# 2019

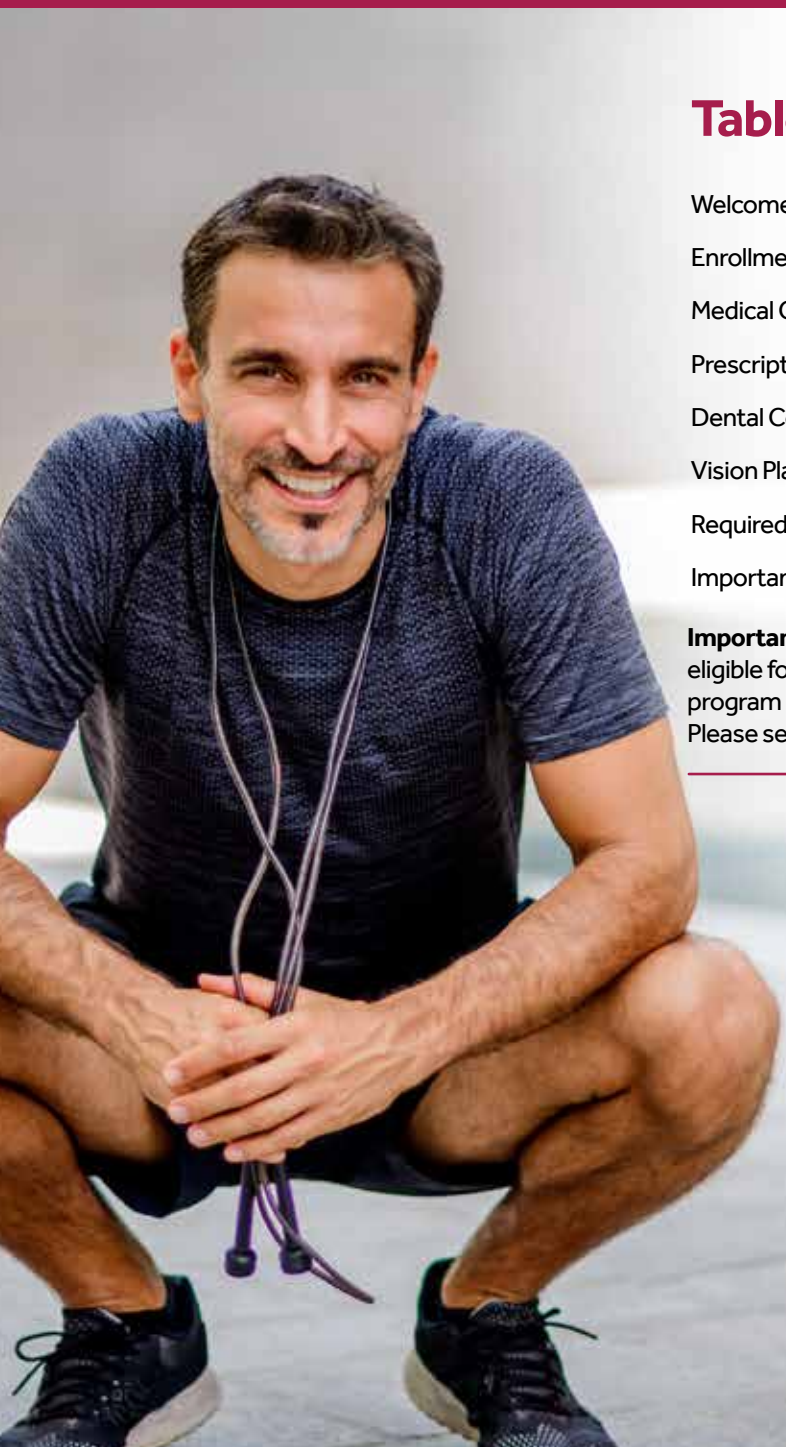
## Retiree (Medicare)

Benefits Enrollment Guide

*Great health care starts with a healthy lifestyle*


City of Dallas

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.



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**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 16 for more details.

City of Dallas

# Greetings City of Dallas Retiree:

Greetings City of Dallas Retiree:

It is our pleasure to welcome you to the 2019 Open Enrollment. The City of Dallas provides an annual open enrollment period for retirees to review their benefits coverage and make new elections for the upcoming year.

**Important things to know regarding 2019 Open Enrollment:**

- **The retiree Open Enrollment period for 2019 starts October 15, 2018 and ends October 26, 201**8
- **Open Enrollment will be passive this year. If you are satisfied with your current benefit elections, no further action is required.**
  To make changes to your benefits elections, or to enroll for 2019, contact the Benefits Service Center at (214) 671-6947 Option 1 or visit the office at: Dallas City Hall, 1500 Marilla Street, Room 1DS.
- **Medicare-eligible Retirees (AARP and UHC Medicare Rx Plans)**
  (877) 647-9423 is the new centralized number for all Medicare-eligible plans (AARP, UHC Rx plans and Group Medicare Advantage plans)
- **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.

