Memorandum

CITY OF DALLAS

DATE November 27, 2013

TO Members of the Budget, Finance and Audit Committee: Jerry R. Allen (Chair), Jennifer Staubach Gates (Vice Chair), Tennell Atkins, Sheffie Kadane, Philip T. Kingston

SUBJECT Upcoming Agenda Item – Benefits Master Plan Document

The December 11, 2013 City Council addendum will include an item authorizing approval of the City's Health Benefits Master Plan Document. The Master Plan Document is a compilation of each of the City's separate health plan documents. This group of plan documents includes the City's Section 125 Cafeteria Plan. The Section 125 Cafeteria Plan allows employees to make contributions to the City's health plan and flexible spending accounts on a pre-tax basis.

The City sponsors separate health benefit plans for active employees and retirees. The City's active employee benefit plan and certain retiree benefits are self-funded; however, certain retiree health benefits are funded through insurance policies such as Medicare Advantage, Medicare Supplement Plans and Part D Prescription Drug Coverage.

The Master Plan Document is approved annually by the City Council.

If you have any questions, please let me know.

A.C. Gonzalez
Interim City Manager

Attachments

C: Honorable Mayor and Members of the City Council
Warren M.S. Ernst, City Attorney
Rosa A. Rios, City Secretary
Craig D. Kinton, City Auditor
Daniel F. Solis, Administrative Judge
Ryan S. Evans, Interim First Assistant City Manager
Jeanne Chipperfield, Chief Financial officer
Jill A. Jordan, P.E., Assistant City Manager
Forest Turner, Assistant City Manager
Joey Zapata, Assistant City Manager
Charles M. Cato, Interim Assistant City Manager
Theresa O'Donnell, Interim Assistant City Manager
Elsa Cantu, Assistant to the City Manager

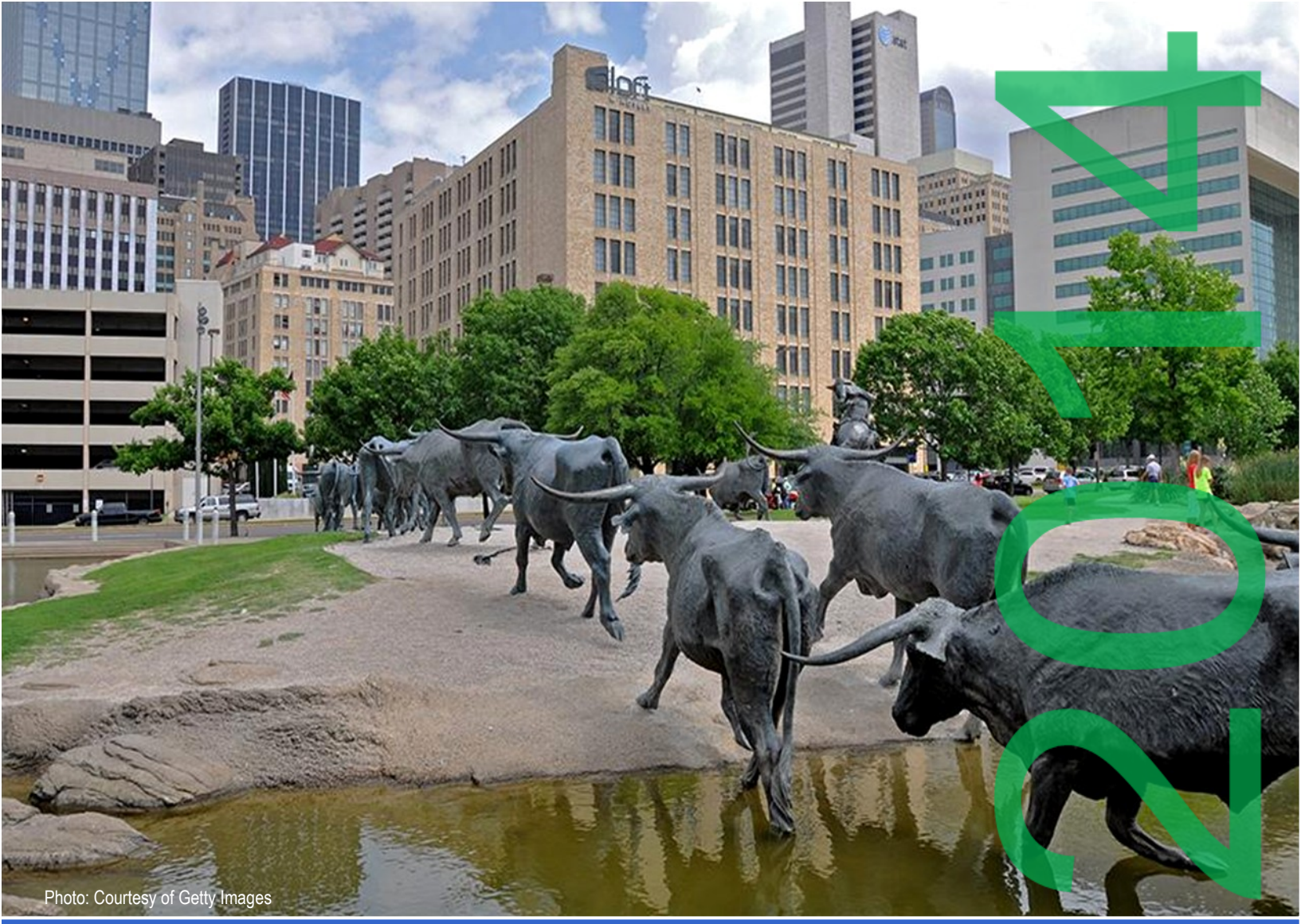


Photo: Courtesy of Getty Images

Active Employee Benefits & Enrollment Guide

Human Resources Department
Benefits Service Center

City of Dallas

Table of Contents

Summary of Benefits and Coverage

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available on the Web at: http://dallascityhall.com/human_resources/benefits_employees.html and www.cityofdallasbenefits.com. A free, paper copy is also available by calling 1-888-752-9122.

Welcome to Benefits 2014!

Greetings, Fellow Employee:

It is my pleasure to welcome you to the 2014 Open Enrollment. The City of Dallas provides an annual open enrollment period for employees to review their benefits coverage and make new elections for the upcoming year.

Important things to know regarding 2014 Open Enrollment:

- The Open Enrollment period for 2014 starts **October 7, 2013**, and ends **November 4, 2013**.
- Open Enrollment will be **active**
  - You must re-enroll in your Medical, Dental and Vision plans.
  - You **must** select your benefits coverage; otherwise, a default plan—the 70/30/$3,000 Deductible Low Option (NEW) with Employee-only Coverage—will go into effect on January 1, 2014. At which time, you will not be able to change your plan unless you experience a Qualifying Life Event.
  - Your Basic Life Insurance, Supplemental Life Insurance, Dependent Life Insurance, and Accidental Death and Dismemberment (AD&D) Insurance will automatically roll over into the new plan year.
  - A Flexible Spending Account (FSA), which includes the Employee Medical Spending Plan (EMSP) and the Dependent Care Assistance Plan (DCAP), **cannot roll over**. You must renew your FSA each year to continue to receive this benefit.
- To make changes to your benefit plan elections or enroll in an FSA plan for 2014, you must re-enroll during Open Enrollment. There are three ways to enroll:
  - Enroll online through Lawson HRIS
    - You may view and/or make changes to your benefits plan via Lawson's online Web portal. Go to https://hris.dallascityhall.com/lawson/portal; you have 24/7 access to this site from any computer with Internet access.
    - Use your network ID and password to access the portal.
  - Call the Benefits Service Center (BSC) at 1-888-752-9122.
  - Visit the BSC at Dallas City Hall, Room 1DS (Hours: Monday-Friday, 8:15 a.m. to 5:15 p.m.)
- If you need to add or delete dependents, please contact the BSC at 1-888-752-9122. Be sure that you have the required documentation to add your dependents. You may also fax your documents to 1-888-202-5571; please include your name, employee ID number and a call-back number on each faxed page to process your request.

What's New for 2014?

The City of Dallas has added a new benefit plan for 2014. The **70/30/$3,000 Deductible Low Option Plan** will include a combined medical and pharmacy deductible and out-of-pocket maximum. Please review the benefit summaries for additional information about this plan.

The Benefits and Enrollment Guide provides details about your benefit options. Reviewing the material contained in this guide will help you make informed decisions about your benefits for 2014. If you have any questions, refer to the vendor contact information section to access our service providers.

As always, I hope you will continue to be pleased with these programs and services as we endeavor to maintain a competitive benefits package for you and your family.

Sincerely,

City of Dallas Benefits Team

City of Dallas

City of Dallas

Dear City of Dallas Employee:

Through the Affordable Care Act, Health Insurance Exchanges will be established across the country. Each state has the option to set up a state-based insurance Marketplace that will allow individuals and employers to easily compare and evaluate health insurance plans. The state of Texas has elected not to implement a state exchange, so the Health Insurance Exchange will be run by the Federal government. Enrollment in health coverage on the Marketplace will open on October 1, 2013, with plans effective on January 1, 2014. The Patient Protection and Accountable Care Act requires employers covered by the Fair Labor Standards Act (FLSA) to provide a notice to employees prior to the beginning date of the Exchange.

On the following pages, you will find the Exchange Notice that notifies employees about the exchanges. Please be advised that the City of Dallas plan meets the minimum value required for health plans; therefore, City employees may not be eligible for a subsidy in the exchange. Specifically, the notice is designed to:

- ❑ Inform employees about the existence of the Exchange and give a description of the services provided by the Exchange;
- ❑ Explain how employees may be eligible for a premium tax credit or a cost-sharing reduction if the employer's plan does not meet certain requirements;
- ❑ Inform employees that if they purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer-provided coverage, and that all or a portion of this employer contribution may be excludable for federal income tax purposes; and
- ❑ Include contact information for the Exchange and an explanation of appeal rights.

Should you have any questions about your coverage, or to get additional information about this form, please contact the Benefits Service Center at 1-888-752-9122.

Sincerely,

City of Dallas
Human Resources Department
Benefits Service Center

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on the premium that you are eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage you employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about the coverage offered by your employer, please check your summary plan description or contact the **City of Dallas Benefits Service Center at 1-888-752-9122**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name City of Dallas		4. Employer Identification Number (EIN)
5. Employer address 1500 Marilla St., 1DS		6. Employer phone number 1-888-752-9122
7. City Dallas	8. State Texas	9. ZIP code 75201
10. Who can we contact about employee health coverage at this job? The City of Dallas Benefits Service Center		
11. Phone number (if different from above)	12. Email address	

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

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:

    Full-time permanent employees and Permanent part-time employees

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    A spouse, children up to age of 26 years and grandchildren

  - ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

New Health Insurance Marketplace Coverage (Continued)

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much will the employee have to pay in premiums for that plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B©(2)(C)(ii) of the Internal Revenue Code of 1986)

Who is Eligible?

You may elect health coverage for you and your eligible dependents during the annual Open Enrollment period and through special enrollments as a result of a Qualifying Life Event. Eligible dependents include the following:

Type of Eligible Dependent	Required Documentation
Spouse	❑ Copy of Marriage License, Copy of Social Security Card, and Date of Birth ❑ If Common-Law Marriage applies, please provide the common-law form* and copies of documentation showing that you and your spouse have lived together for at least six months (provide two documents from list below). ■ Examples include copies of: ■ Lease or deed naming both partners ■ Joint checking account statement ■ Utility bills and/or credit accounts ■ Will and/or life insurance policies
Domestic Partner	❑ Domestic Partner Form** and copies of documentation showing that you and your partner have lived together for at least six months (provide two documents from list below). ■ Examples include copies of: ■ Lease or deed naming both partners ■ Joint checking account statement ■ Utility bills and/or credit accounts ■ Will and/or life insurance policies ❑ Copy of Social Security Card, and Date of Birth
Dependent Child: Child who is married or unmarried, under age 26 and is the biological child, legally adopted child or stepchild of you and/or your spouse, domestic partner or common-law spouse **Dependent Grandchild:** Grandchild who is married or unmarried, under age 26 and is the biological grandchild of you and/or your spouse, domestic partner or common-law spouse	❑ Copy of Birth Certificate showing you as a parent, or ❑ Copy of Adoption Agreement, or ❑ Copy of court custody or guardianship documents, or ❑ Copy of the portion of the divorce decree showing the dependent, or ❑ Copy of Qualified Medical Court Support Order (QMCSO), and ❑ Copy of Social Security Card

*For the Common-Law Spouse Form, go to http://www.dallascounty.org/department/countyclerk/marriage-license.html.
**For the Domestic Partner Form, contact the Benefits Service Center at 1-888-752-9122.
Please note: Your dependents (spouse and/or children) cannot be covered on a plan if you are not covered.

Making Changes to Your Benefits During the Year (Outside the Open Enrollment Period)

The Internal Revenue Service (IRS) requires that you make benefits elections during our annual Open Enrollment period for your benefits to be effective during the 2014 plan year. You may not change your benefits elections after Open Enrollment unless you experience a **Qualifying Life Event**, which may include:

❑ Marriage
❑ Divorce, Legal Separation or Annulment
❑ Birth or Adoption of an Eligible Child
❑ Change in your (or your spouse's) work status that affects benefits eligibility (e.g., change from full-time to part-time employment status)
❑ A change in your child's benefits eligibility
❑ A Qualified Medical Child Support Order

You must report your Qualifying Life Event to the Benefits Service Center **within 30 days** of that event with the required documentation to support your claim. If you fail to report your Qualifying Life Event within the required timeframe, you must wait until the next annual Open Enrollment to change your benefits elections.

If your dependent does not meet the current eligibility rules during the specified period, and/or you do not provide the required documentation, your dependent(s) will not be added to your benefits plan.

Reminders

To enroll in a benefits plan or change your current plan, please remember:

1. New employees have 30 days from their hire dates to enroll in a benefits plan; otherwise, they must wait until Open Enrollment or have a Qualifying Life Event.
2. The Open Enrollment period for 2014 starts **October 7, 2013**, and ends **November 4, 2013**.
3. You must report a Qualifying Life Event **within 30 days of that event** to change your benefits plan.

WELLPOINTS

WellPoints is the wellness incentive program for City employees enrolled in a City sponsored health plan. By participating in WellPoints, you will help lower your 2015 medical plan premium and earn extra cash toward your HRA. To earn a reduced medical premium for 2015, you must earn a **minimum of 250 wellness points**.

To participate, you must be enrolled in a City sponsored health plan.

Active employees may earn WellPoints for the 2015 benefits year starting October 1, 2013, and ending August 31, 2014.

Please use the program guide on the following page to determine how to earn wellness points.

For more information:

City of Dallas
Human Resources Department
Benefits Service Center
1500 Marilla Street, Room 1D-South
Dallas, Texas 75201
(Phone) 1-888-752-9122
(Email) wellness@dallascityhall.com
(Web) www.cityofdallasbenefits.com

Wellness Program Disclosure
If it is unreasonably difficult for you to achieve the standards for a reward under the wellness program due to a medical condition, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the Benefits Service Center at 1-888-752-9122, and we will work with you to develop another way to qualify for the reward.

HOW TO EARN WELLPOINTS — GOAL: 250 POINTS
WELLPOINTS PERIOD: OCTOBER 1, 2013 – AUGUST 31, 2014

To participate in WellPoints, you must complete the Engagement category, which is worth 150 points. Earn the remaining points by participating in some of the activities listed under options one through three.

ENGAGEMENT (REQUIRED)

To participate in WellPoints, you **must** complete the following two Engagement activities:

- ☐ Annual Physical Exam* (100 Points)
  - Includes BMI, Blood Pressure, Fasting LDL & Fasting Glucose
- ☐ MyUHC Online Health Assessment* (50 Points)

*REQUIRED

OPTION 1

Biometric Target

- ☐ Biometric Screening Targets (Max: 100 Points)
  - Earn points for meeting biometric targets:

0-1 Target = 0 Points	2 Targets = 50 Points
3 Targets = 75 Points	4 Targets = 100 Points

  - Targets: BMI (Less than 30); Blood Pressure (Systolic: Less than 140; Diastolic: Less than 90); Fasting LDL (Less than 130); and Fasting Glucose (Less than 100)

OPTION 2

Take Action (Max: 100 Points)

- ☐ Each program worth 100 points
- ☐ Two Options: Disease Management and YMCA Diabetes Prevention
  - Disease Management Program
    - Four Program Options: Asthma, Diabetes, Coronary Artery Disease, and Heart Failure
    - Eligible Participants will Receive an Outreach Call from a UnitedHealthcare Nurse
  - YMCA Diabetes Prevention Program

Behavior Change (Max: 50 Points)

- ☐ Each activity worth 25 points
- ☐ Activities include: Boot Camp, Weight Loss Program, WellAware-sponsored Fitness Activities, Gym/Fitness Center Participation and Community Races

Bonus Activities (Max: 30 Points)

- ☐ Each activity worth 10 points
- ☐ Activities include: City of Dallas Department-sponsored activities (e.g., Walks, Health Fairs & Fitness Activities)

OPTION 3 (REASONABLE ALTERNATIVES)

You may also participate in the following reasonable alternatives:

Online Coaching

- ☐ Earn program worth 25 points (Max: 50 Points)
- ☐ Participate in up to **two** programs
- ☐ Go to www.myuhc.com for online coaching program information

Education

- ☐ Each program worth 10 points (Max: 50 Points)
- ☐ Participate in up to **five** programs
- ☐ Activities include WellAware Health Fair & learning/health seminars hosted or sponsored by WellAware

City of Dallas

Annual Physical Exam Verification
Biometric Target Screening Verification

Instructions for Physicians and Employees

WELLPOINTS
Employee Wellness Incentive Program

This form is to be used by eligible City of Dallas employees (full- or part-time) who would like to submit their Annual Physical Exam or Biometric Target Screening results to the Benefits Service Center as part of their participation in the WellPoints Employee Wellness Incentive Program.

For the Biometric Target Screening, the following measures must be collected and reported via a physician:

- ☐ Blood Pressure
- ☐ Body Mass Index (BMI)
- ☐ Fasting LDL Cholesterol
- ☐ Fasting Glucose (Blood Sugar)

The employee must submit results to the
Benefits Service Center no later than **August 31, 2014**.

Instructions for Physician:

Complete Section 2 of the form (if applicable).

Complete Section 3 of the form and return it to the patient (employee) for submission.

Instructions for City of Dallas Employee:

Complete Section 1 of the form—including signature—and present the form to your physician at your medical appointment. Instruct the physician to complete the required information. You must submit the completed from directly to the Benefits Service Center (mail or hand-deliver). The form cannot be submitted via fax or email.

Benefits Service Center
Dallas City Hall
1500 Marilla Street, Room 1DS
Dallas, TX 75201
(Phone) 1-888-752-9122
(Hours) 8:15 a.m. to 5:15 p.m. (Monday thru Friday)

Employee Reminders

The Benefits Service Center cannot accept a faxed or electronic copy of your results.
Please mail or hand-deliver the results to the address provided.
Submit all results by August 31, 2014.

WellAware
Your Health Matters

City of Dallas

Annual Physical Exam Verification
Biometric Target Screening Verification

WELLPOINTS
Employee Wellness Incentive Program

SECTION 1: PHYSICIAN INSTRUCTIONS

Dear Physician:

The City of Dallas has initiated a new wellness incentive program called WellPoints. As a WellPoints participant, an employee may receive incentives through maintaining a healthy lifestyle. One of the measures required to participate in WellPoints is the completion of an annual physical exam.

Employees earn wellness points for meeting the following biometric targets:

Biometric Target Screening Values Key Measures & Targets	
Body Mass Index (BMI) Less Than 30	**Blood Pressure** Systolic: Less Than 140 Diastolic: Less Than 90
Fasting LDL Cholesterol Less Than 130	**Fasting Glucose** (Blood Sugar) Less Than 100

Physician: Please complete Section 2. The employee must return the completed from to the City of Dallas Benefits Service Center upon your completion. It cannot be faxed or emailed.

Note: If you believe the established target is contraindicated for the health of your patient, the patient may achieve the desired wellness points by participating in other programs such as learning seminars, health fairs and online coaching programs.

SECTION 2: PATIENT INFORMATION (Patient: Complete this section. Please print.)

First Name: _____ Last Name: _____

Employee ID: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____)_____-_____

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Age: _____

Signature: _____ Date: _____/_____/_____

PATIENT : This form must be submitted by August 31, 2014. Do not fax or email.

SECTION 3: PATIENT BIOMETRIC TARGETS

PHYSICIAN: Place your signature on the line next to the number of biometric targets the employee met. Use the Biometric Target parameters listed in Section 1.

☐ 0-1 Target Met _____
☐ 2 Targets Met _____ Exam Date: _____/_____/_____
☐ 3 Targets Met _____
☐ 4 Targets Met _____ Phone: (_____)_____-_____

SECTION 4: ANNUAL PHYSICAL EXAM VERIFICATION

PHYSICIAN: Your signature below confirms that the employee has received an annual physical exam.

