2025 BENEFIT GUIDE

An Overview of Benefits for Employees of
New Braunfels Utilities

NBU®
NEW BRAUNFELS
UTILITIES

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Dear Employee:

Each year, employers are faced with tough decisions regarding employee benefits and our goal is to provide our employees with the most comprehensive benefit package possible. We are proud to present this competitive offering. We believe we have selected great plans to choose from for the 2025 plan year.

This Enrollment Guide has been designed to provide you with information about your benefits. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Thank you,
Your Human Resources Team

Important Contacts

Medical: BlueCross BlueShield of Texas
Customer Service: 1-800-521-2227
Website: www.bcbstx.com
Network: Blue Choice

Dental & Vision: MetLife
Customer Service: 1-800-275-4638
Website: www.metlife.com
Network: PDP Plus

Voluntary Life: MetLife
Customer Service: 1-800-275-4638
Website: www.metlife.com

Health Care Flexible Spending Account (FSA), Dependent Care FSA, Health Savings Account (HSA): HSA Bank
Customer Service: 1-800-357-5232
https://www.hsabank.com/

Employee Assistance Program:
Interface EAP
Customer Service: 1-800-324-4327
Website: www.4eap.com

Voluntary Cancer & Specified Disease Plan: Bay Bridge Administrators
Website: https://www.bbadmin.com/
Customer Service: 1-800-845-7519

New Benefits: Non-Insured Benefits New Benefits
Customer Service: 1-800-800-7616
Website: www.mymemberportal.com

Eligibility

Full-time employees can enroll themselves and their eligible dependents in the benefits package after 30 days of employment. Regular part-time and temporary employees are eligible to participate in the Medical and Dental benefits after 30 days of employment.

Dependent Eligibility

You must remove a dependent from coverage once they no longer meet the definition of an eligible dependent.

Eligible dependent includes:

- Your legal spouse (including Common Law marriage)
- Dependent children up to age 26
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability, and who are indicated as such on your federal tax return

Payroll Deductions

Your premiums for Medical, Dental, Vision, Cancer, New Benefits, and FSA will be deducted on a pre-tax basis because they are covered under your Cafeteria Plan under Section 125 of the Internal Revenue Service Code. This means that once you elect to enroll in any of these plans, you will not be allowed to drop or change your election until NBU's next Open Enrollment period unless you have a qualifying event.

In preparation for your enrollment, please have the following information readily available for yourself and your eligible dependent(s):

- Date(s) of birth
- Social Security Number(s): Federal regulation requires a social security number for all individuals covered under the medical plan. Missing social security numbers may result in delays when filing a claim.
- Your current address, so that we can ensure your ID cards and other important information are sent to the correct address.
- Full name, relationship, and Social Security Number(s) for beneficiary(ies).

Qualifying Life Events:

- Marriage or divorce
- Birth or adoption of a child
- Death of dependent
- Dependent gain and/or loss of coverage

If you have a qualifying life event, you must notify Human Resources and provide the necessary documentation within 30 days of the change. If you do not do so within 30 days, you must wait until the next open enrollment to make plan changes.

Frequently Asked Questions

Q: What is Open Enrollment?

A: Open Enrollment is the only time of year to make your benefit elections, and add or delete dependents unless you have a qualifying event/Family Status Change. Your open enrollment period is from November 12, 2024 to November 26, 2024. The open enrollment period allows employees to make changes to their current benefit elections by:

- Adding and/or deleting dependents on their benefit plan(s)
- Changing the type of benefit or tier of their benefit plan

Q: What is a Qualifying Event or Family Status Change?

A: Qualifying Events include: marriage, divorce, death, birth or adoption of a child, or if a dependent gains or loses coverage. In an event of a qualifying event, you only have 30 days to notify HR of your wish to make a change in your dependent coverage.

The benefits you elect during the open enrollment period will remain in effect from January 1, 2025 through December 31, 2025. You are not allowed to make changes during the benefit plan year unless you have a qualifying event. It is important that you review your benefits confirmation statement before turning it in to ensure that benefits you have elected meet your needs and those of your dependents through the next benefit plan year. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Q: Will I receive a new medical card?

A: No, only if you change plans or add/drop a dependent will you receive a new ID card.

Q: If I am canceling my coverage or dropping a dependent from my plan during open enrollment, when is the last day of coverage?

A: The last day of coverage will be December 31, 2024.

Q: If I am enrolling or adding a dependent to my plan during open enrollment, when is the first day of my coverage?

A: The first day of your coverage will be January 1, 2025.

Q: At what age can my dependent no longer be covered under my medical plan?

A: Your dependent child is eligible for coverage regardless of student or marital status up until they turn 26.

Medical

New Braunfels Utilities will continue to offer medical benefits through BlueCross BlueShield (BCBS) of Texas for the 2025 plan year. You have four plan options with a comparison below. These plans allow you the opportunity to use physicians in or out of the network; however, we recommend using the in-network providers to avoid higher costs. Access the Blue Choice PPO network through the BCBSTXAPP by texting BCBSTXAPP to 33633 for doctor searches and benefit details.

Plan Features	Value 3000 In-Network	Standard 2000 In-Network	Premium 1000 In-Network	High Deductible Health Plan
Calendar Year Deductible				
Individual	$3,000	$2,000	$1,000	$3,500
Family	$6,000	$4,000	$2,000	$7,000
Coinsurance	80%			N/A
Out of Pocket Maximum (includes deductible & copays)				
Individual	$6,000	$5,000	$4,000	$3,500
Family	$12,000	$10,000	$8,000	$7,000
Preventive Services (once annually)*	100% covered			
Virtual Visit: MDLive	$10 Copay			
Physician's Office Visit	$35 PCP & Specialist			
Inpatient Care	80% covered after deductible			
Outpatient Care	80% covered after deductible			
Urgent Care Services	$75 Copay			
Emergency Service				
Hospital	80% covered after $200 Copay			
Physician	Copay waived if admitted & 80% covered after deductible			
Prescription Drug Plan				
Generic Copay	$10			
Preferred Brand Copay	$40			
Non-Preferred Brand Copay	$75			
Mail Order - 90 Day (RxBenefits)	1 copay for 90-day supply			
Mail Order - 30 Day (RxBenefits)	1 copay for 30-day supply			

The employee is responsible for covering the full cost until the deductible is met, after which the expenses are covered 100%.

For OUT OF NETWORK BENEFITS refer to the Summary of Benefits for services covered. Please see Certificate of Coverage for details.

Paying for Medical Coverage

The bi-weekly premium schedule for the 2025 plan year is shown below. Amounts are reflective of the product chosen. Dependent children are eligible for coverage until the day they turn 26 (regardless of marital or student status). Dependents that turn 26 are dropped from coverage on their DATE OF BIRTH.

Scan this QR code to visit bcbstx.com

Bi-Weekly Medical Rates		
High Deductible Health Plan	**Wellness Discount**	**No Wellness Discount**
Employee Only	$10.00	$45.00
Employee & Spouse	$165.39	$200.39
Employee & Child(ren)	$122.94	$157.94
Employee & Family	$243.65	$278.65
Spouse Surcharge*	$124.20	$130.41
Value Plan	**Wellness Discount**	**No Wellness Discount**
Employee Only	$15.73	$52.48
Employee & Spouse	$178.89	$215.64
Employee & Child(ren)	$134.32	$171.07
Employee & Family	$261.06	$297.81
Spouse Surcharge*	$124.20	$130.41
Standard Plan	**Wellness Discount**	**No Wellness Discount**
Employee Only	$27.86	$64.61
Employee & Spouse	$210.42	$247.17
Employee & Child(ren)	$160.21	$196.96
Employee & Family	$301.69	$338.44
Spouse Surcharge*	$124.20	$130.41
Premium Plan	**Wellness Discount**	**No Wellness Discount**
Employee Only	$65.59	$102.34
Employee & Spouse	$256.06	$292.81
Employee & Child(ren)	$219.01	$255.76
Employee & Family	$360.49	$397.23
Spouse Surcharge*	$124.20	$130.41

Spousal surcharge (applies if your spouse has access to insurance through their employer, but takes your coverage instead) rates are in addition to the above premiums.

High Deductible Health Plan

A high deductible health plan (HDHP) is a type of health insurance where you have the opportunity to save on your monthly premiums. With an HDHP, you'll have a higher deductible, which means you'll pay more out of pocket before your insurance coverage begins. However, once you meet the deductible, your insurance will cover all of the remaining costs. HDHPs empower you to take control of your healthcare expenses and make informed decisions. They provide an opportunity for savings while still offering essential coverage when you need it.

The HDHP and Health Savings Account (HSA): How They Work Together
Your contributions help to cover a portion of your deductible.

Free In-Network Preventive Care
To emphasize the importance of wellness, preventive care is covered at 100%, if you receive this care from in-network providers.

Deductible
You pay for your initial medical costs until you meet your annual deductible. This deductible is higher compared to the other medical plan, but offset by your HSA contributions.

Out-of-Pocket Maximum
The plan limits the total amount you'll pay each year. Once you meet your out-of-pocket maximum, the plan pays 100% of your eligible, in-network expenses for the remainder of the year.

Health Savings Account (HSA)

An HSA is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pretax dollars — now or in the future. Once you're enrolled in the HSA, you'll receive a debit card to help manage your HSA reimbursements.

Your HSA can also be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP medical plan.

HSA Bank manages the Health Savings Accounts (HSAs) for New Braunfels Utilities employees. As a special offer, HSA Bank is providing a one-time $25 incentive for those who transfer their HSA from UMB to HSA Bank, applicable to employees who enrolled with HSA Bank in 2024.

How a Health Savings Account (HSA) Works

Eligibility

You must be enrolled in the High Deductible Health Plan.

Your Contributions

You can choose to contribute a portion of your paycheck pre-tax, up to IRS limits: $4,300 for employee-only coverage or $8,550 for family/spouse coverage. You can change your contribution at any time! You can make an additional catch-up contribution if you are 55+ up to IRS limits: $5,300 for employee-only and $9,550 for family/spouse coverages. NBU will contribute $500 ($19.23 per pay period) for employee-only coverage and $1,000 ($38.46 per pay period) for all other coverages. The total NBU contribution will be prorated over the 26 pay periods in a year. Both NBU's contributions and your contributions count toward the IRS annual contribution limit.

