January 1, 2026 - December 31, 2026

EMPLOYEE Benefits GUIDE

2026

city of PUEBLO colorado

WELCOME

Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of valuable benefits to protect your health, family and way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

You are eligible for benefits if you are a full time benefit eligible employee. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse or common law spouse
- Your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

When Coverage Begins

- **New Hires:** You must complete enrollment within 30 days of your date of hire. If you enroll on time, coverage is effective on the first of the month following your date of hire. If you fail to enroll on time, you will NOT have benefits coverage (except for company-paid benefits).
- **Open Enrollment:** Changes made during Open Enrollment are effective January 1 – December 31, 2026.

When Coverage Ends

For employees (and/or covered dependents) who are currently enrolled in medical, dental, vision, and flexible spending accounts, coverage automatically continues under the Company plan until the end of the month in which employment terminates.

Click on any link in the list below to skip to that section in the guide

INSIDE

ENROLLMENT

Benefit Spot

We've gone mobile! To help you access your benefits information— even when you're away from work and need it most—we've launched a mobile benefits app. To get started, download "Benefit Spot" on the Apple App Store or Google Play and enter company code:

CityPueblo

Required Information—You will be required to enter a Social Security number (SSN) for all covered dependents when you enroll. The Affordable Care Act (ACA) requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

WELCOME(CONT'D)

Choose Carefully

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualifying life event during the year. Following are examples of the most common qualifying life events:

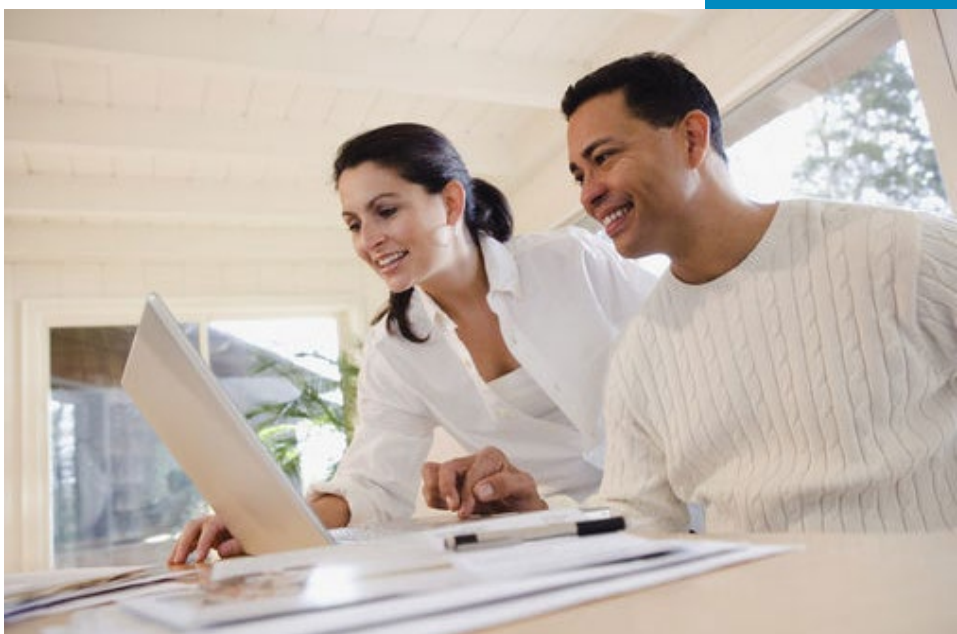
- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse or child
- You lose coverage under your spouse's plan
- You gain access to state coverage under Medicaid or The Children's Health Insurance Program

Making Changes

To change your benefit elections, you must contact Human Resources within 30 days of the qualifying life event. Be prepared to show documentation of the event, such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to change your elections.

Enrollment

Call the Benefits Enrollment Center at 877-282-0808 or log on to www.cityofpueblobenefits.com. There you will find detailed information about the plans available to you and instructions for enrolling.



MEDICAL COVERAGE

UMR HMO – Tier 1 & Tier 2

The Health Maintenance Organization (HMO) plan administered through UMR provides access to care through the UnitedHealthcare Choice network. With this plan, you select a primary care provider (PCP) from the participating network of providers who will coordinate your health care needs. You do not need a referral to see a specialist within the network. There is no out-of-network coverage except for emergencies, so it's important to choose a provider within the UnitedHealthcare Choice network. Two HMO plan options are available, each with different deductibles and cost-sharing levels, giving you the flexibility to choose the plan that best fits your needs.

How You Pay for Services

- **Copayments:** You pay a predetermined flat dollar amount—or copay—for services received from your PCP.
- **Deductibles & Coinsurance**: For certain services, you pay the deductible first, then a percentage of the cost (coinsurance) until you reach the plan's out-of-pocket maximum.
- **Out-of-Pocket Maximum:** Once you reach this limit, the plan pays 100% of covered in-network services for the rest of the plan year.
- If you go outside of the HMO's network, you are responsible for 100% of the cost of the services received.

Scan this code to watch a video about comparing medical plan types.

MEDICAL COVERAGE

UMR PPO

The Preferred Provider Organization (PPO) plan administered through UMR provides access to care through the UnitedHealthcare Choice Plus network. This plan gives you the flexibility to see both in-network and out-of-network providers. You will pay less when you see in-network doctors, hospitals, and facilities, and you do not need a referral to see a specialist. Out-of-network care is covered, but at a higher cost to you. There is one PPO plan option available.