If you need to add or delete dependents, please contact the Benefits Service Center at (214) 671-6947 Option 1. Make sure that you have the required documentation such as a birth certificate, social security card or marriage license to add your dependents. You may also fax your documents to (214) 659-7098; please include your name, Employee/Retiree ID number, and a call-back number on each faxed page to process your request.

The 2019 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 to access our service providers.

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

Sincerely,
City of Dallas Benefits Team

# Enrollment Overview

City of Dallas

## 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.

| Type of Eligible Dependent | Required Documentation |
|---|---|
| **Spouse** | • Copy of Marriage License, copy of Social Security Card and Date of Birth<br>• If Common-Law Marriage applies, please provide copies of two documents showing that you and your spouse live together.<br>  • Lease or deed naming both partners<br>  • Joint checking account statement<br>  • Utility bills and/or credit accounts<br>  • Will and/or life insurance policies |
| **Domestic Partner** | • Copy of Social Security Card and Date of Birth<br>**-AND-**<br>• Copies of two documents showing that you and your partner live together.<br>  • Lease or deed naming both partners<br>  • Joint checking account statement<br>  • Utility bills and/or credit accounts<br>  • Will and/or life insurance policies |
| **Dependent Child:**<br>Child who is married or unmarried up to age 26* and is the biological child, legally adopted child or stepchild of you and/or your spouse, domestic partner or common-law spouse.<br>**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.<br><br>**Dependent Grandchild:**<br>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. | • Copy of Birth Certificate showing you as a parent, or<br>• Copy of Verification of Birth Form (accepted for up to 3 months post-birth only)<br>• Copy of Adoption Agreement, or<br>• Copy of court custody or guardianship documents, or<br>• Copy of the portion of the divorce decree showing the dependent, or<br>• Copy of Qualified Medical Court Support Order (QMSCO)<br>**-AND-**<br>• Copy of Social Security Card<br><br>**Additional documentation required for disabled dependents:**<br>• Physician affirmation of such condition and dependence |

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

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

# Enrollment Overview

City of Dallas

## 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 2019 starts **October 15, 2018** and ends on **October 26, 2018**.
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.*

## How to Enroll for New Retirees after Open Enrollment

If you are planning to retire in 2019, 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 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 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.

## Upon becoming Medicare eligible, you should follow four steps:

**1. 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.

**2. Enrollment in Medicare Parts A and B**

Three months 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.

**3. Enrollment in Medicare Supplement Plans**

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

**4. Enrollment in one of the Medicare Supplement plans is a two-step process.**

To enroll in Medicare Supplement plans C, F or K, contact the Medicare Supplement Enrollment Center at (877) 647-9423, and request an enrollment kit. During the call, please state that you are a City of Dallas retiree. Read and sign the application, and mail it back to the Medicare supplement provider within 14 days. You may also enroll over the phone once you have received your enrollment kit by calling (877) 647-9423. Your application will not be complete until it has been received by the Medicare supplement provider. They will provide an enrollment card once your application has been approved. Contact the Benefits Service Center to inform them that you are enrolling in the Medicare Supplement Plan C, F or K. If you wish to enroll in the City's Medicare Part D Plan, you must provide your Medicare claim number.

## Medicare Eligible Retiree Information

**Enrollment Types:**

- The Medicare-eligible benefits enrollment process will be passive, meaning you do not have to participate if you are satisfied with your current coverage (AARP Plans C, F and K; Medicare Part D; Dental and Vision plans).
- If you are currently enrolled in a City of Dallas medical plan, you must contact your local Social Security Administration office to sign up for Medicare Parts A and B—that is, if you have not already completed this step. If you have already signed up, you must contact AARP to enroll in a supplemental plan (C, F or K), and you should contact the Benefits Service Center to enroll in Medicare Part D (prescription drugs).

**Enrollment Method and Instructions:**

Open Enrollment for 2019 will be passive (you do not participate if you are satisfied with your current benefits elections, including Medical, Dental and Vision).

**Medicare-eligible Retirees (AARP and UHC Medicare Rx Plans):**

- (877) 647-9423 is the new centralized number for all Medicare-eligible plans (AARP, UHC Rx plans and Group Medicare Advantage plans)

**Retirees (UHC Dental and Vision):**

Call the Benefits Service Center (214) 671-6947 Option 1 or visit the center at 1500 Marilla Street, Room 1DS.

