EXPLORING YOUR BENEFITS

Lubbock County

Employee Benefits

2025 Enrollment Guide

WELCOME!

Welcome to your benefits! This guide provides a summary of your benefit options. We ask you to use the guide to navigate yourself in the right direction when selecting your benefits. The key to getting the most value from your benefit package is to take an active role in understanding and utilizing the tools available to assist you in caring for yourself and your family.

You have many resources available for any questions related to your plans as you enroll and throughout the year. Take advantage of these resources to be sure you receive the full benefits you need and all that is available to you.

The health care coverage you elect begins with your initial eligibility date and continues through the end of the enrollment year. Lubbock County's plan year begins January 1st and ends December 31st.

RETIREMENT PROGRAM

Eligible Lubbock County employees are automatically enrolled in the Texas County & District Retirement System upon their date of hire.

How the Plan Works

- You contribute 7% pre-tax each pay period
- You earn 7% compound interest annually
- When eligible to retire, you receive a lifetime monthly benefit

Naming a Beneficiary

- You can designate/update beneficiaries by signing in to tcdrs.org

Vesting: 8 Years of Service

Once vested, you have a right to a lifetime monthly benefit that will include employer matching when you reach retirement eligibility. You are eligible for retirement when you meet one of the following requirements:

Age	Service
Age 60 and	8 years
Age plus	Years of service = 75
Any age with	20 years

Retirement Eligibility

You must be vested to be eligible for retirement. Other ways to earn service time include:

- Multiple TCDRS accounts
- ERS (State of Texas)
- JRS (Courts)
- TRS (Schools)
- TMRS (Select Cities)
- COA (City of Austin)
- Military service*

*Once vested, you can add up to 5 years of military service.

ELIGIBILITY & ENROLLMENT

All full-time Lubbock County employees working at least 30 hours per week are eligible for benefits. As a new hire, you are eligible for benefits the first of the month coinciding or following the date you complete your 60-day waiting period. Additionally, you will enroll during Open Enrollment for a January 1st effective date.

You may enroll the following eligible dependents* in our group benefit plans:

- Your legal spouse
- Your natural child under age 26
- Your legally adopted child under age 26
- Your stepchild under age 26
- A child for whom you have legal guardianship under age 26

**Supporting documentation is required.*

Qualifying Life Events

Benefit elections made during open enrollment are effective at the beginning of the plan year. Most benefits are paid for on a "pre-tax" basis; therefore due to IRS regulations, once you have made your choices for the 2025 plan year, you will not be able to change your benefits until the next enrollment period unless you experience a Qualifying Life Event.

If you experience any of the following qualifying life events, you must request changes to your coverage within **30 days** of the event. Supporting documentation is required.

- Marriage
- Birth
- Adoption
- Loss of other coverage
- Divorce
- Gain of other coverage
- Death

Qualifying Event	Dependent Verification Documentation
Marriage	Government issued Marriage Certificate
Birth	Government issued Birth Certificate naming you as parent OR (if under six months of age only) Hospital documentation reflecting the child's birth, naming you as parent
Adoption	Legal documentation of the adoption
Loss of Other Coverage	Letter indicating the loss of coverage from the prior plan sponsor, including name(s) of the insured, specific coverages that were lost, and date that coverage(s) were lost
Divorce	Government issued Divorce decree showing date of divorce
Gain of Other Coverage	Letter indicating the gain of coverage from the new plan sponsor, including name(s) of the insured, specific coverages that were elected, and date that coverage(s) are effective
Death	Government issued Death Certificate

MEDICAL CONTRIBUTIONS

Lubbock County continues to pay a significant portion of the cost for your healthcare coverage. Premium contributions for medical will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your bi-weekly contributions.

UMR PPO				
PRE-TAX RATES	You Pay Bi-Weekly	Lubbock County Pays Bi-Weekly	Employee Percentage	Lubbock County Percentage
Employee Only	$10.00	$290.00	3%	97%
Employee + Child(ren)	$90.00	$540.00	14%	86%
Employee + Spouse	$130.00	$450.00	22%	78%
Employee + Family	$170.00	$685.00	20%	80%

Access Your Benefits

Medical Enrollees

Register at UMR.com to:

- Download the UMR app to view on your phone
- Find network providers
- View medical or dental ID cards
- View claims, deductibles and maximum out-of-pocket amounts

UMR

A UnitedHealthcare Company

Cost Estimator

Did you know that not all doctors charge the same?

