City of Bellaire

2026 EMPLOYEE BENEFITS

For Active Employees

A comprehensive guide to understanding your employee benefits program

CONTACT INFORMATION

BENEFIT	CARRIER	PHONE	WEBSITE/EMAIL
Human Resources	The City of Bellaire	713-662-8257	hr@bellairetx.gov
Medical	Cigna	800-244-6224	www.mycigna.com
Pharmacy	Cigna	800-244-6224	www.mycigna.com
24-Hour Nurseline	Cigna	800-244-6224	www.mycigna.com
Telehealth	MDLIVE	888-726-3171	www.mdliveforcigna.com
Diabetes Program	Kelsey-Seybold	713-442-6331	www.kelsey-seybold.com/diabetescare
Health Savings Account	Lively	888-576-4837	www.livelyme.com
Dental	Lincoln Financial	800-423-2765	www.lincolnfinancial.com
Vision	Lincoln Financial	800-440-8453	www.lvc.lfg.com
Flexible Spending Accounts	Higginbotham	866-419-3519	flexclaims@higginbotham.net
Long Term Disability Basic and Voluntary Life AD&D	Lincoln Financial	800-423-2765	www.lincolnfinancial.com
Critical Illness, Accident, Cancer, Hospital Indemnity, and Short Term Disability	Colonial	800-325-4368	www.coloniallife.com
Employee Assistance Program	UTEAP	713-500-3327 or 800-346-3549	www.uteap.org
For enrollment, eligibility, benefit questions or benefit issue resolution	Higginbotham Employee Response Center	866-419-3518	helpline@higginbotham.net

This guide highlights the main features of The City of Bellaire Benefits Program. It is intended to help you choose the benefits that are best for you. This guide does not include all plan rules and details. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this guide and the legal plan documents, the plan documents are the final authority. The City of Bellaire reserves the right to change or discontinue the benefit plans at any time.

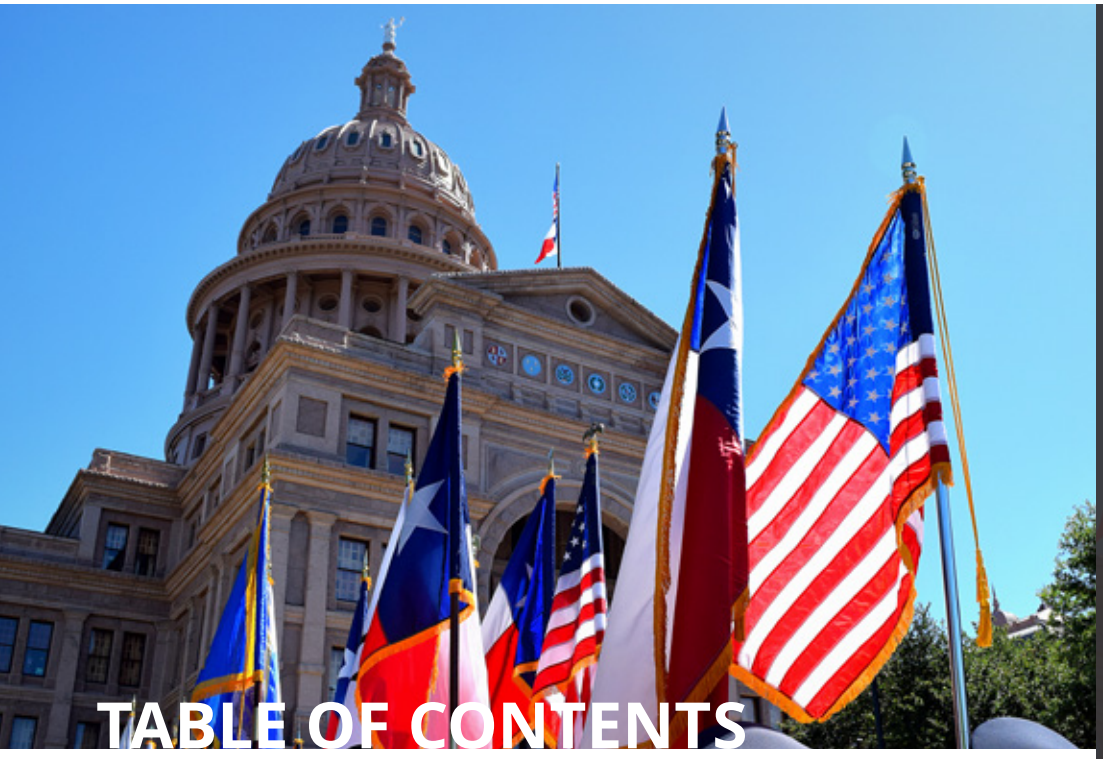


TABLE OF CONTENTS

The 2026 City of Bellaire Benefits Guide provides a general overview of the employee benefit plans as of **January 1, 2026** and is intended for general informational purposes only.

Details contained in this guide are subject to the official plan documents, policies and other booklets and arrangements governing the benefit programs. Nothing contained in this guide shall be construed to amend or alter any of the benefit programs.

Benefit programs are not employment contracts. Eligibility for a benefit or the right to a benefit is not a guarantee of employment. The City of Bellaire reserves the right to amend any benefit at any time.

Our employee benefits program offers three health coverage options. To help you make an informed choice and compare your options, a Summary of Benefit and Coverage (SBC) is available which summarizes important information about your health coverage options in a standard format.

The SBC is available on the web at **www.benefitsinhand.com.** A paper copy is also available, free of charge, by calling Human Resources at **713-662-8257**.

A MESSAGE FROM HUMAN RESOURCES

Dear Valued Employee,

Your City of Bellaire (The City) benefits touch many aspects of your life: health, finances, mental well-being and the protection of your family, just to name a few. The City provides these benefits not only to support you through important events in your life, but also to enhance your life outside of work and help you prepare for the future. This guide summarizes your benefits, effective January 1, 2026. We are pleased to tell you The City continues to offer comprehensive benefits to you as part of your total compensation. The City will continue to cover the majority of the cost for medical and dental premiums and 100% of the cost for basic life/accidental death and dismemberment, short term salary continuation and long term disability.

Each year, eligible employees of The City are given an opportunity to review their current benefit elections and make changes during Open Enrollment. This helps ensure your benefits continue to meet your changing needs and circumstances. This is your ONLY opportunity to make changes to your current enrollment, unless you have a Qualifying Life Event during the 2026 plan year.

BENEFIT	WHO PAYS THE COST
Medical and Pharmacy	The City and You
Dental	The City and You
Vision	The City and You
Short Term Salary Continuation	The City
Long Term Disability	The City
Group Term Life and AD&D	The City
Voluntary Term Life and AD&D	You

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 33 for more details.

2026 HIGHLIGHTS

- **CIGNA** will continue as the medical and pharmacy carrier. There are three plan options to choose from with changes to the deductible and out of pocket on the High Deductible Health Plan. The Kelsey providers are in the Local Plus Network so you can continue to use them.
- **MD Live** remains the carrier for Telehealth services.
- **Lincoln Financial** is our carrier for Dental, Vision, Life and Short Term Disability.
- **Colonial** is the carrier for Supplemental insurance for Critical Illness, Accident, Hospital Indemnity and Cancer.
- The Health Savings vendor is **Lively**. New bank accounts will be set up for you if you elect the HSA. If you are already on the HSA, your account will continue as is.

ENROLLMENT AND ELIGIBILITY

OPEN ENROLLMENT

During the Open Enrollment period you may make changes to your benefit elections or add/remove dependents from your insurance coverage. This year's Open Enrollment period begins on October 27th and ends on November 10th at 5:00 p.m. CT. Open Enrollment is the only time you may change coverage without a Qualifying Life Event (see definition on page 6).

ELIGIBILITY

EMPLOYEES

You are eligible to participate in benefits if you are classified as a regular, full-time employee scheduled to work at least 30 hours per week. You must be actively at work for any coverage to take effect. Benefits begin the first day of the month following your date of hire and end on the last day of the month of a termination.

DEPENDENTS

Your eligible dependents include:

- Your legally married spouse (a fiancé or significant other is not eligible)
- Your dependent children from birth to age 26
- Your unmarried children of any age who are mentally or physically disabled and who are dependent on you for support

CHILDREN

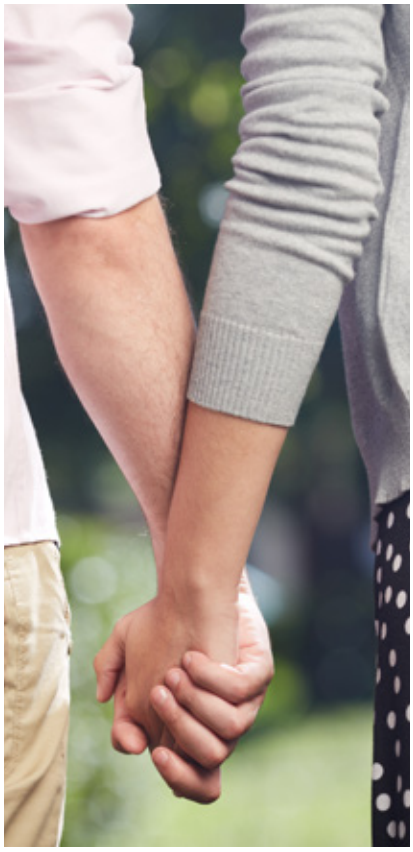
- Natural children
- Legally adopted children (or children placed with you for adoption)
- Stepchildren
- Children for whom you or your spouse are the legal guardian, as long as you have the sole legal right and obligation to provide support and medical care

Dependent coverage takes effect on the same date your coverage begins. You may be asked to provide evidence that your dependents meet the eligibility requirements, such as birth certificates, adoption or guardianship papers, marriage license or a federal income tax return.

ENROLLMENT AND ELIGIBILITY

MAKING CHANGES

Depending on the type of Qualifying Life Event, you will have either 31 or 60 days to submit your supporting documentation to Human Resources. Changes will be effective on the day of the event. If you do not make your changes during the 31- or 60-day change in status period, your changes cannot be made until the next Open Enrollment period. Benefit changes must also be consistent with your Qualifying Life Event. See the Special Enrollment Rights Notice on page 33.