Eligible Expenses

Eligible expenses are any medically necessary medical, dental, vision, and prescription drug expenses incurred by you or an eligible family member. If you enroll in an HDHP and an HSA, you are eligible to enroll in a Limited Purpose FSA as well, which allows you to set aside pre-tax funds for only dental and vision expenses. Please note, you cannot have both an HSA or Limited FSA and a Health Care FSA simultaneously.

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses, or pay for expenses out of your own pocket and save your HSA money for future health care expenses.

Remaining Funds

Money left in your HSA at the end of the year will roll over to the next year – you'll never lose your HSA dollars. If you leave NBU or retire, you can take your HSA with you and continue to pay and save for future eligible healthcare expenses.

Your HSA is always yours - no matter what!

One of the best features of an HSA is that any money left in your HSA account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the NBU or retire, your HSA goes with you!

The Triple Tax Advantage

1. You can use your HSA funds to cover qualified medical expenses, plus dental and vision expenses too – tax-free.
2. Unused funds grow and can earn interest over time – tax-free.
3. You can save your HSA funds to use for your health care when you leave NBU or retire – tax-free AND it can be converted into an IRA!

Step-by-Step: How an HSA Works

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

If you are a participant in a Flexible Spending Account (FSA), you are not eligible for the HSA reimbursement account.

Choose the HDHP option during Open Enrollment.

↓

NBU opens an HSA for you. NBU will contribute money to your HSA account every pay period ($19.23 per pay period for employee-only coverage and $38.46 per pay period for all other coverages).

↓

You determine how much to contribute (tax-free) to your HSA each pay period.

↓

Use money in your HSA for eligible medical, dental and/or vision expenses.

↓

Money left over at the end of the year rolls over for future use.

HSA & HDHP Example

Christine enrolls herself only in the HDHP with HSA. She chooses to use her HSA to pay for covered services – this reduces her out-of-pocket amount needed to meet her deductible before her health plan begins to pay.

Year 1 Example	Year 2 Example
Christine contributes a total of $3,650.	She contributes $3,650 for a total of $6,600. ($2,950 + $3,650)
She uses her HSA to pay $700 of eligible expenses.	She uses her HSA to pay $1,250 of eligible expenses.
She has $2,950 in her HSA to roll over to next year!	**She has $5,350 in her HSA to roll over to next year!**

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using tax-free dollars. This is administered by HSA Bank. There are three types of FSAs – Health Care FSA, Dependent Care FSA, and Limited FSA.

- Health Care FSA: Used to pay for services not covered by your medical, dental or vision plan such as copays, coinsurance, deductibles, prescription expenses, lab exams and tests, contact lenses and eyeglasses.
- Dependent Care FSA: Used to pay for daycare expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. You cannot use your Health Care FSA to pay for Dependent Care expenses.
- Limited Purpose FSA: Used to pay for only vision and dental expenses before you reach your deductible. Unlike the Health Care FSA, a limited FSA can be used with an HSA.

Health Care FSA	VS	Dependent Care FSA	VS	Limited Purpose FSA
Contribute up to $3,300 per year, pretax.		Contribute up to $5,000 per year, pretax.		Contribute up to $3,300 per year, pretax.
Receive a debit card to pay for eligible medical expenses.		You must submit claims and be reimbursed if you enroll in this FSA.		Receive a debit card to pay for eligible dental and vision expenses only.
Eligible expenses include medical copays, coinsurance, deductibles, eyeglasses and over-the-counter medications prescribed by your doctor.		Can only be used to pay for eligible dependent care expenses including day care, after-school programs and elder care programs.		Eligible expenses include dental and vision copays and deductibles, eyeglasses, contacts, and dental work.
Submit claims up to March 31, 2026 for any claims incurred during the previous year (January 1 - December 31, 2025).		Submit claims up to March 31, 2026 for any claims incurred during the previous year (January 1 - December 31, 2025).		Submit claims up to March 31, 2026 for any claims incurred during the previous year (January 1 - December 31, 2025).
If you do not spend all your money in your FSA by December 31, 2025, the maximum you can rollover is $660. These funds can be used for 2025 AND 2026 claims.		If you do not spend all your money in your FSA by December 31, 2025, the maximum you can rollover is $660. These funds can be used for 2025 AND 2026 claims.		If you do not spend all your money in your FSA by December 31, 2025, the maximum you can rollover is $660. These funds can be used for 2025 AND 2026 claims.

How You Can Save on Taxes with FSAs

Here's an example of how much you can save when you use the FSAs to pay for your predictable health care and dependent care expenses.

	Health Care FSA		Dependent Care FSA	
	Without Account	**With Account**	**Without Account**	**With Account**
Your Taxable Annual Income	$50,000	$50,000	$50,000	$50,000
Account Deposit (Before Taxes)	N/A	$2,500	N/A	$5,000
Taxable Wages	$50,000	$47,500	$50,000	$45,000
Annual Tax Savings	$0	**$275**	$0	**$550**

These numbers are estimates and will vary depending on other taxable elections.

It's Easy to Use These Accounts:

1. First, you contribute to the account(s) with pretax dollars deducted from your paycheck. That means no taxes (Federal, State or Social Security) will be withheld from any of those dollars.
2. Then, you pay for certain eligible expenses out of your pocket as usual. You may use your debit card or submit a claim (along with the appropriate documentation) to be reimbursed for those expenses from the dollars in your account.

Qualified Medical Expenses Include:

- Acne treatments
- Allergy medications
- Antacids
- Antibiotic ointments
- Bactine
- Bandages and gauze pads
- Birth control
- Antihistamines
- Anti-itch creams
- Arthritis gloves
- Aspirin
- Diagnostic Items (examples include: blood pressure monitoring devices, blood sugar test kits and test strips, pregnancy tests, and ovulation monitors)

List continued on the next page...

Continued Qualified Medical Expenses Include:

- Calamine lotion
- Carpal tunnel wrist supports
- Cold medicines
- Cold/hot packs (for a medical condition)
- Cold sore relievers
- Contact lenses
- Saline solutions
- Enzyme cleaners
- Cough suppressants
- Crutches
- Decongestants
- Denture adhesives
- Diabetic supplies
- Diaper rash ointments and creams
- Diarrhea medicine
- Ear wax removal products
- Expectorants
- Eye drops
- Fever reducing medications
- First aid creams
- First aid kits
- Hearing aid batteries
- Heating Pads
- Hemorrhoid treatments
- Incontinence supplies
- Insect bite creams and ointments
- Insulin
- Laxatives
- Liniments (i.e., vaporizing rub)
- Menstrual products (pads & tampons)
- Motion sickness medications
- Nasal strips and sprays
- Pain relievers
- Rubbing alcohol
- Sinus medications
- Smoking cessation products
- Sunburn creams and ointments
- Thermometers for medical use
- Throat lozenges
- Toothache and teething pain relievers
- Vaporizer
- Walkers
- Wart removal medications
- Yeast infections

Scan this QR code to view the full list of eligible items and rules set by the IRS.

How to Substantiate Your FSA & HSA Purchases

If you have an FSA or HSA account, any time you make a purchase using your card, you may need to verify that the expense is for a qualified medical purchase, as defined by the IRS. To do this, log into your HSA Bank portal and upload either a detailed receipt with a service code and fee breakdown OR your Explanation of Benefits (EOB).

In most cases, we strongly recommend uploading your Explanation of Benefits, as it contains all the necessary details for HSA Bank to confirm your purchase. If you choose to upload a receipt instead, you may be asked to provide additional information.

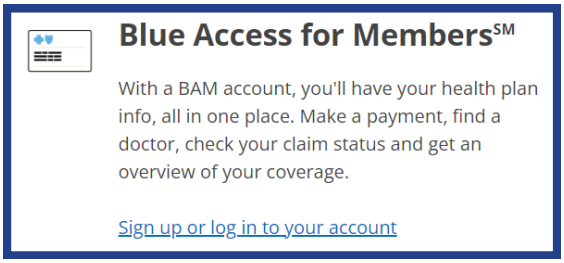
How to Download Your Explanation of Benefits to Submit to HSA Bank for Authentication

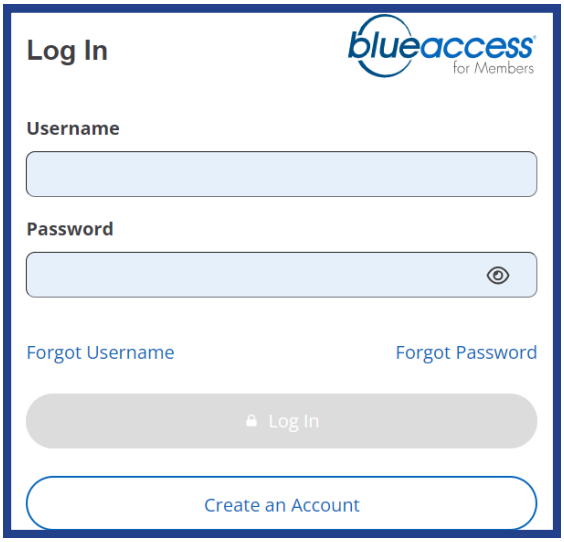
1. Log into your BlueCross BlueShield of Texas account.

Go to: https://www.bcbstx.com/member/member-resources/member-services.

Click "Sign up or log in to your account" under the Blue Access for Members section.

Either log in, or create your account if you are logging in for the first time.





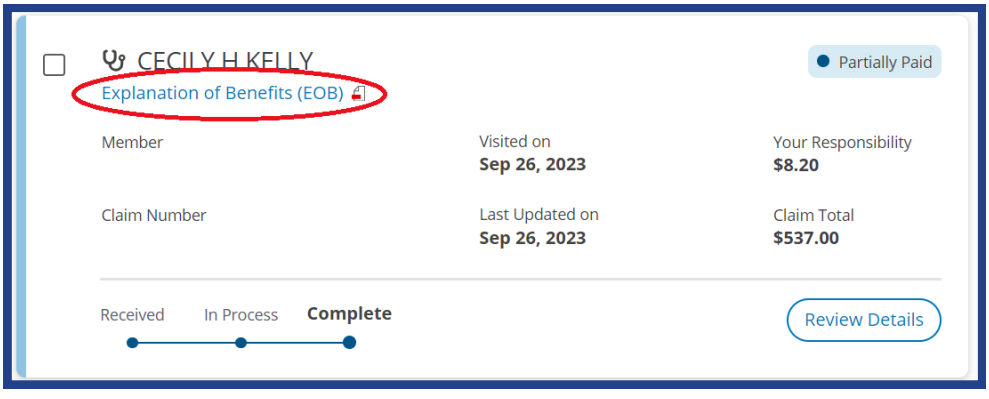
2. Find the claim you need to substantiate & download the Explanation of Benefits for it.

