2025

Employee Benefits Guide

Globe Life

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In this Guide, we use the term Company to refer to Globe Life. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

2025 Plan Year Introduction

You spoke, and Globe Life listened. Many employees asked for lower cost plan options and Globe Life has taken steps in this direction.

As an employee of Globe Life, you are one of our most valuable assets. In order to assist you in taking care of your health financial and insurance needs, Globe Life offers a comprehensive package of benefits. Your role is to review the offerings and make wise choices about which benefits meet your needs, the needs of your family, and how you will use them.

The 2025 Benefits Enrollment period requires actions from you. **Please note all employees must log in to Infor (Lawson) to make your benefit elections. Failure to actively log in and make selections will result in inaccurate coverage elections.**

- Open Enrollment ends November 8th, be sure to take action between October 28th and November 8th.
- This is your one time to change your enrollment elections.
- You can add or drop coverage for yourself or eligible dependents during this time.
- Your benefit elections will be effective January 1st and continue through the plan year ending December 31, 2025.
- After open enrollment ends you will not be able to change your benefit elections until the next enrollment period unless you experience a qualified status change (refer to page 5).

What's New

EVRY Health is now a part of the Globe Life family, providing medical and prescription drug benefit plans for group health plans.

- Globe Life will add two new medical benefit plans for employees living in their major service areas which include most zip codes within Austin, Dallas/Fort Worth, Houston and San Antonio.
- The plans will include an EPO plan and an HDHP EPO plan which are outlined in the medical benefits summary pages. **[Note: if you live in a EVRY major service area noted above and wish to cover a dependent outside these areas you must select one of the BCBS plans for the dependent to have benefit coverage.]**

MetLife Dental Plans

The Basic and Full dental plans will now include coverage for occlusal guards (night guards) at no charge to you or your enrolled dependents.

What's Changing

Health care FSA maximums increase to $3,200.

Health Savings Account maximums increase to:

- $4,300 individual
- $8,550 family

What Stays the Same

You may continue selecting any of the 3 BCBS medical benefit plans with Optum pharmacy.

Dental and vision benefits will continue with MetLife as well as the voluntary pre-paid legal plan, MetLife Legal Plan.

HSA Bank will continue to process our FSA and HSA reimbursements for all medical plans (BCBS and EVRY Health options).

Eligibility & Enrollment

At Globe Life, we are committed to your health and well-being. We are proud to provide you and your family with valuable and significant benefits. This Guide is an overview of the benefits available to you and their impact on your compensation as a whole. Please read it carefully in order to make the best choices for you and your family in the 2025 Plan Year.

You and your family have unique needs, which is why Globe Life offers a variety of benefit plans from which you may choose. Consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Who is Eligible to Enroll?

Full or part-time employees of Globe Life who averaged 30+ hours per week between the time period of October 1, 2023 to September 30, 2024.

When Does Coverage Begin?

The elections you make during the annual open enrollment period will be effective January 1, 2025. Due to IRS regulations, once you have made your choices for the 2025 Plan Year, you won't be able to change your benefits until the next enrollment period unless you experience a Qualifying Life Event (refer to page 5).

Eligible Dependents

Dependents eligible for coverage in the Globe Life benefit plans include:

- Your legal spouse. For specific restrictions on eligibility requirements for employed spouses, please refer to the summary plan descriptions.
- Children up to age 26 on the Medical, Dental and Vision plans (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26 and is already covered on the plan.

Verification of dependent eligibility will be required upon enrollment and is subject to audit at any time.

Working Spouse Surcharge

Working spouses of Globe Life employees are encouraged to first look to their employers' offerings when making benefit elections. If your working spouse has access to medical coverage through his/her employer and you enroll your spouse in one of the Globe Life medical plans, a spousal surcharge of $75 bi-weekly ($37.50 weekly) per paycheck will apply.

If your spouse does not work, is covered by Medicare, works only part time, is not eligible for coverage or has lost coverage as an active employee, but has been offered COBRA, the spousal surcharge will not apply.

If your spouse experiences a Qualifying Life Event (loss of job, etc.) during the year, he or she can be added to your Globe Life coverage within 31 days of the Qualifying Life Event.

Note: The Company reserves the right to verify whether or not your spouse is provided coverage elsewhere. We expect this information to be consistent with the information you reported during Annual Enrollment. Misrepresenting whether your spouse has access to Medical coverage outside of Globe Life may result in disciplinary action up to and including termination.

Tobacco Surcharge

Your health plan is committed to helping you achieve your best health. The Globe Life plan includes a Tobacco/Nicotine Surcharge if you use tobacco and/or nicotine products (including e-cigarettes). A $75 bi-weekly ($37.50 weekly) per pay period surcharge applies to each employee who does not meet the tobacco free requirement and is in addition to the regular bi-weekly or weekly medical premium. You may be eligible to avoid the surcharge by different means. Please contact askHR@globe.life to submit confirmation of completing the designated tobacco cessation program or confirmation of being under a physician's care for tobacco or nicotine use by March 31, 2025.