QUALIFYING LIFE EVENTS

Your benefit elections will remain in effect for the entire plan year as you pay medical, dental, vision and HSA costs pretax (through IRC Section 125). However, a Qualifying Life Event allows you to make changes during the year. There are two notification time frames for Qualifying Life Events:

31-DAY NOTIFICATION TIME FRAME

- Birth, adoption or placement for adoption of an eligible child
- Marriage, legal separation or annulment
- Change in your or your dependent's employment status that affects benefits eligibility (e.g., starting a new job, leaving a job, changing from part-time to full-time)
- Significant change in coverage or cost in your, your spouse's or child's benefit plans
- Court judgment or decree
- Receiving a Qualified Medical Child Support Order (QMCSO)
- Spouse's open enrollment

60-DAY NOTIFICATION TIME FRAME

- Child reaches age limit for benefits
- Divorce
- Death of spouse or child
- Becoming eligible for Medicare, Medicaid, or TRICARE
- Dependent loses eligibility

31-DAY NOTIFICATION REQUIRED	60-DAY NOTIFICATION REQUIRED
Birth/Adoption	Dependent Child Reaches Age Limit
Marriage/Separation/Annulment	Divorce
Changes in Employment Status or Loss of Benefits	Death of spouse or child
Significant Cost/Coverage Change	Becoming Eligible for Medicare or Medicaid
Court Decree/QMCSO	Loss of Dependent Eligibility
Spouse's Open Enrollment	

2026 BENEFITS ENROLLMENT THROUGH BENEFITSINHAND

Enrollment is available online through the **BenefitsInHand** website.

1. To begin the enrollment process, go to **www.benefitsinhand.com**. (First time users: Follow steps 2-5. Returning users: Log in and start at step 6.)
2. If this is your first time to log in, click on the *New User Registration* link. Once you register, you will use your Username and Password to log in.
3. Enter your personal information and Company Identifier of **BELLAIRE** and click *Next*.
4. Create a Username (work email address recommended) and Password, then check the *I agree to terms and conditions* box before you click *Finish*.
5. If you used an email address as your Username, you will receive a validation email to that address. You may now log in to the system.
6. Click the *Start Enrollment* button to begin the enrollment process.
7. Confirm or update your personal information and click *Save & Continue*.
8. Edit or add dependents who need to be covered on your benefits. Once all dependents are listed, click *Save & Continue*.
9. Follow the steps on the screen for each benefit to make your selection. Please notice there is an option to Decline Coverage. If you wish to decline, click the *Don't want this benefit?* button and select the reason for declining.
10. Once you have elected or declined all benefits, you will see a summary of your selections. Click the *Click to Sign* button. Your enrollment will not be complete until you click the *Click to Sign* button.

DO YOU HAVE QUESTIONS ABOUT YOUR BENEFITS OR NEED HELP ENROLLING?

Call the Employee Response Center at **866-419-3518**. Benefits representatives are available to take your call Monday through Friday, 7:00 a.m. – 6:00 p.m. (CT).

UNIQUE IDENTIFIER: BELLAIRE

MEDICAL AND PHARMACY COVERAGE

The medical plan options through **Cigna** protect you and your family from major financial hardship in the event of illness or injury. You have a choice of three plans:

- **Local Plus Plan** - In-Network Only ($3,000/$6,000)
- **Buy Up Plan** - In-Network Only ($2,000/$4,000)
- **HDHP/HSA-eligible Open Access Plan** - ($3,400/$6,800)

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

An HDHP allows you to see any provider when you need care, but you will pay less for care when you go to in-network providers. If you enroll in the HDHP, you may be eligible to open a Health Savings Account (see page 12).

LOCAL PLUS AND BUY UP PLANS (IN-NETWORK ONLY)

With an In-Network Only plan, you must only see in-network providers for your care. With the exception of a true emergency, benefits are only payable if you go to in-network providers or facilities for care. If you go to an out-of-network provider or facility, you will be responsible for all costs. You do not have to select a primary care physician or get a referral to see a specialist. Always confirm that your doctors and specialists are in the network before seeking care.

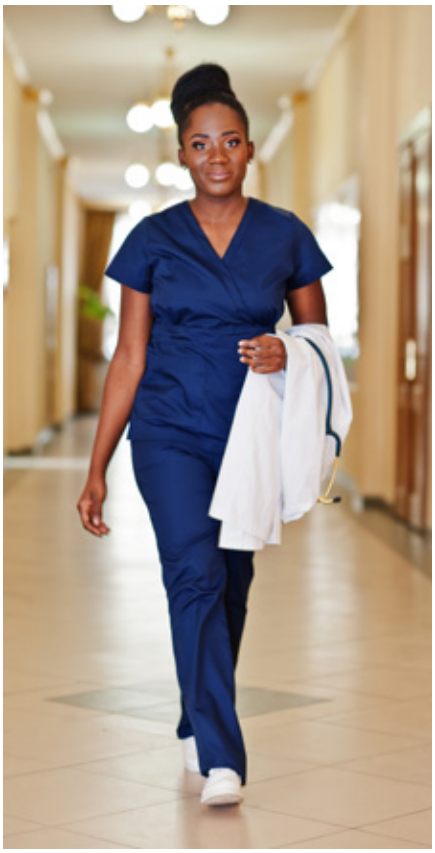
PRESCRIPTION DRUG APPROVAL

This is a program in which certain medications need approval by Cigna before they are covered. When you fill a medication for a Step Therapy drug noted with "ST" on the drug list, you and your doctor will receive a letter that will tell you the steps you need to take before you refill your medication.

Some prescriptions are limited to a specified maximum quantity. Amounts over that quantity are not covered unless approved in advance by the plan. No special steps are necessary by a physician or member to have your drugs covered as long as your medications are prescribed within specified limitations. If you require drugs in a larger quantity than is allowed, your physician may request a coverage exception.

FIND A NETWORK PROVIDER

Visit **www.mycigna.com** or call **800-244-6224**.



MEDICAL ID CARD

To request a temporary ID card visit **www.mycigna.com** or download the Cigna App for digital cards. **You must request a physical card to be mailed to your home.**

MEDICAL AND PHARMACY COVERAGE

MEDICAL PLAN SUMMARY

	HDHP/HSA-Eligible Base Plan		Local Plus Plan	Buy Up Plan
	In-Network	Out-of-Network	In-Network Only	In-Network Only
Calendar Year Deductible Individual Family	Embedded $3,400 $6,800	Embedded $10,000 $20,000	Embedded $3,000 $6,000	Embedded $2,000 $4,000
Calendar Year Out-of-Pocket Maximum (includes deductible) Individual Family	$4,000 $8,000	$30,000 $90,000	$6,000 $12,000	$6,000 $12,000
	You Pay	You Pay	You Pay	You Pay
Preventive Care	$0	50%[1]	$0	$0
Telemedicine	10%[1]	not covered	30%	20%
Primary Care Physician	10%[1]	50%[1]	$25 copay	$25 copay
Specialist	10%[1]	50%[1]	$50 copay	$50 copay
Diagnostic Lab and X-ray	$0	50%[1]	$0	20%[1]
Complex Imaging CT/PET scan, MRI	10%[1]	50%[1]	$250 scan per day	20%[1]
Urgent Care	10%[1]	50%[1]	$75 copay	$75 copay
Emergency Room	10%[1]	10%[1]	$250 copay	$300 copay + 20%
Hospital Care Inpatient Outpatient	10%[1] 10%[1]	50%[1] 50%[1]	30%[1] 30%[1]	20%[1] 20%[1]
Prescription Drugs				
Prescription Drugs - Retail Up to a 30-day supply Tier 1 - Generic Tier 2 - Preferred Brand Tier 3 - Non-preferred Brand Tier 4 - Specialty	 $15 copay $50 copay $90 copay $200 copay	 50%[1] 50%[1] 50%[1] 50%[1]	 $10 copay $35 copay $70 copay $200 copay	 $10 copay $35 copay $70 copay $200 copay
Prescription Drugs - Mail Order Up to a 90-day supply Tier 1 - Generic Tier 2 - Preferred Brand Tier 3 - Non-preferred Brand Tier 4 - Specialty	 $38 copay $125 copay $225 copay n/a	 50%[1] 50%[1] 50%[1] 50%[1]	 $25 copay $88 copay $175 copay $200 copay	 $25 copay $88 copay $175 copay $200 copay

[1]What you will pay after your deductible is met.

BIWEEKLY EMPLOYEE CONTRIBUTIONS

Medical Wellness Rates			
HDHP/HSA-ELIGIBLE BASE PLAN	Total Cost of Coverage	City Pays	Employee Pays
Employee	$457.97	$457.97	$0.00
Employee and Spouse (One Wellness)	$961.72	$829.55	$132.17
Employee and Spouse (Both Wellness	$961.72	$856.63	$105.09
Employee and Child(ren)	$870.13	$831.32	$38.80
Family (One Wellness)	$1,373.89	$1,238.78	$135.11
Family (Both Wellness)	$1,373.89	$1,265.86	$108.03
LOCAL PLUS PLAN			
Employee	$473.65	$457.97	$15.68
Employee and Spouse (One Wellness)	$994.67	$829.55	$165.12
Employee and Spouse (Both Wellness)	$994.67	$856.63	$138.04
Employee and Child(ren)	$899.93	$831.32	$68.60
Family (One Wellness)	$1,420.95	$1,238.78	$182.17
Family (Both Wellness)	$1,420.95	$1,265.86	$155.09
BUY UP PLAN			
Employee	$500.79	$457.97	$42.82
Employee and Spouse (One Wellness)	$1,051.57	$829.55	$222.02
Employee and Spouse (Both Wellnes)	$1,051.57	$856.63	$194.94
Employee and Child(ren)	$951.42	$831.32	$120.10
Family (One Wellness)	$1,502.24	$1,238.78	$263.46
Family (Both Wellness)	$1,502.24	$1,265.86	$236.38
Medical NON-Wellness Rates			
HDHP/HSA-ELIGIBLE BASE PLAN	Total Cost of Coverage	City Pays	Employee Pays
Employee	$457.97	$430.88	$27.08
Employee and Spouse	$961.72	$802.46	$159.25
Employee and Child(ren)	$870.13	$804.24	$65.89
Family	$1,373.89	$1,211.69	$162.19
LOCAL PLUS PLAN	Total Cost of Coverage	City Pays	Employee Pays
Employee	$473.65	$430.88	$42.77
Employee and Spouse	$994.67	$802.46	$192.21
Employee and Child(ren)	$899.93	$804.24	$95.69
Family	$1,420.95	$1,211.69	$209.25
BUY UP PLAN	Total Cost of Coverage	City Pays	Employee Pays
Employee	$500.79	$430.88	$69.91
Employee and Spouse	$1,051.57	$802.46	$249.10
Employee and Child(ren)	$951.42	$804.24	$147.18
Family	$1,502.24	$1,211.69	$290.55

