

2020

ACTIVE EMPLOYEE Benefits Enrollment Guide

YOUR **HEALTH**

YOUR **MONEY**

YOUR **LIFE**

YOUR **BENEFITS.**
THE **PATH TO LIVING WELL**



City of Dallas



¡Español disponible en línea!
 Una copia en español de nuestra guía de inscripción de beneficios 2020 está disponible en línea en www.cityofdallasbenefits.org.



Summaries of Benefits and Coverage
 The government-required Summaries of Benefits and Coverage (SBC), which summarize important information about your City of Dallas Cigna medical plan options, are available online at myCigna.com. A paper copy is also available, free of charge, by calling our benefits enrollment vendor at (214) 556-0971. You can also go online to www.cityofdallasbenefits.org to view coverages.

Important: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see page 37 for more details.

TABLE OF CONTENTS

3	Greetings City of Dallas Employee	23	Dental Coverage
4	Enrollment Overview	26	Vision Coverage
8	Medical Coverage	28	Basic and Additional Life Insurance
10	Health Reimbursement Account (HRA)	30	Voluntary Accidental Death & Dismemberment (AD&D) Insurance
13	About the Health Savings Account (HSA)	32	Retirement Savings Plan
14	Telehealth Connection	33	Disability Products
15	Prescription Drug Coverage	34	Long-Term Disability Insurance
16	Diabetes Management Program	35	Supplemental Health Products
17	Enhanced Benefit Tier	37	Important Notices
17	LocalPlus Network Information	47	Important Contacts
18	CareATC Onsite Clinic		
19	Employee Assistance Program		
20	Flexible Spending Accounts		
22	Benefit Rewards		

GREETINGS CITY OF DALLAS EMPLOYEE

It is our pleasure to welcome you to your 2020 Open Enrollment!

What You Need To Know:

- Your 2020 Open Enrollment period is September 16 – October 4, 2019.
- You must enroll in benefits in order to have coverage for 2020. Your current benefit coverage will end on December 31, 2019.
- The City of Dallas is moving to a new enrollment system. If you want benefits for 2020, you must enroll online, on the phone, or in person during Open Enrollment. **Detailed enrollment steps are on the next page.**
- You must provide supporting documentation in order to enroll a dependent for the first time, such as a Social Security card, marriage license, or birth certificate.
- Open Enrollment is the only time of the year that you will be able to make any changes to your coverage, unless you have a Qualifying Life Event (QLE).

If you have questions about your 2020 benefits or Open Enrollment, please call (214) 556-0971.

What's New for 2020

Coverage Costs

- **Premium Copay Plan (formerly called the Copay Plan):** New salary-banded contribution amounts for full-time employees. Depending on your salary, contribution amounts for this plan will either stay the same or decrease! For permanent part-time employees, coverage costs will remain unchanged!
- **HRA and HSA Plans:** No changes to coverage costs!
- **Dental and Vision Plans:** New contribution amounts for the Dental PPO plan. No changes to Dental HMO or Vision plan coverage costs.

HRA Medical Plan

- ER copay: \$350 (coinsurance and deductible still apply)
- New HRA contribution amounts from the City: \$200 individual/\$700 family

Premium Copay Medical Plan (Formerly called the Copay Plan)

- Reduced urgent care copay: \$40
- ER copay: \$300
- Lower calendar year deductible: \$1,500 individual/\$3,000 family
- Lab and X-ray services: 20% coinsurance after deductible is met (Note: For these services to be covered under your office visit copay, the lab or X-ray must be performed in and billed by your physician's office.)
- Separate prescription drug deductible removed
- New prescription drug copays*: \$15 generic/\$40 preferred/\$75 non-preferred

HSA Medical Plan

- Increased HSA contribution amounts from the City: \$700 individual/\$1,700 family

Flexible Spending Accounts

- New administrator: Cigna
- New Medical Spending/Limited Purpose FSA annual contribution maximum: \$2,700
- Joint debit card for Medical Spending/Limited Purpose FSA and HRA
- No debit card for dependent care FSA

Voluntary Benefits

- New carrier: The Standard
- Enhanced benefits
- Cancer care will be included in the Critical Illness plan
- The city will no longer offer Universal Life insurance

Wellness

- Simpler program for 2020!
- Complete three steps by August 31, 2020: Online health assessment, annual physical/age-appropriate screening, biometric screening
- Submit your completed Wellness Screening Form to Cigna by August 31, 2020
- Receive a \$500 lump sum paycheck deposit in December 2020 if you complete all steps on time

The 2020 Benefits Enrollment Guide provides details about your benefit options. Reviewing the material contained in this guide will help you make informed decisions about your benefits. If you have any questions, please refer to the vendor contact information section at the back of this guide to access our service providers.

Sincerely,
City of Dallas Benefits Team

* Because of these new, low copay amounts, the Preventive Therapy Drug List (PTDL) will no longer apply to the Premium Copay medical plan.

ENROLLMENT OVERVIEW

How to Enroll

The City of Dallas offers three convenient ways for you to enroll in benefits.

Online (Year-Round)

1. Log on to <https://standard.benselect.com/cityofdallas>.
2. At the *Employee Login* screen, enter your user name and PIN. Your user name is your first name, a period, your last name, and your 4-digit birth year (Example: John Smith born in 1965 would be **john.smith1965**). Your PIN is the last 4 digits of your Social Security number followed by the last 2 digits of your birth year. (Example: If the last 4 digits of your Social Security number are 1234 and you were born in 1965, your PIN would be **123465**.)
3. Start your benefits enrollment by clicking *Next* to review your personal and dependent information. (Note: The *My Benefits* page provides a snapshot of your current benefit elections.)
4. Click *Next* to continue through the plan information or on the benefit plan names under *My Benefits* to enroll or waive coverage.
 - A checkmark means “enrolled”
 - An X means “waived” or “not available to enroll”
 - A blank square means “not yet enrolled”
5. Once you have made your benefit elections, click *Sign & Submit*. You **MUST** complete this step in order for the system to process your enrollment choices. In this step, you will sign a benefit confirmation form electronically using your PIN.

If you have any questions about your 2020 benefits or need assistance with the enrollment process, please call (214) 556-0971.

By Phone (Year-Round)

Benefit Specialists can enroll you over the phone as well. The call center is available to help you with questions, rates, and your enrollment. The call center will be open Monday – Friday, 8:15 a.m. – 5:15 p.m. To get started, just call (214) 556-0971.

In Person (Open Enrollment Only)

Sit down one-on-one with a Benefit Specialist who can answer questions, provide rates, and enroll you in the plans. Benefit Specialists will be onsite at a variety of locations from September 16 – October 4. To schedule an appointment, visit www.ebcoh.com/appointment.

Supporting Documentation Required

Any selections that require evidence or documentation will not be accepted or finalized until documentation is provided. All required documentation must be provided prior to the close of the Open Enrollment period. (Example: If you wish to enroll a dependent child for the first time, you must provide the required supportive documentation at the time of enrollment and prior to the close of Open Enrollment, otherwise your dependent child will not be enrolled.)

You can provide dependent documentation in one of several ways:

- Upload it from your computer during the online enrollment process (follow the on-screen instructions)
- Send it from your Smartphone with the *My Selerix* app (available for free in the App Store and Google Play)
- Fax it to (513) 371-5559
- Bring a copy to the Benefits Service Center, Dallas City Hall, Room 1DS





Who Is Eligible

Regardless of your employment classification, if you intend to work an average of 30 hours or more per week, you are eligible for medical, dental and vision benefits from the City of Dallas. If you do not intend to work an average of 30 hours or more per week, you may or may not be eligible for the city's health benefits as a permanent part-time employee.

Variable Hour Employees

Under the Affordable Care Act, employees who have hours that vary from week to week are referred to as “variable hour” employees, not full-time or part-time. All variable hour employees have a 12-month “measurement period” to determine the average number of hours worked per week. If your average is 30 hours per week or more, you'll be eligible for the City of Dallas' health benefits for the 2020 plan year. And if your average is less than 30 hours per week, you won't be eligible for the City of Dallas' health benefits and will need to find other coverage, such as through a spouse, parent, or the Health Insurance Marketplace. The measurement period occurs annually, so your eligibility could change each plan year.

Employees who are intended to work an average of 30 hours a week or more will not have a measurement period. They will be automatically considered benefits-eligible.

Initial Enrollment

You have 30 days from your hire/rehire date (or the date your status changes to benefits-eligible) to enroll yourself and your dependents in benefits. Your coverage begins on your hire date or retroactively to your status change date, as appropriate. If you do not enroll within the 30-day timeframe, you will automatically be enrolled in basic life insurance (full-time employees only). You will have to wait until the next annual enrollment or experience a Qualifying Life Event to enroll in any other benefits.

Open Enrollment

You may also enroll or make changes during Open Enrollment, which occurs during the fall each year. Elections made during this time take effect on January 1.

Dependent Eligibility

If you are covered by a plan, in most cases, you may also cover your eligible dependents as outlined below. Your dependents (spouse and/or children) cannot be covered on a plan if you are not covered.

If you need to add dependents not previously covered, you must provide supporting documentation during your enrollment period. Please be prepared to provide supporting documentation as outlined below. Documentation can be provided in person, via fax to (513) 371-5559, through the *My Selerix* app, or online through the enrollment system.

Type of Eligible Dependent	Required Documentation
Spouse	<ul style="list-style-type: none"> • Copy of Marriage License, copy of Social Security Card and Date of Birth • If Common-Law Marriage applies, please provide copies of two documents showing that you and your spouse live together. <ul style="list-style-type: none"> – Lease or deed naming both partners – Joint checking account statement – Utility bills and/or credit accounts – Will and/or life insurance policies
Domestic Partner	<ul style="list-style-type: none"> • Copy of Social Security Card and Date of Birth <li style="text-align: center;">-AND- • Copies of two documents showing that you and your partner live together. <ul style="list-style-type: none"> – Lease or deed naming both partners – Joint checking account statement – Utility bills and/or credit accounts – Will and/or life insurance policies
Dependent Child Child who is married or unmarried up to age 26* and is the biological child, legally adopted child, grandchildren or stepchild of you and/or your spouse, domestic partner or common-law spouse. <i>Note: Dependent children will become insured on their date of birth if you elect Dependent Insurance no later than 30 days after the birth. If you do not elect to insure your newborn child within such 30 days, coverage for that child will end on the 30th day.</i>	<ul style="list-style-type: none"> • Copy of Birth Certificate showing you as a parent, or • Copy of Verification of Birth Form (accepted for up to 3 months post-birth only) • 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) <li style="text-align: center;">-AND-
Dependent Grandchild Grandchild who is married or unmarried up to age 26* and is the biological grandchild of you and/or your spouse, domestic partner or common-law spouse. You must have guardianship or cover the child to cover a grandchild.	<ul style="list-style-type: none"> • Copy of Social Security Card <p>Additional documentation required for disabled dependents:</p> <ul style="list-style-type: none"> • Physician affirmation of such condition and dependence

*Dependent children and dependent grandchildren are covered until the end of the month of their 26th birth month, for medical, dental and vision coverage and until the age of 25 for life insurance. Disabled children are eligible to be covered past their 26th birthday if they are unmarried, primarily supported by you, and incapable of self-sustaining employment by reason of mental or physical disability.