Medical Costs can vary a lot from one doctor to another - look into your options on UMR.com:

- Search for Care and Compare your Choices
- Research Costs and Make Informed Decisions

MEDICAL BENEFITS

The chart below gives a summary of your 2025 medical coverage provided by UMR. With this plan, you are able to set aside pre-tax dollars to pay for your deductible and other eligible out-of-pocket healthcare costs in a Health Savings Account. Once you satisfy your calendar year deductible, the plan pays 80% for in-network office visits and all other covered services. Learn more about owning a Health Savings Account at healthequity.com.

	UMR PPO	
	In-Network	**Out-of-Network**
Calendar Year Deductible	$1,700 Individual $3,400 Family	$5,000 Individual $10,000 Family
Coinsurance	You pay 20%	You pay 40%
Out-of-Pocket Maximum*	$4,500 Individual $8,500 Family	Unlimited Unlimited
Lifetime Maximum	Unlimited	Unlimited
Routine Annual Exam	Plan pays 100%	Plan pays 60% after deductible
Physician Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Virtual Visit (Teladoc)	$54 for general medicine	N/A
Specialist Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Urgent Care Visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient Hospital	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Hospital	Plan pays 80% after deductible	Plan pays 60% after deductible
Complex Imaging	Plan pays 80% after deductible	Plan pays 60% after deductible
Prescription Drugs	Plan pays 80% after deductible	Plan pays 60% after deductible

*Includes calendar year deductible. For Family coverage, no single individual within the family will be subject to more than the individual out-of-pocket maximum amount.

Benefits presented are only a summary. Please refer to the Plan Document and ACA summaries for the complete details. These can be found on the intranet.

HEALTH SAVINGS ACCOUNT

When you enroll in the UMR PPO health plan, you may be eligible to fund a Health Savings Account (HSA) through **HealthEquity**.

Health Savings Account, or HSA, is a smart money management tool, like a 457(b) but for health care expenses, that allow you to set aside money tax-free to pay for eligible health care expenses. HSA's are a triple tax-advantaged account, which means that contributions, earnings, and withdrawals for eligible expenses are tax-free.

Contribution Limits

2025 IRS annual maximum contributions:	
Employee Only	$4,300
Employee + Dependents	$8,550
If you are age 55+ by December 31st, 2024, you may contribute an additional $1,000.	

Do You Meet the Qualifications to Participate?

- Have coverage under an HSA-qualified consumer driven health plan (CDHP)
- Have no other health insurance plan (this exclusion does not apply to certain other types of insurance such as dental, vision, disability, or long-term care coverage)
- Are not covered by a health care flexible spending account (FSA)
- Are not enrolled in Medicare and/or Tricare
- Not received Veteran's Affairs benefits in the past 3 months
- Cannot be claimed as a dependent on someone else's tax return

Invest

You can invest the money in your HSA when you have a minimum of $2,000 in your account. Any account growth is tax-free! This helps you save for retirement, which makes the HSA an important part of your overall retirement savings strategy. After 65, you can use the money in your HSA for any expense, you'll simply need to pay ordinary income taxes on the withdrawals.

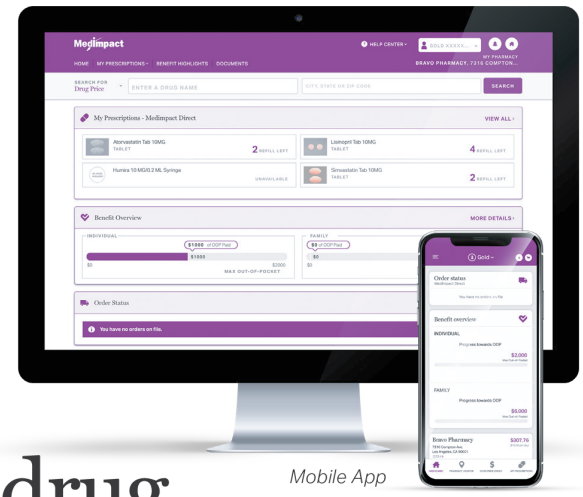
Save

Put tax-free money into an HSA to help pay for current and future health care expenses. If you don't use all the money, that's OK. It rolls over, year after year. The money in the account is always yours, even if you change employers or health plans, the HSA goes with you.