After open enrollment, you cannot change your benefit selections during the Plan Year unless you have a Qualifying Life Event, such as the birth or adoption of a child.

Things to Consider

Take the following situations into account before you enroll to make sure you have the right coverage.

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? If so, do you need to add or remove any dependent(s) and/or update your beneficiary designation by contacting HR?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria. Additional details can be found in the Eligible Dependents section of this Guide.
- Do you and your eligible dependents live in Austin, Dallas/Ft Worth, Houston or San Antonio? You may be eligible to enroll in one of the EVRY Health EPO plans.

Qualifying Life Events

When one of the following events occurs, you have 31 days from the date of the event to notify Human Resources and/or request changes to your coverage.

- Change in your legal marital status (marriage, divorce or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full-time to part-time, or part-time to full-time, resulting in a gain or loss of coverage
- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace
- Change in your address or location that may affect the coverage for which you are eligible

Preparing to Enroll

Globe Life provides its employees the best coverage possible. As a committed partner in your health, Globe Life will be absorbing a significant amount of the costs. Your share of the contributions for Medical, Dental, Vision, HSA contributions and FSA benefits will be deducted on a pre-tax basis, which lessens your tax liability.

Please note that employee contributions for Medical, Dental and Vision coverage may vary depending on your salary and the level of coverage you select. In general, the more coverage you have, the higher your employee contribution will be.

Keep in mind that you may select any combination of Medical, Dental and/or Vision plan coverage categories. For example, you could select Medical coverage for you and your entire family, but select Dental and Vision coverage only for yourself. The only requirement is that you, as an eligible employee of Globe Life, must elect coverage for yourself in order to elect any coverage for eligible dependents.

Be sure to have the Social Security numbers and birthdates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information.

The dates to enroll in or waive all 2025 benefits are: October 28 - November 8, 2024. All employees are required to enroll or waive benefits during the open enrollment period.

You CANNOT change your benefit selections during the plan year unless you have a Qualifying Life Event, such as marriage and/or the birth or adoption of a child.

How to Enroll

You only have a small window of time to make selections that are effective for the entire plan year (unless you have a qualifying life event). Here are some things you should check off your to-do list before you make your selections for Open Enrollment.

Understand Your Choices

This Guide contains very useful reference material to help you prepare for Annual Enrollment. Keep it handy so you can refer to it throughout the year.

Review Your Options With Your Family

Make sure you include any other individuals who will be affected by your elections in the decision-making process.

Open Chrome

Go to glemployeebenefits.com

Click on your company – double check that you are clicking on the correct company. If you are unsure, go to Infor Employee Self-Service/Job Profile to see which company you are employed by.

Sign into Infor (Lawson)

Click on the 'Profile' icon

Go to 2025 Employee Benefits Open Enrollment and follow the steps

Once you have finalized your elections, you should 'Print' your confirmation. You will also receive a confirmation email. Please retain these for your records.

If you have questions, please contact your local HR Department.

Medical Benefits

Our Medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers, as well as affordable prescription medication. Medical benefits are offered through Blue Cross and Blue Shield of Texas and EVRY Health. It is up to you to choose the Plan that best matches your needs. Please keep in mind that the option you elect will be in place for the entire plan year, unless you have a Qualifying Life Event.

Medical Premiums

Premium contributions for Medical will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your contributions. Refer to the contribution information sheet provided with your enrollment material.

How is my annualized benefit salary computed?

- For non-exempt/hourly employees, the benefit salary consists of all earnings such as personal/sick, vacation, incentive and holiday. The 2025 salary was derived from the last 12 months of earnings as of September 1, 2024.
- For non-exempt/hourly employees who have not earned 12 months of pay, the salary will be calculated by first averaging the per pay period earnings and then multiplied by the number of pays expected in the 12 month period of time. The result is the annualized benefit salary.
- For exempt/salaried and non-exempt/salaried employees, the benefit salary is the current annual salary as of September 1, 2024.