NOTE: If you and your spouse work at the City of Dallas and have dependents covered on any of the plans, only one employee can cover all of the dependents. You cannot split dependents with each employee taking Employee + Child(ren) coverage. The City of Dallas will allow employees who both work for the City to determine which coverage will work best for them. For example, married City employees can pick either Employee Only for themselves or one can select Employee + Spouse. If they have children, one employee can elect Employee + Family or they can elect Employee Only or Employee + Child(ren).

Making Changes to Coverage

Once you enroll, you cannot change your benefit choices until the next annual enrollment period. This is an IRS rule. However, you may make certain changes if you have a qualifying event that affects your benefits — and the event is consistent with your requested change. Typical qualifying events include:

- Marriage
- Divorce, legal separation, or annulment
- Birth, adoption, or legal guardianship of a child
- Death of a spouse/domestic partner or eligible dependent
- A change in the employment status of yourself, your spouse/domestic partner, or a dependent
- A dependent qualifies or no longer qualifies due to age
- Significant cost increases for benefit coverage
- Enrollment in or loss of state or federal medical coverage
- You move out of your health plan's service area that requires a change in plans
- A spouse or dependent gains or loses coverage in another qualified health plan

You must notify the Benefits Service Center and provide proof of your qualifying event as soon as possible and before 30 days have passed. Coverage will be effective based on the date of the event. If you wait longer than 30 days, you must wait until the next annual enrollment to make a change.

60-Day Special Enrollment Period

In addition to these qualifying events, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP

Employee Resignation or Termination

- Medical, dental and vision coverage ends at the end of the month of the last day of employment.
- Life insurance, Accidental Death and Dismemberment insurance and FSA/DCAP ends the last day of employment.



MEDICAL COVERAGE

When it comes to medical coverage, the City of Dallas offers three options through Cigna. Each medical plan provides coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs, and hospitalization. Most in-network preventive care services are covered at 100 percent. Under each of the plans, you choose a network provider each time you need medical care. If you use a non-network provider, you receive no benefits from the plan — you will be responsible for 100 percent of the cost for all care you receive.

To find providers in your network, log in to www.myCigna.com and click on *Find Care & Cost* at the top of the screen. From there, you can search for a provider based on primary care doctors, doctors by type, doctors by name, reason for visit, or location. Enter a name, specialty, or search word, and then click on the magnifying glass icon to see your results.

HRA Plan	Premium Copay Plan	HSA Plan
The HRA Plan will cover 75% of your eligible expenses after you have met the deductible. This plan also offers a Health Reimbursement Account (HRA). Note: This plan will not be offered in 2021.	The Premium Copay Plan lets you pay for certain medical services at a set rate, called a copay. You will pay the copay amount even if you have not yet met your deductible for the year.	The HSA Plan has lower monthly premiums and higher deductibles than a traditional health plan. There are no copays associated with this high-deductible health plan – you and the plan begin sharing expenses only after you've met the deductible. This plan also offers a Health Savings Account (HSA).

Medical Plan Comparison	HRA	Premium Copay	HSA
NETWORK	OPEN ACCESS PLUS	LOCALPLUS NETWORK	LOCALPLUS NETWORK
Calendar Year Deductible	\$2,500 (Individual) \$5,000 (Family)	\$1,500 (Individual) \$3,000 (Family)	\$3,000 (Individual) \$6,000 (Family)
City HRA or HSA Contribution	\$200 (Individual) \$700 (Family)	N/A	\$700 (Individual) \$1,700 (Family)
Calendar Year Out-of-Pocket Maximum	\$6,350 Individual \$12,700 Family	\$6,350 Individual \$12,700 Family	\$6,350 Individual \$12,700 Family
Coinsurance	Plan pays 75%	Plan pays 80%	Plan pays 80%
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%
Office Visits (Primary Care Physician/Specialist)	Plan pays 75% after deductible is met	\$25 copay/\$50 copay	Plan pays 80% after deductible is met
Urgent Care Facility	Plan pays 75% after deductible is met	\$40 copay	Plan pays 80% after deductible is met
Inpatient Facility and Services	Plan pays 75% after deductible is met	Plan pays 80% after deductible is met	Plan pays 80% after deductible is met
Outpatient Facility and Services	Plan pays 75% after deductible is met	Plan pays 80% after deductible is met	Plan pays 80% after deductible is met
Emergency Care	\$350 copay (waived if admitted) per visit, then your plan pays 75% after deductible is met	\$300 copay (waived if admitted) per visit	Plan pays 80% after deductible is met
Enhanced Facility Benefit (Facility Charges Only – Baylor or Methodist in the DF W Area)	Plan pays 90% after deductible is met	Plan pays 90% after deductible is met	Plan pays 90% after deductible is met
CVS Minute Clinic/Walgreens Healthcare Clinic	Plan pays 75% after deductible is met	\$25 copay	Plan pays 80% after deductible is met
CareATC Clinic	Plan pays 100%	Plan pays 100%	Plan pays 100% for preventive visits \$25 copay for non-preventive or “sick” visits
Telehealth Connection (MDLIVE or Amwell)	\$40 copay	\$25 copay	Plan pays 80% after deductible is met

HRA PLAN

Open Access Network (In-Network Benefits Only)	
City HRA Contribution	\$200 Individual/\$700 Family
Maximum HRA Carryover from 2019	\$6,000
Lifetime Maximum	Unlimited
Calendar Year Deductible	\$2,500 (Individual); \$5,000 (Family)
Calendar Year Out-of-Pocket Maximum (Combined with Pharmacy)	\$6,350 (Individual); \$12,700 (Family)
Coinsurance	Member pays 25%; Plan pays 75% after deductible is met
Office Visits	Plan pays 75% after deductible is met
X-ray and Lab Work	Plan pays 75% after deductible is met
Preventive Care	Plan pays 100% (In-Network-only), does not reduce HRA
Outpatient Services	Plan pays 75% after deductible is met
Inpatient Services	Plan pays 75% after deductible is met
Emergency Care	\$350 copay (waived if admitted) per visit, then your plan pays 75% after deductible is met
Specialist Services & Urgent Care Services	Plan pays 75% after deductible is met
Enhanced Facility Benefit	Plan pays 90% after deductible is met when you use either Baylor or Methodist Hospitals in Dallas/Fort Worth. This applies to facility charges only. All other charges are paid at 75% after deductible is met.
Rx Coverage (CVS Caremark)	See page 15 for Program details
Urgent Care and Convenience Care	Plan pays 75% after deductible is met
Telehealth	\$40 copay, does not apply to deductible, applies to out-of-pocket max

HRA Plan	Full-Time Employee Bi-Monthly Rate*
Employee Only	\$37.50
Employee + Spouse	\$259.00
Employee + Child(ren)	\$110.50
Employee + Family	\$296.50

HRA Plan	Permanent Part-Time Employee Bi-Monthly Rate*
Employee Only	\$113.00
Employee + Spouse	\$341.00
Employee + Child(ren)	\$223.00
Employee + Family	\$408.50

* Note: Per paycheck (24 out of 26)

HEALTH REIMBURSEMENT ACCOUNT (HRA)

The HRA Plan comes with a City-funded Health Reimbursement Account (HRA) to help you pay for out-of-pocket medical expenses, such as deductibles, coinsurance, and prescription drug copays. The amount the City of Dallas contributes to your HRA depends on your coverage level and your enrollment date.

Prorated HRA Funds (Based on the month of enrollment)

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 below.

Enrollment Month	Employee Only	Employee + Family	
January	\$200.00	\$700.00	With the HRA, you receive a Cigna Healthcare Visa Debit Card to use for qualifying health care expenses. In general, with this card you do not have to file any claims to your account. When you use the card, funds are automatically deducted from your account, and you pay nothing out of your pocket at the time of service. You should keep all receipts and statements – you may need to submit them to Cigna if you use your debit card.
February	\$183.33	\$641.67	
March	\$166.67	\$583.33	
April	\$149.50	\$525.00	
May	\$133.33	\$466.67	
June	\$116.67	\$408.33	
July	\$100.00	\$350.00	
August	\$83.33	\$291.67	
September	\$66.67	\$233.33	
October	\$50.00	\$175.00	
November	\$33.33	\$116.67	
December	\$16.67	\$58.33	

Accessing Your HRA Funds

There are three ways to access your HRA funds:

- You may use the Cigna Healthcare Visa Debit Card, which will automatically debit your HRA balance at the point of purchase. (Please note: When you use the debit card, funds are automatically deducted from your HRA first. Once your HRA funds are depleted, the card will automatically begin deducting funds from your Medical Spending/Limited Purpose FSA, if applicable. If you want to use your FSA funds first, you may manually submit claims for eligible expenses online at www.mycigna.com.)
- You can pay out of your pocket and file a claim for reimbursement from your HRA.
- Contact the provider to make payment after you receive an Explanation of Benefits (EOB).

HRA Details

- The HRA is available when you enroll in the HRA Medical plan and remain continuously enrolled.
- You can use the HRA to help pay for eligible out-of-pocket medical expenses including deductibles, coinsurance amounts, prescription drugs, and other medical services not covered by the plan. HRA funds cannot be used for dental or vision expenses.
- You must use your Cigna Healthcare Visa debit card or pay out-of-pocket and file a claim for reimbursement. Claims will not be automatically paid.
- The City will contribute up to \$200 to your HRA for employee-only coverage or up to \$700 to your HRA for family coverage.
- Your HRA does not count as taxable income. That means you can cover eligible health care costs with tax-free dollars.
- 2020 funds will not carry over; any funds not used by the end of the year will be forfeited. However, you will have until March 31, 2021, to file claims for HRA expenses incurred during the 2020 plan year.
- You can have an HRA and a Medical Spending FSA at the same time. You will use one Cigna Healthcare Visa Debit Card to access both your HRA funds and your Medical Spending FSA account. Funds are automatically deducted from your HRA first.

PREMIUM COPAY PLAN

LocalPlus Network (In-Network Benefits Only)	
Lifetime Maximum	Unlimited
Calendar Year Deductible	\$1,500 (Individual); \$3,000 (Family)
Calendar Year Out-of-Pocket Maximum (Combined with Pharmacy)	\$6,350 (Individual); \$12,700 (Family)
Coinsurance	Member pays 20%; Plan pays 80% after deductible is met
Office Visits	Primary Care Physician \$25 copay/Specialist \$50 copay
X-ray and Lab Work	Plan pays 80% after deductible is met*
Preventive Care	Plan pays 100% (In-Network only)
Outpatient Services	Plan pays 80% after deductible is met
Inpatient Services	Plan pays 80% after deductible is met
Emergency Care	\$300 copay (waived if admitted) per visit
Urgent Care Services	\$40 copay per visit
Enhanced Facility Benefit	Plan pays 90% after deductible is met when you use either Baylor or Methodist Hospitals in Dallas/Fort Worth. This applies to facility charges only. All other charges are paid at 80% after deductible is met.
Rx Coverage (CVS Caremark)	See page 15 for Program details
Urgent Care/Convenience Care	\$25 copay
Telehealth	\$25 copay

*In order for these services to be covered under your office visit copay, they must be performed and billed by your physician's office. If they are performed and/or billed by a third party, they will be subject to the plan's deductible and coinsurance.

