City of Dallas

2026 Post-65 Retiree Benefits (Medicare)

Evidence of Coverage

The benefits information provided in this guide is a summary of what the Blue Cross and Blue Shield of Texas (BCBSTX) medical plans cover and what you pay. It does not list every service that BCBSTX covers or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of covered services. You can see it online at **www.cityofdallasbenefits.org**, or you can call (888) 984-4103. If you enroll in the plan, you will get information that tells you where you can go online to view your Evidence of Coverage.

Important:

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Blue Cross Group Medicare Advantage Open Access (PPOSM) plans gives you more choices about your prescription drug coverage. Please see **page 25** for more details.

Welcome to Your 2026 Benefits Guide

Use this Benefits Guide to see what's new and to learn about your benefit plan options.

What's Inside

Greetings, City of Dallas Retirees

It is our pleasure to welcome you to your 2026 Open Enrollment. The City of Dallas provides an annual Open Enrollment period for retirees to review their benefits coverage and make new elections for the upcoming year.

Open Enrollment is October 6–17, 2025. This year's Open Enrollment process is ACTIVE: You MUST ENROLL to have coverage in 2026, including, but not limited to, the Medical, Dental, and Vision plans. If you do not enroll, you will not have coverage in 2026, and ALL of your 2025 elections will end on December 31, 2025, and you will lose your coverage with the City of Dallas forever.

Carefully review the plan options to ensure you make the best decision for your needs and budget.

2026 HIGHLIGHTS

- **This is an ACTIVE enrollment**: Everyone **MUST complete** the enrollment process by the deadline.
- If you **do not** enroll, you will not have coverage in 2026, and ALL of your 2025 elections will end on December 31, 2025 and you will lose your coverage with the City of Dallas forever.
- **Benefit Plan Designs and Costs**: There are no changes to the Medicare Advantage plans premium costs for 2026 or plan designs other than the CMS mandated changes, including the addition of Intensive Cardiac Rehabilitation Services and Intensive Outpatient Services. In the Medicare Advantage prescription drug plan, the Initial Coverage Limit and True Out-of-Pocket amounts are increasing.

  There will be no changes to the Dental plan design or retiree contributions.

  There will be an increase to the Vision plan retiree contributions, but no changes to the plan design.
- **Health Advocate Retiree Concierge** will walk you through your benefit options through the City of Dallas and non-City of Dallas options.
- **Enrollment Steps**: To enroll, make changes, or get answers to questions about your 2026 benefits, call **(214) 671-6947** (option 1) or email **codretireebenefits@dallas.gov**.

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

Sincerely,
City of Dallas Benefits Team

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 Medicareeligible 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

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. Please note: Only those enrolled in Medicare Parts A and B are eligible to enroll in the Blue Cross Group Medicare Advantage Open Access (PPO) medical plan options outlined in this guide.

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 must be emailed to **codretireebenefits@dallas.gov**.

TYPE OF ELIGIBLE DEPENDENT	REQUIRED DOCUMENTATION
SPOUSE	• Copy of Marriage License 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	• 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, stepchild 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 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), or • Copy of Adoption Agreement, or • Copy of court custody or guardianship documents, or • Copy of the portion of the divorce decree showing the dependent, or • Copy of Qualified Medical Court Support Order (QMCSO) 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: All members are enrolled in the Blue Cross Group Medicare Advantage Open Access (PPO) plans as individuals with no dependents listed on their account. Each individual enrolled will have his or her own account and own unique member ID number.

HOW TO ENROLL

The City of Dallas offers a simple and convenient way for you to enroll in benefits or change your current elections.

To get started, just call **(214)-671-6947** (option 1) or email **codretireebenefits@dallas.gov**. Benefit Specialists are standing by to enroll you over the phone – and they can help answer questions about your benefit options and coverage costs, too!

The call center is open during Open Enrollment, Monday–Friday, 8:00 a.m.–5:00 p.m.

MBI NUMBER REQUIRED!

If your Medicare Beneficiary Identifier (MBI) number (also known as your "Medicare Social Security number") is not already in the system, you will need to provide it during the enrollment process. Your MBI number can be found on your Medicare card.

SUPPORTING DOCUMENTATION REQUIRED

Any selections that require evidence or documentation will not be accepted or finalized until documentation is received. 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 must email your dependent documentation to **codretireebenefits@dallas.gov**.

Note: If you do not email your supporting documentation, your enrollment will not be complete.