Physician Signature: _____ Date: _____/_____/_____

Your Core Benefits

The following core benefits are sponsored by the City of Dallas:

- Medical Insurance
- Pharmacy
- Flexible Spending Account
- Concentra Employee Discount Program
- Dental Insurance
- Vision Insurance
- Life Insurance

Benefits At A Glance

Benefit/Vendor	Funding	Options
Medical (UHC) **Pharmacy (CVS/Caremark)**	City & Employee Contributions	Three Medical Plan Options: ❖ EPO—70/30/3000 High Option ❖ EPO—70/30/3000 Low Option **(NEW)** ❖ EPO—75/25/HRA
Dental (UHC)	100% Employee Paid	Three Options: ❖ HMO ❖ PPO (Indemnity) ❖ EPO
Vision (UHC)	100% Employee Paid	Two Options: ❖ Standard Plan ❖ Buy-up Plan Exams: $10 copayment Materials: $25 copayment
FSA (UHC) **Employee Medical Spending FSA** **Dependent Care FSA**	100% Employee Paid	 $2,500 maximum $5,000 maximum
Life Insurance **Basic Life** **Supplemental Life** **Dependent Life** **Accidental Death & Dismemberment** **Voluntary Long Term Disability (NEW)**	 100% City Paid 100% Employee Paid 100% Employee Paid 100% Employee Paid 100% Employee Paid	$50,000 per FT employee Up to three times annual salary ($500K max) **Two Dependent Life Options**: **(Option 1)** $15K for spouse; $5K per child **(Option 2)** $25K for spouse; $10K per child $25K-250K **Monthly LTD Benefit**: Increments of $100 (up to $2K) **Three Max Benefits Period Options**: 2 Yrs; 5 Yrs; or Social Security Normal Retirement Age

EPO 70/30 High Option Medical Plan Chart (In-Network Benefits Only)	
Total Deductible	$3000 (single); $9000 (with dep(s)
HRA Allocation (City $$)	N/A
Deductible (Your $$)	Same as Total Deductible
Coinsurance	Member pays 30%; plan pays 70%
Preventive Services (See SPD for Injections)	Plan pays 100%
Outpatient Services	Plan pays 70% after deductible
Inpatient Services	Plan pays 70% after deductible
ER Services at hospital (See SPD for Ambulance services)	$100 Copay plus plan pays 70% after deductible
Specialist Services & Urgent Care Services	Plan pays 70% after deductible
Out-of-Pocket Max	$6,350 (single); $12,700 (with dep(s)
Rx Coverage (CVS/Caremark):	
Deductible	$240/person
Generic (31 days)	10% or $10 minimum
Preferred (31 days)	25% or $25 minimum
Non-Preferred (31 days)	40% or $40 minimum
Out-of-Pocket Max	$3,650/person

EPO 70/30 High Option Medical Plan Monthly Rates (Non-Tobacco User)		
Full-Time Employee Rates	**WellPoints Incentive Earned**	**WellPoints Incentive NOT Earned**
Employee Only	$44	$64
Employee + Spouse	$351	$371
Employee + Child(ren)	$119	$139
Employee + Family	$459	$479
Permanent, Part-Time Employee Rates		
Employee Only	$107	$127
Employee + Spouse	$335	$355
Employee + Child(ren)	$221	$241
Employee + Family	$480	$500

EPO 70/30 High Option Medical Plan Monthly Rates (Tobacco User)		
Full-Time Employee Rates	**WellPoints Incentive Earned**	**WellPoints Incentive NOT Earned**
Employee Only	$64	$84
Employee + Spouse	$371	$391
Employee + Child(ren)	$139	$159
Employee + Family	$479	$499
Permanent, Part-Time Employee Rates		
Employee Only	$127	$147
Employee + Spouse	$355	$375
Employee + Child(ren)	$241	$261
Employee + Family	$500	$520

EPO 70/30 Low Option Medical Plan Chart (In-Network benefits only)	
Total Deductible	$3000 (single); $9000 (with dep(s)
HRA Allocation (City $$)	N/A
Deductible (Your $$)	Same as total deductible
Coinsurance	Member pays 30%; plan pays 70%
Preventive Services (See SPD for Injections)	Plan pays 100%
Outpatient Services	Plan pays 70% after deductible
Inpatient Services	Plan pays 70% after deductible
ER Services at hospital (See SPD for Ambulance services)	$100 Copay plus plan pays 70% after deductible
Specialist Services & Urgent Care Services	Plan pays 70% after deductible
Out-of-Pocket Max	$6,350 (single); $12,700 (with dep(s)
Rx Coverage (CVS/Caremark):	
Deductible	Same as (Your $$) deductible above
Generic (31 days)	10% or $10 minimum
Preferred (31 days)	25% or $25 minimum
Non-Preferred (31 days)	40% or $40 minimum
Out-of-Pocket Max	$6,350 (single); $12,700 (with dep(s)

EPO 70/30 Low Option Medical Plan Monthly Rates (Non-Tobacco User)		
Full-Time Employee Rates	**WellPoints Incentive Earned**	**WellPoints Incentive NOT Earned**
Employee Only	$39	$59
Employee + Spouse	$346	$366
Employee + Child(ren)	$114	$134
Employee + Family	$454	$474
Permanent, Part-Time Employee Rates		
Employee Only	$102	$122
Employee + Spouse	$330	$350
Employee + Child(ren)	$216	$236
Employee + Family	$475	$495

EPO 70/30 Low Option Medical Plan Monthly Rates (Tobacco User)		
Full-Time Employee Rates	**WellPoints Incentive Earned**	**WellPoints Incentive NOT Earned**
Employee Only	$59	$79
Employee + Spouse	$366	$386
Employee + Child(ren)	$134	$154
Employee + Family	$474	$494
Permanent, Part-Time Employee Rates		
Employee Only	$122	$142
Employee + Spouse	$350	$370
Employee + Child(ren)	$236	$256
Employee + Family	$495	$515

EPO 75/25 HRA Medical Plan Comparison Chart (In-Network Benefits Only)		
	WellPoints Incentive Earned	**WellPoints Incentive NOT Earned**
Total Deductible	$2500 (single)	$2500 (single)
HRA Allocation (City $$)	$1000 (single)	$700 (single)
Deductible (Your $$)	$1500 (single)	$1800 (single)
Total Deductible	$5000 (with dep(s)	$5000 (with dep(s)
HRA Allocation (City $$)	$2000 (with dep(s)	$1700 (with dep(s)
Deductible (Your $$)	$3000 (with dep(s)	$3300 (with dep(s)
Coinsurance	Member pays 25%; plan pays 75%	Member pays 25%; plan pays 75%
Preventive Services (See SPD for Injections)	Plan pays 100% (in-network only) Doesn't reduce HRA	Plan pays 100% (in-network only) Doesn't reduce HRA
Outpatient Services	Plan pays 75% after deductible	Plan pays 75% after deductible
Inpatient Services	Plan pays 75% after deductible	Plan pays 75% after deductible
ER Services at hospital (See SPD for Ambulance services)	Plan pays 75% after deductible	Plan pays 75% after deductible
Specialist Services & Urgent Care Services	Plan pays 75% after deductible	Plan pays 75% after deductible
Out-of-Pocket Max	$6,350 (single) $12,700 (with deps)	$6,350 (single); $12,700 (with deps)
Rx Coverage (CVS/Caremark):		
Deductible	Same as (Your $$) deductible above	Same as (Your $$) deductible above
Generic (31 days)	10%	10%
Preferred (31 days)	25%	25%
Non-Preferred (31 days)	40%	40%

EPO 75/25 HRA Medical Plan Monthly Rates (Non-Tobacco User)		
Full-Time Rates	**WellPoints Incentive Earned**	**WellPoints Incentive NOT Earned**
Employee Only	$75	$95
Employee + Spouse	$443	$463
Employee + Child(ren)	$221	$241
Employee + Family	$568	$588
Perm Part-Time Rates		
Employee Only	$226	$246
Employee + Spouse	$607	$627
Employee + Child(ren)	$446	$466
Employee + Family	$792	$812

EPO 75/25 HRA Medical Plan Monthly Rates (Tobacco User)		
Full-Time Rates	**WellPoints Incentive Earned**	**WellPoints Incentive NOT Earned**
Employee Only	$95	$115
Employee + Spouse	$463	$483
Employee + Child(ren)	$241	$261
Employee + Family	$588	$608
Perm Part-Time Rates		
Employee Only	$246	$266
Employee + Spouse	$627	$647
Employee + Child(ren)	$466	$486
Employee + Family	$812	$832

CVS Caremark Prescription Benefit Program

HRA Plan

Welcome to your new prescription benefit administered by CVS Caremark. Your prescription benefit is designed to bring you quality pharmacy care that will help you save money.

Following is a brief summary of your prescription benefits. On the back side, you will find details about your prescription benefit plan, which offers two ways for you to save on your long-term medications. CVS Caremark and the City of Dallas are confident you will find value with your new prescription benefit program.

	CVS Caremark Retail Pharmacy Network For short-term medications (Up to a 31-day supply)	**CVS Caremark Mail Service Pharmacy or CVS Caremark Retail-90 Pharmacy** For long-term medications (Up to a 90-day supply)
Where	The CVS Caremark Retail Network includes more than 67,000 participating pharmacies nationwide, including independent pharmacies, chain pharmacies, and 7,400 CVS/pharmacy locations. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-855-465-0023.	You have the convenience of getting your long-term medications at one of our 51,000 Retail-90 Pharmacy locations for your mail service copay. Or simply mail your original prescription and the mail service order form to CVS Caremark. Your medications will be sent directly to your home, office or a location of your choice.
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**10%** for a generic prescription	**10%** for a generic prescription
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	**25%** for a preferred brand-name prescription	**25%** for a preferred brand-name prescription
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	**40%** for a non-preferred brand-name prescription	**40%** for a non-preferred brand-name prescription
Refill Limit	None	None
Annual Deductible	$2,500 for an individual / $5,000 for a family	
Maximum Out-of-Pocket	$6,350 for an individual / $12,700 for a family	
Web Services	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card ready.	
Customer Care	Visit www.caremark.com or call toll-free at 1-855-465-0023.	

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

CVS Caremark Prescription Benefit Program (Continued)

HRA Plan

Use This Plan to Fill Your Long-Term Medications

This plan offers you choice and savings when it comes to filling long-term prescriptions. Now you have two ways to save:

CVS Caremark Mail Service Pharmacy:
- ❑ Enjoy convenient home delivery
- ❑ Receive your medications in private, tamper-resistant and (when needed) temperature-controlled packaging
- ❑ Talk to a pharmacist by phone

Retail-90 Pharmacy:
- ❑ Pick up your medication at a time that is convenient for you
- ❑ Enjoy same-day prescription availability
- ❑ Talk with a pharmacist face-to-face

Plus, you can easily order refills and manage your prescriptions anytime at www.caremark.com.

To Get Started
The following chart provides detailed steps to help you start enjoying all the benefits of your prescription benefit plan.

IF YOU WOULD LIKE...	THEN...
To continue with mail service	You don't have to do anything. We'll continue to send your medications to your location of choice.
To pick up at CVS/pharmacy	Please let us know. You can do so quickly and easily. Choose the option that works best for you: • Visit your local Retail-90 Pharmacy and talk to the pharmacist • Call us toll-free using the number on the back of your Prescription Card, and we'll handle the rest
To sign up for mail service for the first time	You can do so easily online or by phone. • Register or log into www.caremark.com, select "Start a New Prescription," then click on "FastStart®" • Call FastStart toll-free at 1-800-875-0867. We'll handle the rest
More information	Give us a call. Use the phone number on the back of your Prescription Card to call us toll-free.

CVS Caremark Prescription Benefit Program

70/30 Plan

Welcome to your new prescription benefit administered by CVS Caremark. Your prescription benefit is designed to bring you quality pharmacy care that will help you save money.

Following is a brief summary of your prescription benefits. On the back side, you will find details about your prescription benefit plan, which offers two ways for you to save on your long-term medications. CVS Caremark and the City of Dallas are confident you will find value with your new prescription benefit program.

	CVS Caremark Retail Pharmacy Network For short-term medications (Up to a 31-day supply)	**CVS Caremark Mail Service Pharmacy or CVS Caremark Retail-90 Pharmacy** For long-term medications (Up to a 90-day supply)
Where	The CVS Caremark Retail Network includes more than 67,000 participating pharmacies nationwide, including independent pharmacies, chain pharmacies, and 7,400 CVS/pharmacy locations. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-855-465-0023.	You have the convenience of getting your long-term medications at one of our 51,000 Retail-90 Pharmacy locations for your mail service copay. Or simply mail your original prescription and the mail service order form to CVS Caremark. Your medications will be sent directly to your home, office or a location of your choice.
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**10% ($10 min)** for a generic prescription	**10% ($10 min)** for a generic prescription
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	**25% ($25 min)** for a preferred brand-name prescription	**25% ($25 min)** for a preferred brand-name prescription
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	**40% ($40 min)** for a non-preferred brand-name prescription	**40% ($40 min)** for a non-preferred brand-name prescription
Refill Limit	None	None
Annual Deductible	$240 (High Option) for an individual $3,000 (Low Option) for an individual	
Maximum Out-of-Pocket	$3,650 (High Option) $6,350 (Low Option)	
Web Services	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card ready.	
Customer Care	Visit www.caremark.com or call toll-free at 1-855-465-0023.	

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

CVS Caremark Prescription Benefit Program (Continued)

70/30 Plan

Use This Plan to Fill Your Long-Term Medications

This plan offers you choice and savings when it comes to filling long-term prescriptions. Now you have two ways to save:

CVS Caremark Mail Service Pharmacy:
- ❑ Enjoy convenient home delivery
- ❑ Receive your medications in private, tamper-resistant and (when needed) temperature-controlled packaging
- ❑ Talk to a pharmacist by phone

Retail-90 Pharmacy:
- ❑ Pick up your medication at a time that is convenient for you
- ❑ Enjoy same-day prescription availability
- ❑ Talk with a pharmacist face-to-face

Plus, you can easily order refills and manage your prescriptions anytime at www.caremark.com.

To Get Started
The following chart provides detailed steps to help you start enjoying all the benefits of your prescription benefit plan.

IF YOU WOULD LIKE...	THEN...
To continue with mail service	You don't have to do anything. We'll continue to send your medications to your location of choice.
To pick up at CVS/pharmacy	Please let us know. You can do so quickly and easily. Choose the option that works best for you: • Visit your local Retail-90 Pharmacy and talk to the pharmacist • Call us toll-free using the number on the back of your Prescription Card, and we'll handle the rest
To sign up for mail service for the first time	You can do so easily online or by phone. • Register or log into www.caremark.com, select "Start a New Prescription," then click on "FastStart®" • Call FastStart toll-free at 1-800-875-0867. We'll handle the rest
More information	Give us a call. Use the phone number on the back of your Prescription Card to call us toll-free.

Flexible Spending Account (FSA)

What is a Flexible Spending Account?
A Flexible Spending Account (FSA) is a tax-free account that allows you to pay for essential health care expenses that are not covered, or are partially covered, by your medical, dental and vision insurance plans; or pay for child/ dependent care expenses. You save money to pay for your out-of-pocket healthcare expenses, including prescription drug costs, medical, dental, vision and hearing expenses and/or your child or dependent care expenses, including day care, and before- and after-school care expenses.

How does it work?
- You decide how much you want to deduct from your paycheck before federal, state or Medicare taxes are calculated.
- You reimburse yourself from the account as you pay for eligible health care or dependent care expenses.

You save money by reducing your taxable income. It is that simple. City of Dallas employees have two FSA options: the **Employee Medical Spending FSA** and the **Dependent Care FSA**.

What you can pay for with an Employee Medical Spending FSA?

You can find a list of eligible expenses at myuhc.com® or see your benefit plan information. Some sample expenses are:

- Your share of health plan expenses, such as deductibles and copayments (insurance premiums do not qualify)
- Eyeglasses and contact lenses
- Dental work, orthodontia and dentures

You can no longer use your Employee Medical Spending FSA for over-the-counter (OTC) medicines or drugs without a prescription. This change was part of the Affordable Care Act passed in 2010.

Effective January 1, 2014: The maximum annual contribution to your Employee Medical Spending FSA will be $2,500.

You can use your Dependent Care FSA to pay for:

- Daycare services for children under age 13
- Care for other qualifying dependents who are unable to care for themselves

Dependent Care FSA is for dependent daycare only. It is not to be confused with dependents' health care expenses, which should be considered in your calculation of your Employee Medical Spending FSA contributions.

The maximum annual contribution to your Dependent Care FSA is $5,000.

You have more time to spend your FSA dollars.
The federal government now allows a "grace period" to give you more time to use your FSA dollars. This grace period reduces any worry if you have FSA dollars remaining at the end of the plan year.

How long is the grace period?
Two and one-half months after your calendar year plan ends. You have until March 15, 2014, to use your 2013 FSA dollars on eligible expenses. **All claims must be submitted by March 31, 2015.**

What about the "use it or lose it" rule?
This rule still applies. However, having a grace period allows you to use the remaining funds until March 15, 2014.

All claims must be submitted by March 31, 2015.

There are a few ways to access your FSA funds that can save time and paper; they can also reduce the wait time to receive reimbursements.

1. When United Healthcare processes your claim (medical, dental or vision) or CVS Caremark processes your pharmacy claim, the patient responsibility on the claim will "roll over" to the FSA account. As long as there are available funds, you will receive a reimbursement from your FSA account. Please note, if you are also enrolled in the HRA Medical Plan, the medical claim will roll over to your HRA account first and then to your FSA account after your HRA funds have been used.

Flexible Spending Account (continued)

2. Your FSA will also come with a convenient Consumer Accounts MasterCard® that allows you to pay for eligible expenses anywhere that MasterCard® is accepted.
3. All other eligible expenses would require you to file claims for reimbursements. However, you can sign up for Direct Deposit using the "Account Settings" on www.myuhc.com. This allows your FSA reimbursements to be automatically deposited into your savings or checking account.

Prorated HRA Funds (Based on the month of enrollment)

Month	Employee Only	Employee & Dependents
January	$700.00	$1,700.00
February	$641.67	$1,558.33
March	$583.34	$1,416.66
April	$525.01	$1,274.99
May	$466.68	$1,133.32
June	$408.35	$991.65
July	$350.02	$849.98
August	$291.69	$708.31
September	$233.36	$566.64
October	$175.03	$424.97
November	$116.70	$283.30
December	$58.37	$141.63

If you enroll as a New Hire or experience a Qualifying Life Event (QLE) after January 31, the funds allocated to your account balance will be reduced based on the table above.

Concentra™

Concentra TotalCare Health and Wellness Center is the onsite medical clinic located at Dallas City Hall. The center offers select preventive and diagnostic services to employees and dependents (age 5 and older) covered by the City's health plan at no cost. Employees who are not enrolled in City of Dallas medical plans can also receive treatment at a nominal cost.

Onsite Clinic Services for Employees Enrolled in City of Dallas Medical Plans		
Visit Description	**EPO 75/25 HRA Plan**	**EPO 70/30 Plan**
Preventive Care Services ■ Services provided at onsite clinic ■ Lab services that are sent out to LabCorp will be processed according to your medical plan benefits.	■ No cost to employees or dependents ■ Paid at 100%	■ No cost to the employees or dependents ■ Paid at 100%
Injury or Illness Care: **Diagnostic Services** ■ Service provided at onsite clinic ■ Lab services that are sent out to LabCorp will be processed according to your medical plan benefits	■ No cost to employees or dependents ■ Services are subject to 25% coinsurance after $2,500 deductible is met; HRA funds will be used if still available	■ No cost to employees or dependents ■ Services are subject to 30% coinsurance after $3,000 deductible is met

Concentra TotalCare Health and Wellness Center | 1500 Marilla, Room 1CS, Dallas, TX 75201
Phone: 214-671-9140 | Fax: 214-749-0412 | Hours: Monday through Friday, 7:30 a.m. to 5:30 p.m.

Concentra/City of Dallas Employee Discount Program

The Concentra/City of Dallas Employee Discount Program allows City employees and pre-65 retirees covered by the City's health insurance to visit any Concentra Urgent Care Center in the greater Dallas area and receive unmatched medical service at an unmatched price. City employees and pre-65 retirees covered by a City health insurance plan may continue to use Concentra TotalCare Health and Wellness Center in City Hall and pay nothing for most services, which include treatment for common injuries and illnesses such as sprains, cuts, flu and upper respiratory infection. Employees not covered by the City's health insurance will continue to pay a copay of just $25 for the same services at the City Hall location.

If You Are:	Concentra (Dallas City Hall)	Concentra (DFW Metroplex)
Active Employee Covered by City Health Plan	Cost: $0[1]	Cost: $25[1*]/$35[1**]
Active Employee NOT Covered by City Health Plan	Cost: $25[1]	Not Eligible for Discount
Pre-65 Retiree Covered by City Health Plan	Cost: $0[1]	Cost: $25[1*]/$35[1**]
Pre-65 Retiree NOT Covered by City Health Plan	Not Eligible for Discount	Not Eligible for Discount
Medicare-eligible Retiree	Not Eligible for Discount	Not Eligible for Discount

[1] You may incur additional charges for services such as lab work and X-rays during your clinic visit.
[*]Copay for 75/25 HRA Plan Enrollees [**]Copay for 70/30 Plan Enrollees

Choose from several locations throughout the DFW Metroplex:

Addison 15810 Midway Rd. Addison, TX 75001 Hours: 8 a.m.- 8 p.m.(M-F) 8 a.m. - 5 p.m. (Sat) Phone: 972-458-8111 Fax: 972-458-7776	**Arlington North** 2160 E. Lamar Blvd. Arlington, TX 76006 Hours: 8 a.m. - 5 p.m. (M-F) 9 a.m. - 5 p.m. (Sat/Sun) Phone: 972-988-0441 Fax: 972-641-0054	**Arlington South** 511 E. 1-20 Arlington, TX 76018 Hours: 8 a.m. - 8 p.m. (M-F) 9 a.m. - 5 p.m. (Sat/Sun) Phone: 817-261-5166 Fax: 817-275-5432	**Burleson** 811 NE Alsbury Blvd., Suite 800 Burleson, TX 76028 Hours: 8 a.m. - 8 p.m. (M-F) 8 a.m. - 5 p.m. (Sat) Phone: 817-293-7311 Fax: 817-551-1066
Carrollton 1345 Valwood Pkwy., Suite 306 Carrollton, TX 75006 Hours: 8 a.m. - 5 p.m. (M-F) Phone: 972-484-6435 Fax: 972-484-6785	**Fort Worth Forest Park** 2500 West Fwy. (I-30), Suite 100 Fort Worth, TX 76102 Hours: 8 a.m. - 8 p.m. (M-F); 8 a.m. - 5 p.m. (Sat) Phone: 817-882-8700 Fax: 817-882-8707	**Fort Worth Fossil Creek** 4060 Sandshell Drive Fort Worth, TX 76137 Hours: 8 a.m. - 5 p.m. (M-F) Phone: 817-306-9777 Fax: 817-306-9780	**Frisco** 8756 Teel Pkwy., Suite 350 Frisco, TX 75034 Hours: 8 a.m.- 8 p.m.(M-F) 8 a.m. - 5 p.m. (Sat)/ 9 a.m. - 5 p.m. (Sun) Phone: 972-712-5454 Fax: 972-712-5442
Garland 1621 S. Jupiter Rd., Suite 101 Garland, TX 75042 Hours: 8 a.m. - 5 p.m. (M-F) Phone: 214-340-7555 Fax: 214-340-3980	**Irving/Las Colinas** 5910 N. MacArthur Blvd., Suite 133 Irving, TX 75039 Hours: 8 a.m.- 8 p.m.(M-F) 8 a.m. - 5 p.m. (Sat) Phone: 972-554-8494 Fax: 972-438-4647	**Lewisville** 2403 S. Stemmons Fwy., Suite 100 Lewisville, TX 75067 Hours: 8 a.m.- 8 p.m.(M-F) 9 a.m. - 5 p.m. (Sat/Sun) Phone: 972-829-2999 Fax: 972-459-7929	**Mesquite** 4928 Samuell Blvd. Mesquite, TX 75149 Hours: 8 a.m.– 5 p.m.(M-F) Phone: 214-328-1400 Fax: 214-328-2884
Plano 1300 N. Central Expy. Plano, TX 75074 Hours: 8 a.m.- 8 p.m.(M-F) 8 a.m. - 5 p.m. (Sat) Phone: 972-578-2212 Fax: 972-881-7666	**Redbird** 5520 Westmoreland, Suite 200 Dallas, TX 75237 Hours: 8 a.m. - 5 p.m. (M-F) Phone: 214-467-8210 Fax: 214-467-8192	**Stemmons** 2920 N. Stemmons Fwy. Dallas, TX 75247 Hours: 8 a.m. - 8 p.m. (M-F) 9 a.m. - 5 p.m. (Sat/Sun) Phone: 214-630-2331 Fax: 214-905-1323	**Upper Greenville** 5601 Greenville Ave. Dallas, TX 75206 Hours: 8 a.m.- 8 p.m. (M-F) 9 a.m. - 5 p.m. (Sat/Sun) Phone: 214-821-6007 Fax: 214-821-6149

Dental Plan Overview

United Healthcare is our provider for dental offerings for 2014. Your options include:

- Dental PPO, which allows you to select the provider of your choice
- Dental HMO, which provides in-network benefits only while having a co-pay schedule
- Dental EPO, which allows you to select the provider of your choice while having a co-pay schedule

Plan Features	UHC PPO		UHC HMO	UHC EPO
	In-Network	Out-of-Network	In-Network Only	
Calendar Year Deductibles • Individual • Family	$50 $150		$0 $0	$50 $150
Maximum • Calendar Year • Orthodontic Lifetime	$1,000 per person 12-month waiting period for orthodontic services		$0 ********	$1,250 $1,500 (12-month waiting period for orthodontic services)
Visits and Exams • Office visit • Oral Exam • X-rays	You pay 0%	You pay any charges in excess of Allowed Amount*	Office visit: $5 Oral exam: $0 X-rays: $0	Copays vary by service according to Patient Charge Schedule*
Basic Services • Fillings • General Services • Space Maintainers	You pay 0%	You pay 20% and any charges In excess of Allowed Amount*	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*
Major Services • Crowns • Dentures/Bridges	You pay 50%	You pay 50% and any charges in excess of Allowed Amount*	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*
Orthodontic Services	Not Covered	Not Covered	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*

**The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.

Monthly Dental Plan Rates			
Coverage Level	**Dental PPO**	**Dental HMO**	**Dental EPO**
Employee Only	$24.13	$7.76	$18.02
Employee + Spouse	$48.27	$14.29	$33.15
Employee + Child(ren)	$49.23	$14.36	$33.32
Employee + Family	$73.39	$20.20	$46.86

Vision Plan Overview

The City of Dallas has two Vision Plan options for 2014: the Standard Plan and the Buy-up Plan. Both plans include a comprehensive exam and materials, frames and lenses (including contact lenses). The Buy-up Plan includes the following additional lens options: Polycarbonate Lenses and Standard Anti-reflective Coating. Polycarbonate lenses are impact-resistant lenses that are often utilized in children's eyewear. Standard Anti-reflective coating will aid in glare reduction. The Buy-up Plan also includes an out-of-network laser surgery benefit.

