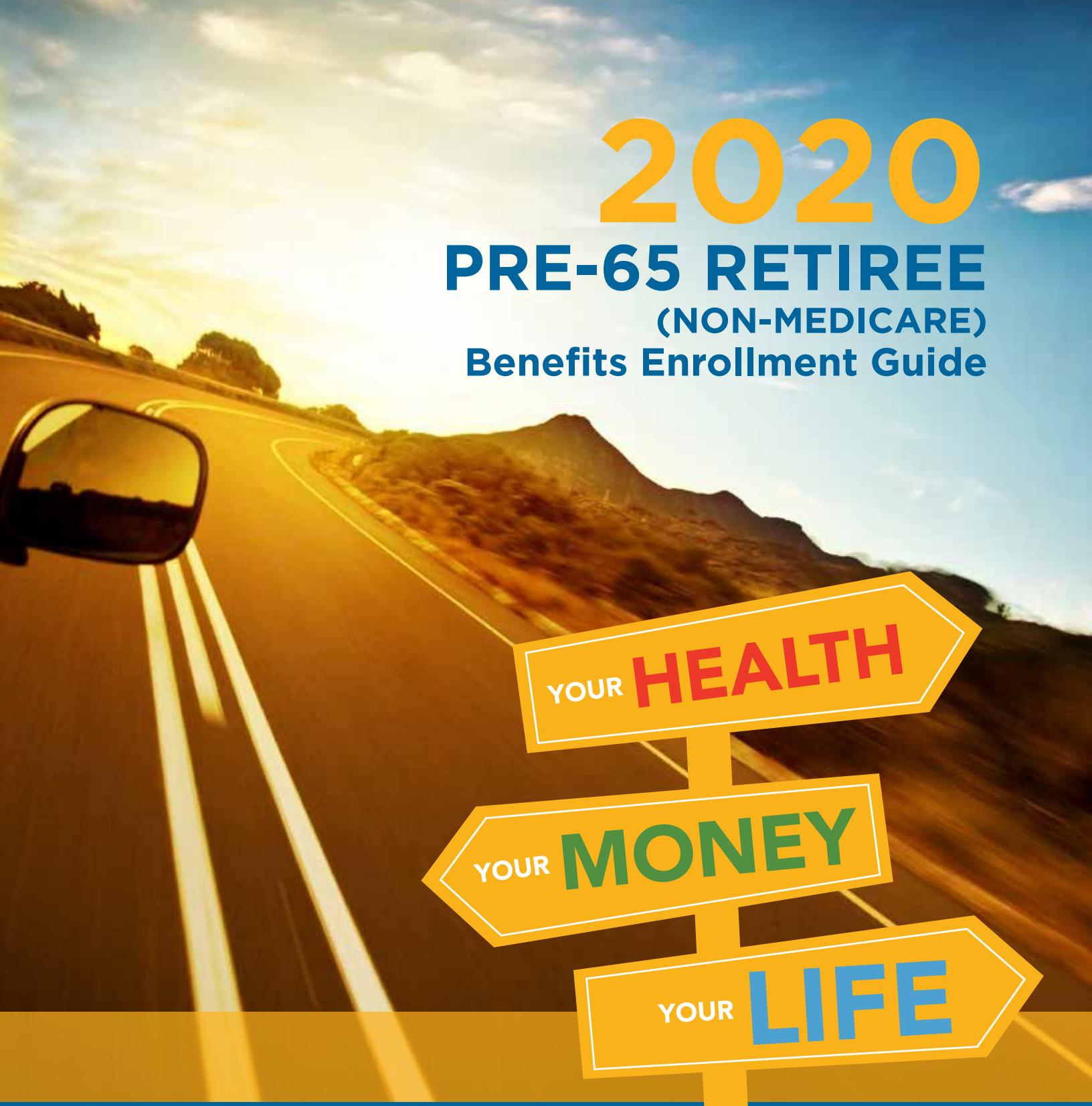
2020
PRE-65 RETIREE
(NON-MEDICARE)
Benefits Enrollment Guide



City of Dallas

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.

