Employee Benefits Package

2025 Plan Year

Buda Fire & EMS

Important Items to Remember

ELIGIBLE EMPLOYEES

To be eligible for company benefits, you must be a full time employee working an average of 30 hours per week during the year.

NEW HIRE WAITING PERIOD

New full-time employees are eligible for company insurance benefits on the 1st of the month following employment.

DEPENDENT CHILDREN

Children under the age of 26 are eligible to be covered under the benefits. They will be taken off of the plan at the end of the month in which they turn 26.

OPEN ENROLLMENT

You can make changes to your plans (enroll in coverage, waive coverage, add/drop dependents, etc.) during this time period each year. All changes made during this time period will take effect on the renewal date.

MAKING PLAN CHANGES DURING THE YEAR

If you've had a major life event (getting married, having a child, getting divorced, losing coverage, becoming eligible for Medicare, etc.) during the year, you're able to make coverage changes to your plan even though it's outside of the open enrollment window. Please turn in all paperwork within 30 days of your qualifying event to ensure it will be processed timely and any claims incurred will be paid. PLEASE NOTE: If adding a newborn baby to your plan, the baby's social security number will not be available right away. Please submit the paperwork without it, and provide it once it's available.

Insurance Terms and Definitions

PPO (PREFERRED PROVIDER ORGANIZATION)

A PPO is a type of insurance network. In this type of network, you may choose to obtain care in or out of your network. If you choose to visit a "Preferred", or "In-Network", provider, your out of pocket expense will be significantly less than if you visit a provider outside your network. The reason for this is the In-Network provider agrees to accept set, contracted rates as payment in full for their services in return for being part of the insurance carrier's Preferred Provider network.

DEDUCTIBLE

The amount you pay before the insurance carrier starts sharing the expense of your medical care. Major medical expenses apply to the deductible like inpatient/outpatient surgeries, MRI's, CT Scans, etc.

CO-INSURANCE

After you've reached your deductible for the year, the insurance carrier will split the balance of the major medical expense with you. They pay a percentage and you pay a percentage of your medical expense until you've reached your Out of Pocket Maximum.

OUT OF POCKET MAXIMUM

This is the maximum amount you will pay for covered medical expenses during your deductible period.

CO-PAYS

This is a set dollar amount you pay when you receive medical care from a Primary Care Physician, Specialist, Urgent Care, Emergency Room, or Pharmacy. It's called a co-pay, because you pay the set dollar amount and your insurance carrier pays the rest of the actual charge from the doctor/facility. Co-pays do not apply to the deductible.

EXPLANATION OF BENEFITS

Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is (Provider Charge - Network Discount = Negotiated Rate). It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

Medical Benefits

curative

PPO Plan

Deductible	In-Network: With Baseline | Without Baseline	Out-of-Network
Single	$0 | $5,000	$10,000
Family	$0 | $10,000	$20,000
Coinsurance		
Member %	0% | 20%	50%
Out of Pocket Maximum		
Single	$0 | $7,500	$15,000
Family	$0 | $15,000	$30,000
Commonly Used Services		
Primary Care Physician Office Visit	$0 | $25 copay after deductible	$50 copay after deductible
Specialist Office Visit	$0 | $50 copay after deductible	$100 copay after deductible
Urgent Care	$0 | 20% coinsurance after deductible	50% coinsurance after deductible
Emergency Room	$0 | 20% coinsurance after deductible	80% coinsurance after deductible
Preventive Care		
Preventive Services	$0 | $0	$50 copay
Major Medical Expenses		
Outpatient Surgery	$0 | 20% coinsurance after deductible	50% coinsurance after deductible
Inpatient Hospitalization / Surgery	$0 | 20% coinsurance after deductible	50% coinsurance after deductible
CT scan, PT scan, MRI	$0 | 20% coinsurance after deductible	50% coinsurance after deductible
Hospital Newborn Delivery	$0 | 20% coinsurance after deductible	50% coinsurance after deductible
Prescription Drug Coverage		
Preferred	$0 | $50 copay after deductible	50% coinsurance after deductible
Non-Preferred	$50 | $100 copay after deductible	50% coinsurance after deductible
Non-Preferred Specialty	$250 | 25% coinsurance after deductible	50% coinsurance after deductible
Plan Information		
Network Type	PPO	
Network Name	First Health	
Member Website	https://curative.com/	
Customer Service Phone Number	(855)-428-7284	