BIWEEKLY EMPLOYEE CONTRIBUTIONS

HSA Health Savings Account			
HSA	Refer to 2026 limits on page 12		
Dental DHMO			
	Total Cost of Coverage	City Pays	Employee Pays
Employee Only	$9.10	$9.10	$0.00
Employee + Spouse	$17.29	$9.10	$8.19
Employee + Child(ren)	$13.21	$9.10	$4.11
Employee + Family	$28.21	$9.10	$19.11
Dental DPPO			
	Total Cost of Coverage	City Pays	Employee Pays
Employee Only	$11.82	$9.10	$2.72
Employee + Spouse	$24.02	$9.10	$14.92
Employee + Child(ren)	$32.40	$9.10	$23.30
Employee + Family	$48.63	$9.10	$39.53
Vision			
	Total Cost of Coverage	City Pays	Employee Pays
Employee Only	$5.68	$2.96	$0.00
Employee + Spouse	$17.88	$2.96	$2.66
Employee + Child(ren)	$26.26	$2.96	$3.63
Employee + Family	$42.49	$2.96	$6.32
Disability			
Short Term Salary Continuation	Paid for by The City of Bellaire		
Long Term Disability	Paid for by The City of Bellaire		
Life and AD&D			
Basic Life and AD&D	Paid for by The City of Bellaire		
Voluntary Life and AD&D	See page 22 for rates		
Supplemental Insurance - Colonial			
Cancer	See BenefitsInHand for rates.		
Accident			
Critical Illness			
Hospital Indemnity			
Short Term Disability			

HEALTH SAVINGS ACCOUNT

If you enroll in **Cigna's** High Deductible Health Plan, you may also take advantage of a special tax-savings feature called a Health Savings Account (HSA). The HSA, administered by **Lively**, is a tax-free bank account you use to help pay the cost of eligible health care expenses. Once enrolled, you will receive more information on how to use this account.

An HSA allows you to make contributions to your account with pretax deductions from your paychecks throughout the year. You can use the HSA funds to pay for qualified medical expenses not covered by your HDHP, such as:

- Deductibles
- Coinsurance
- Amounts above reasonable and customary (R&C) charges for out-of-network services
- Dental and vision expenses not covered by your dental and vision plan
- Prescription drugs (except for preventive prescription drugs)

WHO IS ELIGIBLE?

You can participate in an HSA only if you enroll in Cigna's High Deductible Health Plan. You are not eligible if you are:

- Enrolled in Medicare (Part A, Part B, or Part D).
- Covered by another medical plan (such as your spouse's plan) that does not qualify as a high deductible health plan.
- Enrolled in a general-purpose health care Flexible Spending Account (FSA) (and neither is your spouse).
- Claimed as a dependent on another individual's tax return.

HOW YOU CONTRIBUTE TO THE HEALTH SAVINGS ACCOUNT

For 2026, you can contribute up to a maximum of $4,400 for an individual or up to $8,750 for a family. Your contributions are deducted from your paycheck on a pretax basis. The money is then placed in an account where it earns interest after you contribute a certain amount. The money in your HSA is always yours to keep. **The City will provide a $1,000 annual contribution to your HSA on January 1, 2026. If your spouse and children are enrolled, the contribution will be $1,500.**

Maximum 2026 tax-year contribution (combination of employee and City of Bellaire money).

- ☐ **Single Coverage** - $4,400 ($3,400 is your maximum contribution without the City's contribution)
- ☐ **Family Coverage** - 8,750 ($7,250 is your maximum contribution without the City's contribution)

CATCH-UP CONTRIBUTIONS

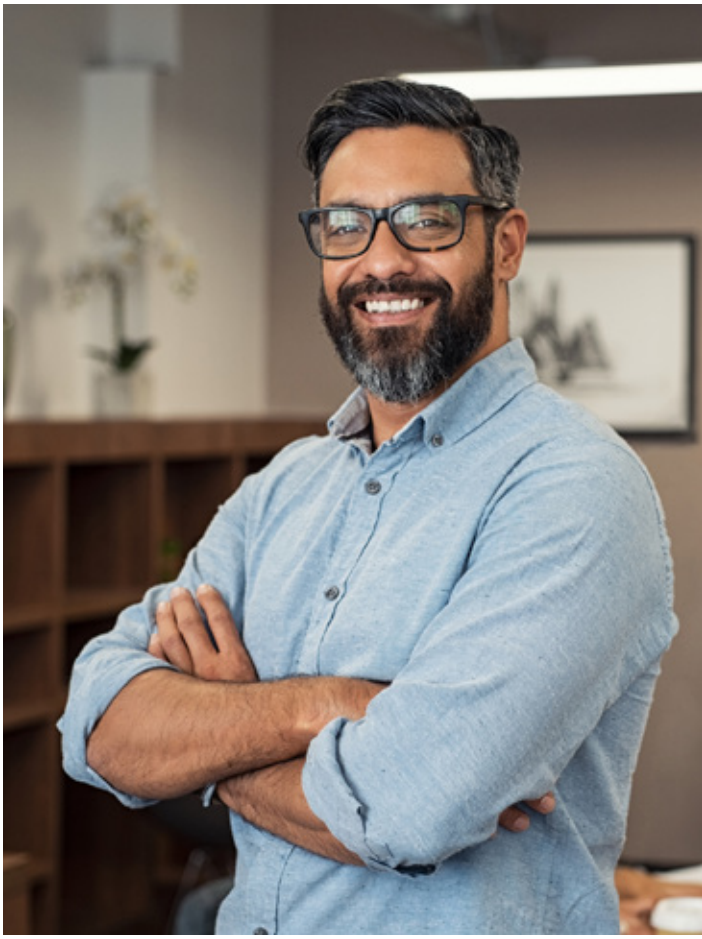
If you are age 55 or older, you can make "catch-up" contributions up to $1,000 in 2026. Keep in mind that you can contribute up to the maximum allowed for the year at any time, up until the tax filing deadline (generally April 15) of the following year.

You can take your HSA with you if you change health plans or jobs, become unemployed, move to a different geographic area or change your marital status.

HEALTH SAVINGS ACCOUNT

HSA QUICK START

- Expect an email from Lively to enroll in your new HSA.
- Complete your enrollment.
- Login to view your Lively HSA dashboard.
- Start the transfer process (if needed) if you have an HSA with a different provider.
- Link your bank or credit union account (optional).
- Contact Lively if you need help or have HSA related questions.



PERSONAL INVESTMENT SOLUTIONS

Taxfree investing is one of the most valuable benefits of owning an HSA. Lively offers access to two personalized solutions to help you make your money go further:

- Schwab Health Savings Brokerage Account (Charles Schwab)
- HSA Guided Portfolio (Devenir)

Regardless of what you investment strategy is, you have easy access to industryleading solutions to help design your ideal portfolio and build toward your financial goals.

Your Lively dashboard will provide singlesignon access to your investments and these features:

- Personalized investment strategy
- First-dollar investing
- Automated transfer features

Get the Lively Benefits mobile app to securely manage your HSA on the go!

CONTACT LIVELY

Download: **Lively Benefits mobile app**

Phone: **888-576-4837**

Web: **www.livelyme.com**

CIGNA RESOURCES

MYCIGNA MOBILE APP

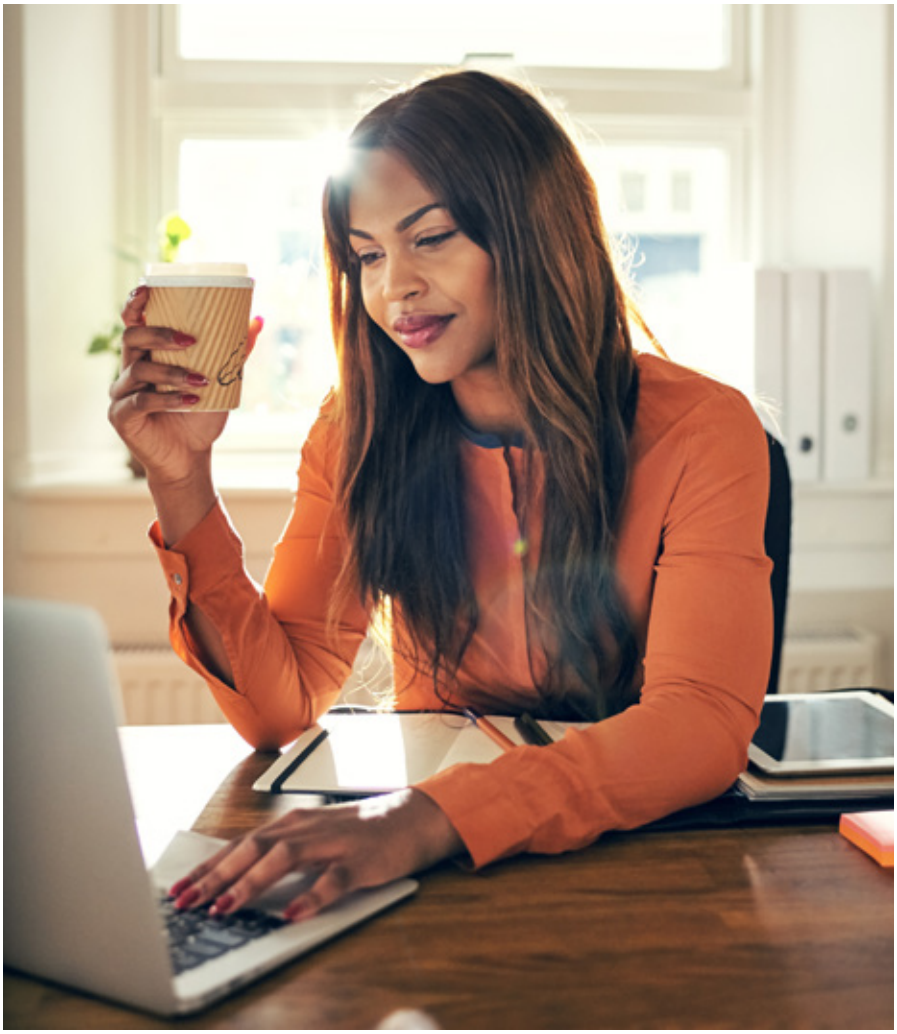
Download the myCigna mobile app to access your Cigna health plan and benefits information while on the go. This app helps you organize and access important plan information on your smartphone or tablet. It is also available in Spanish.

MYCIGNA.COM

myCigna serves as your one-stop-shop for all Cigna health plan and benefits information. Key features include managing and tracking claims, accessing digital ID cards, finding in-network providers, accessing cost comparison tools, reviewing coverage details, and more. Visit **mycigna.com** to register.

24-HOUR NURSELINE

This toll free nurse line — **800-244-6224** — is open 24/7. Feel free to ask about a health condition or things to ask your doctor at your next visit.