You will pay the listed copay amount no matter how much you have spent on healthcare services throughout the year. The copay will not apply towards your deductible, but will apply to your out-of-pocket maximum.

Premium Copay Plan	Full-Time Employee Bi-Monthly Rate*		
	Under \$44,000 Annual Pay	\$44,000 - \$66,000 Annual Pay	\$66,001+ Annual Pay
Employee Only	\$15.00	\$20.00	\$25.00
Employee + Spouse	\$209.00	\$221.50	\$234.00
Employee + Child(ren)	\$65.50	\$75.50	\$85.50
Employee + Family	\$229.00	\$244.00	\$259.00

Premium Copay Plan	Permanent Part-Time Employee Bi-Monthly Rate*
Employee Only	\$57.00
Employee + Spouse	\$225.00
Employee + Child(ren)	\$156.00
Employee + Family	\$269.00

* Note: Per paycheck (24 out of 26)

HSA PLAN

LocalPlus Network (In-Network Benefits Only)	
City HSA Contribution	\$700 Individual/\$1,700 Family
Lifetime Maximum	Unlimited
Calendar Year Deductible	\$3,000 (Individual); \$6,000 (Family)
Calendar Year Out-of-Pocket Maximum (Combined with Pharmacy)	\$6,350 (Individual); \$12,700 (Family)
Coinsurance	Member pays 20%; Plan pays 80% after deductible is met
Office Visits	Plan pays 80% after deductible is met
X-ray and Lab Work	Plan pays 80% after deductible is met
Preventive Care	Plan pays 100% (In-Network-only), does not reduce HSA
Outpatient Services	Plan pays 80% after deductible is met
Inpatient Services	Plan pays 80% after deductible is met
Emergency Care	Plan pays 80% after deductible is met
Specialist Services & Urgent Care Services	Plan pays 80% after deductible is met
Enhanced Facility Benefit	Plan pays 90% after deductible is met when you use either Baylor or Methodist Hospitals in Dallas/Fort Worth. This applies to facility charges only. All other charges are paid at 80% after deductible is met.
Rx Coverage (CVS Caremark)	See page 15 for Program details
Urgent Care/Convenience Care	Plan pays 80% after deductible is met
Telehealth	Plan pays 80% after deductible is met

HSA Plan	Full-Time Employee Bi-Monthly Rate*
Employee Only	\$15.00
Employee + Spouse	\$209.00
Employee + Child(ren)	\$65.50
Employee + Family	\$229.00

HSA Plan	Permanent Part-Time Employee Bi-Monthly Rate*
Employee Only	\$34.00
Employee + Spouse	\$206.00
Employee + Child(ren)	\$120.00
Employee + Family	\$238.00

* Note: Per paycheck (24 out of 26)

ABOUT THE HEALTH SAVINGS ACCOUNT (HSA)

In addition, the HSA Plan offers a tax-savings feature called the Health Savings Account (HSA). With this account, you can pay for certain out-of-pocket medical expenses throughout the year. You can also enroll in the Limited Purpose Flexible Spending Account (FSA) to help you cover eligible out-of-pocket dental and vision expenses.

Who Is Eligible For The HSA?

You can participate in the HSA only if you enroll in the HSA plan. You are not eligible to contribute if:

- You are enrolled in Medicare.
- You are covered by another medical plan (such as your spouse’s plan) that does not qualify as a high deductible health plan.
- You or your spouse participates in a Health Care Flexible Spending Account (FSA) at the City or at your spouse’s employer.
Note: Even if you do not contribute to the HSA, you cannot contribute to the City’s Health Care FSA if you are enrolled in the HSA medical plan.

Prorated HSA Funds

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 below.

Enrollment Month	Employee Only	Employee + Family	<h3>Accessing your HSA Funds</h3> <ol style="list-style-type: none"> Pay with your Cigna Healthcare MasterCard Debit Card which will automatically debit your HSA balance at the point of purchase. Write a check from your HSA. You must order checks when you enroll in the HSA to have this option. And, as with any other type of check, you must have funds available or the check will be returned — and you will be charged an insufficient funds fee. Pay for expenses out of your own pocket, and then reimburse yourself from your HSA.
January	\$700.00	\$1,700.00	
February	\$641.67	\$1,558.33	
March	\$583.33	\$1,416.66	
April	\$525.00	\$1,275.00	
May	\$466.67	\$1,133.33	
June	\$408.33	\$991.66	
July	\$350.00	\$850.00	
August	\$291.67	\$708.33	
September	\$233.33	\$566.67	
October	\$175.00	\$425.00	
November	\$116.67	\$283.33	
December	\$58.33	\$141.67	

HSA Details

- The HSA is available when you enroll in the HSA Medical Plan and remain continuously enrolled.
- You can use the HSA to help pay for eligible health care expenses, such as deductibles, coinsurance, and other out-of-pocket dental, vision, and prescription drug expenses not covered by a health plan.
- You must use your Cigna Healthcare Mastercard Debit Card or write an HSA check to access HSA funds. Claims will not be automatically paid.
- If you contribute to your HSA, the City will contribute up to \$700 to your HSA for employee-only coverage or up to \$1,700 to your HSA for family coverage.
- Your HSA does not count as taxable income. That means you can cover eligible medical, dental, and vision costs with tax-free dollars.
- Your HSA balance rolls over from year to year and there are no “use it or lose it” rules. The HSA is an employee-owned account, you can take it with you even if you are no longer employed at the City of Dallas.
- You can have an HSA and a Limited Purpose FSA at the same time. You will have separate debit cards for each account.

Coverage Level	Total HSA Contribution Allowed in 2020	Additional Catch-Up Contribution (Age 55+)
Employee Only	\$3,550	\$1,000
Employee + Dependents	\$7,100	\$1,000

TELEHEALTH CONNECTION

With Telehealth Connection, you can connect with a board-certified doctor 24/7, 365 days a year, through the convenience of phone or video consults from the comfort of your own home.

Telehealth Connection doesn't replace your primary care physician, but is a convenient option for quality care when needed. Choose from an Amwell or MDLIVE network provider whether you're at home, work, on vacation, or while traveling in the U.S. or internationally.

Telehealth Connection physicians can write prescriptions according to the regulatory guidelines of your state and can treat many of the most common medical conditions, including:

- Colds and flu
- Fever
- Headaches
- Sore throats
- Stomach aches
- Urinary tract infections (UTI)
- And more

Cost Information

For Telehealth Connection costs, please see page 8 of this guide.

With a national network of experienced physicians, you don't need to wait for care, and you will always speak with doctors who are licensed in the state in which you live.

To learn more or start a visit, go to www.amwellforcigna.com or www.mdliveforcigna.com, or download the Amwell or MDLIVE apps available in the iTunes store and Google Play.



PRESCRIPTION DRUG COVERAGE

If you enroll in one of the City of Dallas medical plans, you will automatically receive prescription drug coverage through CVS/ Caremark.

When you need a medication, ask your doctor or other prescriber if there is a generic available, as these generally cost less, and you may be eligible for an additional discount, depending on the generic's Preventive Therapy Drug List (PTDL) status. Employees who participate in the HRA or HSA plans and have generic medications included on this list will pay \$25 (or the lower medication price) if the generic is priced under \$100 and \$40 if the generic is priced over \$100. These reduced copays also bypass the deductible.

Additionally, many diabetic and hypertension drugs are also available at no cost.* Qualifying drugs lists for these cost-saving options are available on the City of Dallas Benefits website.

*Please note: If you are enrolled in the HSA Plan, you will not be eligible for the free diabetic and hypertension medications due to IRS regulations.

CVS Caremark Retail Pharmacy Network

Short-term medications can be filled at network pharmacies up to a 31-day supply. 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 pharmacy, simply click on "Find a Pharmacy" at www.caremark.com.

	HRA Plan	Premium Copay Plan	HSA Plan
Generic Medications	You pay 10% after medical deductible is met	\$15 copay	You pay 20% after medical deductible is met
Preferred Brand-Name Medications	You pay 25% after medical deductible is met	\$40 copay	You pay 20% after medical deductible is met
Non-Preferred Brand-Name Medications (Includes Specialty Drug Formulary)	You pay 40% after medical deductible is met	\$75 copay	You pay 20% after medical deductible is met

Long-Term (Maintenance) Medications

The City's prescription drug coverage offers you choice and savings when it comes to filling long-term, or maintenance, prescriptions (up to a 90-day supply). You have two ways to save, and you can easily order refills and manage your prescriptions anytime at www.caremark.com.

Retail 90	Mail Service Pharmacy
<ul style="list-style-type: none"> • Pick up your maintenance medication at a time that is convenient for you at a retail pharmacy • Enjoy same-day prescription availability • Talk with a pharmacist face-to-face 	<ul style="list-style-type: none"> • Enjoy convenient home delivery • Simply mail your original prescription and the mail service order form to CVS Caremark • To sign up, call FastStart at (866) 281-0636 or register online at www.caremark.com and select "Start a New Prescription"



Generic Step Therapy

For certain high-cost prescription drugs, you may need to try two alternative, generic medications first before “stepping up” to a more costly treatment. Your pharmacist will let you know at the time of purchase if your prescription requires step therapy.

Dispense As Written Penalty

If you elect to fill a brand-name medication when a generic is available, you will pay your generic copay AND the cost difference between the brand-name and the generic medication. Generic drugs can save you money. They are chemically equivalent to brand-name medications, but they generally cost a fraction of the price.

Specialty Drug Formulary Prescriptions

Certain specialty drug formulary prescriptions — medications used to treat complex conditions like cancer, multiple sclerosis, and autoimmune disorders — must be filled with a drug on CVS/Caremark’s approved list. If you choose to fill your prescription with a drug on the “excluded” list, you will be required to pay the full cost of that drug. Please visit cityofdallasbenefits.org for a list of excluded drugs.

Customer Care

Visit www.caremark.com or call at (855) 465-0023.

DIABETES MANAGEMENT PROGRAM

You don’t have to manage diabetes alone.

Living with diabetes can be overwhelming, and it can be difficult knowing how to begin self-management. That’s why there’s Kannact! Kannact is a better way to manage diabetes and gives you the tools and support needed to be successful in your health journey. It’s an optional, no cost benefit for City of Dallas employees and their covered dependents enrolled in a City medical plan. Enroll today and get:

- **Free** diabetic testing supplies delivered right to your door when you need them
- A **wireless glucometer** that uploads your readings to a secure, private cloud
- A dedicated, **certified diabetes coach** to help you self-manage your diabetes
- A personalized action plan based on your lifestyle
- A mobile app that is customizable to your needs

Sign up is easy, confidential and takes less than five minutes to complete. Go to www.kannact.com/cityofdallas to get started.

Once you’ve enrolled, you’ll be assigned your dedicated certified diabetes coach to help support your health. Please note: If you have enrolled in Kannact previously, you do not need to re-enroll.

Questions? Contact Kannact at (855) 722-5513 or support@kannact.com.