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

Bi-Weekly Deduction - Buda Fire & EMS Contribution Included

Employee Only	$0.00
Employee + Spouse	$130.04
Employee + Child(ren)	$95.95
Family	$246.18

Dental Benefits

Deductible	In-Network	Out-of-Network
Single	$50	$50
Family	$150	$150
Maximum the carrier will pay		
Annual Maximum	$1,500	$1,500
Dental Coverage		
Diagnostic & Preventative Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Out of Network Explanation		
	Your insurance carrier will pay the out of network dentist the same rate they pay an in-network dentist, which may result in a balance bill.	
Plan Information		
Network Name	PPO Plus Premier	
Member Website	https://www.deltadental.com/us/en/member/find-a-dentist.html	
Customer Service Phone Number	800-521-2651	

Bi-Weekly Deduction - Buda Fire & EMS Contribution Included

Employee Only	$0.00
Employee + Spouse	$7.80
Employee + Child(ren)	$7.08
Family	$14.66

Vision Benefits

Vision Coverage	In-Network	Out-of-Network
Eye Exam	$10 copay	$45 allowance
Single Vision Lens	$25 copay	$30 allowance
Lined Bi-Focal Lens	$25 copay	$50 allowance
Lined Tri-Focal Lens	$25 copay	$65 allowance
Lenticular Lens	$25 copay	$100 allowance
Contact Lens Allowance	$150 allowance with option to upgrade up to $230	$105 elective and $210 necessary
Frame Allowance	$150 allowance with option to upgrade up to $230	$70 allowance
Frequencies		
Exam Frequency	Once Every 12 Months	
Lens Frequency	Once Every 12 Months	
Frame Frequency	Once Every 12 Months	
Out of Network Explanation		
	While you will receive a reimbursement when you go out of network, the out of network provider may not file the claim for you.	
Plan Information		
Network Name	VSP	
Member Website	www.vsp.com	
Customer Service Phone Number	800-877-7195	

Bi-Weekly Deduction - Buda Fire & EMS Contribution Included

Employee Only	$0.00
Employee + Spouse	$2.87
Employee + Child(ren)	$4.60
Family	$8.79

Employer-Paid Basic Life Insurance

All full-time employees receive a Basic Life benefit at no cost. The basic life program will also provide accidental death and dismemberment (AD&D) coverage. AD&D would pay your beneficiary an additional amount if you were to die as the result of an accident or will provide certain benefits if you suffer a covered dismemberment injury.

Life Insurance Benefits	
Life Insurance Coverage	$50,000 plus 3 times your salary
Accidental Death & Dismemberment	Included
Line of Duty Benefit	Triple benefit in the case of death

Disability Benefits

Disability benefits cover a portion of your salary when you are unable to work due to an accident or illness.
In the event that you become disabled, benefits will be paid weekly once you have satisfied the elimination period.

Employer-Paid Short-Term Disability

STD Insurance Benefits	
Weekly Benefit	66.66% of your weekly earnings, not to exceed $1,000
When do benefits start? (Elimination period)	Accident: 7 days | Sickness: 7 days
How long do my benefits pay out?	3 Months

Employer-Paid Long-Term Disability

LTD Insurance Benefits	
Monthly Benefit	66.66% of your monthly earnings, not to exceed $5,000
When do benefits start? (Elimination period)	90 Days or until the end of the STD Maximum Benefit Period.

DELTA DENTAL

Keep Smiling

Delta Dental PPO™

Stay in network to save

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

If you can't find a PPO dentist, consider a Delta Dental Premier® dentist. These dentists have agreed to set fees and offer another opportunity to save.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **deltadentalins.com**.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need to provide your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.[4] Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

[5] Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

Small Business Program Benefit Highlights

Delta Dental PPO Plus Premier®

Plan: Advantage 200

Eligibility
Who's eligible for benefits?
- You
- Your spouse or domestic partner
- Dependent children up to age 26

Waiting periods[1]
- Basic services: None
- Major services: None
- Prosthodontics: None
- Orthodontics: None