How You Pay for Services

- You pay a flat dollar amount–or copay–for covered health care treatments and services, such as doctor's office visits and prescription drugs.
- Once you satisfy your annual deductible, you will pay a percentage–or coinsurance–of the cost of the visit, and the plan will cover the rest.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

Scan this code to watch a video about comparing medical plan types.

MEDICAL COVERAGE

UMR HDHP - HSA 1 & HSA 2

The High-Deductible Health Plan (HDHP) administered through UMR provides access to care through the UnitedHealthcare Choice Plus network. This plan pairs comprehensive medical coverage with a Health Savings Account (HSA). The highlight of this plan is a tax-advantaged personal savings account that lets you save pre-tax dollars to pay for qualified health-related expenses (state taxation rules may apply). For more information on the HSA, see page 10 of this benefit guide.

With the HDHP, you must meet the plan deductible before most services are covered, though preventive care is covered at 100% in-network. You do not need a referral to see a specialist. There are two HDHP plan options available, each with different deductibles and cost-sharing levels, so you can choose the plan that best fits your needs.

How You Pay for Services

- You pay the full cost of non-preventive health care services and prescription drugs until you meet the annual deductible. The deductible is waived for in-network routine preventive care services and medications on the preventive drug list.
- Once you meet the annual deductible, you pay a percentage of your health care expenses (coinsurance), and the plan pays the rest. *NOTE: If you enroll one or more family members, you must meet the full FAMILY deductible before the plan starts to pay expenses for any one individual.*
- Once your deductible and coinsurance add up to the out-of-pocket maximum, this plan pays the full cost of all qualified health care services for the rest of the year. *NOTE: If you enroll one or more family members, you must meet the full FAMILY out-of-pocket maximum before the plan starts to pay covered*

Scan this code to watch a video about comparing medical plan types.

MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	HMO Tier 1	HMO Tier 2	PPO	
	In-Network Only	In-Network Only	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$0	$0	$500 / $1,500	$1,000 / $3,000
Out-of-Pocket Max (Individual/Family)	$1,000 / $2,000	$3,000 / $6,000	$2,500 / $5,500	$5,000 / $11,000
Office Visits (physician/specialist)	$25 copay	$35 / $40 copay	$20 copay	30%*
Telehealth Virtual Visits (physician/specialist)	$25 copay	$35 / $40 copay	$20 copay	N/A
Routine Preventive Care	No charge	No charge	No charge	$80 per visit; $500 for covered facility services
Diagnostics (lab/X-ray)	No charge	No charge	10%*	30%*
Complex Imaging Free Standing Facility Hospital Based	No charge	No charge $700 copay	10%*	30%*
Chiropractic (20 visits annually)	$25 copay	$35 copay	$20 copay	30%*
Ambulance	No charge	No charge	10%*	
Emergency Room	$100 copay	$100 copay	$100 copay	
Urgent Care Facility	$50 copay	$50 copay	$40 copay	
Inpatient Hospital Stay	$250 copay	$700 copay	10%*	30%*
Outpatient Surgery	No charge	No charge	10%*	30%*
Prescription Drugs (Tier 1/ Tier 2/ Tier 3) – Advantage Preferred Drug List				
Retail: 30-day supply	$8 / $25 / $45	$10 / $30 / $50	$8 / $25 / $45	N/A
Mail Order: 90-day supply	$16 / $50 / $90	$20 / $60 / $100	$16 / $50 / $90	N/A

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	HDHP / HSA 1		HDHP / HSA 2	
	In-Network Only	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$2,000[2] / $3,500[2]	$3,500[2] / $7,000[2]	$2,500[2] / $4,000[2]	$4,000[2] / $7,500[2]
Out-of-Pocket Max (Individual/Family)	$2,000[3] / $3,500[3]	$6,500[3] / $13,000[3]	$2,500[3] / $4,000[3]	$7,000[3] / $13,500[3]
Office Visits (physician/specialist)	0%*	30%*	0%*	30%*
Telehealth Virtual Visits (physician/specialist)	0% (deductible waived)	N/A	0% (deductible waived)	N/A
City of Pueblo Contribution to your HSA (Prorated for new hires/ newly eligible)	$66.67 per month		$66.67 per month	
Routine Preventive Care	No charge	30%*	No charge	30%*
Diagnostics (lab/X-ray)	0%*	30%*	0%*	30%*
Complex Imaging	0%*	30%*	0%*	30%*
Chiropractic (20 visits annually)	0%*	30%*	0%*	30%*
Ambulance	0%*		0%*	
Emergency Room	0%*		0%*	
Urgent Care Facility	0%*		0%*	
Inpatient Hospital Stay	0%*	30%*	0%*	30%*
Outpatient Surgery	0%*	30%*	0%*	30%*
Prescription Drugs (Tier 1/ Tier 2/ Tier 3) – Advantage Preferred Drug List				
Retail: 30-day supply	100% after deductible	N/A	100% after deductible	N/A
Mail Order: 90-day supply	100% after deductible	N/A	100% after deductible	N/A

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying. To be eligible for the HSA, you cannot be covered through Medicare Part A or Part B or TRICARE programs. See the plan documents for full details.