Click Claims in the header near the top of the screen.

Find the claim you need to substantiate and click the linked PDF titled "Explanation of Benefits (EOB)" underneath the doctor's/ company's name.

Save the document & upload to the HSA Bank portal.

Scan this QR code for instructions on how to download your EOB on the BCBSTX app!



Wellness Discount Program

NBU's wellness discount program is designed to incentivize employees to take preventative measures to help avoid illness while also improving and maintaining their general health. We do this by offering a -$35 discounted rate for medical insurance if the employee commits to obtain 15 "wellness points" within one calendar year. Employees must submit a doctor visit form or other forms of proof (i.e. receipt, EOB, etc.) via a smartsheet form in order to receive their wellness points.

2025 Wellness Discount Elections		
Requirement: Earn 15 Points		
Activity	**Points**	**Maximum Points**
Annual Physical	5	5
NBU Sponsored Biometric Screening	7	7
Blood drawn at Doctor's Office	3	3
Preventative Maintenance Screenings	3	6
Teeth Cleanings	2	4
Skin Cancer Detection Screenings	2	2
Eye Exam	2	2
Register with BCBS's MDLive	1	1
NBU Health Fair Attendance (required to have visited 50% of vendors)	3	3
Flu Shot at NBU Health Fair or off-site verification	1	1
Completion of a Wellness Challenge Presented by NBU	2	4
Attendance at NBU sponsored Lunch & Learn (3 opportunities)	1	3
Non-Tobacco User	3	3

If an employee does not meet these requirements within this enrollment year, they will automatically be disqualified for discounts for a ONE-year benefit period. Employees needing accommodations to earn wellness points should contact Human Resources.

Examples of Preventative Maintenance Screenings:

- Mammography Screening
- Colonoscopy Screening
- Annual PAP Screening
- Detection of Prostate Cancer
- Nutritional Counseling

NBU Wellness Challenge Options:

- Road to a Healthy Lifestyle
- Body Transformation Challenge
- Workout Wednesdays
- Maintain Don't Gain Program

Tobacco Cessation Program Information

According to research studies, 70% of tobacco users would like to quit, but only 5% are able to do so on their own. Additionally, non-tobacco users average several thousand dollars less per year in healthcare claims, pharmaceutical claims, and lost productivity over the course of their lifetime. Because the dangers of tobacco use are well documented and we want all employees to have the ability and support to stay, or become tobacco-free, NBU provides a comprehensive support program to help get you started. This is a voluntary program, available to employees who wish to make a change in individually promoting a healthier lifestyle.

Employees eligible for NBU's medical plan will be required to complete a "Tobacco User Affidavit" during the Open Enrollment Process, indicating their use or non-use of tobacco products. The Tobacco Cessation Program provides employees time to use these resources to support them in their efforts to quit tobacco use and be awarded 3 wellness points.

Tobacco user definition: The federal government, for purposes of individual and SHOP coverage, defines tobacco use in 45 CFR 147.102(a)(1)(iv)) as: "…tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months." This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

For tobacco users: After signing the affidavit indicating tobacco use, we would love for you to participate in the tobacco cessation program. To start the Program, simply contact the Texas Tobacco Quitline* to begin receiving services and support. Typically, the Program takes one month, or 4-5 calls, and involves one-on-one counseling with your very own quit coach. It is completely free! Upon completion of the program, you will receive a certificate in the mail. You will then need to share that completed certificate with the Human Resources Department within 30 days of completion in order to receive the 3 wellness points.

Texas Tobacco Quitline: 1-877-YES-QUIT (1-877-937-7848)
https://quitnow.net/

For non-tobacco users: Sign the affidavit at Open Enrollment stating non-tobacco use, and stay tobacco-free in 2025!

For all employees: If at any point your tobacco-use status changes, you will need to re-sign the affidavit indicating the change. If you feel that it is unreasonably difficult for you to quit using tobacco products, you can qualify for an opportunity to earn the same 3 wellness points by completing the Quitline Program, and showing proof of completion (certificate).

*Participation in an alternative tobacco cessation program will require prior approval by Human Resources for consideration of wellness points.

We encourage you to take the first step to a healthier lifestyle. Please be looking for more information during Open Enrollment, and feel free to contact the Human Resources Department at 830-629-8495 for any additional information.

RxBenefits/Caremark

RxBenefits is your Pharmacy Benefits Optimizer. They have partnered with CVS/Caremark to bring you greater discounts, better access, and improved member services.

RxBenefits Member Services

Our Member Services representatives have access to the same system utilized by CVS/Caremark and are equipped to help you, your physician, and your pharmacy with questions such as:

"Is my pharmacy in network?"

"Is my drug covered?"

"How do I start using Mail Order for my medications?"

"How do I get a Prior Authorization?"

"Can you assist me with general benefit questions?"

No matter what the issue or need, members can always expect RxBenefits to act with urgency, remain responsive to change, and follow all issues to resolution.

Contact the RxBenefits Member Services Team at 1.800.334.8134 or RxHelp@rxbenefits.com.

RxBenefits Member Services Team members are available from 7:00 am to 8:00 pm CST, Monday – Friday.

On weekends, after hours, and on holidays, members are given the option to speak with a CVS/Caremark representative or leave a message for the RxBenefits Member Services Team to return their call.

Additional Discounts on Your Prescription Medication

The apps below gather current prices and discounts to help you find the lowest cost pharmacy for your prescriptions. Download them and start saving today!

RxSaver By RetailMeNot™ GoodRx ScriptSave® WellRx

Consumer Tips

Understanding a Formulary

A formulary is a handy list of prescription medications put together by your insurance provider. It outlines which drugs are covered under their plan and the level of coverage they offer. Most formularies come with three tiers of coverage:

- Generic = Low copay for generic drugs
- Preferred Brand = Higher copay for preferred brand name drugs.
- Non-Preferred Brand = Highest copay for the most expensive brand name drugs.

Some drugs are excluded from carrier formularies altogether, and those formularies vary by insurance provider. Your doctor should be able to provide guidance for medications that are part of the covered formulary for your BCBS plan(s). Make sure you review your enrollment materials to understand the costs of your prescription medication. To price a medication covered under your BCBS plan, go to: https://www.caremark.com/.

Generic Drugs

Generic drugs can save you money. Consult with your physician about whether generic drugs are right for you, but know that the Food and Drug Administration (FDA) regulates generics, just as it does name brands, to ensure safety and quality.

Getting Information About Generic Drugs

Consumer Reports Best Buy Drugs (www.crbestbuy.org) provides information about prescription medication available to treat specific illnesses and diseases, the differences among them, and their costs. ALWAYS ask your physician about whether a particular medication is right for you. Remember you can use your FSA Funds to purchase prescribed medications.

What Your Medical Plan Does For You

Your medical plans provide valuable protection from the actual costs of medical products and services. The charts below show examples of how the three medical plans offered by NBU provide financial protection for some commonly used services and medications.

	Cost Without Insurance	Employee Cost Per Plan*			
		Value	Standard	Premium	HDHP
Medical Services					
Preventive Care Visit	$467.00	$0.00	$0.00	$0.00	$0.00
Primary Care Visit	$233.00	$35.00	$35.00	$35.00	The employee is responsible for covering the full cost until the deductible is met ($3,500 for individual & $7,000 for family), after which the expenses are covered 100%.
Specialist Visit	$587.00	$35.00	$35.00	$35.00	
Hospitalization: C-Section	$23,450.00	$6,000.00	$5,000.00	$4,000.00	
MRI Head/Brain Scan	$2,990.00	$1,500.00	$1,500.00	$1,500.00	
Total Knee Replacement	$44,025.00	$6,000.00	$5,000.00	$4,000.00	
Prescription Drugs					
Generic Brand: Hydrocodone with Acetaminophen	$64.45	$10.00	$10.00	$10.00	
Preferred Brand: Vicodin	$94.58	$40.00	$40.00	$40.00	
Non-Preferred Brand: Norvasc	$372.90	$75.00	$75.00	$75.00	

Know Before You Go

Your guide for where to go when you need medical care:

LOWER ← **COST AND TIME** → **GREATER**

MDLive (Virtual)	Doctor's Office	Urgent Care Center	Emergency Room
Access MD Live services to treat minor medical conditions. Connect with board-certified doctors via video or phone when, where and how it works best for you.	The best place to go for routine or preventive care, to keep track of medications, or for a referral to see a specialist.	For conditions that are not life threatening. Staffed by Nurses and Doctors and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life threatening, call 911 or go to the nearest Emergency Room.
• Colds & Flu • Rashes • Sore Throats • Headaches • Stomach aches • Sinus Infection • Fever • Allergies Acne • UTIs & More	• General health issues • Preventive care • Routine checkups • Immunizations and screenings	• Fever and flu symptoms • Minor cuts, sprains, burns, rashes • Headaches • Lower back pain • Joint pain • Minor respiratory symptoms • Urinary tract infections	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath • Chest pain • Head injury/major trauma • Blurry or loss of vision • Severe cuts or burns
$10.00 Copay	$35.00 Copay	$75.00 Copay	$200.00 Copay
• Costs are lower than a visit with your primary care provider • Appointments typically in an hour or less • No need to leave home or work	• May charge copay / preventive care is covered at 100% • Usually need appointment • Short wait times	• Costs are lower than ER but higher than primary care provider • No appointment needed • Wait times may be long	• Highest cost • No appointment needed • Wait time may be long

Deciding Where To Go For Health Care

Sometimes it's easy to know when you should go to an emergency room. At other times, it's less clear. Where do you go when you have an ear infection or just don't feel well? The emergency room is always an option, but it can be an expensive one.

You have choices for receiving in-network care that will work with your schedule and give you access to the care you need.

