The Town of Flower Mound Texas
Employee Benefits Guide

January 2019

FLOWER MOUND
EMPLOYEE BENEFITS GUIDE

January 1, 2019

The Town of Flower Mound is pleased to provide you with a competitive benefits program designed to fit your financial and health care needs for Plan Year 2019.

This benefits guide will assist you in making your benefit decisions and is not intended to serve as a complete description of the benefit plans. This guide should be used to inform you and aid in making the benefit choices that are most suitable for you.

TABLE OF CONTENTS

Introduction

Who is Eligible?

For health insurance purposes, you are eligible to enroll if:

- You are an employee for the Town of Flower Mound who works an average of at least 30 hours per week.

Coverage begins for a new employee on the first day of the following month after date of hire. Coverage begins on January 1 and ends on December 31 for all other enrolled employees.

Who are My Eligible Dependents?

Your spouse (as recognized by the State of Texas)

- Children for which you are the biological Mother or Father
- Legally adopted children, certified disabled children over age 26
- Stepchildren who reside with you and are primarily dependent upon you for support are also eligible and subject to the age limit of 26.
- Dependent children, whether married or not may be covered to age 26, even if they do not meet dependency requirements for tax exemption.
- Married employees may not cover the spouse as a dependent, and only one employee may cover any dependent children.

What Happens if I Fail to Enroll?

If a full time employee fails to enroll in the Town of Flower Mound's Health Insurance Plan within the time specified at new hire orientation or open enrollment, the employee will be automatically enrolled in the PPO Plan, Employee Only, with current optional benefit elections rolling over.

Can I Change My Coverage During the Year?

The benefits you choose will remain in effect through the end of the plan year. You can only make a change to your coverage:

- During open enrollment, or
- During the year if you have a qualifying change in family or employment status. Qualifying changes include:
  - A change in your legal marital status,
  - A change in your number of dependents, including:
    - Birth of your child
    - Your adoption of a child
    - Your dependent child satisfying or ceasing to satisfy eligibility requirements for coverage
    - The death of your dependent child or spouse
  - Your change in employment status or that of your spouse or dependent child
  - Loss of health insurance coverage

Please keep in mind that the change in coverage you wish to make must be consistent with the change in status.

Additionally, your changes outside of open enrollment must be submitted to Human Resources with proper documentation and the Human Resources benefits change form within 31 days of the qualifying event or change in status.

Enrollment Forms

Don't forget to turn in your enrollment forms by the deadline!

Change Requests

Don't be late! Turn in your change request within the allotted timeframe!

Payroll Deductions for Health Insurance

PPO Plan	Per Pay Period Deductions
Medical/Dental/Vision/RX	
• Employee Only • Employee + Family	• $25 • $100
High Deductible Health Plan (HDHP/Health Savings Account (HSA)	
Medical/Rx*	
• Employee Only • Employee + Family	• $0 • $56.11 per pay period (goes to employee health savings account)
Dental/Vision*	
• Employee Only • Employee + Family	• $0 • $18.89 (goes to Town for dental/vision premium)
*Note: • Employee & Town contributions of $750 for individuals and $1,500 for families for the HDHP/HSA medical/rx account will go into the employee's HDHP/HSA account. • Premiums for HDHP/HSA dental/vision will go to the Town to cover the cost of the coverage.	

Note: Deductions are taken from 24 paychecks

The Town will contribute the following to the employee HDHP/HSA account for Plan Year 2019:

- Family - $1,500
- Individual - $750

Town contributions for Plan Year 2019 will be made as follows:

- 1st pay period in January, 2019 – 50%
- 1st pay period in February, 2019 – 25%
- 1st pay period in March, 2019 – 25%

Taxes and Your Benefits

Plan	Who Pays the Cost	Is Your Cost Before Tax or After-Tax?
PPO Plan **Medical/Dental/Vision/RX** • Employee Only • Employee +Dependent(s)	 TOFM TOFM/You*	 Before-Tax Before-Tax
High Deductible Health Plan • Employee Only • Employee +Dependent(s)	TOFM TOFM/You*	Before-Tax Before-Tax
Basic Life/AD&D Insurance • Employee Only	TOFM	N/A
Long-Term Disability • Employee Only	TOFM	N/A
TMRS • Employee Only	TOFM/You*	Before-Tax

*PPO Plan and HDHP/HSA employee only is no cost to the employee

IRS Rules

The IRS has issued regulations that limit the amount of tax-free group term life insurance to $50,000. This means that if the amount of Basic Life Insurance is greater than $50,000, that value of your Life Insurance (as determined by the IRS based upon age) over $50,000 will be considered taxable income (the IRS calls this imputer income). A minimal tax will be assessed and will appear on your W-2.

