City of Dallas

2008 benefits and enrollment guide for employees and retirees

About this guide

This 2008 Benefits and Enrollment Guide describes, in non-technical language, the essential features of the City of Dallas Health Benefits Plan (The Plan). This Guide has been prepared as a reference only. It is not an official Summary Plan Description (SPD) for the City of Dallas Health Benefits Plan, including dental, vision, life and voluntary benefits. The terms and conditions of coverage under The Plan are determined solely by the SPD as adopted by City Council of the City of Dallas. If there is a difference between what you read in this Guide and what you read in the official SPD, the official SPD will govern. In regards to the fully insured Medicare plans, if there is a difference between what you read in this Guide and what you read in the official SPD, federal regulations will govern.

Table of Contents

City of Dallas

Welcome to Benefits 2008

Dear fellow employees and retirees,

It is my pleasure to welcome you to **Annual Enrollment 2008**. The City of Dallas offers employees and retirees an enrollment period on an annual basis to review current benefits coverage and, if necessary, make new elections.

This year, **annual enrollment begins Monday, Nov. 5, 2007, and ends Wednesday, Nov. 21, 2007**. For your convenience, you can elect your 2008 benefits coverage by contacting the BenefitsService Center at 1-888-873-7692 or by enrolling at https://cod.dtolawsonportal.com/lawson/portal/.

The City of Dallas strives to offer an attractive and affordable package of benefits to meet participants' needs. As a result of cost containment strategies, there will be **NO INCREASE** in premiums for active employees and retirees for the 2008 plan year. The following benefit options will remain the same with no rate increase:

- The City of Dallas will continue to offer six Preferred Provider Organization (PPO) plans and one Exclusive Provider Organization (EPO) plan, administered by UnitedHealthcare.
- The Dental Health Maintenance Organization (DHMO) and indemnity plans will be administered by Safeguard.
- Vision services will be administered by Spectera.
- Marsh@Work Solutions will continue to administer the short-term and long-term disability programs through Hartford Insurance Company and long-term care insurance through Metropolitan Life Insurance Company.
- For certain Medicare-eligible retirees, the City will continue to offer AARP Medicare Supplement, MedicareComplete HMO and Medicare Part D Prescription plans, administered by UnitedHealthcare.

The following benefit options will change for the 2008 plan year:

- The City will change its Prescription Drug Plan Design by increasing the retail prescription percentage and minimum copayments of the self-insured PPO prescription drug program. This change makes the PPO prescription design mirror the existing EPO prescription plan.
- An increase in life insurance benefits for eligible employees will take effect Jan.1, 2008. The City will increase the basic life insurance coverage for eligible employees from $40,000 to $50,000, and will decrease the age-banded rates to purchase supplemental insurance for eligible employees effective Jan. 1, 2008.

This Benefits and Enrollment Guide provides details about your benefit options. Reviewing the material contained in this guide will help employees and retirees make informed decisions about your benefits for 2008. If participants have any questions, they may refer to the vendor contact information section to access our service providers.

I hope employees and retirees 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,

David K. Etheridge, Director
Human Resources Department
City of Dallas

Vendor contact information

City of Dallas Customer Service	
Benefits Service Center (BSC)	1-888-873-7692
Health	
PPO and EPO plan: UnitedHealthcare	
Customer Care	1-800-736-1364
Pharmacy services	1-877-842-6048
NurseLine℠ services	1-800-586-6875
Web site	myuhc.com®
AARP Medicare supplement: UnitedHealthcare	
Membership services	1-800-392-7537
Web site	www.aarphealthcare.com
MedicareComplete HMO: UnitedHealthcare	
Membership services	1-800-950-9355
Web site	www.securehorizons.com
Medicare Part D prescription plan: UnitedHealthcare	
Membership services	1-888-556-6648
Web site	www.UnitedMedicareRX.com
Dental and vision	
Vision services: Spectera	1-800-638-3120
Web site	www.spectera.com
Dental HMO: Safeguard	1-800-880-1800
Dental indemnity: Safeguard	1-800-962-9633
Web site	www.safeguard.net
Voluntary benefits: Marsh@Work Solutions	
Membership services	1-800-557-1046
Web site	www.personal-plans.com/cod
Deferred compensation (401K and 457 plans): Fidelity	
Member services	1-800-343-0860
Web site	www.fidelity.com/atwork
Employee assistance program: Alliance Work Partners	
Membership services	1-800-343-3822
Web site	www.alliancewp.com
Life insurance: UnitedHealthcare Specialty Benefits	
Membership services	1-866-615-8727
Web site	www.unimerica.com
COBRA: UnitedHealthcare	
Membership services	1-866-747-0048
Web site	www.uhcdirectbill.com
Employee Retirement Fund	214-580-7700
Web site	www.dallaserf.org
Dallas Police and Fire Pension	214-638-3863
Toll-free	1-800-638-3861
Web site	www.dpfp.org
City of Dallas Web site	www.dallascityhall.com

2008 changes and highlights

No premium increases

For the plan year 2008, there will be **no increase in premiums** for active employees and retirees who are enrolled in the following City-sponsored plans:

- Self-insured PPO medical and prescription drug options
- Self-insured EPO medical and prescription option
- AARP Medicare Supplement options
- MedicareComplete HMO option
- Medicare Part D prescription option
- Dental and vision options

Changes in prescription drug plan design

For 2008, the City will change the retail and mail order prescription percentage and minimum copayments of the City's self-insured PPO prescription drug program. The new drug benefit design **does not mandate generic usage**. The plan design change will continue to provide employees with the option to purchase brand-name drugs or generic drugs. The following is a summary of the benefit changes that will be made to the prescription drug program for 2008:

- The annual deductible of $75 per individual and $2,500 out-of-pocket maximum per individual will not change for 2008
- Tier 1 (generic) for both retail and mail order will not change for 2008
- Tier 2 (preferred) and Tier 3 (non-preferred) increases in order to align with the EPO prescription plan and industry standards.

Members who are registered on **myuhc.com®** can utilize My Rx Choices to review the generic equivalence, price and effectiveness of drugs to discuss with their physicians. Members can also use the Savings Advisor, a tool used to learn about different medications that can save you money. Savings can come from using therapeutic alternatives, generic drugs or in some cases, using a mail-order pharmacy instead of a retail pharmacy. As an example, the brand-name drug Zyrtec® has a generic equivalent that was released Sept. 1, 2007.

Dental and vision

To enroll in dental and vision plans for 2008, please contact the Benefits Service Center at 1-888-873-7692. Marsh@Work Solutions will no longer be responsible for enrollment services for these two products.

Life insurance

UnitedHealthcare will become the City's new life insurance carrier, beginning Jan.1, 2008. The City will increase the basic life insurance coverage for eligible employees from $40,000 to $50,000. The age-banded rates will decrease to purchase supplemental insurance for eligible employees.

WellAware program

The WellAware program will include a new fitness center offering for 2008. Both employees and retirees will have access to an additional 15 park and recreation fitness centers located throughout the City of Dallas at a membership fee of $75 per year, per member. For more information on the WellAware program and how to join a fitness center, see page 35 of this guide.

Benefits and enrollment information for active employees

Annual enrollment information

Enrollment reminders

During the annual enrollment period, you can choose to change your benefits coverage or keep it the same for 2008. It is important that you make your choices carefully, because you will not be able to change your benefit elections until the next annual enrollment period, unless you have a qualified status change.

Enrollment period: Nov. 5, 2007, through Nov. 21, 2007

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

Enrollment correction period: Nov. 26, 2007, through Dec. 7, 2007

This period allows you to make corrections to any benefit election made during the annual enrollment period. After this period is closed, corrections will not be allowed until next annual enrollment, unless there is a qualified status change.

Enrollment types

This year's annual enrollment is a **passive** enrollment. This means if you are satisfied with your 2007 coverage and wish to keep the same coverage for 2008, then no action is required on your part. Your 2007 coverage will roll over as your coverage for 2008.

If you are enrolled in one of the flexible spending accounts (DCAP or EMSP), and wish to continue for 2008, you **must** re-enroll for 2008. **Coverage will not continue automatically.**

Enrollment methods and instructions

Enrolling online

To enroll online, access **https://cod.dtolawsonportal.com/lawson/portal/**. You will need a user ID and Human Resources Information System password to enroll online. You are encouraged to change passwords regularly. If you would like to change your password, you may do so using the Change Password Option on the left-hand side of the Lawson's SEA screen. If you are experiencing technical difficulty, call the Deloitte Help Desk at 1-866-804-3884 for assistance.

Enrolling by telephone

Before calling, make sure you have read through your 2008 Benefits and Enrollment Guide and that you have the following information available:

- Election plan choices
- Social Security numbers and birth dates of all dependents you are adding who were not on your 2007 benefits

Call the Benefits Service Center at 1-888-873-7692 from 8 a.m. to 5 p.m. Central Standard Time, Monday through Friday during the annual enrollment period. Should you experience a long hold time, leave a voice mail message with a daytime telephone number where you can be reached and your call will be returned within 24 to 48 hours. Spanish–speaking assistance is available.