	Standard Plan		Buy-up Plan	
Benefit/Service	**UHC Network Provider**	**Out-of-Network Reimbursement[1]**	**UHC Network Provider**	**Out-of-Network Reimbursement[1]**
Comprehensive Exam (every 12 months)	$10 copay	up to $40.00	$10 copay	up to $40.00
Materials	$25 copay	See spectacle lenses and frame benefit below	$25 copay	See spectacle lenses and frame benefit below
Spectacle Lenses[*] (every 12 months) Standard Plan: • Standard Scratch-Resistant Coating Buy-up Plan: • Standard Scratch-Resistant Coating • Polycarbonate Lenses • Standard Anti-Reflective Coating	$25 copay	Single Vision up to $40.00 Bifocal up to $60.00 Trifocal up to $80.00 Lenticular up to $80.00	$25 copay	Single Vision up to $40.00 Bifocal up to $60.00 Trifocal up to $80.00 Lenticular up to $80.00
Frames (every 24 months)	$130.00 retail frame allowance	Up to $45.00	$130.00 retail frame allowance	Up to $45.00
Contact Lenses[**] (every 12 months) • Fitting/evaluation • Contacts • Two follow-up visits (after $25 copay).	Covered-in-full selection or $105.00 allowance	Elective up to $105.00 Necessary up to $210.00	Covered-in-full selection or $105.00 allowance	Elective up to $105.00 Necessary up to $210.00
Laser Vision[***]	N/A	N/A	N/A	Lifetime Max Reimbursement of $500

[1]Out-of-Network Reimbursements: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UHC Vision, ATTN: Claims Dept., P. O. Box 30978, Salt Lake City, UT 84130.

[*]Benefits available every 12 to 24 months (depending on the benefit frequency), based on last date of service.

[**]Your $105 Contact Lens allowance is applied to the fitting/evaluation fees and the purchase of the contact lenses. For example, if the fitting/evaluation fee is $30, you will have $75 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. If you chose disposable contacts, you may receive up to four boxes of disposable contacts (depending on prescription. This benefit is covered in lieu of eyeglasses when obtained from a network provider. Toric, gas permeable and bifocal contacts are all examples that are outside our covered-in-full selection.

[***]UHC has partnered with the Laser Vision Network of America (LVNA) to provide members with access to discounted laser correction providers (877-25-SIGHT).

Monthly Vision Plan Rates		
Coverage Level	**Standard Plan**	**Buy-up Plan**
Employee Only	$4.79	$5.76
Employee + Spouse	$8.75	$10.52
Employee + Child(ren)	$9.19	$11.04
Employee + Family	$14.14	$17.01

The Standard Life Insurance Plan Overview

One of the most important things about life insurance is the financial peace of mind it gives you and your loved ones. The Standard Life Insurance offers you coverage that allows you to provide for others in the event of your or your dependents' death. You may select from the following options:

- ❑ **Basic Life Insurance**: $50,000 basic term life insurance coverage is available to eligible, full-time employees at no cost. No enrollment action is necessary for full-time employees. Part-time employees must contact the Benefits Service Center to enroll and must pay half the cost.
- ❑ **Supplemental Life Insurance**: Includes coverage options up to three times an employee's base annual salary—not to exceed $500,000. This product's cost increases as you age. New employees can elect one, two or three times their annual salary.
  - ■ Employees who currently are enrolled in supplemental life can only increase their coverage by one increment during open enrollment without submitting evidence of insurability. For example, employees who currently have coverage of one times their annual salary can only increase their coverage to two times their annual salary. If you would like to increase coverage more than one time your salary, you must submit an Evidence of Insurability (EOI) Form. Please contact the onsite representative at Dallas City Hall, Room 1DS, or call 214-670-4181.
- ❑ **Dependent Life Insurance**: You may purchase dependent group term life insurance coverage. If you initially decline coverage for your spouse, you are required to provide evidence of insurability to enroll at a later date. Evidence of insurability is not required for children. An employee may not be insured as both an employee and dependent. A child may not be insured by more than one employee.
- ❑ **Accidental Death and Dismemberment (AD&D)**: You may purchase 24-hour accident protection. Individual and family plans are available. An employee may not be insured as both an employee and dependent. A child may not be insured by more than one employee. You may elect Voluntary AD&D coverage for your spouse/domestic partner and dependent children. The coverage amount for each dependent is as follows:
  - ■ Spouse/domestic partner only; 60 percent of employee's Voluntary AD&D coverage amount
  - ■ Children only; 20 percent of employee's Voluntary AD&D coverage amount; the amount of AD&D insurance for your child may not exceed $50,000.
  - ■ Spouse/domestic partner and children; 50 percent of employee's Voluntary AD&D coverage amount for the spouse/domestic partner and 15 percent of employee's Voluntary AD&D coverage amount for each child. The amount of AD&D insurance for your child may not exceed $50,000.
- ❑ **Beneficiary designation forms** are located on the City of Dallas Intranet/Internet sites under the Life Insurance link.
- ❑ **To file a life claim**, please call 1-877-474-4250 or 214-670-4181.
- ❑ **Please refer to your insurance policy for additional information.**

2014 Supplemental Life Insurance Monthly Rates

Employee's Age (on last January 1)	Rate (Per $1,000 of Total Coverage)
Less than 25	$0.05
25-29	$0.06
30-34	$0.08
35-39	$0.09
40-44	$0.11
45-49	$0.19
50-54	$0.32
55-59	$0.47
60-64	$0.68
65-69	$1.27
70 and older	$2.25

To calculate your premium:

1. Select Amount: (1, 2 or 3 times your annual salary)
2. Divide by $1,000
3. Select your rate based on your age from the table to the left
4. Multiply line 2 by line 3 to get your monthly rate

Example: (1) $40,000 annual salary / (2) $1,000 - 40 x (3) $0.09 (age 35) = (4) $3.60 per month

2014 Accidental Death & Dismemberment (AD&D) Monthly Rates

Employee Only										
	25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
<70	$0.75	$1.50	$2.25	$3.00	$3.75	$4.50	$5.25	$6.00	$6.75	$7.50
70-74	$0.49	$0.98	$1.46	$1.95	$2.44	$2.93	$3.41	$3.90	$4.39	$4.88
75-79	$0.34	$0.68	$1.01	$1.35	$1.69	$2.03	$2.36	$2.70	$3.04	$3.38
80-84	$0.23	$0.45	$0.68	$0.90	$1.13	$1.35	$1.58	$1.80	$2.03	$2.25
85 +	$0.11	$0.23	$0.34	$0.45	$0.56	$0.68	$0.79	$0.90	$1.01	$1.13

Employee/Family										
	25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
<70	$1.13	$2.25	$3.38	$4.50	$5.63	$6.75	$7.88	$9.00	$10.13	$11.25
70-74	$0.73	$1.46	$2.19	$2.93	$3.66	$4.39	$5.12	$5.85	$6.58	$7.31
75-79	$0.51	$1.01	$1.52	$2.03	$2.53	$3.04	$3.54	$4.05	$4.56	$5.06
80-84	$0.34	$0.68	$1.01	$1.35	$1.69	$2.03	$2.36	$2.70	$3.04	$3.38
85 +	$0.17	$0.34	$0.51	$0.68	$0.84	$1.01	$1.18	$1.35	$1.52	$1.69

2014 Dependent Life Insurance Monthly Rates		
Option 1	$15K (Spouse); $5K (Children up to age 25)	$2.85
Option 2	$25K (Spouse); $10K (Children up to age 25)	$5.25

Voluntary Benefits: Colonial Life

Not Sponsored by the City of Dallas
(available on an individual basis)

- Short-Term Disability Insurance
- Critical Illness Insurance
- Hospital Confinement Indemnity Insurance
- Universal Life Insurance

The City of Dallas does not sponsor the Voluntary Benefits disclosed on the following page.

Take Advantage of What Colonial Life Has to Offer!

You have the opportunity to apply for personal insurance products from Colonial Life! These benefits can enhance your current benefits portfolio and can be customized to fit your individual needs.

- ❑ Coverages are available for you and your family, with most products.
- ❑ You will enjoy the convenience of premium payments through payroll deductions.
- ❑ You will have the ability to take most coverages with you if you change jobs or retire.

The following insurance plans will be offered during Open Enrollment:

Short-Term Disability Insurance helps offset the financial losses that result when you are unable to work due to a covered injury or sickness.

Critical Illness Insurance complements your major medical coverage by providing a lump-sum benefit that you can use to help pay the direct and indirect costs related to a covered critical illness, which can often be expensive and lengthy.

Hospital Confinement Indemnity Insurance helps you with the rising costs associated with a covered hospital confinement or eligible outpatient surgery.

Universal Life Insurance enables you to tailor coverage for your individual needs and helps provide financial security for your family members. This policy comes with a long-term care benefit rider.

A Colonial Life benefits counselor will explain how these benefits can help protect you and your family. Your insurance needs can be reviewed in just a few minutes. With Colonial Life, you can select benefits that help meet your individual needs.

Products have exclusions and limitations that may affect benefits payable. See the Outline of Coverage for complete details.

New hires may enroll in these Colonial Life products by following these steps:

1. Gather any information you may need to enroll, such as dependents' names, birth dates, ages, Social Security numbers and addresses.
2. Call the Benefits Service Center (1-888-752-9122) to speak to a benefits counselor who will be onsite during Open Enrollment to answer your questions and enroll you in the coverage of your choice.

For information regarding your existing Colonial Life coverage, contact Colonial Life Policyholder Services at 1-800-325-4368 or visit the Colonial Life website at www.coloniallife.com.

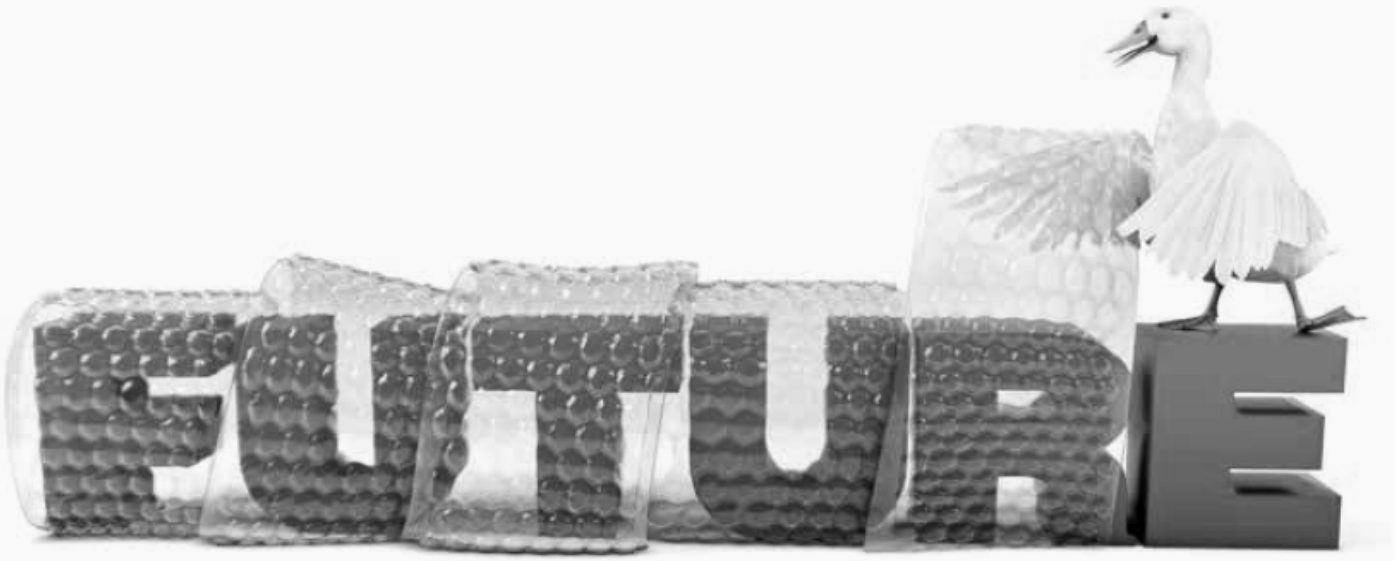
Colonial Life & Accident Insurance Company
1200 Colonial Life Boulevard, Columbia, SC 29210
Policyholder Services: 1-800-325-4368
Web: www.coloniallife.com

Voluntary Benefits: Aflac

Not Sponsored by the City of Dallas
(available on an individual basis)

- Cancer
- Accident

The City of Dallas does not sponsor the Voluntary Benefits disclosed on the following page.



You can't predict it. But you can help protect it.

3 Easy Ways to Apply

1. In Person – Aflac agents will be coming to most departments.
2. By Phone – Contact our call center @ 877-373-4026.
3. On the Web – Visit aflac.com/cityofdallas

Aflac is insurance that helps cover expenses major medical doesn't. It pays cash benefits directly to you.* It provides predetermined benefits that are paid regardless of any other insurance you have. And it fits most budgets—rates don't go up when you file a claim. Learn how we've got you covered under our wing.

Your company is offering the following insurance:

- **Accident – Provides a financial cushion if an accident occurs.**
- **Cancer/Specified Disease – Helps offset cancer-related expenses and to help with a variety of daily living expenses.**

For more information about policy benefits, limitations, and exclusions, please call your Aflac insurance agent, Rosalind George at **972.480.0109** or email her at **rosalind_george@us.aflac.com**.

If you're an existing Aflac policyholder and have any questions or need assistance, call 1.800.981.6537. Customer service representatives are available Monday through Friday, from 7 a.m. to 7 p.m. CT.

Aflac®

*Unless otherwise assigned. Coverage is underwritten by American Family Life Assurance Company of Columbus.

M2083 11/12

Voluntary Benefits: The Standard

Not Sponsored by the City of Dallas
(available on an individual basis)

- Your Choice Group Voluntary Long-Term Disability

The City of Dallas does not sponsor the Voluntary Benefits disclosed on the following page.

City of Dallas
Group Policy #649238
Effective Date: April 1, 2013

TheStandard®

Your Choice Group Voluntary Long Term Disability Insurance

We are pleased to announce that you will now have the opportunity to apply for Your Choice Group Voluntary Long Term Disability (LTD) insurance from Standard Insurance Company. LTD insurance pays a benefit in the event that you cannot work because of illness or injury.

Would you be able to meet your financial obligations if you were disabled and could not work for an extended period of time? For most people, the answer is no, and the risk of disability is greater than you may think. Consider the following:

- One in four workers entering the workforce today will become disabled before retiring. *(Social Security Administration, Fact Sheet July 30, 2012)*
- A disabling injury occurs nearly every second of each day – on and off the job. That's more than 70,000 every day, more than 25 million every year. *(National Safety Council, Injury Facts 2011)*

The Advantages Of Disability Insurance

Your Choice LTD benefits replaces a portion of your income, helping you meet your financial obligations in your time of need. With Your Choice LTD insurance, you'll enjoy:

- **Convenience –** With premiums deducted directly from your paycheck, you don't have to worry about mailing monthly payments
- **Peace of Mind –** You can take comfort and satisfaction in knowing that you've taken a step toward securing your income during a period of a covered disability

Features And Services

Here's a summary of what Your Choice LTD insurance provides:

- Coverage of disabilities that occur 24 hours a day, both on and off the job
- Three available Maximum Benefit Period options: 2 years, 5 years, or Social Security Normal Retirement Age
- 180 day Benefit Waiting Period for accident and sickness
- Automatic premium payments via payroll deduction
- Premium payments are made with "after-tax" dollars, LTD benefits are federally tax-free under current federal tax law

Your Choice LTD insurance offered to you provides the following income protection:

Monthly LTD Benefit Amount: You may select a monthly benefit amount in $100 increments from $200 to 10,000. The monthly benefit amount must not exceed 60 percent of your monthly earnings.
Maximum Monthly Benefit: $10,000
Minimum Monthly Benefit: $100
3 Maximum Benefit Period Options: 2 years, 5 years, or Social Security Normal Retirement Age

To learn more about Your Choice Group Voluntary LTD benefits available to you, including costs and complete details of the coverage, please review Your Choice Group Voluntary LTD insurance Coverage Highlights and Booklet at www.cityofdallasbenefits.com or contact The Standard's onsite representative, Kaleb Jones at (214) 670-4181.

Fax your completed enrollment form to (866) 353-9703

The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of definitions, the limitations, reductions in benefits, exclusions and when The Standard may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For costs and more complete details of coverage, contact The Standard's onsite representative, Kaleb Jones at (214) 670-4181 or visit www.cityofdallasbenefits.com to review Your Choice Group Voluntary LTD insurance Coverage Highlights and Booklet.

GP190-LTD/S399 Your Choice Group Voluntary LTD

SI 16504-649238 (7/13)

Legislative Notices

The following are legal notices regarding your rights under the City-sponsored health plans.

The City of Dallas is required to provide this information to you.

Notice of Privacy Practices – City of Dallas Health Plans
Effective date: April 14, 2003 Revised: September 19, 2013

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. This notice addresses the changes set forth in the Final HIPAA Omnibus Rule. Please review carefully.

OUR PRIVACY PRINCIPLES

We are required by law to maintain the privacy of your protected health information and to inform you about:

- the Plan's practices regarding the use and disclosure of your protected health information.
- your rights with respect to your protected health information.
- the Plan's duties with respect to your protected health information.
- your right to file a complaint about the use of your protected health information;
- whom you may contact for additional information about the Plan's privacy practices; and

any breach of your unsecured PHI.

This notice explains how we may use and disclose your health information to provide benefits to you and our promise to protect your health information. We understand the importance of maintaining the privacy of this information. We are guided by your rights to make inquiries about how we use or disclose your health information. This notice describes rights accorded to you under the Privacy Rule and our legal obligations regarding them. We shall abide by the terms of this notice for all health or medical information we retain.

In this notice the terms "we," "us," "our" and "health plans" are used interchangeably to refer to the health plans listed below. The term "health plans" describes the medical plans offered by the City of Dallas and listed below. The term "health information" refers to information about you or a secondary subscriber to your plan that is used or disclosed to the health plans concerning your physical or mental health or the medical services you received, or your health insurance benefits and payments. Health information includes all identifying information you provide to the health plans to enroll for coverage or health benefits.

This notice applies to the following City of Dallas Health Plans:

UnitedHealthcare 75/25 Health Reimbursement Account Plan
UnitedHealthcare 70/30 Exclusive Provider Organization Plan (with $3,000 deductible)
Caremark Pharmacy Services plan

If you have any questions regarding this notice, please contact the Privacy Officer:

Privacy Officer
Call Compliance Hotline: (855)345-4022
Email: hipaacompliance@dallascityhall.com

HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED OR DISCLOSED

We may access your health information at various times depending on the action required to be completed to your account to maintain your health benefits. We may also document your conversations with the Benefits Division. Employees and business associates will have access to view your health information to perform certain activities for the health plans. They will be given access to your information to help you with your inquiries related to your plan. They may also access your information to perform business or administrative functions for the health plans. At all times, we take steps to ensure that no use or disclosure is inconsistent with the Privacy Rule. Your health records pertaining to your mental health (e.g. psychotherapy notes), substance or drug abuse, and alcohol abuse histories and information relating to HIV test result are subject to stricter disclosure rules under Texas law. We require your written authorization or that of your authorized representative to release this information when requested.

The City has certified that your health information will not be used for any employment-related actions or decisions or activities that deviate from managing the health plans. Violations of these rules are subject to disciplinary action. Below, we describe the different ways we may use and disclose your health information and provide examples for the different disclosures.

Treatment: By itself, the health plans do not provide treatment services (but your health care provider or physician does). We (or the third-party plan administrator) may confirm your health benefits to a health care provider. For example, if your physician wishes to determine whether the plan covers a prospective treatment or medication, they may contact the health plan (or its third-party administrator) for this information.

We may also share your personal information (name, DOB, social security, address or other identifying information) with UnitedHealthcare, or Caremark Pharmacy Services, or other business associates) who update the information we have on file for you in the health plans database(s). For example, a business associate may have access to the health plans' database(s) to add new or additional subscribers to your plan, to make changes to your benefits elections, or to update your profile information – in an effort to provide the most up-to-date information to facilitate the treatment activities of your health care provider.

To Pay Your Health Insurance Premiums or Benefits: The health plans may use and disclose your health information to obtain premiums for the health insurance, to pay for the health care services you receive (claims paid by third-party administrator), to subrogate a claim. For example, we may need to provide your health information to a different insurance company to obtain reimbursement for health care benefits provided under the health plans to you or a secondary subscriber. The health plans may also provide your health information to business associates (e.g. billing companies, claims processing companies) that engage in health care claims processing.

Plan Operations: We may use and disclose your protected health information for our health care operations activities. This interaction is needed to run the plans more efficiently and provide effective coverage. Health care operation activities could include: administering and reviewing the health plans, underwriting health plan benefits, determining coverage policies, performing business planning, arranging for legal and auditing services, customer service related training activities, or determining plan eligibility criteria, etc. Your information may be shared with business associates that perform a service for the health plans. Note, however, the health plans will never use genetic PHI for underwriting purposes.

The health plans will only disclose the minimum information necessary with respect to the amount of health information used or disclosed for these purposes. In other words, only information relating to the task being performed will be used or disclosed. Information not required for the task will not be used or disclosed.