**Dependent Information**

To update your dependent information for 2019, 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 (refer to page 3).
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 long hold times when calling, leave a voicemail message with a daytime telephone number. A customer service representative will call you back within two business days. Spanish-speaking assistance is available.

**Verification of Personal Information**

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

**Changing your Benefits During the Year (Qualified Status Change)**

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

**Reporting Eligibility Changes During the Year**

You must report changes in dependent eligibility to the Benefits Service Center at (214) 671-6947 Option 1 within 30 days of the change (such as divorce, marriage or dependent child becoming ineligible). All status changes must be made within 30 days of the status change. If you are adding a spouse or dependent to your coverage, appropriate documentation will be required.

**Special Note**
If you cancel your medical coverage as a retiree, 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.

## 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 2019 can be found in this benefits and enrollment guide.

- Contributions shall be paid by pension check deduction by all Members who receive pension checks in sufficient amount to permit deduction for the contributions. For each regular pension check during the plan year a member will pay the monthly rates indicated in Article IV of the Master Plan Document. If for any reason a Member's pension check is not reduced by the amount of a contribution or does not receive pension check with a sufficient amount to permit deduction for the contributions, contributions must be paid by 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 themember. If any contribution is not paid within the grace period, the coverage shall terminate on the last datefor 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.

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

- Annual Notice of Change (ANOC), which will include:
  - 2019 Formulary List
  - Summary of Benefits
  - Mail-order information
  - Pharmacy Directory
- Explanation of Benefits (EOB)
- Explanation of Coverage (EOC)

The documents listed above will require no action on your part because you are already enrolled. However, if you receive a Late Enrollment Penalty Letter, you are required to complete and return as instructed in the letter. For help in completing this letter, please call the City of Dallas Benefits Service Center at (214) 671-6947 Option 1.

# Medicare Supplemental **Plans**

**AARP Supplement Plan C**
**AARP Supplement Plan F**
**AARP Supplement K**
**UHC Group Medicare Advantage Plan**
**United Medicare Rx Plan**

# Medicare Supplemental Plan Rates

City of Dallas

| | AARP Supplement Plan Rates | | |
|---|---|---|---|
| Tier | Plan C | Plan F | Plan K |
| Retiree Only | $183 | $181 | $65 |
| Retiree + Spouse | $406 | $370 | $156 |
| Spouse Only | $273 | $267 | $78 |

The rates shown above are based on an average cost. Actual AARP rates will vary by zip code.

| | UHC Medicare Rx Plan Rates | |
|---|---|---|
| Tier | Part D Option 1* | Part D Option 2** |
| Retiree Only | $184 | $100 |
| Retiree + Spouse | $444 | $256 |
| Spouse Only | $222 | $180 |

| | UHC Group Medicare Advantage Plan Rates | |
|---|---|---|
| Tier | High Option | Low Option |
| Retiree Only | $228 | $142 |
| Retiree + Spouse | $652 | $209 |
| Spouse Only | $430 | $282 |

* Option 1 has full gap coverage for brand name and generic drugs.
** Option 2 has full gap coverage for generic drugs only; donut hole would apply only to brand name drugs.

**Monthly Cost for Texas Residents**
Rates are for Texas residents only. Rates for other states will vary. All rates subject to change during 2019. Actual rates, which may contain discounts or surcharges, are subject to change and will be provided in the enrollment kits provided to prospective insured. Retirees also will pay Medicare Part B monthly premiums.

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

# AARP Supplement Plan C

## Medicare Part A
## Hospital Services - Per Beneft Period [1]

| Services | Medicare Pays | Plan C Pays | You Pay |
|---|---|---|---|
| **Hospitalization**[1] Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| **First 60 days** | All but $1,340* | $1,340 (Part A Deductible) | $0 |
| **61st thru 90th day** | All but $335/day* | $335/day | $0 |
| **91st day and after:** | | | |
| • While using 60 lifetime reserve days | All but $670/day | $670/day | $0 |
| • Once lifetime reserve days are used: | | | |
| – Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0[2] |
| – Beyond the additional 365 day | $0 | $0 | All costs |
| **Skilled Nursing Facility Care**[1] You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| **First 20 days** | All approved amounts | $0 | $0 |
| **21st thru 100th day** | All but $167.50/day | Up to $167.50/day | $0 |
| **101st day and after** | $0 | $0 | All costs |
| **Blood** | | | |
| **First three pints** | $0 | Three pints | $0 |
| **Additional amounts** | 100% | $0 | $0 |
| **Hospice Care** | | | |
| **You must meet Medicare's requirements, including a doctor's certification of terminal illness** | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

* The rates illustrated in this table may not be accurate. Please contact AARP to confrm at (877)647-9423.