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, which 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 Life 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 Open Enrollment to make a change.

REMINDERS

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

1. **The Open Enrollment period for 2026 starts October 6, 2025, and ends on October 17, 2025**.
   a. If you **do not** enroll, you will not have coverage in 2026 and ALL of your 2025 elections will end on December 31, 2025 and you will lose your coverage with the City of Dallas forever.
   b. To make any changes to your current benefit elections, you must call **(214)-671-6947** (option 1) or email **codretireebenefits@dallas.gov** by October 17.
2. You must report a Qualifying Life Event within 30 days of that event to change your benefits coverage.
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**.

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) or email **codretireebenefits@dallas.gov**, to report an address change or other corrections. You will also need to contact the Pension Department for address changes.

SPECIAL NOTE

If you cancel your medical coverage as a retiree, this is considered a voluntary waiver of coverage. You may not re-enroll in any City-sponsored medical plans in the future. You will no longer be eligible to continue dental and/or vision through the City of Dallas upon waiver of medical coverage.

DUPLICATE MEDICAL COVERAGE BY RETIREE

All members are enrolled in the Blue Cross Group Medicare Advantage Open Access (PPO) plans as individuals with no dependents listed on their account. Each individual enrolled will have his or her own account and own unique member ID number and card.

IMPORTANT INFORMATION

To be eligible for coverage under the Blue Cross Group Medicare Advantage Open Access (PPO) plans, you must be enrolled in Medicare Parts A and B. You must also continue paying your Medicare Part B premium and any other penalties assessed by Medicare. If you do not, your coverage could be terminated.

Medicare also requires certain information in order to process your enrollment:

- A permanent street address (this cannot be a P.O. Box)
- Your Medicare ID card number

If you are not enrolled in Medicare Parts A and B, you should contact your local Social Security Administration office.

BENEFITS INFORMATION FOR CERTAIN MEDICARE-ELIGIBLE RETIREES

In the next few months, you will receive a letter from your Medicare Part D provider to alert you of the following information.

- Welcome kit, which will include:
  - 2026 Formulary List
  - Summary of Benefits
  - Mail-order information
  - Pharmacy Directory
- Explanation of Coverage (EOC)

The documents listed above will require no action on your part because you are already enrolled. However, if you receive a Late Enrollment Penalty Letter, you are required to complete and return as instructed in the letter.

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 2026 can be found in this guide.

- If you participate in one of the City-sponsored Medicare Advantage plans, 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.

Medicare Advantage PPO Plans

TIER	RETIREE MONTHLY RATES	
	HIGH OPTION	LOW OPTION
RETIREE ONLY	$328.70	$266.50
RETIREE + SPOUSE	$657.40	$533.00
SPOUSE ONLY	$328.70	$266.50

The Blue Cross Group Medicare Advantage Open Access (PPO) plans deliver all the benefits of Original Medicare (Parts A and B), include prescription drug coverage (Part D), and offer additional benefits and features. These plans are not supplement plans and do not pay secondary to Medicare. All claims are submitted directly to BCBSTX for payment, not Medicare.

As a BCBSTX Medicare Advantage Open Access member, your plan will help give you value for your health care dollar, offering benefits and service beyond what you will find with Original Medicare (Parts A and B). You'll have a team committed to understanding your needs, connecting you to the care you need, and helping you manage your health. BCBSTX representatives will link you to health and wellness resources and even schedule your wellness visits, including arranging an annual visit. Below, you can find highlights of what the new plans options offers.

- One ID card for Medical and Prescription Drugs. No need to show Medicare Card.
- The plan travels with you and allows access to services throughout the U.S. and all U.S. territories with no referrals.
- You can see any provider (in-network or out-of-network) at the same cost share, as long as they have not opted out of or been excluded from Medicare.
- Choose from over 61,000 pharmacies across the United States, including national chain, regional, and independent local retail pharmacies. AllianceRx Walgreens Prime is the prescription home delivery (mail-order) vendor.
- SilverSneakers® offers access to exercise equipment, classes, and more at over 17,000+ fitness locations.
- BCBSTX offers Virtual Visits, which allows you to consult an independently contracted, board-certified doctor or therapist for non-emergency situations by phone, mobile app, or online video anytime, anywhere.
- Track your health and keep learning with BCBSTX wellness and educational tools. You can set and track progress toward your health care goals. You can also learn about diabetes self-care, managing blood pressure, eating well and maintaining a healthy weight, stopping tobacco use, stress management and mental health, and safety concerns. All of these Wellness Solutions are designed to help you live your best life at no additional cost to you.
- 24/7 Nurseline is available to answer health questions at any time. Registered nurses answer your call 24 hours a day, 7 days a week.