TABLE OF CONTENTS

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 26 for more details.

GREETINGS CITY OF DALLAS RETIREE

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

What You Need To Know:

- Your 2020 Open Enrollment period is October 2 – October 25, 2019.
- You must enroll in benefits in order to have coverage for 2020. Your current benefits 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 or on the phone 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

- Medical 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

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.

Health benefits coverage under state and federal laws: The City of Dallas Retiree Health Benefit Plan ("Plan") provides all retirees who are not eligible for Medicare benefits with the same level of benefits as the City provides its active employees and substitutes Medicare Supplement coverage for all Medicare-eligible retirees, as provided in Texas Local Government Code chapter 175. The Plan is minimum essential coverage, as defined by section 5000A(f)(E)(2)(A) of the Internal Revenue Code, because it is a governmental plan within the meaning of section 2791(d)(8) of the Public Health Service Act.

ENROLLMENT OVERVIEW

How to Enroll

The City of Dallas offers two 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)

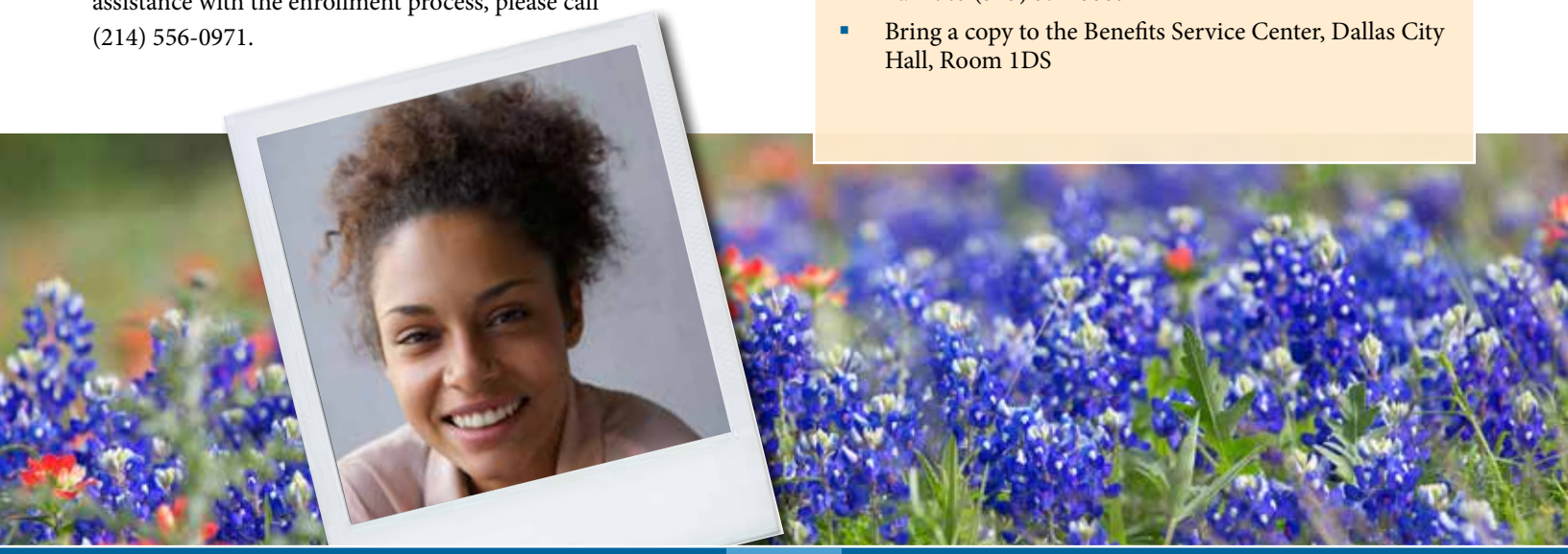
Benefit Specialists can enroll you over the phone as well. The call center is available to help you with questions, rates, and your enrollment. The call center will be open Monday – Friday, 8:15 a.m. – 5:15 p.m. To get started, just call (214) 556-0971.