ENHANCED BENEFIT TIER

All three medical plans offer an enhanced facility benefit that will increase the benefits you receive when you use certain Cigna network facilities.

When you visit a regular Cigna in-network facility for care, the plan pays your facility charges at 75% or 80% coinsurance after you meet your deductible. When you visit a facility that is part of the enhanced benefit tier, the plan pays your facility charges at **90 percent coinsurance** after you meet your deductible. This enhanced benefit applies to facility charges only — all other charges (physician fees, lab services, etc.) are paid at your plan's regular levels.

The enhanced benefit tier currently includes **90 Baylor and Methodist facilities** all over the DFW Metroplex. It includes hospitals, surgical centers, inpatient and outpatient facilities, MRI centers, and even some rehabilitation centers. To view the full list of facilities in the enhanced benefit network, visit www.mycigna.com and click on *Find a doctor*.

What are facility charges?	Facility charges do NOT include
Facility charges include cost for running the facility, such as supplies, equipment, exam rooms and inpatient & outpatient rooms	Physicians fees, office visits, lab work, anesthesiologist, and prescription drugs and medications

LOCALPLUS NETWORK INFORMATION

The Premium Copay and HSA medical plans offer the LocalPlus Network. This is a local network limited to doctors, specialists, and hospitals in your area.

- In your local area, or when in any LocalPlus Network area, you must receive care from a provider or facility in this network to receive coverage.
- If you're away from home and need care, just look for a participating LocalPlus doctor in the area. If one isn't available, you can use doctors or hospitals in the Away From Home Care feature.
- If you choose to go outside the LocalPlus Network when one is available (or outside the Away From Home Care feature when LocalPlus isn't available), your care will not be covered by the plan (except in an emergency). You'll be responsible for the total cost of the services.

The LocalPlus Network can help you get more value for your health care dollars. This network provides:

- The option to choose a primary care physician to help guide your care (it's recommended but not required); no referrals required to see a specialist
- Access to Cigna's national network of labs, X-ray and radiology offices, and dialysis centers
- Up to 75% potential savings through in-network national labs (LabCorp or Quest)
- A nationwide in-network coverage in case of an emergency



CAREATC ONSITE CLINIC

CareATC offers reduced or no-cost medical care to City of Dallas medical plan members. Services are available to employees and their dependents and includes the following:

Services	
Acute Care	Treatment of common illnesses and minor injuries (flu, sinus infections, sprains etc.)
Chronic Disease Evaluation, Monitoring and Care Management	Hypertension, diabetes, asthma, etc.
Minor Procedures and Wound Care	Including simple biopsies and skin tag/mole removal
Preventive Care and Comprehensive Physical Exams	Age appropriate physicals, routine gynecological exams, prostate exams, kids sports/camp physicals, etc.
Diagnostic Testing and Screenings	Including on-site lab work and EKGs
Electronic Medical Records	With referral management ability and e-prescribing to your pharmacy of choice
On-site Medication Distribution	Voucher program available for Texas patients

Is there a fee to use the CareATC clinics?

- HRA Plan and Premium Copay Plan members have no co-pay for office visits, medications dispensed onsite, or lab work performed onsite.
- HSA Plan members visiting the clinic for a preventive appointment will not be required to submit payment for the visit. Preventive appointments include visits for screenings, yearly physicals, etc. **For non-preventive or “sick” visits, a \$25 office visit fee will be required.** Non-preventive or “sick” visits are those for existing conditions such as sore throat, fever, high blood pressure, diabetes, thyroid disorders, etc. Many other services at the clinic, including prescription drug refills and labs, require no additional fee. Once the out-of-pocket maximum has been met, the non-preventive visit fee will drop to \$0.
- Non-health plan member employees may use the clinic at City Hall for a fee of \$25.

Clinic Location

City of Dallas employees and family members currently have access to the clinic located in City Hall at 1500 Marilla Street, Room 1CS, Dallas, TX 75201.

Benefits of accessing CareATC Health Clinics:

- **Longer visits with your medical provider.** For increased quality of care.
- **Chronic Disease Management.**
- **CareATC Mobile App.** With the CareATC mobile app you can make appointments 24/7, refill prescriptions, find clinic locations close to you, view your medical records, and view provider bios (available for iPhone and Android users).
- **No More Worries About Out-of-Network Doctors.** The CareATC doctor knows who is in our healthcare network and will only send you to an in-network specialist.
- **Low to no cost** for you and your family.
- **Convenient Locations and hours,** with little to no wait time to see the doctor.
- **No Cost Labwork.** CareATC will even send your results to your primary care doctor when requested.

Making An Appointment

Appointments are required for care. To make an appointment with CareATC, just call (214) 446-6029 or 1-800-993-8244, log in to <https://portal.careatc.com/Account/Login>, or use the CareATC mobile app. Please be sure to bring a valid I.D. and your medical insurance card.

The clinic is open Monday – Friday, 7:30 a.m. – 5:00 p.m. The clinic closes for lunch daily from 11:30 a.m. – 12:00 p.m.

EMPLOYEE ASSISTANCE PROGRAM

You may be struggling with stress at work, seeking financial or legal advice, or coping with the death of a loved one. Maybe you just want to strengthen your relationships with your family. The Employee Assistance Program (EAP) offers assistance and support for all these concerns and more.

- Depression
- Stress Management
- Relationship difficulties
- Financial and legal advice
- Parenting and family problems
- Child and elder care support
- Dealing with domestic violence
- Substance abuse and recovery
- Eating disorders
- Pet care

EAP Counseling Benefits

You may be eligible for counseling sessions at no cost through your Employee Assistance program. To access your EAP counseling benefits, you need to get authorization before your in-person appointment (telephone appointments do not require authorization, but they can be scheduled online). You can do this online by logging in to www.cignabehavioral.com and clicking on *Look Up Your Benefits*.

Behavioral Benefits

For routine, outpatient behavioral service, you do not need authorization, except in a very limited number of cases. Simply log in to www.cignabehavioral.com and find a psychiatrist or therapist.

The Cigna Website

The Cigna website www.cignabehavioral.com includes valuable resources for managing your stress, work/life balance and personal wellness. The website includes several self-assessment tests to learn more about your health, including your risk for depression to help guide you if you should seek help from your doctor.

The site includes the following features:

- Benefits Information
- Therapist Search
- Education & Resources
- Interactive Self-Assessment Tools
- Forms



2 Ways to Access

1. Call (877) 622-4327
2. Visit www.cignabehavioral.com and enter *dallascityhall* as the employer ID. This service is available 24/7.

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) allows you to save money by using “before-tax” dollars to pay for certain health care and dependent care expenses. To enroll, you elect an amount to be deducted pre-tax from your paycheck over 24 pay periods and deposited into your FSA. Then, you may request reimbursement from the account when eligible expenses are incurred.

Payroll Deduction

Medical Spending FSA (Not compatible with HSA Plan)	Limited-Purpose FSA (Compatible with HSA Plan)	Dependent Care FSA (Compatible with all plan options)
ELECT UP TO \$2,700 TAX-FREE	ELECT UP TO \$2,700 TAX-FREE	ELECT UP TO \$5,000 TAX-FREE
<ul style="list-style-type: none"> Your Medical Spending FSA may be used to reimburse out-of-pocket medical expenses for you, your spouse, and your dependents. Eligible expenses include deductibles, coinsurance and prescriptions. Dental, vision and hearing expenses may also be reimbursed. The maximum annual Medical Spending FSA election is \$2,700. The entire annual amount you elect may be used at any time during the plan year and is available January 1. 	<ul style="list-style-type: none"> If you have elected to contribute to an HSA in 2020, you may also enroll in a Limited-Purpose FSA, even though both accounts may reimburse dental and vision expenses. To comply with HSA rules, your Limited-Purpose FSA may only be used to reimburse out-of-pocket dental and vision expenses for you, your spouse, and your dependents. The maximum annual Limited-Purpose FSA election is \$2,700. The entire annual amount you elect may be used at any time during the plan year and is available January 1. 	<ul style="list-style-type: none"> The annual maximum contribution to a Dependent Care FSA is \$5,000 (or \$2,500 if you are married and filing taxes separately.) The Dependent Care FSA is used to reimburse you for certain expenses for children under age 13, or individuals unable to care for themselves. Unlike Medical Spending FSAs and Limited-Purpose FSAs, Dependent Care FSAs may only reimburse expenses up to the amount you have contributed to date. Funds are available three business days after payroll deduction. Dependent Care FSA is for dependent daycare only.

How to Use Your Funds

- When you enroll in the Medical Spending or Limited Purpose FSA, you will receive a debit card from Cigna in the mail. The card will hold Medical Spending, Limited-Purpose, and/or HRA funds. It will NOT hold Dependent Care funds.
- If you use the card at an Inventory Information Approval System (IIAS) merchant, the transaction will be approved at the point of sale. Generally, large pharmacies, grocery stores, and box stores (i.e.: Walgreens, Albertsons, Walmart) have IIAS capability.
- If the expense will be considered for insurance and/or HRA reimbursement, try to wait until you receive the Explanation of Benefits (EOB) from the insurance company to be sure that the debit card transaction is for the correct out-of-pocket amount.
- If the merchant does not accept the card, submit the expense through the Cigna website (www.mycigna.com) or by mail.
- Medical Spending/Limited Purpose reimbursement requests, as well as debit card transaction documentation, can be sent electronically, by fax, or by mail to Cigna. Claims are normally reimbursed within a week of Cigna receiving the claim.
- For dependent care, you must submit the expense through www.mycigna.com or by mail. After submission, you will be asked which method of reimbursement you prefer (electronic transfer, check, etc.).



FSA Tips

- Visit www.mycigna.com for a list of eligible expenses and to set up direct deposit for expense reimbursement.
- The Medical Spending FSA, Limited Purpose FSA, and Dependent Care FSA are separate. You cannot transfer funds between accounts or charge multiple accounts for the same expenditure.
- Keep your receipts and invoices. You may be required to submit documentation of your expenditures.
- If you participate in the HRA medical plan, funds are automatically deducted from your HRA first when you use your debit card. Once your HRA funds are depleted, the card will automatically begin deducting funds from your Medical Spending/ Limited Purpose FSA. If you want to use your FSA funds first, you may manually submit claims for eligible expenses online at www.mycigna.com or by mail.
- By law, any money left in your FSA(s) at the end of the year must be forfeited. This is called the “use it or lose it” rule. However, there is a grace period ending March 15, 2021 to use your 2020 Medical Spending FSA or Limited Purpose FSA dollars on eligible expenses. All claims must be submitted by March 31, 2021. **Note:** If you currently participate in the Medical Spending FSA and elect the HSA medical plan for 2020, your FSA funds will expire on December 31, 2019. The grace period does not apply, and you may not roll these funds into a Limited Purpose FSA for 2020. This is an IRS rule.
- Dependent Care FSA funds must be used by December 31, 2020, and all claims must be filed by March 31, 2021.





BENEFIT REWARDS

Benefit Rewards is the incentive program for City employees enrolled in a City-sponsored health plan.

- **Employees:** Complete the steps below.
- **Covered spouses:** No action required!

What Steps Should I Take?