If you decide to enroll in a Blue Cross Group Medicare Advantage Open Access (PPO) plan, BCBSTX will send you more plan details in the mail. Until then, please call **(888) 984-4103** (TTY 711) with any questions.

Blue Cross Group Medicare Advantage Open Access (PPO) Plans

	HIGH PLAN		LOW PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
YOU PAY				
Deductible*	$0		$0	
Out-of-Pocket Maximum	$0		$1,500	
Combined OOP Maximum	$0		$1,500	
COINSURANCE / COPAYS				
Inpatient Hospital - Acute	$0 copay per stay		$250 copay per stay	
Inpatient Mental Health Care	$0 copay per admission		$250 per admission	
Skilled Nursing Facility	$0 copay (days 1-20); $0 copay (days 21-100)		$0 copay (days 1-20); $80/day (days 21-100)	
Cardiac Rehabilitation Services	$0 copay		$10 copay	
Pulmonary Rehabilitation Services	$0 copay		$10 copay	
Intensive Cardiac Rehabilitation (ICR) Services	$0 copay		$10 copay	
Emergency Care	$0 copay		$120 copay	
Urgent Care	$0 copay		$10 copay ($5 virtual visits)	$10 copay
Partial Hospitalization	$0 copay		$55 copay	
Intensive Outpatient (IOP) Services	$0 copay		$55 copay	
Home Health Service	$0 copay		$0 copay	
Primary Care Physician Services	$0 copay		$10 copay	
Chiropractic Services	$0 copay		$20 copay	
Occupational Therapy Services	$0 copay		$10 copay	
Physician Specialist Services (excludes psychiatric and radiology services)	$0 copay		$20 copay	
Outpatient Mental Health care Visit	$0 copay ($0 copay virtual visits)	$0 copay	$20 copay ($20 virtual visits)	$20 copay
Podiatry Services	$0 copay ($0 copay per visit for routine podiatry visits up to 6 visits)		$10 copay ($10 copay per visit for routine podiatry visits up to 6 visits)	
Other Health Care Professional Services	$0 copay		$20 copay	
Outpatient Mental Health Care Psychiatric Visit	$0 copay ($0 copay virtual visits)	$0 copay	$20 copay ($20 virtual visits)	$20 copay
Physical Therapy and Speech Language Pathology Services	$0 copay		$10 copay	
Lab Services	$0 copay		$10 copay	
Diagnostic Procedures	$0 copay		$10 copay	
Therapeutic Radiology	$0 copay		$20 copay	

Blue Cross Group Medicare Advantage Open Access (PPO) Plans

	HIGH PLAN	LOW PLAN
	IN-NETWORK	IN-NETWORK
	YOU PAY	
Diagnostic Radiology Services / X-ray	$0 copay	$10 copay
Advanced Imaging (MRI, MRA, CT Scan, PET)	$0 copay	$20 copay
Outpatient Hospital Services	$0 copay	$100 copay
Ambulatory Surgical Center (ASC) Services	$0 copay	$100 copay
Outpatient Substance Abuse: Individual Therapy	$0 copay ($0 copay Opioid Treatment Services)	$20 copay ($0 copay Opioid Treatment Services)
Outpatient Substance Abuse: Group Therapy	$0 copay ($0 copay Opioid Treatment Services)	$10 copay ($0 copay Opioid Treatment Services)
Outpatient Blood Services	$0 copay	$0 copay
Ambulance Services	$0 copay	$50 copay
Transportation Services	Not covered	Not covered
Durable Medical Equipment (DME)	$0 copay	$20 copay
Prosthetics / Medical Supplies	$0 copay	$20 copay
Diabetes Supplies and Services	$0 copay	$0 copay
End-Stage Renal Disease / Dialysis Services	$0 copay	$0 copay
Acupuncture	$0 copay for chronic low back pain. (Up to 12 visits in 90 days. No more than 20 acupuncture treatments may be administered annually)	$0 copay for chronic low back pain. (Up to 12 visits in 90 days. No more than 20 acupuncture treatments may be administered annually)
Over-the-Counter Rx	Not covered	Not covered
Meal Benefit	Not covered	Not covered
Medicare-covered Preventive Services	$0 copay	$0 copay
Annual Physical Exam	$0 copay	$0 copay
Supplemental Education / Wellness Programs	SilverSneakers®	SilverSneakers®
Kidney Disease Education Services	$0 copay	$0 copay
Diabetes Self-Management Training	$0 copay	$0 copay
Medicare Part B Rx Drugs: Chemotherapy / Radiation	$0 copay	$0 copay
Medicare Part B Rx Drugs: Other	$0 copay	$0 copay