DIABETES PROGRAM AND TELEHEALTH

TAKE CONTROL OF YOUR DIABETES

The Kelsey-Seybold **Diabetes Prevention and Care Program** is a voluntary, confidential program available at no cost to you and your eligible dependents. The Diabetes Support Team will help you every step of the way.

You will receive quality care from Kelsey-Seybold physicians who are recognized for excellence in diabetes care. There are no copays for required office visits to physicians, Certified Diabetes Educators or Registered Dietitians at a Kelsey- Seybold clinic. If you fill your diabetes medications prescription at a Kelsey Pharmacy, copays are waived. If weight loss is recommended, WW (formerly Weight Watchers) membership is also included.

Enroll online at **www.kelsey-seybold.com/diabetescare** or call **713-442-6331**.

TELEMEDICINE

Connect anytime day or night with a board-certified doctor via your mobile device or computer for free.

WHEN TO USE MDLIVE

While telemedicine does not replace your primary care physician, it is a convenient and cost-effective option when you need care and:

- Have a non-emergency issue and are considering an after-hours health care clinic, urgent care clinic or emergency room for treatment
- Are on a business trip, vacation or away from home
- Are unable to see your primary care physician

Use telehealth services for minor conditions such as:

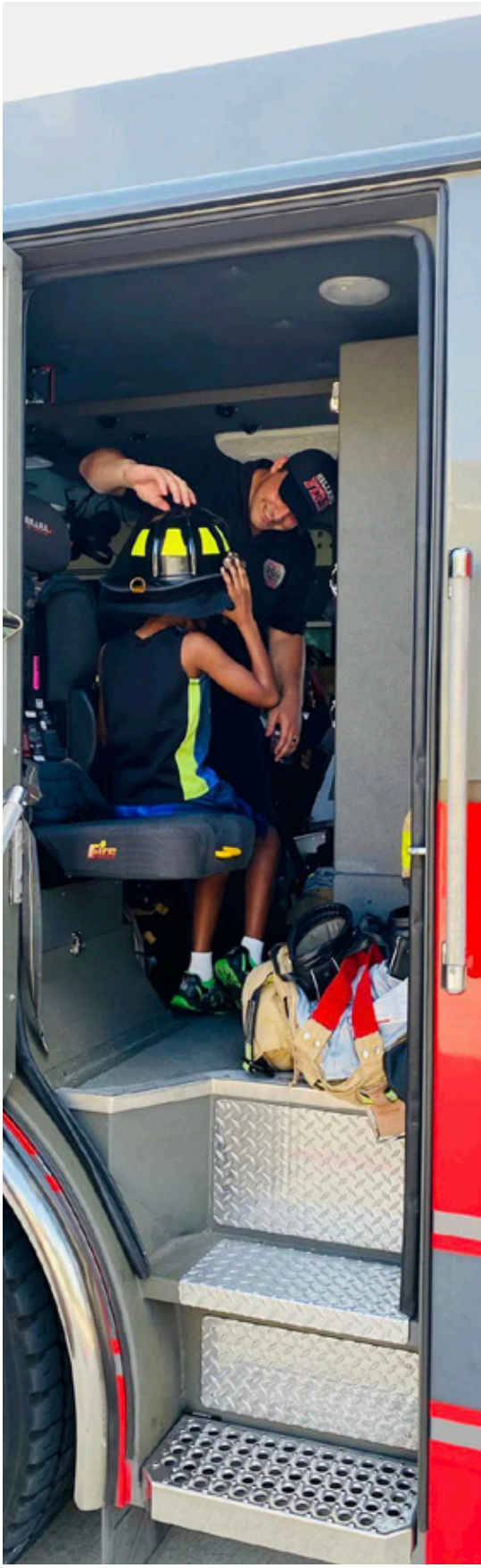
- Sore throat
- Headache
- Stomachache
- Cold
- Flu
- Allergies
- Fever
- Urinary tract infections

Do not use telemedicine for serious or life-threatening emergencies.

REGISTRATION IS EASY

Register with MDLIVE so you are ready to use this valuable service when and where you need it.

- Online – **www.mdliveforcigna.com**
- Phone – **888-726-3171**
- Mobile – download the mobile app to your smartphone or mobile device



HEALTH CARE OPTIONS

Become familiar with your options for medical care. It will save you time and money.

NON-EMERGENCY CARE

Telehealth		Symptoms	Average Cost	Average Wait
	Access to care via phone, online video or mobile app whether you are home, work or traveling; medications can be prescribed **24 hours a day, 7 days a week**	▪ Allergies ▪ Cough/cold/flu ▪ Rash ▪ Stomachache	$	2–5 minutes
Doctor's Office		**Symptoms**	**Average Cost**	**Average Wait**
	Generally, the best place for routine preventive care; established relationship; able to treat based on medical history **Office hours vary**	▪ Infections ▪ Sore and strep throat ▪ Vaccinations ▪ Minor injuries, sprains and strains	$	15–20 minutes
Retail Clinic		**Symptoms**	**Average Cost**	**Average Wait**
	Usually lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies **Hours vary based on store hours**	▪ Common infections ▪ Minor injuries ▪ Pregnancy tests ▪ Vaccinations	$	15 minutes
Urgent Care		**Symptoms**	**Average Cost**	**Average Wait**
	When you need immediate attention; walk-in basis is usually accepted **Generally includes evening, weekend and holiday hours**	▪ Sprains and strains ▪ Minor broken bones ▪ Small cuts that may require stitches ▪ Minor burns and infections	$$	15–30 minutes

EMERGENCY CARE

Hospital ER		Symptoms	Average Cost	Average Wait
	Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility **24 hours a day, 7 days a week**	▪ Chest pain ▪ Difficulty breathing ▪ Severe bleeding ▪ Blurred or sudden loss of vision ▪ Major broken bones	$$$$	4+ hours
Freestanding ER		**Symptoms**	**Average Cost**	**Average Wait**
	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher **24 hours a day, 7 days a week**	▪ Most major injuries except trauma ▪ Severe pain	$$$$$$	Minimal

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

DENTAL BENEFITS

Good oral hygiene can contribute to your overall health, so it is important to get regular dental checkups. The City offers two dental options under **Lincoln Financial Group** that help you pay for preventive, basic and major care and orthodontic treatment (DHMO only).

DENTAL ID CARD

To request a replacement or print a temporary ID card, please visit **www.lincolnfinancial.com** or download the Lincoln Dental mobile app.

DENTAL OPTIONS

DHMO PLAN

The DHMO (Dental Health Maintenance Organization) is a network-only plan which means you must select a primary care dentist and obtain a referral when visiting dental specialists. The plan has no annual deductible nor office visit copay for all preventive and basic services. Orthodontia benefits are available once per lifetime for dependents or adults covered at 60% of eligible expenses. The plan has no annual benefit maximum. You will need a dental ID card to receive care.

DPPO PLAN

Two levels of benefits are available with the DPPO plan: in-network and out-of-network. You may see any dental provider for care, but you will pay less and get the highest level of benefits with in-network providers. You could pay more if you use an out-of-network provider.

DENTAL PLAN SUMMARY

	DHMO Plan	DPPO Plan	
Network	Lincoln	Lincoln	
	In-Network Only[1]	In-Network	Out-of-Network
Calendar Year Maximum Benefit	N/A	$2,000	$2,000
Orthodontia Lifetime Maximum Benefit	N/A	$2,000	$2,000
	You Pay	You Pay	
Calendar Year Deductible Individual Family	 N/A N/A	 $50 $150	 $50 $150
Preventive Care Exams, cleanings, complete series X-rays, sealants, fluoride	$0	$0	$0
Basic Restorative Fillings, extractions, periodontics	fixed copay based on service	20%	20%
Major Restorative Crowns, bridges, dentures, endodontics	fixed copay based on service	40%	40%
Orthodontia Covered Individuals[2] Benefit	 dependent children to age 19 fixed copay based on service[3]	 dependent children to age 19 50%	 dependent children to age 19 50%

[1]This plan covers in-network benefits only. Care must be coordinated by your chosen Primary Care Dentist to be covered by the plan.
[2]Plan benenfits aren't payable if the orthodontic appliance was installed after age 19. There is a 6-month waiting period for orthodontics.
[3]Your Primary Care Dentist must provide a referral for care to be covered under the plan.

FIND DPPO PROVIDERS

Visit **www.lincolnfinancial.com**, then select Find a Dentist

Call **800-423-2765**

Download **Lincoln Dental mobile app**

FIND DHMO NETWORK PROVIDERS

Visit **ldc.lfg.com**, then select Find a Dentist

Call **888-877-7828**

VISION BENEFITS

The vision plan is designed to provide your basic eyewear needs and preserve your health and sight. Coverage is offered through **Lincoln Financial** at no additional cost to you.

HOW THE VISION PLAN WORKS

The *Lincoln VisionConnect* plan helps pay the cost of routine eye examinations and the cost of eyeglasses or contact lenses. Under the vision plan, you may seek care from any licensed optometrist, ophthalmologist or optician. Plan benefits are higher, however, when you use in-network Spectera Vision providers.

When you visit your vision provider, let the office know you are a **Spectera** customer to maximize your in-network provider benefits.