Complete these three steps to earn a total of 3 points by August 31, 2020, and you'll receive \$500 dollars in your paycheck in December 2020:

- The online health assessment, found on www.myCigna.com (1 point).
- An annual physical or age-appropriate screening with your physician (1 point).
- A biometric screening with your physician or at a City of Dallas onsite event (1 point).

The Wellness Screening form, needed for your annual physical and biometric screening, must be completed by your physician and submitted to Cigna by the program deadline. The form is available at www.myCigna.com, the City's HR Benefits website, in the Benefits Service Center, and at the CareATC clinic at City Hall.

If you complete all three steps outlined above by August 31, 2020, you will receive extra funds in your paycheck in December 2020.

DENTAL COVERAGE

The City of Dallas offers two dental plans through MetLife – Dental PPO and Dental HMO. Both plans offer valuable features to save you money on dental care.

Dental Plan Comparison	Dental PPO	Dental HMO
Choice of Dentist	<p>You may use any dentist you wish. When you choose a MetLife Dentist, though, you receive service at discounted prices.</p> <p>When you use a non-MetLife dentist, you pay more out of your own pocket since you're responsible for 100% of the amount the dentist charges that exceeds MetLife's network-negotiated fee.</p>	<p>Plan requires you to pre-select two in-network dentists at the time of enrollment.¹</p> <p>If your first choice provider is no longer accepting DHMO patients or is no longer a part of the DHMO network, your provider will default to your second provider choice.</p>
Specialty Care	No referral needed	Your dentist will provide you with a referral to an in-network specialist.
In-Network Discount	Participating dentists have agreed to accept negotiated fees as payment in full for in-network services.	Plan provides access to hundreds of dental services that may be lower than your cost would be without the plan. ²
Benefits	Plan has a yearly deductible and annual benefits maximum. Plan covers a percentage of negotiated fees.	Plan has no annual maximums, deductibles or claims. You are responsible for the co-payments for each covered procedure performed.

Finding a MetLife Participating Dentist

- Visit www.metlife.com and click on *Find a Dentist* on the right side of the home page
- Enter your zip code and select your plan
- For DPPO dentists, choose *PDP Plus* network
- For DHMO dentists, choose *Dental HMO/Managed Care*, then select plan name *City of Dallas*

¹ If your first choice provider is no longer accepting DHMO patients or is no longer a part of the DHMO network, your provider will default to your second provider choice.

² Certain limitations apply to some services. Please refer to your Schedule of Benefits at www.cityofdallasbenefits.org for full details.

Mobile App

Users must register on www.mybenefits.metlife.com first before having access to information in the app.



DENTAL PPO PLAN

With The City of Dallas' Dental PPO Plan, you may use any dentist you wish. When you choose a MetLife Dentist, though, you receive service at discounted prices.

When you use a non-MetLife dentist, you pay more out of your own pocket since you're responsible for 100% of the amount the dentist charges that exceeds MetLife's network-negotiated fee.

	In-Network % of Negotiated Fee*	Out-of-Network % of Negotiated Fee*
Deductible (Per Person**)	\$50	\$50
Annual Maximum Benefit (Per Person)	\$1,750	\$1,750
Orthodontia Lifetime Maximum (Per Person)	\$1,750	\$1,750
Coverage Type		
Type A - Preventive		
<ul style="list-style-type: none"> Two cleanings every 12 months Two exams every 12 months Two fluoride treatments per calendar year for dependent children up to 16th birthday Full mouth X-rays: one per 36 months Bitewing X-rays: one set per calendar year for adults; one per calendar year for children 	100%	100%
Type B - Basic Restorative		
<ul style="list-style-type: none"> Fillings Extractions General Anesthesia: When dentally necessary in connection with oral surgery, extractions or other covered dental services 	80%	80%
Type C - Major Restorative[†]		
<ul style="list-style-type: none"> No waiting period for major services Crown, Denture, and Bridges Endodontics Periodontics Oral Surgery [†] Implants not covered	50%	50%
Type D - Orthodontia		
<ul style="list-style-type: none"> All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia 	50%	50%

Dental PPO Bi-Monthly Rate	
Employee Only	\$16.39
Employee + Spouse	\$30.15
Employee + Child(ren)	\$30.55
Employee + Family	\$42.61

* Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

** Subject to the section titled Dental Benefits: Limitations and Additional Charges and Dental Benefits: Exclusions.

Note: Child(ren)'s eligibility for dental coverage is from birth up to age 26.

DENTAL HMO PLAN

The DHMO Plan offers a wide range of dental benefits through a network of participating dentists. With this plan, you are responsible for copayments associated with each covered procedure.

This plan offers lower out-of-pocket costs on more than 400 procedures.

Here are some of the services in this plan, all of which will help you lower your dental care costs.

	Co-payment
Office Visit	\$5 per visit (including all fees for sterilization and/or infection control)
Preventive Services Visit	\$5 exams \$6 sealants (per tooth) \$0 X-rays
Crowns	\$255 porcelain, metal and titanium
Orthodontics	\$2,600 adults* \$2,400 children*
Osseous surgery	\$200
Root canals	\$95 – \$225
Extractions	\$15 – \$110 (higher cost for impacted tooth)
General anesthesia & nitrous oxide	\$0
Yearly cleanings (up to 4)	\$5 for the first two cleanings Additional cleanings: \$45 adults/\$35 children
Implants	See fee schedule

Dental HMO Bi-Monthly Rate	
Employee Only	\$4.10
Employee + Spouse	\$7.54
Employee + Child(ren)	\$7.58
Employee + Family	\$10.66

Please note, if you elect the MetLife Dental HMO Plan, you MUST select a dental provider to be able to use your benefits. You will not be able to see a dentist until you elect a provider.

To locate a participating dentist and the most current MetLife dental information visit www.metlife.com/dental. If you are already registered you can go directly to www.metlife.com/mybenefits.

- Click on “Find a Dentist”
- Enter your ZIP Code
- Select “Dental HMO/Managed Care” for the Network Type
- Complete all required information (CITY OF DALLAS should be used for the plan name)

*Additional charges for initial exam (\$250), removable appliance therapy and fixed appliance therapy.

VISION COVERAGE

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan through Davis Vision helps you care for your eyes while saving you money⁵. Choose from a national network of independent, private practice doctors or select retail partners in 50 states. Visit www.davisvision.com/Member (client code: 7955) to find providers in your network.

In-Network Benefits	
Eye Examination	
Every 12 months. Covered in full after \$10 copayment	
Eyeglasses (One-year eyeglass breakage warranty is included on plan eyewear)	
Spectacle Lenses (Every 12 months)	<ul style="list-style-type: none"> Covered in full after \$10 copayment Clear plastic lenses in any single vision, bifocal, trifocal, or lenticular prescription; tinting; scratch-resistant coating; UV coating; standard and premium ARC; polycarbonate lenses; and standard progressives
Frames (Every 12 months)	<ul style="list-style-type: none"> Covered in full: Any Fashion, Designer or Premier frame from Davis Vision's Collection¹ (retail value up to \$195) <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> \$140 retail allowance toward any frame from provider, plus 20% off balance² <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> Receive a FREE frame at Visionworks³
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care (Every 12 months)	<ul style="list-style-type: none"> Collection Contacts: Covered in full after \$10 copay <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> Non Collection Contacts Standard & Specialty Contacts⁴: \$60 allowance with 15% off balance² less \$10 copay
Contact Lenses – if you do not choose eyeglasses (Every 12 months)⁴	<ul style="list-style-type: none"> Covered in full: Any contact lenses from Davis Vision's Contact Lens Collection up to 4 boxes for Planned Replacement or 8 boxes for Disposables¹ <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> \$130 retail allowance toward provider supplied contact lenses, plus 15% off balance, no copay required²

1 The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.

2 Additional discounts not applicable at Walmart, Sam's Club or Costco locations.

3 The free frame benefit is available at all Visionworks locations nationwide and includes all frames except Maui Jim eyewear.

4 Including, but not limited to toric, multifocal and gas permeable contact lenses.

5 Refer to the plan summary for a complete list of lens options and applicable member charges.



Out-Of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement. The out-of-network claim form can be found on the member portion of the website at www.davisvision.com/Member, using client code 7955. Out-of-network claims may also be submitted directly through the Davis Vision Mobile App.

Reimbursement Amount	Claims
Eye Examination up to \$40, Frame up to \$50 Spectacle Lenses (per pair) up to: Single Vision \$40 Bifocal \$60, Trifocal \$80, Lenticular \$100 Elective Contacts up to \$105 Visually Required Contacts up to \$225	Pay the provider directly for all charges and then submit a claim for reimbursement to: Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110

Value-Added Features and Extras

- **Mail Order Contact Lenses:** Replacement contacts (after initial benefit) through DavisVisionContacts.com
- **Laser Vision Correction:** Significant savings with discounts of up to 40-50 percent off the national average price of traditional LASIK. In addition, a one-time/lifetime allowance of \$500 is available. For more information regarding Laser Eye Services, contact Davis Vision at (855) 502-2020
- **One Year Breakage Warranty:** Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a Visionworks location where the Collection is not displayed.
- **Greater Benefits:** By visiting a Visionworks family of store locations you will receive a free frame (excludes Maui Jim brands)
- **Additional Savings:** At most participating network locations, members receive up to 20% off additional eyeglasses, sunglasses and items not covered by the benefit and 15% off disposable contact lenses.
- **Mail Order Contact Lenses:** Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.
- **Low Vision Services:** Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.
- **Eye Health & Wellness:** Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

Vision Bi-Monthly Rate	
Employee Only	\$2.46
Employee + Spouse	\$4.50
Employee + Child(ren)	\$4.72
Employee + Family	\$7.25



BASIC AND ADDITIONAL LIFE INSURANCE

It's not easy to think about, but could your family live without your income if you suddenly passed away? Would your family be able to cover the medical expenses associated with a terminal illness or with burial and funeral expenses? The City of Dallas offers life insurance for you and your family when tough situations arise. This coverage is administered through The Standard.

Eligibility

To be eligible for Basic and Additional Life:

- You must be an active employee of the City of Dallas excluding temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors
- If you are a full-time employee, you must be regularly working at least 40 hours each week
- If you are a part-time employee, you must be regularly working at least 20 hours each week, but less than 40 hours
- For Additional Life, you must be insured for Basic Life
- For Dependent Life insurance – Your spouse/domestic partner or children must not be full-time members of the armed forces or an active City of Dallas employee

Basic Life Insurance

- Full-time employees receive \$50,000 of Basic Life insurance coverage — the City of Dallas pays the full cost of this coverage for you.
- If you are a part-time employee, you may elect to purchase this coverage — your bi-monthly premium rate for this plan is \$0.0175 per \$1,000 of coverage per pay period (\$0.875 per pay period for \$50,000 in coverage).

Supplemental Life Insurance

In addition to Basic Life insurance, you may elect Supplemental Life insurance for yourself. You must have Basic Life insurance to elect Supplemental Life insurance.

