2021-2022

EMPLOYEE BENEFITS

CITY OF KEENE TEXAS

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We all work together to make the City of Keene a success, and our teamwork extends to your benefits. Your health and well-being are important to us, so we provide benefit options to make your and your family's lives better. Together, let's invest in you. Read over this guide for details on your 2021-2022 benefits from A to Z. If you have questions, your Human Resources Department department is here to help.

See **page 23** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to City of Keene. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

ELIGIBILITY & ENROLLMENT

The City of Keene offers a variety of benefits to support your and your family's needs. Choose options that cover what's important to your unique lifestyle.

Eligibility

If you are a full-time employee of the City of Keene who is regularly scheduled to work at least 30 hours a week, you are eligible to participate in the **medical, dental, vision, life and disability plans and additional benefits.**

When Does Coverage Begin?

Your elections are effective the first of the month following 30 days of employment. You won't be able to change your benefits until the next enrollment period unless you experience a qualifying life event.

Eligible Dependents

Dependents eligible for coverage in the City of Keene benefits plans include:

- Your legal spouse (see spousal exclusion information)
- Your common-law spouse where applicable (documents filed with the courthouse with proof of common-law marriage will be required)
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility is required upon enrollment.

Working Spouse Exclusion

If your spouse has access to healthcare coverage through their employer, they are not eligible for City of Keene coverage. If your spouse does not work, is not eligible for coverage, or has lost coverage as an active employee, the spousal exclusion does not apply.

Note: The company reserves the right to verify if your spouse is provided coverage elsewhere. We expect this information to be consistent with the information you report. Misrepresenting whether your spouse has access to medical coverage may result in disciplinary action.

Thoughts & Tips: You CANNOT change your benefit selections during the plan year unless you have a qualifying life event, such as marriage and/or the birth or adoption of a child.

Enroll Now. You've Got One Shot!

What are **Qualifying Life Events?**

Most people know you can change your benefits when you start a new job or during Open Enrollment. But did you know that changes in your life may permit you to update your coverage at other points in the year? Qualifying Life Events (QLEs) determined by the IRS could allow you to enroll in health insurance or change your elections outside of the annual time.

Common qualifying events include:

A change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility

A change in your legal marital status (marriage, divorce or legal separation)

Entitlement to Medicare or Medicaid

A change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)

Eligibility for coverage through the Marketplace

A change in your spouse's employment status (resulting in a loss or gain of coverage)

Changes in your address or location that may affect the coverage for which you are eligible

Some lesser-known qualifying events are:

Turning 26 and losing coverage through a parent's plan

Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Death in the family (leading to change in dependents or loss of coverage)

When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Keep in mind your change in coverage must be consistent with your change in status.

Questions regarding specific life events and your ability to request changes should be directed to the City of Keene's Human Resources Department. Don't miss out on a chance to update your benefits!

PREPARING FOR OPEN ENROLLMENT

As a committed partner in your health, the City of Keene absorbs a significant amount of your benefit costs. Your contributions for medical, dental and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Please note that employee contributions vary depending on level of coverage. Typically, the more coverage you have, the higher your portion.

You may select any combination of medical, dental and/or vision plan coverage. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of the City of Keene, must elect coverage for yourself in order to elect any dependent coverage.

Open Enrollment To-Do

Update your personal information.

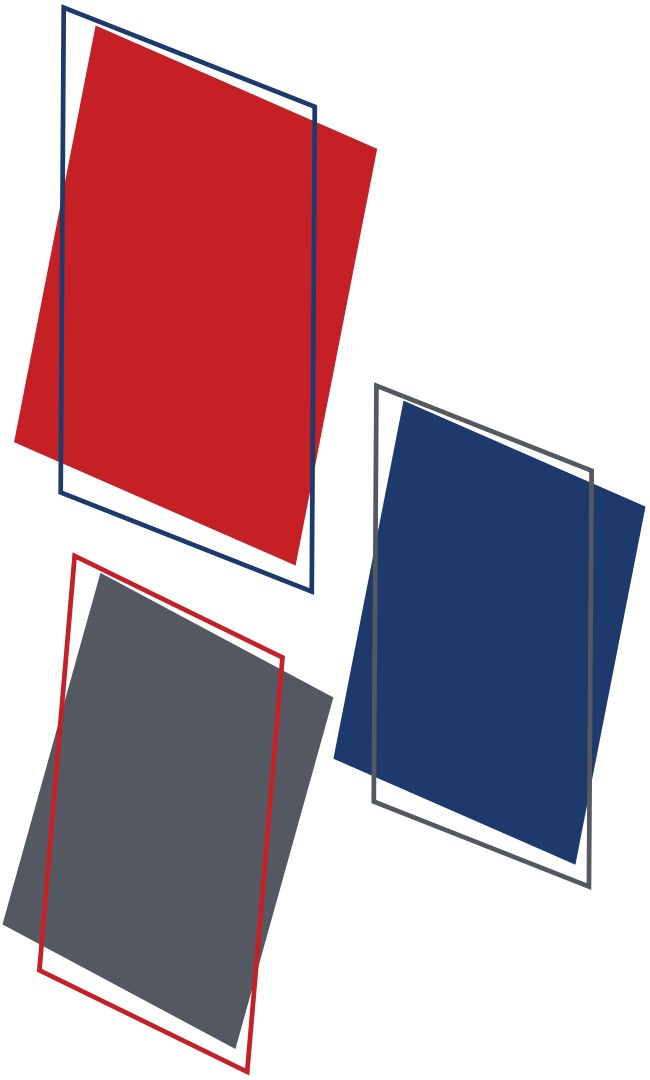
If you've experienced a qualifying life event in the last year, you may need to change your elections or update your details.

Double-check covered and restricted medications.

Consider your FSA.

An FSA can help cover healthcare costs including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals.

Check to see if your pharmacy is in-network.