Use

Pay for eligible health care expenses, like your medical plan deductibles, co-insurance, vision and dental care, prescriptions, plus some over-the-counter items like cold and flu medicine, pain-relievers, and more.

Refer to healthequity.com for more information.



CONSUMER PORTAL OVERVIEW

Access personalized drug information. Anywhere. Anytime.

Pricing, Savings & Adherence

See prescription drug information and find ways you may be able to save money.

- View past price paid for a current prescription drug
- View fill history for a current prescription drug
- See upcoming refills
- Identify new prescription drug price
- Review cost-savings options*

View Prescription Drug Information

Know more about the prescription drugs you take, including:

- Indications or what conditions the prescription drug are used to treat
- Potential side effects
- Drug interactions
- Generic or therapeutic alternatives

Convenience

MedImpact offers convenience at your fingertips.

- Print/access ID card
- View/update account information, password & email
- View prescription history

Online Tools to Help You.

You can set your notification preferences by signing in to www.medimpact.com or MedImpact mobile app. Use the portal or app anytime 24/7/365 for Birdi to provide you with these services:

- Order new prescriptions or transfer from retail pharmacy.
- Refill mail-order drugs or renew expired mail-order prescriptions.
- Opt in or out of Auto Refill.
- Review estimated copay amount, last order status, and date for next refill.
- Get reminders and alerts via automated call, email, or text.
- View and sort your list of mail-order drugs.
- Manage account information.
- Make payments (if applicable).
- Get tax statement.

What To Do Next?

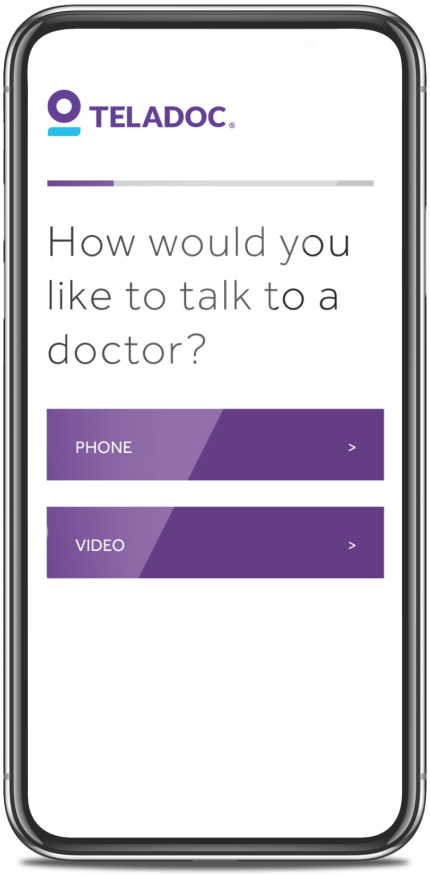
Go to **www.medimpact.com** on your computer or mobile device to register or sign in. First-time users will need Member ID, Name, Date of Birth

Download the MedImpact mobile app from your **App Store Today!**

For questions regarding benefits coverage, pharmacy network, account, or site navigation: Call toll-free: **+1 (888) 648-6759** or the number on your ID card; Email: **customerservice@medimpact.com**

Medimpact

You've got Teladoc Health



Your Teladoc Health services:

General Medical **$54 / visit**

Talk to a U.S.-licensed doctor for non-emergency conditions 24/7 from anywhere you are.

- Bronchitis
- Flu
- Rashes
- Sinus infections
- Sore throats
- And more

Mental Health Care

Talk to a therapist or psychiatrist of your choice 7 days a week from wherever you are

- Anxiety
- Depression
- Not feeling like yourself
- Marital issues
- Stress
- And more

$95 / therapist visit
$235 / psychiatrist first visit
$105 / psychiatrist ongoing visit

Dermatology **$85 / online review**

Upload images of a skin issue online or on the app and get a custom treatment plan within 24 hours

- Acne
- Eczema
- Skin infection
- Psoriasis
- Rosacea
- And more

Get quality care by phone, video or app

Visit TeladocHealth.com

Call 1-800-835-2362 | Download the app

YOUR PLAN ADVISOR

Ready to connect – and guide you to the answers you seek

Health care in the modern world calls for a sensitive, personal approach to service – one that's built on real relationships and trust.