Blue Cross Group Medicare Advantage Open Access (PPO) Plans

	HIGH PLAN	LOW PLAN
	IN-NETWORK	IN-NETWORK
	YOU PAY	
Preventive Dental	Not covered	Not covered
Comprehensive Dental	$0 copay Medicare-covered services	$0 copay Medicare-covered services
Eye Exams	$0 copay for Medicare-covered eye exam $0 copay for Medicare-covered glaucoma screening $0 copay for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery. $0 copay for 1 routine eye exam every year.	$20 copay for Medicare-covered eye exam $0 copay for Medicare-covered glaucoma screening $0 copay for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery. $20 copay for 1 routine eye exam every year.
Eye Wear	$0 copay Medicare covered $70 eyeglasses allowance or $105 allowance for contact lenses in lieu of eyeglasses. Combined in-network and out-of-network every 2 years	$0 copay Medicare covered $70 eyeglasses allowance or $105 allowance for contact lenses in lieu of eyeglasses. Combined in-network and out-of-network every 2 years
Hearing Exams	$0 copay Medicare covered $0 copay for 1 routine hearing exam every year	$20 copay Medicare covered $0 copay for 1 routine hearing exam every year
Hearing Aids	$500 combined in-network and out-of-network allowance on hearing aids every 3 years	$500 combined in-network and out-of-network allowance on hearing aids every 3 years
Travel Benefit	For members that are outside of the service area for up to 6 months	For members that are outside of the service area for up to 6 months
Worldwide Emergency	Urgent/Emergent Care only; No annual limit; $0 copay	Urgent/Emergent Care only; No annual limit; $120 copay
Rewards Program	$25 worth of gift cards up to 4 times per yea	$25 worth of gift cards up to 4 times per year

A note about treatment to affirm gender identity: You are covered for management, consultation, counseling, hormones, laboratory services, and surgical services for purposes of affirming your gender identity and/or gender transition (diagnostically this may be referred to as "gender dysphoria"), including all related medical visits.

Blue Cross Group Medicare Advantage℠ Prescription Drug Coverage

If you enroll in one of the City-sponsored Blue Cross Group Medicare Advantage Open Access (PPO) plans, you will automatically receive prescription drug coverage.

- There are no deductibles or out-of-pocket maximums; you'll start saving with the first prescription you fill.
- The National Pharmacy Network includes more than 61,000 convenient locations, so you are covered at home or while you are traveling across the United States. The Pharmacy Network also includes preferred pharmacies, such as Walgreens, that offer you savings when filling prescriptions.
- **With this comprehensive prescription drug coverage, there is no need to worry about the coverage gap or "doughnut hole" – you are fully covered.**

	RETAIL PHARMACY PREFERRED / STANDARD			MAIL-ORDER PREFERRED / STANDARD		
DESCRIPTION OF BENEFIT	**30-DAY SUPPLY**	**60-DAY SUPPLY**	**90-DAY SUPPLY**	**30-DAY SUPPLY**	**60-DAY SUPPLY**	**90-DAY SUPPLY**
PART D PHASE: DEDUCTIBLE	**$0 deductible**					
FORMULARY TYPE	5 Tier Premier Formulary					
TRUE OUT-OF-POCKET (TROOP) AMOUNT THAT BEGINS CATASTROPHIC PHASE	**$2,100**					
PART D PHASE: INITIAL COVERAGE LIMIT (ICL) — THE FOLLOWING COST SHARES WILL APPLY UP TO THE OUT-OF-POCKET MAXIMUM						
TIER 1 — PREFERRED GENERIC	$5/$10	$10/$20	$15/$30	$5/$10	$10/$20	$10/$20
TIER 2 — GENERIC	$5/$10	$10/$20	$15/$30	$5/$10	$10/$20	$10/$20
TIER 3 — PREFERRED BRAND	$20/$25	$40/$50	$60/$75	$20/$25	$40/$50	$40/$50
TIER 4 — NON-PREFERRED BRAND	$45/$50	$90/$100	$135/$150	$45/$50	$90/$100	$90/$100
TIER 5 — SPECIALTY	$45/$50	$90/$100	$135/$150	$45/$50	$90/$100	$90/$100
PART D PHASE: CATASTROPHIC	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$2,000**, you pay: Beneficiary cost sharing is reduced to $0 for those who reach the catastrophic spending level.					