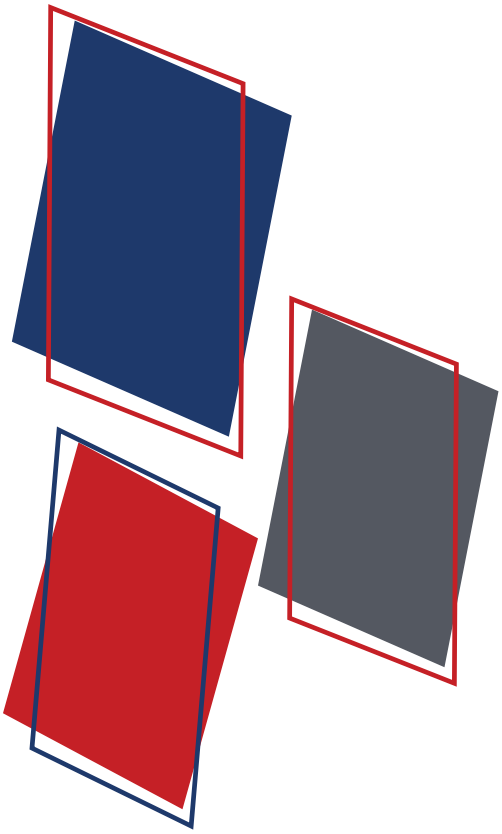
MEDICAL BENEFITS

Medical benefits are provided through BlueCross BlueShield of Texas. Choose the plan that works best for your life. Consider the physician networks, premiums and out-of-pocket costs for each plan. Keep in mind your choice is effective for the entire 2021-2022 plan year, unless you have a qualifying life event.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your semi-monthly contributions.

	BCBS MEDICAL PLAN
SEMI-MONTHLY CONTRIBUTIONS	
EMPLOYEE ONLY	$0.00
EMPLOYEE + SPOUSE	$125.11
EMPLOYEE + CHILD(REN)	$88.53
EMPLOYEE + FAMILY	$228.58



How to Find a Provider

Visit www.bcbstx.com or call Customer Care at 800-445-2227 for a current list of BCBSTX network providers.

Thoughts & Tips: **Most preventive care offered by an in-network physician is covered at 100%.**

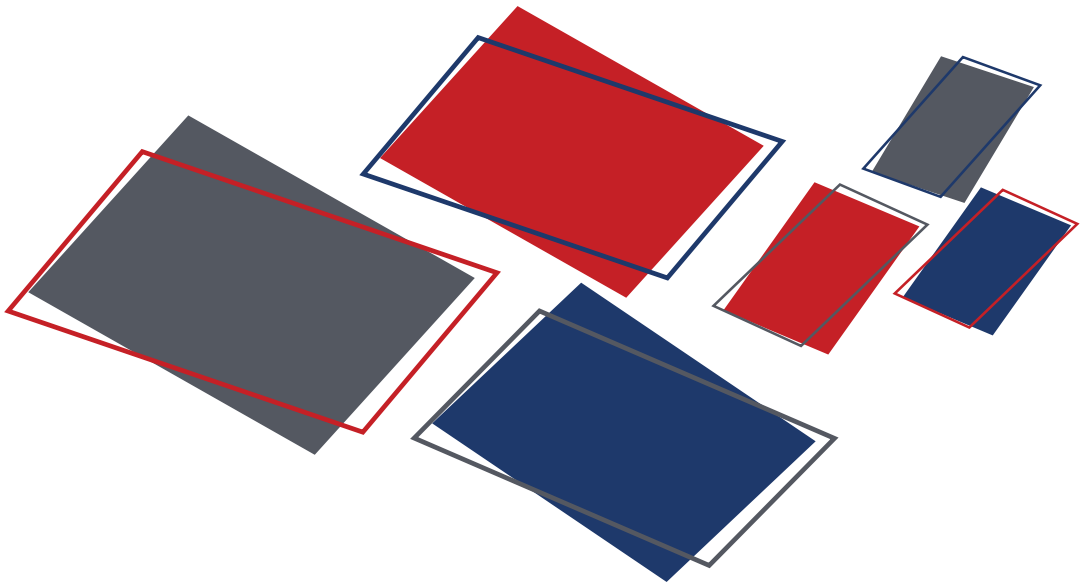
Medical Plan Summary

This chart summarizes the 2021-2022 medical coverage provided by BCBSTX. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

BCBS MEDICAL PLAN

	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$500	$1,000
FAMILY	$1,500	$3,000
COINSURANCE (PLAN PAYS)	80%	60%
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)		
INDIVIDUAL	$3,000	Unlimited
FAMILY	$9,000	Unlimited
COPAYS/COINSURANCE		
PREVENTIVE CARE	100%	60%*
PRIMARY CARE	$30 copay	60%*
SPECIALIST SERVICES	$60 copay	60%*
URGENT CARE	$75 copay	60%*
DIAGNOSTIC CARE	80%*	60%*
EMERGENCY ROOM	80% after $500 copay*	60%*

*After Deductible



VIRTUAL MEDICINE

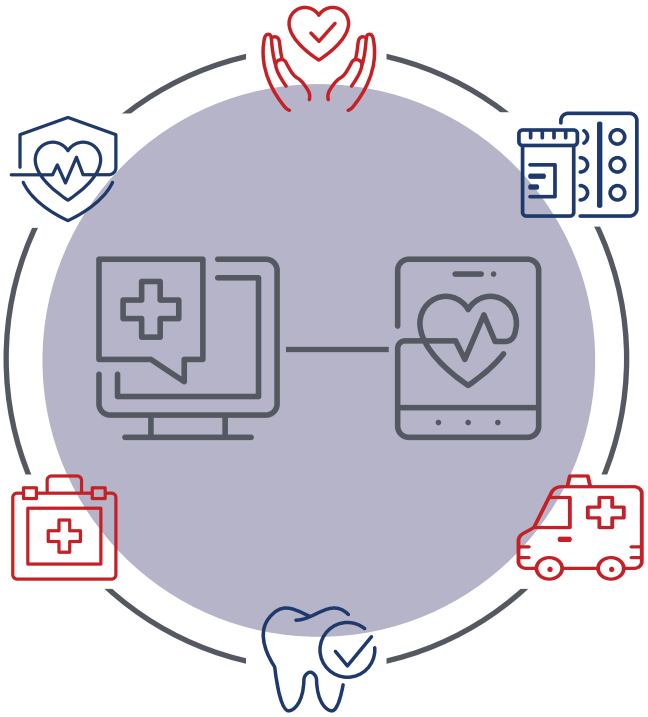
When you're sick, the last thing you want to do is leave the cozy comfort of your home. Or sometimes you're just too on the go to pop in for a visit. Virtual medicine is a convenient and easy way to talk to a doctor fast.

Telemedicine

Telemedicine with BCBSTX lets you see and talk to a doctor from your phone, tablet or computer without an appointment. Most visits take about 10-15 minutes, and doctors can write a prescription (in participating states). Try telemedicine when your doctor is not available or you're traveling.