VISION PLAN SUMMARY

Network	Spectera Vision	
	Participating Provider	Non-Participating Provider
	You Pay	Reimbursement
Exam	$0	Up to $40
Standard Lenses		
Single Vision	$0	Up to $40
Lined Bifocal	$0	Up to $60
Lined Trifocal	$0	Up to $80
Lenticular	$0	Up to $80
Frames	Up to $130 allowance	Up to $45
Contact Lenses		
Fitting and Evaluation	$0	Up to $125
Elective	Up to $125 allowance	Up to $125
Necessary	$0	Up to $210
Benefit Frequency		
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 12 months	
Contacts	Once every 12 months	

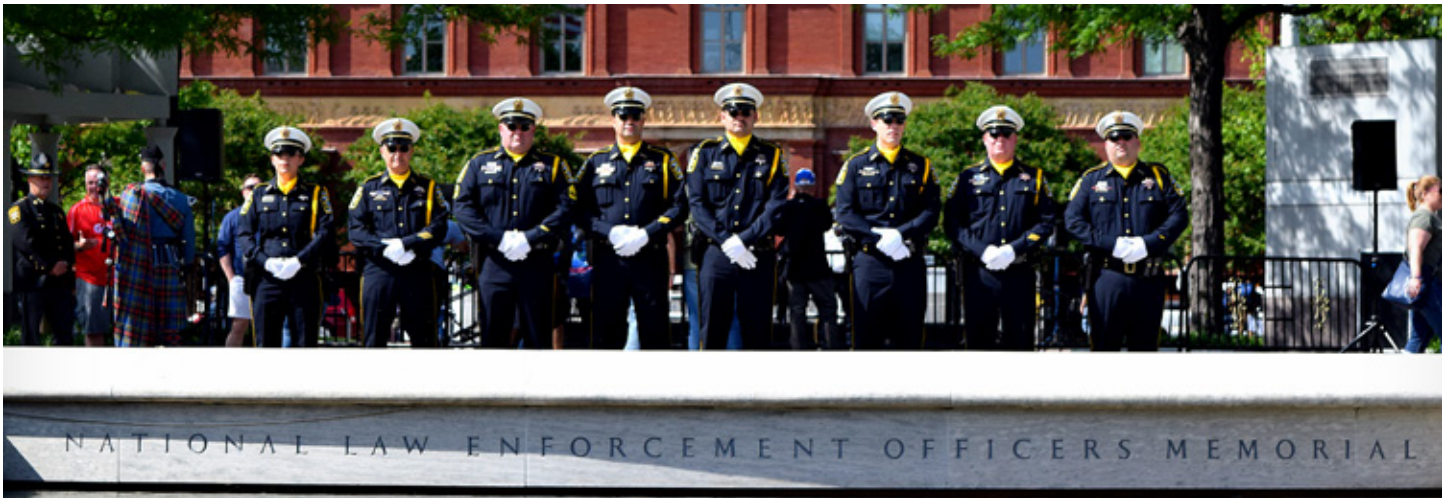
FIND AN IN-NETWORK PROVIDER

Call **800-440-8453**

Visit **www.LVC.lfg.com**

Search the **Spectera** vision network

Access online vision tools for convenient web-based services and resources, including discounts, benefit information, what eyewear is best for you, and more. Register at **lvc.lfg.com**.



FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) allows you to set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses. We offer two different FSAs: one for health care expenses and one for dependent care expenses. **Higginbotham** administers our FSAs.

HEALTH CARE FSA

The Health Care FSA is available to you if you are enrolled in the **Cigna Local Plus** or **Buy Up plans**. This account covers qualified medical, dental and vision expenses for you or your eligible dependents. You may contribute up to $3,400 annually to a Health Care FSA and you are entitled to the full election from day one of your plan year. Eligible expenses include:

- Dental and vision expenses
- Medical deductibles and coinsurance
- Prescription copays
- Hearing aids and batteries

You may not contribute to a Health Care FSA if you enrolled in a High Deductible Health Plan (HDHP) and contribute to a Health Savings Account (HSA).

HIGGINBOTHAM BENEFITS DEBIT CARD

The Higginbotham Benefits Debit Card gives you immediate access to funds in your Health Care FSA when you make a purchase without needing to file a claim for reimbursement. If you use the debit card to pay anything other than a copay amount, you will need to submit an itemized receipt or an Explanation of Benefits (EOB). If you do not submit your receipts, you will receive a request for substantiation. You will have 60 days to submit your receipts after receiving the request for substantiation before your debit card is suspended. Check the expiration date on your card to see when you should order a replacement card(s).

HOW THE HEALTH CARE FSA WORKS

You can access the funds in your Health Care FSA two different ways:

- Use your Higginbotham Benefits Debit Card to pay for qualified expenses, doctor visits and prescription copays.
- Pay out-of-pocket and submit your receipts for reimbursement:
  - ☐ **Fax** – **866-419-3516**
  - ☐ **Email** – **flexclaims@higginbotham.net**
  - ☐ **Online** – **https://flexservices.higginbotham.net**

DEPENDENT CARE FSA

The Dependent Care FSA helps pay for expenses associated with caring for elder or child dependents so you or your spouse can work or attend school full time. You can use the account to pay for day care or baby sitter expenses for your children under age 13 and qualifying older dependents, such as dependent parents. Reimbursement from your Dependent Care FSA is limited to the total amount deposited in your account at that time. To be eligible, you must be a single parent or you and your spouse must be employed outside the home, disabled or a full-time student.

THINGS TO CONSIDER REGARDING THE DEPENDENT CARE FSA

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns 13 midyear, you may only request reimbursement for the part of the year when the child is under age 13.
- You may request reimbursement for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts			
Account Type	Eligible Expenses	Annual Contribution Limits	Benefit
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over-the-counter medications)	$3,400	Saves on eligible expenses not covered by insurance, reduces your taxable income
Dependent Care FSA	Dependent care expenses (such as day care, after-school programs or elder care programs) so you and your spouse can work or attend school full-time	$7,500 single $3,750 if married and filing separate tax returns	Reduces your taxable income

HIGGINBOTHAM PORTAL

The Higginbotham Portal provides information and resources to help you manage your FSAs.

- Access plan documents, letters and notices, forms, account balances, contributions and other plan information
- Update your personal information
- Utilize Section 125 tax calculators
- Look up qualified expenses
- Submit claims
- Request a new or replacement Benefits Debit Card

REGISTER ON THE HIGGINBOTHAM PORTAL

- Visit **https://flexservices.higginbotham.net** and click *Register*. Follow the instructions and scroll down to enter your information.
- Enter your Employee ID, which is your Social Security number with no dashes or spaces.
- Follow the prompts to navigate the site.
- If you have any questions or concerns, contact Higginbotham:
  - ☐ Phone – **866-419-3519**
  - ☐ Email – **flexclaims@higginbotham.net**
  - ☐ Fax – **866-419-3516**

IMPORTANT FSA RULES

- The maximum per plan year you can contribute to a Health Care FSA is $3,400. The maximum per plan year you can contribute to a Dependent Care FSA is $7,500 when filing jointly or head of household and $3,750 when married filing separately.
- You cannot change your election during the year unless you experience a Qualifying Life Event.
- You can continue to file claims incurred during the plan year for another 90 days.
- Your Health Care FSA debit card can be used for health care expenses only. It cannot be used to pay for dependent care expenses.
- The IRS has amended the "use it or lose it rule" to allow you to carry-over up to $680 in your Health Care FSA into the next plan year. The carry-over rule does not apply to your Dependent Care FSA.

HIGGINBOTHAM FLEX MOBILE APP

Easily access your Health Care FSA on your smartphone or tablet with the Higginbotham mobile app. Search for Higginbotham in your mobile device's app store and download as you would any other app.

View Accounts – Includes detailed account and balance information

Card Activity – Account information

SnapClaim – File a claim and upload receipt photos directly from your smartphone

Manage Subscriptions – Set up email notifications to keep up to date on all account and Health Care FSA debit card activity Log in using the same username and password you use to log in to the Higginbotham Portal.

Note: You must register on the Higginbotham Portal to use the mobile app.

SHORT TERM SALARY CONTINUATION AND LONG TERM DISABILITY

The Short Term Salary Continuation and Long Term Disability plans provide you with an income if you are medically unable to work for an extended period of time. Both plans are administered by Lincoln Financial at no cost to you.

SHORT TERM SALARY CONTINUATION

The City has arranged for you to be protected against loss of income due to medical disability by providing a Short Term Salary Continuation plan.

Short Term Salary Continuation may be effective on the 31st calendar day of your time away from work due to a non-occupational illness or injury, or after all accrued sick leave, vacation, holiday and compensatory time has been exhausted, whichever occurs last.

Holidays, vacation leave and sick leave will not accrue during periods of extended absence away from work. An extended absence is defined as any leave that exceeds three months. However, in the case of such leaves, The City will continue to contribute to insurance premiums in the same manner as any employee actively at work. During such leaves, the amounts of insurance premiums that are usually paid by the employee through payroll deductions will need to be paid to The City by check or money order.

Note: The Short Term Salary Continuation plan may not be converted to a private plan upon termination.

	Coverage
Short Term Salary Continuation	▪ 30 days due to an accident or 30 days due to an illness*
Weekly Benefit	▪ Available for those who qualify
Less than 1 year of service	▪ None (i.e., sick pay only)
1–3 years of service	▪ 66 2/3% of predisability earnings for the first 60 days ▪ 50% of predisability earnings for the next 90 days
3–5 years of service	▪ 75% of predisability earnings for the first 60 days ▪ 60% of predisability earnings for the next 90 days
5+ years of service	▪ 100% of predisability earnings for the first 60 days ▪ 75% of predisability earnings for the next 90 days
Benefit Duration	▪ Up to a maximum of 45 weeks

* All accumulated sick leaves, vacation, holiday and compensatory time must be exhausted before any payments begin. The elimination period runs concurrently with the employee exhausting sick leave, vacation, holiday and compensatory time.

LONG TERM DISABILITY

Long Term Disability is provided by The City at no cost to you. Coverage is provided through **Lincoln Financial**.

	Coverage
Benefits begin on	▪ 181st day of injury or illness
Percent of your salary you will receive	▪ 60% of base monthly salary
Maximum benefit	▪ $5,000 per month
Maximum benefit period	▪ Social Security Normal Retirement Age
Own Occupation Period	▪ First 24 months – regular occupation ▪ After 24 months – any gainful occupation

LIFE INSURANCE

Life insurance provides you with the peace of mind of knowing you can help meet your family's financial needs even if you are not there to provide for them.

GROUP TERM LIFE AND AD&D INSURANCE

The City provides Basic Life and Accidental Death & Dismemberment (AD&D) insurance at no cost to you. Coverage is provided through **Lincoln Financial**. Benefits are reduced by 35% at age 65, 60% at age 70 and 75% at age 75. Coverage terminates at retirement.

	Coverage
Basic Life benefit amount	2 times pay up to $200,000
AD&D benefit amount	2 times pay up to $200,000

VOLUNTARY TERM LIFE AND AD&D INSURANCE

For an added layer of protection, you may purchase Voluntary Term Life and/or AD&D insurance for you, your spouse and dependent child(ren). These are separate elections. You must enroll in Voluntary Term Life and AD&D for yourself in order to cover your dependents. Evidence of Insurability will be required for initial insurance amounts in excess of $200,00 and for insurance amounts in excess of the Guarantee Issue that are increased by more than $25,000 after initial enrollment. Coverage is provided through **Lincoln Financial**.

	Coverage
Employee	$10,000 increments up to the lesser of 5 times salary or $300,000
Spouse	$5,000 increments up to the lesser of the employee's elected benefit amount or $100,000
Child(ren)[1]	Options of $1,000, $2,000, $4,000, $5,000 or $10,000 not to exceed spouse's amount
Guarantee Issue ▪ Employee ▪ Spouse	At Initial Eligibility ▪ $200,000 ▪ $50,000

[1] Children are covered to age 26.

You must submit Evidence of Insurability (proof of good health) if any of the following conditions are met:

- Coverage was previously waived the first time even though you were previously eligible.
- You are electing an amount in excess of the Guarantee Issue amount.