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

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

# AARP Supplement Plan C

## Medicare Part B
## Hospital Services - Per Calendar Year

| Services | Medicare Pays | Plan C Pays | You Pay |
|---|---|---|---|
| **Medical Expenses**<br>Includes treatment in or out of the hospital and outpatient hospital treatment, such as physician services; inpatient and outpatient medical and surgical services and supplies; physical and speech therapy; diagnostic tests; and durable medical equipment. | | | |
| **First $183 of Medicare-approved amounts** [3] | $0 | $183<br>(Part B Deductible) | $0 |
| **Remainder of Medicare-approved amounts** | Generally 80% | Generally 20% | $0 |
| **Part B excess charges (Above Medicare-approved amounts)** | $0 | $0 | All costs |
| **Blood** | | | |
| **First three pints** | $0 | All costs | $0 |
| **Next $183 of Medicare-approved amounts** [3] | $0 | $183<br>(Part B Deductible) | $0 |
| **Remainder of Medicare-approved amounts** | 80% | 20% | $0 |

## Medicare Parts A and B

| Services | Medicare Pays | Plan C Pays | You Pay |
|---|---|---|---|
| **Home Health Care**<br>Medicare-Approved Services | | | |
| **Medically necessary skilled care services and medical supplies** | 100% | $0 | $0 |
| **Durable Medical Equipment** | | | |
| **First $183 of Medicare-approved amounts** [3] | $0 | $183<br>(Part B Deductible) | $0 |
| **Remainder of Medicare-approved amounts** | 80% | 20% | $0 |

## Benefits Not Covered by Medicare

| Services | Medicare Pays | Plan C Pays | You Pay |
|---|---|---|---|
| **Foreign Travel- Not Covered by Medicare**<br>Medically necessary emergency car e services beginning during the first 60 days of each trip outside the U.S. | | | |
| **First $250 each calendar year** | $0 | $0 | $250 |
| **Remainder of charges** | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

[3] Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

# AARP Supplement Plan F

## Medicare Part A
## Hospital Services - Per Beneft Period [1]

| Services | Medicare Pays | Plan F Pays | You Pay |
|---|---|---|---|
| **Hospitalization**[1] Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| **First 60 days** | All but $1340* | $1,340 (Part A Deductible) | $0 |
| **61st thru 90th day** | All but $335/day* | $335/day | $0 |
| **91st day and after:** | | | |
| • While using 60 lifetime reserve days | All but $670/day | $670/day | $0 |
| • Once lifetime reserve days are used: | | | |
| – Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0[2] |
| – Beyond the additional 365 day | $0 | $0 | All costs |
| **Skilled Nursing Facility Care**[1] You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| **First 20 days** | All approved amounts | $0 | $0 |
| **21st thru 100th day** | All but $167.50/day | Up to $167.50/day | $0 |
| **101st day and after** | $0 | $0 | All costs |
| **Blood** | | | |
| **First 3 pints** | $0 | Three pints | $0 |
| **Additional amounts** | 100% | $0 | $0 |
| **Hospice Care** | | | |
| **Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.** | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

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

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

# AARP Supplement Plan F

## Medicare Part B
## Hospital Services - Per Calendar Year

| Services | Medicare Pays | Plan F Pays | You Pay |
|---|---|---|---|
| **Medical Expenses**<br>Includes treatment in or out of the hospital and outpatient hospital treatment, such as physician services; inpatient and outpatient medical and surgical services and supplies; physical and speech therapy; diagnostic tests; and durable medical equipment. | | | |
| **First $183 of Medicare-approved amounts** [3] | $0 | $183<br>(Part B Deductible) | $0 |
| **Remainder of Medicare-approved amounts** | Generally 80% | Generally 20% | $0 |
| **Part B excess charges (Above Medicare-approved amounts)** | $0 | 100% | $0 |
| **Blood** | | | |
| **First three pints** | $0 | All costs | $0 |
| **Next $183 of Medicare-approved amounts** [3] | $0 | $183<br>(Part B Deductible) | $0 |
| **Remainder of Medicare-approved amounts** | 80% | 20% | $0 |
| **Clinical Laboratory Services** | | | |
| **Tests for diagnostic services** | 100% | $0 | $0 |

## Medicare Parts A and B

| Services | Medicare Pays | Plan F Pays | You Pay |
|---|---|---|---|
| **Home Health Care**<br>Medicare-Approved Services | | | |
| **Medically necessary skilled care services and medical supplies** | 100% | $0 | $0 |
| **Durable Medical Equipment** | | | |
| **First $183 of Medicare-approved amounts** [3] | $0 | $183<br>(Part B Deductible) | $0 |
| **Remainder of Medicare-approved amounts** | 80% | 20% | $0 |