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Bladder infection/ Urinary tract infection
- Bronchitis
- Cold/flu
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache



Access telemedicine:

- Log in to MDLive.com/BCBSTX to learn more
- Call MDLIVE (888-680-8646)
- Download the MDLIVE app from Google Play™ or the Apple® App Store®

OUT-OF-POCKET COSTS

Deductible

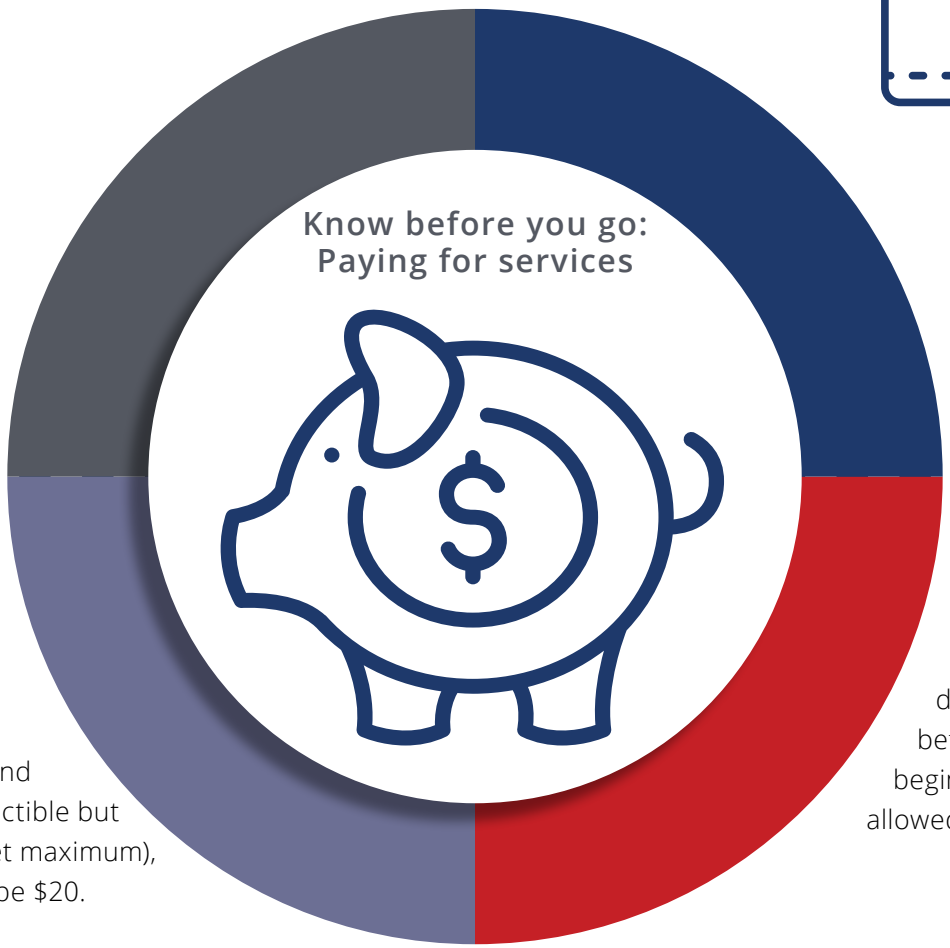
The amount you must pay for covered services before your insurance starts paying its portion.

UP TO DEDUCTIBLE

YOU PAY 100%

Copay

The fixed amount you pay for healthcare services at the time you receive them.



Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 80% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

% YOU PAY

% PLAN PAYS

UP TO THE OUT-OF-POCKET MAXIMUM

AFTER DEDUCTIBLE IS REACHED

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

AFTER OUT-OF-POCKET MAXIMUM IS REACHED

PLAN PAYS **100%** THROUGH END OF PLAN YEAR

PREVENTIVE CARE

Most health plans are required to cover a set of preventive services — at no cost to you!

Screening tests and routine checkups are considered preventive, which means they're often paid at 100%. Keep up to date with your primary care physician to save time and money and keep yourself healthier in the long run. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

Wellness visits, physicals and standard immunizations

Screenings for blood pressure, cancer, cholesterol, depression, obesity and diabetes

Pediatric screenings for hearing, vision, obesity and developmental disorders

Anemia screenings, breastfeeding support and pumps for pregnant and nursing women

Iron supplements (for children ages 6 to 12 months at risk for anemia)

Take advantage of these covered services. However, remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. This means if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through BCBSTX. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.bcbstx.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Tier I, Tier II, Tier III or Tier IV. You may find information on your benefits coverage and search for network pharmacies by logging on to www.bcbstx.com or by calling the Customer Care number on your ID Card.

BCBS MEDICAL PLAN

	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)		
TIER I	$0/$10 copay	50% after copay
TIER II	$10/$20 copay	50% after copay
TIER III	$50/$70 copay	50% after copay
TIER IV	$100/$120 copay	50% after copay
MAIL ORDER RX (90-DAY SUPPLY)		
TIER I	$0 copay	No Benefit
TIER II	$30 copay	No Benefit
TIER III	$150 copay	No Benefit
TIER IV	$300 copay	No Benefit

Generic Drugs

Looking to save money on medication costs? You've most likely heard that generic prescription drugs are a more affordable option, so here's the skinny: Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety and strength. Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, **a generic version costs 80% to 85% less than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Note: Apps such as GoodRx and RxSaver let you compare prices of prescription drugs and find possible discounts. If you use these tools, make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. As a result, if you choose to use a discount card from an app such as GoodRx or RxSaver, the amount you pay will not count toward your deductible or out-of-pocket maximum under the benefit plan.

FLEXIBLE SPENDING ACCOUNTS

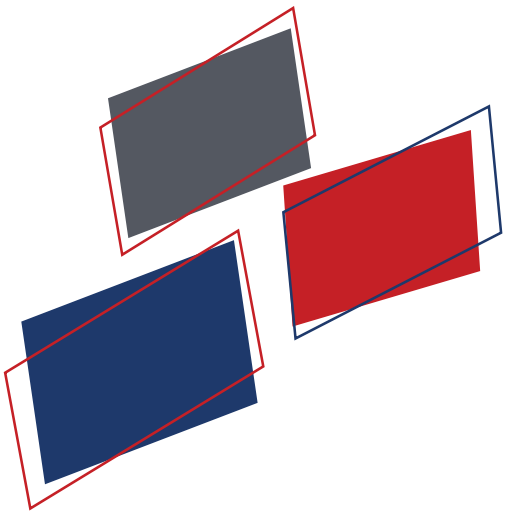
Flex your spending power! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $2,750 annually for qualified medical expenses (deductibles, copays and coinsurance) with pre-tax dollars, reducing your taxable income and increasing your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them without waiting for reimbursement.