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



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

Reminders

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

1. The Open Enrollment period for 2020 starts October 2, 2019 and ends on October 25, 2019.

2. You must report a Qualifying Life Event within 30 days of that event to change your benefits plan.

3. New retirees must enroll in a benefits plan within 30 days of their retirement date; otherwise, they forfeit coverage.

NOTE: As a retiree, you may waive coverage at any time by completing a waiver form. Please be advised once your benefits are waived, you may not re-enroll in a City of Dallas benefits plan.

Non-Medicare Eligible Retiree Information

Enrollment Period: **October 2, 2019** through **October 25, 2019.** We encourage you to enroll early in this period to avoid the high volume of activity that occurs late in the enrollment period.

Verification of Personal Information

To receive your identification cards promptly, make sure that the Benefits Service Center maintains your correct address in the City's Human Resources Information System (HRIS). You may call the Benefits Service Center at (214) 671-6947, option 1 to report an address change or other corrections.

How to Enroll for New Retirees after Open Enrollment

If you are planning to retire in 2020, call or make an appointment with the Benefits Service Center before your retirement date to discuss retiree enrollment options and payroll deductions. You must enroll within 30 days of your date of retirement. You may be asked to pay up to 1.5 months of retiree health premiums in advance, depending on the date of retirement. If you do not enroll within 30 days of your retirement date, the Benefits Service Center will presume that you have waived your retiree coverage with the City of Dallas. You will not be eligible to participate in the City's health coverage in the future.

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

Dependent Information

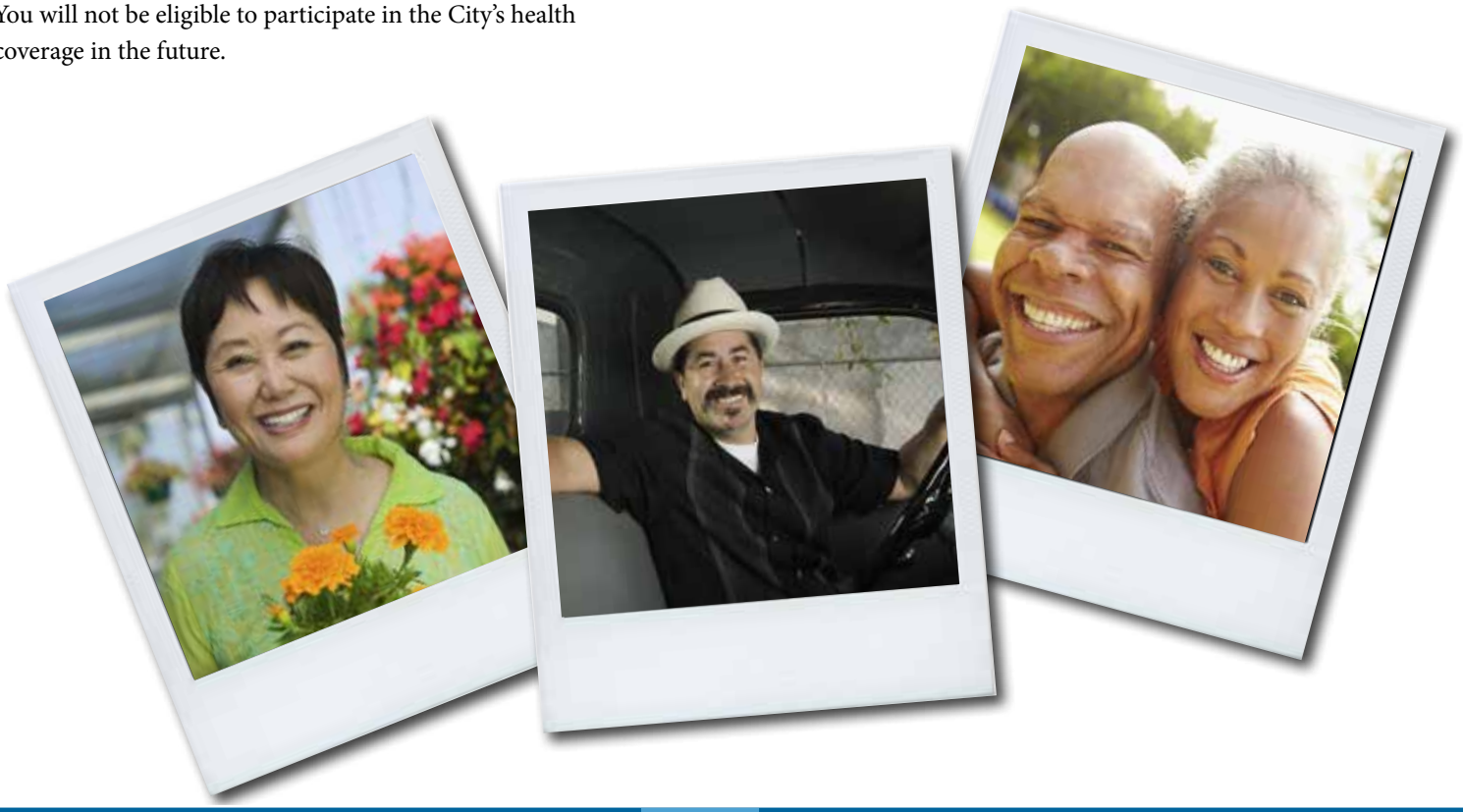
To update your dependent information for 2020, please take one of the following steps:

1. Call the Benefits Service Center and speak with a representative to add or remove a dependent(s). Please provide documentation as listed on the Eligible Dependent chart in this guide.

2. If you do not plan to make changes, no action is required. Please check your current information for accuracy.

- Elections made by calling the Benefits Service Center will be treated as an agreement to pay any required premium through pension check deductions.

Should you experience a long hold time when calling, leave a voicemail message with a daytime telephone number. A customer service representative will call you back within two business days. Spanish-speaking assistance is available.



Special Note

If you cancel your medical coverage as a retiree, this is considered a voluntary waiver of coverage. You or your dependents may not re-enroll in any City–Sponsored medical plans in the future.

Duplicate Medical Coverage by Retiree

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

Important Disclaimers

Paying for Medical Coverage

Medical contributions are paid on a post-tax basis for all retirees. Your annual cost of medical coverage depends on the benefit option you choose and the level of coverage you need. Contribution costs for 2020 can be found in this benefits guide.

- Contributions shall be paid by pension check deduction by all Members who receive pension checks in sufficient amount to permit deduction for the contributions. For each regular pension check during the plan year a member will pay the monthly rates indicated in Article IV of the Master Plan Document. If for any reason a Member's pension check is not reduced by the amount of a contribution or does not receive pension check with a sufficient amount to permit deduction for the contributions, contributions must be paid by cashier's check or money order on a monthly basis.
- A grace period of 30 days shall be allowed for the payment of each contribution paid directly by the member. If any contribution is not paid within the grace period, the coverage shall terminate on the last date for which contributions are paid.
- Dropping Coverage: In order to drop the City's coverage, a waiver must be signed. The waiver for the City of Dallas states that all benefits will be stopped at the end of the month in which it is received. A waiver of coverage prevents the Retiree and dependents from future enrollment in the City's plan. Termination of coverage due to non-payment will automatically be considered a request to waive coverage.