Medical Plan Summary: BCBSTX

The chart below gives a summary of the Medical coverage provided by BCBSTX. All covered services are subject to medical necessity as determined by the Plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	PREMIER PPO		HDHP W/HSA		BASIC PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
(1) CALENDAR YEAR DEDUCTIBLE						
INDIVIDUAL	$2,500	$5,500	$3,300	$6,000	$6,500	$15,000
FAMILY	$5,000	$16,500	$6,600	$18,000	$13,000	$30,000
COINSURANCE PLAN PAYS	80%	50%	80%	50%	80%	50%
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE						
INDIVIDUAL - MEDICAL	$4,000	$10,500	$6,000	$12,000	$8,000	$18,000
FAMILY - MEDICAL	$8,000	$31,500	$12,000	$36,000	$16,000	$36,000
COPAYS/COINSURANCE (MEMBER PAYS)						
PREVENTIVE CARE	$0*, plan pays 100%	Not Covered	$0*, plan pays 100%	Not Covered	$0*, plan pays 100%	Not Covered
VIRTUAL VISITS - GENERAL MEDICINE	$10 copay	Not Covered	$48 visit	Not Covered	$10 copay	Not Covered
VIRTUAL VISITS - BEHAVIORAL HEALTH	$10 copay	Not Covered	Varies by service	Not Covered	$10 copay	Not Covered
PCP OFFICE VISIT	$30 copay	50%**	20%**	50%**	$55 copay	50%**
SPECIALIST OFFICE VISIT	$45 copay	50%**	20%**	50%**	$65 copay	50%**
ROUTINE LAB & X-RAYS (DRS OFFICE)	$0*, after physician copay	50%**	20%**	50%**	$0*, after physician copay	50%**
IMAGING (CT/PET SCANS, MRIS)	20%**	50%**	20%**	50%**	20%**	50%**
AIRROSTI PROCEDURES	$30 copay	Not Covered	20%**	Not Covered	$55 copay	Not Covered
URGENT CARE	$45 copay	50%**	20%**	50%**	$65 copay	50%**
EMERGENCY ROOM - EMERGENCY CARE	$750 copay, then 20%		20%**	50%**	$1,000 copay, then 20%	50%**
HOSPITAL SERVICES - INPATIENT	20%**	50%**	20%**	50%**	20%**	50%**
HOSPITAL SERVICES - OUTPATIENT	20%**	50%**	20%**	50%**	20%**	50%**
CHEMOTHERAPY	20%**	Excluded	20%**	Excluded	20%**	Excluded
DIALYSIS	20%**	Excluded	20%**	Excluded	20%**	Excluded
BDC AND BDC+ PROVIDERS	10%**	Not Applicable	10%**	Not Applicable	10%**	Not Applicable

The individual deductible must be satisfied by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will be applied toward the "per family" amount. When the family deductible is reached, no further individual deductibles will have to be satisfied for the remainder of that calendar year. No member may contribute more than the individual deductible amount to the "per family" deductible amount.

*Deductible waived

**After calendar year deductible

How to Find a Provider

To see a current list of BCBSTX network providers online, go to www.bcbstx.com. If you do not have internet access or need assistance please call BCBSTX Customer Care.

Medical Plan Summary: Evry Health

If you an your eligible dependents live in an EVRY Major Service Area (MSA) which includes most zip codes in Austin, Dallas/Fort Worth, Houston or San Antonio, you may want to consider enrolling in the EPO or HDHP EPO outlined below.

The chart below gives a summary of the medical coverage provided by EVRY EPO. All covered services are subject to medical necessity by the Plan. Please be aware that out-of-network services are not covered by the EVRY EPO plans (except for emergency care).

	EPO PREMIER	EPO HDHP W/HSA
	IN-NETWORK ONLY	IN-NETWORK ONLY
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$0*	$5,000
FAMILY	$0*	$10,000
COINSURANCE PLAN PAYS	80%	60%
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)		
INDIVIDUAL - MEDICAL	$5,250	$8,000
FAMILY - MEDICAL	$10,500	$16,000
COPAYS/COINSURANCE (MEMBER PAYS)		
PREVENTIVE CARE	$0*, plan pays 100%	$0*, plan pays 100%
VIRTUAL VISITS - DOCTOR ON DEMAND - GENERAL MEDICINE	$0*, plan pays 100%	$0*, plan pays 100%
VIRTUAL VISITS - DOCTOR ON DEMAND - BEHAVIORAL HEALTH	$0*, plan pays 100%	$0*, plan pays 100%
PCP OFFICE VISIT	$0*, plan pays 100%	0%**
SPECIALIST OFFICE VISIT	$0*, plan pays 100%	0%**
ROUTINE LAB & X-RAYS (DRS OFFICE)	$0*, plan pays 100%	0%**
IMAGING (CT/PET SCANS, MRIS)	20%*	40%**
AIRROSTI PROCEDURES	$0*	$0**
URGENT CARE	20%*	40%**
EMERGENCY ROOM - EMERGENCY CARE	$300 copay, then 20%*	$300 copay, then 40%**
HOSPITAL SERVICES - INPATIENT	20%*	40%**
HOSPITAL SERVICES - OUTPATIENT	20%*	25%**
CHEMOTHERAPY	20%*	25% or 40%**
DIALYSIS	20%*	25% or 40%**

The individual deductible must be satisfied by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will be applied toward the "per family" amount. When the family deductible is reached, no further individual deductible will have to be satisfied for the remainder of that calendar year. No member may contribute more than the individual deductible amount to the "per family" deductible amount.

*No deductible

**After calendar year deductible

How to Find a Provider

To see a current list of EVRY EPO network providers online, go to www.EVRYhealth.com. If you do not have internet access or need assistance please call EVRY Customer Care at 855-579-3879.

EVRY Health EPO plans include, but are not limited to, the following hospitals:

Austin - Arise Austin Medical Center, Dell Children's Ascension, Ascension Seton, Heart Hospital of Austin and St David's Health Care.