Please note: Over-the-counter (OTC) drugs are not eligible for reimbursement through an FSA unless you have a prescription for them.

Thoughts & Tips: **Your FSA money can cover the cost of going to a chiropractor or acupuncturist, if your insurance doesn't already cover it.**



Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — whether or not you elect any other benefits. You can set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the principal place of residence as the employee for more than half the year may be a qualifying individual.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. Examples of eligible dependent care expenses include:

- In-home babysitting services (not provided by a tax dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

You can use your FSA debit card at doctor and dentist offices, pharmacies and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you attempt to use the card at an ineligible location.

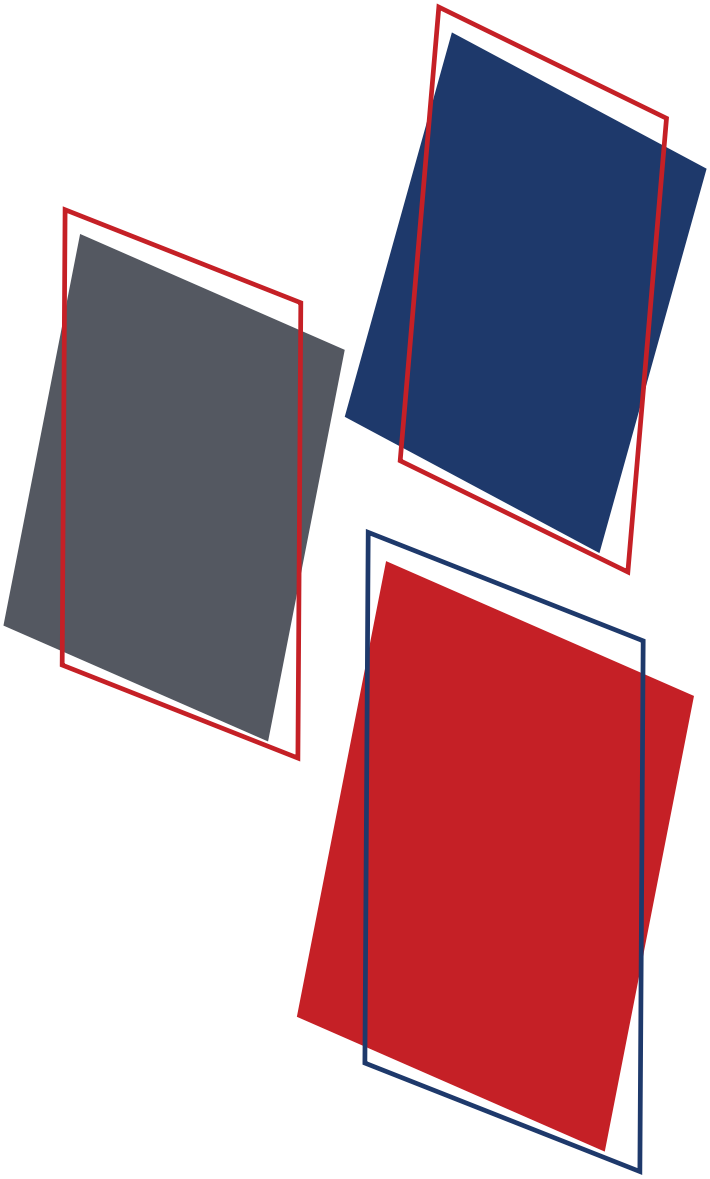
Once you incur an eligible expense, submit a claim form along with the required documentation. Contact StreamlineHR with reimbursement questions. If you need to submit a receipt, you will be notified by StreamlineHR. Always retain a receipt for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Without proof that an expense was valid, your card could be turned off and your expense deemed taxable.

General Rules and Restrictions

The IRS has the following rules and restrictions for Healthcare and Dependent Care FSAs:

- Expenses must be incurred during the 2021-2022 plan year.
- Dollars cannot be transferred between FSAs.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You cannot change your FSA election in the middle of the plan year unless you experience a qualifying life event.



DENTAL BENEFITS

Brushing your teeth and flossing are great, but don't forget to visit the dentist too! The City of Keene offers affordable plan options for routine care and beyond. Coverage is available from United Healthcare.

Network Dentists

If you use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit United Healthcare at www.uhc.com.

Dental Premiums

Premium contributions for dental are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your semi-monthly premium.

Dental Plan Summary

This chart summarizes the 2021-2022 dental coverage provided by United Healthcare.

	UHC LOW PLAN		UHC HIGH PLAN	
SEMI-MONTHLY CONTRIBUTIONS				
EMPLOYEE ONLY	$0.00		$9.35	
EMPLOYEE + SPOUSE	$7.93		$26.64	
EMPLOYEE + CHILD(REN)	$9.80		$32.03	
EMPLOYEE + FAMILY	$19.04		$52.38	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
CALENDAR YEAR DEDUCTIBLE				
INDIVIDUAL	$50	$50	$50	$50
FAMILY	$150	$150	$150	$150
CALENDAR YEAR MAXIMUM				
PER PERSON	$1,000	$1,000	$1,500	$1,500
COVERED SERVICES				
PREVENTIVE SERVICES	100%	100%	100%	100%
BASIC SERVICES	80%	80%	80%	80%
MAJOR SERVICES	0%	0%	50%	50%
ORTHODONTICS Dependent Child(ren) Only	Not covered		50%	
ORTHODONTIC LIFETIME MAXIMUM	Not covered		$1,500	

Thoughts & Tips: Only 60% of adults ages 20 to 64 have been to the dentist in the past year. Take advantage of your dental coverage to keep your smile healthy.

VISION BENEFITS

Don't wear glasses? Even you shouldn't skip an annual eye exam! The City of Keene provides you and your family access to quality vision care with a comprehensive vision benefit through United Healthcare.

Vision Premiums

Premium contributions for vision are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your semi-monthly premium.

Vision Plan Summary

This chart summarizes the 2021-2022 vision coverage provided by United Healthcare.