After making enrollment elections, a confirmation statement will be mailed to you by the Benefits Service Center showing your 2008 benefit elections before the enrollment correction period has ended. Ensure that your current mailing address is correct in the City's Human Resources Information System (HRIS). To correct your address, log into the HRIS Web site or contact your departmental Human Resources Assistant.

Review of benefit elections

Review the confirmation statement that you receive in the mail from the Benefits Service Center or as a printout statement from your computer if you enroll through SEA. Retain it for your records as proof of your timely enrollment. If there are any errors on your confirmation statement or printout, you must contact the Benefits Service Center at 1-888-873-7692 by Dec. 7, 2007. Changes will not be permitted after this period.

Verification of personal information

To receive your medical identification cards from your benefit providers promptly, ensure that your current mailing address is correct in the City's Human Resource Information System. To correct your address or other personal information, go online or contact your departmental Human Resources Assistant. Be sure to review your January 2008 payroll check to verify your benefit elections and insurance deductions are correct.

Consistency rules

If you have a qualified change in status during the year, you can request a change in your benefit elections. Your election change must satisfy the appropriate consistency rules.

- **Changing your benefits mid-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 31 days of the qualifying event. If you fail to change your benefit elections within 31 days of your event, you are required to wait until the next year's annual enrollment period to change your benefit elections.

- **Reporting eligibility changes during the year**
  You must report changes in dependent eligibility to the Benefits Service Center at 1-888-873-7692 within 31 days of the change (such as divorce, marriage or dependent child becoming ineligible). All status changes must be made within 31 days of the status change. If you are adding a spouse or dependent to your coverage, appropriate documentation will be required.

  When adding a spouse to your coverage, a copy of your marriage certificate will be required. When adding a dependent child, a copy of the child's birth certificate will be required. The effective date for newborn child coverage will be the date of birth. All other changes will be effective on the date of the qualified status change. Any change in deductions will go into effect at the next available pay period.

- **Dependent and disabled children up to age 25**
  Children can be covered up to age 25 and are **not required to be full-time students**. Children also must be unmarried and dependent upon the employee for support. When your child loses eligibility for coverage, you must notify the Benefits Service Center at 1-888-873-7692, within 31 days of the change in eligibility.

  If your child is permanently disabled and incapable of self-support, please notify the Benefits Service Center before your child reaches the age of 25. If qualified, your covered, disabled child may be eligible to continue on the plan beyond age 25.

Paying for medical coverage

Medical premiums are paid on a pretax basis for employees and on a post-tax basis for domestic partners. Your annual cost of medical coverage depends on the benefit option you choose and the level of coverage you need. Premium costs for 2008 can be found in this benefits and enrollment guide.

Duplicate medical and life insurance coverage by employees

In the case where two city employees both are eligible for coverage, only one may enroll for dependent coverage. Both employees **cannot cover** each other. When both employees have eligible dependents, only one employee can cover the dependents. Both employees **cannot cover** their eligible dependents. If an employee and their spouse are employed by different employers and both cover each other, the two health plans will pay **only up** to the amount allowable and not 100 percent of total charges.

Leave of absence and your benefits

The following information provides important details regarding your rights and responsibilities for maintaining benefits coverage during an approved leave of absence. Failure to follow the requirements detailed below may result in the loss of health care coverage for you and your covered dependents. Read this information carefully. **You are responsible for notifying** your department and your supervisor of all leaves of absence. The type and length of leave may affect the amount you are required to pay to maintain your benefit coverage elections. If you have questions about costs, payment options or eligibility to continue your coverage while on a leave of absence, contact the Benefits Service Center at 1-888-873-7692 for assistance before starting your leave of absence.

Employees on leave of absence without pay who are not receiving a regular paycheck should make arrangements to pay their premiums while off work. If premium payments are not made when due, past due premiums will accrue in arrears and be deducted from the employee's paycheck upon return to work. Coverage **will be canceled** for nonpayment and claims **will not** be processed for the time period when premiums are past due **beyond 60 days**. Employees on military leave have the option to retain or cancel coverage by contacting the Benefits Service Center within 31 days. The employee returning from military leave must call the Benefits Service Center within 31 days of returning to work to reinstate benefit coverage.

New hire enrollment instructions

New employees have **31 days from their date of hire** to enroll in the City's health benefit plan or waive health coverage. After 31 days, if new employees have not enrolled in the City's health benefit plan, they must wait until next year's annual enrollment period to enroll, unless there is a change in status.

To enroll online, access **https://cod.dtolawsonportal.com/lawson/portal/**. You must have an HRIS user ID and password, which will be assigned within approximately two weeks of employment. Contact the Deloitte Help Desk at 1-866-804-3884 for assistance.

Enroll by calling the Benefits Service Center at 1-888-873-7692 between 8 a.m. and 5 p.m. Central Standard Time. No special user ID or password is required to enroll through the Benefits Service Center. Spanish-speaking assistance is available.

New employee orientation

The City of Dallas welcomes new employees and looks forward to helping them become successful members of the team that serves the Dallas community. New employee orientation provides an insight into the City's commitment to serve the citizens of Dallas. All new employees of the City of Dallas should attend this **mandatory** class **within 31 days of employment.**

Topics include Introduction to Quality Customer Service, City of Dallas Organizational Structure, Personnel Rules and Policies, Employee Benefits and more. All employees attending this orientation also will undergo Sexual Harassment Prevention, Workplace Violence and Customer Service/Diversity Training. These usually are separate mandatory courses, but upon successful completion of the two-day training, employees will be considered to have met the training requirement.

Medical benefit options

PPO medical benefit options

The preferred provider organization (PPO), administered by UnitedHealthcare, gives you the freedom to see any health care professional in UnitedHealthcare's national network, including specialists, without a referral and without designating a primary care physician. You can even visit any non-network physician and still enjoy your benefits with somewhat higher out-of-pocket costs.

There are six PPO options from which to choose. The $1,000 and $3,000 deductible PPO options will allow you to receive preventive care benefits from network physicians and other health care professionals who are not subject to the deductible. You will be responsible for 20 percent or 30 percent of costs. This preventive care benefits copayment arrangement is **not available with non-network physicians and facilities.**

PPO plan designs:

- 80/20 coinsurance with a $300, $1,000 and $3,000 deductible
- 70/30 coinsurance with a $300, $1,000 and $3,000 deductible

EPO medical benefit option

Exclusive provider organization (EPO), administered by UnitedHealthcare, offers full access to the same local and national network as offered to the City's PPO plan members.

EPO plan enhanced benefits:

- **Networks:** Full access to the same local and national network as PPO members.
- **Referrals:** No referrals required. It is not required to see a primary care physician before seeing a specialist. This non-referring system allows employees to visit network specialists without delay.
- **Pharmacy:** Full access to same local and national pharmacy network as PPO members (mail order and retail).
- **NurseLine℠ services:** Anytime access to UnitedHealthcare registered nurses, who can assist you and your family with a wide range of health care questions and concerns. NurseLine also gives you access to an audio health information library with more than 1,100 health and well-being topics, with 600 messages also available in Spanish.
- **Health and wellness:** Full access to UnitedHealthcare's wellness resources, online tools, programs and the City's robust wellness activities.
- **Care Coordination℠:** Disease management, inpatient care and critical indicators, monitored by a dedicated staff of UnitedHealthcare nurses.

Prescription drug program

Effective Jan. 1, 2008, the City will increase the retail percentage and minimum copayments of its preferred and brand-name medications on the PPO prescription drug program, as shown:

Retail design and mail order design

- Tier One (generic) drug copayment: Remains the same at 10 percent, or a $10 minimum
- Tier Two (preferred) drug copayment: Increases from 20 percent to 25 percent, or a $25 minimum
- Tier Three (brand-name) drug copayment: Increases from 30 percent to 40 percent, or a $40 minimum

The annual individual deductible of $75 and annual out-of-pocket maximum of $2,500 will remain the same for 2008.

Flexible spending accounts

- **Employee Medical Spending Plan (EMSP):** Eligible employees can contribute up to $5,000 per year in pretax dollars to help pay for eligible health care expenses.
- **Dependent Care Assistance Program (DCAP):** Eligible employees can contribute up to $5,000 per year in pretax dollars to help pay for eligible dependent day care expenses.

Voluntary benefit options

Dental plans

Effective Jan. 1, 2008, the City will provide enrollment services for the dental plans. You will have a choice between a dental HMO and a dental indemnity plan. DHMO plan participants must receive services from their primary care dentist and obtain referrals to see network specialists. Benefits, including orthodontia, are reimbursed based on a scheduled amount. Routine cleaning, exam and X-rays are covered at no cost to the participant twice a year.

Indemnity plan participants are allowed to see any licensed dentist. The plan includes a deductible, calendar-year maximum, and a one-year waiting period for major services. **Orthodontia is not covered by this plan**.