*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. If you enroll one or more family members, you must meet the full **family** deductible before the plan starts to pay expenses for any one individual.
3. If you enroll one or more family members, you must meet the full **family** out-of-pocket maximum before the plan starts to pay eligible covered services at 100% for any individual.

HEALTH SAVINGS ACCOUNT (HSA)

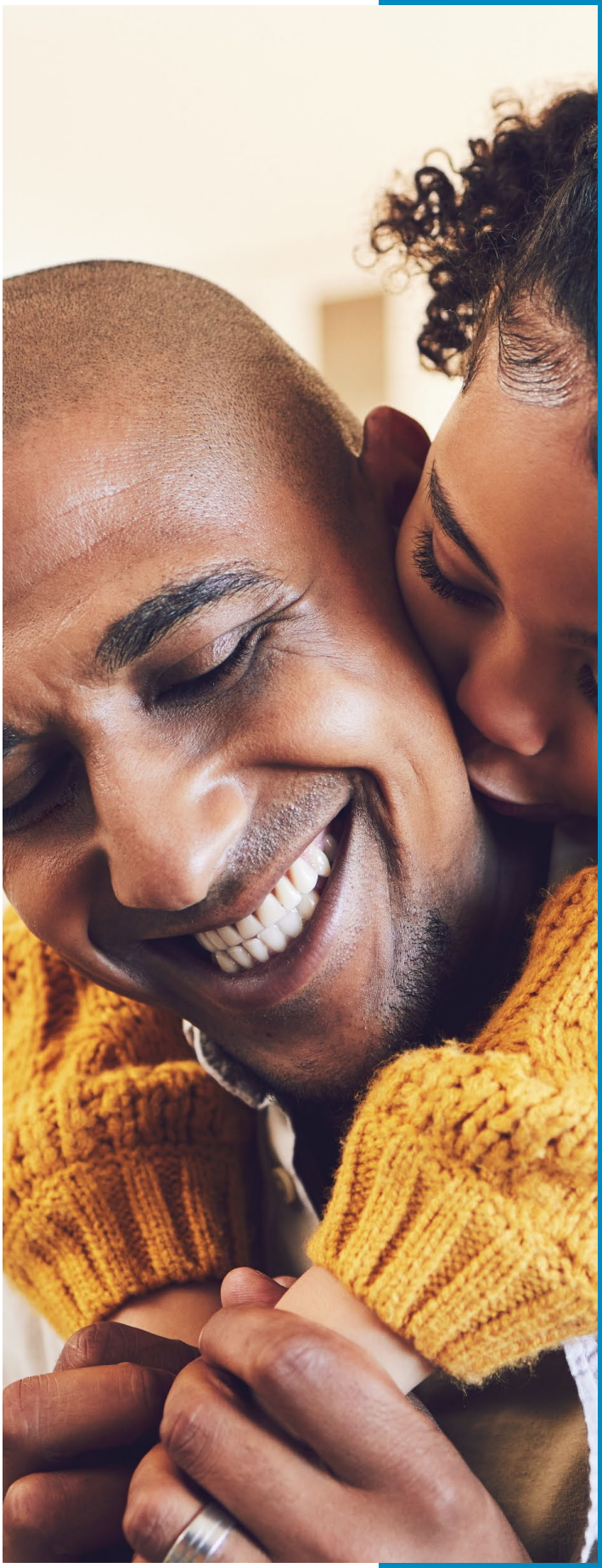
The UnitedHealthcare HDHP pairs medical coverage with a Health Savings Account (HSA), giving you a flexible way to manage health care costs.

How the HSA Works

- You contribute pre-tax dollars through automatic payroll deductions or make after-tax contributions that are deductible when you file your taxes.
- You may change your contributions at any time throughout the year.
- You can withdraw HSA funds tax free to pay for current qualified health care expenses, or save them for the future, also tax free. Unused funds roll over from year to year and are yours to keep, even if you change medical plans or leave your employer.
- **The City of Pueblo will make an annual contribution of $800 to your Health Savings Account (HSA) if you enroll in one of the High-Deductible plans. This contribution helps reduce the out-of-pocket amount you pay toward eligible medical expenses.**

Contribution Limits

Coverage Tier	IRS contribution maximum for 2026
Individual	$4,400
Family	$8,750
Catch-up Contributions (Age 55+)	$1,000
City of Pueblo Contributions (Employee / Family)	$66.67 monthly



HEALTH SAVINGS ACCOUNT (HSA)

Key Features of the HSA

Triple-Tax Advantage

- You contribute funds pre-tax through convenient payroll deductions. This means the money comes out of your paycheck before income tax is calculated. So, you get to keep a bigger portion of your paycheck.
- HSA funds grow tax free and unused funds roll over year to year. So, the more you save, the more your account will grow—just like a bank savings account.
- If you need to use your HSA funds, you can withdraw them tax free to pay for qualified health care expenses now and in the future—even in retirement.

Control

You own and control the money in your HSA. You decide how or whether you want to spend it. You can use it to pay for doctor's visits, prescriptions, braces, glasses—even laser vision correction surgery.

Investment Opportunities

Once you reach and maintain a minimum threshold, you can make investments to help your money grow tax free.

Savings Potential

Your HSA is like a "health care 401(k)." There is no "use it or lose it" rule. Your account grows over time as you continue to roll over unused dollars from year to year.

Portability

Your HSA is yours for life. The money is yours to spend on eligible medical expenses or save, even if you change health plans, retire or leave the organization.