## Benefits Not Covered by Medicare

| Services | Medicare Pays | Plan F Pays | You Pay |
|---|---|---|---|
| **Foreign Travel- Not Covered by Medicare**<br>Medically necessary emergency car e services beginning during the first 60 days of each trip outside the U.S. | | | |
| **First $250 each calendar year** | $0 | $0 | $250 |
| **Remainder of charges** | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

[3] Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

# AARP Supplement Plan K

## Medicare Part A
## Hospital Services - Per Beneft Period [1]

| Services | Medicare Pays | Plan K Pays | You Pay |
|---|---|---|---|
| **Hospitalization**[1] Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| **First 60 days** | All but $1,340* | $670 (50% of Part A deductible) | $670 (50% of Part A Deductible) ◊ |
| **61st thru 90th day** | All but $335/day | $335/day | $0 |
| **91st day and after:** | | | |
| • While using 60 lifetime reserve days | All but $670/day | $670/day | $0 |
| • Once lifetime reserve days are used: | | | |
| – Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0 [2] |
| – Beyond the additional 365 day | $0 | $0 | All costs |
| **Skilled Nursing Facility Care**[1] You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| **First 20 days** | All approved amounts | $0 | $0 |
| **21st thru 100th day** | All but $167.50/day | Up to $83.75/day | Up to $83.75/day ◊ |
| **101st day and after** | $0 | $0 | All costs |
| **Blood** | | | |
| **First three pints** | $0 | 50% | 50% ◊ |
| **Additional amounts** | 100% | $0 | $0 |
| **Hospice Care** | | | |
| **Available as long as you meet Medicare's requirements, your doctor certifies you are terminally ill and you elect to receive these services.** | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | 50% of copayment/ coinsurance | 50% of Medicare copayment/ coinsurance ◊ |

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

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

◊ You will pay half of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $5,240 each calendar year. The amounts that count toward your annual limit are noted with diamonds(◊) in the chart above. Once you reach the annual limit, the plan pays 100 percent of the Medicare copayment and Coinsurance fees for the remainder of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"); you will be responsible for paying the difference of the amount charged by your provider and the amount paid by Medicare for the item or service.

# AARP Supplement Plan K

## Medicare Part B
## Hospital Services - Per Calendar Year

| Services | Medicare Pays | Plan K Pays | You Pay |
|---|---|---|---|
| **Medical Expenses**<br>Includes treatment in or out of the hospital and outpatient hospital treatment, such as physician services; inpatient and outpatient medical and surgical services and supplies; physical and speech therapy; diagnostic tests; and durable medical equipment. | | | |
| **First $183 of Medicare-approved amounts** [3] | $0 | $0 | $183 (Part B Deductible) |
| **Preventive Benefits for Medicare-covered services** | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts |
| **Part B excess charges (Above Medicare-approved amounts)** | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of $5,240 ) [4] |
| **Blood** | | | |
| **First three pints** | $0 | 50% | 50% ◊ |
| **Next $183 of Medicare-approved amounts** [3] | $0 | $0 | $183 (Part B Deductible) [5◊] |
| **Remainder of Medicare-approved amounts** | Generally 80% | Generally 10% | Generally 10% ◊ |
| **Clinical Laboratory Services** | | | |
| **Tests for diagnostic services** | 100% | $0 | $0 |

## Medicare Parts A and B

| Services | Medicare Pays | Plan K Pays | You Pay |
|---|---|---|---|
| **Home Health Care**<br>Medicare-Approved Services | | | |
| **Medically necessary skilled care services and medical supplies** | 100% | $0 | $0 |
| **Durable Medical Equipment** | | | |
| **First $183 of Medicare-approved amounts** [3] | $0 | $0 | $183 (Part B Deductible) [5◊] |
| **Remainder of Medicare-approved amounts** | 80% | 10% | 10% ◊ |

[3] Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.
[4] This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $5,240 per calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"); you will be responsible for paying the difference of the amount charged by your provider and the amount paid by Medicare for the item or service.
[5] Once you have been billed $183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.
[6] Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.
◊ You will pay half of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $5,240 each calendar year. The amounts that count toward your annual limit are noted with diamonds(◊) in the chart above. Once you reach the annual limit, the plan pays 100 percent of the Medicare copayment and Coinsurance fees for the remainder of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"); you will be responsible for paying the difference of the amount charged by your provider and the amount paid by Medicare for the item or service.