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	• 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. – Lease or deed naming both partners – Joint checking account statement – Utility bills and/or credit accounts – Will and/or life insurance policies
Domestic Partner	• Copy of Social Security Card and Date of Birth **-AND-** • Copies of two documents showing that you and your partner live together. – 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 of you and/or your spouse, domestic partner or common-law spouse. 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.	• 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) **-AND-** • Copy of Social Security Card **Additional documentation required for disabled dependents:** • Physician affirmation of such condition and dependence
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.	

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

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 16 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	Retiree Monthly Rate
Retiree Only	$590.15
Retiree + Spouse	$1,449.09
Retiree + Child(ren)	$983.44
Retiree + Family	$1,771.38
Spouse Only	$1,002.00
Spouse + Child(ren)	$1,318.00

HRA Plan	Retiree Hired After 1/1/2010 Monthly Rate (not eligible for City subsidy)
Retiree Only	$1,073.00
Retiree + Spouse	$2,355.00
Retiree + Child(ren)	$1,660.00
Retiree + Family	$2,871.00
Spouse Only	$1,282.00
Spouse + Child(ren)	$1,798.00

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 retiree 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	Retiree Only	Retiree + Family
January	$200.00	$700.00
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

With the HRA, you receive a Cigna Health Care 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.

Accessing Your HRA Funds

There are three ways to access your HRA funds:

- You may use the Cigna Health Care Visa Debit Card, which will automatically debit your HRA balance at the point of purchase.
- 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 Health Care 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.

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 16 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 health are services throughout the year. The copay will not apply towards your deductible, but will apply to your out-of-pocket maximum.

Premium Copay Plan	Retiree Monthly Rate
Retiree Only	$568.70
Retiree + Spouse	$1,248.58
Retiree + Child(ren)	$847.25
Retiree + Family	$1,513.13
Spouse Only	$884.00
Spouse + Child(ren)	$1,135.00

Premium Copay Plan	Retiree Hired After 1/1/2010 Monthly Rate (not eligible for City subsidy)
Retiree Only	$1,034.00
Retiree + Spouse	$2,198.00
Retiree + Child(ren)	$1,599.00
Retiree + Family	$2,649.00
Spouse Only	$1,164.00
Spouse + Child(ren)	$1,615.00

HSA PLAN

Retirees currently receiving coverage under Medicare or Social Security benefits are NOT eligible to contribute to a Health Savings Account (HSA) per IRS regulations; therefore, they are not eligible to enroll in an HSA. If you are covered by Medicare or Social Security, please contact the Benefit Service Center.

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 16 for Program details
Urgent Care/Convenience Care	Plan pays 80% after deductible is met
Telehealth	Plan pays 80% after deductible is met

HSA Plan	Retiree Monthly Rate
Retiree Only	$557.70
Retiree + Spouse	$1,322.84
Retiree + Child(ren)	$928.88
Retiree + Family	$1,582.02
Spouse Only	$862.00
Spouse + Child(ren)	$1,104.00

HSA Plan	Retiree Hired After 1/1/2010 Monthly Rate (not eligible for City subsidy)
Retiree Only	$1,014.00
Employee + Spouse	$2,156.00
Retiree + Child(ren)	$1,568.00
Retiree + Family	$2,598.00
Spouse Only	$1,142.00
Spouse + Child(ren)	$1,584.00

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
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

Accessing your HSA Funds

1. Pay with your Cigna Health Care MasterCard Debit Card which will automatically debit your HSA balance at the point of purchase.

2. 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.

3. Pay for expenses out of your own pocket, and then reimburse yourself from your HSA.

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 9 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
• 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	• 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 plan members 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 health care 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.

WILL YOU BECOME MEDICARE ELIGIBLE SOON?

If you are approaching Medicare eligibility, here are the steps you should take to ensure a smooth transition to Medicare coverage:

1. Enroll in Medicare Parts A and B

Three months (90 days) before you become Medicare eligible, contact your local Social Security Administration Office to enroll in Medicare Parts A and B.

