities, participation in employee activities, and related matters. We subscribe to a policy of equal opportunity not only because it is a legal requirement, but also because it is consistent with our basic beliefs. In support of these beliefs and philosophies, below is a partial listing of the federal statutes to which the City is committed to upholding:

- Title VII of the Civil Rights Act
- The Americans with Disabilities Act
- The Age Discrimination in Employment Act
- The Equal Pay Act
- The Civil Rights Act of 1866 and 1871
- The Civil Rights Act of 1991
- Genetic Information Nondiscrimination Act (GINA)

One of the major objectives of City of Sugar Land is to follow the spirit and the letter of the law and to maintain a reputation for high standards of business. Creative, enthusiastic employees are our most important resource and the basis for our success. We seek an environment characterized by respect for each individual, where cultural and ethnic diversity are blended by teamwork into a harmonious work force.

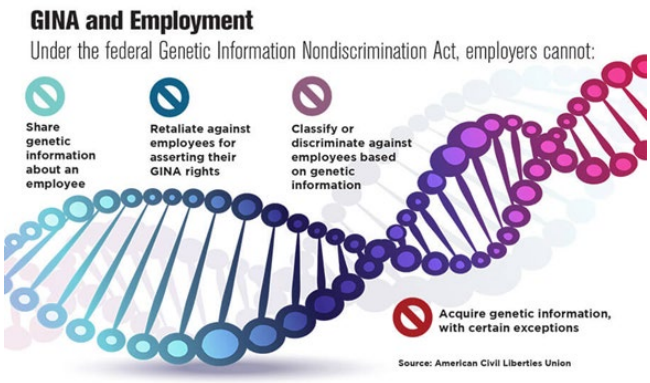
Guidelines

Equal employment opportunity is adopted to ensure the rights and dignity of each person. All persons shall enjoy the benefits of decisions which are free of harassment or discrimination on the grounds of race, religion, color, genetic information, national origin, physical, sensory or mental disability, marital status, sex, sexual orientation, age, or veteran status. We will ensure that both the spirit and intent of the laws prohibiting discrimination are fully implemented in all working relationships.

All employees share the responsibility for mutual understanding and a spirit of cooperation. Successful achievement can result only if each person acts to make equal opportunity a reality.

City of Sugar Land will not discriminate against an individual in the hiring, firing, compensation, terms, or privileges of employment on the basis of genetic information of the individual or family member of the individual. A family member is defined by the Genetic Information Nondiscrimination Act as the:

- ✓ spouse of the individual;
- ✓ a dependent child of the individual, including a child who is born to or placed for adoption with the individual; or
- ✓ parent, grandparent, or great-grandparent.



Nondiscrimination Notice

Discrimination is Against the Law - The City of Sugar Land complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The City of Sugar Land does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
If you need services such as written information in other formats or languages, or an interpreter, contact Paula Kutchka, Director of People and Culture. If you believe that the City of Sugar Land has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

City of Sugar Land

Paula Kutchka, Director of People and Culture
pkutchka@sugarlandtx.gov 281-275-2735
2700 Town Center Blvd. North
Sugar Land, TX 77479

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your HR Business Partner is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20251 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Wellness Notice

HIPPA Wellness Notice

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all participants. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact People and Culture at 2700 Town Center Blvd. North, Sugar Land, TX 77479, (281) 275-2735, ***pkutchka.sugarlandtx.gov*** and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status, if you are eligible for an alternate standard.

EEOC Wellness Notice

City of Sugar Land's wellness program through FitThumb is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, you will be asked to complete a voluntary health risk assessment or "HA" that asks a series of questions about your health-related activities and behaviors. You will also be asked to complete a biometric screening, or physical exam, which will gather information such as your height, weight, waist circumference or BMI, blood pressure, and will include a blood test to learn your total and HDL Cholesterol. You are not required to complete the HA or participate in the blood test or other medical examinations.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Paula Kutchka, Director of People and Culture at 281-275-2735.

Your results will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, we will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection

with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Paula Kutchka, Director of People and Culture at 2700 Town Center Blvd. North, Sugar Land, TX 77479.

NOTICE: THE BENEFITS DESCRIBED IN THE CITY OF SUGAR LAND BENEFITS GUIDE 2025 ARE FOR REPRESENTED EMPLOYEES ONLY. THIS BOOKLET GIVES YOU AN OVERVIEW OF THE MAIN FEATURES OF YOUR BENEFIT PLANS. THE PLANS ARE ADMINISTERED ACCORDING TO LEGAL PLAN DOCUMENTS AND INSURANCE CONTRACTS. ALTHOUGH WE'VE TRIED TO SUMMARIZE THE PROVISIONS OF THESE LEGAL DOCUMENTS CLEARLY AND ACCURATELY, IF ANY INFORMATION PRESENTED HERE CONFLICTS WITH THE LEGAL DOCUMENTS, THE LEGAL DOCUMENTS WILL ALWAYS GOVERN. FOR MORE DETAILED INFORMATION ON THE PLANS AND YOUR LEGAL RIGHTS UNDER THE PLANS, BE SURE TO READ THE SUMMARY PLAN DESCRIPTIONS ON SLIC OR REQUEST A COPY OF THE PLAN DOCUMENTS FROM THE DEPARTMENT OF PEOPLE & CULTURE. ALL BENEFIT PLANS ARE SUBJECT TO CHANGE FROM TIME TO TIME AND THE CITY OF SUGAR LAND RESERVES THE RIGHT TO AMEND OR CANCEL ANY BENEFITS DESCRIBED IN THIS BOOKLET, WITH OR WITHOUT NOTICE. YOU WILL BE NOTIFIED OF ANY CHANGES TO THESE PLANS AND HOW THEY AFFECT YOUR BENEFITS, IF AT ALL. THIS DOCUMENT DOES NOT GUARANTEE ANY BENEFITS AND IS NOT A CONTRACT.


CITY OF SUGAR LAND
TEXAS