Vision plan

For the plan year 2008, the City will provide enrollment services for the vision plan. With Spectera, you'll get access to a broad national network of vision care providers, as well as conveniently located retail chain eyewear stores. Plus, many network providers offer evening and weekend hours. If you use a Spectera network provider, all you pay is your copayment for a regular vision exam and prescribed lenses. Benefit plan features include vision exam, eyeglass lenses and frame coverage, contact lens coverage (in lieu of lenses and frames) and low out-of-pocket costs.

Life insurance

One of the most important things about life insurance is the financial peace of mind it gives your loved ones. UnitedHealthcare Specialty Benefits, a UnitedHealth Group® company, offers life insurance coverage that allows you to provide for others upon death. Select from the following coverage options:

- **Basic life insurance:** $50,000 basic term life insurance coverage to eligible full-time employees at no cost. No enrollment action is necessary for full-time employees. Part-time employees must contact the Benefits Service Center to enroll and pay half the cost.
- **Supplemental life insurance:** Includes coverage options of up to three times an employee's base annual salary, not to exceed $500,000. Evidence of insurability rules may apply. This product's cost increases as you age. New employees can elect one, two or three times their annual salary. Employees who currently are enrolled in supplemental life can only increase their coverage by one increment during open enrollment. For example: an employee who currently has coverage of one times their annual salary can only increase their coverage to two times their annual salary. If you decline coverage initially, you may be required to provide evidence of insurability to enroll at a later date.
- **Dependent life insurance:** You may purchase dependent term life insurance coverage. If coverage is declined initially, providing evidence of insurability may be required to enroll at a later date. An employee may not be insured as both an employee and dependent. A child may not be insured by more than one employee.
- **Accidental death and dismemberment:** You may purchase 24-hour accident protection. Individual and family plans are available. An employee may not be insured as both an employee and dependent. A child may not be insured by more than one employee.

Other voluntary benefits

Long-term care insurance

MetLife Group long-term care (LTC) insurance is available to you and your eligible family members. This voluntary benefit can be an essential part of your overall financial plan. A recent study showed that more than 70 percent of individuals that entered a nursing home depleted their savings and other assets to fund one year of care. That's not surprising — the average cost for a year's stay in a nursing home is $54,900 per year, according to the Health Insurance Association of America.

Whether you are in your 30's, 50's or 70's, the need for long-term care can arise at any time. Since premiums are based on your age as of your effective date of coverage, and do not increase due to changes in your health or age, your premium may never be lower than it is right now.

If you are a new hire who enrolls within 90 days of your hire date, you are guaranteed coverage and will not need to submit proof of good health to qualify, as long as you are actively at work (not absent due to illness, injury or medical leave of absence) on your effective date of coverage.

For more detailed information on the plans, pricing and enrollment procedures, please call Marsh at 1-800-557-1046.

Short-term and long-term disability Paycheck Protector

Paycheck Protector, underwritten by The Hartford, helps protect your income and your family's financial future if an accident or serious illness leaves you disabled and prevents you from working and earning a paycheck. You have three Paycheck Protector plans from which to choose:

- **Short-term Paycheck Protector:** Disability benefits start on the 30th day of disability or illness and may continue for up to 22 weeks. This plan allows for cash benefits that replace 60 percent of your weekly earnings, to a maximum of $500 per week.
- **Long-term Paycheck Protector:** Disability benefits start on the 181st day of disability or illness and may continue for up to five years. The plan coordinates with any other disability benefits you may receive through your pension or other plans. This base plan gives protection by replacing up to 60 percent of your monthly earnings, to a maximum of $5,000 per month.
- **Long-term Paycheck Protector PLUS:** Disability benefits start on the 181st day of disability or illness and may continue for up to five years. This plan gives you cash benefits equaling 30 percent of your earnings, to a maximum of $5,000 per month. The PLUS plan does not coordinate with any other disability plans. All cash benefits are paid on top of other coverage, including workers' compensation, your pension or any other coverage.

Long-term disability insurance provides benefits to participants who become totally disabled and cannot work for an extended period of time. The long-term disability plan offers two options: a 90-day or 140-day waiting period. Evidence of insurability rules may apply.

For more detailed information on the plans, pricing and enrollment procedures, please call Marsh at 1-800-557-1046.

Whole life insurance

Whole life insurance is designed to provide a base of life insurance coverage for your lifetime. It offers you life insurance protection, tax-deferred cash accumulation (based on current tax laws), and cash value loan privileges – all in one policy.

The premium you pay is based on the death benefit you select and the optional riders you choose as well as your age and tobacco use status. The insurance coverage, premium accounts, and cash value are guaranteed as long as you meet the required premium payments.

Should you retire or leave the City you can take the policy with you and choose one of a number of convenient payment plans. The coverage you choose and the policy premium are guaranteed to be fixed for the life of the policy as long as you meet the required premium payment plans.

For more detailed information on the plans, pricing and enrollment procedures, please call Marsh at 1-800-557-1046.

Employee assistance program

An employee assistance program (EAP) is available to all employees and their eligible dependents. Through this program, you can receive confidential, personal support for a wide range of issues, from everyday concerns to serious problems. Referral services are provided for child or elder care services, legal advice, and budgeting and debt management. There is no charge for obtaining a referral or seeing an EAP counselor.

Deferred compensation

Employees have an opportunity to save for retirement by contributing to one or both of two tax-deferred, supplemental retirement 401(k) and/or 457 plans. You can authorize deductions from your paycheck and direct the deductions into one or more of a broad range of mutual funds and other investment options.
The record keeper and administrator for both plans is Fidelity Investments. For more information:

- COD Intranet > Benefits > Deferred Compensation
- www.fidelity.com/atwork
- Call Fidelity at 1-800-343-0860 or the Deferred Compensation Office at 214-670-4861

The Fidelity Retirement Counselor for the City of Dallas can be reached at 214-670-4954. The Deferred Compensation Office is located at City Hall, Room 2CS.

Whether you're three months or three decades away from retirement Fidelity Investments' on-line service called Fidelity NetBenefits® can help you get ready. It's quick and easy. Just log on any time you choose to access your 401(k) and 457 retirement plan accounts and manage your retirement portfolio. Chances are that after just a few visits you'll be familiar with how to:

- Log on and explore, starting with the Home page
- View your retirement account balance
- Access your account information and take action
- View your personal information and change how you receive your account statements
- Assess your retirement readiness with robust planning tools and learning resources

To reach NetBenefits®, log on to **www.fidelity.com/atwork** and click Access My Account. At the login page, enter your Social Security number or Customer ID and designate a six- to 12-digit/character personal identification number (PIN). If you need any assistance, call Fidelity at 1-800-343-0860.

2008 medical plan rates for active employees

80/20 coinsurance PPO monthly rates

	$300 deductible	$1,000 deductible	$3,000 deductible
Full-time employees			
Member only	$ 131	$ 58	$ 39
Member + spouse	$ 518	$ 371	$ 330
Member + child (ren)	$ 268	$ 140	$ 105
Member + family	$ 656	$ 453	$ 396
Part-time employees			
Member only	$ 242	$ 169	$ 150
Member + spouse	$ 629	$ 482	$ 441
Member + child (ren)	$ 448	$ 320	$ 285
Member + family	$ 836	$ 633	$ 576
Mayor and Council members			
Member only	$ 131	$ 58	$ 39
Member + spouse	$ 518	$ 371	$ 330
Member + child (ren)	$ 268	$ 140	$ 105
Member + family	$ 656	$ 453	$ 396
COBRA			
Member only	$ 359	$ 285	$ 265
Member + spouse	$ 754	$ 604	$ 562
Member + child (ren)	$ 640	$ 509	$ 473
Member + family	$ 1,035	$ 828	$ 770

70/30 coinsurance PPO monthly rates

	$300 deductible	$1,000 deductible	$3,000 deductible
Full-time employees			
Member only	$ 111	$ 36	$ 16
Member + spouse	$ 460	$ 325	$ 282
Member + child (ren)	$ 218	$ 100	$ 65
Member + family	$ 575	$ 388	$ 331
Part-time employees			
Member only	$ 222	$ 147	$ 127
Member + spouse	$ 571	$ 436	$ 393
Member + child (ren)	$ 398	$ 280	$ 245
Member + family	$ 755	$ 568	$ 511
Mayor and Council members			
Member only	$ 111	$ 36	$ 16
Member + spouse	$ 460	$ 325	$ 282
Member + child (ren)	$ 218	$ 100	$ 65
Member + family	$ 575	$ 388	$ 331
COBRA			
Member only	$ 339	$ 262	$ 242
Member + spouse	$ 695	$ 557	$ 513
Member + child (ren)	$ 589	$ 468	$ 432
Member + family	$ 953	$ 762	$ 704

Exclusive provider organization (EPO) monthly rates

Full-time employees	Monthly rates
Member only	$ 180
Member + spouse	$ 701
Member + child (ren)	$ 511
Member + family	$ 1,043
Part-time employees	
Member only	$ 291
Member + spouse	$ 812
Member + child (ren)	$ 691
Member + family	$ 1,223
Mayor and Council members	
Member only	$ 180
Member + spouse	$ 701
Member + child (ren)	$ 511
Member + family	$ 1,043
COBRA	
Member only	$ 409
Member + spouse	$ 940
Member + child (ren)	$ 887
Member + family	$ 1,430

2008 voluntary benefits rates for active employees

Dental and vision monthly rates

	Dental HMO plan	Indemnity dental	Vision plan
Member only	$ 7.99	$23.23	$ 6.04
Member + spouse	$14.78	$46.46	$11.03
Member + child (ren)	$14.78	$47.38	$11.58
Member + family	$20.77	$70.62	$17.81

2008 life insurance monthly rates for active employees

1. **Basic life: Noncontributory**
   Basic life insurance will increase from $40,000 to $50,000 effective Jan. 1, 2008. There is no cost to full-time employees. Permanent part-time employees must pay 50 percent of the cost.