Qualified Health Care Expenses

- Qualified medical, dental and vision expenses not covered by the plans, as defined by the IRS in Publication 502 (https://www.irs.gov/forms-pubs/about-publication-502).
- COBRA premiums
- Qualified long-term care insurance and expenses
- Health insurance premiums when receiving unemployment compensation
- Medicare and retiree health insurance premiums (not Medicare Supplement premiums)
- Medigap insurance premiums

Important Notes

- You must meet certain eligibility requirements to have an HSA: You a) must be at least 18 years old, b) must be covered under a qualified HDHP, c) must not be enrolled in Medicare, Medicaid, or other first-dollar coverage and d) cannot be claimed as a dependent on another person's tax return. For more information, please refer to IRS Publication 969 (https://www.irs.gov/forms-pubs/about-publication-969).
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA.

DENTAL COVERAGE

Aetna DMO & PPO

DMO: With this plan, you choose a primary dental provider to manage your care. There are no charges for most preventive services, no claim forms and no deductibles. Reduced, pre- set charges apply to other services.

PPO: This plan offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a dentist who participates in the Aetna PPO network.

One unique benefit about our dental plans is that you may switch back and forth between the PPO and DMO throughout the year, without a qualifying life event. Please see human resources for more information on how to switch plans.

Following is a high-level overview of the coverage available.

Key Benefits	PPO		DMO
	In-Network	Out-of-Network[1]	In-Network Only
Deductible (Individual/Family)	$0		$0
Annual Benefit Maximum (per person)	$2,000		None
Preventive Services	No charge		No charge
Basic Services	30%, 20%, 10%, or 0% based on length of coverage and annual diagnostic exam		No charge
Major Services	50%		50%
Orthodontic Services (Child Only)	%50 deductible, 40%, $1,000 lifetime benefit		50%; No lifetime benefit

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.

*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

VISION COVERAGE

Vision Plan – VSP

This plan, provided through VSP, gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the VSP network. If you decide to use an out-of-network provider, you will pay the provider in full at the time of your appointment and submit a claim form for reimbursement up to the amount allowed by the plan. Following is a high-level overview of your vision plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Vision Benefits	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	$10 Routine retinal screening up to $39 copay	Up to $45
Essential Medical Eye Care (Available as needed)	$20 copay per exam	N/A
Materials Copay	$25	N/A
Frames (once every 24 months)	Covered up to $150, $170 Enhanced Featured Frame Brands Allowance, 20% off balance	Up to $70
Lenses (once every 12 months)		
Single Vision	$25 copay	Up to $30
Bifocal		Up to $50
Trifocal		Up to $65
Contact Lenses (in lieu of glasses; once every 12 months)	Covered up to $150 Up to $60 copay for contact lens exam (fitting and evaluation)	Up to $105

VOLUNTARY BENEFITS

Accident Insurance

Accident insurance, provided through AFLAC, can soften the financial impact of an accidental injury by paying a benefit to you to help cover the unexpected out-of-pocket costs related to treating your injuries. Some accidents, like breaking your leg, may seem straightforward: you visit the doctor, take an X-ray, put on a cast and rest up until you're healed. But treating a broken leg can cost thousands of dollars. When your medical bill arrives, you'll be relieved you have accident insurance on your side.

Accident insurance pays a fixed cash benefit directly to you when you have a covered accident-related injury, like a sprain or bone fracture. Examples of covered expenses include:

- Doctor's office visits
- Diagnostic exams
- Broken leg rehab treatment
- Physical therapy sessions

Accident Insurance in Practice	
Situation	Sam broke his leg in a bike accident.
Covered Benefits	• Doctor's office visits • Diagnostic exams • Broken leg rehab treatment • Physical therapy sessions
Total Benefit Paid Directly to Employee	$4,250

Scan this code to watch a video about how an accident plan works.

VOLUNTARY BENEFITS

Critical Illness Insurance

About half of U.S. adults report being unable to pay an unexpected medical bill of $500 without going into debt. With critical illness insurance provided through AFLAC, you won't have to. This benefit provides a fixed, lump-sum cash benefit directly to you when you are diagnosed with a covered health condition such as a heart attack or stroke. You can use this benefit however you like, including to help pay for:

- Increased living expenses
- Prescriptions
- Travel expenses
- Treatments

	Benefit Amount
Employee	Up to $30,000 (in increments of $10,000)
Spouse	100% of Employee Coverage Amount
Child(ren)	50% of Employee Coverage Amount

Scan this code to watch a video about how a critical illness plan works.

1. Kaiser Family Foundation. "Americans' Challenges with Health Care Costs." Kaiser Family Foundation, kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs.

VOLUNTARY BENEFITS

Hospital Indemnity Insurance

When you or a dependent need to be hospitalized, your family deserves to focus on their well-being, not the stress of a stint at the hospital, which can cost an average of $3,025 per inpatient day.[1] Hospital indemnity, provided through AFLAC pays a fixed cash benefit directly to you when you experience:

- Hospital admissions
- Hospital stays
- Intensive care unit stays

	Benefit Amount
Hospital Admission	$1,500
Hospital ICU Admission	$1,700
Hospital Confinement Per Day	$100 (Up to 30 days, beginning day 1)
Hospital ICU Confinement Per Day	$200 (Up to 30 days, beginning day 2)

Scan this code to watch a video about how a hospital indemnity plan works.