The health plans may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

To Business Associates: We may share your health information with third-party business associates who perform certain business activities for the health plans. Examples include consultants, billing or claims processing companies, interpreters, and auditors. Business associates are required through contract with us and by law to appropriately safeguard your PHI.

The health plans are also allowed to use or disclose your health information without your written authorization as required by law.

Disposal of Protected Health Information: Once we no longer need your protected health information we will either destroy it, return it, or if neither is feasible, we will store it securely and prohibit further uses and disclosures except to the extent use or disclosure is unavoidable.

Other Uses and Disclosures Requiring Your Authorization: We are prohibited from using or disclosing your health information if the use or disclosure is not covered by a situation above. We will ask for your written authorization for other uses or disclosures. If you give us your written authorization to use or disclose your protected health information, you may revoke that permission, in writing, at any time, but not for any actions we have already taken. If you revoke your permission, you must be specific about which entity's permission is being revoked.

Rights You Have Regarding Your Health Information

Right to Inspect and Copy: You have the right to inspect and copy your health information that the Health Plan maintains for enrollment, payment, claims determination, or case or medical management activities, or that the Plan uses to make enrollment, coverage or payment decisions (the "designated record set"). However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. You must submit your request in writing to the Benefits Division. You may be charged a fee for the related costs, such as copying and mailing. If your request to inspect or copy your health information has been denied, you will be notified in writing of your rights of appeal at that time.

Right to access electronic records: You may request access to electronic health records (usually compiled by health care providers) or electronic copies of your PHI held in a designated record set, or you may request in writing or electronically that another person receive an electronic copy of these records. The electronic PHI will be provided in a mutually agreed-upon format, and you may be charged for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Amend: If you feel that protected health information held in the Health Plan's official file is incorrect or incomplete, you must submit a written request that the information be amended; you must support the basis for your request. We are not required to grant your request if we do not maintain or did not create the information, or if it is correct. We must respond to your request within 60 days, unless a written notice of a 30-day extension is provided.

Right to an Accounting of Disclosures: You may seek an accounting of certain disclosures by requesting a list of the times we have shared your health information. Your request must be in writing. Your request should indicate in what form you want the list (for example, paper or electronically). The first list you request within a 12-month period will be free. For additional lists, you may be charged for the costs of providing the list. Your will receive a response no later than 60 days from when we receive your request, unless a written notice of a 30-day extension is provided.

Right to Request Restrictions: You may request that we limit the way we use or share your health information. You should submit your request in writing. We will consider your request and respond accordingly. We are not required to agree to the request.

Right to Request Confidential Communications: You may request that we contact you in a certain way or at a certain location, for example, you can ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. Due to procedural or system limitations, in some instances, it may not be reasonable to send confidential communications to multiple addresses for persons who reside in the same household or derive coverage through the same individual participant. However, the health plans must accommodate your reasonable request to receive communication of PHI by alternative means or at alternative locations, if you clearly state that the disclosure of all or part of the information through normal processes could endanger you in some way. The Privacy Officer will monitor and manage this process according to protections afforded under applicable law.

Right to Receive Notice of A Breach: You may receive a notice from us regarding the breach of your unsecured health information if you are affected. We will inform you of the action we will take and how you can protect yourself from potential harm.

Receive a Copy of This Notice
You may ask for a paper copy of this notice by calling the Benefits Division at 1-888-752-9122. You may also view this notice at the health plans websites: http://www.dallascityhall.com/human_resources/benefits_employees.html or www.cityofdallasbenefits.com.

Changes To This Notice
We reserve the right to change this notice and will distribute as required. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. We will post the revised copy on the health plans' websites and distribute information about the update as required by the regulations.

Complaints and Questions
If you have questions about your HIPAA privacy rights or if you believe your rights have been violated, you may contact the City or one of the health plans' representatives listed below or you may file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.

Human Resources Department	**Health Plan Representatives Contact Information**	
ATTN: Benefits Division 1500 Marilla Street, Room 1D South Dallas, Texas 75201-6390 Phone: 1-888-752-9122 Fax: 1-888-202-5571	UnitedHealthcare (UHC) EPO Plans (75/25/HRA & 70/30) Caremark (CVS) - Prescription Services	800-736-1364 855-465-0023

Legislative Notices (Continued)

What is COBRA?
The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with group health benefit plans to offer employees the opportunity to continue temporarily their group health care coverage under their employer's plan if their coverage otherwise would cease due to termination, layoff or other change in employment status (referred to as "qualifying events").

How long must COBRA continuation coverage be available?
- Up to 18 months for termination or reduction of hours
- Up to 29 months to employees who are determined to have been disabled at any time during the first 60 days of COBRA coverage and to the disabled employee's nondisabled beneficiaries.
- Up to 36 months for spouses and dependents due to an employee's death, divorce or legal separation.

What plans are subject to COBRA?
Group health, vision, dental and health care spending account (EMSP) plans are subject to COBRA.

What specific events can be qualifying events?
- Death of employee
- Voluntary or involuntary termination of employment (other than by reason of gross misconduct)
- Retirement
- Reduction in hours
- Divorce or legal separation
- Dependent child ceasing to be a dependent

How much does COBRA cost for City sponsored plans?

COBRA *(includes 2% admin)*	70/30/ EPO (Low Option) Monthly Rates*	Tobacco Rate
Employee Only	$355	$375
Employee + Spouse	$773	$793
Employee + Childr(ren)	$667	$687
Employee + Family	$1,011	$1,031

*100% Employee Contribution

COBRA *(includes 2% admin)*	70/30/ EPO (High Option) Monthly Rates*	Tobacco Rate
Employee Only	$367	$397
Employee + Spouse	$801	$821
Employee + Childr(ren)	$691	$711
Employee + Family	$1,047	$1,067

*100% Employee Contribution

COBRA *(includes 2% admin)*	75/25/HRA EPO Monthly Rates*	Tobacco Rate
Employee Only	$481	$501
Employee + Spouse	$959	$979
Employee + Childr(ren)	$879	$899
Employee + Family	$1,244	$1,264

*100% Employee Contribution

COBRA Monthly Vision Plan Rates		
Coverage Level	Standard Plan	Buy-up Plan
Employee Only	$4.89	$5.88
Employee + Spouse	$8.93	$10.73
Employee + Child(ren)	$9.37	$11.26
Employee + Family	$14.42	$17.35

COBRA Monthly Dental Plan Rates			
Coverage Level	Dental PPO	Dental HMO	Dental EPO
Employee Only	$24.61	$7.92	$18.38
Employee + Spouse	$49.24	$14.58	$33.81
Employee + Child(ren)	$50.21	$14.65	$33.99
Employee + Family	$74.86	$20.60	$47.80

Women's Health Cancer Rights Act (WHCRA) Enrollment Notice
If you have had or plan to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

The benefits provided are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like additional information on WHCRA benefits, call your plan administrator at 800-736-1364.

Continuation of Health Coverage During Family and Medical Leave (FMLA)
The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. This provision is intended to comply with the laws and any pertinent regulations, and its interpretation is governed by them. See the City of Dallas Personnel Rules to find out how this continuation applies to you.

For the duration of FMLA leave, the employer must maintain the employee's health coverage. The employee may continue the plan benefits for himself or herself and his or her dependents on the same terms as if they employee had continued to work. The employee must pay the same contributions toward the cost of the coverage that he or she made while working. If the employee fails to make the payments on a timely basis, the employer, after giving the employee written notice, can end the coverage during the leave if payment is more than 30 days late. Upon return from a FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms. The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

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

Important Notice About Your Prescription Drug Coverage & Medicare

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

Legislative Notices (Continued)

2. The City of Dallas has determined that the prescription drug coverage offered by United MedicareRx offered by United Healthcare is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you are enrolled in the City's Active employee or Pre-65 retiree EPO health plan; that coverage pays for medical expenses in addition to prescription drug expenses which are included the plan's design. As a retiree, if you decide to join a non-City of Dallas sponsored Medicare drug plan, your current City of Dallas coverage will be affected as you cannot be enrolled in two plans. If you decide to join a Medicare drug plan as a retiree that is not sponsored by the City of Dallas and drop your current City of Dallas coverage, be aware that you and your dependents will not be able to get this coverage back. *See pages seven through nine of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.*

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the City of Dallas and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Please contact the Benefits Service Center at 1-888-752-9122 or send written correspondence to the address listed at the end of this notice.

NOTE: This notice will be provided in each annual enrollment guide and if this coverage through the City of Dallas changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage, visit www.medicare.gov. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty). To receive a copy of this notice, please use the contact information listed below.

City of Dallas
Benefits Service Center
1500 Marilla Street, 1D-South, Dallas, TX 75201
(Phone) 1-888-752-9122

CITY OF DALLAS
Notice of Medical Privacy Practices
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting Your Personal Health Information
The City of Dallas understands that your health information is personal and private. We are committed to protecting the privacy of your health information and the health information of your family members that we, and the Health Plans we sponsor for the benefit of our employees, receive and maintain. This health information is referred to in this Notice as "your protected health information."

We are required by law—the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA")—to:

- ❑ Make sure that your protected health information is kept private
- ❑ Give you this Notice of our legal duties and privacy practices with respect to your protected health information
- ❑ Follow the terms of this Notice, as currently in effect.

This Notice became effective April 14, 2003, and applies to all of the medical records the City and our business associates maintain that have been provided to us through the Health Plans. If you are covered under one of the City's insured Health Plans, you may receive a similar notice from your Health Plan's insurance carrier.

How Your Personal Health Information May be Used and Disclosed
The City's Health Plans may disclose your protected health information to the claims payers, to business associates, and to certain employees of the City. These individuals may only use your protected health information for Health Plan payment and operations and certain other limited purposes, as described below. We may not and will not use your protected health information for any employment-related actions or decisions or in connection with any of the City's non-Health Plan benefits. Violations of these rules are subject to disciplinary action.

The City has certified that it will not use or disclose your protected health information other than as provided in this Notice or as required by law. Any business associates who are given your protected health information must agree to be bound by these restrictions and conditions concerning your protected health information.

Health Plan Payment: We will use and disclose your protected health information for Health Plan payment activities. For example, the Health FSA third party administrator ("TPA") will use protected health information to determine coverage eligibility, process reimbursement claims, and coordinate benefits with other health care programs or insurance carriers.

Health Care Operations: We may use and disclose your protected health information for Health Plan operations, such as monitoring the Carriers and TPAs to ensure that they are properly and accurately paying claims in accordance with the terms of the Health Plan documents, and that they are providing proper and timely services to you as required under the Health Plans. Designated employees of the City may receive, use, and disclose protected health information when assisting you with Health Plan problems or questions, such as eligibility, benefit coverage, and appeals. Protected health information also may be used when conducting quality assessment and improvement activities; underwriting and soliciting bids from potential Carriers or TPAs, establishing City and employee premium contributions and funding-related activities; determining need for disease management programs; submitting claims for stop-loss coverage; arranging medical or legal reviews or fraud detection programs; and managing costs. We may also share your protected health information with business associates who assist us in monitoring Health Plan costs, utilization, plan design, Health Plan disputes, and similar Health Plan payment and operations. Our auditors, attorneys, and other business associates may use protected health information in assuring accurate and complete compliance with the Health Plans' terms.

As Required By Law or Judicial Order: We will disclose information about you when required to do so by federal, state or local law, including when required by court orders and subpoenas, or by the police or other authorized governmental organizations. For example, we may disclose protected health information when required by a domestic relations order, a child support order, or a court order involving a civil lawsuit or criminal prosecution. In most instances, this information will be provided by the Carrier or the TPA.

To Avert a Serious Threat to Health or Safety: We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of others. Any disclosure, however, would only be to someone able to help mitigate or prevent the threat to health or safety and only to the extent necessary to mitigate or prevent the problem.

Special Situations: Although unlikely, we may be required or permitted by HIPAA to use or disclosure protected health information in certain special situations, including, but not limited to, disclosures: (1) required to comply with workers' compensation requirements; (2) to assist law enforcement, such as to identify a missing person or witness; (3) to health oversight agencies, for example in the course of Medicare audits and compliance with other applicable laws; and (4) to report on public health risks, such as to report adverse reactions to medicines.

Disposal of Protected Health Information: Once we no longer need your protected health information we will either destroy it, return it, or if neither is feasible, we will store it securely and prohibit further uses and disclosures except to the extent use or disclosure is unavoidable.

Your Written Authorization to Release Information

In addition to the uses and disclosures of protected health information described in this Notice or as provided in HIPAA regulations, your protected health information will be used or disclosed only with your written permission. If you give us your written authorization to use or disclose your protected health information, you may revoke that permission, in writing, at any time, but not for any actions we have already taken. If you revoke your permission, you must be specific about which entity's permission is being revoked.

Legislative Notices (Continued)

Your Rights Regarding Your Protected Health Information

Right to Inspect and Copy: You have the right to inspect and copy your protected health information that is held in the Health Plan's official file, with certain exceptions, such as you cannot be given access to psychotherapy notes or information prepared for litigation. If you request a copy of the information, you may be charged a fee for the related costs, such as copying and mailing. If your request to inspect or copy your protected health information has been denied, you will be notified in writing of your rights of appeal at that time.

Right to Amend: If you feel that protected health information held in the Health Plan's official file is incorrect or incomplete, you must submit a written request that the information be amended; you must support the basis for your request. We are not required to grant your request if we do not maintain or did not create the information, or if it is correct. We must respond to your request within 60 days, unless a written notice of a 30-day extension is provided.

Right to an Accounting of Disclosures: You have the right to request an accounting, or list, of certain uncommon disclosures of your protected health information. Your request for a list of disclosures must state the time period for which you are requesting the accounting, but your request may not cover a time period that is longer than six years and may not include the period before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronically). The first list you request within a 12-month period will be free. For additional lists, you may be charged for the costs of providing the list. Your request for an accounting of the disclosures of your protected health information must be responded to no later than 60 days after receipt of the request, unless a written notice of a 30-day extension is provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for Health Plan payment or operations. You also have the right to request a limit on the protected health information disclosed about you to someone who is involved in your care or the payment for your care, such as a family member or friend when you are incapacitated or unavailable. In your request for restrictions, you must indicate: (1) what information you want to limit; (2) whether you want to limit the use, disclosure, or both; and (3) to whom you want the limits to apply, for example, prohibit disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that communications with you regarding your protected health information be made in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. Although we are not required to agree to your request, we will accommodate all requests we deem reasonable.

Use of Personal Representatives: Your personal representative may act on your behalf. For example, a parent is a personal representative of a dependent minor, and a person with your power of attorney or a court order may be your personal representative.

Human Resources Department	Health Plan Representatives Contact Information	
ATTN: Benefits Division 1500 Marilla Street, Room 1D South Dallas, Texas 75201-6390 Phone: 1-888-752-9122 Fax: 1-888-202-5571	United Healthcare (UHC) EPO Plans (75/25/HRA & 70/30) Caremark (CVS) - Prescription Services United Healthcare (UHC) - Flexible Spending Accounts United Healthcare (UHC) - Dental PPO & EPO Plans United Healthcare (UHC) - Dental HMO Plan United Healthcare (UHC) - Vision Standard & Buy-up Plans OptumHealth EAP (Employee Assistance Program) Colonial Life - Voluntary Benefit Plans AFLAC - Voluntary Benefit Plans	800-736-1364 855-465-0023 877-311-7849 877-816-3596 800-232-0990 800-638-3120 800-586-6875 800-325-4368 800-992-3522

Legislative Notices (Continued)

Changes To This Notice
We reserve the right to change this Notice and will distribute as required. We reserve the right to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on the Plan websites at http://www.dallascityhall.com/human_resources/benefits_employees.html and www.cityofdallasbenefits.com.

Complaints and Questions
If you have questions about your HIPAA privacy rights or if you believe your rights have been violated, you may contact the City or one of the Health Plan representatives listed below or you may file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.

Special Enrollment Notice
If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for your other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or place for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days following the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Benefits Service Center at 1-888-752-9122.

Wellness Program Disclosure
If it is unreasonably difficult for you to achieve the standards for a reward under the wellness program due to a medical condition, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the Benefits Service Center at 1-888-752-9122, and we will work with you to develop another way to qualify for the reward.

Children's Health Insurance Program Notice

Medicaid and the Children's Health Insurance Program (CHIP) Free Offer or Low-Cost Health Coverage to Children & Families

If you are eligible for health coverage from your employer but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

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

Once it has been determined that your or your dependents qualify for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—granted that you and your dependents are eligible but not already enrolled in your employer's plan. This is called a "special enrollment" opportunity. **You must request coverage within 60 days of being determined eligible for premium assistance.**

You may be eligible for payment assistance with your employer's health plan premiums. You should contact your state for information on eligibility:

Texas Residents: Go to http://www.gethipptexas.com/ or call **1-800-440-0493**.

To see which states have implemented a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you may use the following resources:

U. S. Department of Labor
Employee Benefits Security Administration
Website: www.dol.gov/ebsa
Phone: 1-866-444-EBSA (3272)
OMB Control Number 1210-0137
(expires 9-30-2014)

U. S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Website: www.cms.hhs.gov
Phone: 1-877-267-2323, Ext. 61565

Vendor Directory

City of Dallas HR-Benefits Service Center	
City of Dallas Benefits Website Website Phone	 www.cityofdallasbenefits.com 1-888-752-9122
City of Dallas Website	http://www.dallascityhall.com/
Medical Plan	
United Healthcare (UHC) EPO and HRA Plans Membership Services EPO/HRA myNurseLine Website	 1-800-736-1364 1-800-586-6875 www.myuhc.com
Pharmacy Plan	
CVS/Caremark Website	1-855-465-0023 www.caremark.com
Vision Plan (UHC)	
Vision Services Website	1-800-638-3120 www.myuhcvision.com
Dental Plan (UHC)	
Dental HMO Dental PPO and EPO Website	1-800-232-0990 1-877-816-3596 www.myuhcdental.com
COBRA (UHC)	
Membership Services Website	1-866-747-0048 www.uhcservices.com
Life Insurance (Standard Life)	
Membership Services Website	1-877-474-4250 or 214-670-4181 www.standard.com
Employee Assistance Program (EAP): OptumHealth	
Membership Services Website Access Code	1-800-586-6875 www.liveandworkwell.com/public CityofDallas
Deferred Compensation	
401K and 457 Plans (Fidelity) Website	1-800-343-0860 www.mysavingsatwork.com/atwork.htm
Employee Retirement Fund	
Phone Website	214-580-7700/1-877-246-1791 www.dallaserf.org
Dallas Police and Fire Pension	
Phone Website	1-800-638-3861 www.dpfp.org
Wellness	
WellAware Website	http://cod/HumanResources/WellAware/index.htm
Voluntary Benefits	
Colonial Life Membership Services Website **Aflac** Membership Services Website	 1-800-325-4368 www.coloniallife.com 972-480-0109/1-800-992-3522 www.aflac.com

City of Dallas Publication No. 12-13:51
Additional copies may be obtained from the Benefits Service Center.

About this Guide

This 2014 Benefits and Enrollment Guide describes, in non-technical language, the essential features of the City of Dallas Health Benefits Plan (The Plan). This Guide has been prepared as a reference only. It is not an official Master Plan Document for the City of Dallas Health Benefits Plan, which includes dental, vision, life and voluntary benefits. The terms and conditions of coverage under The Plan are determined solely by the Master Plan Document as adopted by the City of Dallas City Council. If there is a difference between what you read in this Guide and what you read in the official Summary Plan Document (SPD), the official Master Plan Document will govern.

City of Dallas

Human Resources Department
Benefits Service Center | 1500 Marilla Street, Room 1DS | Dallas, TX 75201
1-888-752-9122 (ph) | 1-888-202-5571 (fax)

The Benefits Service Center is open Monday through Friday from 8:15 a.m. to 5:15 p.m.

Photo: Courtesy of Getty Images

Retiree Benefits & Enrollment Guide

Human Resources Department
Benefits Service Center

City of Dallas

Table of Contents

Summary of Benefits and Coverage

As a retiree, the health benefits available to you represent a significant component of your retirement package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available on the Web at: http://dallascityhall.com/human_resources/benefits_employees.html and www.cityofdallasbenefits.com. A free, paper copy is also available by calling 1-888-752-9122.

Welcome to Benefits 2014!

Dear Retiree:

It is our pleasure to welcome you to 2014 Open Enrollment. The City of Dallas provides an annual open enrollment period for retirees to review their benefits coverage and make new elections for the upcoming year.

Important things to know regarding 2014 Open Enrollment:

- The retiree Open Enrollment period for 2014 starts **September 4, 2013**, and ends **October 11, 2013**.
- Open Enrollment will be **passive**. **If you are satisfied with your current benefit elections, no further action is required.**

To make changes to your benefits elections, or to enroll for 2014, contact the Benefits Service Center at 1-888-752-9122 or visit the office at: Dallas City Hall, 1500 Marilla, Room 1DS.

- Pre-65 Retirees (UHC Medical: EPO 70/30 and EPO 75/25 HRA Plan)
  - During Open Enrollment, you may call the Benefits Service Center 1-888-752-9122 or visit the office Monday through Friday from 7 a.m. to 7 p.m.
- Post-65 Retirees (AARP and UHC Medicare Rx Plans)
  - For AARP (plans C, F and K), call 1-800-392-7537.
  - For UHC Medicare Rx, contact the Benefits Service Center at 1-888-752-9122.
  - For UnitedHealthcare Group Medicare Advantage (High or Low Option), call 1-800-950-9355
- Retirees (UHC Dental and Vision)
  - Contact the Benefits Service Center at Dallas City Hall, 1500 Marilla Street, Room 1DS
- If you need to add or delete dependents, please contact the Benefits Service Center at 1-888-752-9122. Make sure that you have the required documentation to add your dependents. You may also fax your documents to 1-888-202-5571; please include your name and a call-back number on each faxed page to process your request.

What's New for 2014?

The City of Dallas has created a new medical plan that will include a combined medical and pharmacy deductible. If you are currently enrolled in the 70/30/$3,000 Deductible Plan, you will automatically be enrolled in the new **70/30/$3,000 Deductible Low Option Plan**. Please take notice of the changes to the high option, which include an increase in the pharmacy deductible from $150 to $240 and an increased out-of-pocket maximum (from $2,500 to $3,650). Please review the medical plan comparison chart more details.

The City of Dallas has also created a wellness incentive program for pre-65 retirees. WellPoints is the new, points-based incentive program designed to encourage pre-65 retirees enrolled in a City sponsored health plan to participate in health and wellness activities. These activities include an annual physical, the MyUHC online health assessment and preventive care screenings. You may also attend informative, health and wellness seminars presented by experts on current health and wellness topics or participate in online coaching, disease management or diabetes management programs. When you attend or participate in these wellness events or activities, you earn points. The total points you earn will help to determine the amount you will pay toward your 2015 medical plan premium. More information on this new program is provided in this benefits and enrollment guide.

The 2014 Retiree Benefits and Enrollment Guide provides details about your benefit options. Reviewing the material contained in this guide will help you make informed decisions about your benefits for 2014. If you have any questions, refer to the vendor contact information section to access our service providers.

We hope you will continue to be pleased with these programs and services as we endeavor to maintain a competitive benefits package for you and your family.