Dallas/Fort Worth - Cook Children's, Medical City, Methodist Health System, and Legent Hospital System. NOTE: Excludes Baylor, Scott & White.

Houston - HCA Healthcare, Houston Methodist, St. Joseph's Hospital, St. Lukes' Health, Texas Children's Hospital, The Woman's Hospital of Texas and UTMB Health.

San Antonio - Baptist Health System, Methodist Healthcare, Legent Hospital System and St. Luke's Baptist Hospital.

Pharmacy Benefits

Prescription Drug Coverage for BCBS Medical Plans

The Prescription Drug Program for the BCBS Medical plans (Premier PPO, HDHP W/HSA and Basic PPO) is coordinated through Optum Rx.

You will have one ID card for Medical care and Prescriptions. You may find information on your benefits coverage and search for network pharmacies by logging on to www.optumrx.com or by calling OptumRx customer service at 855-896-9779.

Your cost is determined by the tier assigned to the prescription drug product. All products on the list are assigned as Generic, Preferred or Non-Preferred.

	PREMIER PPO		HDHP W/HSA		BASIC PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PHARMACY (30-DAY SUPPLY)						
GENERIC DRUGS	$20 copay	50% of allowable amount minus copay	20%**	50% of allowable amount minus copay	$20 copay	50% of allowable amount minus copay
PREFERRED BRAND DRUGS	$60 copay		20%**		$80 copay	
NON-PREFERRED BRAND DRUGS	$90 copay		20%**		$120 copay	
SPECIALTY DRUGS	Based on tier		20%**		Based on tier	
PHARMACY - RETAIL						
GENERIC DRUGS	$40 copay	Not covered	20%**	Not covered	$40 copay	Not covered
PREFERRED BRAND DRUGS	$120 copay		20%**		$160 copay	
NON-PREFERRED BRAND DRUGS	$180 copay		20%**		$240 copay	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)						
INDIVIDUAL - PHARMACY	Included with medical					
FAMILY - PHARMACY	Included with medical					

**After calendar year deductible

Step Therapy

This program applies to certain high-cost drugs. In order for the drug to be covered, you will need to first try a proven, cost-effective medication before using a more costly treatment if needed.

Prior Authorization

This program applies to certain high-cost drugs that have the potential for misuse. The program will require your doctor to obtain approval through OptumRx. If your medication does not receive approval, you may still purchase the medication; however you will be responsible for the full cost.

Important Reminder: Pharmacy Benefit Enhancements

Flu shots received at an in-network pharmacy will be covered at a $0 copay.

Obesity medications; will be covered with Prior Authorization.

Sexual dysfunction medications will be covered up to 8 doses per month with Prior Authorization.

Important Note: CVS/Caremark pharmacies are considered out-of-network. You may use CVS/Caremark pharmacies to fill your retail prescriptions; however benefits will be paid at the out-of-network benefit level.

Pharmacy Benefits

Prescription Drug Coverage for EVRY Health Medical Plans

You will have one ID card for Medical care and Prescriptions. You may find information on your benefits coverage and search for network pharmacies by logging on www.EVRYhealth.com or calling customer service at 855-579-3879.

Prescription Drug Coverage for EVRY Health Medical Plans

The Prescription Drug Program for the EVRY Health Medical plans (EPO and HDHP EPO) are coordinated through Prime Therapeutics.

You will have one ID card for Medical care and Prescriptions. You may find information on your benefits coverage and search for network pharmacies by logging on to https://www.primetherapeutics.com/member or by calling Prime Therapeutics Member Services customer service at 833-605-0625. TTY users call 711. 24 hours a day, 7 days a week.

Your cost is determined by the tier assigned to the prescription drug product. All products on the list are assigned a Generic, Preferred or Non-Preferred.

	EPO PREMIER	EPO HDHP W/HSA
	IN-NETWORK ONLY	IN-NETWORK ONLY
PHARMACY - RETAIL		
GENERIC DRUGS	$0*, plan pays 100%	$0*, plan pays 100%
PREFERRED BRAND DRUGS	20%*	35%**
NON-PREFERRED BRAND DRUGS	20%*	35%**
SPECIALTY DRUGS	20%*	35%**
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)		
INDIVIDUAL - PHARMACY	$1,500	$1,500
FAMILY - PHARMACY	$3,000	$3,000
COPAYS/COINSURANCE		

*No deductible
**After deductible

More information about prescription drug coverage is available at www.EVRYhealth.com/formulary.

2025 BCBS Medical Programs

MDLive

Access to a board certified doctor 24 hours a day, seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits can be a better alternating that going to the emergency room or urgent care. They can treat the following conditions and more: General health (allergies, asthma, nausea, sinus infections); Pediatric care (cold/flu, ear problems, pinkeye); Behavioral health (anxiety, depression, marriage problems, child behavior/learning issues).

Benefits Value Advisor

Benefit Value Advisors can assist a member in selecting the right provider for your condition, find in-network providers, schedule doctor appointments and help with admissions, discharges and follow-up care and much more!