PLEASE NOTE:

- Initial coverage limit and true out-of-pocket amounts are required by the federal government for all Medicare Part D programs and are not subject to negotiation.
- All cost-sharing presumes eligible prescriptions filled at a network pharmacy or our mail-order vendor.
- The Blue Cross Group MedicareRx formulary is reviewed and approved annually by the Centers for Medicare and Medicaid Services (CMS) but is subject to change as maintenance updates are made throughout the year.
- Plan includes MAPD Expanded Formulary.

Health Advocate Retiree Concierge

Retirement is an important milestone, but it can also come with many questions about health care and Medicare.

The City of Dallas has partnered with Health Advocate to help make navigating your health care easier. Whether you're considering retirement, a current pre-65 or post-65 retiree, or transitioning to post-65, Health Advocate's experts can walk you through all of your choices so you can make the best decisions. This benefit is available at no cost to you.

HEALTH ADVOCATE CAN:

- Answer questions about the benefits provided by the City of Dallas.
- Explain your Medicare and City of Dallas health plan options, and help choose the best plan for you by comparing coverage costs and features.
- Review the many plans and parts of Medicare, what each covers, and what they cost.
- Discuss the City of Dallas' Comeback Provision for retirees.
- Inform you about enrollment deadlines and when to sign up to avoid paying late Medicare enrollment penalties.

Contact Health Advocate:

- Email **answers@HealthAdvocate.com**
- Call **(866) 799-2731**
- Visit **www.HealthAdvocate.com/cityofdallas** or scan the QR code to send a message or chat live with a representative

Dental Coverage

The City of Dallas offers two Dental plans through Delta Dental — Dental PPO (DPPO) and Dental HMO(DHMO). 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 Delta Dentist, though, you receive service at discounted prices. When you use a non-Delta dentist, you pay more out of your own pocket since you're responsible for 100% of the amount the dentist charges that exceeds Delta Dental's program allowance.	Plan requires you to pre-select in-network dentists at the time of enrollment.[1] You MUST pre-select a dental provider to be able to use your benefits. You will not be able to see a dentist until you select a provider.
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 covers a percentage of an in-network dentist's negotiated fee or the program allowance for non-Delta Dental dentists.	Plan has no annual maximums, deductibles, or claims. You are responsible for the copayments for each covered procedure performed.

Finding a Delta Dental Participating Dentist

- Visit **www.deltadentalins.com** and click on *Find a Dentist*.
- Enter your zip code and select your plan network
  - DPPO dentists, choose Delta Dental PPO network[3]
  - DHMO dentists, choose DeltaCare USA network

Create an Online Account

Get information about your plan anytime, anywhere by signing up for an online account. Visit **www.deltadentalins.com** or scan the QR code, then click *Log In* in the upper right-hand corner. This useful service lets you check benefits and eligibility information, find a network dentist, and more.

1. If your first-choice provider is no longer accepting DHMO patients or is no longer a part of the DHMO network, you must select another in-network provider before plan benefits can begin.
2. Certain limitations apply to some services. Please refer to your Schedule of Benefits at **www.cityofdallasbenefits.org** for full details.
3. If you do not locate a provider in the PPO network, your next best option is to search for a Delta Dental Premier dentist before selecting a non-Delta dentist.

Dental PPO Plan

With the City of Dallas' Dental PPO plan, you may use any dentist you wish. When you choose a Delta Dentist, though, you receive services at discounted prices.

When you use a non-Delta dentist, you pay more out of your own pocket since you're responsible for 100% of the amount the dentist charges that exceed Delta Dental's program allowance.