1. Kaiser Family Foundation. "Expenses per Inpatient Day." Kaiser Family Foundation, kff.org/health-costs/state-indicator/expenses-per-inpatient-day.

VOLUNTARY BENEFITS

Whole Life through Allstate Benefits

With Group Whole Life Insurance from Allstate Benefits, you get simplified and straightforward coverage. You can decide how much coverage and who to cover. You get guaranteed rates for the life of the policy and a guaranteed death benefit to be paid to your beneficiaries. As the policy builds cash value, you can achieve your financial goals or borrow against it should you need to.

Accelerated Death Benefit for Long Term Care with Extension of Benefits—a monthly advance up to 4% of the death benefit for up to 50 full months while receiving qualified long-term care services, when certified chronically ill by a licensed health care practitioner.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

The flexible spending accounts (FSAs), provided through Alerus, are tax-advantaged accounts that can help you cover certain qualified out-of-pocket expenses. Each account works in much the same way but has different eligibility requirements, list of qualified expenses and contribution limits. You may choose to enroll in the following accounts.

	Health Care FSA	Limited-Purpose FSA (HSA Participants Only)	Dependent Care FSA
Eligibility Requirements	You must be benefits eligible; enrollment in a Healthcare FSA disqualifies you from making or receiving HSA contributions	You must be enrolled in a High-Deductible Health Plan (HDHP) to participate in the Limited Purpose Flexible Spending Account.	Available to all employees
Examples of Qualified Expenses	• Coinsurance • Copayments • Deductibles • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia • Prescriptions	• Dental and vision coinsurance only • Dental and vision deductibles only • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia	• Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers • Care of household members who are physically or mentally incapable of caring for themselves and who qualify as your federal tax dependent
Annual Contribution Limit	$3,400	$3,400	$7,500 per family (or $3,750 each if you are married and file separate tax returns)

Important FSA Rules

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

- **You must enroll each year to participate.**
- **Healthcare FSA:** Unused funds of up to $680 from one year can carry over to the following year. Carryover funds will not count against or offset the amount that you can contribute annually. Unused funds over $680 will **not** be returned to you or carried over to the following year.
- **Limited Purpose FSA:** This type of account can be used toward eligible dental and vision expenses only.
- **Dependent Care FSA:** You can incur dependent care expenses through March 15, 2027, and must files claims by March 31, 2027

Scan this code to watch a video about how an FSA works.

Scan this code to watch a video comparing an HSA and an FSA.

LIFE INSURANCE

Life insurance, provided through Lincoln Financial, provides your named beneficiaries with a benefit following your death.

Accidental Death & Dismemberment (AD&D) insurance provides a benefit to you following a covered accident that leads to dismemberment (such as the loss of a hand, foot or eye). Should your death occur due to a covered accident, both the life benefit and the AD&D benefit would be payable to your beneficiary.

Basic Life and AD&D (employer-paid)

Coverage Tier	Benefit Amount
Employee	$25,000 Life/AD&D
Spouse	$2,000 Life Only
Child(ren)	$1,000 Life Only

Supplemental Life and AD&D (employee-paid)

If you determine you need more than the basic coverage, you may purchase additional insurance for yourself and your eligible family members.

Coverage Tier	Benefit Amount	Guaranteed Issue Amount
Employee	$10,00 increments; up to $300,000, Life and AD&D	$200,000*
Spouse	$5,000 increments; up to $100,000 (not to exceed 50% of your additional life coverage,) Life and AD&D	$30,000
Child(ren)	$2,000 minimum, increments of $1,000 to $10,000, Life Only	$10,000

*You or your spouse may elect or increase insurance coverage up to 2 increments on a guaranteed acceptance basis during your annual open enrollment period, provided that you or your spouse have not been previously declined for coverage.

Scan this code to watch a video about how life insurance works.

Note: During your initial eligibility period, you can secure coverage up to the Guaranteed Issue limits without the need for Evidence of Insurability (EOI, or information about your health). Please note that coverage amounts requiring EOI will only go into effect once the insurance carrier approves them.

DISABILITY INSURANCE

Disability insurance, provided through Lincoln Financial, provides benefits that replace part of your lost income when you cannot work due to a covered illness or injury.

Short-Term Disability (employee-paid)

Provided at NO COST to you	
Benefit	60% of base salary
Maximum weekly benefit	$1,500
When benefit begins	Later of 15th day of disability or the date you exhaust your paid time off
When benefit ends	26 weeks

Long-Term Disability (employee-paid)

Provided at an affordable group rate.	
Benefit	60% of base salary
Maximum monthly benefit	$5,000
When benefit begins	Later of 181st day of disability or the date you exhaust your paid time off
When benefit ends	Social Security Retirement Age

Scan this code to watch a video about how disability insurance works.

EMPLOYEE ASSISTANCE PROGRAM

We help you become the best you.

CommonSpirit offers a unique level of support to help you find balance and feel more in control.

Our experts provide help 24/7 and ensure you get the right information and assistance at the right time. Our services are completely confidential and available to you, your spouse, and dependents at no cost.