Airrosti

Airrosti providers are experts at diagnosing and rapidly resolving the source of your injury. Each patient receives one full hour of assessment, diagnosis, treatment, and education designed to eliminate the pain associated with many common conditions, allowing you to quickly and safely return to activity - usually within 3 visits (based on patient-reported outcomes).

Hinge Health

Reduce your back and joint pain at home with Hinge Health. Using gentle exercises designed just for you, plus 1-on-1 support from your own care team.

Join Hinge Health to:

- get a personal care team, including a physical therapist and health coach
- schedule personal physical therapy sessions as needed
- receive wearable sensors that give live feedback on your form in the app
- get a second opinion on your recommended surgery and treatment plan

Livongo

Livongo (through Teladoc) provides employees and eligible dependents diagnosed with diabetes, pre-diabetes and/or hypertension with a program to better manage your disease at no cost to you. The program includes digitally enabled devices that connect to your real-time support team 24/7/365.

Member Rewards Program

Member rewards helps you compare costs for procedures and services, save money and earn cash rewards.
Medical procedure costs vary by location. With Member Rewards, you can shop for medical care, compare costs and maybe even each a cash reward. It is quick and easy to shop in-network for common procedures like screenings, scans, lab/blood draws and more. The Member Rewards program is part of your BCBSTX medical health plan benefits and administered by Sapphire Digital.

STEP 1	STEP 2	STEP 3
Call a Benefits Value Advisor or search online via Provider Finder to find a reward eligible location for your procedure or service.	Get the procedure or service at your chosen reward eligible location.	Receive a cash reward by check, which will be mailed directly to your home, after your claim is paid and the location is verified as reward eligible.

To get started, call a Benefits Value Advisor (BVA) at the number on the back of your member ID card. Or shop online with Provider Finder by visiting bcbstx.com, register or log in to Blue Access for Members℠ and select "Find Care."

IMPORTANT REMINDER: Your Globe Life Member Rewards program includes a call requirement when you seek certain services (MRI and CT scans, diagnostic radiology, joint replacement surgery, bariatric surgery, musculoskeletal inpatient and outpatient procedures). Call your Benefits Value Advisor prior to receiving care to avoid a $100 penalty.

2025 EVRY Health Medical Programs

Care Guides

All EVRY members are assigned a nurse care guide and a personalized care plan. These care guides serve as a dedicated concierge service, helping members with everything from finding doctors, scheduling appointments, signing up for free digital wellness programs, preparing for procedures, earning rewards and much more.

Doctor on Demand

Offers free 24/7 telehealth built around you for everyday and urgent care, psychology and psychiatry visits. Connect with board-certified medical provider within minutes or schedule appointments in advance.

Blueberry Pediatrics

Provides free 24/7 pediatric telehealth from pediatricians and specialists. Upon signup, you will receive a home test kit which includes a pulse oximeter, oral thermometer and wireless ear scope that securely sends your child's vitals to your virtual provider.

Joint Academy

All-in-one solution for treating chronic joint and back pain.

Maven

Fertility, pregnancy, postpartum and parenthood support for women.

Omada

Omada provides employees and eligible dependents diagnosed with diabetes, and/or hypertension with a program to better manage your disease at no cost to you. The program includes digitally enabled devices that connect to your real-time support team 24/7/365

Osara Health

Support and caregivers for cancer patients.

Pelago

Virtual clinic offers personalized substance abuse care for members wanting to cut back, stop or otherwise manage their tobacco, alcohol, cannabis and opioid usage.

Meomind

On-demand alternative to psychotherapy.

EVRY Reward Card

Earn up to $1,000 per year on your EVRY Reward Card by completing activities that improve your health and wellness. From simply signing up for free telehealth to starting an exercise program, to using one (or more) of the digital wellness partners. There are no requirements or opt-oms necessary to get started. An EVRY health reward card will be sent to all eligible members alongside your member ID card.

EARN $20	EARN $100	EARN $25
Become an EVRY Member. $20 will be loaded onto your card.	Complete your 15 minute health survey that assists your EVRY Care Team provide personalized resources for you.	Meet your EVRY Care Guide. Schedule your first meeting with them to walk through the free services available to you.
EARN UP TO $250	**EARN $100**	**EARN $25**
$50 to begin a wellness program and $75 if you complete one. There will be additional rewards during your journey up to $250 during the first two programs you participate in every year.	Try yoga, kick boxing, a spin class or training section (and more). Receive as much as $100 per year ($50 per activity).	Sign up for free Telehealth.

Unlock even more rewards based on your participant and achievements.

WHERE TO GO FOR CARE

You think you may be sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new medication, but the pharmacy is closed. Instead of immediately choosing an expensive trip to the emergency room or relying on questionable information from the internet, take a look below at various care centers and resources and the types of care they provide.

PRIMARY CARE CENTER

When would I use this?

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?*

- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

What are the costs and time considerations?**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

NURSE LINE

When would I use this?