ACCELERATED LIFE BENEFIT

If you are diagnosed with a terminal condition, you may request a portion of your Life insurance benefit while you are still living. See the plan document for specific details.

VOLUNTARY LIFE/AD&D RATES

Employee Age	Employee and Spouse Coverage Biweekly Rate Per $1,000
<24	$0.043
25-29	$0.043
30-34	$0.050
35-39	$0.055
40-44	$0.073
45-49	$0.108
50-54	$0.163
55-59	$0.246
60-64	$0.352
65-69	$0.601
70-74	$0.964
75+	$0.964
Child(ren) Life Insurance	$0.240
AD&D Rates Per $1,000	
Employee	$0.290
Spouse	$0.290
Child	$0.290

LIFE INSURANCE

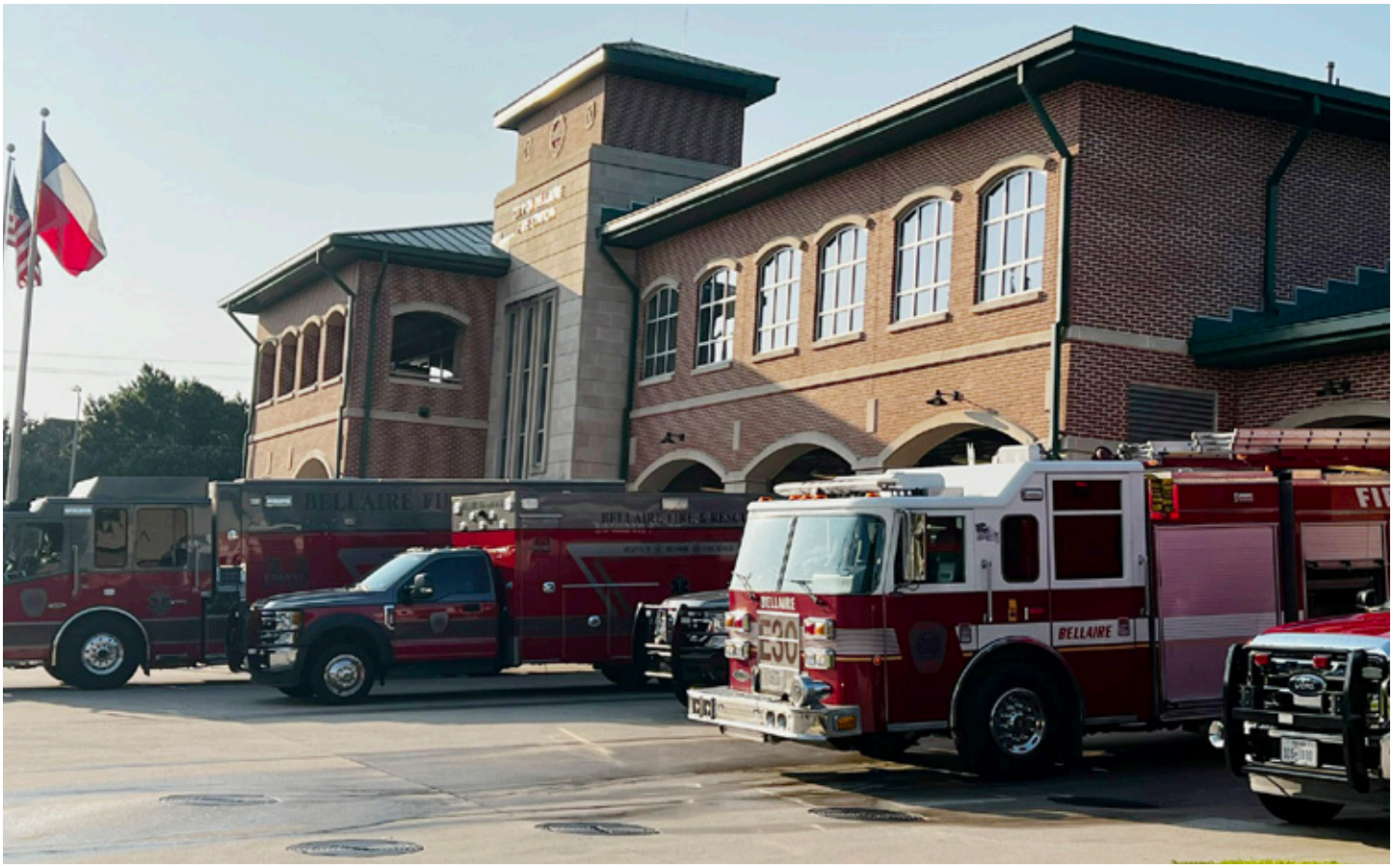
LINCOLN FINANCIAL ADDITIONAL BENEFITS

Lincoln Financial provides the following program and services at no additional cost.

TRAVELCONNECT

On Call International offers TravelConnect services to give you timely help and support when you travel. These benefits are available 24/7 and apply if you are 100 or more miles from home.

Emergency Support	Travel Support
▪ Arrange travel if you are injured and need to be taken for help ▪ Plan and pay for evacuations due to natural disasters or threats ▪ Board or return pets ▪ Transport the dead and more	▪ Recover lost or stolen items ▪ Translation ▪ Replace medical devices or eyewear ▪ Deliver medicine ▪ And more
On Call International must manage all the planning. Add them as a contact on your phone or computer so you have ready support and coverage when you need it. **Phone:** In the U.S. or Canada: 866-525-1955 Other locations: collect +1-603-328-1955 **Email:** mail@oncallinternational.com	



WELLNESS INCENTIVE

We offer wellness incentives because we care about you and your family. We also want to help manage your costs as well as The City's. When we work together toward better health, the cost of our health care will grow at a slower rate. Wellness incentives are designed to thank you — and reward you — for taking steps to improve the quality of your life and the overall health of our organization.

The City encourages you to participate in wellness activities so The City can continue to offer low rates.

CITY OF BELLAIRE 2026 LIFESTYLE REWARDS PROGRAM

It takes 15 points to receive your 2027 incentive! Earn your incentive by completing the items below:

- Annual physical exam or complete an onsite biometric screening – required and worth 5 points
- Completion of the Health Risk Assessment Survey is required – also worth 5 points
- Meeting the health score outcome of 71 – worth 5 points
  - Your health score is determined from the biometric results of your biometric screening.
  - Those who do not receive a score of 71 can participate in activities such as preventive exams, challenges, seminars, community events, etc. to earn your remaining 5 points.

Refer to the Lifestyle Rewards platform on your myHealthCheck360 app or portal to see the full list of activities you can earn points for completing.

COMPANY CODE: CYBLR

SUBMITTING ON THE HEALTHCHECK360 APP

1. Log in to your myHealthCheck360 account
2. On your main dashboard, scroll to the "Rewards" screen
3. Click "Submit New Reward"
4. Click the "Reward Activity" collapsible list and select the reward you completed
5. To provide proof of completion, click "Upload Receipt" and upload a photo from your library or take a photo of your form of proof.

IMPORTANT NOTES

Employees hired after June 30, 2026: Wellness activities are prorated and participants are only required to complete the annual physical exam.

Employees hired after August 1, 2026: No wellness activities are required to earn the full 2027 wellness incentive.

Spouses covered under the Employee Health Plan are also eligible to receive a $650 incentive to complete the required activities.

Children are eligible to receive wellness dollars of $650 with employee participation in wellness activities under the Employee and Children Plan.

HEALTHCHECK360 – LIFESTYLE REWARDS UPDATE

Wellness Incentive for HSA participants granted once annually for completion of wellness activities during prior year qualification period and/or upon a qualified family status change during the plan year.

WELLNESS INCENTIVE

HOW TO SUBMIT PROOF OF ACTIVITY COMPLETION

As wellness activities are completed, participants will need to provide proof of completion through the Lifestyle Rewards platform in order to earn credit.

Submitting on myHealthCheck360:

1. Log in to **www.myhealthcheck360.com** (Company Code: CYBLR)
2. Click *Lifestyle Rewards* on the left-hand toolbar
3. Find the tile that represents the reward you are submitting
4. Click *Submit Activity* when you hover over tile
5. Fill in activity details. To attach proof, choose the file you'd like to attach and click *Submit*

Your rewards will then be audited and approved or denied by HealthCheck360.

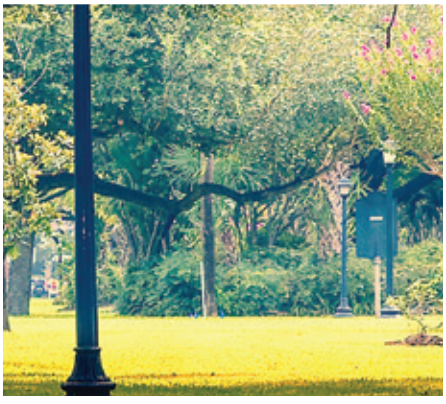
	ALL PLANS
Single Coverage	Avoids up to $650 annual increase by enrollment tier or $54.17 increase per month
Dependent Coverage	Up to $650 annually/$54.17 monthly or $1,300 annually/$108.34 monthly (if both EE & SP participate in annual contribution

QUESTIONS ABOUT HEALTHCHECK360?

Email the HealthCheck360 Support Team at **support@healthcheck360.com** or call **866-511-0360**.

WELLNESS PROGRAM DISCLOSURE

If you have a health factor that makes it unreasonably difficult or medically inadvisable for you to achieve the requirements of this program to qualify for the incentive/s, please contact Human Resources and we will work with you and/or your physician to develop an alternative. The purpose of this program is to promote health and prevent disease by alerting employees to potential health risks. This program is confidential and HIPAA compliant. Protected Health Information will only be collected in aggregate form in order to design programs for the purpose of addressing the company's overall risk. Any information shared will not be disclosed, except in accordance with HIPAA laws.



SUPPLEMENTAL COVERAGE

SUPPLEMENTAL COVERAGE FROM COLONIAL LIFE

You and your eligible family members have the opportunity to enroll in additional coverage that complements our traditional health care programs. Health insurance covers medical bills, but if you have an unexpected illness or accident, you may face unexpected out-of-pocket costs such as deductibles, coinsurance, travel expenses, and non-medical expenses. This is where supplemental benefits can help provide extra financial protection. You have the opportunity to purchase the following benefits through **Colonial Life**:

- **Cancer Insurance** provides a benefit to help offset the out-of-pocket medical and indirect, non-medical expenses related to cancer.
- **Accident Insurance** provides a benefit for a range of accidental injuries and treatments. You can use the money any way you choose.
- **Critical Illness Insurance** provides a lump sum benefit to help you manage the financial impacts of a critical illness.
- **Hospital Indemnity Insurance** provides a benefit for hospital confinement or other occurrences to help with deductibles.