Sincerely,

City of Dallas Benefits Team

City of Dallas

City of Dallas

Dear City of Dallas Retiree:

Through the Affordable Care Act, Health Insurance Exchanges will be established across the country. Each state has the option to set up a state-based insurance Marketplace that will allow individuals and employers to easily compare and evaluate health insurance plans. The state of Texas has elected not to implement a state exchange, so the Health Insurance Exchange will be run by the Federal government. Enrollment in health coverage on the Marketplace will open on October 1, 2013, with plans effective on January 1, 2014. The Patient Protection and Accountable Care Act requires employers covered by the Fair Labor Standards Act (FLSA) to provide a notice to retirees prior to the beginning date of the Exchange.

On the following pages, you will find the Exchange Notice that notifies retirees about the exchanges. Please be advised that the City of Dallas plan meets the minimum value required for health plans; therefore, City retirees may not be eligible for a subsidy in the exchange. Specifically, the notice is designed to:

- ❑ Inform retirees about the existence of the Exchange and give a description of the services provided by the Exchange;
- ❑ Explain how retirees may be eligible for a premium tax credit or a cost-sharing reduction if the employer's plan does not meet certain requirements;
- ❑ Inform retirees that if they purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer-provided coverage, and that all or a portion of this employer contribution may be excludable for federal income tax purposes; and
- ❑ Include contact information for the Exchange and an explanation of appeal rights.

Should you have any questions about your coverage, or to get additional information about this form, please contact the Benefits Service Center at 1-888-752-9122.

Sincerely,

City of Dallas
Human Resources Department
Benefits Service Center

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on the premium that you are eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage you employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about the coverage offered by your employer, please check your summary plan description or contact the **City of Dallas Benefits Service Center at 1-888-752-9122**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name City of Dallas		4. Employer Identification Number (EIN)
5. Employer address 1500 Marilla St., 1DS		6. Employer phone number 1-888-752-9122
7. City Dallas	8. State Texas	9. ZIP code 75201
10. Who can we contact about employee health coverage at this job? The City of Dallas Benefits Service Center		
11. Phone number (if different from above)	12. Email address	

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

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:

    Full-time permanent employees and Permanent part-time employees

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    A spouse, children up to age of 26 years and grandchildren

  - ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

New Health Insurance Marketplace Coverage (Continued)

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much will the employee have to pay in premiums for that plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B©(2)(C)(ii) of the Internal Revenue Code of 1986)

Who is Eligible?

You may elect health coverage for you and your eligible dependents during the annual Open Enrollment period and through special enrollments as a result of a Qualifying Life Event. Eligible dependents include the following:

Type of Eligible Dependent	Required Documentation
Spouse	❑ Copy of Marriage License, Copy of Social Security Card, and Date of Birth ❑ If Common-Law Marriage applies, please provide the common-law form* and copies of documentation showing that you and your spouse have lived together for at least six months (provide two documents from list below). ■ Examples include copies of: ■ Lease or deed naming both partners ■ Joint checking account statement ■ Utility bills and/or credit accounts ■ Will and/or life insurance policies
Domestic Partner	❑ Domestic Partner Form** and copies of documentation showing that you and your partner have lived together for at least six months (provide two documents from list below). ■ Examples include copies of: ■ Lease or deed naming both partners ■ Joint checking account statement ■ Utility bills and/or credit accounts ■ Will and/or life insurance policies ❑ Copy of Social Security Card, and Date of Birth
Dependent Child: Child who is married or unmarried, under age 26 and is the biological child, legally adopted child or stepchild of you and/or your spouse, domestic partner or common-law spouse **Dependent Grandchild:** Grandchild who is married or unmarried, under age 26 and is the biological grandchild of you and/or your spouse, domestic partner or common-law spouse	❑ Copy of Birth Certificate showing you as a parent, or ❑ Copy of Adoption Agreement, or ❑ Copy of court custody or guardianship documents, or ❑ Copy of the portion of the divorce decree showing the dependent, or ❑ Copy of Qualified Medical Court Support Order (QMCSO), and ❑ Copy of Social Security Card

*For the Common-Law Spouse Form, go to http://www.dallascounty.org/department/countyclerk/marriage-license.html.

**For the Domestic Partner Form, contact the Benefits Service Center at 1-888-752-9122.

Please note: Your dependents (spouse and children) cannot be covered on a plan if you are not covered.

Making Changes to Your Benefits During the Year (Outside the Open Enrollment Period)

The Internal Revenue Service (IRS) requires that you make benefits elections during our annual Open Enrollment period for your benefits to be effective during the 2014 plan year. You may not change your benefits elections after Open Enrollment unless you experience a **Qualifying Life Event**, which may include:

- ❑ Marriage
- ❑ Divorce, Legal Separation or Annulment
- ❑ Birth or Adoption of an Eligible Child
- ❑ Change in your (or your spouse's) work status that affects benefits eligibility (e.g., change from full-time to part-time employment status)
- ❑ A change in your child's benefits eligibility
- ❑ A Qualified Medical Child Support Order

Making Changes to Your Benefits (Continued)

You must report your Qualifying Life Event to the Benefits Service Center **within 30 days** of that event with the required documentation to support your claim. If you fail to report your Qualifying Life Event within the required timeframe, you must wait until the next annual Open Enrollment to change your benefits elections.

If your dependent does not meet the current eligibility rules during the specified period, and/or you do not provide the required documentation, your dependent(s) will not be added to your benefits plan.

Reminders

To enroll in a benefits plan or change your current plan, please remember:

1. The Open Enrollment period for 2014 starts **September 4, 2013**, and ends **October 11, 2013**.
2. You must report a Qualifying Life Event **within 30 days of that event** to change your benefits plan.
3. New retirees must enroll in a benefits plan within 30 days of their retirement date; otherwise, they forfeit coverage.

Non-Medicare Eligible Retiree Information

Enrollment Period: September 4, 2013, through **October 11, 2013**

We encourage you to enroll early in this period to avoid the high volume of activity that occurs late in the enrollment period.

Enrollment Method and Instructions:

- ❑ Annual Enrollment will be **passive**, meaning that retirees who do not wish to make any benefit election changes do not have to participate; their current plan—consisting of Medical (Pre- and Post-65, Dental and Vision)—will roll over into the new plan year.
- ❑ If you would like to make changes to your existing plans or enroll in Colonial's voluntary benefits (Pre-65 only) for 2014, you must contact the Benefits Service Center (Monday through Friday, 7 a.m. to 7 p.m.) at 1-888-752-9122 to enroll during Open Enrollment.
- ❑ To update your dependent information for 2014, please contact the Benefits Service Center. Please have the required documentation available to add dependents. You may fax these documents to 1-888-202-5571. Please write your name and a call-back number on each faxed page.
- ❑ If you make benefit elections by calling the Benefits Service Center, it will be treated as an agreement to pay any required premium through pension check deductions. If you call and experience a long hold time, please leave a voicemail message with a daytime call-back number. Your call will be returned within two business days. Spanish-speaking assistance will be available.

Verification of Personal Information

To receive your identification cards promptly, make sure that the Benefits Service Center maintains your correct address in the City's Human Resources Information System (HRIS). You may call the Benefits Service Center at 1-888-752-9122 to report an address change or other corrections.

How to Enroll for New Retirees after Open Enrollment

If you are planning to retire in 2014, call or make an appointment with the Benefits Service Center before your retirement date to discuss retiree enrollment options and payroll deductions. You must enroll within 30 days of your date of retirement. You may be asked to pay the first two months' retiree health premiums in advance, depending on the date of retirement. If you do not enroll within 30 days of your retirement date, the Benefits Service Center will presume that you have waived your retiree coverage with the City of Dallas. **You will not be eligible to participate in the City's health coverage in the future.**

How to Enroll for New Retirees after Open Enrollment (Continued)

If you enroll in retiree coverage, that coverage is effective on the first day of the month following your termination date with the City. Upon retirement, all life insurance benefits will end unless you exercise your right to convert your coverage to an individual plan. Please contact the Benefits Service Center for additional information.

When turning age 65, you should follow four steps:

1. **Notify the Benefits Service Center within 30 days of your birthday.**
   Within 30 days of reaching age 65, you and/or your covered spouses must report the change in age to the Benefits Service Center. If a rate adjustment is required as a result of your and/or your spouse turning age 65, the rate adjustment/reduction will be made the month following the birthday month of you and/or your spouse—provided the age change is reported to the Benefits Service Center before the first day of the month in which you and/or your spouse turn age 65. The effective rate before turning age 65 will be charged for the month you and/or your covered spouse turned age 65.

2. **Enrollment in Medicare Parts A and B**
   Three months before you turn age 65, contact your local Social Security Administration Office to enroll in Medicare Parts A and B.
   - ❑ Retirees and/or their covered spouses must enroll in Medicare Parts A and B at age 65 as a requirement of medical coverage through the City's benefit programs. Contact the Benefits Service Center if you or your spouse is not otherwise qualified for premium-free Medicare Part A coverage due to quarters earned through your employment or your spouse's employment.
   - ❑ Retirees must pay the full cost of the monthly premium for Medicare Part B. Medicare may charge a penalty to retirees who delay enrollment in Medicare Part B at the time of initial eligibility.
   - ❑ If a retiree waives coverage in a City sponsored health plan, the retiree will not be eligible for inclusion of Medicare Part A premium payments to be made on their behalf by the City of Dallas. Contact your local Social Security Administration office or go to www.ssa.gov to enroll and determine eligibility.

3. **Enrollment in Medicare Supplement Plans**
   Once you have enrolled in Medicare Parts A and B, and become Medicare-eligible, you are no longer eligible to participate in the City's health plans. You must enroll in a medical supplement plan offered by the City. We suggest that you consider adding drug coverage since the Medicare Supplement Plan does not include prescription drug coverage. You have an option to either enroll in the City's Medicare Part D Plan or one of the Medicare Part D plans offered by various private insurance carriers. We strongly urge that you consider your personal needs before selecting any drug coverage option plan.

4. **Enrollment in one of the Medicare Supplement plans is a two-step process.**
   To enroll in Medicare Supplement plans C, F or K, contact the Medicare Supplement Enrollment Center at 1-800-392-7537, and request an enrollment kit. During the call, please state that you are a City of Dallas retiree. Read and sign the application, and mail it back to the Medicare supplement provider within 14 days. You may also enroll over the phone once you have received your enrollment kit by calling 1-800-392-7537. Your application will not be complete until it has been received by the Medicare supplement provider. They will provide an enrollment card once your application has been approved. Contact the Benefits Service Center to inform them that you are enrolling in the Medicare Supplement Plan C, F or K. If you wish to enroll in the City's Medicare Part D Plan, you must provide your Medicare claim number.

How to Enroll When Turning Age 65 (continued)

Medicare Eligible Retiree Information

Enrollment Types:

- ❑ The post-65 benefits enrollment process will be passive, meaning you do not have to participate if you are satisfied with your current coverage (AARP Plans C, F and K ; Medicare Part D; Dental and Vision plans).
- ❑ If you are currently enrolled in the 75/25/HRA or the 70/30/3000 medical plans, you must contact your local Social Security Administration office to sign up for Medicare Parts A and B—that is, if you have not already completed this step. If you have already signed up, you must contact AARP to enroll in a supplemental plan (C, F or K), and you should contact the Benefits Service Center to enroll in Medicare Part D (prescription drugs). Post-65 members cannot be enrolled in the 75/25/HRA plan or the 70/30/3000 plan beginning January 1, 2014.

Enrollment Method and Instructions:

- ❑ Open Enrollment for 2014 will be passive (you do not participate if you are satisfied with your current benefits elections, including Medical, Dental and Vision).

Post-65 Retirees (AARP and UHC Medicare Rx Plans):

- ❑ For AARP (Plans C, F and K), call 1-800-449-4954.
- ❑ For UHC Medicare Rx, call the Benefits Service Center (1-888-752-9122) or visit the center at Dallas City Hall, Room 1DS.
- ❑ For UnitedHealthcare Group Medicare Advantage (High or Low Option), call 1-800-950-9355.

Retirees (UHC Dental and Vision):

- ❑ Call the Benefits Service Center (1-888-752-9122) or visit the center at 1500 Marilla Street, Room 1DS.

Dependent Information

To update your dependent information for 2014, please take one of the following steps:

1. Call the Benefits Service Center and speak with a customer service representative to remove a dependent(s).
2. To add a dependent, contact the Benefits Service Center; please provide documentation as listed on the Eligible Dependent chart (refer to page 5).
3. If you do not plan to make changes, no action is required. Please check your current information for accuracy.
   - ❑ Elections made by calling the Benefits Service Center will be treated as an agreement to pay any required premium through pension check deductions.
   - ❑ Should you experience long hold time when calling, leave a voicemail message with a daytime telephone number. A customer service representative will call you back within two business days. Spanish-speaking assistance is available.

Verification of Personal Information

To receive your identification cards promptly, make sure that your current mailing address is correct in the City's Human Resources Information System (HRIS). You may call the Benefits Service Center at 1-888-752-9122 to report an address change or other corrections.

Changing your Benefits During the Year (Qualified Status Change)

You can only change your benefit elections during the plan year if you undergo a qualified status change as defined by Internal Revenue Service guidelines. Your enrollment changes must be completed within 30 days of the qualifying event. If you fail to change your elections within 30 days of your event, you will have to wait until the next year's annual enrollment period to change your elections.

How to Enroll When Turning Age 65 (continued)

Reporting Eligibility Changes During the Year

You must report changes in dependent eligibility to the Benefits Service Center at 1-888-752-9122 within 30 days of the change (such as divorce, marriage or dependent child becoming ineligible). All status changes must be made within 30 days of the status change. If you are adding a spouse or dependent to your coverage, appropriate documentation will be required.

Special Note

If you cancel your medical coverage as a retiree, you or your dependents may not re-enroll in any City-Sponsored medical plans in the future.

Duplicate Medical Coverage by Retiree

In the case where two city retirees are eligible for coverage, only one may enroll for dependent coverage. Both retirees cannot cover each other. In the case both retirees have eligible dependents, only one retiree can cover the dependents. Both retirees cannot cover their eligible dependents. If a retiree and his or her spouse are employed or retired from different employers, and are covered by the same insurance carrier, the health plan will pay only up to the allowable.

Important Disclaimers

Paying for Medical Coverage

Medical contributions are paid on a post-tax basis for all retirees. Your annual cost of medical coverage depends on the benefit option you choose and the level of coverage you need. Contribution costs for 2014 can be found in this benefits and enrollment guide.

- ❑ Contributions shall be paid by pension check deduction by all Members who receive pension checks in sufficient amount to permit deduction for the contributions. For each regular pension check during the plan year a member will pay the monthly rates indicated in Article IV of the Master Plan Document. If for any reason a Member's pension check is not reduced by the amount of a contribution or does not receive pension check with a sufficient amount to permit deduction for the contributions, contributions must be paid by check or money order on a monthly basis.
- ❑ For each regular pension check during the plan year a member will pay the monthly rates indicated in this enrollment guide.
- ❑ A grace period of thirty days shall be allowed for the payment of each contribution paid directly by the member. If any contribution is not paid within the grace period, the coverage shall terminate on the last date for which contributions are paid.
- ❑ Dropping Coverage: If the notice for dropping coverage is received prior to the 15th of the month, deductions will not be taken and coverage will end the last day of the previous month. If the notice for dropping dependent coverage is received after the 15th of the month, deductions and coverage will be discontinued the first day of the following month.

Benefits Information for Certain Medicare-eligible Retirees

For certain, Medicare-eligible retirees, the City will continue to offer its Medicare Supplements, Medicare HMO and Medicare Part D benefit options. If you have any questions, please contact the benefits provider. In the next few months, you will receive a letter from your Medicare Part D provider to alert you of the following information.

- ❑ Annual Notice of Change (ANOC), which will include:
  - 2014 Formulary List
  - Summary of Benefits
  - Mail-order information
  - Pharmacy Directory
- ❑ Explanation of Benefits (EOB)
- ❑ Explanation of Coverage (EOC)

The documents listed above will require no action on your part because you are already enrolled. However, if you receive a Late Enrollment Penalty Letter, you are required to complete and return as instructed in the letter. For help in completing this letter, please call the City of Dallas Benefits Service Center at 1-888-752-9122.

WELLPOINTS (Pre-65 Retirees Only)

WellPoints is the wellness incentive program for City of Dallas pre-65 retirees enrolled in a City sponsored health plan. By participating in WellPoints, you will help lower your 2015 medical plan premium and earn extra cash toward your HRA. To earn a reduced medical premium for 2015, you must earn a **minimum of 250 wellness points**.

To participate, you must be enrolled in a City sponsored health plan.

Pre-65 retirees may earn WellPoints for the 2015 benefits year starting October 1, 2013, and ending August 31, 2014.

Please use the program guide on the following page to determine how to earn wellness points.

For more information:

City of Dallas
Human Resources Department
Benefits Service Center
1500 Marilla Street, Room 1D-South
Dallas, Texas 75201
(Phone) 1-888-752-9122
(Email) wellness@dallascityhall.com
(Web) www.cityofdallasbenefits.com

Wellness Program Disclosure
If it is unreasonably difficult for you to achieve the standards for a reward under the wellness program due to a medical condition, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the Benefits Service Center at 1-888-752-9122, and we will work with you to develop another way to qualify for the reward.

HOW TO EARN WELLPOINTS (Pre-65 Retirees)

GOAL: 250 POINTS

Pre-65 retirees who wish to participate in WellPoints must complete the Engagement category, which is worth 150 points. The remaining points can be acquired through participating in events or activities listed under options one, two and three.

ENGAGEMENT (REQUIRED)

The Engagement component consists of the following:

- ☐ You **must** perform both Engagement activities to participate in WellPoints.
- ☐ MyUHC Online Health Assessment* (50 Points)
  - Go to www.myuhc.com to complete the assessment.
- ☐ Annual Physical Exam* (100 Points)
  - Includes BMI, Blood Pressure, Fasting LDL and Fasting Glucose

***REQUIRED**

OPTION 1

Take Action (Max: 100 Points)

- ☐ Each program worth 100 points
- ☐ Two Options: Disease Management and YMCA Diabetes Prevention
  - Disease Management Program
    - Four Program Options: Asthma, Diabetes, Coronary Artery Disease, and Heart Failure
    - Eligible participants will receive an outreach call from a UnitedHealthcare nurse.
  - YMCA Diabetes Prevention Program

OPTION 2

Behavior Change (Max: 50 Points)

- ☐ Qualifying activities are approved by the City of Dallas WellAware Program.
- ☐ Some qualifying activities are conducted independently through nationally recognized health and fitness programs and community events approved by WellAware Program.
- ☐ Each activity worth 25 points (Max: 50 Points)
- ☐ Activities include self-reported activity tracking of exercise; gym membership; water aerobics; ballroom dancing; and WellAware-approved and/or sponsored activities and races.
- ☐ Verification of participation in Behavior Change activities includes exercise verification forms, receipt of participation in community events, copy of event bib or a photo of a pre-65 retiree participating in a race.

OPTION 3 (REASONABLE ALTERNATIVES)

You may participate in the following reasonable alternatives:

Education

- ☐ Pre-65 retirees have access to free, monthly health and wellness seminars, health fairs and other wellness events sponsored by WellAware.
- ☐ Each activity is worth 10 points (Max: 50 Points).

Online Coaching

- ☐ Earn 25 points per program
- ☐ You can participate in up to two programs (Max: 50 Points)
  - Please allow yourself enough time to complete online programs; some programs may take longer to complete than others.

How to Earn WellPoints (Continued)

To access an online coaching program:

1. Log onto www.myuhc.com
2. Click on the Health & Wellness tab
3. Select the "I DO" icon

- ❑ Each online program consists of 12 educational activities and 5 tracker entries within an online program.
- ❑ You are required to make one tracker entry per week for 5 weeks and complete 12 activities per online program.
- ❑ Please allow yourself enough time to complete each online wellness coaching program; some programs may take longer to complete than others.
- ❑ Up to two programs may count toward your WellPoints total (Max: 50 Points)

City of Dallas

WELLPOINTS

PRE-65 RETIREE

Annual Physical Exam Verification

This form is to be used by eligible City of Dallas pre-65 retirees who would like to submit verification that they received an annual physical exam as part of their participation in the WellPoints Wellness Incentive Program.

This following form is required ONLY if you have received your annual physical exam through an out-of-network physician or if you plan to use an out-of-network physician to complete your annual physical exam.

Please submit the Annual Physical Verification Form to the
Benefits Service Center no later than **August 31, 2014**.

Instructions for Physician:

Complete Section 2 of the form and return it to the patient (pre-65 retiree) for submission.

Instructions for City of Dallas Pre-65 Retiree:

Use this form ONLY if you plan to complete your annual physical exam using an out-of-network physician or Concentra TotalCare Health and Wellness Center at Dallas City Hall.

Complete Section 1 of the form—including signature—and present the form to your physician at your medical appointment. Instruct the physician to complete the required information.

You must submit the completed from directly to the Benefits Service Center.

Benefits Service Center
Dallas City Hall
1500 Marilla Street, Room 1DS
Dallas, TX 75201
(Phone) 1-888-752-9122
Hours: 8:15 a.m. to 5:15 p.m. (Monday through Friday)

WellAware

Your Health Matters

City of Dallas Employee Wellness Program

City of Dallas **Annual Physical Exam Verification**

WELLPOINTS
PRE-65 RETIREE

Dear Physician:

The City of Dallas has initiated a new wellness incentive program called **WellPoints**. As a WellPoints participant, a pre-65 retiree can receive incentives through maintaining a healthy lifestyle. To participate in WellPoints, the pre-65 retiree must complete an annual physical.

Physician: Please complete Section 2. The pre-65 retiree must return the completed from to the City of Dallas Benefits Service Center upon your completion. **This form is required ONLY if you are an out-of-network physician.**

Patient: This form must be submitted no later than August 31, 2014. **Please Note**: If your physician is in-network, you are not required to return this form to the Benefits Service Center.

SECTION 1: PATIENT INFORMATION (Patient: Complete this section. Please print.)

First Name: _____ Last Name: _____

Employee ID: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____)_____-_____

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Age: _____

Signature: _____ Date: _____/_____/_____

PATIENT: This form must be submitted no later than August 31, 2014.

SECTION 2: ANNUAL PHYSICAL EXAM VERIFICATION

PHYSICIAN: Your signature below confirms that the pre-65 retiree has received an annual physical exam.