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

What type of care would they provide?*

Answers to questions regarding:

- Symptoms
- Medications and side effects
- Self-care home treatments
- When to seek care

What are the costs and time considerations?**

- Nurse lines are usually available 24 hours a day, 7 days a week.
- This service is usually free as part of your medical insurance.

TELEMEDICINE

When would I use this?

You need care for minor illnesses and ailments, but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of care would they provide?*

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

What are the costs and time considerations?**

- There is usually a first-time consultation fee and a flat fee or copay for any visit thereafter.
- Access to care is usually immediate.
- Some states may not allow for prescriptions through telemedicine or virtual visits.

URGENT CARE CENTER

When would I use this?

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

What type of care would they provide?*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

What are the costs and time considerations?**

- Often requires a copay and/or coinsurance that is usually higher than an office visit.
- Walk-in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first.

DO YOUR HOMEWORK

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

EMERGENCY ROOM

When would I use this?

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of care would they provide?*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

What are the costs and time considerations?**

- Often requires a much higher copay and/or coinsurance.
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first.

* This is a sample list of services and may not be all-inclusive.
** Costs and time information represent averages only and are not tied to a specific condition or treatment.

Dental Benefits

Routine preventive care such as regular Dental checkups can help lower your risk of stroke and heart disease. Globe Life's Dental coverage will provide you and your family affordable options for overall health. Coverage is available from MetLife.

Network Dentists

Your Plan's in-network dentists have agreed to charge lower fees, which helps keep money in your pocket. If you choose to use a dentist who doesn't participate in your Plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C) limitations. To find a network dentist, visit MetLife at www.metlife.com/mybenefits.

What's New

The Basic and Full dental plans will include coverage for occlusal guards (night guards).

	BASIC PLAN		FULL PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE				
INDIVIDUAL	$75		$50	
FAMILY	$225		N/A	
CALENDAR YEAR MAXIMUM				
PER PERSON	$1,000		$2,250	
COVERED SERVICES (AMOUNT PLAN PAYS)				
PREVENTIVE SERVICES	100%, no deductible	100%, no deductible, R&C limits apply	100%, no deductible	100%, no deductible, R&C limits apply
BASIC SERVICES	70%*	70%, R&C limits apply*	80%*	80%, R&C limits apply*
MAJOR SERVICES	40%*	40%, R&C limits apply*	50%*	50%, R&C limits apply*
ORTHODONTICS	Not covered		50%*	50%, R&C limits apply*
ORTHODONTIC LIFETIME MAXIMUM	N/A		$1,500	

*After Deductible

Vision Benefits

If you wear glasses or contacts, chances are you already have a steady appointment with an eye doctor. But even those with perfect eyesight should have their Vision checked on a regular basis. To ensure that you and your family have access to quality Vision care, Globe Life offers a comprehensive Vision benefit provided by MetLife accessing the Vision Service Plan (VSP) network of providers.

	METLIFE (VSP)	
	IN-NETWORK	OUT-OF-NETWORK
COVERED MATERIALS		
LENSES		
SINGLE VISION LENSES	Covered in full*	$30 allowance
BIFOCAL LENSES	Covered in full*	$50 allowance
TRIFOCAL LENSES	Covered in full*	$65 allowance
FRAMES		
RETAIL FRAME EQUIVALENT	$150 allowance* (Costco $85 allowance*)	$70 allowance
CONTACT LENSES		
NECESSARY	Covered in full*	Covered in full
ELECTIVE	$150 allowance*	$105 allowance
COPAYS		
EXAMINATION	$20 copay	$45 allowance
MATERIALS	$20 copay	N/A
BENEFIT FREQUENCY		
EXAMINATION	1 x 12 months	
LENSES	1 x 12 months	
FRAMES	1 x 24 months	
CONTACTS (in lieu of Lenses and Frames)	1 x 12 months	

*After copay

Health Savings Account

Your HSA can be used for qualified expenses, including those of your spouse, and/or tax dependent(s), even if they are not covered by your plan.

HSA Bank will issue you a debit card, giving you direct access to your account balance. When you have a qualified Medical expense, you can use your debit card to pay. You must have a balance to use your debit card. There are no receipts to submit for reimbursement.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to open and fund an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse's non-HDHP and your spouse does not have a Health Care Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Individually Owned Account

Your HSA is a personal bank account that you own and administer. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over unused HSA funds to the next year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change jobs. There are no vesting requirements or forfeiture provisions.

Federal regulations related to HSA are indicated in the enrollment guide.

Important Note: Employees who have a health care FSA with remaining funds as of January 1, 2025 will be ineligible to contribute to a HSA until the first of the following month after the grace period is over (April 1, 2025).

How to Enroll

You must elect the HDHP w/HSA plan with Globe Life. You will need to complete all HSA enrollment materials and designate the amount to contribute through payroll deduction. Globe Life will establish an HSA account in your name with HSA Bank and send in your contribution once bank account information has been provided and verified.