Helpful Definitions

- **Allowable Amount** – means the maximum amount determined by the Claims Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply or procedure.
- **Calendar Year** – January 1 through December 31 of each year.
- **Claims Administrator** – means Blue Cross and Blue Shield of Texas.
- **Co-Share** – The percent of eligible charges that the plan pays.
- **Copayment (Copay)** – The amount paid by a covered person to a network provider at the time services are rendered. Copayments for covered services are not applied to your deductible.
- **Deductible** – The amount you pay each calendar year before the plan begins to pay for certain covered health care expenses.
- **Effective Date** – means the date the coverage for a Participant actually begins.
- **Guarantee Issue** – The amount of coverage pre-approved by the Life Insurance Company regardless of health status.
- **HIPAA** – means the Health Insurance Portability and Accountability Act of 1996
- **Identification Card** – means the card issued to the Employee by the Claims Administrator of the Plan indicating pertinent information applicable to his/her coverage.
- **Medical Emergency** – A sudden, serious, unexpected and acute onset of an illness or injury where a delay in treatment would cause irreversible deterioration resulting in a threat to the patient's life or body part.
- **Network Benefits** – The benefits applicable for the covered services of a network provider.
- **Non-Network Benefits** – The benefits applicable for the covered services of a non-network provider.
- **Open Enrollment** – The period during which existing employees and their dependents are given the opportunity to enroll in or change their current elections.
- **Out-of-Pocket Maximum** – the most a covered person can pay in coinsurance in a calendar year for covered health care expenses (excluding reductions for provider contracts and usual and customary guidelines and copays).
- **Plan Administrator** – means the named administrator of the Plan having fiduciary responsibility for its operation. The Town of Flower Mound is the Plan Administrator.
- **Plan Year** – January 1 through December 31 of each year.
- **Preferred Provider Organization (PPO)** – A network of health care providers contracted to provide medical services to covered employees and dependents at negotiated rates. You may seek care from either a network or non-network provider, but *network care is covered at a higher benefit level and the employee is responsible for a greater portion of the cost when using a non-network provider*.

Using network providers makes GOOD FINANCIAL SENSE!

Medical Benefits Plan Comparison

	2019 PPO Option		2019 HDHP/HSA Option	
Services	**In-Network**	**Out-of Network**	**In-Network**	**Out-of Network**
Physician Visit	$25 PCP/$50 SCP copay	50% after deductible	100% after deductible	80% after deductible
Deductible • Individual • Family	 $500 $1,500	 $500 $1,500	 $2,500 $5,000	 $5,000 $10,000
Medical Annual Out of Pocket Maximum (includes deductible) • Individual • Family	 $3,000 $9,000	 $4,000 $12,000	 $2,500 $5,000	 $10,000 $20,000
Hospitalization	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Preventative Care	100%	50% after deductible	100%	80% after deductible
Emergency Room	$500 copay	$500 copay	100% after deductible	100% after deductible
Urgent Care	$50 copay	50% after deductible	100% after deductible	80% after deductible
Prescription Drugs	Retail/Mail Order	Retail/Mail Order	Retail/Mail Order	Retail/Mail Order
$50 deductible per member • Generic • Preferred Brand • Non-preferred Brand • Specialty Preferred & Non - Preferred	 $0/$0 copay $30/$60 copay $60/$120 copay 25% w/$75 maximum	 80% of allowable minus copay 80% of allowable minus copay 80% of allowable minus copay	 100% after deductible 100% after deductible	 100% after deductible 100% after deductible
Prescription Drug (RX) Annual Out-of-Pocket Maximum	$3,600 – Individual $4,200 – Family	$3,600 – Individual $4,200 - Family	Not Applicable	Not Applicable

* Please refer to the Blue Cross Blue Shield Summary of Benefits for a full outline of your medical coverage.

Access your personal benefit details through www.bcbstx.com and click on Blue Access for members.