Physician Signature: _____ Date: _____/_____/_____

Your Core Benefits

The following core benefits are sponsored by the City of Dallas:

- Medical Insurance
- Pharmacy
- Dental Insurance
- Vision Insurance
- Medicare Plan

Medical Plans Overview

Retiree EPO 75/25 HRA Medical Plan Comparison Chart (In-Network Benefits Only)		
	Health Assessment Completed	**Health Assessment NOT Completed**
Total Deductible	$2500 (single)	$2500 (single)
HRA Allocation (City $$)	$1000 (single)	$700 (single)
Deductible (Your $$)	$1500 (single)	$1800 (single)
Total Deductible	$5000 (with dep(s)	$5000 (with dep(s)
HRA Allocation (City $$)	$2000 (with dep(s)	$1700 (with dep(s)
Deductible (Your $$)	$3000 (with dep(s)	$3300 (with dep(s)
Coinsurance	Member pays 25%; plan pays 75%	Member pays 25%; plan pays 75%
Preventive Services (See SPD for Injections)	Plan pays 100% (in-network only) Doesn't reduce HRA	Plan pays 100% (in-network only) Doesn't reduce HRA
Outpatient Services	Plan pays 75% after deductible	Plan pays 75% after deductible
Inpatient Services	Plan pays 75% after deductible	Plan pays 75% after deductible
ER Services at hospital (See SPD for Ambulance services)	Plan pays 75% after deductible	Plan pays 75% after deductible
Specialist Services & Urgent Care Services	Plan pays 75% after deductible	Plan pays 75% after deductible
Out-of-Pocket Max	$6,350 (single) $12,700 (with deps)	$6,350 (single); $12,700 (with deps)
Rx Coverage (CVS/Caremark):		
Deductible	Same as (Your $$) deductible above	Same as (Your $$) deductible above
Generic (31 days)	10%	10%
Preferred (31 days)	25%	25%
Non-Preferred (31 days)	40%	40%

Retiree EPO 75/25 HRA Medical Plan Monthly Rates (Non-Tobacco User)		
Retiree Rates	**Health Assessment Completed**	**Health Assessment NOT Completed**
Retiree Only	$509	$529
Retiree + Spouse	$1,166	$1,186
Retiree + Child(ren)	$812	$832
Retiree + Family	$1,439	$1,459
Spouse Only	$785	$805
Spouse + Child(ren)	$1,058	$1,078

Retiree EPO 75/25 HRA Medical Plan Monthly Rates (Tobacco User)		
Retiree Rates	**Health Assessment Completed**	**Health Assessment NOT Completed**
Retiree Only	$529	$549
Retiree + Spouse	$1,186	$1,206
Retiree + Child(ren)	$832	$852
Retiree + Family	$1,459	$1,479
Spouse Only	$805	$825
Spouse + Child(ren)	$1,078	$1,098

Retiree EPO 70/30 High Option Plan Comparison Chart (In-Network benefits only)	
Total Deductible	$3000 (single); $9000 (with dep(s)
HRA Allocation (City $$)	N/A
Deductible (Your $$)	Same as Total Deductible
Coinsurance	Member pays 30%; plan pays 70%
Preventive Services (See SPD for Injections)	Plan pays 100%
Outpatient Services	Plan pays 70% after deductible
Inpatient Services	Plan pays 70% after deductible
ER Services at hospital (See SPD for Ambulance services)	$100 Copay plus plan pays 70% after deductible
Specialist Services & Urgent Care Services	Plan pays 70% after deductible
Out-of-Pocket Max	$6,350 (single); $12,700 (with dep(s)
Rx Coverage (CVS/Caremark):	
Deductible	$240/person
Generic (31 days)	10% or $10 minimum
Preferred (31 days)	25% or $25 minimum
Non-Preferred (31 days)	40% or $40 minimum
Out-of-Pocket Max	$3,650/person

Retiree EPO 70/30 High Option Plan Monthly Rates (Non-Tobacco User)		
Retiree Rates	**Health Assessment Completed**	**Health Assessment NOT Completed**
Retiree Only	$434	$454
Retiree + Spouse	$1,053	$1,073
Retiree + Child(ren)	$675	$695
Retiree + Family	$1,286	$1,306
Spouse Only	$772	$792
Spouse + Child(ren)	$1,013	$1,033

Retiree EPO 70/30 High Option Plan Monthly Rates (Tobacco User)		
Retiree Rates	**Health Assessment Completed**	**Health Assessment NOT Completed**
Retiree Only	$454	$474
Retiree + Spouse	$1,073	$1,093
Retiree + Child(ren)	$695	$715
Retiree + Family	$1,306	$1,326
Spouse Only	$792	$812
Spouse + Child(ren)	$1,033	$1,053

Retiree EPO 70/30 Low Option Plan Comparison Chart (In-Network benefits only)	
Total Deductible	$3000 (single); $9000 (with dep(s)
HRA Allocation (City $$)	N/A
Deductible (Your $$)	Same as total deductible
Coinsurance	Member pays 30%; plan pays 70%
Preventive Services (See SPD for Injections)	Plan pays 100%
Outpatient Services	Plan pays 70% after deductible
Inpatient Services	Plan pays 70% after deductible
ER Services at hospital (See SPD for Ambulance services)	$100 Copay plus plan pays 70% after deductible
Specialist Services & Urgent Care Services	Plan pays 70% after deductible
Out-of-Pocket Max	$6,350 (single); $12,700 (with dep(s)
Rx Coverage (CVS/Caremark):	
Deductible	Same as (Your $$) deductible above
Generic (31 days)	10% or $10 minimum
Preferred (31 days)	25% or $25 minimum
Non-Preferred (31 days)	40% or $40 minimum
Out-of-Pocket Max	$6,350 (single); $12,700 (with dep(s)

Retiree EPO 70/30 Low Option Plan Monthly Rates (Non-Tobacco User)		
Retiree Rates	**Health Assessment Completed**	**Health Assessment NOT Completed**
Retiree Only	$409	$429
Retiree + Spouse	$1,028	$1,048
Retiree + Child(ren)	$650	$670
Retiree + Family	$1,261	$1,281
Spouse Only	$747	$767
Spouse + Child(ren)	$988	$1,008

Retiree EPO 70/30 Low Option Plan Monthly Rates (Tobacco User)		
Retiree Rates	**Health Assessment Completed**	**Health Assessment NOT Completed**
Retiree Only	$429	$449
Retiree + Spouse	$1,048	$1,068
Retiree + Child(ren)	$670	$690
Retiree + Family	$1,281	$1,301
Spouse Only	$767	$787
Spouse + Child(ren)	$1,008	$1,028

Prorated HRA Funds

(Based on the month of enrollment)

Month	Retiree Only	Retiree & Dependents
January	$700.00	$1,700.00
February	$641.67	$1,558.33
March	$583.34	$1,416.66
April	$525.01	$1,274.99
May	$466.68	$1,133.32
June	$408.35	$991.65
July	$350.02	$849.98
August	$291.69	$708.31
September	$233.36	$566.64
October	$175.03	$424.97
November	$116.70	$283.30
December	$58.37	$141.63

Onsite Health Clinic Medical Plan Services

Concentra TotalCare Health and Wellness Center is the on-site medical clinic located at Dallas City Hall. The center offers select preventive and diagnostic services to pre-65 retirees and dependents (age 5 and older) covered by the City's health plan at no cost.

Onsite Clinic Services for Retirees Enrolled in City of Dallas Medical Plans

Visit Description	EPO 75/25 HRA Plan	EPO 70/30 Plan
Preventive Care Services ❑ Services provided at onsite clinic ❑ Lab services that are sent out to LabCorp will be processed according to your medical plan benefits.	❑ No cost to retirees or dependents ❑ Paid at 100%	❑ No cost to the retiree or dependents ❑ Paid at 100%
Injury or Illness Care: **Diagnostic Services** ❑ Service provided at onsite clinic ❑ Lab services that are sent out to LabCorp will be processed according to your medical plan benefits	❑ No cost to retirees or dependents ❑ Services are subject to 25% coinsurance after $2,500 deductible is met; HRA funds will be used if still available	❑ No cost to retirees or dependents ❑ Services are subject to 30% coinsurance after $3,000 deductible is met

Concentra TotalCare Health and Wellness Center | 1500 Marilla, Room 1CS, Dallas, TX 75201
Phone: 214-671-9140 | Fax: 214-749-0412 | Hours: Monday through Friday, 7:30 a.m. to 5:30 p.m.

Concentra urgent care

We're here. For you.
Concentra.com

Concentra/City of Dallas Discount Program

The Concentra/City of Dallas Discount Program allows City employees and pre-65 retirees covered by the City's health insurance to visit any Concentra Urgent Care Center in the greater Dallas area and receive unmatched medical service at an unmatched price. City employees and pre-65 retirees covered by a City health insurance plan may continue to use Concentra TotalCare Health and Wellness Center in City Hall and pay nothing for most services, which include treatment for common injuries and illnesses such as sprains, cuts, flu and upper respiratory infection.

If You Are:	Concentra (Dallas City Hall)	Concentra (DFW Metroplex)
Active Employee Covered by City Health Plan	Cost: $0[1]	Cost: $25[1*]/$35[1**]
Active Employee NOT Covered by City Health Plan	Cost: $25[1]	Not Eligible for Discount
Pre-65 Retiree Covered by City Health Plan	Cost: $0[1]	Cost: $25[1*]/$35[1**]
Pre-65 Retiree NOT Covered by City Health Plan	Not Eligible for Discount	Not Eligible for Discount
Medicare-eligible Retiree	Not Eligible for Discount	Not Eligible for Discount

[1] You may incur additional charges for services such as lab work and X-rays during your clinic visit.
[*]Copay for 75/25 HRA Plan Enrollees [**]Copay for 70/30 Plan Enrollees

Choose from several locations throughout the DFW Metroplex:			
Addison 15810 Midway Rd. Addison, TX 75001 Hours: 8 a.m.- 8 p.m.(M-F) 8 a.m. - 5 p.m. (Sat) Phone: 972-458-8111 Fax: 972-458-7776	**Arlington North** 2160 E. Lamar Blvd. Arlington, TX 76006 Hours: 8 a.m. - 5 p.m. (M-F) 9 a.m. - 5 p.m. (Sat/Sun) Phone: 972-988-0441 Fax: 972-641-0054	**Arlington South** 511 E. 1-20 Arlington, TX 76018 Hours: 8 a.m. - 8 p.m. (M-F) 9 a.m. - 5 p.m. (Sat/Sun) Phone: 817-261-5166 Fax: 817-275-5432	**Burleson** 811 NE Alsbury Blvd., Suite 800 Burleson, TX 76028 Hours: 8 a.m. - 8 p.m. (M-F) 8 a.m. - 5 p.m. (Sat) Phone: 817-293-7311 Fax: 817-551-1066
Carrollton 1345 Valwood Pkwy., Suite 306 Carrollton, TX 75006 Hours: 8 a.m. - 5 p.m. (M-F) Phone: 972-484-6435 Fax: 972-484-6785	**Fort Worth Forest Park** 2500 West Fwy. (I-30), Suite 100 Fort Worth, TX 76102 Hours: 8 a.m. - 8 p.m. (M-F); 8 a.m. - 5 p.m. (Sat) Phone: 817-882-8700 Fax: 817-882-8707	**Fort Worth Fossil Creek** 4060 Sandshell Drive Fort Worth, TX 76137 Hours: 8 a.m. - 5 p.m. (M-F) Phone: 817-306-9777 Fax: 817-306-9780	**Frisco** 8756 Teel Pkwy., Suite 350 Frisco, TX 75034 Hours: 8 a.m.- 8 p.m.(M-F) 8 a.m. - 5 p.m. (Sat)/ 9 a.m. - 5 p.m. (Sun) Phone: 972-712-5454 Fax: 972-712-5442
Garland 1621 S. Jupiter Rd., Suite 101 Garland, TX 75042 Hours: 8 a.m. - 5 p.m. (M-F) Phone: 214-340-7555 Fax: 214-340-3980	**Irving/Las Colinas** 5910 N. MacArthur Blvd., Suite 133 Irving, TX 75039 Hours: 8 a.m.- 8 p.m.(M-F) 8 a.m. - 5 p.m. (Sat) Phone: 972-554-8494 Fax: 972-438-4647	**Lewisville** 2403 S. Stemmons Fwy., Suite 100 Lewisville, TX 75067 Hours: 8 a.m.- 8 p.m.(M-F) 9 a.m. - 5 p.m. (Sat/Sun) Phone: 972-829-2999 Fax: 972-459-7929	**Mesquite** 4928 Samuell Blvd. Mesquite, TX 75149 Hours: 8 a.m.– 5 p.m.(M-F) Phone: 214-328-1400 Fax: 214-328-2884
Plano 1300 N. Central Expy. Plano, TX 75074 Hours: 8 a.m.- 8 p.m.(M-F) 8 a.m. - 5 p.m. (Sat) Phone: 972-578-2212 Fax: 972-881-7666	**Redbird** 5520 Westmoreland, Suite 200 Dallas, TX 75237 Hours: 8 a.m. - 5 p.m. (M-F) Phone: 214-467-8210 Fax: 214-467-8192	**Stemmons** 2920 N. Stemmons Fwy. Dallas, TX 75247 Hours: 8 a.m. - 8 p.m. (M-F) 9 a.m. - 5 p.m. (Sat/Sun) Phone: 214-630-2331 Fax: 214-905-1323	**Upper Greenville** 5601 Greenville Ave. Dallas, TX 75206 Hours: 8 a.m.- 8 p.m. (M-F) 9 a.m. - 5 p.m. (Sat/Sun) Phone: 214-821-6007 Fax: 214-821-6149

CVS Caremark Prescription Benefit Program

HRA Plan

Welcome to your new prescription benefit administered by CVS Caremark. Your prescription benefit is designed to bring you quality pharmacy care that will help you save money.

Following is a brief summary of your prescription benefits. On the back side, you will find details about your prescription benefit plan, which offers two ways for you to save on your long-term medications. CVS Caremark and the City of Dallas are confident you will find value with your new prescription benefit program.

	CVS Caremark Retail Pharmacy Network For short-term medications (Up to a 31-day supply)	**CVS Caremark Mail Service Pharmacy or CVS Caremark Retail-90 Pharmacy** For long-term medications (Up to a 90-day supply)
Where	The CVS Caremark Retail Network includes more than 67,000 participating pharmacies nationwide, including independent pharmacies, chain pharmacies, and 7,400 CVS/pharmacy locations. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-855-465-0023.	You have the convenience of getting your long-term medications at one of our 51,000 Retail-90 Pharmacy locations for your mail service copay. Or simply mail your original prescription and the mail service order form to CVS Caremark. Your medications will be sent directly to your home, office or a location of your choice.
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**10%** for a generic prescription	**10%** for a generic prescription
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	**25%** for a preferred brand-name prescription	**25%** for a preferred brand-name prescription
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	**40%** for a non-preferred brand-name prescription	**40%** for a non-preferred brand-name prescription
Refill Limit	None	None
Annual Deductible	$2,500 for an individual / $5,000 for a family	
Maximum Out-of-Pocket	$6,350 for an individual / $12,700 for a family	
Web Services	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card ready.	
Customer Care	Visit www.caremark.com or call toll-free at 1-855-465-0023.	

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

CVS Caremark Prescription Benefit Program (Continued)

HRA Plan

Use This Plan to Fill Your Long-Term Medications

This plan offers you choice and savings when it comes to filling long-term prescriptions. Now you have two ways to save:

CVS Caremark Mail Service Pharmacy:
- ❑ Enjoy convenient home delivery
- ❑ Receive your medications in private, tamper-resistant and (when needed) temperature-controlled packaging
- ❑ Talk to a pharmacist by phone

Retail-90 Pharmacy:
- ❑ Pick up your medication at a time that is convenient for you
- ❑ Enjoy same-day prescription availability
- ❑ Talk with a pharmacist face-to-face

Plus, you can easily order refills and manage your prescriptions anytime at www.caremark.com.

To Get Started
The following chart provides detailed steps to help you start enjoying all the benefits of your prescription benefit plan.

IF YOU WOULD LIKE...	THEN...
To continue with mail service	You don't have to do anything. We'll continue to send your medications to your location of choice.
To pick up at CVS/pharmacy	Please let us know. You can do so quickly and easily. Choose the option that works best for you: • Visit your local Retail-90 Pharmacy and talk to the pharmacist • Call us toll-free using the number on the back of your Prescription Card, and we'll handle the rest
To sign up for mail service for the first time	You can do so easily online or by phone. • Register or log into www.caremark.com, select "Start a New Prescription," then click on "FastStart®" • Call FastStart toll-free at 1-800-875-0867. We'll handle the rest
More information	Give us a call. Use the phone number on the back of your Prescription Card to call us toll-free.

CVS Caremark Prescription Benefit Program

70/30 Plan

Welcome to your new prescription benefit administered by CVS Caremark. Your prescription benefit is designed to bring you quality pharmacy care that will help you save money.

Following is a brief summary of your prescription benefits. On the back side, you will find details about your prescription benefit plan, which offers two ways for you to save on your long-term medications. CVS Caremark and the City of Dallas are confident you will find value with your new prescription benefit program.

	CVS Caremark Retail Pharmacy Network For short-term medications (Up to a 31-day supply)	**CVS Caremark Mail Service Pharmacy or CVS Caremark Retail-90 Pharmacy** For long-term medications (Up to a 90-day supply)
Where	The CVS Caremark Retail Network includes more than 67,000 participating pharmacies nationwide, including independent pharmacies, chain pharmacies, and 7,400 CVS/pharmacy locations. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-855-465-0023.	You have the convenience of getting your long-term medications at one of our 51,000 Retail-90 Pharmacy locations for your mail service copay. Or simply mail your original prescription and the mail service order form to CVS Caremark. Your medications will be sent directly to your home, office or a location of your choice.
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**10% ($10 min)** for a generic prescription	**10% ($10 min)** for a generic prescription
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	**25% ($25 min)** for a preferred brand-name prescription	**25% ($25 min)** for a preferred brand-name prescription
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	**40% ($40 min)** for a non-preferred brand-name prescription	**40% ($40 min)** for a non-preferred brand-name prescription
Refill Limit	None	None
Annual Deductible	$240 (High Option) for an individual $3,000 (Low Option) for an individual	
Maximum Out-of-Pocket	$3,650 (High Option) $6,350 (Low Option)	
Web Services	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card ready.	
Customer Care	Visit www.caremark.com or call toll-free at 1-855-465-0023.	

Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

CVS Caremark Prescription Benefit Program (Continued)

70/30 Plan

Use This Plan to Fill Your Long-Term Medications

This plan offers you choice and savings when it comes to filling long-term prescriptions. Now you have two ways to save:

CVS Caremark Mail Service Pharmacy:
- ❑ Enjoy convenient home delivery
- ❑ Receive your medications in private, tamper-resistant and (when needed) temperature-controlled packaging
- ❑ Talk to a pharmacist by phone

Retail-90 Pharmacy:
- ❑ Pick up your medication at a time that is convenient for you
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Plus, you can easily order refills and manage your prescriptions anytime at www.caremark.com.

To Get Started
The following chart provides detailed steps to help you start enjoying all the benefits of your prescription benefit plan.

IF YOU WOULD LIKE...	THEN...
To continue with mail service	You don't have to do anything. We'll continue to send your medications to your location of choice.
To pick up at CVS/pharmacy	Please let us know. You can do so quickly and easily. Choose the option that works best for you: • Visit your local Retail-90 Pharmacy and talk to the pharmacist • Call us toll-free using the number on the back of your Prescription Card, and we'll handle the rest
To sign up for mail service for the first time	You can do so easily online or by phone. • Register or log into www.caremark.com, select "Start a New Prescription," then click on "FastStart®" • Call FastStart toll-free at 1-800-875-0867. We'll handle the rest
More information	Give us a call. Use the phone number on the back of your Prescription Card to call us toll-free.

Dental Plan Overview

United Healthcare is our provider for dental offerings for 2014. Your options include:

- ❑ Dental PPO, which allows you to select the provider of your choice
- ❑ Dental HMO, which provides in-network benefits only while having a co-pay schedule
- ❑ Dental EPO, which allows you to select the provider of your choice while having a co-pay schedule

Plan Features	UHC PPO		UHC HMO	UHC EPO
	In-Network	Out-of-Network	In-Network Only	
Calendar Year Deductibles • Individual • Family	$50 $150		$0 $0	$50 $150
Maximum • Calendar Year • Orthodontic Lifetime	$1,000 per person 12-month waiting period for orthodontic services		$0 ********	$1,250 $1,500 (12-month waiting period for orthodontic services)
Visits and Exams • Office visit • Oral Exam • X-rays	You pay 0%	You pay any charges in excess of Allowed Amount*	Office visit: $5 Oral exam: $0 X-rays: $0	Copays vary by service according to Patient Charge Schedule*
Basic Services • Fillings • General Services • Space Maintainers	You pay 0%	You pay 20% and any charges In excess of Allowed Amount*	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*
Major Services • Crowns • Dentures/Bridges	You pay 50%	You pay 50% and any charges in excess of Allowed Amount*	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*
Orthodontic Services	Not Covered	Not Covered	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*

*The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.

Monthly Dental Plan Rates			
Coverage Level	**Dental PPO**	**Dental HMO**	**Dental EPO**
Retiree Only	$24.13	$7.76	$18.02
Retiree + Spouse	$48.27	$14.29	$33.15
Retiree + Child(ren)	$49.23	$14.36	$33.32
Retiree + Family	$73.39	$20.20	$46.86

Vision Plan Overview

The City of Dallas will offer two Vision plan options for 2014: the Standard Plan and the Buy-up Plan. The Buy-up Plan will include the following additional lens options: polycarbonate lenses and standard anti-reflective coating. Polycarbonate lenses are impact-resistant lenses that are often utilized in children's eyewear. Standard anti-reflective coating will aid in glare reduction. The Buy-up Plan also includes an out-of-network laser surgery benefit.

Benefit/Service	Standard Plan		Buy-up Plan	
	UHC Network Provider	Out-of-Network Reimbursement[1]	UHC Network Provider	Out-of-Network Reimbursement[1]
Comprehensive Exam (every 12 months)	$10 copay	up to $40.00	$10 copay	up to $40.00
Materials	$25 copay	See spectacle lenses and frame benefit below	$25 copay	See spectacle lenses and frame benefit below
Spectacle Lenses* **(every 12 months)** Standard Plan: • Standard Scratch-Resistant Coating Buy-up Plan: • Standard Scratch-Resistant Coating • Polycarbonate Lenses • Standard Anti-Reflective Coating	$25 copay	Single Vision up to $40.00 Bifocal up to $60.00 Trifocal up to $80.00 Lenticular up to $80.00	$25 copay	Single Vision up to $40.00 Bifocal up to $60.00 Trifocal up to $80.00 Lenticular up to $80.00
Frames (every 24 months)	$130.00 retail frame allowance	Up to $45.00	$130.00 retail frame allowance	Up to $45.00
Contact Lenses (every 12 months)** • Fitting/evaluation • Contacts • Two follow-up visits (after $25 copay).	Covered-in-full selection or $105.00 allowance	Elective up to $105.00 Necessary up to $210.00	Covered-in-full selection or $105.00 allowance	Elective up to $105.00 Necessary up to $210.00
Laser Vision***	N/A	N/A	N/A	Lifetime Max Reimbursement of $500

[1]Out-of-Network Reimbursements: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UHC Vision, ATTN: Claims Dept., P. O. Box 30978, Salt Lake City, UT 84130.

*Benefits available every 12 to 24 months (depending on the benefit frequency), based on last date of service.

**Your $105 Contact Lens allowance is applied to the fitting/evaluation fees and the purchase of the contact lenses. For example, if the fitting/evaluation fee is $30, you will have $75 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. If you chose disposable contacts, you may receive up to four boxes of disposable contacts (depending on prescription. This benefit is covered in lieu of eyeglasses when obtained from a network provider. Toric, gas permeable and bifocal contacts are all examples that are outside our covered-in-full selection.