Which is why Plan Advisor delivers an experience that's beyond traditional models of member support. Our advisors partner with you so you feel more confident in the decisions you make about your health, and comforted by the steps you're taking to get there.

Because we all need a person we can rely on.
Let your Plan Advisor be yours.

Connecting you to the care you need

Whether your question is common or complex, we make it easier for you to get answers by ensuring you have the information you need.

Keeping it real

Your plan advisor is an actual person who's focused on serving you, equipped with knowledge and options to support and anticipate your unique needs and goals.

We're in it with you

If you need something that's out of our reach, we'll connect you to the resources you need – and we'll even stay on the call as long as you need.

Dedicated to YOU

To connect with your Plan Advisor, call the number on the back of your member ID card.

Plan Advisor
Your personal guide to all things health care

UMR
A UnitedHealthcare Company

One call. One advocate.

Guiding members to better health

UMR
A UnitedHealthcare Company

Simplified health care experience

Members make better decisions about care, feel more confident in their decisions, and take ownership of their health

Single-entry point
for true member advocacy, 24/7

Educating members on their health plan and benefits

Engaging members with a simplified and streamlined experience

Connecting members with higher quality, more efficient and cost-effective care

Informing members about health and wellness opportunities

A closer look — What Plan Advisor delivers to members:

- Provide benefit and eligibility information
- Explain EOBs and benefit information
- Resolve claims and billing inquiries
- Help members find a provider and schedule appointments
- Promote preventive care and identify any gaps in care
- Ensure connection with primary care provider
- Deliver network guidance
- Guide members on using online tools
- Engage members in care opportunities with seamless transfers
- Coordinate with employer's external vendors
- Communicate health information, employer-specific events and reminders
- Redirecting care opportunities for better health outcomes and improved cost savings

1-800-207-3172

WHERE TO GO FOR CARE

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

	Conditions Treated	Your Cost & Time
Emergency Room $$$$ For the immediate treatment of critical injuries or illness. If a situation is life-threatening, call 911 or go to the nearest emergency room. Open 24/7.	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath • Chest pain • Head injury/major trauma • Blurry or loss of vision • Severe cuts or burns • Overdose	• Costs are highest • No appointment needed • Wait times may be long, averaging over 4 hours
Urgent Care Center $$$ For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	• Minor cuts, sprains, burns, rashes • Fever and flu symptoms • Headaches • Chronic lower back pain • Joint pain • Minor respiratory symptoms • Urinary tract infections	• Costs are lower than an ER visit • No appointment needed • Wait times vary
Doctor's Office $$ The best place to receive routine or preventive care, track medications, or get a referral to see a specialist.	• General health issues • Preventive services • Routine checkups • Immunizations and screenings	• May include coinsurance and/or deductible • Appointment usually needed • May have little wait time
Convenience Care Clinic $ Located in retail stores and pharmacies, they're often open nights and weekends. Treat minor medical concerns that are not life threatening.	• Common cold/flu • Rashes or skin conditions • Sore throat, earache, sinus pain • Minor cuts or burns • Pregnancy testing • Vaccinations	• Costs are same or lower than office visit • No appointment needed • Wait times typically 15 minutes or less
Virtual Visits $ Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or mobile app.	• Cold and flu symptoms such as a cough, fever and headaches • Allergies & sinus infections • Family health questions	• Cost is lower than office visit • No appointment needed • Immediate, private, and secure visits

DENTAL BENEFITS

Lubbock County offers dental coverage through UMR. Regular dental cleanings and check-ups are extremely important to your overall health and you are encouraged to take advantage of your preventive dental benefits.

The dental plan offers a variety of benefits for those enrolled and features the freedom to choose any dentist, however, choosing an in-network provider will lower your out-of-pocket costs as out-of-network services are subject to Reasonable and Customary (R&C) limitations. If you select a dentist in the UMR network, you will receive guaranteed savings. To find a dentist in the UMR network login at umr.com.