2. **Supplemental life: Contributory**
   The amount of supplemental life insurance that can be purchased is up to three times an employee's salary, with a maximum of $500,000. In no event shall the combined amount of basic and supplemental life insurance exceed $550,000. Age-banded rates are as follows:

Age	Monthly rate: per $1000
<25	$0.05
25-29	$0.06
30-34	$0.06
35-39	$0.07
40-44	$0.11
45-49	$0.19
50-54	$0.32
55-59	$0.47
60-64	$0.68
65-69	$1.19
70+	$2.25

2008 dependent life rates	
Monthly rate:	$ 2.85
Amount of coverage for spouse:	$15,000
Amount to coverage for a child or children:	$ 5,000

2008 accidental death and dismemberment (AD&D) monthly rates

Principal sum: Amount of coverage	Employee only	Employee + family
$25,000	$0.45	$0.68
$50,000	$0.90	$1.35
$75,000	$1.35	$2.03
$100,000	$1.80	$2.70
$125,000	$2.25	$3.38
$150,000	$2.70	$4.05
$175,000	$3.15	$4.73
$200,000	$3.60	$5.40
$225,000	$4.05	$6.08
$250,000	$4.50	$6.75

2008 Benefits and enrollment information for non-Medicare-eligible retirees

Annual enrollment information

Enrollment reminders

During the annual enrollment period, you can choose to change or keep your same benefit coverage for 2008. It's important to make your choices carefully, as you will not be able to change your elections until the next annual enrollment period, unless you have a qualified status change.

Enrollment period: Nov. 5, 2007, through Nov. 21, 2007

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

Enrollment correction period: Nov. 26, 2007, through Dec. 7, 2007

This period allows you to make corrections to any benefit elections that you have made during the annual enrollment period. After this period is closed, corrections will not be allowed until next annual enrollment, unless there is a qualified status change.

Enrollment types

This year's annual enrollment is a **passive** enrollment. This means if you are satisfied with your 2007 coverage and wish to keep the same coverage for 2008, then no action is required on your part. Your 2007 coverage will roll over as your coverage for 2008.

Enrollment method and instructions

Enrolling by telephone

Before calling, make sure you have read through your 2008 Benefits and Enrollment Guide and that you have the following information available:

- Election plan choices
- Social Security numbers on all dependents you are adding who were not on your 2007 benefits, along with dates of birth

Call the Benefits Service Center at 1-888-873-7692 from 8 a.m. to 5 p.m. Central Standard Time, Monday through Friday during the annual enrollment period. Should you experience a long hold time, leave a voice mail message with a daytime telephone number where you can be reached and your call will be returned within 24 to 48 hours. Spanish–speaking assistance is available.

After making enrollment elections, a confirmation statement will be mailed by the Benefits Service Center showing your 2008 benefit elections before the enrollment correction period has ended. Make sure that your current mailing address is correct in the City's Human Resources Information System (HRIS). To correct your address, go online or contact your departmental Human Resources Assistant.

Review of benefit elections

Review the confirmation statement that you receive in the mail from the Benefits Service Center or as a printout statement from your computer if you enroll through SEA. Retain it for your records as proof of your timely enrollment. If there are any errors on your confirmation statement or printout, you must contact the Benefits Service Center at 1-888-873-7692 between Nov. 26, 2007, and Dec. 7, 2007. Changes will not be permitted after this period.

Verification of personal information

To receive your identification cards promptly, make sure that your current mailing address is correct in the City's Human Resource Information System. You can call the Benefits Service Center for enrollment changes, or to report an address change or other corrections as necessary. Make sure that you review your January 2008 pension check to verify your benefit elections and insurance deductions are correct.

Changing your benefits mid-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 31 days of the qualifying event. If you fail to change your elections within 31 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 1-888-873-7692 within 31 days of the change (such as divorce, marriage or dependent child becoming ineligible). All status changes must be made within 31 days of the status change. If you are adding a spouse or dependent to your coverage, appropriate documentation will be required.

Paying for medical coverage

Medical premiums are paid on a post-tax basis for retirees and on a post-tax basis for domestic partners. Your annual cost of medical coverage depends on the benefit option you choose and the level of coverage you need. Premium costs for 2008 can be found in this enrollment guide.

Duplicate medical coverage by retiree

In the case where two city retirees both 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 by different employers and are covered by the same insurance carrier, the health plan will pay only up to the allowable.

New retiree enrollment instructions

If you are planning to retire in 2008, make an appointment with your department Human Resources assistant before your retirement to discuss retiree enrollment options and payroll deductions. You **must enroll** within 31 days after your date of retirement. You may be asked to pay the first two months' retiree health premiums in advance, depending on the date of retirement. Call the Benefits Service Center at 1-888-873-7692 from 8 a.m. to 5 p.m., Monday through Friday, within 31 days following your retirement to enroll. If you do not enroll within 31 days, you will be considered to have waived retiree coverage and **will not be eligible for future coverage.**

Retirees who have waived coverage will not be eligible to participate in the City's plan in the future. Your retiree 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. To convert your life insurance, contact Unimerica Insurance Company within 31 days after your retirement date toll-free at 1-866-293-1794.

Special instructions when turning age 65

When turning age 65, you should follow four steps:

1) Notify the Benefits Service Center within 31 days

Within 31 days before reaching age 65, retirees and/or their covered spouses **must** report their change in age to the Benefits Service Center at 1-888-873-7692. If a rate adjustment is required as a result of the retiree and/or his or her covered spouse turning age 65, the adjustment/reduction in rate will be made in the month following the month the retiree and/or his or her covered spouse turned age 65, providing the age change is reported to the Benefits Service Center before the first day of the month in which you turn age 65.

The retiree and/or his or her covered spouse rate will not be adjusted or reduced in the month they turned age 65. The effective rate, before turning age 65 will be charged for the month the retiree and/or his or her covered spouse turned 65.

2) Enrollment in Medicare Part A and B

Three months before you turn age 65, contact your local Social Security Administration Office to enroll in Medicare Parts A and B.

- Retirees and/or their covered spouses must enroll in Medicare Parts A and B at age 65 as a requirement of medical coverage through the City's benefit programs. Contact the Benefits Service Center at 1-888-873-7692 if you or your spouse is not otherwise qualified for premium-free Medicare Part A coverage due to quarters earned through employment or 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 his or her behalf by the City of Dallas. Contact your local Social Security Administration office or go online at **www.ssa.gov** to enroll and determine your 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 PPO plan. 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 suggest 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

Enroll in Medicare Supplement plan F or K, contact the Medicare Supplement Enrollment Center at 1-800-392-7537 to request an enrollment kit and let them know you are City of Dallas retiree. Read and sign the application and mail it back to the Medicare Supplement Provider within 14 days. Your application will not be complete until it is received by the Medicare Supplement provider. They will provide an enrollment card once your application has been approved.

Contact the City's Benefits Service Center at 1-888-873-7692 to inform them that you are enrolling in the Medicare Supplement plan F or K. If you wish to enroll in the City's Medicare Part D plan, you will need to provide your Medicare claim number in order to complete the Medicare Part D enrollment

Medical benefit options

PPO benefit options

The preferred provider organization (PPO), administered by UnitedHealthcare, gives you the freedom to see any health care professional in UnitedHealthcare's national network, including specialists, without a referral and without designating a primary care physician. You can even visit any non-network physician and still enjoy your benefits with somewhat higher out-of-pocket costs.

There are six PPO options from which to choose. The $1,000 and $3,000 deductible PPO options will allow you to receive preventive care benefits from network physicians and other health care professionals who are not subject to the deductible. You will be responsible for 20 percent or 30 percent of costs. This preventive care benefits copayment arrangement is **not available with non-network physicians and facilities.**

PPO plan designs:

- 80/20 coinsurance with a $300, $1,000 and $3,000 deductible
- 70/30 coinsurance with a $300, $1,000 and $3,000 deductible

EPO benefit option

Exclusive provider organization (EPO), administered by UnitedHealthcare, offers full access to the same local and national network as offered to the City's PPO plan members.