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

2. Notify the Benefits Service Center within 30 days of your birthday.

Within 30 days of becoming Medicare eligible, you and/or your covered spouse must report the change in age to the Benefits Service Center. If a rate adjustment is required as a result of you and/or your spouse becoming Medicare eligible, the rate adjustment/reduction will be made the month following the birthday month of you and/or your spouse—provided the age change is reported to the Benefits Service Center before the first day of the month in which you and/or your spouse become Medicare eligible. The effective rate before becoming Medicare eligible will be charged for the month you and/or your covered spouse became Medicare eligible.

3. Enroll in a Medical Supplement Plan

Once you have enrolled in Medicare Parts A and B, and become Medicare-eligible, you are no longer eligible to participate in the City's regular health plans. You may instead enroll in a one of the Medicare Advantage plans offered by the City or another Medicare plan offered through a private insurance carrier. Both plans offered by the City include prescription coverage — you do not need to enroll in a separate Medicare Part D plan in addition to a medical supplement plan if you choose one of the City-sponsored options.

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	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.	Plan requires you to pre-select two in-network dentists at the time of enrollment.[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.
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

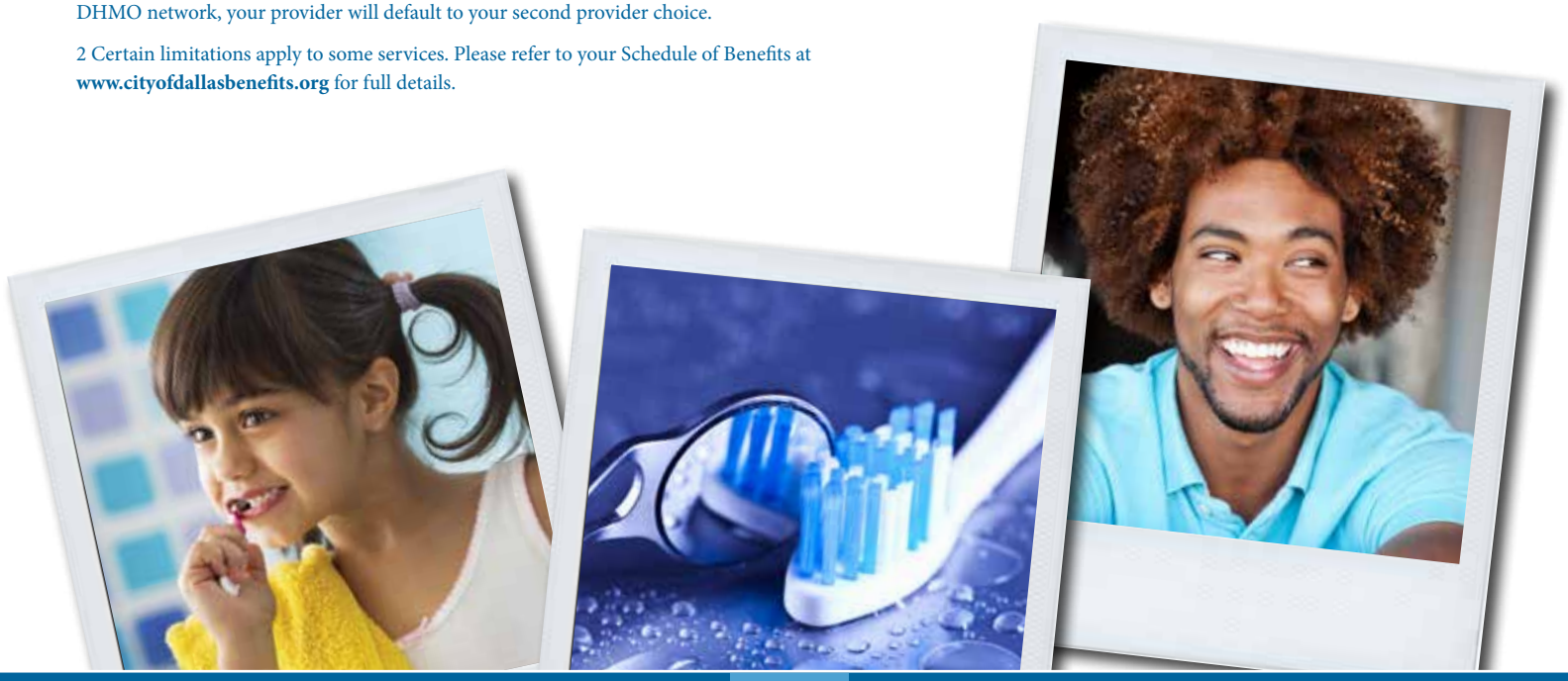
- Visit **www.metlife.com** and click on *Find a Dentist* on the right side of the home page
- Enter your zip code and select your plan
- For DPPO dentists, choose *PDP Plus* network
- For DHMO dentists, choose *Dental HMO/Managed Care*, then select plan name *City of Dallas*