Deductibles
$50 per person, $150 per family each calendar year

Maximums
$1,500 per person each calendar year

Benefits and Covered Services*	Delta Dental PPO dentists[2]	Delta Dental Premier dentists[2, 3]	non-Delta Dental dentists[2, 4]
Diagnostic & preventive services (D&P) Exam, cleanings, x-rays and enhanced pregnancy benefit	100%	100%	100%
	You don't have to meet your deductible to get coverage for diagnostic and preventive services.		
	The costs of diagnostic & preventive services are waived against your annual maximum.		
Basic services Fillings, denture repair and sealants	80%	80%	80%
Endodontics Root canals	80%	80%	80%
Oral surgery	80%	80%	80%
Periodontics Gum treatment	80%	80%	80%
Major services Crowns, inlays, onlays and cast restorations	50%	50%	50%
Prosthodontics Bridges, dentures and implants	50%	50%	50%
Orthodontics	Not Covered	Not Covered	Not Covered

[1] The waiting period may be waived: 1) if you were enrolled when your employer initially purchased this dental plan or 2) if you were enrolled in your employer's prior comprehensive dental plan with no break in coverage.
[2] Reimbursement is based on: 1) PPO contracted fees for PPO dentists, 2) Premier contracted fees for Premier dentists and 3) the plan contract allowance for non-Delta Dental dentists.
[3] Delta Dental Premier® dentists are considered non-PPO dentists.
[4] Non-Delta Dental Providers have no agreement with Delta Dental and are free to bill you any difference between what Delta Dental pays and the submitted fee.

Delta Dental Insurance Company
1130 Sanctuary Pkwy, Suite 600
Alpharetta, GA 30009
deltadentalins.com

Customer service
800-521-2651

Claims address
P.O. Box 1809
Alpharetta, GA 30023-1809

* This benefit information is not intended to replace or serve as the plan's Evidence of Coverage, Summary Plan Description or Group Dental Service Contract. If you have specific questions about the benefits, limitations or exclusions of your plan, please consult your company's benefits representative.

DELTA DENTAL®

DeltaVision®

See healthy and live happy

Value and savings you love.

DeltaVision[1] saves you money on eyeware and eyecare when you visit a VSP® network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

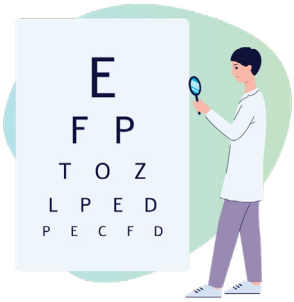
Provider choices you want.

DeltaVision uses VSP's Choice network, which is VSP's largest network and has retail options like Visionworks, Costco®, Walmart and Sam's Club. With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network provider. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

Like shopping online? Go to **eyeconic.com** and use your vision benefits to shop over 50 brands of contacts, eyeglasses and sunglasses.

Quality vision care you need.

You'll get personalized care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.



VSP® Vision Care

Member services:
1-800-877-7195 or **vsp.com**

DeltaVision Easy Options Plan Highlights

Benefits	Your coverage with a VSP provider	Copay
WellVision Exam® Every 12 months	• Focuses on your eyes and overall wellness	$10
Prescription glasses		$25
Frame Every 12 months	• $150/$230* frame allowance • 20% savings on the amount over your allowance • $80 Costco® frame allowance	Included in prescription glasses
Lenses Every 12 months	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in prescription glasses
Lens enhancements Every 12 months	• Standard progressive lenses	$0
	• Premium progressive lenses	$95 - $105
	• Custom progressive lenses	$150 - $175
	• Average savings of 30% on other lens enhancements	
Contacts (Instead of glasses) Every 12 months	• $150/$230* allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60
Diabetic Eyecare Plus Program™ As needed	• Retinal screening for members with diabetes • Additional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration. Limitations and coordination with your medical coverage may apply. Ask your VSP provider for details.	$0 $20 per exam
Extra savings	**Glasses and sunglasses** • Extra $20 to spend on Featured Frame Brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Routine retinal screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser vision correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from VSP contracted facilities	
Your coverage with out-of-network providers		
Out-of-network coverage options are offered for all plans except plans purchased in Maryland. For further information, review your Evidence of Coverage, log into your account at **vsp.com**, or call member services at **1-800-877-7195**.		
Coverage is guaranteed with a Benefit Authorization from In-Network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with Delta Dental, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.		

* Members may choose to upgrade to one of the following: higher frame or contact lens allowance ($230), premium progressive lens coverage at no additional cost, anti-reflective coating, or photochromic lens coverage at no additional cost.