Blue Cross and Blue Shield customer service can be reached as1.800.521.2227

Prescription Drug Benefits

Prescription Drugs are covered under the medical plan if prescribed for the treatment of a covered medical condition. For the highest level of benefits you must use a participating pharmacy. Mail order service is also available through Prime Therapeutics.

$50 deductible per member

PPO Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Drug Card (30 day supply)	Generic - $0 Copayment Preferred Brand - $30 Copayment Non-preferred Brand- $60 Specialty- 25% up to max of $75	80% of Allowable Amount minus Copayment Amount
Mail Order (90 day supply)	Generic - $0 Copayment Preferred Brand - $60 Copayment Non-preferred Brand- $120	N/A

The Town of Flower Mound had mandatory generic prescription drug program. This means that if there is a generic equivalent available and the participant chooses the brand name prescription, the participant will be required to pay the retail cost difference between the brand name prescription and the generic/generic equivalent including the copay.

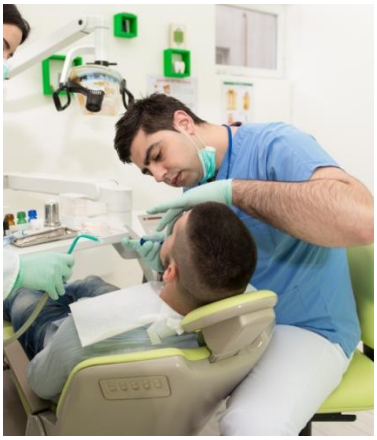
HDHP/HSA Prescription Drug Program	Participating Pharmacy	Non- Participating Pharmacy
Drug Card (30 day supply)	Generic – 100% after deductible Brand - 100% after deductible	Generic – 100% after deductible Brand - 100% after deductible
Mail Order (90 day supply)	Generic – 100% after deductible Brand - 100% after deductible	Generic – 100% after deductible Brand - 100% after deductible

Vision Benefits	
Services • Vision Exam • Lenses & Frames	100% (1 per Calendar Year) Coverage at 85% after a one time annual Copayment of $25 $325 per Calendar Year Maximum (applies to lenses, contacts and frames)

Dental Benefits

Basic & Major Services have a Calendar Year Deductible of: Individual/Family	$50/$150
The Plan Plays: Preventive Services • Oral Exams, X-Rays, Bitewing X-Rays, Sealants • Prophylaxis/Cleanings, Topical Fluoride Application	100%
Basic Services • Fillings, Extractions, Oral Surgery • Repairs of dentures, crowns, inlays and onlays • Endodontics, Periodontics • Anesthesia, Antibiotic Injections	80%
Major Services • Bridged, Dentures • Crowns/Inlays/Onlays	50%
Calendar Year Maximum Benefit:	$1,500
Orthodontia	50%
Orthodontia Lifetime Maximum:	$1,500

* Please refer to the Blue Cross Blue Shield Summary of Benefits for a full outline of your medical coverage.



Inspection and early detection of dental conditions are key elements to having a healthy smile!

Each time you need dental care, you can choose to:

See A Contracting Dentist		*See A Non-Contracting Dentist*
BlueCare Dentist	**DentaBlue Dentist**	
– Your out-of-pocket maximum will generally be the least amount because BlueCare Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses.	– Your out-of-pocket maximum may be greater because DentaBlue Dentists have contracted to accept a higher Allowable Amount as payment in full for Eligible Dental Expenses.	– Your out-of-pocket maximum may be greater because Non-Contracting Dentists have not entered into a contract with BCBSTX to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses.
– You are not required to file claim forms.	– You are not required to file claim forms.	– You are required to file claim forms.
– You are not balance billed for costs exceeding the BCBSTX Allowable Amount for BlueCare Dentists.	– You are not balance billed for costs exceeding the BCBSTX Allowable Amount for DentaBlue Dentists	– You are balance billed for costs exceeding the BCBSTX Allowable Amount.

Fitness Opportunities

Who is Eligible?

All regular full-time Town employees and their immediate families are eligible for a free membership at the Community Activity Center. Membership requires a completed CAC enrollment form submitted to the CAC. All members will need to have ID card pictures taken at the CAC before or on the first day of center access.

Flexible Benefits Plan

Health Flexible Spending Account (FSA)

Employees may contribute funds to the account through a pre-tax payroll deduction from twenty-four paychecks. The funds can be used to pay for qualified healthcare expenses not reimbursable under the Town's Group Health Plan. The Plan Year runs from January 1, 2019 - December 31, 2019. The Town offers a 2 ½ month grace period therefore, any funds remaining in the account on April 1, 2020 are forfeited.