$10
COPAY

Virtual Visits (MDLive)

Available 24 hours a day, 7 days a week

Convenience, whether you're home or traveling you have access to board-certified doctors

$35
COPAY

Doctor's Office

Office hours vary

Generally best choice for non-emergency care

Doctor to patient relationship established and therefore able to treat, based on knowledge of medical history

$75
COPAY

Urgent Care

Generally, includes evenings, weekends and holidays

Used when your doctor's office is closed, and there is no true emergency

Wait time is often about an hour

Most have online and/or telephone check-in

$200
COPAY

Free Standing Emergency Room

24 hours, 7 days a week

Wait time may be less than a hospital emergency room

Could be transferred to an emergency room based on medical situation

Services do not include trauma care

Multiple bills for service

$200
COPAY

Hospital Emergency Room

24 hours, 7 days a week

Highest out-of-pocket cost to you

Wait time average 2.5 - 3 hours Multiple bills for services

Multiple bills for services

If you need emergency care, call 911 or go to a hospital!

Urgent Care Center vs Free Standing Emergency Room - Knowing the Difference Can Save You Money!

Urgent care centers and free-standing emergency rooms can be hard to tell apart. Free standing emergency rooms often look a lot like urgent care centers, but costs are higher, just as if you went to the emergency room at a hospital. Here are some ways to know if you are at a free-standing emergency room:

- Check for "EMERGENCY" in the facility name
- Open 24/7
- Physically separate from a hospital
- Share the same copay as hospital ERs
- Staffed by ER physicians

Additional Medical Resources

Free 24-Hour Nurse Line

Getting the right information is vital, and the skills and resources of a trained healthcare professional such as a nurse can be one of the most effective ways to get the information you need. Sometimes you just need a quick answer to a health issue that doesn't require immediate medical treatment or a physician visit. That's why BlueCross BlueShield of Texas offers a 24-hour nurse line.

With a 24-hour nurse line, you can call 7 days a week, 365 days a year to ask basic health questions and address concerns such as:

- Your symptoms
- Medications and side effects
- Reliable self-care home treatments
- Self-help and support groups
- When to go to your doctor
- When to go to the emergency room
- Local physician and hospital resources
- Wellness information
- Best of all, the BCBS 24-hour nurse line is a free resource to BCBS members

GET YOUR QUESTIONS ANSWERED TODAY!

CALL 1-800-581-0353

MDLIVE

Getting sick is never convenient, and finding time to get to the doctor can be hard. BlueCross BlueShield of Texas provides you and your covered dependents access to care for non-emergency medical issues and behavioral health needs through MDLIVE.

MDLIVE doctors or therapists can help treat the following conditions and more:

General Health
- Allergies
- Asthma
- Nausea
- Sinus Infection

Pediatric Care
- Cold/Flu
- Ear Problems
- Pinkeye

Behavioral Health
- Anxiety/Depression
- Marriage Problems
- Child Behavioral & Learning Issues

MDLIVE lets you have a live consultation with an independently contracted board-certified MDLIVE doctor or therapist. Your visit can happen 24 hours a day, seven days a week by mobile app, online video, or phone. Activating your MDLIVE account and scheduling your visit is easy!

Medical Visit: $10*
Providers available 24/7 by secure video or phone

Therapist: $10*
Talk therapy and strategy sessions

Psychiatrist: $10*
Assessment and medication management

These rates only apply if you are on the Value, Standard, or Premium Health Insurance Plans. If you are on the High Deductible Health Plan, you will pay full price for MDLive medical, therapy, and psychiatric visits, until you reach your deductible.

Utilizing MDLIVE offers unparalleled convenience, as it grants you access through a user-friendly mobile app, online video consultations, or traditional telephone calls. Furthermore, MDLIVE boasts professionalism through its team of board-certified doctors who can seamlessly prescribe medication, allowing members to choose their preferred pharmacy for added convenience. Beyond these advantages, MDLIVE proves to be a cost-effective healthcare solution by potentially diverting individuals from costly urgent care and emergency room visits, leading to substantial savings.

To access MDLIVE Virtual Visits, log on to your Blue Cross Blue Shield of Texas account at www.bcbstx.com, scan the QR code, or call MDLIVE at 888-680-8646 and select the type of service you need (Medical Visit, Therapist, or Psychiatrist) and click "Schedule Your Visit".

Dental

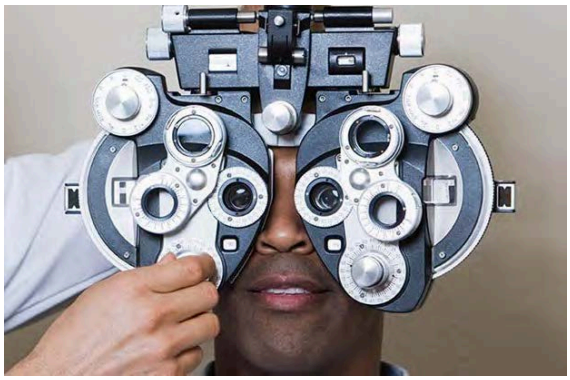
New Braunfels Utilities will continue to offer Dental benefits through MetLife for the 2025 plan year. You have two dental plans to choose from. The Low Plan offers the same general benefits as the high plan, but has a lower annual maximum per covered person of $1,000 and excludes Orthodontic coverage. The High Plan has an annual maximum per covered person of $1,500. The dental insurance network is PDP Plus. Use this network to find providers in your area.

	Low Plan	High Plan
Annual Deductible	$50 Individual / $150 Family	$50 Individual / $150 Family
Preventative Services (Exams, Cleanings- Once every Six Months, X-rays)	100% Covered	100% Covered
Basic Services (Fillings, Extractions, Oral Surgery, Endodontics)	80% Covered up to annual maximum after Deductible	80% Covered up to annual maximum after Deductible
Major Services (Crowns, Dentures, Periodontics)	50% Covered up to annual maximum after Deductible	50% Covered up to annual maximum after Deductible
Annual Maximum	$1,000 per covered person	$1,500 per covered person
Child Orthodontic Services (Up to 18 Years Old)	Not Covered	50% to Lifetime Maximum of $1,500
Out of Network Benefits	Paid at 90th percentile of U&C	Paid at 90th percentile of U&C
Bi-Weekly Employee Contribution		
Employee Only	$12.69	$21.08
Employee + Spouse	$31.01	$48.23
Employee + Child(ren)	$28.95	$55.84
Employee + Family	$49.49	$91.16

Scan this QR code to find a dentist, file a claim, and learn more about your dental insurance!

Vision

New Braunfels Utilities will continue to offer vision through MetLife for the 2025 plan year. Your in-network benefits are described below. If you use an out-of-network doctor or facility, the plan reimburses at a flat dollar amount.



NOTE: you may not be reimbursed 100% of the costs paid when going out-of-network. Use the PPO Network to find providers in your area.

Type of Service	In Network Charge
Eye Exam	$10 Copay
Frames (every 24 months)	$130 Allowance
Standard Lenses (every 12 months)	$10 Copay
Contact Lenses (every 12 months)	$130 Allowance
Bi-Weekly Employee Contribution	
Employee Only	$3.51
Employee + One	$6.59
Employee + Family	$9.38

Additional Vision Resources:

- Discount Prescription Eyeglasses: RX Glasses starting at $6.95, visit www.zennioptical.com.
- Affordable Eyeglasses: visit www.glassesusa.com.
- Designer Eyeglasses: lenses starting at $95. Free Home Try On – Order 5 pairs to try on. Keep what you want or return all by visiting www.warbyparker.com!

Scan this QR code to find an eye doctor, file a claim, and learn more about your vision insurance!

Individual Cancer and Specified Disease Insurance

Why consider a Cancer plan when you have Major Medical coverage? According to the American Cancer Society's Facts and Figures, direct medical costs only represent about 35% of the cost when you are stricken with Cancer. That means about two-thirds of the cost relating to the treatment of Cancer are non-medical, such as travel and lodging to and from treatment, medication, co-payments, special diets and treatment not covered by health insurance.

Many families do not anticipate the increase in expenses when fighting Cancer, but when income decreases due to missed work in order to seek treatment, the economic burden can financially drain a family.

Bay Bridge Administrators offers a Cancer insurance policy that supplements your major medical coverage to offset the high cost of cancer treatment. The Cancer plan pays benefits directly to you to help with out of pocket expenses, such as mortgage, utility bills, transportation costs and everyday living expenses. You use the money however you want. **The Cancer policy provides benefits for Cancer and 32 specified diseases. Benefits include:**

Benefit	Benefit Amounts
Wellness Benefit: For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, hemoccult stool specimen, or prostate screen. No Lifetime Maximum.	Low Option: Up to $50 per calendar year Mid Option: Up to $75 per calendar year High Option: Up to $100 per calendar year
Positive Diagnosis Test: Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to $300 per calendar year
Non-Local Transportation: Payable for transportation to a Hospital, clinic or treatment center which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum.	Actual charges by a common carrier or 50 cents per mile if a personal vehicle is used.
Continued on the next page...	

Benefit	Benefit Amounts
Adult Companion Lodging and Transportation: Payable for one adult companion to stay with a Covered Person who is confined in a Hospital that is more than 60 miles and less than 700 miles from his or her home. Covered expenses include a single room in a motel or hotel up to 60 days per confinement; and the actual charge of round-trip coach fare by a common carrier or a mileage allowance for the use of a personal vehicle. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. No Lifetime Maximum.	Up to $75 per day for lodging. 50 cents per mile if a personal vehicle is used.
Ambulance: For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. No Lifetime Maximum.	Actual Charges
Surgery: Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum.	Low Option: $1,500 Mid Option: $3,000 High Option: $6,000
Donor Benefit Bone Marrow and Stem Cell Transplant: We will pay the following expenses incurred by the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual Charges up to $50 per day for lodging and meals expense for donor to remain near Hospital.	Low Option: (a) $200 per day Mid Option: (a) $200 per day High Option: (a) $400 per day (b) Actual charges for round trip coach fare; or personal automobile expense of 50 cents per mile. (c) Actual charges up to $50 per day
Bone Marrow and Stem Cell Transplant: We will pay Actual Charges per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant.	Actual charges to a combined lifetime maximum of $15,000
Anesthesia: For services of an anesthesiologist during a Covered Person's surgery. For anesthesia in connection with the treatment of skin Cancer. No Lifetime Maximum.	Up to 25% of surgical benefit paid.
Ambulatory Surgical Center: We will pay the expense incurred at an Ambulatory Surgical Center. No Lifetime Maximum.	$100 maximum per Covered Person
Continued on the next page...	