- **Talk to a licensed Professional Counselor**
  - Up to 6 sessions in person or via phone, text or video. Get help with:
- **Confidential support for personal problems**
  - Get help with depression, anxiety, family issues, substance abuse and more
  - Learn strategies such as mindfulness to manage stress and anger and improve focus
- **Personalized help no matter where you are in life**
  - Work through relationship problems, divorce, grief and loss, and other life transitions
  - Build coping skills to manage life's challenges and gain control of your life

BetterHelp

As part of the many benefits available to you through City of Pueblo, Profile EAP has partnered with BetterHelp to offer convenient and confidential direct access to a licensed therapist through Chat, Phone, or Video. Anytime. Anywhere. Get matched with a licensed therapist based on your own preferences and needs.

- To schedule a telehealth appointment directly go to **profileeap.eapintake.com** to fill out the registration form and click on SUBMIT. Call 800-645-6571 to speak with a Profile EAP staff. Scan the QR Code to download the MyLifeExpert mobile app. The company code is CPUEB.

Scan this code to schedule an appointment through CommonSpirit.

WELLNESS AND RESOURCES

GuaranteedRate Platinum Mortgage Program

City of Pueblo employees and your friends and family receive the following benefits when you work with Rate to finance your home loan:

- A $1,640 waived lender fee and free appraisal
- Discounted mortgage rates
- A dedicated team of mortgage experts
- Receive a complimentary mortgage review
- Receive $650 to $6,000 if you buy or sell your home with the GRate Realty Connect program.
- Eligible first-time homebuyers who meet minimum credit score requirements could get lower interest rates, down payment options as low as 3%, reduced mortgage insurance requirements & more with the FirstHome+ program.
- Consolidate your credit card debt with a Home Equity Loan which takes 5 minutes to apply at rate.com/PMPHeloc and gets money in your pocket in a few days
- For more information and get approved to become a homeowner in one business day with Same Day Mortgage!
- 833-936-0662, Pueblo@rate.com, **www.Rate.com/Pueblo**

Additional Personalized Benefits

Please refer to your Personalized Benefits Guide for more information on the following personalized benefits that you are eligible to participate in.

- NortonLifeLock—identity theft program
- Nationwide—pet insurance
- ARAG—legal coverage
- Discount Marketplace—free discount program

Valuable Extras

These products are available year-round, not just during Open Enrollment. Please see HR staff for information on how to enroll.

- PERA 401(k)
- ICMA 457
- ICMA Roth
- FPPA 457
- FPPA 457 Roth

PLAN CONTRIBUTIONS

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Medical Monthly Contributions

HDHP/HSA 1

Coverage Tier	Premium for All Employees	Police		Fire		General Service & Management	
		City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Employee Only	$998.33	$876.37	$121.96	$998.33	$0.00	$876.37	$121.96
Employee + Spouse	$2,086.52	$1,637.19	$449.33	$1,865.22	$221.30	$1,637.19	$449.33
Employee + Children	$1,896.82	$1,480.39	$416.43	$1,686.57	$210.25	$1,480.39	$416.43
Family	$2,445.89	$1,934.28	$511.61	$2,203.74	$242.15	$1,934.28	$511.61

HDHP/HSA 2

Coverage Tier	Premium for All Employees	Police		Fire		General Service & Management	
		City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Employee Only	$942.19	$873.35	$68.84	$942.19	$0.00	$873.35	$68.84
Employee + Spouse	$1,969.21	$1,631.85	$337.36	$1,865.22	$103.99	$1,631.85	$337.36
Employee + Children	$1,790.16	$1,475.54	$314.62	$1,686.57	$103.59	$1,475.54	$314.62
Family	$2,308.39	$1,928.02	$380.37	$2,203.74	$104.65	$1,928.02	$380.37

HMO TIER 1

Coverage Tier	Premium for All Employees	Police		Fire		General Service & Management	
		City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Employee Only	$1,205.51	$985.80	$219.71	$1,145.23	$60.28	$985.80	$219.71
Employee + Spouse	$2,519.52	$1,756.90	$762.62	$1,965.22	$554.30	$1,756.90	$762.62
Employee + Children	$2,290.48	$1,598.31	$692.17	$1,786.57	$503.91	$1,598.31	$692.17
Family	$2,953.51	$2,057.39	$896.12	$2,303.74	$649.77	$2,057.39	$896.12

PLAN CONTRIBUTIONS

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Medical Monthly Contributions

HMO TIER 2

Coverage Tier	Premium for All Employees	Police		Fire		General Service & Management	
		City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Employee Only	$1,162.73	$984.63	$178.10	$1,145.23	$17.50	$984.63	$178.10
Employee + Spouse	$2,376.90	$1,752.99	$623.91	$1,965.22	$411.68	$1,752.99	$623.91
Employee + Children	$2,160.85	$1,591.10	$569.75	$1,786.57	$374.28	$1,591.10	$569.75
Family	$2,786.33	$2,049.78	$736.55	$2,303.74	$482.59	$2,049.78	$736.55

PPO

Coverage Tier	Premium for All Employees	Police		Fire		General Service & Management	
		City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Employee Only	$1,137.28	$982.70	$154.58	$1,137.28	$0.00	$982.70	$154.58
Employee + Spouse	$2,376.90	$1,750.41	$626.49	$1,965.22	$411.68	$1,750.41	$626.49
Employee + Children	$2,160.85	$1,592.41	$568.44	$1,786.57	$374.28	$1,592.41	$568.44
Family	$2,786.33	$2,049.78	$736.55	$2,303.74	$482.59	$2,049.78	$736.55