Option 1	1 times your annual earnings, rounded to the next higher multiple of \$1,000, if not already of multiple of \$1,000. The maximum amount is \$500,000
Option 2	2 times your annual earnings, rounded to the next higher multiple of \$1,000, if not already of multiple of \$1,000. The maximum amount is \$500,000
Option 3	3 times your annual earnings, rounded to the next higher multiple of \$1,000, if not already of multiple of \$1,000. The maximum amount is \$500,000

You will be required to name a beneficiary – the person(s) who will receive the life insurance benefit in the event of your death – upon your initial enrollment. If you want to make changes to your beneficiary(ies) at any time during the year, please contact our benefits enrollment vendor at (214) 556-0971.

Calculating Your Costs

Follow these steps to calculate your Supplemental Life Insurance coverage cost:

Choose the amount of coverage you want. _____
Line 1

Divide the amount in Line 1 by \$1,000. _____
Line 2

Use the chart to the right to find the cost for your age and enter on Line 3. Your rate = _____
Line 3

Multiply the amount in Line 2 by the amount in Line 3 to find your bi-weekly cost. _____
Line 4

You may also visit The Standard's online coverage cost calculator at <https://www.standard.com/individual/products-services/workplace-benefits/insurance/estimate-life-insurance-needs>.

Supplemental Life Insurance Bi-Monthly Rate	
Employee's Age (on last January 1)	Rate (Per \$1,000 of total coverage)
<25	\$0.0215
25-29	\$0.0260
30-34	\$0.0360
35-39	\$0.0370
40-44	\$0.0450
45-49	\$0.0750
50-54	\$0.1150
55-59	\$0.2110
60-64	\$0.3050
65-69	\$0.5750
70+	\$1.0300

Evidence of Insurability

You may elect to increase your coverage by 1 times your annual earnings during annual enrollment without submitting Evidence of Insurability (EOI). However, EOI is required if:

- You increase coverage by more than 1 times your annual earnings, not to exceed 3 times your annual earnings
- The date you apply is more than 30 days after you become eligible
- You request coverage increases, reinstatement of terminated coverage, or coverage for members eligible but not insured under prior plans

If you have questions regarding the EOI form, please contact our benefits enrollment vendor at (214) 556-0971.

Dependent Life Insurance

You may also buy optional life insurance for your eligible dependents. The amount of coverage for your spouse or children may not exceed 100 percent of your combined basic and additional life coverage.

Option 1	\$15,000 Spouse \$5,000 Children	\$1.215 per pay period, regardless of the number of eligible dependents covered
Option 2	\$25,000 Spouse \$10,000 Children	\$2.230 per pay period, regardless of the number of eligible dependents covered

Accelerated Benefits

Under the Accelerated Benefit provision, if you are a full-time employee regularly working at least 40 hours each week, you may be eligible to receive up to 75 percent, or a maximum of \$500,000, of your Additional Life insurance coverage if you become terminally ill, have a life expectancy of less than 12 months, and meet other eligibility requirements.

The amount of Additional Life insurance payable upon your death is reduced by the Accelerated Benefit paid and an interest charge.

Active Work Requirements

If you are not actively at work on the day before the scheduled effective date of insurance including Dependent Life insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Age Reductions

Under this plan, your insurance will not be reduced because of your age.

Suicide Exclusion

Contributory (employee paid) Life coverage includes an exclusion for death resulting from suicide or other intentionally self-inflicted injury. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage. Please contact The Standard at (877) 474-4250 for additional information.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Voluntary AD&D insurance provides benefits to you or your beneficiaries in the event of an accidental injury or death.

Employee Coverage

You may elect voluntary AD&D coverage in increments of \$25,000, up to a maximum of \$250,000. However, amounts above \$150,000 cannot exceed 10 times your annual earnings.

Dependent Coverage

If you elect coverage for yourself, you may also elect coverage for your dependents.

- Spouse/Domestic Partner only: 60 percent of your voluntary AD&D coverage amount
- Children only: 20 percent of your voluntary AD&D coverage amount, up to a maximum of \$50,000 per child
- Spouse/Domestic Partner and Children: 50 percent of your voluntary AD&D coverage amount for your spouse/domestic partner and 15 percent of your voluntary AD&D coverage amount for each child. The amount of coverage for your children may not exceed \$50,000 per child

Benefit Amount

The amount of this AD&D Insurance Benefit for other covered losses is a percentage of the amount payable for Additional AD&D insurance coverage on the date of the accident.

Type of Loss	Percentage Payable
Life ¹	100%
One hand or foot ²	50%
Sight in one eye	50%
Audible speech	50%
Hearing in both ears	50%
Two or more of the losses listed above	100%
Thumb and index finger of the same hand ³	25%
Quadriplegia ⁴	100%
Hemiplegia ⁴	50%
Paraplegia ⁴	75%
Uniplegia ⁴	25%
Coma	*

Features

- Air Bag Benefit** – provides an additional benefit in the event of a covered automobile accident for which a Seat Belt Benefit is payable
- Family Benefits Package** – eligible family members may be entitled to receive additional financial help for child care, college or career training. Included are the Child Care Benefit, Higher Education Benefit and Career Adjustment Benefit
- Paralysis Benefit** – provides a portion of your AD&D benefit if you suffer an accident that results in quadriplegia, hemiplegia, or paraplegia
- Public Transportation Benefit** – provides an additional benefit in the event of death as a result of an accident that occurs while you are riding as a fare-paying passenger on public transportation
- Seat Belt Benefit** – provides an additional benefit in the event of a covered automobile accident
- Adaptive Home and Vehicle Benefit** – provides an additional benefit if you suffer a loss, other than loss of life and is a onetime benefit in which accommodations may be made to your principal residence or automobile
- Line of Duty Benefit** – Additional benefit for Public Safety Officers who suffer an AD&D loss. Lesser of \$50,000 or 100 percent of the AD&D benefit inconvenience

¹ This benefit includes loss of life due to exposure or disappearance. Disappearance must be caused directly by an accident that could have reasonably resulted in death and must occur independently of all other causes continuing for a period of 365 days after the date of the accident despite reasonable search efforts.

² This benefit is payable whether or not the hand or foot is surgically reattached.

³ This benefit is not payable if an AD&D insurance benefit is payable for the loss of the entire hand.

⁴ This benefit is not payable for loss of function of a hand or foot if an AD&D Insurance Benefit is payable for Quadriplegia, Hemiplegia, Paraplegia or Uniplegia involving that same hand or foot.

* Payments for coma is 1 percent per month of the remainder of the AD&D Insurance Benefit payable for Loss of life after reduction by any AD&D Insurance Benefit paid for any other Loss as a result of the same accident. Payments for coma will not exceed a maximum of 11 months.



Premium Examples (Age under 70)

Below you will find the actual cost per Pay Period, based on the benefit amount you elect.

Employee Only	
Benefit Amount	Bi-Monthly Rate
\$25,000	\$0.310
\$50,000	\$0.625
\$75,000	\$0.935
\$100,000	\$1.250
\$125,000	\$1.560
\$150,000	\$1.875
\$175,000	\$2.185
\$200,000	\$2.500
\$225,000	\$2.810
\$250,000	\$3.125

Employee/Family	
Benefit Amount	Bi-Monthly Rate
\$25,000	\$0.500
\$50,000	\$1.000
\$75,000	\$1.500
\$100,000	\$2.000
\$125,000	\$2.500
\$150,000	\$3.000
\$175,000	\$3.500
\$200,000	\$4.000
\$225,000	\$4.500
\$250,000	\$5.000

Active Work Requirements

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until you complete one day of active work as an eligible employee.

Age Reductions

Under this policy, insurance coverage reduces to 65 percent at age 70, 45 percent at age 75, 30 percent at age 80, and 15 percent at age 85. If you are age 70 or over, ask The Standard at (877) 474-4250 for the amount of coverage available.

Limitations

The loss must occur solely by an accident and independently of all other causes, within 365 days after the accident. Loss of life must be evidenced by a certified copy of the death certificate. All other losses must be certified by a physician in the appropriate specialty as determined by The Standard.

RETIREMENT SAVINGS PLAN

Everyone wants to be financially secure in retirement. At the City of Dallas, we're here to help by offering you the exceptional opportunity to save for retirement through our 401(k) or 457(b) plan. After all, it's never too early to start saving.

Why Invest?

Convenience	Your contributions are automatically deducted regularly from your paycheck.
Tax savings now	Your pretax contributions are deducted from your pay before income taxes are taken out. This means that you can actually lower the amount of current income taxes you pay each period. It could mean more money in your take-home pay versus saving money in a taxable account.
Roth options	You may make after-tax contributions and take any associated earnings tax-free* at retirement — as long as the distribution is a qualified one. Additionally, converting to a Roth can be beneficial if you expect your tax rate to increase in the future, because you pay taxes on the money you convert now.
Tax-deferred savings opportunities	You pay no taxes on any earnings until you withdraw them from your account, enabling you to keep more of your money working for you now.
Portability	You can rollover eligible savings from a previous employer into this Plan. You can also take your plan vested account balance with you if you leave the City.
Investment options	You have the flexibility to select from investment options that range from more conservative to more aggressive, making it easy for you to develop a well-diversified investment portfolio.

Key Features

- You can contribute up to 99 percent of your gross annual pay, up to the annual IRS dollar limits.
- You are always 100 percent vested in your own contributions.
- You decide how you invest your savings by choosing from a portfolio of investment options.
- You receive account statements and have 24-hour access to your account information.

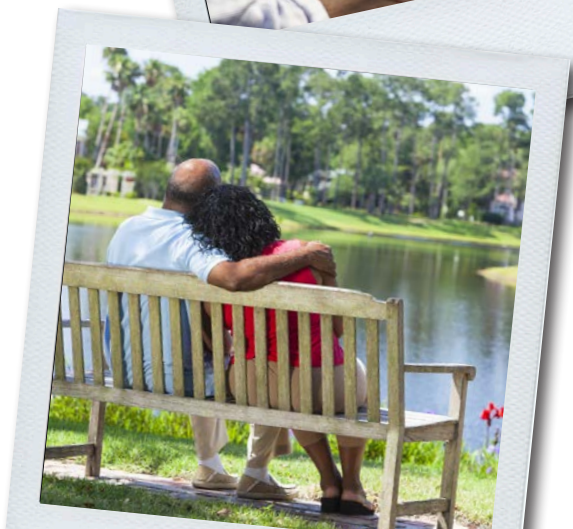
Enrolling and More Information

If you are ready to enroll or would like more information, log on to Fidelity NetBenefits at www.netbenefits.com/enroll or call the Fidelity Retirement Representatives at (800) 343-0860.

Need More Help?

Schedule a complimentary one-on-one appointment with a Fidelity Retirement Planner by calling 1 (800) 642-7131 or go to www.getguidance.fidelity.com.

*A distribution from a Roth account is tax free and penalty free, provided the five-year aging requirement has been satisfied and one of the following conditions is met: age 59½, disability, qualified first-time home purchase, or death.





DISABILITY PRODUCTS

Disability benefits can help injured or ill employees meet their financial obligations, such as mortgage or rent payments - expenses that medical insurance does not cover. Coverage through City of Dallas can give you access to affordable rates and comprehensive services, including assistance when you are returning to your job.

Are you interested in Short-Term or Long-Term Disability insurance? Contact our benefits enrollment vendor at (214) 556-0971 for rates and additional details.