POLICYHOLDERS PORTAL

If you become a Colonial Life policyholder, register for an account through the Colonial Life Policyholders Portal to easily and quickly file a claim and manage your benefits. The portal enables you to file claims, set up direct deposit for approved payments, view claims status, and more. Go to coloniallife.com/access to register and click Create an Account.

LEARN MORE

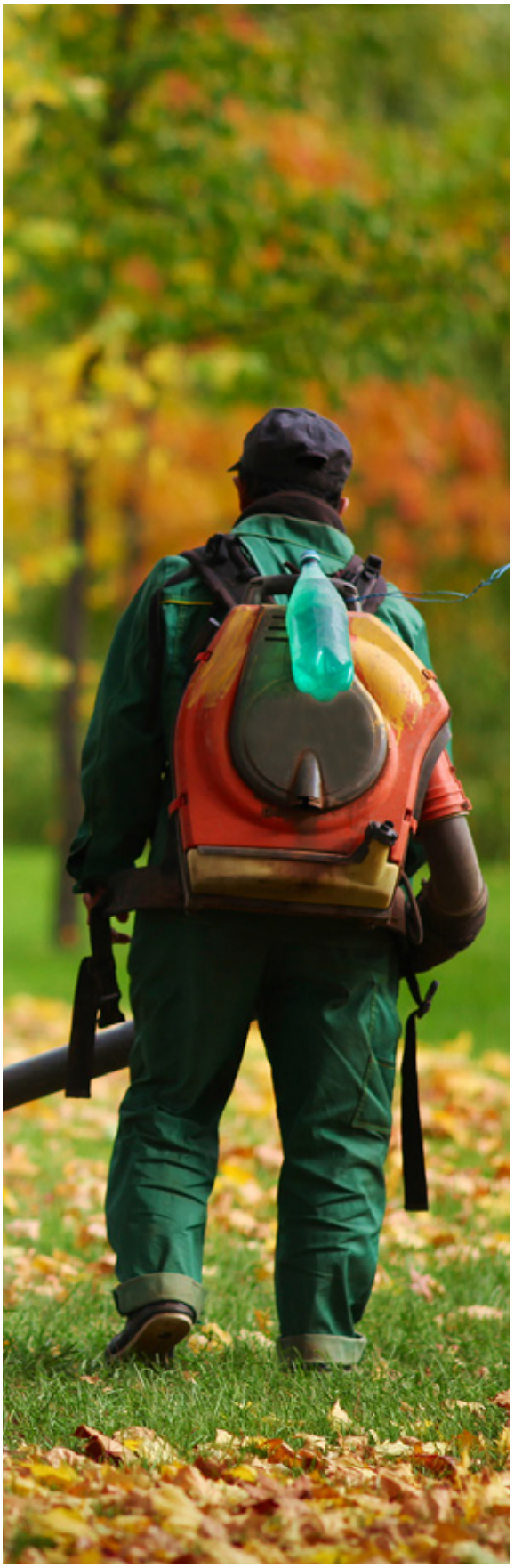
Call Colonial Life Call Center at **800-325-4368** or access **https://midd.me/OHcW**.

NEED RATES?

See BenefitsInHand for rates.

All plans are Guaranteed Issue during Open Enrollment. Pre-existing conditions are waived on Critical Illness, and Hospital Indemnity.

ADDITIONAL BENEFITS



EMPLOYEE ASSISTANCE PROGRAM

Through the **University of Texas Employee Assistance Program (UTEAP)**, you and your family members can access free, convenient and confidential services. The UTEAP offers a variety of services including counseling sessions with a licensed mental health professional, legal and financial resources and WorkLife referrals. Available services include confidential counseling, free simple will, financial advice and analysis, workshops and seminars, identity theft solutions, legal consultations and solutions to personal challenges. Employees are eligible for five counseling sessions per issue. To learn more about the variety of services offered by UTEAP, contact Human Resources or UTEAP directly at **713-500-3327 (or 800-346-3549)** or visit **www.uteap.org**.

HOLIDAYS

All employees working 40 hours per week receive 88 hours of holiday time per year. The following 11 holidays are official holidays for The City employees:

- New Year's Day
- Martin Luther King, Jr. Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Veterans Day
- Thanksgiving Day (fourth Thursday in November)
- Day after Thanksgiving (fourth Friday in November)
- Christmas Eve
- Christmas Day

FLOATING HOLIDAYS

In addition to the 11 holidays listed above, most regular full-time employees will be eligible for five floating holidays per year. These floating holidays may be taken any time during the calendar year but will not be carried forward to the next year.

Fire Department personnel who work a 48-96 (48 hours on duty and 96 hours off duty) shift cycle and Police Department personnel who work a twelve (12)-hour shift cycle will earn the eleven (11) declared official holidays and three (3) floating holidays each year. Each of these holidays will represent twelve (12) hours of paid holiday time off.

ADDITIONAL BENEFITS

VACATION LEAVE

All regular full-time employees will be entitled to accrue vacation leave for each complete month of active service with The City. Accrual rate will be based on length of service with the City and number of hours worked per regular workweek. Accruals are calculated proportionately and occur each pay period.

VACATION LEAVE – MAXIMUM ACCRUAL

Employees may accrue a maximum of 240 hours. For Police Department personnel working the twelve (12)-hour shift and Fire Department personnel working the 48-96 shift cycle (2,756 hours/year), the maximum accrual is 360 vacation hours. Employees who reach the maximum accrual of 240/360 hours will not accrue additional vacation hours until the balance falls below 240/360 hours. Upon termination of employment, employees may be paid for vacation time not to exceed the maximum accrual rate of 240 hours or 360 hours for fire and police personnel.

EMPLOYEES	40 HOUR PER WEEK		FIRE DEPT. 48-96 SHIFT CYCLE POLICE DEPT. 12-HOUR SHIFT	
Years of Completed Service	Monthly/Biweekly Accrual	Annual Accrual	Monthly/Biweekly Accrual	Annual Accrual
0-4.9 years	8/3.6923 hours	96 hours/12 days	12/5.5384 hours	144 hours
5-9.9 years	10/4.6153 hours	120 hours/15 days	15/6.9230 hours	180 hours
10-14.9 years	12/5.5384 hours	144 hours/18 days	18/8.3076 hours	216 hours
15-19.9 years	13.3333/6.1538 hours	160 hours/20 days	20/9.2307 hours	240 hours
20-24.9 years	14.6666/6.7692 hours	176 hours/22 days	22/10.1538 hours	264 hours
25+ years	15.3333/7.0769 hours	184 hours/23 days	23/10.6153 hours	276 hours

SICK LEAVE

For employees working eight (8) -hour days and other alternate work schedules, except Fire Department personnel who work a 48-96 (48 hours on duty and 96 hours off duty) shift cycle and Police Department personnel who work a twelve (12)-hour shift cycle, sick leave will be accrued at the rate of eight (8) hours for each month of active service. Fire Department personnel who work a 48-96 (48 hours on duty and 96 hours off duty) shift cycle and Police Department personnel who work a twelve (12)-hour shift cycle will earn sick leave at a rate of twelve (12) hours per month of active service. Maximum cumulative sick leave accrual will be 60 days of 480 hours for employees working five (5) eight (8)-hour days or other alternative work schedules. Fire Department personnel who work a 48-96 (48 hours on duty and 96 hours off duty) shift cycle and Police Department personnel who work a twelve (12)-hour shift cycle may accumulate up to 60 twelve-hour shifts or 720 hours.

SICK LEAVE BUY BACK

After five years of continuous service, employees may be eligible to receive partial pay for unused sick leave through the City's Sick Leave Buy-Back Program. To be eligible for the program, an employee must have an excess of 480 hours (720 hours for Fire Department personnel who work a 48-96 [48 hours on duty and 96 hours off duty] shift cycle and Police Department personnel who work a twelve (12)-hour shift cycle) of sick leave as of September 30 and must be employed by the City on November 1 of the year in which buyback occurs. The sick leave hours the City buys back over 480/720 will be purchased at a 50 percent rate of pay, based on the September 30 pay rate. In no case may the sick leave balance after buyback be less than 480/720 hours. Thus, the maximum sick leave the City will buy back in any given year is 96/144 hours.

ADDITIONAL BENEFITS

LONGEVITY PAY

All regular, full-time employees will receive a longevity payment of $4.00 per month per year for continuous service with The City. Longevity payments will be made during the first pay period in December of each year.

FAMILY AND MEDICAL LEAVE AND MILITARY CAREGIVER LEAVE

Eligible employees may receive up to 12 weeks of leave per year for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. If the employee is an eligible family member or next of kin (spouse, son, daughter or parent) of a covered service member, the employee can take up to 26 work weeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness.

BEREAVEMENT LEAVE

All regular employees may be granted bereavement leave with pay for a period not to exceed three (3) days (36 hours for 720 hours for Fire Department personnel who work a 48-96 [48 hours on duty and 96 hours off duty] shift cycle and Police Department personnel who work a twelve (12)-hour shift cycle) to be used in the event of the death of an immediate family member.

RETIREMENT PLAN

The City is a member of the **Texas Municipal Retirement System (TMRS)**. The purpose of this plan is to provide an adequate and dependable program for the retirement of employees of Texas municipalities. Participation in the program is compulsory for all regular, full-time employees and for all part-time, non-temporary employees who are expected to work in excess of 1,000 hours per year. State laws governing TMRS require a specified contribution by each eligible employee. Employee contributions will be deducted from each paycheck (currently 7% of gross pay). Under present law, TMRS deductions are tax-free.

The City contributes two dollars for every one dollar contributed by the employee, to be available for the employee through monthly lifetime annuities when they retire from the City. There are several annuity options available to retiring employees, which are explained in detail in the TMRS Benefits Guide available online at **www.tmrs.org** or in the Human Resources Department.

ELIGIBILITY FOR RETIREMENT

While you are a member of TMRS, you are eligible to retire and receive an annuity payment monthly for the rest of your life if:

- You are at least 60 years of age and have at least five years of credited service with the system; or
- You are any age and have completed 20 years of service with the system.

For additional information regarding retirement benefits please visit **www.tmrs.org** or contact the Human Resources Department.

ADDITIONAL BENEFITS

DEFERRED COMPENSATION

The City offers a 457 Deferred Compensation Plan for those employees who would like to participate. As a public sector employer, such a plan affords employees the privilege of saving money for their retirement, and at the same time, temporarily deferring the payment of federal income taxes on a portion of their taxable income. This means if your salary is $30,000 per year and you voluntarily defer 6% of your annual salary ($1,800) into the deferred compensation plan, your annual federal withholding tax will be calculated on the $28,200 balance, not on the entire $30,000. Be advised that you cannot borrow against or use your account as collateral of any kind, and there are specific IRS regulations pertaining to withdrawals.