	IN-NETWORK	OUT-OF-NETWORK
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	**PLAN PAYS % OF NEGOTIATED FEE****	**PLAN PAYS % OF PROGRAM ALLOWANCE****
PREVENTIVE[1]		
• Exams • Cleanings (2 per calendar year) • X-rays • Sealants 1. Services do not apply to annual maximum	100%	100%
BASIC		
• Fillings • Extractions • Oral surgery • Non-surgical periodontics • General anesthesia: When administered by a provider for covered oral surgery or selected endodontic and periodontal surgical procedures	80% after deductible	80% after deductible
MAJOR[2]		
• Crowns, dentures, bridges • Endodontics • Surgical periodontics 2. Implants not covered	50% after deductible	50% after deductible
TYPE D – ORTHODONTIA (Adults and Dependent Children up to Age 26)		
• All dental procedures performed in connection with orthodontic treatment are payable as orthodontia	50%	50%

DENTAL PPO	MONTHLY RATE
RETIREE ONLY	$44.53
RETIREE + SPOUSE	$81.93
RETIREE + CHILD(REN)	$82.99
RETIREE + FAMILY	$115.77

* Subject to limitations, additional charges, and exclusions. **Note**: Child(ren)'s eligibility for Dental coverage is from birth up to age 26.

** 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.

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.

	COPAYMENT
OFFICE VISIT	$5 per visit (including all fees for sterilization and/or infection control)
PREVENTIVE SERVICES VISIT (cleanings, exams, fluoride, x-rays)	No Cost
CROWNS	$160 – $380 (resin, porcelain, metal, or titanium)
ORTHODONTICS	$2,100 adults* $1,900 children*
OSSEOUS SURGERY	$275 – $345
ROOT CANALS	$110 – $380
EXTRACTIONS	$5 – $130 (higher cost for impacted tooth)
GENERAL ANESTHESIA AND IV SEDATION	$80
CLEANINGS (every 6 months)	No cost per 6-month period; additional cleanings within the 6-month period: $45 adults/$35 children
PERIODONTAL CLEANINGS (every 6 months)	$40 per 6-month period; additional periodontal cleanings within the 6-month period: $55
IMPLANTS	Not covered

* Additional charges for pre-treatment exam, treatment planning session, orthodontic retention, and pre- and post-orthodontic records.

DENTAL HMO	MONTHLY RATE
RETIREE ONLY	$12.33
RETIREE + SPOUSE	$22.70
RETIREE + CHILD(REN)	$22.82
RETIREE + FAMILY	$32.09

You Must Select a Provider

Please note: If you elect the Delta 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.

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 by MetLife helps you care for your eyes while saving you money.[1] Choose from a national network of independent, private practice doctors, or select retail partners in 50 states. Visit **www.mybenefits.metlife.com** to find providers in your network.

IN-NETWORK BENEFITS	HIGH PLAN	LOW PLAN
FREQUENCY		
EYE EXAM	Once every calendar year	Once every calendar year
CONTACT LENS EVALUATION AND FITTING	Once every calendar year	Once every calendar year
FRAMES	2 pairs per calendar year or mix and match with contacts	Once every other calendar year
SPECTACLE LENSES	Once every calendar year or mix and match with contacts	Once every calendar year
CONTACT LENSES	2 pairs per calendar year or mix and match with glasses	Once every calendar year in lieu of glasses
COPAY		
EYE EXAM	$10	$10
RETINAL IMAGING	$39	$39
CONTACT LENS EVALUATION, FITTING, AND FOLLOW-UP CARE	$10	$20
SPECTACLE LENSES	$10	$20
FRAMES		
ANY FRAME IN THE EYE CARE PROFESSIONAL'S OFFICE	20% off balance after $150 OR Covered-in-full frames at Visionworks locations[3]	20% off balance after $140 OR Covered-in-full frames at Visionworks locations[3]
DAVIS VISION FASHION/DESIGNER/ PREMIER FRAME COLLECTION[2]	$0/$0/$0 (in lieu of allowance)	$0/$0/$25 (in lieu of allowance)
SPECTACLE LENSES		
SINGLE VISION, LINED BIFOCAL, LINED TRIFOCAL, LENTICULAR, OVERSIZE	$10	$20
GRADIENT OR SOLID TINTING	$0	$15
BASIC SCRATCH-RESISTANT COATING	$0	$0
POLYCARBONATE LENSES	$0	$0[4] or $35
UV COATING	$0	$15
STANDARD AR COATING	$0	$40
STANDARD PROGRESSIVE	$0	$65
CONTACTS		
EVALUATION AND FITTING • Davis Vision collection[2] • Non-Davis Vision collection	$10 15% discount after $60 allowance[2,5]	$20 15% discount after $60 allowance[2,5]
ELECTIVE • Davis Vision collection[2] • Non-Davis Vision collection	$0 (up to 8 boxes) 15% discount after $130 allowance[2,5]	$0 (up to 4 boxes) 15% discount after $130 allowance[2,5]
• Visually Required (with prior approval)	$0	$0

See footnotes on the bottom of the next page.