Triple Tax Savings

Contributions to an HSA are not subject to federal income tax. The money in this account (including interest and investment earnings) grows without being subject to federal income tax. When the funds are used for qualified medical expenses, they are spent tax free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Funding and Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2025, contributions (which include your contribution plus any Globe Life contribution detailed on the rate sheet) are limited to the following:

HSA FUNDING LIMITS		
	EMPLOYEE CONTRIBUTION	EMPLOYER CONTRIBUTION*
EMPLOYEE	$4,300	$250
EMPLOYEE +1	$8,550	$500
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000	N/A

*Employer contribution prorated over your pay cycle. The Employer Contribution reduces the annual employee contribution.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax payroll deductions to pay for out-of-pocket health care expenses such as deductibles, copays and coinsurance, as well as dependent care expenses.

Health Care Flexible Spending Account

You can contribute up to $3,200 for qualified Medical expenses with pre-tax dollars, which will reduce the amount of your taxable income and increase your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them, allowing you to avoid waiting for reimbursement.

Limited Purpose Flexible Spending Account

Designed to complement a Health Savings Account, a Limited Purpose Flexible Spending Account (LPFSA) allows reimbursement of eligible Dental and Vision expenses. You must decide how much to set aside for this account. You may contribute up to $3,200 in the LPFSA.

Dependent Care Flexible Spending Account

In addition to the Health Care FSA, you may opt to participate in the Dependent Care FSA as well—whether or not you elect any other benefits. The Dependent Care FSA allows you to set aside pre-tax funds to help pay for expenses associated with caring for elder or child dependents. Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you are allowed to set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under age 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- Expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes.
- In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

Eligible Dependent Care Flexible Spending Account Expenses

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time.

Examples of eligible dependent care expenses include:

- In-home babysitting services (not by an individual you claim as a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs.

NOTE: Globe Life benefit plans do not include coverage for domestic partners or their dependent children.

How to Use the Account

You may use your FSA debit card at locations such as doctor and dentist offices, pharmacies, and Vision service providers. The card cannot be used at locations that do not offer services under the Plan, unless the provider has also complied with IRS regulations. Should you attempt to use the card at an ineligible location, the swipe transaction will be denied.

Once you incur an eligible expense, submit a claim form along with the required documentation. If you have a question about a reimbursement, contact HSA Bank. Should you need to submit a receipt, you will receive an email or be mailed a receipt notification from HSA Bank. You should always retain a receipt for your records.

General Rules and Restrictions

In exchange for the tax advantages that FSAs offer, the IRS has imposed the following rules and restrictions for both Health Care and Dependent Care FSAs:

- Your expenses must be incurred during the 2025 Plan Year.
- Your dollars cannot be transferred from one FSA to another.
- You cannot participate in Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it"—any unused funds will be forfeited.
- The Health Care FSA provides a grace period of up to 2.5 months after the end of the Plan Year. With the grace period, qualified expenses incurred during that period can be paid from the amount left in the account at the end of the previous year. All reimbursement requests must be submitted by April 15th.
- For members terminating mid-year, you will have 30 days after last day 'Active' to file qualified expenses for reimbursement under your Health Care FSA and/or Dependent Care FSA.
- You cannot change your FSA election in the middle of the Plan Year unless you experience a Qualifying Life Event like marriage, divorce or birth of a child.

Those considered highly compensated employees (family gross earnings were $125,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more information.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. This means that you must always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Failure to provide proof that an expense was valid can result in your card being turned off and your expense being deemed taxable.

You cannot use FSA funds to pay for insurance premiums.

FSA vs HSA

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are two ways to save pre-tax money to pay for your eligible health care costs. But how do you know which one is right for you? The chart below explains the main differences between FSAs and HSAs to help you make the right choice for you and your family.

	FLEXIBLE SPENDING ACCOUNTS	HEALTH SAVINGS ACCOUNTS
OWNERSHIP	The FSA is owned by your employer. If you leave your employer, you lose access to the account unless you have a COBRA right.	The HSA is an account owned by you. It is a savings account in your name and you always have access to the funds, even if you leave your employer.
ELIGIBILITY & ENROLLMENT	The employer determines eligibility for an FSA. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event.	You must be enrolled in a Qualified High Deductible Health Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
TAXATION	Contributions are tax free via payroll deduction.	1. Contributions are not subject to federal income tax. 2. The account grows without being subject to federal income tax. 3. Funds are spent tax free (if used for qualified expenses).
CONTRIBUTIONS	The contribution limit is $3,200.	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for 2025 is $4,300 for individuals and $8,550 for families. This amount includes the employer contribution. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year.
PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and get reimbursed from the account. You must submit your receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal or checkbook. You may use the debit card to pay for qualified expenses directly. You could also use online bill payment services from the HSA financial bank to pay for qualified expenses. You decide when and if you should use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future qualified expenses or retirement.
ROLLOVER OR GRACE PERIOD	You must use the money in the account by end of Plan Year; however some plans allow up to $640 to roll over to the next year. Other plans include a 2.5-month grace period after the end of the Plan Year for any extra expenses to be incurred and reimbursed. A plan can have either a rollover or a grace period, but not both. Any unclaimed funds at the end of the run out are lost and returned to your employer.	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
OTHER TYPES	Other types of FSAs include: • Dependent Care FSA – Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as baby-sitting, day care and before- and after-school care. • Limited Purpose FSA – Some employers offer a Limited Use FSA that only covers eligible Dental and Vision expenses. Limited Purpose FSAs are typically offered in conjunction with an HSA as the IRS does not allow someone to have a Health FSA and an HSA.	There is only one type of HSA.