[1] In California, DeltaVision is underwritten by Delta Dental of California. In Alabama, Delaware, District of Columbia, Florida, Georgia, Louisiana, Maryland, Mississippi, Montana, Nevada, New York, Pennsylvania, Texas, Utah and West Virginia, DeltaVision is underwritten by Delta Dental Insurance Company. DeltaVision is administered by Vision Service Plan (VSP). Benefits are subject to the terms of the Contract including limitations and exclusions.

DELTA DENTAL® | VSP® Vision Care

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Member Services at (855)-428-7284 or visit **www.curative.com**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary** or call (855)-428-7284 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**With Baseline Completion:** $0 in-network. $10,000 individual/ $20,000 family **out-of-network** **Without Baseline Completion**: $5,000 individual/$10,000 family in-network. $10,000 individual/$20,000 family **out-of-network**	Generally, you must pay all the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**. Curative requires the completion of a Baseline Visit within 120 days of your effective date in the Curative Plan, to ensure you will pay the lowest cost (typically $0) for your **copays**, **deductible**, and **coinsurance**. The Baseline Visit is a meeting with a Curative Clinician to onboard you to the health plan and understand your health goals. The Baseline visit must be scheduled and completed within 120 calendar days of your effective date in the Curative Plan. In your first year, for the first 120 calendar days your costs will automatically align with the amounts noted for Baseline Completion, if you use a **network provider**. Reference your benefit booklet for Baseline Visit requirements at renewal. If you do not complete the Baseline Visit within 120 days, the **copays**, **deductibles**, and **coinsurance** shown in this and the following tables for "Without Baseline Completion" will apply. You are not required to answer health questions regarding disability or genetic information or complete medical examinations during the Baseline Visit in order to qualify as completed.
Are there services covered before you meet your deductible?	Yes. **Preventive care** and immunizations for children under the age of 6 are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/**.

Important Questions	Answers	Why This Matters:
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services
What is the out-of-pocket limit for this plan?	**With Baseline Completion:** For **network providers** $0 individual/ $0 family; Non-Preferred Brand Name & Generic drugs and Non-preferred Specialty Drugs $7,500/ Individual & 15,000 family.. For **out-of-network** providers $15,000 individual / $30,000 family. **Without Baseline Completion:** For **network providers** $7,500 individual/ $15,000 family; for **out-of-network** providers $15,000 individual/ $30,000 family.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, **balance-billing** charges, health care this **plan** doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.curative.com** or call (855)428-7284 for a list of **network providers**.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without a **referral**.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (With Baseline Completion. You will pay the least)	Network Provider (Without Baseline Completion. You will pay more.)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0	$25 copay/visit	$50 copay/visit	None
	Specialist visit	$0	$50 copay/visit	$100 copay/visit	None
	Preventive care/screening/ immunization	$0	$0	$50 copay for Preventive Care/Screening $0 for immunizations for children under the age of 6	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$0	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$0	20% coinsurance	50% coinsurance	Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at curative.com/drugs	Preferred drugs (includes certain Generic, Brand Name & Specialty drugs	$0	$50 copay/ prescription	50% coinsurance	Prior authorization may be required. If you don't get prior authorization, your drug may not be covered. *For network providers $7,500 individual/ $15,000 family.
	Non-preferred Brand Name & Generic drugs (annual max out-of-pocket)*	$50 copay/ prescription*	$100 copay/ prescription	50% coinsurance	
	Non-preferred Specialty drugs (annual max out-of-pocket)*	$250 copay/ prescription*	25% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (With Baseline Completion. You will pay the least)	Network Provider (Without Baseline Completion. You will pay more.)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0	20% coinsurance	50% coinsurance	Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service.
	Physician/surgeon fees	$0	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$0	20% coinsurance	20% coinsurance	Limited to services in the United States
	Emergency medical transportation	$0	20% coinsurance	20% coinsurance	Limited to services in the United States
	Urgent care	$0	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$0	20% coinsurance	50% coinsurance	Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service.
	Physician/surgeon fees	$0	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Intensive Outpatient & partial hospitalization	$0	20% coinsurance	50% coinsurance	Prior authorization may be required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service.
	Inpatient services	$0	20% coinsurance	50% coinsurance	Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (With Baseline Completion. You will pay the least)	Network Provider (Without Baseline Completion. You will pay more.)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$0	$25 copay/ visit (first visit only)	50% coinsurance	None
	Childbirth/delivery professional services	$0	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	$0	20% coinsurance	50% coinsurance	Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service.
If you need help recovering or have other special health needs	Home health care	$0	20% coinsurance	50% coinsurance	Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service.
	Rehabilitation services	$0	20% coinsurance	50% coinsurance	
	Skilled nursing care	$0	20% coinsurance	50% coinsurance	
	Durable medical equipment	$0	20% coinsurance	50% coinsurance	Prior authorization required for equipment totaling over $750, standard manual and electric breast pumps covered up to $500.
	Hospice services	$0	20% coinsurance	50% coinsurance	Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Care outside of the United States
- Chiropractic
- Cosmetic surgery
- Infertility Treatment
- Long-term care
- Private-duty nursing
- Routine dental care
- Routine foot care
- Routine vision care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (20 visits / plan year)
- Bariatric Surgery(once per lifetime)
- Hearing Aids(limits apply. See Benefit Booklet)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for COBRA – U.S. Department of Labor – (866) 444-3272; for Texas state continuation – Texas Department of Insurance – (800) 252-3439. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Curative Member Services at (855) 428-7284.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (855)-428-7284.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (855)-428-7284.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (855)-428-7284.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (855)-428-7284.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-18