Services	Dental Plan
Annual Deductible	$25 Individual / $100 Family
Calendar Year Maximum Benefit	$1,500 per person
Preventive Services Oral Exams, X-Rays, Bitewing X-Rays, Routine Cleanings, Fluoride Treatments*, Sealants per tooth**	Plan pays 100%, deductible waived
Basic Services Basic Restorations, Endodontics (root canal therapy), Periodontal (gum treatment)	Plan pays 80% after deductible
Major Services Inlays, Onlays, Crowns, Dentures, Bridges, Simple and Complex Oral Surgery	Plan pays 50% after deductible
Orthodontia (Adult and Child)	Plan pays 50%, $1,000 lifetime max per person
Frequencies • Oral Exams and Routine Cleanings • Complete Mouth X-Rays • Bitewing X-Rays • Fluoride Treatment • Sealants (per tooth)	2x per calendar year Once every 3 calendar years 2x per calendar year Once every 12 months* Once every 3 calendar years per permanent molar**
Bi-Weekly, Pre-Tax Contributions	
Employee Only	$0
Employee + Child(ren)	$10
Employee + Spouse	$15
Employee + Family	$20

*Under age 17 only

**Under age 14 only

You can choose to seek treatment from any dentist. If your dentist does not file insurance claims, you will pay up front and then complete a reimbursement form and submit it to UMR. If you select a dentist in the UMR network, you will receive guaranteed savings. To find dentist in the UMR network go to umr.com.

Benefits presented are only a summary. Please refer to the Plan Documents for the complete details. These can be found on the intranet.

VISION BENEFITS

Vision coverage is offered through Superior Vision. Your routine vision exams, eyeglasses or contact lenses are available through a national network of vision care providers. In addition to routine eye care benefits, you have access to discounts on lens options and laser vision correction. To find an in-network provider, go to superiorvision.com.

	Vision Plan	
	In-Network	**Out-of-Network**
Eye Exam	$10 copay	Up to $35
Materials	$10 copay	N/A
Frames	$175 retail allowance + 20% discount	Up to $70
Standard Lenses		
• Single vision	Covered in full	Up to $40
• Bifocal	Covered in full	Up to $60
• Trifocal	Covered in full	Up to $80
• Progressive	See description[1]	Up to $80
• Ant-reflective coating (standard)	Covered in full	Up to $35
• Scratch resistant coating	Covered in full	Up to $25
Contact Lenses[2]		
• Elective	$175 retail allowance + 20% discount	Up to $105
• Medically Necessary	Covered in full	Up to $210
Laser Vision Correction[3]	$250 retail allowance	
Bi-Weekly, Pre-Tax Contributions		
Employee Only	$3.26	
Employee + 1	$5.56	
Employee + Family	$8.18	

Copays apply to In-Network benefits; copays for out-of-network visits are deducted from reimbursements

[1]Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay

[2]Contact lenses and related professional services (fitting, evaluation and follow-up) are covered in lieu of eyeglass lenses and frames benefit

[3]Lasik Vision Correction is in lieu of eyewear benefit, subject to routine regulatory filings and certain exclusions and limitations

Benefits presented are only a summary. Please refer to the Plan Documents for the complete details. These can be found on the intranet.

LIFE AND AD&D

Basic Life and AD&D Insurance

Lubbock County provides benefit eligible employees with $40,000 Basic Life and $40,000 Accidental Death & Dismemberment (AD&D) coverage at no cost through Mutual of Omaha.

Supplemental Life and AD&D Insurance

Lubbock County employees have the option to supplement their Basic Life and AD&D insurance by purchasing additional amounts of coverage through Mutual of Omaha.

In addition, Life and AD&D insurance may be purchased to cover a spouse and/or child(ren) after electing coverage for yourself.

Evidence of Insurability

Selections above the guarantee issue amount will require an Evidence of Isurability (EOI).

The insurance carrier must approve your application before the newly elected coverage becomes effective

Life	Amount Available
Employee	Election maximum is the lesser of 10x your salary or $500,000 in increments of $20,000
Spouse	Increments of $10,000 not to exceed 100% of the employee election to a maximum of $250,000
Child(ren)	$20,000

Supplemental Life Bi-Weekly Rates/$1,000	
<25	$0.028
25-29	$0.033
30-34	$0.042
35-39	$0.051
40-44	$0.070
45-49	$0.107
50-54	$0.180
55-59	$0.300
60-64	$0.462
65-69	$0.887
70+	$1.436
Child(ren) Bi-Weekly Rates/$20,000	
Birth to age 26	$0.849

AD&D Bi-Weekly Rates/$1,000	
Employee Only	$0.014
Spouse	$0.014
***Child(ren)**	$0.014

*Birth to age 19 and full-time students under age 26.