Locate an In-Network Eye Care Professional

Visit **www.mybenefits.metlife.com** or call (833) 393-5433 to find an in-network eye care professional.

Out-of-Network Benefits

REIMBURSEMENT AMOUNT	HIGH PLAN	LOW PLAN
EYE EXAM	Up to $40	Up to $45
FRAMES	Up to $50	Up to $50
SPECTACLE LENSES (Single Vision/ Bifocal/Trifocal/ Lenticular)	Up to $40/$60/ $80/$100	Up to $40/$60/ $80/$90
CONTACT LENSES (Elective/Visually Required)	Up to $105/$225	Up to $120/$225

VISION MONTHLY RATE	HIGH PLAN	LOW PLAN
RETIREE ONLY	$11.75	$6.67
RETIREE + SPOUSE	$21.49	$12.19
RETIREE + CHILD(REN)	$22.54	$12.79
RETIREE + FAMILY	$34.62	$19.64

1. Refer to the plan summary for a complete list of lens options and applicable member charges.
2. 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.
3. Additional discounts not applicable at Walmart, Sam's Club, or Costco locations.
4. The free frame benefit is available at all Visionworks locations nationwide and includes all frames except Maui Jim eyewear.
5. Including, but not limited to toric, multifocal, and gas permeable contact lenses.
6. The breakage warranty applies to Davins Collection frames and the lenses installed in them for one year from the date of delivery. The warranty does not apply to non-Collection frames.

Value-Added Features and Extras

- **Paid-in-full eyeglasses and contacts**
  - Frame collection:[2] The plans include a selection of designer, name-brand frames that are covered for no more than a $25 copay.
  - Contact lens collection:[2,5] Select from the most popular contact lenses on the market today with Davis Vision by MetLife's contact lens collection.
- One-year eyeglass breakage warranty included on Davis Collection frames and lenses at no additional cost.[6]
- A national network of top-notch eye care professionals throughout the 50 states.
- Use your in-network benefits to shop online at **www.1800Contacts.com**, **www.Befitting.com**, and **www.Glasses.com**.
- Freedom of choice with access to care through either Davis Vision by MetLife's network of independent, private practice doctors (optometrists and ophthalmologists), or select retail partners.
- Additional value-added features.
  - Ordering contact lenses or replacement contacts (after initial benefit) through **www.DavisVisionContacts.com** mail-order service ensures easy, convenient purchasing online and quick, direct shipping to your door.
  - Davis Vision by MetLife provides you and your eligible dependents with the opportunity to receive discounted laser vision correction through QualSight. For more information, visit **www.mybenefits.metlife.com**. In addition, a one-time/lifetime allowance of $500 is available.
  - Hearing services receive discounts of up to 40% off with the Your Hearing Network.

Claims

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

Or, submit your claim via the Davis Vision by MetLife mobile app.

Enrollment for New Retirees after Open Enrollment

How to Enroll for New Retirees after Open Enrollment

If you are planning to retire in 2026, call 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 or Medicare eligibility. You may be asked to pay half a month or one-half and a full month of retiree health premiums in advance, depending on the date of retirement. If you do not enroll within 30 days of your retirement or Medicare eligibility 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 the City-sponsored Post-65 retiree coverage, that coverage is effective on the first day of the month once your application with Medicare is approved. You will be required to enroll in the City's Pre-65 plan and pay the Pre-65 rates until your Post-65 plan is approved by Medicare.

Upon retirement, all life insurance and voluntary 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.

If You're Approaching Medicare Eligibility, You Should Follow These Steps:

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 were hired prior to April 1, 1986, and do not qualify for premium-free Medicare Part A coverage due to quarters earned through your employment or your spouse's employment. Spouses do not qualify for premium-free Medicare Part A coverage through the City of Dallas.
- 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 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.

Health Advocate

Health Advocate helps navigate healthcare options for those considering retirement, those who are a current pre-65 or post-65, or transitioning to post-65. See **page 13** for additional information.