Benefit	Benefit Amounts
Drugs and Medicines: Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum.	Up to $25 per day, $600 per calendar year
Outpatient Anti-Nausea Drugs: Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum.	Up to $250 per calendar year
Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy: Covers treatment administered by a Radiologist, Chemotherapist or Oncologist on an inpatient or outpatient basis. No Lifetime Maximum.	Low Option: Actual charges up to $200 per day Mid Option: Actual charges up to $1,000 per day High Option: Actual charges up to $5,000 per month
Miscellaneous Therapy Charges: Covers charges for lab work or x-rays in connection with radiation and chemotherapy treatment. Service must be performed while receiving treatment(s) in Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy or within 30 days following a covered treatment.	Actual charges up to a lifetime maximum of $10,000
Self-Administered Drugs: We will pay the actual expenses incurred for self-administered chemotherapy, including hormone therapy, or immunotherapy agents. This benefit is not payable for planning, monitoring, or other agents used to treat or prevent side effects, or other procedures related to this therapy treatment. No Lifetime Maximum.	Actual charges up to $4,000 per month
Colony Stimulating Factors: We will pay expenses incurred for: [a] cost of the chemical substances and [b] their administration to stimulate the production of blood cells. Treatment must be administered by an Oncologist or Chemotherapist. No Lifetime Maximum.	Low Option: Actual charges up to $500 per month Mid Option: Actual charges up to $1,000 per month High Option: Actual charges up to $1,500 per month
Blood, Plasma and Platelets: For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum.	Actual charges up to $200 per day
Physician's Attendance: For one visit per day while Hospital confined. No Lifetime Maximum.	Up to $35 per day
Private Duty Nursing Service: For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum.	Up to $100 per day
Continued on the next page...	

Benefit	Benefit Amounts
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit: We will pay the expense incurred if a Covered Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Covered Person's place of residence, We will also pay the transportation and lodging expenses incurred. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non-Local transportation Benefits of the policy.	Expenses incurred limited to a lifetime maximum up to $750 for evaluation. Expenses incurred limited to a lifetime maximum up to $350 for transportation and lodging.
Breast Prosthesis: Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum.	Actual Charges
Artificial Limb or Prosthesis: Covers implantation of an artificial limb or prosthesis when an amputation is performed.	$1,500 lifetime maximum per amputation.
Physical or Speech Therapy: Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum.	Up to $35 per session
Extended Benefits: If a Covered Person is confined in a Hospital for 60 continuous days We will pay three times the selected Hospital Confinement Benefit beginning on the 61st day for Hospital Confinement. This benefit is payable in place of the Hospital Confinement Benefit. No Lifetime Maximum.	Low Option: $300 per day Mid Option: $300 per day High Option: $600 per day
Extended Care Facility: Limited to number of days of prior Hospital confinement. Must begin within 14 days after Hospital confinement, and be at the direction of the attending Physician. No Lifetime Maximum.	Up to $50 per day
At Home Nursing: Limited to number of days of prior Hospital confinement. Must begin immediately following a Hospital confinement, and be authorized by the attending Physician. No Lifetime Maximum.	Up to $100 per day
New or Experimental Treatment: We will pay the expenses incurred by a Covered Person for New or Experimental Treatment judged necessary by the attending Physician and received in the United States or in its territories. No Lifetime Maximum.	Up to $7,500 per calendar year
Hospice Care: If a Covered Person elects to receive hospice care, we will pay the expenses incurred for care received in a Free-Standing Hospice Care Center. No Lifetime Maximum.	Up to $50 per day
Government or Charity Hospital: Payable if the Covered Person is confined in a U. S. Government Hospital or a Hospital that does not charge for its services. Paid in place of all other benefits under the Policy. No Lifetime Maximum.	$200 per day
Hairpiece: We will pay the actual expense incurred per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.	Actual charge up to a lifetime maximum of $150

Other Specified Diseases Covered:

- Addison's Disease
- Meningitis (epidemic cerebrospinal)
- Scarlet Fever
- Amyotrophic Lateral Sclerosis
- Multiple Sclerosis
- Sickle Cell Anemia
- Cystic Fibrosis
- Muscular Dystrophy
- Tay-Sachs Disease
- Diphtheria
- Myasthenia Gravis
- Tetanus
- Encephalitis
- Niemann-Pick Disease
- Toxic Epidermal Necrolysis
- Epilepsy
- Osteomyelitis
- Tuberculosis
- Hansen's Disease
- Poliomyelitis
- Rocky Mountain Spotted Fever
- Tularemia
- Legionnaire's Disease
- Rabies
- Typhoid Fever
- Lupus Erythematosus
- Reye's Syndrome
- Undulant Fever
- Lyme Disease
- Rheumatic Fever
- Whipple's Disease
- Malaria

Renewability:

As long as premiums are paid on time, you have the right to renew your policy and riders.

Premiums:

Premiums for this policy are calculated at age at issue class as of the effective date of the policy. You lock in your age class for the life of the policy. The premium for this policy and rider, if selected, may change, but will not change because you attain the next premium rate age classification. Any change in premium will apply to all policies and riders of this form number issued in your State of residence.

Payment of Benefits:

Benefits are payable for a Covered Person's Positive Diagnosis of a Cancer or Specified Disease that begins after the Policy Effective Date and while this Policy has remained in force.

Exceptions and Other Limitations:

The Policy pays benefits only for diagnoses resulting from Cancer or Specified Diseases, as defined in the Policy. It does not cover:

1. any other disease or sickness;
2. injuries;
3. any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by:
    a. Specified Disease or Specified Disease treatment; or
    b. Cancer or Cancer treatment, unless otherwise defined in the Policy
4. care and treatment received outside the United States or its territories;
5. treatment not approved by a Physician as medically necessary;
6. experimental Treatment by any program that does not qualify as Experimental Treatment as defined in the Policy.

Pre-Existing Condition Limitation:
During the first 12 months of a Covered Person's insurance, losses incurred for Pre-Existing Conditions are not covered. During the first 12 months following the date a Covered Person makes a change in coverage that increases his or her benefits, the increase will not be paid for Pre-Existing Conditions. After this 12-month period, however, benefits for such conditions will be payable unless specifically excluded from coverage. This 12-month period is measured from the Policy Effective Date for each Covered Person.

Pre-existing condition means Cancer or a Specified Disease, for which a Covered Person has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended or for which medication has been prescribed during the 12 months immediately preceding the effective date of coverage.

Right to Examine Policy:
If you decide not to keep this Policy, send it to us or our agent within 30 days after you receive it. We will treat the Policy as though it had never been issued. We will refund any premiums paid.

Covered Persons:
Covered Person means any of the following:

1. the Named Insured; or
2. any eligible Spouse or Child, as defined and as indicated on the Policy Schedule whose coverage has become effective;
3. any eligible Spouse or Child, as defined and added to this Policy by endorsement after the Policy Effective Date whose coverage has become effective; or
4. a newborn child (as described in the Eligibility Section).

Child (Children) means the Named Insured's unmarried child, including a natural child from the moment of birth, stepchild, foster or legally adopted child, or child in the process of adoption (including a child while the Named Insured is a party to a proceeding in which the adoption of such child by the Named Insured is sought); a child for whom the Named Insured is required by a court order to provide medical support, and grandchildren who are dependent on the Named Insured for federal income tax purposes at the time of application, who is:

1. not yet age 25; or
2. not yet age 26 if a full-time student at an accredited school.

Option To Add Additional Benefits
Hospital Intensive Care Insurance Rider
Form Number HIC-ICR-TX 5/09
In consideration of additional premiums, this coverage will provide you with benefits if you go into a Hospital Intensive Care Unit (ICU).

Benefits:
Your benefits start the first day you go into ICU. The benefit is payable for up to 45 days per ICU stay.

Hospital Intensive Care Confinement Benefit:
You may choose the benefit of $325 or $625 per day. The benefit amount is reduced by one-half at age 75.

Double Benefits:
We will double the daily benefits for each day you are in an ICU as a result of Cancer or a Specified Disease. We will also double the benefit for an injury that results from: being struck by an automobile, bus, truck, motorcycle, train, or airplane; or being involved in an accident in which the name insured was the operator or was a passenger in such vehicle. ICU confinement must occur within 48 hours of the accident.

Emergency Hospitalization and Subsequent Transfer to an ICU:
We will pay the benefit selected by you for the highest level of care in a hospital that does not have an ICU if you are admitted on an emergency basis and you are transferred within 48 hours to the ICU of another Hospital.

Step Down Unit:
We will pay a benefit equal to one half the chosen daily benefit for confinement in a Step-Down Unit.

Exceptions and Other Limitations:
Except as provided in Step Down Unit and Emergency Hospitalization and Subsequent Transfer to an ICU, coverage does not provide benefits for: surgical recovery rooms; progressive care; intermediate care; private monitored rooms; observation units; telemetry units; or other facilities which do not meet the standards for a Hospital Intensive Care Unit.

Individual Cancer Plan - Monthly Rates				
Low Options (BBAC - 379)				
Coverage	**0-29**	**30-44**	**45-59**	**60+**
Employee Only	$5.31	$9.93	$21.20	$32.04
One Parent Family	$10.02	$14.63	$26.00	$35.93
Two Parent Family	$11.50	$20.67	$42.76	$63.5
Mid Option (BBAC - 053)				
Coverage	**0-29**	**30-44**	**45-59**	**60+**
Employee Only	$8.80	$17.22	$36.04	$52.54
One Parent Family	$16.47	$24.89	$43.87	$59.05
Two Parent Family	$18.92	$35.29	$72.19	$104.18

Individual Cancer Plan - Monthly Rates				
High Options (BBAC - 372)				
Coverage	**0-29**	**30-44**	**45-59**	**60+**
Employee Only	$12.43	$23.83	$50.46	$75.27
One Parent Family	$22.94	$34.35	$61.18	$84.24
Two Parent Family	$26.48	$48.91	$101.30	$149.68
Intensive Care Rider $325				
Coverage	**0-29**	**30-44**	**45-59**	**60+**
Employee Only	$1.48	$2.59	$3.24	$3.61
One Parent Family	$3.02	$4.13	$4.80	$5.18
Two Parent Family	$3.70	$5.78	$6.89	$6.53
Intensive Care Rider $625				
Coverage	**0-29**	**30-44**	**45-59**	**60+**
Employee Only	$2.85	$4.99	$6.22	$6.95
One Parent Family	$5.80	$7.94	$9.23	$9.96
Two Parent Family	$7.12	$11.22	$13.25	$12.56
Variable Benefit Elections				
Benefit		**Low Options**	**Mid Options**	**High Options**
Hospital Confinement		$100	$100	$200
Surgical		$1,500	$3,000	$6,000
Radiation/Chemotherapy		$200 per day	$1,000 per day	$5,000 per day
First Diagnosis		$2,500	$2,500	$5,000
Colony Stimulating Factors Wellness		$500	$1,000	$1,500
Wellness		$50	$75	$100

Benefits are not payable: if you go into an ICU before the Policy Effective Date; if you go into an ICU for intentionally self-inflicted bodily injury or suicide attempts; if you go into an ICU due to being intoxicated or under the influence of alcohol, drugs or any narcotics, unless administered on the advice of a Physician and taken according to the Physician's instructions.