	UHC VISION PLAN		
SEMI-MONTHLY CONTRIBUTIONS			
EMPLOYEE ONLY	$0.00		
EMPLOYEE + SPOUSE	$3.51		
EMPLOYEE + CHILD(REN)	$4.66		
EMPLOYEE + FAMILY	$8.40		
	IN-NETWORK	**OUT-OF-NETWORK**	**FREQUENCY**
EXAMS			
COPAY	$10	Up to $40	Every 12 months
LENSES			
SINGLE VISION	$25	Up to $40	Every 12 months
BIFOCAL	$25	Up to $60	
TRIFOCAL	$25	Up to $80	
LENTICULAR	20% Discount at Box Stores - $25 Warby Parker	Up to $60	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
ELECTIVE	$105 allowance; or $25 - Up to 4 boxes of formulary contacts	Up to $105	Every 12 months
FRAMES			
ALLOWANCE	$130 Retail Frame allowance + 30% discount above allowance	Up to $45	Every 12 months

Thoughts & Tips: More than 150 million Americans use corrective eyewear to compensate for refractive errors.

SURVIVOR BENEFITS

It's difficult to think about what would happen if something ever happened to you, but it's important to have a plan in place to make sure your family is provided for. Survivor benefits provide financial protection and security in the event of an absence or unexpected event. Securing Life insurance now ensures your family will be protected for the future.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

The City of Keene provides employees with Basic Life and AD&D insurance as part of your basic coverage through BlueCross BlueShield of Texas, which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after death.

Your Basic Life and AD&D insurance benefit is $50,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

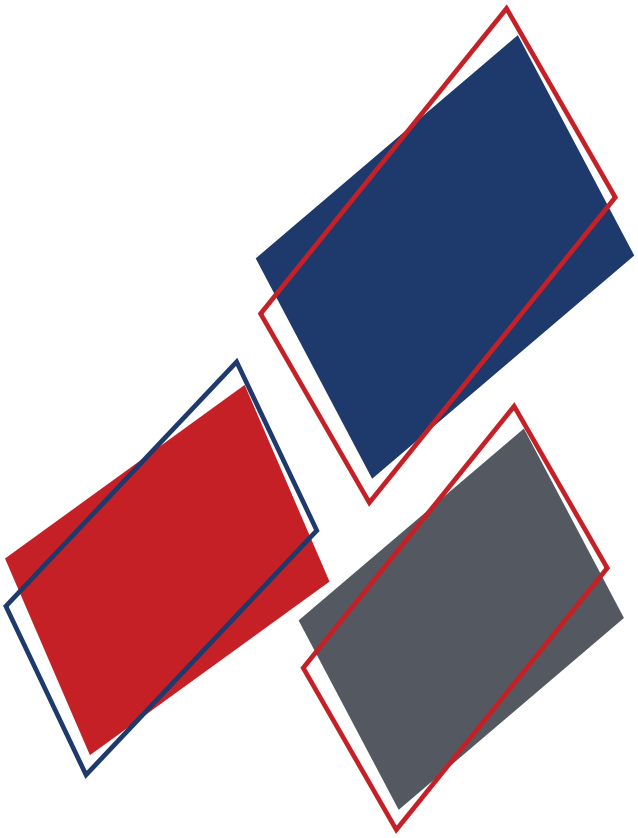
Also provided as part of your basic life coverage is spouse Basic Life coverage in the amount of $10,000. Basic Life for your child(ren) is provided in the amount of $5,000.

Voluntary Life and AD&D Insurance

Life and AD&D benefits are an important part of your family's financial security. The basic benefits provided to you by the City of Keene may not be enough to cover expenses in a time of need. Therefore, extra coverage is available to protect you and your family through Mutual of Omaha. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

What's a beneficiary? Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by the City of Keene. You receive the benefit payment for a dependent's death under the insurance.

Name a primary and contingent beneficiary to make your intentions clear. Make sure to indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches majority age at 18. If you need assistance, contact Human Resources Department or your own legal counsel.



Life/AD&D Plan Summary

This chart summarizes the 2021-2022 Life and AD&D coverage provided by BCBSTX and Mutual of Omaha.

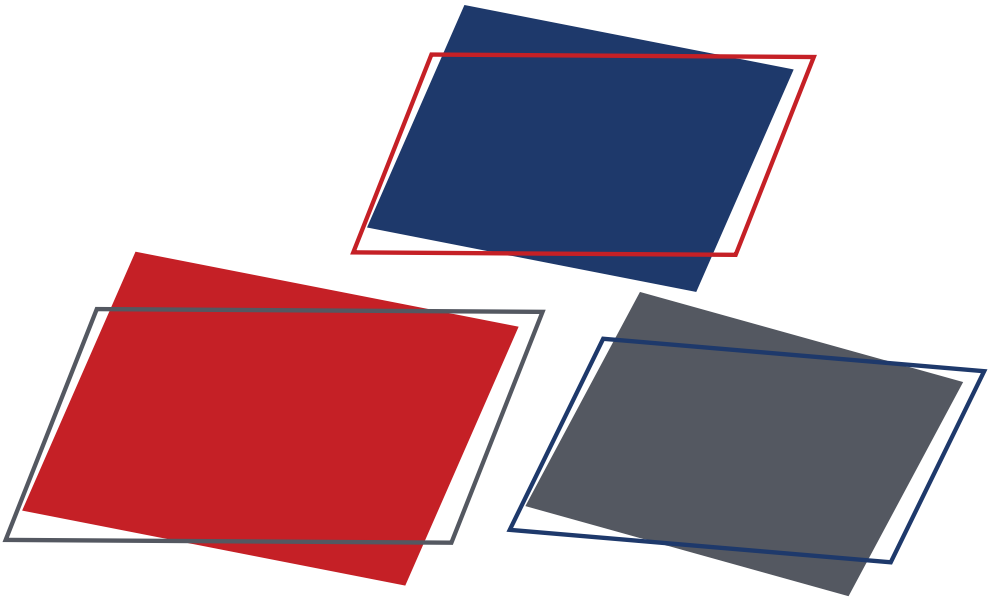
BASIC EMPLOYEE LIFE/AD&D (CITY PROVIDED)	
COVERAGE AMOUNT	$50,000
WHO PAYS	The City of Keene
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
CARRIER	BCBSTX
BASIC DEPENDENT LIFE/AD&D (CITY PROVIDED)	
COVERAGE AMOUNT	Spouse: $10,000; Child(ren): $5,000
WHO PAYS	The City of Keene
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
CARRIER	BCBSTX
VOLUNTARY EMPLOYEE LIFE	
COVERAGE AMOUNT	Increments of $10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	The lesser of $500,000 or 5x annual earnings
GUARANTEE ISSUE	$100,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Yes
CARRIER	Mutual of Omaha
VOLUNTARY SPOUSE LIFE	
COVERAGE AMOUNT	Increments of $5,000
WHO PAYS	Employee
MAXIMUM BENEFIT	The lesser of $100,000 or 100% of Employee amount
GUARANTEE ISSUE	$30,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Yes
CARRIER	Mutual of Omaha
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	Increments of $2,500
WHO PAYS	Employee
MAXIMUM BENEFIT	$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
CARRIER	Mutual of Omaha