Important Contacts

For questions about your 2026 enrollment, please call the City of Dallas Benefits Service Center at **(214) 671-6947** (option 1) or email **codretireebenefits@dallas.gov**. For questions about your Medicare Advantage plan choices, please call the Medicare Education Line at **(888) 984-4103**.

RESOURCE	CARRIER	PHONE	WEBSITE/EMAIL
CITY OF DALLAS BENEFITS SERVICE CENTER	N/A	**(214) 671-6947** (option 1)	**codretireebenefits@dallas.gov**
MEDICARE PARTS A & B	N/A	Contact your local Social Security Administration office	**www.ssa.gov**
BLUE CROSS GROUP MEDICARE ADVANTAGE OPEN ACCESS (PPO) PLANS	Blue Cross and Blue Shield of Texas	**(888) 984-4103** **TTY 711**	**www.getbluetx.com/mapd**
HEALTH ADVOCACY	Health Advocate	**(866) 799-2731**	**answers@HealthAdvocate.com** **www.HealthAdvocate.com/members**
DENTAL PLAN	Delta Dental	DPPO: **(800) 521-2651** DPPO Group# 21015 DHMO: **(800) 422-4234** DHMO Group# 79345	**www.deltadentalins.com**
VISION PLAN	Davis Vision	**(800) 999-5431** Client code: 7955 (High), 9573 (Low)	**www.davisvision.com/member** Client code: 7955 (High), 9573 (Low)
EMPLOYEE RETIREMENT FUND (CIVILLIAN)	N/A	**(214) 580-7700**	**www.dallaserf.org**
DALLAS POLICE & FIRE PENSION (UNIFORM)	N/A	**(800) 638-3861**	**www.dpfp.org**

Health Coverage Notices

FOR YOUR FILES

This guide contains legal notices for participants in group health plans sponsored by The City of Dallas. The notices included in this guide are:

- Health Insurance Marketplace Coverage Options and Your Health Coverage that describes the Health Insurance Marketplace and eligibility and tax credit information.
- Notice of Privacy Practices that explains how the health care plan(s) protect your personal medical information.
- Medicare Part D Notice that provides information about how your current prescription drug coverage under the health care plan(s) is affected—and your options for coverage—when you become eligible for Medicare.
- Newborn & Mothers Health Protection Notice that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.
- Women's Health and Cancer Rights Act that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.
- Notice of Special Enrollment Rights that explains when you can enroll in the health care plan(s) due to special circumstances.
- 60-Day Special Enrollment Period that describes a special 60-day timeframe to elect or discontinue coverage.

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 pages 25 and 26 for more details.

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 9.96% 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.

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 retiree 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 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.

3. Employer Name City of Dallas		**4. Employer Identification Number** 75-6000508
5. Employer Address 1500 Marilla Street, 1DS		**6. Employer Phone** (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, Room 1DS		
11. Phone Number (if different from above)		**12. Email Address** **codretireebenefits@dallas.gov**

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

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

- Full-time permanent employees, permanent part-time employees and variable-hour employees who intend 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

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

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

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

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

OUR COMPANY'S PLEDGE TO YOU

This notice is intended to inform you of the privacy practices followed by the Plan and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 1/1/2026.

The Plan often needs access to your protected health information in order to provide payment for health services and perform administrative plan functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. The City of Dallas requires all members of our workforce and third parties that are provided with access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted

to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of the City of Dallas for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

City of Dallas
1500 Marilla St, Room 1DS
Dallas, Tx 75201
codretireebenefits@dallas.gov

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit **www.hhs.gov/ocr** for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND 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 City of Dallas 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 decide to join a Medicare drug plan, your current City of Dallas coverage will be affected. If you do decide to join a Medicare drug plan and drop your current City of Dallas coverage, be aware that you and your dependents may not be able to get this coverage back.

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 City of Dallas and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, 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 "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this creditable coverage notice. 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).

City of Dallas
1500 Marilla St, Room 1DS
Dallas, TX 75201
codretireebenefits@dallas.gov

OTHER NOTICES

60-DAY SPECIAL ENROLLMENT PERIOD

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

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) 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.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in the City of Dallas's medical coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no more than 30 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in the City of Dallas's medical coverage as long as you request enrollment by contacting the benefits manager no more than 30 days after 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).

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).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going 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 consultations with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, call your plan administrator at (800) 736-1364.

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City of Dallas