# UnitedHealthcare® Group Medicare Advantage

UnitedHealthcare®

| Benefits & Coverage | High Option HMO Plan 18409 | Low Option HMO Plan 18410 |
|---|---|---|
| Physician Services/Basic Health Services<br>• Consultation, Diagnosis and Treatment, Primary Care Physician<br>• Specialist | $10 copayment per office visit<br>$20 copayment per office visit | $15 copayment per office visit<br>$25 copayment per office visit |
| Annual Physical Examination (Includes Pap smears) | $0 Primary Care Physician | Covered in Full |
| Immunizations<br>• Flu Shots, Pneumococcal Vaccine and Hepatitis B Injections<br>• All other Medicare-approved Immunizations | Covered in Full<br>Covered in Full | |
| Hospitalization | $250 copayment per admission* | $500 copayment per admission* |
| Non-network/ Out-of-Area Urgent Care | $10 copayment | $15 copayment |
| Ambulance Services<br>Medically Necessary Ambulance Transport | $50 copayment | |
| Outpatient Surgical Services<br>• Certified Ambulatory Surgical Center<br>• Outpatient Hospital Facility | $125 copayment<br>$125 copayment | $250 copayment<br>$250 copayment |
| Outpatient Mental Health Care/ Outpatient Substance Abuse Treatment | $20 copayment | $25 copayment |
| Inpatient Psychiatric Care/Inpatient Substance Abuse Treatment | $250 copayment per admission, up to 190 days lifetime maximum in a psychiatric hospital | $500 copayment per admission, up to 190 days lifetime maximum in a psychiatric hospital |
| Emergency Services (Covered worldwide) You may go to any emergency room if you reasonably believe you need emergency care | $50 copayment, waived if admitted to hospital within 24 hours for the same condition | |
| Prescription Drugs - Retail (up to 30-day supply) | $10 generic; $20 brand-name;$40 non-formulary | $15 generic; $25 brand-name;$40 non-formulary |
| Prescription Drugs - Mail Order (90-day supply) | $20 generic; $40 brand-name $80 non-formulary | $20 generic; $50 brand-name$80 non-formulary |
| Renal Dialysis | $20 at network facility or Medicare facility | $25 at network facility or Medicare facility |
| Radiation Therapy | $20 copayment | $25 copayment |
| Radiology Services<br>• Standard X-ray Films<br>• Specialized Scanning & Imaging Procedures: CT, SPECT, PET, MRI (with or without contrast media) | Covered in Full | $15 Primary Care Physician<br>$25 Specialist copayment, per office visit |
| Skilled Nursing Facility Care | $0/day for Days 1-20; $50/day for Days 21-100: up to 100 days per benefit period** in a Medicare-certified Skilled Nursing Facility | |
| Vision Care<br>Examination for Eyeglasses (Refraction) | $20 per visit for Medicare-covered eye exams | $25 per visit for Medicare-covered eye exams |
| Hearing Services<br>Routine Hearing Examination | Medicare diagnostic hearing examinations - $20 Specialist copayment per office visit | $25 per visit for Medicare-covered hearing exams |
| Chiropractic Services | 50% coinsurance for Medicare-covered services | |

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

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

# United Medicare Rx™ Part D Prescription Drug Plans

UnitedHealthcare®

## Key Features

- No annual deductible or out-of-pocket maximum – start saving with the first prescription you fill.
- Predictable and affordable flat copays as low as $10.00 for generic drugs.
- The United Medicare Rx plan has three different levels of copays for a 30-day supply of prescription drugs
- National pharmacy network with more than 65,000 convenient locations so you are covered at home or while you are traveling across the United States.
- A formulary that includes 100 percent of the drugs covered by Medicare Part D. A complete formulary listing will be available on request or online at www.UnitedMedicareRx.