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5000
Copayments (1st office visit)	$25
Coinsurance (20% of $7625)	$1535
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$6560**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well- controlled condition)

The plan's overall deductible	$5000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5000
Copayments (4 office visits)	$200
Coinsurance (20% of $400)	$80
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5280**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$5000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2800**

Note: These numbers assume the patient has not completed their Baseline Visit. If you have completed your Baseline Visit, you will pay $0 for your Copays, Deductible, and Coinsurance for each of these examples.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Notices & Disclosures

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

** 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."

RETIREE COVERAGE ONLY:

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 Buda Fire & EMS, 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;
- Retiree coverage only: 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: Buda Fire & EMS.

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, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period* to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

* https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

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

Molissa, 512-295-2232, mwelch@budafire.org

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	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
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	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
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – 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: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
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.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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	**NEW YORK – 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – 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: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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:

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

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

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 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI) and includes all individually identifiable health information held by a health plan; whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (Plan), sponsored by your employer (plan sponsor). The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer. You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management.

Your employer is committed to the privacy of your health information. The administrators of the employer-sponsored group health plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting your Human Resources representative.

HIPAA Special Enrollment Rights

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, **you must request enrollment within 30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your

dependents lose eligibility for that other coverage. However, **you must request enrollment within 60 days** after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, **you must request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, **you must request enrollment within 60 days** after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, please contact your Human Resources representative.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

No Surprise Billing Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact Federal No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services at 1-800-985-3059.

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

For Patients and Plans that have protections under the State Law by **the Texas Department of Insurance, please visit https://www.tdi.texas.gov/medical-billing/index.html for more information.**

Medicare Part D Creditable Coverage Notice

Important Notice 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 your employer 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. Your employer has determined that the prescription drug coverage offered by the employer-sponsored 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 15 to December 7.

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 employer-sponsored group health plan coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current employer-sponsored group health plan coverage, be aware that you and your dependents may not be able to get this coverage back until the plan's next open enrollment period.

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 your employer 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%per month of the Medicare base beneficiary premium 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 your Human Resources representative 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 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 our 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).

Women's Health and Cancer Act of 1998 (WHCRA)

Under Women's Health and Cancer Rights Act of 1998 (WHCRA), group health plans are required to provide benefits for mastectomy-related services. If you have had or are going to have a mastectomy, you may be entitled to certain benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

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 resulting from a mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Please review your plan materials regarding deductibles and coinsurance or contact your Human Resources representative for more information on WHCRA benefits.

Notice for Newborns' and Mothers' Health Protection Act (Newborns' Act)

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

USERRA Notice

HEALTH INSURANCE PROTECTION

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

For your full Uniformed Service Employment and Reemployment Rights Act protections, please visit: https://www.dol.gov/agencies/vets/programs/userra

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the Plan Year with respect to mental health or substance use disorder benefits, please contact your Human Resources representative.

Summary of Material Modifications Disclosure

This Employee Benefits Communication serves as notice of material changes to your employer-sponsored health benefits plan(s). It describes the changes that affect your benefits plans and updates the Summary Plan Description (SPD). Please read this information thoroughly and keep it with your group health plan SPD. You can request a copy of your SPD by contacting your group health plan administrator.

This Benefit Booklet

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