Voluntary Life Insurance

Voluntary Life will be offered through MetLife. Employees who want to supplement their group life insurance benefits may purchase additional coverage. If you choose Voluntary Life, you pay the full cost through payroll deductions.

Note: If you want to cover dependents you must also cover yourself. For existing employees with coverage: MetLife will allow you to increase your coverage after the first year, by $10,000 annually for yourself only, without answering medical questions. This is available ONLY if you have less than $200K in place. If you have $200K or more in place, any additional amount you apply for will require an Evidence of Insurability (EOI) medical questionnaire. Any employee not in a waiting period who applies for new coverage will need to complete an EOI medical questionnaire and go through underwriting for approval of coverage.

Employee

- Coverage is available in $10,000 increments (Minimum of $10,000); up to five (5) times your annual salary or up to $500,000, whichever is less.
- Guarantee Issue Amount (GI) - For New Hires only: $200,000 employee - No medical questions asked.

Spouse

- Coverage is available in $5,000 increments up to $250,000 (not to exceed 50% of employees elected benefit amount).
- Guarantee Issue Amount (GI) - For Spouse of New Hires: $30,000 (under age 60) - No medical questions asked.

Child

- Any amount is guaranteed issue - no medical questions asked when dependents are first eligible.
- Child(ren) Birth to 6 months- $1,000 maximum benefit
- Child(ren) older than 6 months to 26 years old - Sold options are $1,000, $2,000, $4,000, $5,000 or $10,000.

The charts on the following page will assist you in what contributions you should make.

Age Bands	<20-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Employee	0.037	0.046	0.06	0.092	0.143	0.222	0.378	0.618	1.02	1.612
Spouse/ Domestic Partner	0.037	0.046	0.06	0.092	0.143	0.222	0.378	0.618	1.02	1.612
Child(ren)	$0.240 per $1,000 of Coverage									
Premium Calculation										
Step 1	_____/1,000 = _____ Benefit # of Units									
Step 2	_____ X _____ = $_____ # of Units Age-Band Rate Premium Per Month									
Step 3	(_____ X 12 = _____) / 26 = _____ Monthly Premium Annual Premium Payroll Deduction									
Example: 34 year old with a $200,000 benefit										
Step 1	$200,000 / 1,000 = 200 Units									
Step 2	200 X .046 (34 year old age band rate) = $9.20 Premium Per Month									
Step 3	($9.20 X 12 = $110.40) / 26 = 4.25 Payroll Deduction Per Pay Period									

Smart Dollar

What is Smart Dollar?

Smart Dollar is a financial wellness program from Dave Ramsey that will get you pumped up and dreaming big while walking you through your financial journey.

What does Smart Dollar offer?

This program includes powerful video lessons, interactive budgeting tools, and live group coaching that will help you learn how to:

- Pay off debt faster
- Save money for emergencies
- Prepare for retirement
- Build a budget for your future

Who qualifies for a FREE Smart Dollar Account?

All full-time and part-time NBU employees are eligible to create a FREE Smart Dollar Account! However, if an employee resigns or is terminated, their Smart Dollar Account will be deactivated.

New Benefits

For less than $1 a day, you have access to these convenient benefits -- this comes out to $4.62 per pay period. This program includes your immediate family—so everyone is healthy and happy!

ID Sanctuary
Safeguard your identity with Sanctuary's comprehensive protection services. With ID Sanctuary, you have immediate access to expert fraud specialists who provide personalized assistance to reduce the risk of identity theft. Plus, our coverage extends to your employees and up to four legal dependents over 18, offering peace of mind for your whole family.

Roadside Assistance
Stranded? Car trouble is no trouble. Roadside Assistance is there for you and your immediate family to help with a flat tire, lock-out, battery, collision and even towing—with coverage up to $80. They will even bring you fuel, oil, fluid and water 24/7!

Legal Services
Have legal questions? Get legal answers from experienced lawyers at discounted rates. Attorneys help with traffic tickets, bankruptcy, divorce, and spousal and child support. Additional services are also available at no cost to you!

Pharmacy
Save 10% to 85% on most prescriptions at 60,000 pharmacies nationwide including CVS, Walgreens, Target and more.

Pet Care
Caring for pets can be rrrrruf! Keep your pets happy and healthy with discounts on everything from toys and treats to grooming and eats! You can save on boarding, doggie daycare, training, veterinary services and more.

Global Travel Assistance
Got a trip planned? Protect yourself and your loved ones. When traveling 100 miles or more from home, you can rest easy knowing you have a global network of doctors, assistance personnel and emergency benefits. Get medical help around the world with emergency medical evacuation, monitoring of treatment, replacement of lost or stolen travel documents and more. Global Travel Assistance not available to FL, NY, OR or WA residents.

Hearing Aids
Want to save big on hearing aids? We hear you! You'll save 35% off the suggested retail price (MSRP) at thousands of retail locations nationwide.

Additional Benefits

Retirement

All regular full-time employees are automatically enrolled in TMRS effective their date of hire.

- Employees contribute a mandatory 7% of gross income (pre-tax) through payroll deductions.
- NBU matches the contributions 2:1 from your start date. Employees become vested after 5 years of service and can retire after 20 years of service or 60 years of age and 5 years of service, in which case you will receive NBU's match.
- NBU recognizes prior service credit for employees who have previously contributed to TMRS. To apply, please contact HR and complete a Prior Service Credit Application.

457 Deferred Compensation Plan

A governmental 457(b) deferred compensation plan is a retirement savings plan that allows eligible employees to contribute pre-tax money via payroll deduction to start building their retirement savings. NBU partners with Hoffman Financial to administer our 457(b) deferred compensation plan. Contact your HR team for more details.

Vacation, Sick & Personal Leave

NBU recognizes the importance of Vacation, Personal, and Sick Leave as everyone tries to achieve a work-life balance. You start accruing and can use this leave immediately.

- Full-time employees accrue vacation based on their years of service (see breakdown below).
- Full-time employees accrue 96 hours of sick leave annually.
- Full-time employees receive 24 hours of personal leave annually, and it reloads every year on your anniversary.

Years of Service	Vacation Hours Accrued Per Year	Vacation Hours Accrued Per Pay Period
0-1	80	3.08
1-2	88	3.39
2-3	96	3.70
3-4	104	4.00
4-5	112	4.31
5-7	120	4.62
7-9	128	4.93
9-11	136	5.24
11-13	144	5.54
13-15	152	5.85
15+	160	6.16

Additional Benefits

Bereavement Leave

NBU provides full-time employees five days of paid time away from work in the event of the death of a:

- Employee's Spouse
- Employee's Parent (including step-parents)
- Employee's Sibling (including half-siblings and step-siblings)
- Employee's Child (including step-child, foster child, and any fertility-related loss)

NBU provides full-time employees three days of paid time away from work in the event of the death of a:

- Employee's Grandparent
- Employee's Grandchild
- Employee's Aunt
- Employee's Uncle
- Employee's Spouse's Parent
- Employee's Spouse's Sibling
- Employee's Spouse's Grandparent

Parental Leave

We understand the importance of family. That's why we offer six weeks of paid leave following the birth of your child or the placement of a child in your care through adoption and foster care, if you are a regular full-time employee with at least one year of service.

Voting Time Off

Employees may take up to 2 hours of paid time off to vote in any local or presidential election, from the start of early voting through Election Day. This ensures you have ample time to vote without using your lunch break or affecting your workday, giving you the flexibility to manage both your civic duties and personal well-being.

Paid Holidays

New Braunfels Utilities observes 15 paid holidays annually:

- Martin Luther King Day
- President's Day
- Founder's Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Comal County Fair Day
- Veteran's Day
- Thanksgiving Day
- Friday after Thanksgiving
- Christmas Eve
- Christmas
- New Year's Day
- Floating Holiday (receive immediately & reloads to 8 hours every August 1st)

Tuition Reimbursement

All regular full-time employees with at least six months of service are eligible for up to $5,000 in tuition reimbursement per calendar year. This applies to associate's, bachelor's (whether it's your first degree or not), and your first master's degree. To qualify for reimbursement, you must earn a grade of C or higher for associate's or bachelor's courses, B or higher for master's courses, and a Pass for any Pass/Fail courses. For more information and to apply, please contact Human Resources.

Recognition

At NBU, we're committed to celebrating both your personal and professional milestones. That's why we send personalized gifts for life's major moments, such as getting married or welcoming a child, whether by birth or fostering. We also make it a priority to recognize your professional achievements through quarterly and annual awards, service pins, up to $450 retirement gift(s), as well as ongoing perks and prizes throughout the year.

Training & Development

At NBU, professional growth and development are top priorities. We're dedicated to helping you take the next step in your career! To support your success, we offer year-round training on key topics such as emotional intelligence, crucial conversations, Gallup Strengths, growth mindset, leadership, and more. Our goal is to equip you with the skills and knowledge you need to thrive and grow at NBU!

Short Term Disability

Employees on a certified medical leave (FMLA or Non- FMLA) for their own serious health conditions may apply for Short-Term Disability coverage. The plan pays 70% of an eligible employee's wages beginning the 31st day after the qualifying event. Employees are automatically enrolled in this benefit at no cost to them.

Long Term Disability

Long-term disability (LTD) coverage is there to provide financial support if you can no longer work due to a disability. With LTD, you'll receive 60% of your pre-disability monthly earnings every month, up to a maximum of $10,000, regardless of your annual salary. This benefit continues until you reach a specific age, which is determined by your Social Security Normal Retirement Age (a scale based on what year you're born). Benefits begin after the end of the elimination period, which begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit. NBU's elimination period for LTD is 180 days.