Voluntary Life and AD&D Insurance Premiums

VOLUNTARY LIFE INSURANCE			
RATES/$1,000 (SEMI-MONTHLY)			
AGE	EMPLOYEE	AGE	SPOUSE
Under age 20	$0.09	Under age 20	$0.09
20-24	$0.09	20-24	$0.09
25-29	$0.10	25-29	$0.10
30-34	$0.11	30-34	$0.11
35-39	$0.14	35-39	$0.14
40-44	$0.19	40-44	$0.19
45-49	$0.29	45-49	$0.29
50-54	$0.45	50-54	$0.45
55-59	$0.70	55-59	$0.70
60-64	$0.94	60-64	$0.94
65-69	$1.51	65-69	$1.51
70-74	$2.52	70+	No Coverage
75-79	$7.42		
80-84	$7.42		
85+	$7.42		

VOLUNTARY CHILD LIFE INSURANCE
PREMIUM RATES – $1,000 SEMI-MONTHLY
$0.307

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:					
$	÷ 1,000 =	$	x Age Based Rate =	$	
Benefit Elected				Semi-Monthly Premium	



INCOME PROTECTION

Maintaining your quality of life counts on your income. The City of Keene offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury. A portion of your income is protected until you can return to work or until you reach retirement age.

Voluntary Short Term Disability (STD) Insurance

Short Term Disability (STD) benefits are available for purchase on a voluntary basis. STD insurance replaces 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources Department for details.

WEEKLY MAXIMUM BENEFIT	$1,000
ELIMINATION PERIOD	7 days
MAXIMUM BENEFIT PERIOD	26 weeks

Basic Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are available at no cost. LTD insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources Department for details.

MONTHLY MAXIMUM BENEFIT	$5,000
ELIMINATION PERIOD	180 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

VOLUNTARY STD	
RATES/$10 OF TOTAL WEEKLY BENEFITS (MONTHLY)	
AGE RANGE	**STD RATE**
<20-24	$0.462
25-29	$0.482
30-34	$0.540
35-39	$0.578
40-44	$0.295
45-49	$0.341
50-54	$0.467
55-59	$0.710
60-64	$1.017
65-69	$0.629
70-99	$0.302

TO CALCULATE HOW MUCH YOUR STD COVERAGE WILL COST:

$	÷ 52 =	$	x 60%	$	x STD Rate	$	÷ $10	$
Annual Salary		Weekly Income		Weekly Benefit		Amount		Monthly Premium

SUPPLEMENTAL HEALTH BENEFITS

The City of Keene offers several ways for you to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and is offered at discounted group rates.

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident Coverage, available through Mutual of Omaha, provides benefits for you and your covered family members if you have expenses related to an accidental injury. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help you pay deductibles, copays and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you to use as you wish.

The Accident insurance plan pays cash benefits to help with costs associated with out-of-pocket expenses and bills in the event of a covered accident:

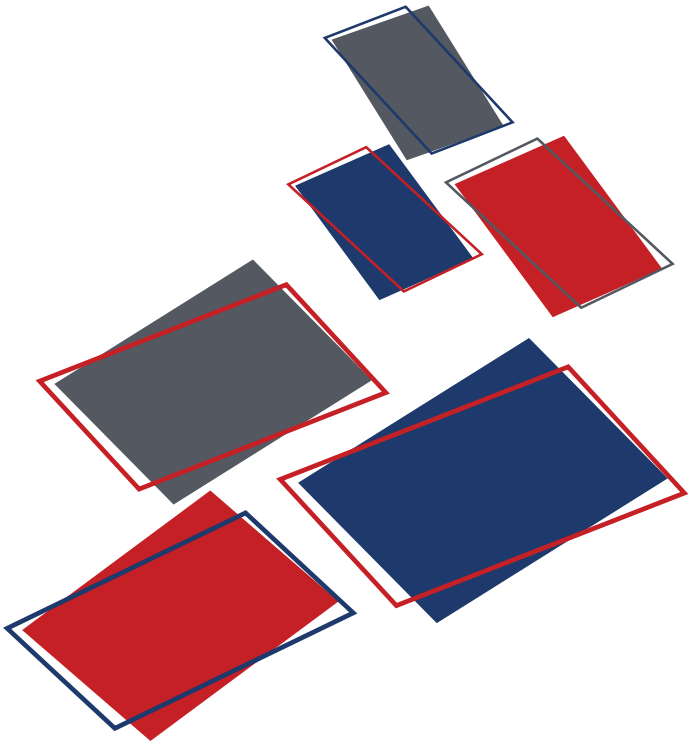
- Emergency Room Treatment - $150
- Hospital Admission - $1,000
- Intensive care unit - $400/day
- Ambulance transportation - $200
- Injuries - varies (for a schedule of payments for fractures, dislocations, lacerations, burns, etc., please reach out to HR for specific plan documents.)

Voluntary Accident Premiums

Voluntary Accident coverage is available to you for purchase on a voluntary basis. Your tier of coverage determines your semi-monthly premium.

VOLUNTARY ACCIDENT PLAN

SEMI-MONTHLY RATES	
EMPLOYEE ONLY	$7.35
EMPLOYEE + SPOUSE	$9.91
EMPLOYEE + CHILD(REN)	$10.92
EMPLOYEE + FAMILY	$13.48



Critical Illness Coverage

Critical Illness coverage through Mutual of Omaha pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like; for example: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home healthcare costs or any of your regular household expenses.