Short-Term Disability (STD) Insurance

Definition of Disability

You will be considered disabled if, as a result of physical disease, injury, pregnancy, or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, and
- You suffer a loss of at least 20 percent in your pre-disability earnings (PDE) when working in your own occupation
- You are not disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

Overview of Your Benefits

Pre-disability earnings (PDE) means your average earnings, which are the greater of your base compensation in effect on the effective date or your actual total pay for the prior fiscal year. Your benefit may be reduced by deductible income if you earn income from certain other sources while receiving disability benefits.

Short-Term Disability	
Benefit Amount	Your weekly STD benefit is 60 percent of the first \$2,500 of your weekly insured pre-disability earnings, reduced by deductible income. Your minimum weekly benefit is \$25.
Maximum Benefit Period	180 days minus the length of the benefit waiting period.

Resources for Employees

- **Reasonable Accommodation Expense Benefit (if you are on the job):** The purchase of equipment or tools for an employee to use in the workplace may be covered through The Standard's Reasonable Accommodation Expense Benefit (up to \$25,000). You do not need to have an active claim to qualify.
- **Contact our benefits enrollment vendor at (214) 556-0971 for cost and additional details.**

LONG-TERM DISABILITY INSURANCE

Definition of Disability

For the benefit waiting period and the first 24 months for which LTD benefits are paid, you are considered disabled if, as a result of physical disease, injury, pregnancy, or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation AND are suffering a loss of at least 20 percent of your indexed pre-disability earnings when working in your own occupation. You are not disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

After the own occupation period of disability, you will be considered disabled if, as a result of physical disease, injury, pregnancy, or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Overview of Your Benefits

Long-Term Disability	
Benefit Amount	Your monthly benefit is 60 percent of the first \$8,333 of your insured pre-disability earnings reduced by deductible income. Your minimum monthly benefit is \$100.
Maximum Benefit Period	If you become disabled before age 62, LTD benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years and 6 months, whichever is longer. If you become disabled at age 62 or older, the benefit is based on a schedule.

Pre-disability earnings (PDE) means your average earnings, which is the greater of your base compensation in effect on the effective date or your actual total pay for the prior fiscal year. Your benefit may be reduced by deductible income if you earn income from certain other sources while receiving disability benefits.

Resources for Employees

- **Reasonable Accommodation Expense Benefit (if you are on the job):** The purchase of equipment or tools for an employee to use in the workplace may be covered through The Standard's Reasonable Accommodation Expense Benefit (up to \$25,000). You do not need to have an active claim to qualify.
- **Contact our benefits enrollment vendor at (214) 556-0971 for cost and additional details.**



SUPPLEMENTAL HEALTH PRODUCTS

Hospital Indemnity: A Cash Benefit When You Need It.

Even the best budgeters can forget to set aside money for medical expenses. Hospital Indemnity insurance provides a way to cover unexpected out-of-pocket expenses when you end up in the hospital. It also allows you to:

- **Choose how to spend your benefit.** It's your money — spend it however you want, whether it's to pay for your groceries, rent or medical bills.
- **Get a break from paying premiums during long hospital stays.** If you are in the hospital for more than 30 days, you will be able to stop making premium payments until you're discharged.
- **Take it with you.** If you leave your job, you can take your coverage with you.
- **Receive a benefit for taking care of your health.** You can get a Health Maintenance Screening Benefit of \$50 once a calendar year just for going to the doctor for a covered wellness exam, such as a bone density screening or mammogram — routine preventive visits that typically cost you nothing under your medical plan.

Accident Insurance: Help Ensure Your Financial Plans Stay Healthy Even When You're Not.

In the event of a covered accident, your Accident insurance will pay a benefit directly to you. You can use this money wherever you need it most — whether that's to help with your deductible, copays and other medical bills, or your daily expenses while you recover. Just a couple of the many benefits of this plan include:

- **Affordable group rates.** Because you'll be buying this insurance through City of Dallas, you'll have access to affordable group rates. You'll also have the convenience of having your premium deducted directly from your paycheck. Your rates will not increase as you grow older — meaning you'll pay the same premium for the life of the policy, even if you continue your coverage after your employment with City of Dallas ends (this is known as portability).
- **Health maintenance screening benefit.** You can get a Health Maintenance Screening Benefit of \$75 each year just for going to the doctor for a covered wellness exam, such as a stress test or lipid panel — a routine preventive visit that typically costs you nothing under your medical insurance.

Supplemental Health Products, including Hospital Indemnity, Accident insurance and Critical Illness insurance, can help you pay for medical expenses not covered by medical insurance!

Hospital Indemnity Bi-Monthly Rates	
Employee Only	\$7.35
Employee + Spouse	\$15.62
Employee + Child(ren)	\$13.97
Employee + Family	\$23.69



Accident Insurance Bi-Monthly Rates	
Employee Only	\$7.33
Employee + Spouse	\$11.57
Employee + Child(ren)	\$13.82
Employee + Family	\$21.62

Critical Illness insurance: An Extra Layer of Protection

- **Update your coverage as needed.** As your life circumstances change, increase* or decrease your coverage.
- **Lock in your rate.** For example, if you're 35 when your coverage becomes effective, you'll pay a 35-year-old's rate for as long as you have the coverage. If you increase your coverage amount at age 45, you will continue to pay a 35-year-old's rate for that increased coverage amount for so long as you have that increased coverage amount.
- **Take it with you.** If you leave your job, you can take your coverage with you.
- **Pick and choose how to spend your benefit.** Spend your lump-sum benefit however you want.
- **Protect your loved ones.** Cover your spouse up to \$30,000. Your kids are automatically covered at 50 percent of the amount elected for yourself for the same critical illnesses that you are. Kids are also covered for 21 additional childhood diseases, including cystic fibrosis, Down syndrome, muscular dystrophy, spina bifida and cerebral palsy.
- **Receive a benefit for taking care of your health.** You and your covered loved ones receive a Health Maintenance Screening benefit of \$50 once per calendar year when visiting the doctor for a covered wellness exam, such as a cholesterol screening (part of a lipid panel) or mammogram — routine preventive visits that typically cost you nothing under your medical insurance.
- **Receive additional benefits.** If you are diagnosed with a covered illness again after a treatment-free period of 12 months, you will receive 100 percent of the original benefit amount. If you are diagnosed with a different and subsequent covered illness at least 90 days after the diagnosis of the first critical illness, you will receive an additional Critical illness benefit.

*Evidence of good health may be necessary in some cases. Contact the Benefits Service Center for more information.

Non-Tobacco Bi-Monthly Issue Age Premiums					
Coverage Amount	Age Band				
	< 30	30-39	40-49	50-59	60-70
\$5,000	\$1.60	\$2.78	\$4.75	\$9.18	\$16.48
\$10,000	\$3.20	\$5.55	\$9.50	\$18.35	\$32.95
\$15,000	\$4.80	\$8.33	\$14.25	\$27.53	\$49.43
\$20,000	\$6.40	\$11.10	\$19.00	\$36.70	\$65.90
\$25,000	\$8.00	\$13.88	\$23.75	\$45.88	\$82.38
\$30,000	\$9.60	\$16.65	\$28.50	\$55.05	\$98.85
\$35,000	\$11.20	\$19.43	\$33.25	\$64.23	\$115.33
\$40,000	\$12.80	\$22.20	\$38.00	\$73.40	\$131.80
\$45,000	\$14.40	\$24.98	\$42.75	\$82.58	\$148.28
\$50,000	\$16.00	\$27.75	\$47.50	\$91.75	\$164.75

Tobacco Bi-Monthly Issue Age Premiums					
Coverage Amount	Age Band				
	< 30	30-39	40-49	50-59	60-70
\$5,000	\$2.20	\$4.58	\$9.18	\$19.95	\$37.53
\$10,000	\$4.40	\$9.15	\$18.35	\$39.90	\$75.05
\$15,000	\$6.60	\$13.73	\$27.53	\$59.85	\$112.58
\$20,000	\$8.80	\$18.30	\$36.70	\$79.80	\$150.10
\$25,000	\$11.00	\$22.88	\$45.88	\$99.75	\$187.63
\$30,000	\$13.20	\$27.45	\$55.05	\$119.70	\$225.15
\$35,000	\$15.40	\$32.03	\$64.23	\$139.65	\$262.68
\$40,000	\$17.60	\$36.60	\$73.40	\$159.60	\$300.20
\$45,000	\$19.80	\$41.18	\$82.58	\$179.55	\$337.73
\$50,000	\$22.00	\$45.75	\$91.75	\$199.50	\$375.25



IMPORTANT NOTICES

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 the Plan 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 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 are eligible for Medicare 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 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% 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 (214) 671-6947 Option 1 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 800-MEDICARE (800-633-4227). TTY users should call (877) 486-2048.

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

August 2019
City of Dallas
Benefits Service Center
1500 Marilla Street, 1D South,
Dallas, TX 75201
(214) 671-6947 Option 1

Notice of Privacy Practices

Effective Date: April 14, 2003 Revised: August 31, 2015

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. The Health and Wellness Organized Health Care Arrangement "OHCA" includes the following plans and wellness program of the City of Dallas:

3. City of Dallas Active Employee Health Benefits Plan;
4. City of Dallas Retiree Health Benefits Plan
5. City of Dallas Active Employee Prescription Drug Plan;
6. City of Dallas Retiree Prescription Drug Plan;
7. Employee Medical Spending Account that is part of the City of Dallas Cafeteria Plan;
8. City of Dallas Onsite Clinic;
9. City of Dallas Active Employee Vision Benefits Plan
10. City of Dallas Active Employee Dental Benefits Plan
11. City of Dallas Retiree Vision Benefits Plan
12. City of Dallas Retiree Dental Benefits Plan; and
13. City of Dallas Wellness Program

These plans and program will be working together purposes of healthcare operations, using common systems to provide benefits to you.

Our Privacy Principles

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

- Our practices regarding the use and disclosure of your protected health information
- Your rights with respect to your protected health information
- Our 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 our privacy practices and
- Any breach of your unsecured Protected Health Information (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 according to the Privacy Rule and our legal obligations regarding them. We shall abide by the terms of this notice for all health or medical information retained by the OHCA. In this notice the terms "we," "our," and "OHCA" are used interchangeably to refer to the separate plans and program listed above as part of the City of Dallas Health and Wellness OHCA. The term "health information" refers to the information about you, your spouse, or your dependent(s) that is used or disclosed to the OHCA concerning your physical or mental health or the medical services you received, your health benefits and payments. Health information includes all identifying information you provide to the any plans or program listed above to enroll for coverage, receive benefits, or participate in a program.

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

Privacy Officer: (214) 670-1208

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 or Wellness Staff. Employees and business associates will have access to view your health information to perform certain activities for the OHCA. They will be given access to your information to help you with your inquiries related to your plan(s) or program. They may also access your information to perform business or administrative functions for the plan(s) and program. 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 results 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 plans and program listed above. 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

When the plans and program in the OHCA 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 a plan covers a prospective treatment or medication, they may contact us (or our third-party administrator) for this information. We may also share your personal information (name, DOB, social security, address or other identifying information) with Cigna, 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 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, Health Plan Contributions or Benefit

The plans and program 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) or 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, your spouse, or your dependents. The OHCA may also provide your health information to business associates (e.g. billing companies, claims processing companies) that participate in billing and payment activities for the plans and program in the OHCA.