## Copays

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

## Drug Benefits

| | United Medicare Rx™ Option I | United Medicare Rx™ Option II |
|---|---|---|
| Coverage Detail | **No Coverage Gap**<br>No need to worry about the coverage gap or "doughnut hole"; you are fully covered. | **Coverage Gap (donut hole)**<br>• Tier 1 drugs covered at copays in the gap<br>• Medicare Part D covered brand medications in the gap at 50-percent Coinsurance |
| **Outpatient Prescription Drugs** | | |
| Out-of-Pocket Costs | $0 - $5,100(a) in Enrollee/Plan Out-of-Pocket | $0 - $3,820(a) in Enrollee/Plan Out-of-Pocket.<br>(Until you reach the coverage gap/donut hole) |
| Retail<br>One month (30 day) supply | $10 copay for Tier 1 drugs<br>$25 copay for Tier 2 drugs<br>$50 copay for Tier 3 or Specialty Tier drugs | |
| Mail Services †<br>Three month (90 day) supply | $20 copay for Tier 1 drugs<br>$50 copay for Tier 2 drugs<br>$100 copay for Tier 3 drugs | |
| **Coverage Gap (Donut Hole)** | | |
| Out-of-Pocket Costs | N/A | $3,820 - $5,100 (a) in Enrollee/Plan/<br>Manufacturer Out-of-Pocket Expense |
| Retail<br>One month (30 day) supply | N/A | • $10 copay for generic drugs<br>• Approximately 44% Coinsurance for Medicare coverage generic drugs and 35% Coinsurance for Medicare coverage brand name drugs. (Tier 2 and 3) |
| Mail Services †<br>Three month (90 day) supply | N/A | • $20 copay for generic drugs<br>• Approximately 44% Coinsurance for Medicare coverage generic drugs and 35% Coinsurance for Medicare coverage brand name drugs. (Tier 2 and 3) |
| **Coverage Gap (Donut Hole)** | | |
| Out-of-Pocket Costs/Your Costs | After your total out-of-pocket costs reach $5,100, you will pay the greater of a small copay or coinsurance amount of $3.40 for generics and $8.50 for all other drugs or 5% coinsurance | |

† Get through our contracted Mail Service Pharmacy.

# Dental & Vision Coverage

**Dental PPO Plan**
**Dental HMO Plan**
**Vision Plan**

# Dental Coverage

MetLife

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 | Choose any dentist in-network or out-of-network (out-of-pocket costs may be higher when using out-of-network dentists). | Plan requires you to pre-select two in-network dentists at the time of enrollment[1]<br><br>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 offers no annual maximums, deductibles or claims.<br><br>You are responsible for the co-payments for each covered procedure. |

## 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


**Mobile APP**

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

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

# Dental PPO Plan

MetLife

The Dental PPO plan offers coverage for preventive, basic & major restoration, as well as orthodontia.

| | 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 in 12 months<br>• Two exams per calendar year<br>• Two fluoride treatments per calendar year for dependent children up to 16th birthday<br>• Full mouth X-rays: one per 36 months<br>• Bitewing X-rays: one set per calendar year for adults; one per calendar year for children | 100% | 100% |
| **Type B - Basic Restorative** | | |
| • Fillings: No Limit<br>• Extractions<br>• 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<br>• Crown, Denture, and Bridges<br>• Endodontics<br>• Periodontics<br>**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** | $22.00 |
| **Retiree + Spouse** | $40.47 |
| **Retiree + Child(ren)** | $40.69 |
| **Retiree + Family** | $57.19 |

* 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. † 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 co-payments associated with each covered procedure.

## 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 ServicesVisit** | $5 exams<br>$6 sealants (per tooth)<br>$0 x-rays |
| **Crowns** | $255 porcelain, metal and titanium |
| **Orthodontics** | $2,400 adults*<br>$2,600 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:<br>$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 |

† Subject to the section titled Dental Benefits: Limitations and Additional Charges and Dental Benefits: Exclusions.
*Additional charges for initial exam ($250), removable appliance therapy and fixed appliance therapy.

**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 denist 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)

# Vision Coverage

DAVIS VISION
EYECARE REFRAMED

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. Choose from a national network of independent, private practice doctors or select retail partners in 50 states. Visit www.davisvision.com to find providers in your network.

## In-Network Benefits

| **Eye Examination** |
|---|
| **Every January 1. Covered in full after $10 copayment** |

| **Eyeglasses** (One-year eyeglass breakage warranty is included on plan eyewear) | |
|---|---|
| **Spectacle Lenses**<br>(Every January 1) | • Covered in full after $10 copayment<br>• Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription |
| **Frames**<br>(Every January 1) | • Covered in full: Any Fashion, Designer or Premier frame from Davis Vision's Collection[1] (retail value up to $195)<br>***OR***<br>• $140 retail allowance toward any frame from provider, plus 20% off balance [2]<br>***OR***<br>• Receive a **FREE frame at Visionworks**[3] |

| **Contact Lenses** | |
|---|---|
| **Contact Lens Evaluation, Fitting & Follow Up Care**<br>(Every January 1) | • Collection Contacts: Covered in full after $10 copay<br>***OR***<br>• Non Collection Contacts<br>• Standard & Specialty Contacts[4]: $60 allowance with 15% off balance[2] less $10 copay |
| **Contact Lenses – if you do not choose eyeglasses**<br>(Every January 1) | • 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]<br>***OR***<br>• $130 retail allowance toward provider supplied contact lenses , plus 15% off balance, no copay required [2] |