Dental Monthly Contributions

Coverage Tier	Premium for All Employees	Police		Fire		General Services & Management	
		City Pays	You Pay	City Pays	You Pay	City Pays	You Pay
Employee Only	$35.59	$25.00	$10.59	$25.00	$10.59	$24.66	$10.93
Family	$120.89	$25.00	$95.89	$25.00	$95.89	$24.66	$96.23

Vision Monthly Contributions

Coverage Tier	Premium for All Employees	City Pays	You Pay
Employee Only	$5.81	$0.00	$5.81
Employee + Spouse	$11.62	$0.00	$11.62
Employee + Children	$12.43	$0.00	$12.43
Employee + Family	$19.81	$0.00	$19.81

IMPORTANT CONTACTS

Coverage	Carrier	Phone #	Website / Email
Medical	UMR	800-207-3172	umr.com
Dental	Aetna	877-238-6200	www.aetna.com
Vision	VSP	800-877-7195	www.vsp.com
Health Savings Account	Optum	866-386-3409	engage@optum.com
Flexible Spending Accounts	Alerus	877-661-4727	www.alerusrb.com healthbenefits@alerus.com
Life/AD&D & Disability	Lincoln Financial	800-423-2765	www.lfg.com Group ID: CITYPUEBLO
Employee Assistance Program (EAP)	Profile EAP	800-645-6571	www.profileeap.org Company code: CPUEB
Personalized Benefits	Brandy McGraw HUB International	720-207-2347	brandy.mcgraw@hubinternational.com
Escalated Issues	Shanekia Martin HUB International	303-252-3733	shanekia.martin@hubinternational.com
Benefits Enrollment Center	SMBO	877-282-0808	www.cityofpueblobenefits.com
Questions	HR Team	719-553-2633	benefits@pueblo.us

BENEFITS WEBSITE

Call the Benefits Enrollment Center at 877-282-0808 or log on to www.cityofpueblobenefits.com. There you will find detailed information about the plans available to you and instructions for enrolling.

QUESTIONS?

If you have additional questions, you may also contact:

benefits@pueblo.us

BENEFIT TERMINOLOGY

Allowed amount

This is the amount agreed upon between the provider and the insurance company for the service provided. It is almost always less than the billed amount, which is why enrollees see different amounts on their Explanation of Benefit statements (EOBs). For example, a provider may charge $120 per hour of psychotherapy, but the insurance company pays them $95—the allowed amount for that service.

Balance billing

When an out-of-network provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for the covered services.

Beneficiary

A person who is designated as the recipient of proceeds from an insurance policy.

Coinsurance

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Consider an example in which the medical plan's allowed amount for a medical service is $100 and you've met your deductible. If your plan pays 70%, then you are responsible for the remaining 30%, which is $30.

Copayment

Oftentimes referred to as a "copay," this is the amount you are responsible for paying when seeing a doctor, picking up a prescription, or visiting an urgent care facility or emergency room.

Deductible

The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. For example, if your individual deductible is $1,500, your plan will not pay anything for certain medical services until you have paid $1,500. The deductible may not apply to all services, such as services that are covered by a copay.

Dependent

Dependents are usually an immediate relative, such as a spouse or child (up to age 26, as per the ACA), who is eligible to be included on your health insurance policy. The Company also allows domestic/civil union partners to be listed as dependents.

Dependent care FSA

A flexible spending account (FSA) is designed to provide tax-exempt funds that can be used to offset qualifying expenses for children and elderly dependents. Eligible dependent care expenses include daycare, before- and after-school care, summer day camps and eldercare for dependents claimed on your income taxes. Funds deposited in an FSA must be spent in the same year in which they are set aside, or they are forfeited. This rule is often referred to as "use it or lose it."

Diagnostic test

Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

BENEFIT TERMINOLOGY

Durable medical equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs or crutches.

Eligible expense

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "negotiated rate." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. See balance billing.

Embedded deductible

Once a person covered under a family plan reaches the individual embedded deductible, all covered expenses for that individual will be paid at the coinsurance amount even when the family deductible may not have been satisfied. For example, OAP PPO Plan $750 features an in-network family deductible of $1,500. If one member of the family satisfies the individual $750 deductible, the medical carrier will pay 80% of the remaining in-network expenses. Once another person or a combination of persons meet the remaining $750, the embedded family deductible is considered satisfied.

Embedded out-of-pocket maximum

Once a person covered under a family plan reaches the individual embedded out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum may not have been satisfied. For example, OAP PPO Plan $750 features a family out-of-pocket maximum of $6,000. If one member of the family satisfies the individual out-of-pocket maximum of $3,000, the medical carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the embedded family out-of-pocket maximum is considered satisfied.

team member contribution

The amount an team member contributes through payroll deductions for their medical and other insurance and savings program benefits.

Excluded services

Medical services that your medical plan doesn't pay for or cover.

Explanation of benefits

Every time you use your health insurance, your health plan sends you a record called an "explanation of benefits" (EOB) or "member health statement" that explains how much you may owe. The EOB also shows the total cost of care, how much your plan paid, and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount"). An EOB is generated for every single health claim, including prescriptions. It is not a bill, but rather a tool members can use to make sure they're not paying more than their insurer expects them to for services rendered.