EPO plan enhanced benefits:

- **Networks:** Full access to the same local and national network as PPO members.
- **Referrals:** No referrals required. It is not required to see a primary care physician before seeing a specialist. This non-referring system allows employees to visit network specialists without delay.
- **Pharmacy:** Full access to same local and national pharmacy network as PPO members (mail order and retail).
- **NurseLine℠ services:** Anytime access to UnitedHealthcare registered nurses, who can assist you and your family with a wide range of health care questions and concerns. NurseLine also gives you access to an audio health information library with more than 1,100 health and well-being topics, with 600 messages also available in Spanish.
- **Health and wellness:** Full access to UnitedHealthcare wellness resources, online tools, programs and the City's robust wellness activities.
- **Care Coordination℠:** Disease management, inpatient care and critical indicators, monitored by a dedicated staff of UnitedHealthcare nurses.

Prescription drug program

Effective Jan. 1, 2008, the City will increase the retail and mail order prescription minimum copayments of its preferred and brand-name medications on the PPO prescription drug program, as shown:

- **Tier One (generic) drug copayment:** Remains the same at 10 percent, or a $10 minimum
- **Tier Two (preferred) drug copayment:** Increases from 20 percent to 25 percent, or a $25 minimum
- **Tier Three (brand-name) drug copayment:** Increases from 30 percent to 40 percent, or a $40 minimum

The annual individual deductible of $75 and annual out-of-pocket maximum of $2,500 will remain the same for 2008.

Voluntary benefit options

Dental plans

Effective Jan. 1, 2008, the City will provide enrollment services for the dental plans. You will have a choice between a dental HMO and a dental indemnity plan. DHMO plan participants must receive services from their primary care dentist and obtain referrals to see network specialists. Benefits, including orthodontia, are reimbursed based on a scheduled amount. Routine cleaning, exam and X-rays are covered at no cost to the participant twice a year.

Indemnity plan participants are allowed to see any licensed dentist. The plan includes a deductible, calendar-year maximum and a one-year waiting period for major services. **Orthodontia is not covered by this plan.**

Vision plan

For the plan year 2008, the City will provide enrollment services for the vision plan. With Spectera you'll get access to a broad national network of vision care providers, as well as conveniently located retail chain eyewear stores. Plus, many network providers offer evening and weekend hours. If you use a Spectera network provider, all you pay is your copayment for a regular vision exam and prescribed lenses. Benefit plan features include:

- Vision exam
- Eyeglass lenses and frame coverage
- Contact lens coverage (in lieu of lenses and frames) and low out-of-pocket costs

2008 medical plan rates for non-Medicare-eligible retirees

80/20 coinsurance PPO over 65

Non-Medicare-eligible retirees	$300 deductible	$1,000 deductible	$3,000 deductible
Retiree only	$ 294	$ 201	$ 174
Spouse only over 65 split	$ 454	$ 367	$ 342
Spouse only under 65 split	$ 653	$ 515	$ 476
Retiree + spouse (both over 65)	$ 748	$ 568	$ 516
Retiree + spouse (one under 65/one 65+)	$ 947	$ 716	$ 650
Retiree + child (ren)	$ 599	$ 448	$ 404
Spouse + child (ren) (spouse under 65 split)	$ 929	$ 738	$ 684
Retiree + family (both 65 and over)	$1,041	$ 806	$ 737
Retiree + family (one under 65/one 65+)	$1,223	$ 939	$ 858

70/30 coinsurance PPO over 65

Non-Medicare-eligible retirees	$300 deductible	$1,000 deductible	$3,000 deductible
Retiree only	$ 257	$ 171	$ 144
Spouse only over 65 split	$ 418	$ 339	$ 313
Spouse only under 65 split	$ 597	$ 471	$ 431
Retiree + spouse (both over 65)	$ 675	$ 510	$ 457
Retiree + spouse (one under 65/one 65+)	$ 854	$ 642	$ 575
Retiree + child(ren)	$ 538	$ 398	$ 354
Spouse + child(ren) (spouse under 65 split)	$ 852	$ 676	$ 621
Retiree + family (both 65 and over)	$ 945	$ 728	$ 658
Retiree + family (one under 65/one 65+)	$1,109	$ 847	$ 765

80/20 coinsurance PPO under 65

Non-Medicare-eligible retirees	$300 deductible	$1,000 deductible	$3,000 deductible
Retiree only	$ 451	$ 305	$ 264
Retiree + spouse	$1,145	$ 863	$ 784
Retiree + child (ren)	$ 721	$ 522	$ 466
Retiree + family	$1,404	$1,072	$ 978

70/30 coinsurance PPO under 65

Non-Medicare-eligible retirees	$300 deductible	$1,000 deductible	$3,000 deductible
Retiree only	$ 395	$ 260	$ 219
Retiree + spouse	$1,033	$ 774	$ 693
Retiree + child (ren)	$ 643	$ 459	$ 403
Retiree + family	$1,272	$ 965	$ 871

Exclusive preferred provider organization (EPO) monthly rates

Retirees	
Retiree only	$ 503
Retiree + spouse	$1,510
Retiree + child(ren)	$1,408
Retiree + family	$2,433

2008 dental and vision monthly rates

Member	Dental HMO Plan	Dental Indemnity	Vision plan
Member only	$ 7.99	$23.23	$ 6.04
Member + spouse	$14.78	$46.46	$11.03
Member + child (ren)	$14.78	$47.38	$11.58
Member + family	$20.77	$70.62	$17.81

Benefits information for certain Medicare-eligible retirees

Medical benefit options

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:
  - 2008 Formulary List
  - Summary of Benefits
  - Mail-order information
  - Pharmacy Directory
- Explanation of Benefits
- Explanation of Coverage (EOC)

The documents listed above will require no action on your part because you are already enrolled. **However**, if you receive a **Late Enrollment Penalty Letter**, you are required to *complete and return* as instructed in the letter. For help in completing this letter, please call the City of Dallas Benefits Service Center at 1-888-873-7692.

Voluntary benefit options

Dental plans

Effective Jan. 1, 2008, the City's will provide enrollment services for the Dental plans. You will have a choice between a dental HMO and a dental indemnity plan. **DHMO plan** participants must receive services from their primary care dentist and obtain referrals to see network specialists. Benefits, including orthodontia, are reimbursed based on a scheduled amount. Routine cleaning, exam and X-rays are covered at no cost to the participant twice a year. **Indemnity plan** participants are allowed to see any licensed dentist. The plan includes a deductible, calendar-year maximum and a one-year waiting period for major services. **Orthodontia is not covered by this plan.**

Vision plan

For the plan year 2008, the City's will provide enrollment services for the vision plan. With Spectera, you'll get access to a broad national network of vision care providers, as well as conveniently located retail chain eyewear stores. Plus, many network providers offer evening and weekend hours. If you use a Spectera network provider, all you pay is your copayment for a regular vision exam and prescribed lenses. Benefit plan features include a vision exam; eyeglass lenses and frame coverage; contact lens coverage (in lieu of lenses and frames) and low out-of-pocket costs.

2008 medical plan rates

Medicare Supplement plans: Monthly cost for Texas residents

Rates are for Texas residents only. Rates for other states will vary. All rates subject to change during 2008. 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.

	More than six months post-eligibility			Within six months of eligibility		
	No pharmacy			No pharmacy		
	Plan C	Plan F	Plan K	Plan C	Plan F	Plan K
Retiree only	$ 85.25	$ 86.00	$ 51.50	50% of actual AARP rate	50% of actual AARP rate	50% of actual AARP rate
Retiree + spouse	$247.47	$249.02	$154.50	50% of actual AARP rate	50% of actual AARP rate	50% of actual AARP rate
Spouse only	$162.23	$163.01	$103.00	50% of actual AARP rate	50% of actual AARP rate	50% of actual AARP rate

Medicare Part D prescription-only plan

No medical included. Purchase with or without Medicare Supplement plan. Cannot be purchased with PPO plans.

Retiree only	$ 76.47
Spouse only	$152.94
Retiree + spouse	$229.41

MedicareComplete HMO plans

	Individual HMO	Group HMO Plan 1	Group HMO Plan 2
Retiree Only	$ 0	$ 89.30	$ 57.19
Retiree + Spouse	$ 0	$ 178.60	$ 152.94
Spouse Only	$ 0	$ 267.90	$ 229.41

2008 dental and vision monthly rates

Member	Dental HMO plan	Dental indemnity	Vision plan
Member only	$ 7.99	$23.23	$ 6.04
Member + spouse	$14.78	$46.46	$11.03
Member + child (ren)	$14.78	$47.38	$11.58
Member + family	$20.77	$70.62	$17.81

Medical plan designs

2008 EPO and PPO medical plan summaries

Exclusive provider organization (EPO) plan design

UnitedHealthcare EPO offering

Provider networks: Full access to the same local and national UnitedHealthcare network accessed by current City of Dallas PPO members. **No out-of-network benefits.**

Referrals: No referrals required. EPO members are not required to see their primary care physician before visiting a specialist.

Pharmacy: Full access to the local and national pharmacy network accessed by current City of Dallas PPO members. Mail-order and retail options are available. See UnitedHealthcare's pharmacy section to learn more at our pharmacy program, network and how to access mail-order services.

NurseLine services: 24/7 access to UnitedHealthcare nurses at no extra cost, as part of your benefit plan.