***UHC has partnered with the Laser Vision Network of America (LVNA) to provide members with access to discounted laser correction providers (877-25-SIGHT).

Monthly Vision Plan Rates		
Coverage Level	**Standard Plan**	**Buy-up Plan**
Retiree Only	$4.79	$5.76
Retiree + Spouse	$8.75	$10.52
Retiree + Child (ren)	$9.19	$11.04
Retiree + Family	$14.14	$17.01

Medicare Plan Overview

Coverage Includes:

- Post-65 Medicare Supplemental Plan Rates
- Medicare Part A (Plan C)
- Medicare Part B (Plan C)
- Medicare Part A (Plan F)
- Medicare Part B (Plan F)
- Medicare Part A (Plan K)
- Medicare Part B (Plan K)

Medicare Prescription Drug Plans

- United Medicare Rx (Option I)
- United Medicare Rx (Option II)
- UHC Group Medical Advantage (Low Option)
- UHC Group Medical Advantage (High Option)

Post-65 Medicare Supplemental Plan Rates

AARP Supplement Plan Rates			
Tier	**Plan C**	**Plan F**	**Plan K**
Retiree Only	$149	$149	$55
Retiree + Spouse	$330	$303	$134
Spouse Only	$222	$219	$67

United Medicare Rx		
Tier	**Part Dˆ (Option 1)**	**Part Dˆˆ (Option 2)**
Retiree Only	$147	$89
Retiree + Spouse	$355	$228
Spouse Only	$177	$160

ˆ**Option 1** has full gap coverage for Brand name and Generic drugs.
ˆˆ**Option 2** has full gap coverage for Generic drugs only; donut hole would apply only to Brand name drugs.

UHC Group Medicare Advantage		
Tier	**High Option**	**Low Option**
Retiree Only	$185	$121
Retiree + Spouse	$530	$178
Spouse Only	$349	$241

Medicare Supplemental Plans

Monthly Cost for Texas Residents
Rates are for Texas residents only. Rates for other states will vary. All rates subject to change during 2014. Actual rates, which may contain discounts or surcharges, are subject to change and will be provided in the enrollment kits provided to prospective insured. Retirees also will pay Medicare Part B monthly premiums.

ˆMedicare Part D Prescription-only Plan
No medical included. Purchase with or without Medicare Supplement plan. This plan **cannot** be purchased with the PPO plans.

Plan C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD
(2014 MEDICARE BENEFITS)

*A benefit period begins on the first day you receive service as a hospital inpatient and ends after you have been discharged and have not received skilled care in any other facility for 60 consecutive days.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184*	$1,184 (Part A Deductible)	$0
61st thru 90th day	All but $296/day*	$296/day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $592/day	$592/day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$00**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $148/day	Up to $148/day	$0
• 101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*The rates illustrated in this table may not be accurate. Please contact AARP to confirm at 1-800-392-7537.

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (2014 MEDICARE BENEFITS)

***Once you have been billed $148 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
MEDICAL EXPENSES (IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT), such as physician services; inpatient and outpatient medical and surgical services and supplies; physical and speech therapy; diagnostic tests; and durable medical equipment			
First $147 of Medicare-approved amounts*** **Remainder of Medicare-approved amounts**	$0 Generally 80%	$147 (Part B Deductible) Generally 20%	$0 $0
PART B EXCESS CHARGES (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD—First three pints Next $141.50 of Medicare-approved amounts*** Remainder of Medicare-approved amounts	$0 $0 80%	All costs $147 (Part B Deductible) 20%	$0 $0 $0
PARTS A and B			
HOME HEALTH CARE—MEDICARE-APPROVED SERVICES			
❑ Medically necessary skilled care services and medical supplies	100%	$0	$0
❑ Durable medical equipment:			
■ First $147 of Medicare-approved amounts***	$0	$147 (Part B Deductible)	$0
■ Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL—NOT COVERED BY MEDICARE (Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.)			
First $250 each calendar year Remainder of Charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 and amounts over the $50,000 lifetime maximum

Medical benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Plan Benefit Tables: Plan F

Medicare Part A: Hospital Service per Benefit Period[1]

Service		Medicare Pays	Plan F Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but $1,184	$1,184 (Part A Deductible)	$0
	Days 61-90	All but $296/day	$296/day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $592/day	$592/day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare-eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21-100	All but $148/day	Up to $148/day	$0
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/co-insurance	$0

Notes:

[1] A benefit period begins on the first day you receive service as a hospital inpatient, and ends after you have been discharged and received no skilled care in any other facility for 60 consecutive days.

[2] **NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan Benefit Tables: Plan F (Continued)

Medicare Part B: Medical Services per Calendar Year				
Service		**Medicare Pays**	**Plan F Pays**	**You Pay**
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies; physical and speech therapy; diagnostic tests; and durable medical equipment.	First $147 of Medicare-approved amounts[3]	$0	$147 (Part B Deductible)	$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 80%	$0
Part B Excess Charges Above Medicare-approved amounts		$0	100%	$0
Blood	First 3 pints	$0	All costs	$0
	Next $147 of Medicare-approved amounts[3]	$0	$147 (Part B Deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0
Parts A and B				
Service		**Medicare Pays**	**Plan F Pays**	**You Pay**
Home Health Care **Medicare-approved services**	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment Medicare-approved services	First $147 of Medicare-approved amounts	$0	$147 (Part B Deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits not Covered by Medicare				
Service		**Medicare Pays**	**Plan F Pays**	**You Pay**
Foreign Travel **NOT COVERED BY MEDICARE:** **Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.**	**First $250 each calendar year**	**$0**	**$0**	**$250**
	Remainder of charges	**$0**	**80% to a lifetime maximum benefit of $50,000**	**20% and amounts over the $50,000 lifetime maximum**

Notes:

[3] Once you have been billed $147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan K

Medicare Part A: Hospital Service per Benefit Period[1]

Service		Medicare Pays	Plan K Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but $592	$592 (50% of Part A Deductible)	$592 (50% of Part A Deductible) ◊
	Days 61-90	All but $296/day	$296/day	$0
	Days 91 and later while using 60 lifetime reserve days	All but $592/day	$592/day	$0
	After lifetime reserve days are used, an additional 365 days	$0	100% of Medicare-eligible expenses	$0[2]
	Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	Days 21-100	All but $148/day	Up to $74/day	Up to $74/day◊
	Days 101 and later	$0	$0	All costs
Blood	First 3 pints	$0	50%	50%◊
	Additional amounts	100%	$0	$0
Hospice Care Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited co-payment/co-insurance for outpatient drugs and inpatient respite care	50% of co-payment/co-insurance	50% of Medicare co-payment/co-insurance◊

Notes:

[1] A benefit period begins on the first day you receive service as a hospital inpatient, and ends after you have been discharged and received no skilled care in any other facility for 60 consecutive days.

[2] **NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

◊ You will pay half of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $4,800 each calendar year. The amounts that count toward your annual limit are noted with diamonds(◊) in the chart above. Once you reach the annual limit, the plan pays 100 percent of the Medicare co-payment and co-insurance fees for the remainder of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"); you will be responsible for paying the difference of the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan Benefit Tables: Plan K (Continued)

Medicare Part B: Medical Services per Calendar Year

Service		Medicare Pays	Plan K Pays	You Pay
Medical Expenses INCLUDES TREATMENT IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies; physical and speech therapy; diagnostic tests; and durable medical equipment.	First $147 of Medicare-approved amounts[5]	$0	$0	$147 (Part B Deductible)[5◊]
	Preventive Benefits for Medicare-covered Services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Part B Excess Charges Above Medicare-approved amounts		$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $4,640)[4]
Blood	First 3 pints	$0	50%	50%[v]
	Next $147 of Medicare-approved amounts[3]	$0	$0	$147 (Part B Deductible)[5◊]
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10% [◊]
Clinical Laboratory Services	Tests for diagnostic services	100%	$0	$0

Parts A and B

Service		Medicare Pays	Plan K Pays	You Pay
Home Health Care Medicare-approved services	Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment Medicare-approved services	First $147 of Medicare-approved amounts[6]	$0	$0	$147 (Part B Deductible)[◊]
	Remainder of Medicare-approved amounts	80%	10%	10%[◊]

Notes:

[4] This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,800 per calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"); you will be responsible for paying the difference of the amount charged by your provider and the amount paid by Medicare for the item or service.

[5] Once you have been billed $147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

[6] Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

United Medicare Rx™ - Option I

United MedicareRx Enhance Medicare Part D Prescription Drug Plan

The City of Dallas is pleased to be able to provide with you a Medicare Part D prescription drug plan called United MedicareRx, which is offered through UnitedHealthcare Insurance Company. Coverage will be effective beginning January 1, 2014. With United MedicareRx, you have prescription drug insurance you can count on to protect you and meet your prescription drug needs today and in the future.

Here are some of the key features of this prescription drug coverage:

- ❑ **No annual deductible or out-of-pocket maximum** – start saving with the first prescription you fill
- ❑ Predictable and **affordable** flat **co-pays** as low as $10.00 for generic drugs
- ❑ No need to worry about the coverage gap or "doughnut hole"; you are fully covered
- ❑ A **formulary** that includes 100 percent of the drugs covered by Medicare Part D
- ❑ **National pharmacy network** with more than 65,000 convenient locations so you are covered at home or while you are traveling across the United States.

Part D Benefits

- ❑ The United MedicareRx plan has three different levels of co-pays for a 30-day supply of prescription drugs.
- ❑ A complete formulary listing will be available on request or online at www.UnitedMedicareRx.com.

Summary of Prescription Drug Benefits (Effective January 1, 2014, through December 31, 2014)		
Drug Benefit	**2014 Out-of-Pocket Costs**	**You Pay**
Outpatient Prescription Drugs	$0 - $4,550 (a) in Enrollee/Plan Out-of-Pocket	**Retail** $10 co-pay for a one month (30 day) supply of **Tier 1** drugs $25 co-pay for a one month (30 day) supply of **Tier 2** drugs $50 co-pay for a one month (30 day) supply of **Tier 3** or **Specialty Tier** drugs **Mail Services** $20 co-pay for a three month (90 day) supply of Tier 1 drugs you get through Our contracted Mail Service Pharmacy $50 co-pay for a three month (90 day) supply of Tier 2 drugs you get through our contracted Mail Service Pharmacy $100 co-pay for a three month (90 day) supply of Tier 3 drugs you get through our contracted Mail Service Pharmacy
Catastrophic Care	Over $4,550 (a) in Enrollee Out-of-Pocket	You pay the greater of $2.55 or 5 percent co-insurance for generic or a preferred brand name drug that is a multi -source drug, and $6.35 for all other drugs, or 5 percent once your total out-of-pocket costs reach $4,550

Your Co-pays for the three tiers are:

Contracted retail Pharmacy Co-pay Levels	Type of Medication
Tier 1 - $10	Most generic drugs, lowest co-pay
Tier 2 - $25	Preferred brand-name drugs, medium co-pay
Tier 3/Specialty - $50	Non-preferred or unique drugs, higher co-pay

United Medicare Rx™ - Option II

United MedicareRx Enhance Medicare Part D Prescription Drug Plan

The City of Dallas is pleased to be able to provide you a Medicare Part D prescription drug plan called United MedicareRx, which is offered through UnitedHealthcare Insurance Company. Coverage will be effective beginning January 1, 2014. With United MedicareRx, you have prescription drug insurance you can count on to protect you and meet your prescription drug needs today and in the future.

Here are some of the key features of this prescription drug coverage:

- **No annual deductible or out-of-pocket maximum** – start saving with the first prescription you fill
- Predictable and **affordable** flat **co-pays** until you reach the gap.
- **Coverage Gap (donut hole):** Tier 1 drugs covered at co-pays in the gap. Medicare Part D covered brand medications in the gap at 50-percent co-insurance. A **formulary** that includes 100 percent of the drugs covered by Medicare Part D
- **National pharmacy network** with more than 66,000 convenient locations so you are covered at home or while you are traveling across the United States.

Part D Benefits
The United MedicareRx plan has three different levels of co-pays for a 30-day supply of prescription drugs. The United MedicareRx plan formulary covers 100 percent of the drugs covered by Medicare Part D.

A complete formulary listing will be available on request or online at www.UnitedMedicareRx.com.

Your co-pays prior to reaching the gap for the three tiers are:

Contracted Retail Pharmacy Co-pay Levels	Type of Medication
Tier 1 - $10	Most generic drugs, lowest co-pay
Tier 2 - $25	Preferred brand-name drugs, medium co-pay
Tier 3/Specialty - $50	Non-preferred or unique drugs, higher co-pay

United Medicare Rx™ - Option II (continued)

Summary of Prescription Drug Benefits (Effective January 1, 2014, through December 31, 2014)		
Drug Benefit	**2014 Out-of-Pocket Costs**	**You Pay**
Outpatient Prescription Drugs	$0 - $2,850 (a) in Enrollee/Plan Out-of-Pocket. (Until you reach the coverage gap/donut hole)	**Retail** $10 co-pay for a one month (30 day) supply of **Tier 1** drugs $25 co-pay for a one month (30 day) supply of **Tier 2** drugs $50 co-pay for a one month (30 day) supply of **Tier 3** or **Specialty Tier** drugs **Mail Services** $20 co-pay for a three month (90 day) supply of Tier 1 drugs you get through our contracted Mail Service Pharmacy $50 co-pay for a three month (90 day) supply of Tier 2 drugs you get through our contracted Mail Service Pharmacy $100 co-pay for a three month (90 day) supply of Tier 3 drugs you get through our contracted Mail Service Pharmacy
Coverage Gap (Donut Hole)	$2,850 - $4,550 (a) in Enrollee/Plan/ Manufacturer Out of Pocket Expense	**Retail** $10 co-pay for a one month (30 day) supply of **generic drugs** 50% co-insurance for a one month (30 day) supply of Medicare Coverage Brand drugs. (Tier 2 and 3) **Mail Services** $20 co-pay for a three month (90 day) supply of **generic drugs** you get through our contracted Mail Service Pharmacy 50% co-insurance for a three month (90 day) supply of Medicare coverage brand drugs. (Tier 2 and 3)
Catastrophic Care	Over $4,550 (a) in Enrollee Out-of-Pocket	You pay the greater of $2.55 or 5 percent co-insurance for generic or a preferred brand name drug that is a multi-source drug, and $6.35 for all other drugs, or 5 percent once your total out-of-pocket costs reach $4,550

UnitedHealthcare® Group Medicare Advantage

UnitedHealthcare® Group Medicare Advantage - High Option HMO Plan 18409	
Benefits and Coverage	**Member's Cost**
Physician Services/Basic Health Services Consultation, Diagnosis and Treatment Primary Care Physician Specialist	 $10 co-payment per office visit $20 co-payment per office visit
Annual Physical Examination Includes Pap smears	 $0 Primary Care Physician
Immunizations Flu Shots, Pneumococcal Vaccine and Hepatitis B Injections All other Medicare-approved Immunizations	 Covered in Full Covered in Full
Hospitalization	$250 co-payment per admission*
Non-network/Out-of-Area Urgent Care	$25 co-payment
Ambulance Services Medically Necessary Ambulance Transport	 $50 co-payment
Outpatient Surgical Services Certified Ambulatory Surgical Center Outpatient Hospital Facility	 $125 co-payment $125 co-payment
Outpatient Mental Health Care/Outpatient Substance Abuse Treatment	$20 co-payment
Inpatient Psychiatric Care/ Inpatient Substance Abuse Treatment	$250 co-payment per admission, up to 190 days lifetime maximum in a psychiatric hospital
Emergency Services You may go to any emergency room if you reasonably believe you need emergency care	Covered worldwide $50 co-payment, waived if admitted to hospital within 24 hours for the same condition
Prescription Drugs-Retail (up to 30-day supply)	$10 generic; $20 brand name; $40 non-formulary
Prescription Drugs-Mail Order (90-day supply)	$20 generic; $40 brand name; $80 non-formulary
Renal Dialysis	$20 at network facility or Medicare facility
Radiation Therapy	$20 co-payment
Radiology Services Standard X-ray Films Specialized Scanning & Imaging Procedures CT, SPECT, PET, MRI (with or without contrast media)	Covered in Full
Skilled Nursing Facility Care	Covered $0/day for Days 1-20; $50/day for Days 21-100; up to 100 days per benefit period** in a Medicare-certified Skilled Nursing Facility
Vision Care Examination for Eyeglasses (Refraction)	$10 per visit for Medicare-covered eye exams $20 Specialist co-payment per office visit
Hearing Services Routine Hearing Examination	Medicare diagnostic hearing examinations—$20 Specialist co-payment per office visit
Chiropractic Services	$10 co-payment per office visit; Medicare benefit only

*Inpatient Hospital co-payments are not charged on a per-admission or daily basis. **Original Medicare hospital benefit periods do not apply**. For Inpatient Hospital, you are covered for an unlimited number of days as long as the hospital stay is medically necessary and authorized by UnitedHealthcare or contracting providers. When you are admitted to an Inpatient Hospital and then subsequently transferred to another Inpatient Hospital, you pay the co-payment charged for the first hospital admission. You do not pay a co-payment for the second hospital admission; the co-payment is waived.

**A benefit period begins the day you go to a hospital. The period ends when you have not received care in a hospital or skilled nursing facility for 60 consecutive days. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the skilled nursing facility care co-payment, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

UnitedHealthcare® Group Medicare Advantage

UnitedHealthcare® Group Medicare Advantage - Low Option HMO Plan 18410 Benefits and Coverage	Member's Costs
Physician Services/Basic Health Services Consultation, diagnosis, and treatment Primary Care Physician Specialist	 $15 co-payment per office visit $25 co-payment per office visit
Annual Physical Examination Includes Pap smears	Covered in full
Immunizations Flu shots, pneumococcal vaccine and Hepatitis B injections All other Medicare-approved immunizations	 Covered in full Covered in full
Hospitalization	$500 co-payment per admission*
Non-network/out-of-Area Urgent Care	$25 co-payment
Ambulance Services Medically necessary ambulance transport	 $50 co-payment
Outpatient Surgical Services Certified Ambulatory Surgical Center Outpatient Hospital Facility	 $250 co-payment $250 co-payment
Outpatient Mental Health Care/ Outpatient Substance Abuse Treatment	 $25 co-payment
Inpatient Psychiatric Care/ Inpatient Substance Abuse Treatment	$500 co-payment per admission, up to 190 Days lifetime maximum in a psychiatric hospital
Emergency Services You may go to any emergency room if you reasonably believe you need emergency care	Covered Worldwide $50 co-payment, waived if admitted to hospital Within 24 hours for the same condition
Prescription Drugs – Retail (up to 30 day-supply)	$15 generic; $25 brand-name; $40 non-formulary
Prescription Drugs – Mail Order (90 day-supply)	$30 generic; $50 brand-name; $80 non-formulary
Renal Dialysis	$25 at network facility or Medicare Facility
Radiation Therapy	$25 co-payment
Radiology Services Standard X-ray films Specialized scanning and imaging procedures CT, SPECT, PET, MRI–with or without contrast media	 $15 Primary Care Physician $25 Specialist co-payment, per office visit
Skilled Nursing Facility Care	Covered $0/day Days 1-20, $50/day Days 21-100 up to 100 days per benefit period** in a Medicare-certified Skilled Nursing Facility
Vision Care Examination for eyeglasses (Refraction)	$25 for Medicare covered eye exams, per visit
Hearing Services Routine hearing examination	$25 for Medicare covered hearing exams, per visit
Chiropractic Services	$25 co-payment, per office visit; Medicare Benefit only

*Inpatient Hospital co-payments are not charged on a per admission or daily basis. **Original Medicare hospital benefit periods do not apply.** For Inpatient Hospital, you are covered for an unlimited number of days as long as they hospital stay is medically necessary and authorized by UnitedHealthcare or contracting providers. When you are admitted to an Inpatient Hospital and then subsequently transferred to another Inpatient Hospital, you pay the co-payment charged for the first hospital admission. You do not pay a co-payment for the second hospital admission; the co-payment is waived.

**A benefit period begins the day you go to a hospital. The benefit period ends when you have not received hospital or skilled care (in a SNF) for 60 consecutive days. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the skilled nursing facility care co-payment, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

Voluntary Benefits: Colonial Life

Not Sponsored by the City of Dallas
(available on an individual basis)

- Accident Insurance
- Cancer Insurance

The City of Dallas does not sponsor the Voluntary Benefits disclosed on the following page.

Take Advantage of What Colonial Life Has to Offer!

You have the opportunity to apply for personal insurance products from Colonial Life! These benefits can enhance your current benefits portfolio and can be customized to fit your individual needs.

Also:

- ❖ Coverages are available for you and your family with most products.
- ❖ You will enjoy the convenience of premium payment through pension deductions.
- ❖ You will have the ability to take most coverages with you if you change jobs or retire.

The following insurance plans will be offered during your enrollment:

Accident Insurance helps offset the direct and indirect expenses such as co-payments, deductibles and other costs not covered by traditional health care plans.

Cancer Insurance helps offset the out-of-pocket medical and indirect, non-medical expenses related to cancer treatment.

A Colonial Life benefits counselor will explain how these benefits can help protect you and your family. Your insurance needs can be reviewed in just a few minutes. With Colonial Life, you can select benefits that help meet your individual needs.

Products have exclusions and limitations that may affect benefits payable. See the Outline of Coverage for complete details.

Pre-65 retirees may enroll in these Colonial Life products by following these steps:

- ❖ Gather any information you may need to enroll, such as dependents' names, birth dates, ages, Social Security numbers and addresses.
- ❖ Call the Benefits Service Center at 1-888-752-9122 to be transferred to a benefits counselor who will be able to answer your questions and enroll you in the coverage of your choice.

To make changes or apply for Colonial voluntary benefits, please see a Colonial Life benefits counselor who will be available onsite during Open Enrollment or call the Benefits Service Center at 1-888-752-9122; when calling during Open Enrollment, select call options 1, 2 and 1.

For questions regarding your existing Colonial Life coverage, contact the Colonial Life Policyholder Services Department at 1-800-325-4368 or visit the Colonial Life website at www.coloniallife.com.

Colonial Life℠

Making benefits count.

Colonial Life & Accident Insurance Company
1200 Colonial Life Boulevard, Columbia, SC 29210
Policyholder Services: 1-800-325-4368
Website: www.coloniallife.com

Legislative Notices

The following are legal notices regarding your rights under the City-sponsored health plans.

The City of Dallas is required to provide this information to you.

Notice of Privacy Practices – City of Dallas Health Plans
Effective date: April 14, 2003 Revised: September 19, 2013

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. This notice addresses the changes set forth in the Final HIPAA Omnibus Rule. Please review carefully.

OUR PRIVACY PRINCIPLES

We are required by law to maintain the privacy of your protected health information and to inform you about:

- the Plan's practices regarding the use and disclosure of your protected health information.
- your rights with respect to your protected health information.
- the Plan's duties with respect to your protected health information.
- your right to file a complaint about the use of your protected health information;
- whom you may contact for additional information about the Plan's privacy practices; and

any breach of your unsecured PHI.