BENEFIT TERMINOLOGY

Health care FSA

Funded through pre-tax payroll deductions, a health care flexible spending account (FSA) is a cost-savings tool that allows you to pay for qualified health care-related expenses with pre-tax dollars.

Generic drugs

Medications that are comparable to brand-name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand-name counterparts. (These are typically "Tier 1" drugs in the City of Pueblo's medical plans.)

High-Deductible health plan (HDHP)

A HDHP is a type of health insurance plan that typically offer lower premiums in exchange for higher deductibles. The deductible, which is the amount you must pay out of pocket for covered medical expenses before your insurance begins to pay, is higher for HDHPs compared to traditional PPO plans. These plans allow individuals to pay a lower monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles.

Health savings account (HSA)

An employer- and employee-funded savings plan that reimburses you for qualified out-of-pocket medical expenses. Funded through pre-tax payroll deductions by the employer and team member, HSAs are only available to people enrolled in a qualified high-deductible health plan. Unspent balances aren't forfeited; they roll over and accumulate over time.

In-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network coinsurance costs you less than out-of-network coinsurance payments.

In-network provider

The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Mail order Rx

The Company's medical carrier offers this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can obtain a 90-day supply at one time versus a 30-day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your copay is cheaper through mail order.

Medically necessary

Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, and that meet accepted standards of medicine.

Member health statement

Every time you use your health insurance, your health plan sends you a record called a "member health statement" or an "explanation of benefits" (EOB) that explains how much you may owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount").

BENEFIT TERMINOLOGY

Negotiated rate

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Network

The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at a pre-negotiated discount. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Non-preferred brand-name drugs

Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand-name drug or a generic. (These are typically ["Tier 3"] drugs in the City of Pueblo's medical plans.)

Non-preferred provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Open Enrollment

A period during which a health insurance company is required to accept applicants without regard to health history.

Out-of-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network coinsurance costs you more than in-network coinsurance. An out-of-network provider can balance bill you for charges over the allowed amount.

Out-of-network provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

Out-of-pocket maximum

The most you pay during a policy period (a calendar year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-counter drug

A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment allowance

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "negotiated rate" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

BENEFIT TERMINOLOGY

Preauthorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preferred/brand-name drug

These are medications for which generic equivalents are not available. They have been on the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs. (These are typically ["Tier 2"] drugs in the City of Pueblo's medical plans.)

Preferred provider

A provider who has a contract with your health insurer or plan to provide services to you at a pre-negotiated discount.

Prescription drugs

Medications you can only obtain with a prescription from your doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicodin and Albuterol can only be obtained with a prescription. The opposite of an over-the-counter drug.

Prescription drug coverage

Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA-approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the copayment you will pay for the drug. These tiers typically, but not always, are: Generic (Tier 1), Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty.

Your cost will depend on the level of drug specified by your doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand-name drugs generally do not have a generic equivalent, while those listed as non-preferred brand-name drugs generally do have a generic or preferred brand-name equivalent.

Your copay for preferred brand-name drugs is less than the copay for non-preferred brand-name drugs because you don't have the generic option available to you.

Premium (Insurance)

The fees paid to an insurance carrier to provide coverage. These fees are usually shared between you and the Company, though there are insurance benefits the Company pays for entirely, while there are others that you pay for yourself.

Premium (Medical)

The amount that is paid for your medical coverage. You and the Company share this cost, which is paid monthly to the insurance carrier.

Pre-tax deduction

Payments deducted from your gross pay before Medicare, federal, and state taxes are calculated, thus reducing your taxable wages and tax liability.

BENEFIT TERMINOLOGY

Prior approval/authorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Post-tax deduction

Payments deducted from your net pay after Medicare, federal and state taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventive care

Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

Primary care physician (PCP)

A physician who directly provides or coordinates a wide range of medical services for a patient. Primary care physicians include medical doctors, doctors of osteopathic medicine, internists, family practitioners, general practitioners, OB/GYNs and pediatricians. The opposite of a specialist.

Provider

A physician, health care professional or health care facility, certified or accredited as required by state law.

Qualifying life event (QLE)

QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an annual Open Enrollment period. This usually includes the birth or adoption of a child, marriage, divorce, death of a spouse or change in the spouse's employment or insurance status. These changes must typically be made within 31 days of the QLE.

Special enrollment period

Special enrollment periods allow you to make changes to your insurance plan or sign up for a new policy outside of Open Enrollment. They're almost always triggered by QLEs.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a primary care physician. For example, a dermatologist is considered a specialist.

Specialty drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

Telehealth

Telehealth is the use of telecommunication technologies through which you and your personal physician, who is treating you and knows your health history, can talk live over the phone or video chat, by appointment, during regular office hours. Services such as medication management, regular visits and online counseling are particularly well suited to Telehealth, since consistent and regular visits with your physician typically improve outcomes.

BENEFIT TERMINOLOGY

Telemedicine

Telemedicine is the use of telecommunication technologies where you and an on-call physician can talk live (24/7/365) over the phone or video chat. Services that are particularly well-suited to telemedicine include the discussion of symptoms, receiving a diagnosis, learning your treatment options and minor health issues such as pink eye or sore throat. Prescription can also be facilitated through telemedicine. Please note that each time you reach out for telemedicine services, you might speak with a different physician.

Urgent care

An illness or injury serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Wellness

Wellness refers to a healthy state of being.

Click here to watch a video about benefits terms.

In Partnership on your Benefits