Employees participating in this plan cannot make changes during the plan year unless he/she experiences a change in family status.

The maximum amount an employee can contribute annually is $2,650. The funds can be used to reimburse all qualified expenses for the employee and IRS eligible dependents regardless of whether they are enrolled in the Town's Group Health Plan. The annual contribution amount is available on the effective date.

Participants will receive a debit card which can be used as the point of service. Claims can also be filed online, by mail or fax. Employees are encouraged to retain documents that support and validate debit card transactions. In some cases, employees may be required to submit receipts or records to substantiate a claim.

Dependent Care Spending Account

Employees may contribute funds to the account through a pre-tax payroll deduction from twenty four paychecks. The funds can be used to pay for qualified dependent or elderly care. The Plan Year runs from January 1, 2019 – December 31, 2019. The Town offers a 2 ½ month grace period, therefore any funds remaining in the account on April 1, 2019 are forfeited.

Employees participating in this plan cannot make changes during the plan year unless he/she experiences a change in family status.

The maximum amount an employee can contribute annually is $5,000. The funds can be used to reimburse all qualified expenses for the employee's eligible dependents. Funds are only available as money is put into the account via payroll deduction. Employees may be required to submit receipts or records to substantiate a claim prior to receiving reimbursement.

Health Savings Account

High Deductible Health Plan Health Savings Account

Employees participating in the High Deductible Health Plan may contribute funds to their Health Savings Account through a pre-tax payroll deduction from twenty-four paychecks. The funds can be used to pay for qualified medical expenses. The Plan Year runs from January 1, 2019 – December 31, 2019. Funds remaining in the account will remain property of the employees and will roll over to the next plan year.

The maximum amount an employee with employee only coverage can contribute annually is $3,500. The maximum amount an employee with family coverage may contribute annually is $7,000. The funds can be used to pay for and/or reimburse all qualified expenses for the employee and eligible dependents. The Town contributes $750 annually for employee only coverage and $1,500 for family coverage.

Retirement

The Town of Flower Mound is a member of the Texas Municipal Retirement System (TMRS). The purpose of the retirement system is to provide adequate and dependable retirement benefits for employees retiring from Texas Municipalities.

Participation is mandatory for all regular, full-time employees. There is no maximum age for participation in TMRS. As a TMRS participant, you receive an additional life insurance benefit of 1x your annual salary.

Vesting

Employees are vested after 5 years of service. Vesting means you have worked enough years and established enough service credit to meet the minimum length of service requirement for retirement. Once vested, and you leave the Town of Flower Mound, you may leave your member deposits with TMRS until you reach retirement eligibility.

Retirement Eligibility

You can retire under TMRS when you have at least five years of service and are at least age 60. You may also retire at any age if you have at least 20 years of service. Upon retirement, you will choose a monthly payment option to receive your benefit. All options pay you a monthly benefit for the rest of your life.

Plan Contributions

Employees contribute 7% of gross income, on a pre-tax basis, each pay period and the Town matches the employee contribution at a 2 to 1 ratio. Contributions to the system are not taxable until withdrawn.

Important Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act (WHCRA) requires that mastectomy patients be provided additional benefits for breast reconstruction, surgery and reconstruction of the other breast to produce symmetry. Coverage should also be provided for prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes).

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT (NMHPA)

The Newborn's and Mother's Health Protection Act (NMHPA) restricts limiting the length of a hospital stay in connection with childbirth for a mother or newborn child to less than 48 hours (or 96 hours for a cesarean delivery). The law does not prohibit earlier discharge if the mother and her attending physician are in agreement that an earlier discharge is appropriate. In addition, authorization of the hospital stay cannot be required for stays of 48 hours or less (or 96 hours) nor are early discharge incentives allowed. Hospital stays begin at delivery or upon hospital admission (whichever is later).

MEDICAID & THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you are eligible for health coverage from your employers, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State that provides premium assistance, you can 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, you can contact your state Medicaid or CHIP office, or dial **1-877KIDS-NOW** or go to **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan - as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. CHIP is available in every state. Each state designs its own CHIP program; however, all states cover routine check-ups, immunizations, hospital care and lab and x-ray services. You should contact your State for further information on -eligibility.