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		
• 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		
• Fillings • Extractions • General Anesthesia: When dentally necessary in connection with oral surgery, extractions or other covered dental services	80%	80%
Type C – Major Restorative†		
• No waiting period for major services • Crown, Denture, and Bridges • Endodontics • Periodontics • Oral Surgery †Implants not covered	50%	50%
Type D – Orthodontia		
• All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia	50%	50%

Dental PPO Monthly Rate	
Retiree Only	$32.78
Retiree + Spouse	$60.30
Retiree + Child(ren)	$61.10
Retiree + Family	$85.22

* 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 Monthly Rate	
Retiree Only	$8.20
Retiree + Spouse	$15.08
Retiree + Child(ren)	$15.16
Retiree + Family	$21.32

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 money[5]. 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)	• 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)	• Covered in full: Any Fashion, Designer or Premier frame from Davis Vision's Collection[1] (retail value up to $195) **OR** • $140 retail allowance toward any frame from provider, plus 20% off balance[2] **OR** • Receive a **FREE frame at Visionworks**[3]
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care (Every 12 months)	• Collection Contacts: Covered in full after $10 copay **OR** • Non Collection Contacts • Standard & Specialty Contacts[4]: $60 allowance with 15% off balance[2] less • $10 copay
Contact Lenses – if you do not choose eyeglasses (Every 12 months)[4]	• Covered in full: Any contact lenses from Davis Vision's Contact Lens Collection up to 4 boxes for Planned Replacement or 8 boxes for Disposables[1] **OR** • $130 retail allowance toward provider supplied contact lenses, plus 15% off balance, no copay required[2]

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 Monthly Rate	
Retiree Only	$4.92
Retiree + Spouse	$9.00
Retiree + Child(ren)	$9.44
Retiree + Family	$14.50

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. Fr additional lists, you may be charged for the costs of providing the list. Your will receive a response no later than 60 days from when we receive your request, unless a written notice of a 30-day extension is provided.

Right to Request Restrictions

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

Right to Request Confidential Communications

You may request that we contact you in a certain way or at a certain location, for example, you can ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. Due to procedural or system limitations, in some instances, it may not be reasonable to send confidential communications to multiple addresses for persons who reside in the same household or derive coverage through the same individual participant.

However, the health plans must accommodate your reasonable request to receive communication of PHI by alternative means or at alternative locations, if you clearly state that the disclosure of all or part of the information through normal processes could endanger you in some way. The Privacy Officer will monitor and manage this process according to protections afforded under applicable law.

Right to Receive Notice of A Breach

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

Receive a Copy of This Notice

You may ask for a paper copy of this notice by calling the Benefits Division at (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 filling 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

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.gethipptexas.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.

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.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

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.

[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.

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

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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
Employee Retirement Fund (Civilian)	N/A	(214) 580-7700	www.dallaserf.org
Dallas Police and Fire Pension (Uniform)	N/A	(800) 638-3861	www.dpfp.org
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