Health and wellness: Full access to UnitedHealthcare's wellness resources, online tools and on-site wellness coordinator.

Customer services: Telephonic support, online support through **myuhc.com** and access to UnitedHealthcare's on-site representative.

Care Coordination: Disease management, inpatient care and critical indicators supported by a dedicated staff of UnitedHealthcare nurses.

Summary plan document: Review and download a copy of the EPO plan document on the City's Web site.

EPO plan benefit summary	
	In-network only
Annual deductibles	None
Out-of-pocket maximums:	
Per person	$2,500
Per family	$5,000
Maximum plan benefit:	Unlimited
Physician office visits	
Primary care physician: Primary care	$20 copayment
Specialty care physician: Specialist	$45 copayment
Hospital: Inpatient stay	$600
Outpatient surgery	$300 copayment
Emergency room services	$150 copayment
Urgent care services	$45 copayment
Pharmacy benefits:	
Retail:	
Tier one	$10 copayment
Tier two	$25 copayment
Tier three	$40 copayment
Mail-order: (three-month supply)	
Tier one	$20 copayment
Tier two	$50 copayment
Tier three	$80 copayment

PPO plan design: 80/20 plans

	$3,000 deductible PPO plan*		$1,000 deductible PPO plan*		$300 deductible PPO plan*	
Coinsurance	**In-network 80/20**	**Out-of-network 60/40**	**In-network 80/20**	**Out-of-network 60/40**	**In-network 80/20**	**Out-of-network 60/40**
Calendar year deductible						
Per person	$3,000	$6,000	$1,000	$2,000	$300	$600
Per family	$9,000	$18,000	$3,000	$6,000	$900	$1,800
Coinsurance	80%	60%	80%	60%	80%	60%
Out-of-pocket maximum (includes deductible)						
Per person	$7,500	$15,000	$4,000	$8,000	$2,800	$5,600
Per family	$15,000	$30,000	$8,000	$16,000	$5,400	$11,800
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Physician / ER physician services	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Preventive care services (see next page)	Plan pays 80% **No** Deductible	Plan pays 60% after deductible	Plan pays 80% **No** Deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient hospital services	Plan pays 80% after deductible	Plan pays 60% after deductible and $250 confinement deductible	Plan pays 80% after deductible	Plan pays 60% after deductible and $250 confinement deductible	Plan pays 80% after deductible	Plan pays 60% after deductible and $250 confinement deductible
Hospital emergency room care**	$100 copay per visit	$100 copay per visit	$100 copay per visit	$100 copay per visit	$100 copay per visit	$100 copay per visit
**If the diagnosis is determined not to be a true emergency	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Urgent care services	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible

*See 2008 Summary Plan Description for detailed benefit information.

PPO plan design: 70/30 plans

	$3,000 deductible PPO plan*		$1,000 deductible PPO plan*		$300 deductible PPO plan*	
Coinsurance	**In-network 70/30**	**Out-of-network 50/50**	**In-network 70/30**	**Out-of-network 50/50**	**In-network 70/30**	**Out-of-network 50/50**
Calendar year deductible						
Per person	$3,000	$6,000	$1,000	$2,000	$300	$600
Per family	$9,000	$18,000	$3,000	$6,000	$900	$1,800
Coinsurance	70%	50%	70%	50%	70%	50%
Out-of-pocket maximum (includes deductible)						
Per person	$7,500	$15,000	$5,500	$11,000	$4,000	$8,000
Per family	$15,000	$30,000	$12,000	$24,000	$8,300	$16,600
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Physician / ER physician services	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Preventive care services (see next page)	Plan pays 70% **No** Deductible	Plan pays 50% after deductible	Plan pays 70% **No** Deductible	Plan pays 50% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Inpatient hospital services	Plan pays 70% after deductible	Plan pays 50% after deductible and $250 confinement deductible	Plan pays 70% after deductible	Plan pays 50% after deductible and $250 confinement deductible	Plan pays 70% after deductible	Plan pays 50% after deductible and $250 confinement deductible
Hospital emergency room care**	$100 copay per visit	$100 copay per visit	$100 copay per visit	$100 copay per visit	$100 copay per visit	$100 copay per visit
** If the diagnosis is determined not to be a true emergency	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Urgent care services	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible

*See 2008 Summary Plan Description for detailed benefit information.

Pharmacy benefits: All PPO plans

Retail	Mail-order: Home delivery
Up to a 31-day supply	Three-month supply
Tier one: 10% with a $10 minimum	Tier one: 10% with a $10 minimum
Tier two: 25% with a $25 minimum	Tier two: 25% with a $25 minimum
Tier three: 40% with a $40 minimum	Tier three: 40% with a $40 minimum

Annual drug deductible: $75 combined retail and mail-order deductible per individual

Out-of-pocket drug maximum: $2,500 combined retail and mail-order annual out-of-pocket maximum per individual

City of Dallas PPO Preventive Care Program

Covered benefits: In-network

- $1,000 and $3,000 deductible plans (80/20 and 70/30): Not subject to deductible
- $300 deductible plans (80/20 and 70/30): Subject to deductible

Covered benefits: Out-of-network

Subject to out-of-network deductibles and coinsurance

Gender/Age	Service
Male and female Birth to 24 months	Well visits up to age six All immunizations
Male and Female Age 2 to 16 yrs.	Well visits: one per year All immunizations
Male and Female Age 17 and up	Physical exam: Once every two years
Male and Female Age 50 and up	Colonoscopy screening: Once every five years
Female Age 35 and up	Annual mammogram
Female Age 20 and up	Annual Pap smear
Male Age 35 and up	Annual prostate antigen testing

Managing your UnitedHealthcare account

The City of Dallas' medical plan has approximately 30,000 accounts (employees, retirees and dependents) and you are one. To help you manage your health care account, and access personalized services and information regarding your health care costs, register on **myuhc.com**. Below are instructions to the enclosed CD-Rom that illustrates how to view the Site Demo and register on **myuhc.com** to access your health care account.

1. Insert the CD-Rom into your computer
2. Click "View the Interactive Demo"
3. Go to the Site Login section and click "log-in" (top left-hand side of screen)
4. Click "OK" to pop-up message
5. After you have logged in, you will be able to tour the Interactive Site on your own to view the tools available to manage your health care plan.

6. After familiarizing yourself with the site, log on to **myuhc.com**
7. Click "register now" and begin the process to take control of your health

The site also has links to the following information: Claims & Accounts, Physicians & Facilities, Pharmacies & Prescriptions, Benefits & Coverage, Personal Info and Health & Welfare.

Support services

We want to help you take control and make the most of your health care benefits. Our mission is to help you achieve optimal health and well-being. We provide you with a wealth of informational tools and clinical approaches designed to support you through the entire health care process.

Here are a few suggestions and reminders to help you get started.

Your member ID card is the key

Showing it is the best way to make sure that you receive quick care and that you're not billed unnecessarily. You and your covered family members should carry it with you at all times, and present it whenever you receive services from a doctor or other health care professional.

Finding a physician or health care professional

You have access to a national network of more than 520,000 doctors and 4,700 hospitals. To help you find the right doctor, we provide current, relevant information on the doctors in our network. This includes credentials, range of services offered, fees charged, quality and efficiency measures and patient satisfaction surveys. Remember, it's your choice, and we want you to make an educated one.

Network vs. Non-network: More to know about selecting a doctor

Consider this. The doctor or facility you choose may save you money. If your benefit plan allows for coverage outside of our network, chances are it will cost you more for services from doctors that are not in our network. If you seek care outside the network, we only pay a portion of the charges, and you're responsible for paying the remainder. We'll send you a check for our portion of the covered charges, and it's your responsibility to pay the doctor or facility.

To make sure you're not billed for your lab or diagnostic imaging services, tell your doctor you want to be referred to a network provider.

By the numbers:

520,000 doctors

4,700 hospitals

60,000 pharmacies

57,000 counselors and mental health practitioners

UnitedHealth Premium® designation program

When it comes to our network, we make it easier for you to see which doctors and hospitals in your area meet measures on quality and efficiency. The UnitedHealth Premium designation program evaluates hospitals and doctors in 21 specialties, including primary care, and specialty areas of medicine such as cardiac, orthopaedic and cancer care. Criteria for designation comes from evidence-based clinical guidelines and specialty clinical societies.

UnitedHealth Premium offers you:

- **Informed choice** – We've done the homework for you, sharing the same information we provide doctors and hospitals, so you can make the best choice about where to seek care.
- **Peace of mind** – You can rest easy knowing you're receiving care from doctors and hospitals that have shown they adhere to best practices and achieve better outcomes for their patients.
- **Resources at your fingertips** – It's easy for you to get information, online or over the telephone, so you can spend time focusing on other important care decisions.
- **Easy access** – These doctors are part of UnitedHealthcare's network, so you can easily identify and access them without a referral.

NCQA Physician Recognition Programs

For our members with special medical concerns, we also provide information from the National Committee for Quality Assurance (NCQA) Physician Recognition Program. The program highlights superior performance and practice for doctors in three important areas: diabetes care, cardiac care and stroke care. Plus, the NCQA Physician Practice Connection recognizes doctors who use up-to-date information and systems to enhance patient care. NCQA is an independent, nonprofit organization that has developed these programs in association with the American Diabetes Association, American Heart Association and American Stroke Association.