COVERAGE AFTER TERMINATION (COBRA) CONTINUATION OF HEALTH COVERAGE

If you or your dependents have coverage at the time of a qualifying event, you may be eligible to elect continuation of coverage under one or more of the following:

- Medical Plan
- Dental Plan
- Vision Plan

You have a legal right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to purchase a temporary extension of your coverage at group rates. However, you must pay the full cost of the coverage, plus a 2% administrative fee.

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 or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

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.

COVERAGE AFTER TERMINATION - CONTINUED

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event.
This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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.

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.

Town of Flower Mound Employee Health Plan Summary Notice of Privacy Practices (HIPAA)

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.

Uses and Disclosures of Health Information

The Town of Flower Mound uses health information about you for treatment, to pay for treatment, and for other allowable healthcare purposes. Health care providers submit claims for payment for treatment that may be covered by the group health plan. Part of payment includes ascertaining the medical necessity of the treatment and the details of the treatment or service to determine if the group health plan is obligated to pay. Information may be shared by paper mail, electronic mail, fax, or other methods. Subject to certain requirements, Town of Flower Mound may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. Town of Flower Mound provides information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and distribute the new notice. You can also request a copy of our full notice at any time. For more information about our privacy practices, contact the Office of the Privacy Officer in the Human Resources Department listed below.

Your Health Information Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you the normal copy fees that reflect the actual costs of producing the copies including such items as labor and materials. You also have the right to receive a list of instances where Town of Flower Mound has disclosed health information about you for reasons other than treatment, payment, healthcare operations, related administrative purposes, and when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that Town of Flower Mound correct the existing information or add the missing information. You have the right to request that Town of Flower Mound restrict the use and disclosure, and Town of Flower Mound must abide by the request and may only reverse the position after you have been appropriately notified. You have the right to request an alternative means of communication with Town of Flower Mound and are not required to explain why you want the alternative means of communication.

Privacy Complaints

If you are concerned that Town of Flower Mound has violated your privacy rights, or you disagree with a decision Town of Flower Mound has made about access to your records, you may address them to the Privacy Contact listed in this notice. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Town of Flower Mound Responsibilities

The Town of Flower Mound is required by law to protect the privacy of your information, provide this notice about the City's information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

Detailed Notice of Privacy Practices

For further details about your rights and the federal Privacy Rule, refer to the detailed statement of this Notice. You can ask for a written copy of the detailed Notice by contacting the Privacy Contact listed in this notice.

Deferred Compensation/457 Plan

The Town of Flower Mound's deferred compensation option is an investment for your future, designed to provide an additional source of income to help you financially in your retirement years. Participation in the deferred compensation plan is voluntary and full-time employees are eligible to join and make changes at any time. The Town does not contribute to 457 Plans.

Providers

You have a variety of investment options to achieve a maximum return on your savings by working with the following providers.

- Nationwide Retirement System
- International City Management Association Retirement Corporation
- FT Jones Fund Choice

Long Term Disability

Financial planning includes taking steps to protect yourself and your family when the unthinkable happens. Having adequate insurance coverage in the event of a disabling condition is the foundation of a solid financial plan. Long-term disability provides the protection you need to ensure that your way of life is protected in case of a serious injury or illness. Town of Flower Mound is pleased to provide all eligible employees with long – term disability coverage at no cost.

LTD Benefit	
Basic Benefit	60% of salary
Maximum Monthly Benefit	$5,000
Benefit Waiting Period	120 days

Life Insurance

Basic Life Insurance:

Life doesn't always bring us what we expect. It helps to know that financial security is available for your family…even if you aren't. Life Insurance coverage will help protect your family's security.

Town of Flower Mound automatically provides you with a Basic Life Insurance policy at no cost to you:

- You receive two times your base annual earnings to a maximum or $100,000.
- The following benefit reductions will apply: 65% @ Age 65 and 50% of Original Amount @ Age 70. All coverage cancels at retirement.

Accidental Death and Dismemberment:

The Town of Flower Mound automatically provides eligible regular, full-time employees with Accidental Death & Dismemberment coverage, which is 2 times your annual salary to a maximum of $100,000. Accidental Death benefits are payable to your beneficiary, in addition to your Life Insurance benefit. Accidental Dismemberment benefits are payable to you if you suffer a loss that is covered under the plan. The loss must have occurred within 365 days of the covered accident.