Voluntary Legal

Globe Life knows the value of well-rounded, balanced plans, which is why we offer additional benefits to help manage your life.

MetLife Legal Plan (formerly known as Hyatt Legal Plan)

This voluntary plan provides you and your family with legal assistance through an extensive network of legal professionals and services. You can receive assistance with the following:

- Court Appearances
- Document Review & Preparation
- Money Matters
- Estate Planning
- Family Law
- Real Estate Matters
- And more

For more information, visit info.legalplans.com and enter access code: GetLaw

Or call 800-821-6400, Monday – Friday 8:00 a.m. – 7:00 p.m. EST.

Once you've enrolled, visit www.metlife.com/mybenefits to find a legal professional in your area.

Glossary

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. For instance, if your plan's allowed amount for an office visit is $100 and you've met your deductible (but haven't yet met your out-of-pocket maximum), your coinsurance payment of 20% would be $20. Your plan sponsor or employer would pay the rest of the allowed amount.

Copay – The fixed amount, as determined by your insurance plan, you pay for health care services received.

Deductible – The amount you owe for health care services before your health insurance or plan sponsor (employer) begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've met your $1,000 deductible for covered health care services. This deductible may not apply to all services, including preventive care.

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

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, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Health Savings Account (HSA) – A personal health care bank account funded by your or your employer's tax-free dollars to pay for qualified Medical expenses. You must be enrolled in a qualified HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, meaning if you change jobs your account goes with you.

High Deductible Health Plan (HDHP) – Plan option that provides choice, flexibility and control when it comes to spending money on health care. Preventive care is covered at 100% with in-network providers, there are no copays, and all qualified employee-paid Medical expenses count toward your deductible and your out-of-pocket maximum.

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

Out-of-Network – Out-of-network providers are doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.

Out-of-Pocket Maximum – 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. This limit does not include your premium, charges beyond the Reasonable & Customary, or health care your plan doesn't cover. Check with your health insurance 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 to you by a doctor. Cost of these medications is determined by their assigned tier: Generic, Preferred or Non-Preferred.

- Generic Drugs – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding Preferred or Non-Preferred versions. The color or flavor of a Generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.
- Preferred Drugs – Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.
- Non-Preferred Drugs – Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.

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.

Summary of Benefits and Coverage (SBC) – Mandated by health care reform, your insurance carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

Important Contacts

BCBSTX MEDICAL PLAN	PHONE NUMBER	ONLINE ACCESS
MEDICAL – BCBSTX	800-521-2227	www.bcbstx.com
OPTUMRX	855-896-9779	www.optumrx.com
MDLIVE	888-680-8646	
AIRROSTI	800-404.6050	airrosti.com
HINGE HEALTH	855-902-2227	
LIVONGO	800-945-4355 Registration Code: GLOBELIFE	
MEMBER REWARDS		www.bcbstx.com click "Doctors and Hospitals tab"
BENEFIT VALUE ADVISOR CUST SVC	800-521-2227	
EVRY HEALTH MEDICAL PLAN	**PHONE NUMBER**	**EMAIL**
MEDICAL - EVRY HEALTH	855-579-3879	support@EVRYhealth.com
PHARMACY - PRIME THERAPEUTICS	855-579-3879	www.primetherapeutics.com/member
DOCTOR ON DEMAND	855-579-3879	https://doctorondemand.com/microsite/EVRYhealth/
WELLNESS PARTNERS	855-579-3879	https://portal.EVRYhealth.com/
EVRY REWARDS	855-579-3879	https://portal.EVRYhealth.com/
	PHONE NUMBER	**ONLINE ACCESS**
HEALTH SAVINGS ACCOUNT – HSA BANK	855-731-5220	hscs.hsabank.com
FLEXIBLE SPENDING ACCOUNT – HSA BANK	855-731-5220	hscs.hsabank.com
	PHONE NUMBER	**ONLINE ACCESS**
DENTAL – METLIFE	800-438-6388	www.metlife.com/mybenefit NOTE: ID cards are not issued for the dental plan
VISION – METLIFE (VSP)	855-638-3931	www.metlife.com/mybenefit NOTE: ID cards are not issued for the dental plan
VOLUNTARY LEGAL – METLIFE LEGAL PLAN	800-821-6400	www.legalplans.com
BENEFITS CONTACT	**PHONE NUMBER**	**EMAIL**
GENERAL QUESTIONS		askhr@globe.life


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Life