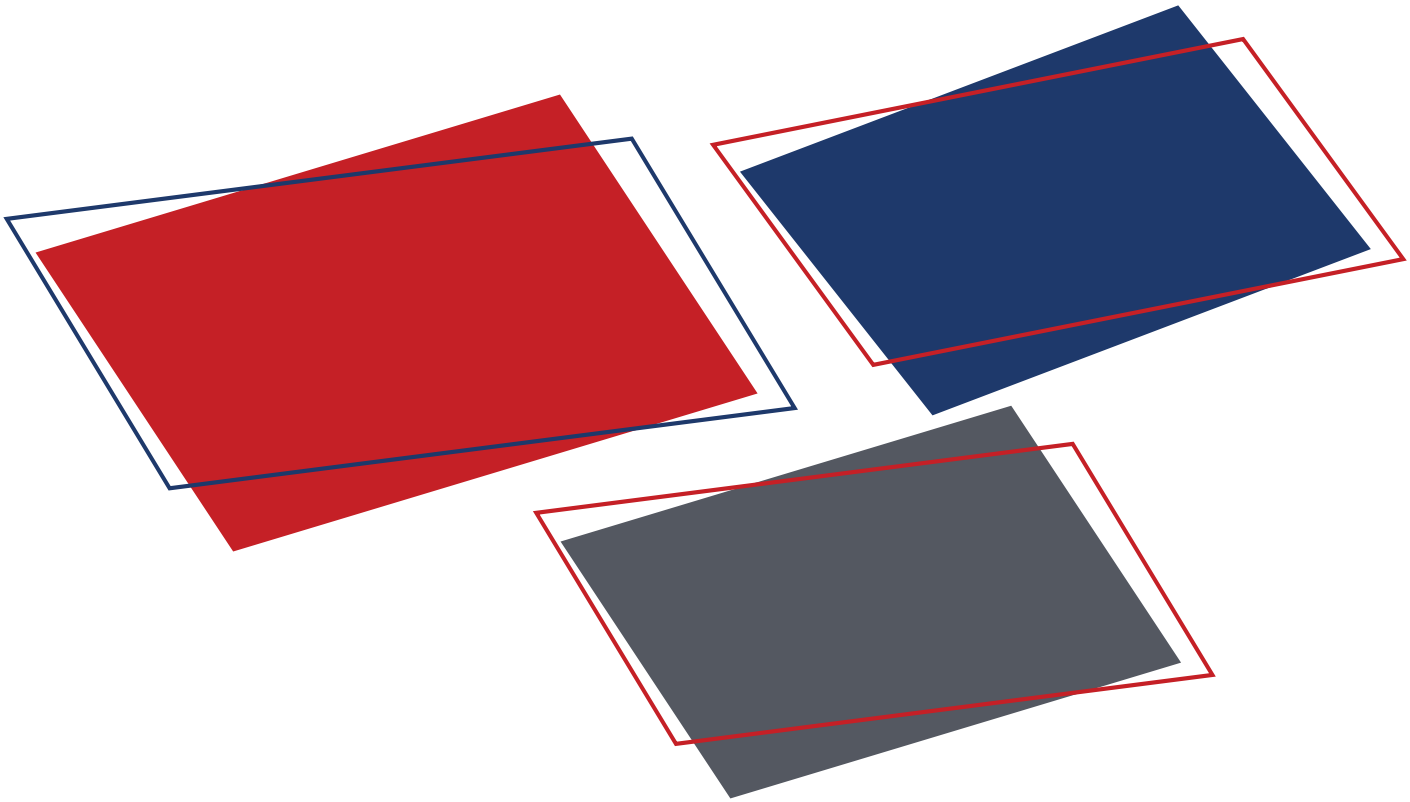
Covered Benefits

- Heart Attack
- Stroke
- Coronary Artery Bypass
- Invasive Cancer
- Carcinoma in Situ
- Benign Brain Tumor
- End Stage Renal Failure
- Major Organ Transplant

Plan Highlights

Rates are based on your age and benefit amount and will be calculated for you by Human Resources. Rates for this plan are grouped in five-year increments and are subject to increase each time you enter a new age-band. Insurance for any Dependent child(ren) under the policy is automatic if the Employee is insured. A separate premium is not required.

	MINIMUM AMOUNT	MAXIMUM AMOUNT	GUARANTEE ISSUE AMOUNT
Employee	$10,000	$10,000	$10,000
Spouse	$10,000	100% of Employee, up to $10,000	$10,000
All Children	25% of Employee, up to $3,000		$3,000



GLOSSARY

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount, as determined by your insurance plan, you pay for healthcare services received.

Deductible – The amount you owe for healthcare services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," meaning that funds not used by the end of the plan year will be lost.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Network – A group of physicians, hospitals and other healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage, make changes or decline coverage.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

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

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, your insurance carrier provides you with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) - The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice from City of Keene About Your Prescription Drug Coverage and Medicare under the BCBSTX Plan(s)

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 Keene 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. City of Keene has determined that the prescription drug coverage offered by the BCBSTX plan(s) 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 during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through 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 City of Keene coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current City of Keene coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Keene 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 at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Keene 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 Medicare Part D 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:	October 1, 2021
Name of Entity/Sender:	City of Keene
Contact—Position/Office:	Human Resources
Address:	1000 N Old Betsy Rd. Cleburne, TX 76031
Phone Number:	817-641-3336 x106

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 817-641-3336 x106.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 817-641-3336 x106.

HIPAA 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 later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

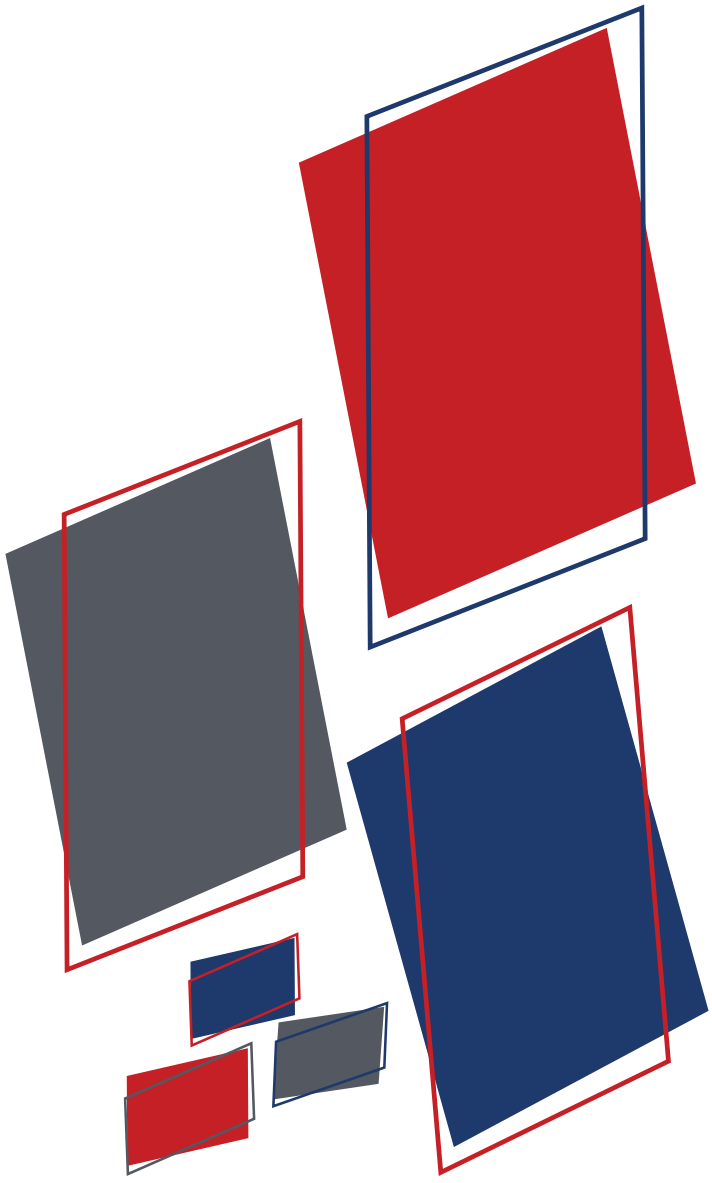
If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 817-641-3336 x106.