# Vision Coverage

DAVIS VISION
EYECARE REFRAMED

## 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, using client code 7955.

| Reimbursement Amount | Claims |
|---|---|
| **Eye Examination** up to $40, **Frame** up to $50<br>**Spectacle Lenses** (per pair) up to: Single Vision $40, Bifocal $60, Trifocal $80, Lenticular $100<br>**Elective Contacts** up to $105<br>**Visually Required Contacts** up to $225 | Pay the provider directly for all charges and then submit a claim for reimbursement to:<br>**Vision Care Processing Unit**<br>**P.O. Box 1525**<br>**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[5] is available. For more information regarding Laser Eye Services, contact Davis Vision at 1 (855) 502-2020
- **One Year Breakage Warranty:** Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail 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 10% 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 |

[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] Applicable both in- and out-of-network. Additional discounts apply in-network.

# Required **Notices**

# Required Notices

## 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:

1. City of Dallas Active Employee Health Benefits Plan;
2. City of Dallas Retiree Health Benefits Plan
3. City of Dallas Active Employee Prescription Drug Plan;
4. City of Dallas Retiree Prescription Drug Plan;
5. Employee Medical Spending Account that is part of the City of Dallas Cafeteria Plan;
6. City of Dallas Onsite Clinic;
7. City of Dallas Active Employee Vision Benefits Plan
8. City of Dallas Active Employee Dental Benefits Plan
9. City of Dallas Retiree Vision Benefits Plan
10. City of Dallas Retiree Dental Benefits Plan; an
11. 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 identify-ing 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 docu-ment 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 ad-ministrative 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 CVS - 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.

# Required Notices

**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.

# Required Notices

**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.

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| **Human Resources Department** | ATTN: Benefits Service Center<br>1500 Marilla Street, Room 1D South<br>Dallas, TX 75201-6390<br>Phone: (214) 671-6947 Option 1<br>Fax: (214) 659-7098 |

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| **Human Resources Department** | **AARP (Medicare Part A & B)**<br>(877) 647-9423<br>**UHC Medicare Advantage**<br>(877) 647-9423<br>**United Medicare RX**<br>(877) 647-9423<br>**Davis Vision - Vision Plan**<br>Phone: (800) 999-5431 ; Client Code 7955<br>**MetLife - Dental Plan**<br>Phone: (855) 676-9442 |
| **U. S. Department of Health and Human Services** | **Centers for Medicare and Medicaid Services**<br>Website: www.cms.hhs.gov<br>Phone: (877) 267-2323, Ext. 61565 |

## 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.

# Required Notices

**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.

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| Date: | September 2017 |
| Name of Sender: | City of Dallas |
| Office: | Benefits Service Center |
| Address: | 1500 Marilla Street, 1D South, Dallas, TX 75201 |
| Phone Number: | (214) 671-6947 Option 1 |

## 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).

# Required Notices

### 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

### Wellness Program Disclosure

If it is unreasonably difficult for you to achieve the standard for a reward under the wellness program due to a medical condition, or if it is medically inadvisable for you to attempt to achieve the standards for a program reward, call the Benefits Service Center at (214) 671-6947 Option 1, and we will work with you to develop another way to qualify for the reward.

### 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 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, 2015, or for more information on special enrollment rights, contact either

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| **U. S. Department of Labor** | Employee Benefits Security Administration<br>Website: www.dol.gov/ebsa<br>Phone: (866) 444-EBSA (3272)<br>OMB Control Number: 1210-0137 (expires 10-31-2017) |
| **U. S. Department of Health and Human Services** | Centers for Medicare and Medicaid Services<br>Website: www.cms.hhs.gov<br>Phone: (877) 267-2323, Ext. 61565 |

# Important Contacts

| Resource | Carrier | Phone Number | Email/Web Address |
|---|---|---|---|
| **City of Dallas Benefits Service Center** | N/A | 214-671-6947 Option 1 | hrbenefits@dallascityhall.com |
| **Medicare Part A&B** | AARP | (877) 647-9423 | www.aarphealthcare.com |
| **UnitedHealthcare Group Medicare Advantage** | UnitedHealthcare | (877) 647-9423 | www.uhcretiree.com |
| **Medicare Part D Prescription Plan** | UnitedHealthcare | (877) 647-9423 | www.unitedmedicarerx.com |
| **Dental Plan** | MetLife | 855-676-9442 | www.mybenefits.metlife.com |
| **Vision Plan** | Davis Vision | 855-465-0023 Client Code 7955 | www.davisvision.com/member Client code 7955 |
| **Employee Retirement Fund** | N/A | 214-580-7700 | www.dallaserf.org |
| **Dallas Police and Fire Pension** | N/A | 800-638-3861 | www.dpfp.org |

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Additional copies may be obtained from the Benefits Service Center