NurseLine services

Need help making smart health care decisions? Let NurseLine services point you in the right direction. Call and speak with a registered nurse to:

- Better manage an illness or injury.
- Recognize urgent and emergency symptoms.
- Locate doctors and hospitals in your area that meet criteria for quality and efficiency.
- Understand medication interactions and how to reduce your prescription costs.
- Connect with resources for pregnancy, cancer, diabetes, asthma, heart disease and more.

Emotional support also is available from master's-level specialists when you need help dealing with life's challenges. Get help with stress, anxiety, depression, grief, marriage difficulties and much more. And best of all, NurseLine services are included as part of your benefit plan. Call the number on the back of your member ID card any time — 24 hours a day, every day.

Healthy Pregnancy Program

At no extra charge, expectant mothers can find help through all stages of pregnancy with the Healthy Pregnancy Program. To enroll, call **1-800-411-7984** between 8 a.m. and 11 p.m. Central time, Monday through Friday, or visit **www.healthy-pregnancy.com** for more information. It's best to enroll within the first 12 weeks of your pregnancy, but you can enroll through week 33 of your pregnancy.

Find a leading doctor or hospital

Visit myuhc.com to search the directory and look for these symbols next to your results:

★★ UnitedHealth Premium quality and efficiency physician/hospital

★ UnitedHealth Premium quality physician/hospital

NCQA/ADA Diabetes Physician Recognition Program (DPRP)

NCQA/AHA/ASA Heart/Stroke Recognition Program (HSRP)

NCQA Physician Practice Connection (PPC)

UnitedHealthcare wellness tools and resources

Whether you want to eat right, exercise more, stop smoking or just relax, you have a wide range of resources to help you stay healthy. Even better, these are already included in your benefit plan. Get started today by visiting **myuhc.com.**

Health Assessment and personalized report	Complete an online questionnaire to help your overall state of health. Once completed, you receive immediate and confidential results from an online personalized report, plus suggestions for improving your health.
Health improvement tools and programs	Choose from many online "Take Action" guides to help you develop skills to improve your health and well-being. Plus, you can enroll in an online six-week Healthy Living Program. These programs focus on helping you make lifestyle changes.
Personal health record	Find all the information about your health conditions, medication, medical procedures and lab results in one place.
Discounts	Save 5 to 60 percent on thousands of wellness products and services, including certain health care services not covered by your benefit plan. These include alternative medicine, cosmetic dentistry, laser eye vision correction, hearing services, long-term care services and more.
Libraries	Find information an a wide range of health and wellness topics, plus quizzes, calculators and charts. Topics include: addiction, family, fitness and nutrition, healthy aging, pregnancy, preventive medicine and more.

Care Coordination: Helping you take an active role in your health care

Designed as a unique program for members who are living with a chronic condition or dealing with complex health care needs, the Custom Care Solutions Team provides a high level of support and service for the employees and families of the City of Dallas. A dedicated team of nurses, physicians and pharmacists provide:

- **Dedicated Care Coordination nurse** for each high-risk employee and his or her family members.
- **Integration** with NurseLine and EAP services.
- **Disease management**, to include greater intervention for coronary artery disease, diabetes and congestive heart failure.
- **Long-term behavior change plan for members with high-intensity to complex conditions.** This includes an assigned disease management nurse who works with the member for six to 12 months, frequent clinical contacts and an on-site medical director for reviewing complex cases and providing ongoing education.
- **Educational plan for members with low-intensity conditions,** which includes program participation letters, quarterly disease-specific newsletters, disease-specific Web resources and behavior-change programs on **myuhc.com.**
- **Inpatient advocacy,** meaning we work with hospitals to ensure the physician's orders and treatment plan are carried out in a timely manner, plus work with family members and other service providers to coordinate needs after discharge.
- **Readmission prevention program:** helps facilitate a safe transition from the hospital to the home for those at a higher risk for re-admittance.
- **Hospital admission counseling:** Nurses call individuals scheduled for certain procedures to answer questions and discuss expectations, discharge plans and health care options. Don't be surprised if a UnitedHealthcare nurse contacts you to provide their support, care and expertise.

Wellness e-news the way you want it

UnitedHealthcare's Healthy Mind, Healthy Body e-newsletter allows you to choose the wellness information that best fits your daily life. You will receive articles from leading doctors who have appeared in television programs such as "Oprah" and magazines such as "Health". Issues are sent to your designated e-mail address each month. Sign up today by visiting **www.uhc.com/myhealthnews.**

Your privacy is vital

Any personal health information you share with UnitedHealthcare's health and wellness programs will not be distributed to the City of Dallas, per federal regulations. You also have the right to privacy and confidentiality for any treatments, tests and procedures you receive during the course of your health care. For more information, see your Summary Plan Description.

Accessing customer service

The City of Dallas is committed to providing you with quality customer service when it comes to your health benefits. To ensure we are able to provide you the service you need and respond as quickly as possible, we need your help. You can help us serve you better by following the steps outlined below to access customer service:

The City of Dallas Benefits Service Center has been established to assist you with general questions concerning your benefits. If your customer service need falls in one of the categories below, please contact the Benefits Service Center at 1-888-873-7692.

- Claims issues or appealing how a claim was paid
- Medicare Part D prescription coverage
- Membership ID card
- Medical coverage
- Prescription drugs
- Dental coverage
- Vision coverage
- Life insurance coverage
- Voluntary benefits
- Medicare Supplement coverage
- Medicare Advantage HMO coverage
- Verify eligibility
- Update personal information
- Verify insurance rates
- Payroll deductions
- Update your benefits
- Vendor complaints
- Drop coverage
- Add a new born or spouse
- Turning age 65
- Claim payment dispute

Note: If you get voice mail, you can leave a confidential message and your call will be returned within 24 to 48 hours. Please provide:

- Your name
- Social Security number
- Nature of your concern
- Insurance plan you are enrolled in

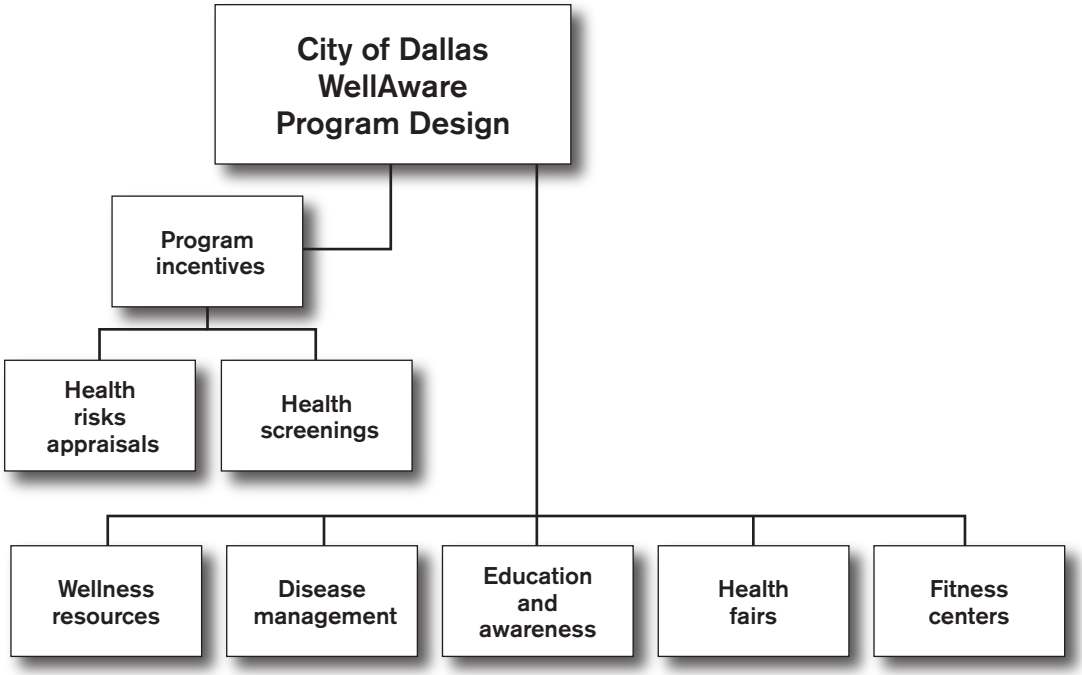
Before calling the Benefits Service Center, please contact the appropriate vendor directly if you have general coverage and exclusion questions. (See vendor contact information on page 3 of this guide)

City of Dallas WellAware program

The goal of the City of Dallas WellAware program is to improve the health status of our employees and retirees, one member at a time. We will accomplish this goal by educating and empowering our members through wellness resources and tools, identifying and implementing intervention and behavioral-change programs, and increasing the physical activity options among our members. Some of the key focus areas for 2008 include hypertension management, diabetes and weight management. In 2008, you can take advantage of the following programs and services.