Benefits presented are only a summary. Please refer to the Plan Documents for the complete details. These can be found on the intranet.

WORK-LIFE BALANCE

Employee Assistance Program

The Employee Assistance Program (EAP) provides a confidential and cost-free professional consultation, referral services for employees that are experiencing work, and personal related issues. Employees and their immediate family members will have access to five face-to-face counseling sessions.

Call for free, confidential help with issues including:

- Stress
- Depression
- Anxiety
- Substance Abuse
- Marital Issues
- Family Issues
- Grief/Loss
- Legal Issues
- Financial Issues
- Career Development
- Work/Life Balance

Interface Behavioral Health

Call 800-324-4327 for more information (Spanish: 800-324-2490). Or visit 4eap.com, and enter user name: **Lubbock County**, password: **842**

TERMS TO KNOW

Deductible - Amount an employee pays out of pocket prior to the insurance company paying a percentage of the provider charges.

Coinsurance - The amount of payment split between the employee and their insurance plan. Example: The plan pays 80% and employee pays 20% of the charges after the deductible is met.

Out-of-Pocket Maximum - The maximum an employee is responsible for paying out of pocket in any one calendar year prior to the insurance company paying the entire eligible amount for the remaining of the calendar year.

Network Providers - Doctors, hospitals and other providers who have an agreement/ contract with insurance companies agreeing to charge a discounted amount for services they render.

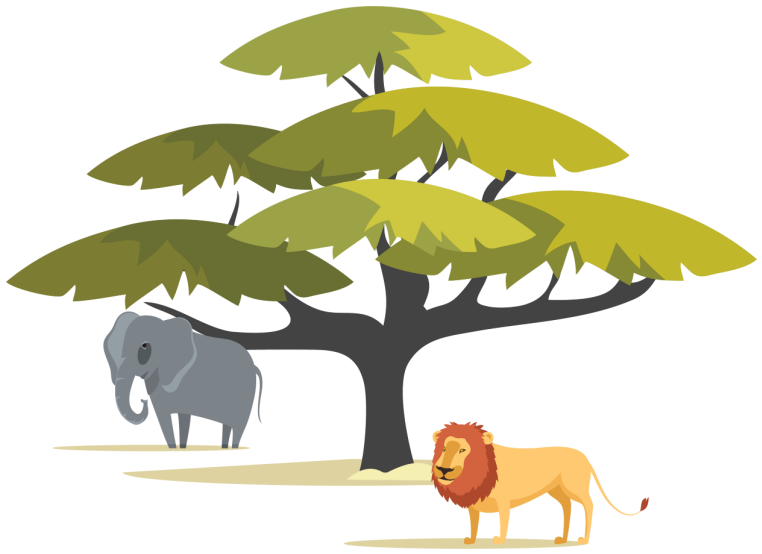
Pre-Authorization - Certain procedures or hospitalizations may require that the provider receive authorization. The provider is typically the one to go through this process with the insurance company and obtain pre-authorization.

Pre-Determination - If you are having a major procedure done, your doctor or dentist can submit a pre-determination to the insurance company so you can know in advance of treatment how much of the bill you will be responsible for.

Explanation of Benefits (EOB) - The EOB is mailed to the employee after a claim is received and processed by the insurance company. The EOB will describe how the claim was processed and outline what portion of the charges are applied to the deductible, what portion the employee is responsible for, and explain if there is a denial or error processing the claim.

Appeal - If your health insurance company doesn't pay for a specific health care provider or service, you have the right to appeal the decision and have it reviewed by an independent third party.

Evidence of Insurability (EOI) - The form containing medical questions that are required to be answered if you decide to elect voluntary life insurance after you have previously declined coverage, or if you decide to increase your current coverage.