IMPORTANT CONTACTS

COVERAGE	CONTACT
MEDICAL	BlueCross BlueShield of Texas 800-445-2227 www.bcbstx.com
VIRTUAL VISITS	MDLIVE www.MDLIVE.com/BCBSTX 888-680-8646
DENTAL	United Healthcare 800-357-0978 www.uhc.com Policy #: 09Y1939
VISION	United Healthcare 800-357-0978 www.uhc.com Policy #: 09Y1939
FLEXIBLE SPENDING ACCOUNTS	StreamlineHR 877-262-7291 www.streamlinehr.com
BASIC LIFE AND AD&D	BlueCross BlueShield of Texas 800-348-4512 www.bcbstx.com
VOLUNTARY LIFE AND AD&D	Mutual of Omaha 800-775-5176 www.mutualofomaha.com Policy #: G000BF64
DISABILITY	Mutual of Omaha 800-775-5176 www.mutualofomaha.com Policy #: G000BF64
SUPPLEMENTAL HEALTH (ACCIDENT AND CRITICAL ILLNESS)	Mutual of Omaha 800-775-5176 www.mutualofomaha.com Policy: G000BF64
CITY OF KEENE HUMAN RESOURCES	Nathan Drambareanu 1000 N. Old Betsy Rd. Cleburne, TX 76031 817-641-3336 ext. 106



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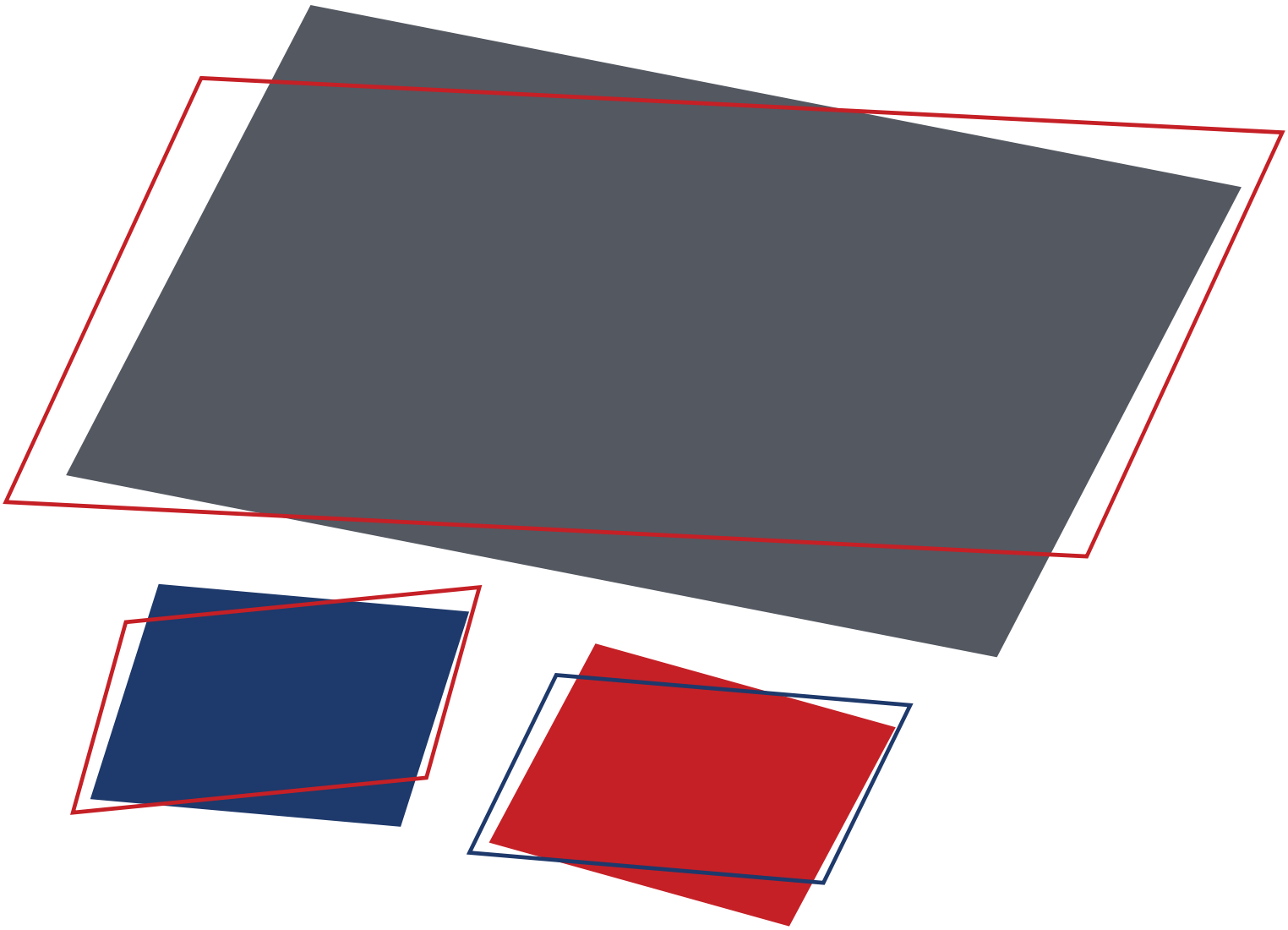

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