- Annual Health & Lifestyle Expo
- Incentive campaigns
- Lunch-n-learns and much more

The WellAware program will incorporate the following design to help you improve your health:



During the 2007 fiscal year, the City of Dallas WellAware program accomplished a number of milestones:

- Hosted a Health and Lifestyle Expo
- Launched a walking campaign with more than 2,500 participants
- Added 15 park and recreation fitness centers to the program

As a City of Dallas employee or retiree, you and your family members have access to "Fitness Centers across the City." Employees and retirees must agree to the following requirements to qualify for a membership:

- **Active employees**
  - Complete a Personal Health Assessment online at **myuhc.com.**
  - Consult with a health coach if the Personal Health Assessment is flagged.
  - Complete a membership survey at the beginning and end of the first year.
  - Fill out any additional forms required by the Park Department.
- **Retired employees**
  - Complete a Personal Health Assessment online at **myuhc.com.**
  - Consult with a health coach if the Personal Health Assessment is flagged.
  - Fill out any additional forms required by the Park Department.

Other important information

Employees and retirees can take advantage of using the following 15 Park and Recreation Fitness Centers for a flat fee of $75 per year, per member.

Name of center	Address	ZIP Code	Location	Contact number
Exall	1355 Adair	75204	Central Dallas	214-670-7812
Reverchon	3505 Maple Ave.	75219	Central Dallas	214-670-7720
MLK	2922 M.L. King Blvd.	75215	Fair Park	214-670-8363
Kiest	3080 S. Hampton	75224	Oak Cliff	214-670-1918
T. Marshall	5150 Mark Trail	75232	Oak Cliff	214-670-1928
T. Allen	7071 Bonnieview	75241	Oak Cliff	214-670-0986
J.C. Turner	6424 Elam	75217	SE Dallas	214-670-8277
Kleberg-Rylie	1515 Edd Rd	75253	SE Dallas	214-670-8648
Umphress	7616 Umphress	75217	SE Dallas	214-670-0956
Park In the Woods	6801 Mt Creek Pkwy	75249	SW Dallas	214-671-0219
Lake Highlands	9940 White Rock Trail	75238	NE Dallas	214-670-7793
Timberglen	3810 Timberglen Rd.	75287	NW Dallas	214-671-0644
A. Martinez	3212 Winnetka	75212	W Dallas	214-670-7773
J.C. Zaragoza	3114 Clymer	75212	W Dallas	214-670-6188
Walnut Hill	10011 Midway	75229	N Dallas	214-670-7112

Please contact the fitness center nearest to you for more information and learn how to become a member. For additional information regarding the WellAware program, please contact WellAware@dallascityhall.com.

Legislative notices

What is COBRA?

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

How long must COBRA continuation coverage be available?

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

What plans are subject to COBRA?

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

What specific events can be qualifying events?

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

What events are not considered qualifying events?

The following events are not considered triggering events:

- A change in insurance carriers
- Filing for divorce (official divorce decree or legal separation is triggering event)
- Employer amends plan to reduce coverage
- Employee drops coverage for spouse or dependents

When must the employee or beneficiary notify the plan administrator?

The covered employee or beneficiary must notify the plan administrator within 60 days of the occurrence of divorce or legal separation, or dependent child ceasing to be a dependent under the plan.

When must the employer notify the plan administrator?

The employer must notify the plan administrator within 30 days of the date of the following qualifying events:

- Death of a covered employee
- Termination or reduction of hours of the covered employee
- Covered employee becomes entitled to Medicare

When must the COBRA notice be sent out?

The plan administrator must notify any beneficiary with respect to his or her COBRA election rights within 14 days after it has been notified by the employer or by a beneficiary that the qualifying event has occurred.

What is the time period for electing COBRA?

A beneficiary may elect COBRA coverage at any time within 60 days after the date of the notice from the plan administrator.

What are the premium payment deadlines regarding COBRA coverage?

If a beneficiary fails to make the initial premium payment within the 45–day period, the plan administrator may terminate the COBRA coverage. Thereafter, payments are due on the first of each month, subject to a 30–day grace period.

Women's Health and Cancer Rights Act of 1998 annual notice

Did you know that your benefit plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy (including lymphadema)? Contact the Benefits Service Center at 1-888-873-7692 for more information.

Continuation of health coverage during family and medical leave

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12–month period to eligible employees for certain family and medical reasons. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Contact the Benefits Service Center at 1-888-873-7692 to find out details about how this continuation applies to you.

For the duration of a FMLA leave, the employer must maintain the employee's health coverage. The employee may continue the plan benefits for himself or herself and his or her dependents on the same terms as if the employee had continued to work. The employee must pay the same contributions toward the cost of the coverage that he or she made while working. If the employee fails to make the payments on a timely basis, the employer, after giving the employee written notice, can end the coverage during the leave if payment is more than 30 days late.

Upon returning from a FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms. The use of a FMLA leave cannot result in the loss of any employment benefit that accrued before the start of an employee's leave.

Statement of rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending health professional (such as your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48–hour (or 96–hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care professional obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain physicians or facilities or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the Benefits Service Center at 1-888-873-7692.

Notice of medical privacy practices

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

Protecting your personal health information

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

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

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

How your personal health information may be used and disclosed

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

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

Health plan payment

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

Health care operations

We may use and disclose your protected health information for Health Plan operations, such as monitoring the Carriers and TPAs to ensure that they are properly and accurately paying claims in accordance with the terms of the Health Plan documents and that they are providing proper and timely services to you as required under the Health Plans. Designated employees of the City may receive, use, and disclose protected health information when assisting you with Health Plan problems or questions, such as eligibility, benefit coverage, and appeals.

Protected health information also may be used when conducting quality assessment and improvement activities; underwriting and soliciting bids from potential Carriers or TPAs, establishing City and employee premium contributions and funding related activities; determining need for disease management programs; submitting claims for stop-loss coverage; arranging medical or legal reviews or fraud detection programs; and managing costs. We may also share your protected health information with business associates who assist us in monitoring Health Plan costs, utilization, plan design, Health Plan disputes, and similar Health Plan payment and operations.

Our auditors, attorneys, and other business associates may use protected health information in assuring accurate and complete compliance with the Health Plans' terms. As required by Law or Judicial Order: We will disclose information about you when required to do so by federal, state or local law, including when required by court orders and subpoenas, or by the police or other authorized governmental organizations. For example, we may disclose protected health information when required by a domestic relations order, a child support order or a court order involving a civil lawsuit or criminal prosecution. In most instances, the Carrier or the TPA will provide this information.

To avert a serious threat to health or safety

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

Special situations

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

Disposal of protected health information

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

Your written authorization to release information

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

Your rights regarding your protected health information

Right to inspect and copy

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

Right to amend

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

Right to an accounting of disclosures

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

Right to request restrictions

You have the right to request a restriction or limitation on the protected health information we use or disclose about you for Health Plan payment or operations.

Notice of medical privacy practices

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

Right to request confidential communications

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

Use of personal representatives

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

Changes to this notice

We reserve the right to change this Notice and will distribute as required. We reserve the right to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on the Plan Web site at www.dallascityhall.com.

Complaints and questions

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

Health plan contact information

Human Resource Department
1500 Marilla Street, Rm. 6AS
Dallas, Texas 75201 - 6390
Telephone: 214-670-3120
Fax: 214-670-3764

UnitedHealthcare: PPO and EPO plans	**1-800-736-1364**
UnitedHealthcare: PPO/EPO prescriptions drug services	**1-877-842-6048**
Marsh@Work Solutions: Voluntary benefit plans	**1-800-557-1046**
Safeguard: Dental indemnity plan	**1-800-962-9633**
Safeguard: Dental HMO plan	**1-800-880-1800**
Spectera: Vision plan	**1-800-638-3120**
Alliance Work Partners: EAP program	**1-800-343-3822**
Flexible spending accounts: EMSP and DCAP	**1-877-311-7849**

Administrative services provided by United HealthCare Insurance Company, United HealthCare Services, Inc. or their affiliates.

For informational purposes only. The NurseLine service can not diagnose problems or recommend specific treatment. The information provided through the NurseLine service is not a substitute for your doctor's care.

Please remember, UnitedHealthcare does not provide health care services nor practice medicine. Doctors are solely responsible for medical judgments and treatments. The UnitedHealth Premium® designation program provides consumers with information using data from externally published, widely accepted data sets and UnitedHealthcare claims and survey data from doctors to create a multidimensional view of doctor performance.

Only doctors who apply and meet UnitedHealth Premium criteria, and who have sufficient claims data for analysis, may be included. Doctors listed in the network but not designated as a UnitedHealth Premium doctor, either have not applied for designation, did not have adequate claims data or did not meet program criteria. Designations do not guarantee the quality of care being rendered. Regardless of designation, enrollees have access to all doctors and facilities in the UnitedHealthcare network.

The Healthy Pregnancy Program follows national practice standards from the Institute for Clinical Systems Improvement. The Healthy Pregnancy Program can not diagnose problems or recommend specific treatment. The information provided is not a substitute for your doctor's care.

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