All guidelines regarding this 457 Deferred Compensation Plan, including those pertaining to participation, withdrawals and rollovers of funds, are in accordance with strict IRS regulations and cannot be deviated from by any representative of the City or the Retirement Plan Administrators. Questions regarding this deferred compensation plan may be directed to the Human Resources Department or the Retirement Plan Administrators "Empower". For more information, you can visit the website at **https://www.empower.com/**.

WORKERS' COMPENSATION

The City is self-insured for Workers' Compensation coverage through the **Texas Municipal League Intergovernmental Risk** Pool to protect employees injured as a direct result of the duties being performed in the course of employment with The City. If you are injured on the job, Workers' Compensation insurance may pay medical costs and income benefits to replace part of lost wages. Death benefits may also be paid to legal beneficiaries of employees killed on the job. Workers' Compensation is designed to cover the costs associated with injuries resulting from identifiable and specific accidents or injuries occurring on the job. It is not designed to cover "ordinary diseases of life".

If you are injured on the job you must notify your supervisor immediately. If it is a life-threatening emergency, go to the nearest hospital emergency room. For all other medical treatment, including follow-up care after hospital treatment you must coordinate the treatment through the Human Resources Department. A doctor must be selected from the Political Subdivision Workers Compensation Alliance. A list of Alliance doctors may be found at **www.pswca.org** or may call **866-99-PSWCA**. Please contact the Human Resources Department for any questions.

PAID PARENTAL LEAVE (PPL)

The City of Bellaire's Paid Parental Leave (PPL) policy provides valuable support to employees following the birth or adoption of a child. Eligible employees receive up to six weeks of paid leave, ensuring financial stability while allowing time to bond with their new family member. PPL runs concurrently with FMLA where applicable, but employees not eligible for FMLA can still use unpaid leave to care for their child. With continued accrual of sick leave, vacation, and uninterrupted benefits during PPL, employees can focus on family without worrying about disruptions to their compensation or career progression. This policy reflects the City's commitment to employee well-being by offering flexibility and ensuring a seamless return to work.

ADDITIONAL BENEFITS

TUITION REIMBURSEMENT

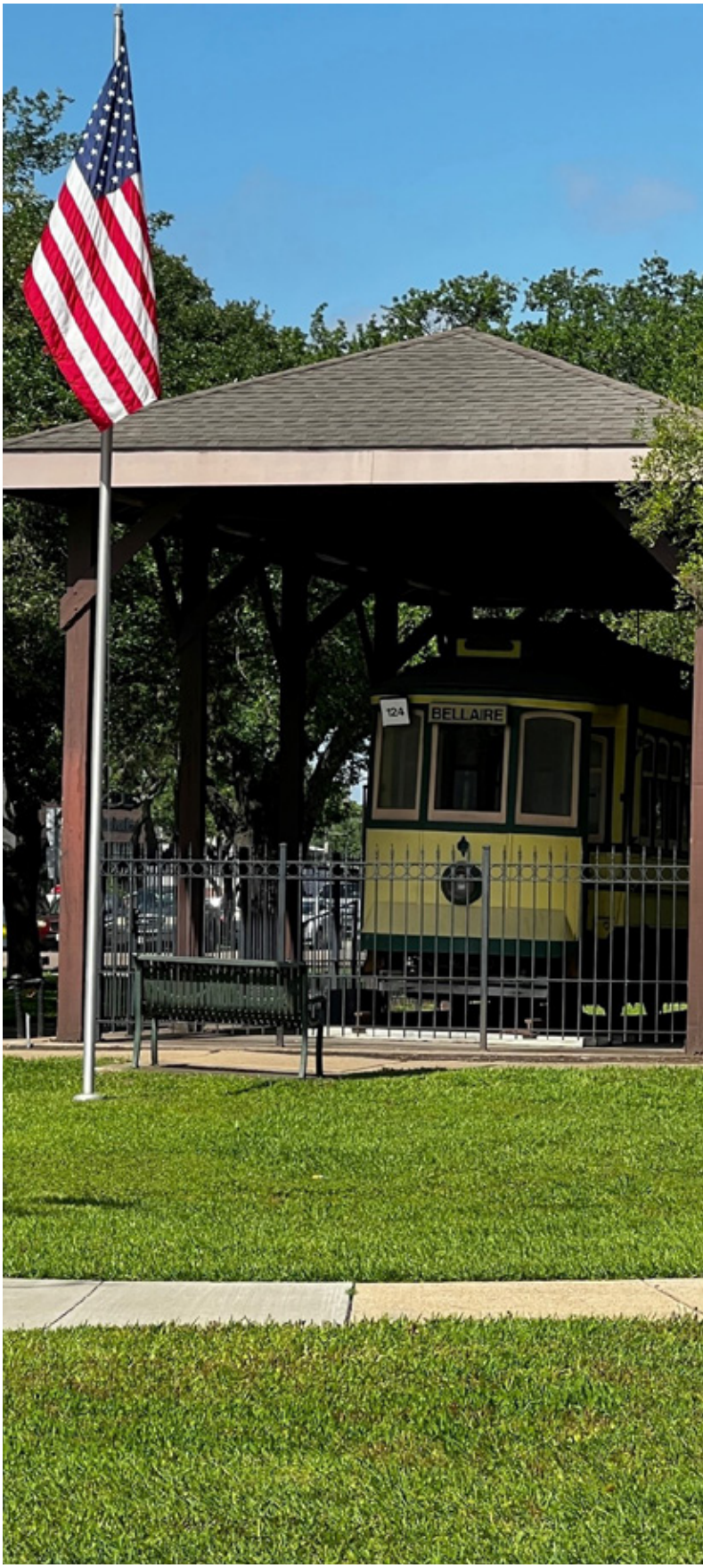
Tuition reimbursement is offered to all regular, full-time employees who have completed their in-training period with The City and who wish to enroll in college-level course(s) for academic credits. Tuition reimbursement is intended to help you maintain a satisfactory level of knowledge and expertise in your present position as well as to help you develop your skills and increase your potential for future advancement with The City. Tuition reimbursement will be available for both undergraduate and graduate courses. Courses taken must be job-related, or must be required to complete a job-related declared degree. Maximum amount of tuition reimbursement will be $1,000 per semester regardless of the number of courses taken. This amount includes all related mandatory fees and textbooks.

PARKS AND RECREATION DISCOUNT & LIBRARY CARD

Full-time employees receive up to a 50% discount off City of Bellaire's parks and recreation facility memberships, camps, classes, swimming pool passes and other related programs. Visit parks and recreation for details. Also stop by the library to register for your library card to borrow books, books-on tape, magazines, compact discs and DVDs.

SOCIAL SECURITY

Full time employees for the City of Bellaire are not covered under Social Security. When you retire or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your spouse or former spouse, your pension may affect the amount of the Social Security you receive. Your Medicare benefits, however, will not be affected. For more information, please visit **www.socialsecurity.gov** or call **800-772-1213**.



GLOSSARY OF TERMS

Beneficiary – Who will receive a benefit in the event of the insured's death. A policy may have more than one beneficiary.

Coinsurance – Your share of the cost of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for health care services received.

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

Employee Contribution – The amount you pay for your insurance coverage.

Employer Contribution – The amount our company contributes to the cost of your benefits.

Explanation of Benefits (EOB) – A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, what portion of the claim is your responsibility and information on how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Flexible Spending Account (FSA) – An option that allows participants to set aside pretax dollars to pay for certain qualified expenses during a specific time period (usually a 12-month period).

Health Savings Account (HSA) – A personal savings account that allows you to pay for qualified medical expenses with pretax dollars.

High Deductible Health Plan (HDHP) – A medical plan with a higher deductible in exchange for a lower monthly premium. You must meet the annual deductible before any benefits are paid by the plan.

In-Network – Doctors, hospitals and other providers that contract with your insurance company to provide health care services at discounted rates.

Out-of-Network – Doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network provider, you may be responsible for costs over the amount allowed by your insurance carrier.

Out-of-Pocket Maximum – Also known as an out-of-pocket limit. The most you pay during a policy period (usually a 12-month period) before your health insurance or plan begins to pay 100% of the allowed amount. The limit does not include your premium, charges beyond the Reasonable & Customary (R&C) or health care your plan does not cover. Check with your health insurance carrier to confirm what payments apply to the out-of-pocket maximum.

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

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier.

Preventive Care – The care you receive to prevent illness or disease. It also includes counseling to prevent health problems.

Generic Drugs – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding brand name versions. The color or flavor of a generic medicine may be different, but the active ingredient is the same.

Reasonable and Customary Allowance – (R&C) – Also known as an eligible expense or the Usual and Customary (U&C). The amount your insurance company will pay for a medical service in a geographic region based on what providers in the area usually charge for the same or similar medical service.

SSNRA – Social Security Normal Retirement Age

REQUIRED NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

SPECIAL ENROLLMENT RIGHTS

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

January 1, 2026
City of Bellaire
Human Resources
7008 South Rice Ave.
Bellaire, TX 77401
713-662-8257

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 City of Bellaire and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Bellaire has determined that the prescription drug coverage offered by the City of Bellaire medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting City of Bellaire at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current City of Bellaire prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at **713-662-8257**.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription 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 **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, 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 whether or not you are required to pay a higher premium (a penalty).

January 1, 2026
City of Bellaire
Human Resources
7008 South Rice Ave.
Bellaire, TX 77401
713-662-8257

NOTICE OF HIPAA 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 it carefully.

Effective Date of Notice: September 23, 2013

City of Bellaire's Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;

4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1 – Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In which case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2 – Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

Protected Health Information (PHI)

Includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set

Includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3 – The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4 – Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5 – Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

City of Bellaire
Human Resources
7008 South Rice Ave.
Bellaire, TX 77401
713-662-8257

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2025. Contact your State for more information on eligibility.

TEXAS – MEDICAID

Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

To see if any other States have added a premium assistance program since **July 31, 2025**, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under the City of Bellaire group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the City of Bellaire plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

City of Bellaire
Human Resources
7008 South Rice Ave.
Bellaire, TX 77401
713-662-8257

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 have not 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.

REQUIRED NOTICES

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 cannot be balance billed for these emergency services. This includes services you may get after you are 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 cannot 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 cannot balance bill you, unless you give written consent and give up your protections.

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

When balance billing is not 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 have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

NOTES

NOTES

Higginbotham™

This brochure highlights the main features of the City of Bellaire Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. City of Bellaire reserves the right to change or discontinue its employee benefits plans at anytime.