	Basic AD&D Benefit
Loss of Life	100%
Loss of Both Hands, Feet, or Eyes	100%
Loss of one Hand, Foot, or an Eye	50%

Basic Accidental Death & Dismemberment (AD&D)

Town of Flower Mound automatically provides eligible regular, full-time employees with Basic AD&D Coverage at two times your base annual earning to a maximum of $100,000.

Dependent Life Insurance

Dependent Life coverage is available to purchase for those that want a greater level of protection. Contact the Human Resources Division for more information.

Some things in life are too important to pass up! Elect coverage now to protect your family's financial needs.

Workers' Compensation

The Town of Flower Mound provides workers' compensation. The Town contracts with a third party administrator to administer worker's compensation claims. If you are injured in the scope and course of your employment with the Town, you may be eligible to receive Workers' Compensation.

Worker's Compensation is required under state law and covers the cost of hospitalization, physician fees, drugs, treatment, and other related expenses. Employers are required by state law to report a workers' compensation injury as soon as they are aware the injury may be work related. Town policy requires notification to be made immediately; but no later than 24 hours after the injury.

Employees who are unable to report to work as a result of a work related injury and whose inability to work extends beyond eight calendar days will begin to accrue temporary income benefits (TIBs) on the eighth day of the lost time following the injury. TIBs are equal to approximately 70% of an employee's pre-injury wages and are capped at a maximum amount set by the Texas Workers Compensation.

Please contact the Human Resources Division for more detailed information regarding workers' compensation.

The Town will supplement the employee's pay for the first 12 weeks of workers' compensation leave. Upon expiration of the first 12 weeks, the employee will supplement their own pay to approximately 30% of pre-injury wages via use of accrued leave balances.

The employee retains the weekly temporary income benefit check that is received from the workers' compensation administrator. Employees may receive both a TIBs check and a Town check; however, all TIBs payments received will be deducted from future employee paychecks.

Employee Assistance Program (EAP)

All regular full-time and part-time employees and dependents have access to the Deer Oaks Employee Assistance Program provided by the Town of Flower Mound and at no cost to the employee. Participants can access the EAP Helpline at 866.EAP.2400, 24 hours per day, 7 days a week, 365 days per year. Employees also have access to EAP services for six months after separation of employment.

Deer Oaks provides up to six (6) counseling sessions per incident per year. Referrals to the program are typically sought for the following types of issues:

- Stress, tension, anxiety
- Anger management, depression and grief
- Marital/family problems
- Work related difficulties
- Legal/financial concerns
- Health and wellness issues
- Trauma recovery, substance abuse
- Child care and elder care services
- Adolescent and teen concerns
- Crisis intervention

Visit www.deeroaks.com for an interactive website that gives you free access to resources and tools for improving health and enhancing life.

Contact Information

If you have any questions about any of your benefits, below is a list of the companies, the plans they administer, and their phone numbers.

Plan	Company	Phone Number
Medical/Dental/Vision/RX	Blue Cross Blue Shield	(800) 521-2227
Basic Life/AD&D/LTD	Cigna	Contact TOFM Human Resources Division
Retirement	TMRS	(800) 924-8677
Flexible Spending Account	NAVIA Benefit Solutions	(800) 669-3539
Pharmacy Mail Order	Alliance Rx Walgreens Prime	(877) 357-7463
Speciality Medications	Alliance Rx Walgreens Prime	(877) 627-6337
Employee Assistance Program	Deer Oaks	(866) EAP-2400

This booklet summarizes the provisions of the Town of Flower Mound's Group Health Insurance Plan effective January 1, 2019. Complete details of the plan are included in the official plan documents and contracts. If there is a difference between this book and the documents or contracts, then the documents and contracts will govern. Benefits described in this book may be changed at any time and do not represent a contractual obligation on the part of the Town of Flower Mound.

FLOWER MOUND
EMPLOYEE BENEFITS GUIDE

January 1, 2019

Complete copies of individual plan summaries and booklets are available by contacting Human Resources or viewing the Town's intranet. If you still have questions, please contact Human Resources at (972) 874-6011.

The information in this enrollment guide is intended to help you enroll in 2019 benefits. Not all plan provisions, limitations, or exclusions are described in the 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. The company reserves the right to change to terminate benefits at any time. Neither the benefits, not this enrollment guide, should be interpreted as a guarantee or future benefits.