Required Notices

Women's Health and Cancer Rights Act: If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

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

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

Lubbock County medical plan complies with the Mental Health Parity Act of 1996 ("MHPA"). Pursuant to such compliance, the annual and lifetime limits on Mental Health Benefits, if any, will not be less than the annual and lifetime plan limits on other types of medical and surgical services (if any limits apply). The plan does utilize cost containment methods, applicable for Mental Health Benefits, including cost-sharing, limits on the number of visits or days of coverage, and other terms and conditions that relate to the amount, duration and scope of Mental Health Benefits.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP): If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

Your Prescription Drug Coverage and Medicare: Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Lubbock County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Lubbock County has determined that the prescription drug coverage offered by the **Lubbock County** Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current coverage with Lubbock County will not be affected. You and/or your dependents can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Lubbock County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage. Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Lubbock County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage.

Visit www.medicare.gov. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). **Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Coverage After Termination (COBRA) - Health Coverage: You're getting this notice because you recently gained coverage under a group health plan **(Lubbock County Group Health Plan).** This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events: Your hours of employment are reduced, or Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events: Your spouse dies; Your spouse's hours of employment are reduced; Your spouse's employment ends for any reason other than his or her gross misconduct; Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events: The parent-employee dies; The parent-employee's hours of employment are reduced; The parent-employee's employment ends for any reason other than his or her gross misconduct; The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); The parents become divorced or legally separated; or The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events: The end of employment or reduction of hours of employment; Death of the employee; Commencement of a proceeding in bankruptcy with respect to the employer; or The employee becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to: Phone: 806.775.1695

How is COBRA continuation coverage provided? Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage: If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. **Second qualifying event extension of 18-month period of continuation coverage:** If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of: The month after your employment ends; or The month after group health plan coverage based on current employment ends. If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

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

If you have questions: Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes: To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Lubbock County
PO Box 10536
Lubbock, Texas, 79408
Phone: 806.775.1695

HIPAA Employee Health Plan Summary Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Your Rights: You have the right to: Get a copy of your health and claims records; Correct your health and claims records; Request confidential communication; Ask us to limit the information we share; Get a list of those with whom we've shared your information; Get a copy of this privacy notice; Choose someone to act for you; and File a complaint if you believe your privacy rights have been violated.

Your Choices: You have some choices in the way that we use and share information as we: Answer coverage questions from your family and friends; Provide disaster relief; and Market our services and sell your information

Our Uses and Disclosures: We may use and share your information as we: Help manage the health care treatment you receive; Run our organization; Pay for your health services; Administer your health plan; Help with public health and safety issues; Do research; Comply with the law; Respond to organ and tissue donation requests and work with a medical examiner or funeral director; Address workers' compensation, law enforcement, and other government requests; Respond to lawsuits and legal actions

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records: You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records: You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us at 806.775.1695. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in payment for your care; Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* In these cases we never share your information unless you give us written permission: Marketing purposes or Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive: We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization: We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. *Example: We use health information about you to develop better services for you.*

Pay for your health services: We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan: We may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director: We can share health information about you with organ procurement organizations; We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety activities authorized by law; For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date: 1/1/2025

Privacy Contact: Lubbock County
PO Box 10536
Lubbock, Texas, 79408
Phone: 806.775.1695

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information: When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2024 for coverage starting as early as January 1, 2025.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.* Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. *An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.*

PART B: Information About Health Coverage Offered by Your Employer: This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

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

-Eligible employees are Full time employees who work 30 hours per week and have completed the newly eligible 30 day waiting period. Coverage begins the first day of the month following the first 60 days of employment.

-Eligible dependents include the employee's spouse and eligible dependent children up to age 26.

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

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Special Enrollment Notice: If you are declining enrollment for yourself or your dependents including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance. To request special enrollment or obtain more information, contact the plan administrator listed below: Phone: 806.775.1695

Consolidated Appropriations Act (CAA) No Surprises Act

Your Rights and Protections Against Surprise Medical Bills When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care, like when you have an emergency or when you schedule a visit at an in network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for: Emergency services If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. Certain services at an in-network hospital or ambulatory surgical center When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network. When balance billing isn't allowed, you also have the following protections: You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly. Your health plan generally must Cover emergency services without requiring you to get approval for services in advance (prior authorization). Cover emergency services by out-of-network providers. Base what you owe the provider or facility (cost -sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits. Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your Human Resources Department. In addition, if you have questions about a provider's network status or you believe you've been wrongly billed, please contact your carrier.

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

Visit www.tdi.texas.gov for more information about your rights under state law.

This guide prepared by

The information in this benefits guide is intended to help you enroll in your 2025 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern.

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