Corporate Gym Memberships

New Braunfels Utilities (NBU) offers discounted corporate gym memberships to all employees with a limit of 1 gym at a time. NBU contributes $10.00 per month for employee-only plans and $15.00 per month for employee + add-on plans. New employees can enroll after 30 days during open enrollment, while existing employees can enroll, cancel, or make changes to their gym membership at any time through ADP.

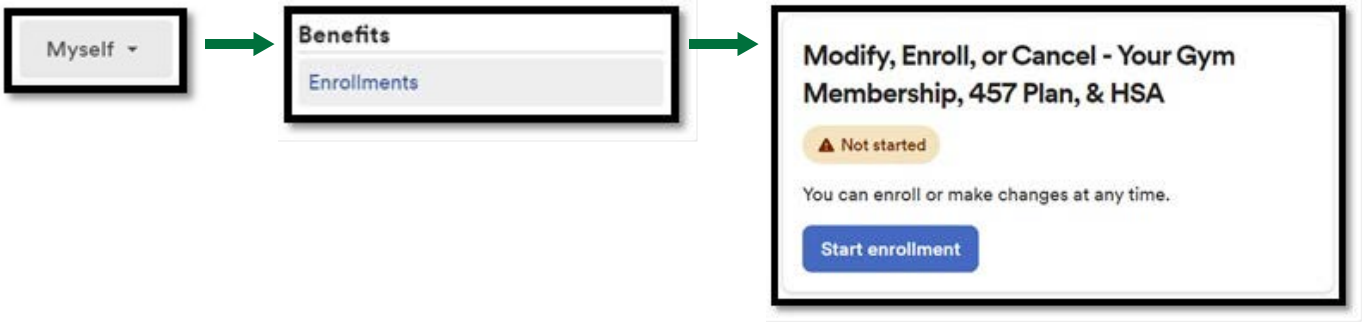
How to Enroll, Cancel, or Make Changes to Your Gym Membership:

Everything can be done through ADP! Follow these easy steps below:

Log into ADP > Click Myself.

Click Enrollments under the Benefits section.

Click Start enrollment under the "Modify, Enroll, or Cancel – Your Gym Membership, 457 Plan, & HSA" section.



Go through the process to change your gym membership. If you're joining, changing, or ending your membership with Gold's Gym or Das Rec, you'll need to fill out extra forms. These forms are available for download, completion, and uploading as you go through the process.

Then, hit submit! Your new gym changes will be effective the 1st of the following month.

If you need further assistance, feel free to visit the HR office, where you can utilize our dedicated computer kiosk.

How Your Gym Membership Selection Will Show Up on Your Paycheck

- Regular deductions: The discount for your gym membership is deducted every pay period under the code "Fitness Program." This deduction already includes NBU's contribution/discount.
- Monthly adjustment: Due to government rules, we need to show that this benefit has been taxed. So, on the LAST pay period of every month, you'll see an additional deduction AND earnings entry titled "NBU Fitness." This essentially cancels out for employees, resulting in no net change to your pay.

Plan	Gym Cost	NBU's Contribution	Employee Cost Per Month	Employee Cost Per Pay Period
American Fitness				
Employee Only	$23.65	-$10.00	$13.65	$6.30
Employee + Add On *You can add any family member (spouse, partner, or child). Children must be 12 or older to join, and those under 17 need a parent present. Members 17 and up do not require parental supervision.*	$41.85	-$15.00	$26.85	$12.39
Employee + Family (3 -4 Members)	$60.00	-$15.00	$45.00	$20.77
Anytime Fitness				
Employee Only	$28.15	-$10.00	$18.15	$8.38
Employee + Add On *You can add any family member (spouse, partner, or child). Children must be 16 or older to join, and those under 17 need a parent present. Members 17 and up do not require parental supervision.*	$48.15	-$15.00	$33.15	$15.30
Das Rec				
Employee Only	$32.00	-$10.00	$22.00	$10.15
Employee Only (60+)	$22.00	-$10.00	$12.00	$5.54
Employee + Family (2-4 Members)	$51.00	-$15.00	$36.00	$16.62
Employee + Family + Add On	$62.00	-$15.00	$47.00	$21.69
Gold's Gym				
Employee Only	$25.99	-$10.00	$15.99	$7.38
Employee + Add On *You can add any family member (spouse, partner, or child). Children must be 10 or older to join, however, only children 15 or older can work out alone, while those under 15 must be with a parent.*	$51.98	-$15.00	$36.98	$17.07
Employee + 2 Add Ons	$77.97	-$15.00	$62.97	$29.06
Employee + 3 Add Ons	$103.96	-$15.00	$88.96	$41.06
Employee + 4 Add Ons	$129.95	-$15.00	$114.95	$53.05
Planet Fitness				
Employee Only (White Card)	$10.00	-$10.00	$0	$0
Employee + Add On (White Card) *You can add any family member (spouse, partner, or child). Children must be 13 or older to join, and those under 14 need a parent present. Members 14 and up do not require parental supervision IF they have a parent waiver on file.*	$20.00	-$15.00	$5.00	$2.31
Employee Only (Black Card)	$19.99	-$10.00	$9.99	$4.61
Employee + Add On (Black Card) *You can add any family member (spouse, partner, or child). Children must be 13 or older to join, and those under 14 need a parent present. Members 14 and up do not require parental supervision IF they have a parent waiver on file.*	$39.38	-$15.00	$24.98	$11.53

Employee Assistance Program

New Braunfels Utilities provides an Employee Assistance Program (EAP) benefit for you, your spouse and eligible dependents up to the age of 26. Interface EAP provides access to free and confidential counseling services with a therapist in your area, and referrals to attorneys and financial advisors.

What is EAP?

EAP is one of the most effective ways to identify and address personal problems. The EAP provides referral assistance for professional, confidential, short-term counseling services for employees and their family members who may be experiencing difficulties. The EAP also provides referral assistance for legal and financial consultations.

How does EAP work?

When you first call, you will be connected with a Care Coordinator who will assist to identify your concerns and match you with the right support. A free and confidential referral can be provided to assist with a number of issues including but not limited to:

- Stress
- Anxiety/Depression
- Relationships/Marriage
- Grief & Loss
- Addiction & Recovery
- Eldercare Support
- Debt Management
- Career Development
- Legal Consultations
- Mental Wellness
- Workplace Concerns
- Dealing with Trauma

What does your EAP provide?

Counseling Services	Legal Services	Financial Counseling & Planning	Online Work/ Life Resources	Online Wellness Resources
Employees and their immediate family members can access up to 6 free face-to-face counseling sessions with a licensed therapist. These sessions aren't limited to one reason per year. For longer-term care, EAP will help individuals find community referrals and access mental health networks.	Your legal benefits offer a lot: a free 30-minute attorney consultation, a simple will kit, up to 6 pages of document review, attorney correspondence on your behalf, and up to 25% off their regular rates. Each family has access to three 30-minute consultations per plan year.	Access financial counseling and planning resources, including debt consolidation, identity theft counseling, retirement planning, and licensed Financial Planners. Each family has three 30-minute phone consultations with a financial advisor per plan year.	Unlimited self-help tools on work/life resources are available to all employees and their families. These encompass child care, elder care, school/college support, adoption assistance, pet care services, and educational materials and calculators.	Access weekly wellness lessons covering topics like stress, healthy weight, back pain management, and more. Additionally, enjoy quarterly wellness webinars on subjects such as sleep, exercise, healthy eating, and stress management.

EAP is private and confidential.
It is difficult to know where to turn when personal problems arise. The EAP is free and confidential. No one will know if you have used this program. The files are kept separate and strictly confidential. There are times when additional help is needed to establish things and get to the root of the problems. It is in those moments there is objective and professional help offered by your Employee Assistance Program

Working Advantage

Access your employee perks program today! We're here to support your personal and financial well-being through exclusive deals and limited-time offers on the products, services and experiences you need and love by offering...

MORE PERKS . MORE SAVINGS. MORE OF WHAT MAKES YOU HAPPY.

Start saving on:

- Electronics
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- Apparel
- Cars
- Flowers
- Fitness Memberships
- Gift Cards
- Groceries
- Hotels
- Movie Tickets
- Rental Cars
- Special Events
- Theme Parks
- And More

New to Working Advantage? Getting Started is Easy!

1. Visit WorkingAdvantage.com.
2. Click Become a Member.

Glossary of Health Terms

Affordable Care Act: A comprehensive law passed in 2010, the Affordable Care Act was aimed at reforming America's health care system to improve access and affordability for more Americans.

Allowable Charge: The maximum amount a health plan will reimburse a doctor or hospital for a given service.

Annual Deductible: The amount you are required to pay annually before reimbursement by your health plan begins. The deductible requirement does not apply to preventive services.

Benefits: The health care items or services covered by a health plan. Your health plan may sometimes be referred to as a "benefits package."

Catastrophic Plan: Catastrophic plans have lower premiums and the same essential benefits as other plans, but have much higher deductibles. They are available to young adults and people for whom coverage would otherwise be unaffordable.

Claim Form: A form you or your doctor fill out and submit to your health plan for payment.

Claim: An itemized bill from a health care provider for services provided to a member.

COBRA: This stands for Consolidated Omnibus Budget Reconciliation Act of 1985. This federal act requires group health plans to allow employees and covered dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, job loss, a child becoming an over-aged dependent, Medicare eligibility, death or divorce of a covered employee, among others.

Coinsurance: The percentage of the costs of a covered health care service or prescription drug you pay after you've paid your deductible. You pay 100 percent of the full allowed amount until you meet your deductible.

Contracting Hospital: A hospital that has contracted with a particular health plan to provide hospital services to members of that plan.

Coordination of Benefits: When you need care and are on two different health plans, your insurers will coordinate your benefits to give you maximum coverage when you need it. It helps avoid duplicate payments and ensure the right payments are made by each plan.

Copay: The set dollar amount you pay for a covered health care service at the time you receive care or when you pick up a prescription drug.

Cost-Sharing Reduction (CSR): A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copays. You can get this discount if your income is below a certain level and you choose a health plan from the Silver plan category. If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.

Covered Person: The eligible person enrolled in the health plan and any enrolled eligible family members.

Covered Service: A service that is covered according to the terms in your health plan. Deductible: The amount you pay for most covered services before your health plan starts to pay. When you go to a provider that is in the plan's network, before you meet the deductible you may pay a discounted amount that has been negotiated with the provider. The deductible resets at the beginning of the calendar year or when you enroll in a new plan.