This notice explains how we may use and disclose your health information to provide benefits to you and our promise to protect your health information. We understand the importance of maintaining the privacy of this information. We are guided by your rights to make inquiries about how we use or disclose your health information. This notice describes rights accorded to you under the Privacy Rule and our legal obligations regarding them. We shall abide by the terms of this notice for all health or medical information we retain.

In this notice the terms "we," "us," "our" and "health plans" are used interchangeably to refer to the health plans listed below. The term "health plans" describes the medical plans offered by the City of Dallas and listed below. The term "health information" refers to information about you or a secondary subscriber to your plan that is used or disclosed to the health plans concerning your physical or mental health or the medical services you received, or your health insurance benefits and payments. Health information includes all identifying information you provide to the health plans to enroll for coverage or health benefits.

This notice applies to the following City of Dallas Health Plans:

UnitedHealthcare 75/25 Health Reimbursement Account Plan
UnitedHealthcare 70/30 Exclusive Provider Organization Plan (with $3,000 deductible)
Caremark Pharmacy Services plan

If you have any questions regarding this notice, please contact the Privacy Officer:

Privacy Officer
Call Compliance Hotline: (855)345-4022
Email: hipaacompliance@dallascityhall.com

HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED OR DISCLOSED

We may access your health information at various times depending on the action required to be completed to your account to maintain your health benefits. We may also document your conversations with the Benefits Division. Employees and business associates will have access to view your health information to perform certain activities for the health plans. They will be given access to your information to help you with your inquiries related to your plan. They may also access your information to perform business or administrative functions for the health plans. At all times, we take steps to ensure that no use or disclosure is inconsistent with the Privacy Rule. Your health records pertaining to your mental health (e.g. psychotherapy notes), substance or drug abuse, and alcohol abuse histories and information relating to HIV test result are subject to stricter disclosure rules under Texas law. We require your written authorization or that of your authorized representative to release this information when requested.

The City has certified that your health information will not be used for any employment-related actions or decisions or activities that deviate from managing the health plans. Violations of these rules are subject to disciplinary action. Below, we describe the different ways we may use and disclose your health information and provide examples for the different disclosures.

Treatment: By itself, the health plans do not provide treatment services (but your health care provider or physician does). We (or the third-party plan administrator) may confirm your health benefits to a health care provider. For example, if your physician wishes to determine whether the plan covers a prospective treatment or medication, they may contact the health plan (or its third-party administrator) for this information.

We may also share your personal information (name, DOB, social security, address or other identifying information) with UnitedHealthcare, or Caremark Pharmacy Services, or other business associates) who update the information we have on file for you in the health plans database(s). For example, a business associate may have access to the health plans' database(s) to add new or additional subscribers to your plan, to make changes to your benefits elections, or to update your profile information – in an effort to provide the most up-to-date information to facilitate the treatment activities of your health care provider.

To Pay Your Health Insurance Premiums or Benefits: The health plans may use and disclose your health information to obtain premiums for the health insurance, to pay for the health care services you receive (claims paid by third-party administrator), to subrogate a claim. For example, we may need to provide your health information to a different insurance company to obtain reimbursement for health care benefits provided under the health plans to you or a secondary subscriber. The health plans may also provide your health information to business associates (e.g. billing companies, claims processing companies) that engage in health care claims processing.

Plan Operations: We may use and disclose your protected health information for our health care operations activities. This interaction is needed to run the plans more efficiently and provide effective coverage. Health care operation activities could include: administering and reviewing the health plans, underwriting health plan benefits, determining coverage policies, performing business planning, arranging for legal and auditing services, customer service related training activities, or determining plan eligibility criteria, etc. Your information may be shared with business associates that perform a service for the health plans. Note, however, the health plans will never use genetic PHI for underwriting purposes.

The health plans will only disclose the minimum information necessary with respect to the amount of health information used or disclosed for these purposes. In other words, only information relating to the task being performed will be used or disclosed. Information not required for the task will not be used or disclosed.

The health plans may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

To Business Associates: We may share your health information with third-party business associates who perform certain business activities for the health plans. Examples include consultants, billing or claims processing companies, interpreters, and auditors. Business associates are required through contract with us and by law to appropriately safeguard your PHI.

The health plans are also allowed to use or disclose your health information without your written authorization as required by law.

Disposal of Protected Health Information: Once we no longer need your protected health information we will either destroy it, return it, or if neither is feasible, we will store it securely and prohibit further uses and disclosures except to the extent use or disclosure is unavoidable.

Other Uses and Disclosures Requiring Your Authorization: We are prohibited from using or disclosing your health information if the use or disclosure is not covered by a situation above. We will ask for your written authorization for other uses or disclosures. If you give us your written authorization to use or disclose your protected health information, you may revoke that permission, in writing, at any time, but not for any actions we have already taken. If you revoke your permission, you must be specific about which entity's permission is being revoked.

Rights You Have Regarding Your Health Information

Right to Inspect and Copy: You have the right to inspect and copy your health information that the Health Plan maintains for enrollment, payment, claims determination, or case or medical management activities, or that the Plan uses to make enrollment, coverage or payment decisions (the "designated record set"). However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. You must submit your request in writing to the Benefits Division. You may be charged a fee for the related costs, such as copying and mailing. If your request to inspect or copy your health information has been denied, you will be notified in writing of your rights of appeal at that time.

Right to access electronic records: You may request access to electronic health records (usually compiled by health care providers) or electronic copies of your PHI held in a designated record set, or you may request in writing or electronically that another person receive an electronic copy of these records. The electronic PHI will be provided in a mutually agreed-upon format, and you may be charged for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Amend: If you feel that protected health information held in the Health Plan's official file is incorrect or incomplete, you must submit a written request that the information be amended; you must support the basis for your request. We are not required to grant your request if we do not maintain or did not create the information, or if it is correct. We must respond to your request within 60 days, unless a written notice of a 30-day extension is provided.

Right to an Accounting of Disclosures: You may seek an accounting of certain disclosures by requesting a list of the times we have shared your health information. Your request must be in writing. Your request should indicate in what form you want the list (for example, paper or electronically). The first list you request within a 12-month period will be free. For additional lists, you may be charged for the costs of providing the list. Your will receive a response no later than 60 days from when we receive your request, unless a written notice of a 30-day extension is provided.

Right to Request Restrictions: You may request that we limit the way we use or share your health information. You should submit your request in writing. We will consider your request and respond accordingly. We are not required to agree to the request.

Right to Request Confidential Communications: You may request that we contact you in a certain way or at a certain location, for example, you can ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. Due to procedural or system limitations, in some instances, it may not be reasonable to send confidential communications to multiple addresses for persons who reside in the same household or derive coverage through the same individual participant. However, the health plans must accommodate your reasonable request to receive communication of PHI by alternative means or at alternative locations, if you clearly state that the disclosure of all or part of the information through normal processes could endanger you in some way. The Privacy Officer will monitor and manage this process according to protections afforded under applicable law.

Right to Receive Notice of A Breach: You may receive a notice from us regarding the breach of your unsecured health information if you are affected. We will inform you of the action we will take and how you can protect yourself from potential harm.

Receive a Copy of This Notice
You may ask for a paper copy of this notice by calling the Benefits Division at 1-888-752-9122. You may also view this notice at the health plans websites: http://www.dallascityhall.com/human_resources/benefits_employees.html or www.cityofdallasbenefits.com.

Changes To This Notice
We reserve the right to change this notice and will distribute as required. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. We will post the revised copy on the health plans' websites and distribute information about the update as required by the regulations.

Complaints and Questions
If you have questions about your HIPAA privacy rights or if you believe your rights have been violated, you may contact the City or one of the health plans' representatives listed below or you may file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.

Human Resources Department	**Health Plan Representatives Contact Information**	
ATTN: Benefits Division 1500 Marilla Street, Room 1D South Dallas, Texas 75201-6390 Phone: 1-888-752-9122 Fax: 1-888-202-5571	UnitedHealthcare (UHC) EPO Plans (75/25/HRA & 70/30) Caremark (CVS) - Prescription Services	800-736-1364 855-465-0023

Legislative Notices (Continued)

What is COBRA?

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with group health benefit plans to offer employees the opportunity to continue temporarily their group health care coverage under their employer's plan if their coverage otherwise would cease due to termination, layoff or other change in employment status (referred to as "qualifying events").

How long must COBRA continuation coverage be available?

- Up to 18 months for termination or reduction of hours
- Up to 29 months to employees who are determined to have been disabled at any time during the first 60 days of COBRA coverage and to the disabled employee's nondisabled beneficiaries.
- Up to 36 months for spouses and dependents due to an employee's death, divorce or legal separation.

What plans are subject to COBRA?

Group health, vision, dental and health care spending account (EMSP) plans are subject to COBRA.

What specific events can be qualifying events?

- Death of employee
- Voluntary or involuntary termination of employment (other than by reason of gross misconduct)
- Retirement
- Reduction in hours
- Divorce or legal separation
- Dependent child ceasing to be a dependent

How much does COBRA cost for City-sponsored plans?

COBRA *(includes 2% admin)*	70/30/ EPO (Low Option) Monthly Rates*	Tobacco Rate
Member Only	$355	$375
Member + Spouse	$773	$793
Member + Childr(ren)	$667	$687
Member + Family	$1,011	$1,031

*100% Member Contribution

COBRA *(includes 2% admin)*	70/30/ EPO (High Option) Monthly Rates*	Tobacco Rate
Member Only	$367	$397
Member + Spouse	$801	$721
Member + Childr(ren)	$691	$711
Member + Family	$1,047	$1,067

*100% Member Contribution

COBRA *(includes 2% admin)*	75/25/HRA EPO Monthly Rates*	Tobacco Rate
Member Only	$481	$501
Member + Spouse	$959	$979
Member + Childr(ren)	$879	$899
Member + Family	$1,244	$1,264

*100% Member Contribution

COBRA Monthly Vision Plan Rates		
Coverage Level	Standard Plan	Buy-up Plan
Member Only	$4.89	$5.88
Member + Spouse	$8.93	$10.73
Member + Child(ren)	$9.37	$11.26
Member + Family	$14.42	$17.35

COBRA Monthly Dental Plan Rates			
Coverage Level	Dental PPO	Dental HMO	Dental EPO
Member Only	$24.61	$7.92	$18.38
Member + Spouse	$49.24	$14.58	$33.81
Member + Child(ren)	$50.21	$14.65	$33.99
Member + Family	$74.86	$20.60	$47.80

Women's Health Cancer Rights Act (WHCRA) Enrollment Notice

If you have had or plan to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- ❑ All stages of reconstruction of the breast on which the mastectomy was performed;
- ❑ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ❑ Prosthesis; and
- ❑ Treatment of physical complications of the mastectomy, including lymphedema.

The benefits provided are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like additional information on WHCRA benefits, call your plan administrator at 800-736-1364.

Newborns' Act Disclosure

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

Important Notice About Your Prescription Drug Coverage & Medicare

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

2. The City of Dallas has determined that the prescription drug coverage offered by United MedicareRx offered by UnitedHealthcare is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you are enrolled in the City's Active employee or Pre-65 retiree EPO health plan; that coverage pays for medical expenses in addition to prescription drug expenses which are included the plan's design. As a retiree, if you decide to join a non-City of Dallas sponsored Medicare drug plan, your current City of Dallas coverage will be affected as you cannot be enrolled in two plans. If you decide to join a Medicare drug plan as a retiree that is not sponsored by the City of Dallas and drop your current City of Dallas coverage, be aware that you and your dependents will not be able to get this coverage back. *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of Dallas and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least one percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Please contact the Benefits Service Center at 1-888-752-9122 or send written correspondence to the following address: Benefits Service Center, 1500 Marilla Street, 1DS, Dallas, TX 75201

NOTE: This notice will be provided in each annual enrollment guide and if this coverage through the City of Dallas changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage: visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for their telephone number) for personalized help, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty). To receive a copy of this notice, please use the contact information listed below.

City of Dallas Benefits Service Center, 1500 Marilla Street, 1DS, Dallas, TX 75201 (Phone) 1-888-752-9122

CITY OF DALLAS
Notice of Medical Privacy Practices
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting Your Personal Health Information

The City of Dallas understands that your health information is personal and private. We are committed to protecting the privacy of your health information and the health information of your family members that we, and the Health Plans we sponsor for the benefit of our employees, receive and maintain. This health information is referred to in this Notice as "your protected health information."
We are required by law—the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA")—to:

- Make sure that your protected health information is kept private

- Give you this Notice of our legal duties and privacy practices with respect to your protected health information
- Follow the terms of this Notice, as currently in effect

This Notice is effective April 14, 2003, and applies to all of the medical records the City and our business associates maintain that have been provided to us through the Health Plans. If you are covered under one of the City's insured Health Plans, you may receive a similar notice from your Health Plan's insurance carrier.

How Your Personal Health Information May be Used and Disclosed

The City's Health Plans may disclose your protected health information to the claims payers, to business associates, and to certain employees of the City. These individuals may only use your protected health information for Health Plan payment and operations and certain other limited purposes, as described below. We may not and will not use your protected health information for any employment-related actions or decisions or in connection with any of the City's non-Health Plan benefits. Violations of these rules are subject to disciplinary action.

The City has certified that it will not use or disclose your protected health information other than as provided in this Notice or as required by law. Any business associates who are given your protected health information must agree to be bound by these restrictions and conditions concerning your protected health information.

Health Plan Payment

We will use and disclose your protected health information for Health Plan payment activities. For example, the Health FSA third party administrator ("TPA") will use protected health information to determine coverage eligibility, process reimbursement claims, and coordinate benefits with other health care programs or insurance carriers.

Health Care Operations

We may use and disclose your protected health information for Health Plan operations, such as monitoring the Carriers and TPAs to ensure that they are properly and accurately paying claims in accordance with the terms of the Health Plan documents, and that they are providing proper and timely services to you as required under the Health Plans. Designated employees of the City may receive, use, and disclose protected health information when assisting you with Health Plan problems or questions, such as eligibility, benefit coverage, and appeals. Protected health information also may be used when conducting quality assessment and improvement activities; underwriting and soliciting bids from potential Carriers or TPAs, establishing City and employee premium contributions and funding-related activities; determining need for disease management programs; submitting claims for stop-loss coverage; arranging medical or legal reviews or fraud detection programs; and managing costs. We may also share your protected health information with business associates who assist us in monitoring Health Plan costs, utilization, plan design, Health Plan disputes, and similar Health Plan payment and operations. Our auditors, attorneys, and other business associates may use protected health information in assuring accurate and complete compliance with the Health Plans' terms.

As Required By Law or Judicial Order

We will disclose information about you when required to do so by federal, state or local law, including when required by court orders and subpoenas, or by the police or other authorized governmental organizations. For example, we may disclose protected health information when required by a domestic relations order, a child support order, or a court order involving a civil lawsuit or criminal prosecution. In most instances, this information will be provided by the Carrier or the TPA.

To Avert a Serious Threat to Health or Safety

We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of others. Any disclosure, however, would only be to someone able to help mitigate or prevent the threat to health or safety and only to the extent necessary to mitigate or prevent the problem.

Legislative Notices (Continued)

Special Situations

Although unlikely, we may be required or permitted by HIPAA to use or disclosure protected health information in certain special situations, including, but not limited to, disclosures: (1) required to comply with workers' compensation requirements; (2) to assist law enforcement, such as to identify a missing person or witness; (3) to health oversight agencies, for example in the course of Medicare audits and compliance with other applicable laws; and (4) to report on public health risks, such as to report adverse reactions to medicines.

Disposal of Protected Health Information

Once we no longer need your protected health information we will either destroy it, return it, or if neither is feasible, we will store it securely and prohibit further uses and disclosures except to the extent use or disclosure is unavoidable.

Your Written Authorization to Release Information

In addition to the uses and disclosures of protected health information described in this Notice or as provided in HIPAA regulations, your protected health information will be used or disclosed only with your written permission. If you give us your written authorization to use or disclose your protected health information, you may revoke that permission, in writing, at any time, but not for any actions we have already taken. If you revoke your permission, you must be specific about which entity's permission is being revoked.

Your Rights Regarding Your Protected Health Information

Right to Inspect and Copy

You have the right to inspect and copy your protected health information that is held in the Health Plan's official file, with certain exceptions, such as you cannot be given access to psychotherapy notes or information prepared for litigation. If you request a copy of the information, you may be charged a fee for the related costs, such as copying and mailing. If your request to inspect or copy your protected health information has been denied, you will be notified in writing of your rights of appeal at that time.

Right to Amend

If you feel that protected health information held in the Health Plan's official file is incorrect or incomplete, you must submit a written request that the information be amended; you must support the basis for your request. We are not required to grant your request if we do not maintain or did not create the information, or if it is correct. We must respond to your request within 60 days, unless a written notice of a 30-day extension is provided.

Right to an Accounting of Disclosures

You have the right to request an accounting, or list, of certain uncommon disclosures of your protected health information. Your request for a list of disclosures must state the time period for which you are requesting the accounting, but your request may not cover a time period that is longer than six years and may not include the period before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronically). The first list you request within a 12-month period will be free. For additional lists, you may be charged for the costs of providing the list. Your request for an accounting of the disclosures of your protected health information must be responded to no later than 60 days after receipt of the request, unless a written notice of a 30-day extension is provided.

Right to Request Restrictions

You have the right to request a restriction or limitation on the protected health information we use or disclose about you for Health Plan payment or operations. You also have the right to request a limit on the protected health information disclosed about you to someone who is involved in your care or the payment for your care, such as a family member or friend when you are incapacitated or unavailable. In your request for restrictions, you must indicate: (1) what information you want to limit; (2) whether you want to limit the use, disclosure, or both; and (3) to whom you want the limits to apply, for example, prohibit disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that communications with you regarding your protected health information be made in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. Although we are not required to agree to your request, we will accommodate all requests we deem reasonable.

Use of Personal Representatives
Your personal representative may act on your behalf. For example, a parent is a personal representative of a dependent minor, and a person with your power of attorney or a court order may be your personal representative.

Changes To This Notice
We reserve the right to change this Notice and will distribute as required. We reserve the right to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on the Plan websites at http://dallascityhall.com/human_resources/benefits_retirees.html and www.cityofdallasbenefits.com.

Complaints and Questions
If you have questions about your HIPAA privacy rights or if you believe your rights have been violated, you may contact the City or one of the Health Plan representatives listed below or you may file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.

Human Resources	Health Plan Representatives Contact Information	
ATTN: Benefits Division 1500 Marilla Street, Room 1D South Dallas, Texas 75201-6390 Phone: 1-888-752-9122 Fax: 1-888-202-5571	United Healthcare (UHC) EPO Plans (75/25/HRA & 70/30) Caremark (CVS) - Prescription Services United Healthcare (UHC) - Flexible Spending Accounts United Healthcare (UHC) - Dental PPO & EPO Plans United Healthcare (UHC) - Dental HMO Plan United Healthcare (UHC) - Vision Standard & Buy-up Plans OptumHealth EAP (Employee Assistance Program) Colonial Life - Voluntary Benefit Plans AFLAC - Voluntary Benefit Plans	800-736-1364 855-465-0023 877-311-7849 877-816-3596 800-232-0990 800-638-3120 800-586-6875 800-325-4368 800-992-3522

Special Enrollment Notice
If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for your other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or place for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days following the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Benefits Service Center at 1-888-752-9122.

Wellness Program Disclosure

If it is unreasonably difficult for you to achieve the standards for a reward under the wellness program due to a medical condition, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the Benefits Service Center at 1-888-752-9122, and we will work with you to develop another way to qualify for the reward.

Children's Health Insurance Program Notice
Medicaid and the Children's Health Insurance Program (CHIP) Free Offer or Low-Cost Health Coverage to Children & Families

If you are eligible for health coverage from your employer but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

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

Once it has been determined that your or your dependents qualify for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—granted that you and your dependents are eligible but not already enrolled in your employer's plan. This is called a "special enrollment" opportunity. **You must request coverage within 60 days of being determined eligible for premium assistance.**

You may be eligible for payment assistance with your employer's health plan premiums. You should contact your state for information on eligibility:

Texas Residents: Go to http://www.gethipptexas.com/ or call **1-800-440-0493**.

To see which states have implemented a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you may use the following resources:

U. S. Department of Labor
Employee Benefits Security Administration
Website: www.dol.gov/ebsa
Phone: 1-866-444-EBSA (3272)
OMB Control Number 1210-0137 (expires 9-30-2014)

U. S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Website: www.cms.hhs.gov
Phone: 1-877-267-2323, Ext. 61565

VENDOR CONTACT LIST

City of Dallas HR-Benefits Service Center	
City of Dallas Benefits Website Phone	www.cityofdallasbenefits.com 1-888-752-9122
City of Dallas Website	www.dallascityhall.com
Medical Plan	
United Healthcare (UHC) EPO and HRA Plans Membership Services EPO/HRA Care 24 Website	 1-800-736-1364 1-800-586-6875 www.myuhc.com
Pharmacy Plan	
CVS/Caremark Website	1-855-465-0023 www.caremark.com
Vision Plan (UHC)	
Vision Services Website	1-800-638-3120 www.myuhcvision.com
Dental Plan (UHC)	
Dental HMO Dental PPO and EPO Website	1-800-232-0990 1-877-816-3596 www.myuhcdental.com
Voluntary Benefits - Colonial Life	
Membership Services Website	1-800-325-4638 www.coloniallife.com
COBRA (UHC)	
Membership Services Website	1-866-747-0048 www.uhcservices.com
Employee Retirement Fund	
Phone Website	214-580-7700/1-877-246-1791 www.dallaserf.org
Dallas Police and Fire Pension	
Phone Website	1-800-638-3861/ www.dpfp.org
Wellness (WellAware)	
WellAware Website	http://cod/HumanResources/WellAware/index.htm
UnitedHealthcare Group Medicare Advantage	
Membership Services (To ask questions, enroll or change plans) Website	1-800-950-9355 www.uhcretiree.com
Medicare Part D Prescription Plan (UHC)	
Membership Services (To ask questions only) City of Dallas Benefits Service Center (To enroll or change plans) Website	1-888-556-6648 1-888-752-9122 www.unitedmedicarerx.com
AARP	
Membership Services Website	1-800-392-7537 www.aarphealthcare.com

City of Dallas Publication No. 12-13:52
Additional copies may be obtained from the Benefits Service Center

About this Guide

This 2014 Benefits and Enrollment Guide describes, in non-technical language, the essential features of the City of Dallas Health Benefits Plan (The Plan). This Guide has been prepared as a reference only. It is not an official Master Plan Document for the City of Dallas Health Benefits Plan, which includes dental, vision, life and voluntary benefits. The terms and conditions of coverage under The Plan are determined solely by the Master Plan Document as adopted by the City of Dallas City Council. If there is a difference between what you read in this Guide and what you read in the official Summary Plan Document (SPD), the official Master Plan Document will govern.

City of Dallas

Department of Human Resources
Benefits Service Center | 1500 Marilla Street, Room 1DS | Dallas, TX 75201
1-888-752-9122 (ph) | 1-888-202-5571 (fax)

The Benefits Service Center is open Monday through Friday from 8:15 a.m. to 5:15 p.m.