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 plans and program in the OHCA. 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, attorneys, 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 for up to seven (7) years.

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 your 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 official file is incorrect or incomplete, you must submit 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. You 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 (214) 671-6947 Option 1. You may also view this notice at the health plans website at www.cityofdallasbenefits.org.

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 regarding your privacy rights, please call the City of Dallas Privacy Officer at (214) 670-1208. If you believe your privacy rights have been violated, you may file a complaint by contacting the City of Dallas Privacy Officer at (214) 670-1208, by calling the Confidential Hotline at (855)345-4022, by email at hipaacompliance@dallascityhall.com or with the Department of Health and Human Services. You will not be penalized for filing a complaint.

Human Resources Department	ATTN: Benefits Service Center 1500 Marilla Street, Room 1D South Dallas, TX 75201-6390 Phone: (214) 671-6947 Option 1 Fax: (214) 659-7098
Human Resources Department	Cigna Plans (HRA – Premium Copay – HSA) Phone: (800) 244-6224 Caremark (CVS) – Prescription Services Phone: (855) 465-0023 Davis Vision – Vision Plan Phone: (800) 999-5431 MetLife – Dental Plan Phone: (855) 676-9442
U. S. Department of Health and Human Services	Centers for Medicare and Medicaid Services Website: www.cms.hhs.gov Phone: (877) 267-2323, Ext. 61565

COBRA Rights Notice

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

For City of Dallas employees, the right to COBRA continuation coverage is maintained by Title XXII of the Public Health Service Act. COBRA continuation coverage can become available to you and other members of your family when City health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child"

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

For more information about your rights under the Public Health Service Act, contact the Centers for Medicare & Medicaid Services at 410-786-1565 or online at www.cms.gov. For information about your rights under the Patient Protection and Affordable Care Act, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

August 2019
City of Dallas
COBRA Call Center
1500 Marilla Street, 1D South,
Dallas, TX 75201
(866) 747-0048

COBRA Coverage: What You Pay

COBRA Monthly HRA Plan Rates (100% employee contribution + 2% admin fee)	
Coverage Level	Monthly Contribution
Employee Only	\$569.02
Employee + Spouse	\$1,134.80
Employee + Child(ren)	\$1,040.50
Employee + Family	\$1,472.35

COBRA Monthly Premium Copay Plan Rates (100% employee contribution + 2% admin fee)	
Coverage Level	Monthly Contribution
Employee Only	\$515.45
Employee + Spouse	\$1,118.45
Employee + Child(ren)	\$965.94
Employee + Family	\$1,458.80

COBRA Monthly HSA Plan Rates (100% employee contribution + 2% admin fee)	
Coverage Level	Monthly Contribution
Employee Only	\$534.16
Employee + Spouse	\$1,159.07
Employee + Child(ren)	\$1,001.02
Employee + Family	\$1,511.78

COBRA Monthly Dental Plan Rates		
Coverage Level	Dental PPO	Dental HMO
Employee Only	\$33.44	\$8.36
Employee + Spouse	\$61.51	\$15.38
Employee + Child(ren)	\$62.31	\$15.46
Employee + Family	\$86.91	\$21.75

COBRA Monthly Vision Plan Rates	
Coverage Level	Monthly Contribution
Employee Only	\$5.01
Employee + Spouse	\$9.17
Employee + Child(ren)	\$9.62
Employee + Family	\$14.78

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.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not 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 delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

Notice of Special Enrollment Rights

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 (214) 671-6947 Option 1.

60-Day Special Enrollment Period

In addition to the qualifying events mentioned in this guide, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP

Continuation of Health Coverage During Family & 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.

Health Insurance Marketplace Notice

Through the Affordable Care Act, Health Insurance Exchanges have been established across the country. Each state had the option to set up a state-based insurance Marketplace that allows individuals and employers to easily compare and evaluate health insurance plans. The state of Texas elected not to implement a state exchange, so the Health Insurance Exchange is run by the Federal government. Enrollment in health coverage on the Marketplace will open in November, with plans effective on January 1, 2018. 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 plans meet 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 (214) 671-6947 Option 1

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

Texas Residents

Website: <http://www.gethiptexas.com>

Phone: (800) 440-0493

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U. S. Department of Labor	Employee Benefits Security Administration Website: www.dol.gov/ebsa Phone: (866) 444-EBSA (3272) OMB Control Number: 1210-0137
U. S. Department of Health and Human Services	Centers for Medicare and Medicaid Services Website: www.cms.hhs.gov Phone: (877) 267-2323, Ext. 61565

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Since key parts of the health care law took effect in 2014, there is another 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 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 tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

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 doesn't meet certain standards. The savings on your premium that you're 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 9.86 percent of your household income for the year, or if the coverage your 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 your coverage offered by your employer, please check your summary plan description or contact the City of Dallas Benefits Service Center at (214) 671-6947 Option 1.

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 Street, 1DS		6. Employer Phone Number (214) 671-6947 Option 1	
7. City Dallas	8. State TX	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 hrbenefits@dallascityhall.com	

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

As your employer, we offer a health plan to some employees. Eligible employees are:

- Full-time permanent employees, permanent part-time employees and variable hour employees who are intended to work at least 30 hours per week on average

With respect to dependents, we do offer coverage. Eligible dependents are:

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

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](https://www.healthcare.gov) will guide you through the process.

Benefit Participation Upon Retirement

Per Article IV SEC. 34-32 (4) of the City of Dallas Personnel Rules, if a person is not participating in the city's health benefit program at the time the person retires from the city, the person is not eligible for continued health benefits coverage.

NOTES

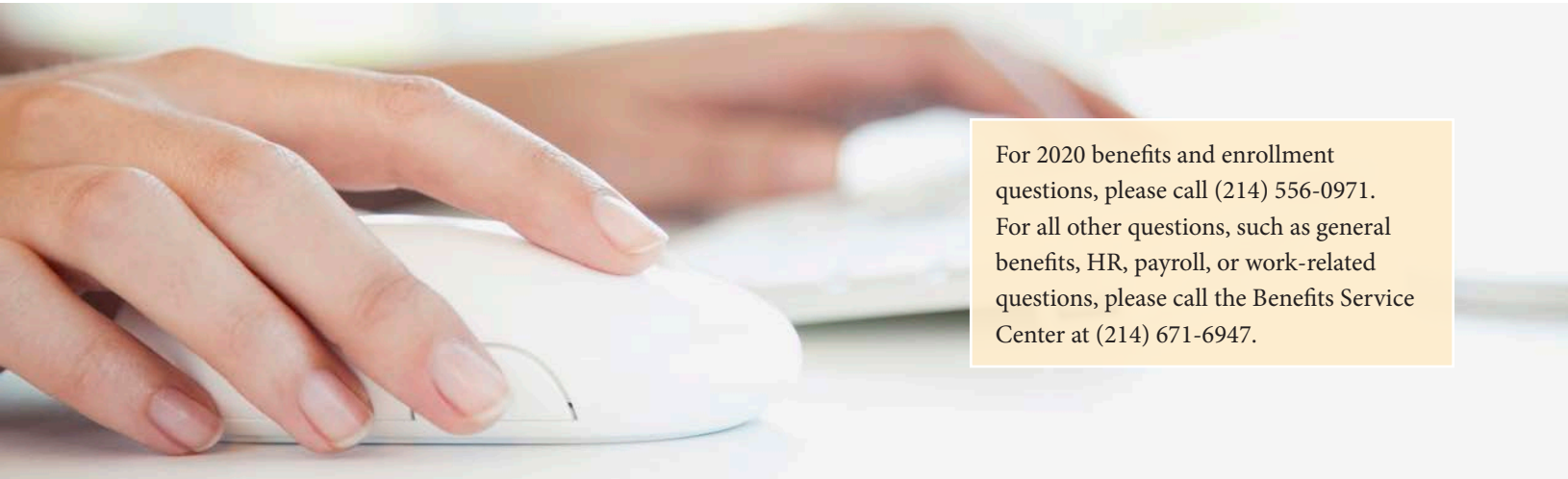
Notes area containing 20 horizontal dotted lines for writing.

NOTES

A series of horizontal dotted lines for writing notes.

IMPORTANT CONTACTS

Resource	Carrier	Phone Number	Email/Web Address
City of Dallas Benefits Service Center	N/A	(214) 671-6947	hrbenefits@dallascityhall.com
Benefits Enrollment	Enrollment Benefit Concepts (EBC)	(214) 556-0971	https://standard.benselect.com/cityofdallas
Medical Plan	Cigna	(800) 244-6224	www.mycigna.com
Telehealth Connection	Amwell for Cigna/ MDLIVE for Cigna	(855) 667-9722; (888) 726-3171	AmwellforCigna.com MDLIVEforCigna.com
Onsite and Near-site Clinics	CareATC	(214) 446-6029 (800) 993-8244	https://portal.careatc.com/Account/Login
Diabetes Management	Kannact	(855) 722-5513	www.kannact.com/cityofdallas
Pharmacy Plan	CVS/Caremark	(855) 465-0023	www.caremark.com
Vision Plan	Davis Vision	(800) 999-5431 Client code 7955	www.davisvision.com/member Client code 7955
Dental Plan	MetLife	(855) 676-9442	www.mybenefits.metlife.com
COBRA	Cushion	(866) 218-0614	https://cushion1.webcobra.com/Default.aspx
Basic and Additional Life Insurance	The Standard	(800) 628-8600	www.standard.com
Voluntary AD&D Insurance	The Standard	(800) 628-8600	www.standard.com
Hospital Confinement Indemnity	The Standard	(866) 851-5505	www.standard.com
Accident Insurance	The Standard	(866) 851-5505	www.standard.com
Lump Sum Critical Illness	The Standard	(866) 851-5505	www.standard.com
Short-Term Disability Insurance	The Standard	(800) 368-2859	www.standard.com
Long-Term Disability Insurance	The Standard	(800) 368-1135	www.standard.com
Employee Assistance Program	Cigna	(877) 622-4327	www.cignabehavioral.com Employer ID: dallascityhall
401(k) and 457 Plans	Fidelity	(800) 343-0860	www.mysavingsatwork.com/atwork.htm
Employee Retirement Fund	N/A	(214) 580-7700	www.dallaserf.org
Dallas Police and Fire Pension	N/A	(800) 638-3861	www.dpfp.org
FSA/DCAP	Cigna	(877) 424-3570	www.mycigna.com
City of Dallas Help Desk	N/A	(214) 670-1234	1234@dallascityhall.com
City of Dallas Human Resources	N/A	(214) 670-3120	askhr@dallascityhall.com



For 2020 benefits and enrollment questions, please call (214) 556-0971. For all other questions, such as general benefits, HR, payroll, or work-related questions, please call the Benefits Service Center at (214) 671-6947.



This guide highlights the main features of many of the benefit plans sponsored by the City of Dallas. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. The City of Dallas reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time.



City of Dallas