Dependent: An eligible person, other than the member (generally a spouse or child), who has health care benefits under the member's policy.

Drug Formulary: A list of preferred drugs chosen by a panel of doctors and pharmacists. Both brand and generic medications are included on the formulary.

Effective Date of Coverage: The date your coverage begins or the date a change in your coverage takes effect.

Emergency Medical Care: Services provided for the initial outpatient treatment of an acute medical condition, usually in a hospital setting. Most health plans have specific guidelines to define emergency medical care.

Employer Responsibility: If an employer with at least 50 full-time equivalent employees doesn't provide affordable health insurance and an employee uses a tax credit to help pay for insurance through the Health Insurance Marketplace, the employer must pay a fee to help cover the cost of tax credits.

Essential Health Benefits: Some benefits that are included in every health plan, meant to make sure basic health concerns are covered. For example, preventive care screenings and annual wellness exams are covered with any plan you buy.

Exclusions: Specific medical conditions or circumstances that are not covered under a health plan.

Explanation of Benefits (EOB): An EOB is created after a claim payment has been processed by your health plan. It explains the actions taken on a claim, such as the amount that will be paid, the benefit available, discounts, reasons for denying payment and the claims appeal process. EOBs are available as a paper copy or electronically.

Family Coverage: Health care coverage for a primary policyholder (called a "subscriber") and their spouse and any eligible dependents.

Federal Poverty Level (FPL): The income level of an individual or household used by the Department of Health and Human Services to determine eligibility for certain programs and benefits. FPL will be used to determine the amount of tax credit you qualify for to offset the cost of buying health insurance.

Generic Drug: A prescription drug that is the generic equivalent of a brand name drug listed on your health plan's formulary and costs less than the brand name drug.

Grandfathered Health Plan: A health plan that was in place when the Affordable Care Act was passed into law in 2010. A grandfathered plan is exempt from some requirements of the law. The grandfather rule allows businesses and families to keep the plan they have, if they wish to.

Group Plan: A group of people covered under the same health plan and identified by their relation to the same employer or organization.

Guaranteed Issue: A requirement under the Affordable Care Act that health plans must permit you to enroll in some form of insurance coverage regardless of health status, age, gender or other factors.

Health Insurance Marketplace: The Health Insurance Marketplace, or Health Insurance Exchange, is a federal government website where you can shop, compare and buy plans offered by participating health insurance companies in your area. You can access the Marketplace at Healthcare.gov , through BlueCross BlueShield of Texas or by phone.

Health Maintenance Organization (HMO): A type of health plan that provides health care coverage to its members through a network of doctors, hospitals and other health care providers. An HMO may cost less than other plans but has some limitations.

Health Savings Account: With a Health Savings Account, or HSA, you set aside money before taxes. When you visit a doctor or go to a hospital, you can pay for qualified expenses from your HSA. Only certain plans meet the high deductible amounts needed for you to be able to use your HSA.

HIPAA: A federal law that outlines the rules and requirements plans must follow to provide health insurance coverage for individuals and groups.

Individual & Family Health Plan Out-of-Pocket Maximums: This represents the maximum amount you'll ever pay for covered services within a plan year, exclusive of your monthly premium. After you meet your deductible, pay any copays or coinsurance, your health plan covers 100 percent of the costs for covered benefits. If your plan includes multiple individuals, each person's out-of-pocket maximum contributes to the overall family limit. Once the family out-of-pocket maximum is reached, the plan covers 100% of the cost for covered benefits for everyone on your plan.

Individual Coverage HRA (ICHRA): Starting January 1, 2020, employers can offer their employees an individual coverage Health Reimbursement Arrangement (HRA) instead of a traditional group health plan. This type of account may help reimburse qualifying health care expenses. As examples, these expenses could be monthly premiums and out-of-pocket costs, such as copays and deductibles.

Individual Health Insurance Plan: Health care coverage for an individual with no covered dependents. Also known as individual coverage.

Infusion Drug Care: Infusion drug treatments are often used for chronic "maintenance" conditions like asthma, immune deficiencies or rheumatoid arthritis. The drugs are often covered under your health plan's medical benefit, not the drug benefit. Where you get this care could change your out-of-pocket costs.

In-Network: Services provided by a physician or other health care provider with a contractual agreement with the insurance company and covered at a higher benefit level. Inpatient Services: Services provided when a member is registered as a bed patient and is treated as such in a health care facility, such as a hospital.

Insured Person: The person who a contract holder (an employer or insurer) has agreed to provide coverage for, often referred to as a member/subscriber.

Lifetime Limit: A cap on the total benefits you may get from your insurance company over the life of your plan for certain conditions. A health plan may have a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like one gastric bypass per lifetime), or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. There are no lifetime limits on essential health benefits, such as emergency services and hospital stays.

Medicaid: A joint federal and state funded program that provides health care coverage for low-income children and families, and for certain aged and disabled individuals.

Medical Cost-Sharing Group: A medical cost-sharing group (also called health sharing ministries) is a group of like-minded individuals that help each other pay their medical expenses. These groups are similar to a health plan. However, instead of paying a monthly premium bill, contributions are made to a shareable account. This way, when a member needs health care funds, the shared money may be used to help cover the costs.

Medical Group: A group of doctors and other health professionals that have a shared medical practice and contract with a health plan to deliver health care services to plan members.

Medicare: The federal program established to provide health care coverage for eligible senior citizens and certain eligible disabled persons under age 65.

Member: The person to whom health care coverage has been extended by the policyholder (generally their employer) or any of their covered family members. Sometimes referred to as the insured or insured person.

Minimum Essential Coverage (MEC): The type of health coverage an individual needs to maintain throughout the year in order to meet the individual responsibility requirement under the Affordable Care Act. Health plans that are considered MEC include individual and family plans bought through the Health Insurance Marketplace, qualified health plans bought directly through an insurance company such as Blue Cross and Blue Shield of Illinois, job-based coverage, Medicare, Medicaid, and certain other coverage.

Network: The group of doctors, hospitals and other health care professionals that contracts with a health plan to deliver medical services to its members.

Non-Contracting Hospital: A hospital that has not contracted with a particular health plan to provide hospital services to members in that plan.

Open Enrollment Period: The period of time set up to allow you to choose from available health insurance plans, usually once a year.

Out-of-Network Provider: Services you receive are considered out of network when you use a doctor or other health care provider that does not have a contract with your health plan. When you go to an out-of-network provider, services may not be covered, or may be covered at a lower level. You may be responsible for all or part of the bill when you use out-of-network providers.

Out-of-Pocket Maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copays and coinsurance, your health plan pays 100 percent of the costs of covered benefits. The out-of-pocket maximum doesn't include your monthly premium payments or anything you spend for services your plan doesn't cover.

Outpatient Services: Treatment that is provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility.

Participating Provider Option (PPO): A health plan that supplies services at a higher level of benefits when members use contracted health care providers. PPOs also provide coverage for services rendered by health care providers who are not part of the PPO network; however, the plan member generally shares a greater portion of the cost for such services.

Pharmacy Benefit Manager (PBM): A separate, or third-party, company that handles your health plan's pharmacy benefit. A PBM processes and pays for your prescription drug claims based on the terms of your pharmacy benefit.

Premium: The ongoing amount that must be paid for your health plan. You and/or your employer usually pay it monthly, quarterly or yearly. The premium may not be the only amount you pay for insurance coverage. Typically, you will also have a copay and deductible amount.

Premium Tax Credit: Based on your family size and income, you may qualify for a tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium costs. Sometimes called an advanced premium tax credit (APTC), or tax credit.

Prescription Drugs: Prescription drugs must be ordered by a doctor and obtained at a pharmacy. They are reviewed and approved through a formal process set by the U.S. Food and Drug Administration (FDA).

Prescription Drug List: A list of commonly prescribed drugs (also known as a drug formulary). Not all drugs listed in a plan's prescription drug list are automatically covered under that plan.

Prescription Drug Payment Level Tier: A prescription drug list has different levels of payment coverage, called “tiers." These tiers determine how much you will pay out of pocket for your prescription drug, based on the terms of your pharmacy benefit and whether the drug is covered on the drug list. Drugs in a lower tier will often cost less than drugs in a higher tier.

Preventive Care Services: Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Physician (PCP): The physician you choose to be your primary source for medical care. Your PCP coordinates all your medical care, including hospital admissions and referrals to specialists. Not all health plans require a PCP.

Prior Authorization: The process by which a plan member or their doctor gets approval from their health plan before the member undergoes a course of care, such as a hospital admission or a complex diagnostic test. Also called preauthorization.

Provider: A licensed health care facility, program, agency, doctor or health professional that delivers health care services.

Qualified Health Plan: A health plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (deductibles, copays, and out-of-pocket amounts) and meets other requirements.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA): Small companies may offer their employees a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) if they don’t offer group health coverage. This kind of account may help pay for things like monthly premiums or other qualifying health care costs.

Referral: For an HMO or point-of-service (POS) coverage, a written authorization from a member's primary care physician (PCP) to receive care from a different contracted doctor, specialist or facility.

Specialist: A health care professional whose practice is limited to a certain branch of medicine, including specific procedures, age categories of patients, specific body systems or certain types of diseases.

Special Enrollment Period: A time outside of the open enrollment period during which you can sign up for health insurance. You generally qualify for a special enrollment period of 60 days following certain life events that change your family status (for example, marriage or birth of a child) or loss of other health coverage.

Specialty Drug: A prescription drug used to treat complex health conditions. These drugs are usually given as a shot, but may be added to the skin or taken by mouth. Also, they may:

- Require following a specific treatment plan
- Have special handling or storage needs
- Not be sold in retail pharmacies

Conditions like hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis are treated with specialty drugs.

State Continuation Coverage: This health care coverage continuation program is offered by the state of Texas. It's not the same as COBRA because it's only for companies with less than 20 workers. If your employment ended (not due to cause), and you were on your job's health plan for at least 3 months in a row, you and your family may choose to stay covered under a state health plan for an extra 9 months.

Subsidy (Also Known as Premium Tax Credit): Based on your family size and income, you may qualify for a subsidy, also known as a premium tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium bill.

Utilization Management: The way we review the type and amount of care you're getting. This involves looking at the setting for your care and its medical necessity. Examples may include prior authorization, case management, accompanying reviews or proper discharge planning.

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

Notes

Prepared by Your Human Resources Team

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