City of Dallas

2007
Benefits & Enrollment Guide
For
City of Dallas Employees

About This Guide

This 2007 Benefits & 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 Health Benefits Plan, including health, 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.

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Welcome To Benefits 2007

Dear Fellow Employees,

It is my pleasure to welcome you to **Benefits 2007**. This year, as it has been for the past several years, the City was again faced with the challenge of controlling raising health care costs and balancing health care needs with available resources. This year, the City Manager presented to City Council a FY06-07 Health Care Strategy plan to control health care costs that focused on:

- Reducing health care costs trend to a single digit
- Maintaining broad network access to quality and cost-effective care
- Evaluating past and current plan performance
- Seeking alternate delivery systems and plan options
  - Medicare risk contracts for post-65 retirees
  - Review/analyze continued viability of HMO plan
- Developing a strategy for implementing a Comprehensive We**l**ness Program
- Increasing employee/retiree engagement: value-conscious consumers
- Improving communication and distribution of benefits information

By implementing the FY06-07 Health Care Strategy Plan, the City will avoid an anticipated increase of 6.9M in the health care budget for FY06-07. In addition, for a second year, it will positively impact the provision of benefits for employees in the following ways for 2007:

- There will be **no premium increase** for employees who are enrolled in the City's self-Insured PPO program for the plan year 2007;

- New offering a self-insured Exclusive Provider Organization (EPO) plan that will replace the fully-insured HMO plan, effective January 1, 2007. The EPO will look-like a HMO plan, however it will offer full access to the same local and national network as the City's current PPO plan members. This change will allow employees to utilize the same network as PPO members, which is much larger network. Current HMO members will be automatically enrolled in the new EPO plan and their **premiums will not increase** for 2007.

- No referrals will be required to see a Primary Care Physician before seeing a specialist. This non-referring system allows employees to visit their physician without delay to various specialists.

During the FY05-06, we have made great stride toward the development of a comprehensive Wellness and Disease Management Program. For details on what all has been accomplished this year, visit the section tilted "City Wellness Program Update" of this Guide. As the City begins to focus more on **WELLNESS,** our goal is to provide you the right tools to help you to improve your health and enable you to control your health costs. The first step to improving your health is completing a health risks assessment. If you are enrolling in the City's PPO or EPO plans, you can register at: **MYUHC.COM** to complete a health assessment. In addition, while on myuhc.com, you can find resources that will help you to understand:

- Your benefits and how to read and understand your Explanation of Benefits (EOB)
- How to access the 24 hour Nurseline and the Premium Designation Network
- Your Pharmacy Benefits and what generic options are available
- How to access personal health and wellness tools and programs

Welcome To Benefits 2007 (cont)

We are also please to announce that for 2007, UnitedHealthcare will offer access to a Consumer Account Card for all FSA participants. A welcome kit will be sent to your primary address with two cards, information on how to activate and additional frequently asked questions. More information can be found on the Consumer Account Card in the UnitedHealthcare section of this Guide.

Please review the enrollment materials that are present in this Guide to help you in choosing the right combination of benefits that are best suited for you and your family. Some of the more significant items to remember for Benefits 2007 include:

- This year's Annual Enrollment period will begin **Monday, November 6th, and continue through Friday, November 17th**. Corrections or changes can be made through Friday, December 8th.

- Confirmation statements will be mailed following the Annual Enrollment Period to verify your medical benefit elections for 2007 by the Benefit Service Center. To confirm you're dental or vision elections, contact Marsh@Work Solutions at 1-800-557-1046 from 8:00 AM. to 5:00 PM. CST, Monday through Friday.

This year's, Annual Enrollment will be **"PASSIVE**" , which means, if you do not want to make changes to your benefit elections, your current benefit elections will rollover for plan year 2007.

We are committed to meeting the challenge of providing employees the very best in benefit services for the upcoming year. Again, Welcome to Benefits 2007!

Sincerely,

David Etheridge, Director
Human Resources Department

About This Guide

We are pleased to provide you with the Benefits and Enrollment Guide for the City of Dallas Health Benefits Plan for the plan year beginning January 1, 2007 and ending December 31, 2007. This guide provides a summary of the benefit options available to eligible employees. If any discrepancy exists between the information in this guide and the Summary Plan Description document, the Summary Plan Description document will govern. Included in this guide is information regarding the benefit programs available to you and your eligible dependent(s). You will also find important information regarding what you must do to add or drop dependents, and other actions that affect your health benefits. ***PLEASE DO NOT THROW THIS GUIDE AWAY!***

This Guide will present 2007 benefits and enrollment information exclusively for active employees enrolled in the City's self-insured PPO plan and those enrolled in the fully-insured HMO plan. This Guide does not include any benefits and enrollment information pertaining to the City of Dallas Retirees. A separate Guide will be produced exclusively for retirees for the 2007 Annual Enrollment Period.

This year's annual enrollment will take place from **November 6, 2006 through November 17, 2006**. Please review the enrollment materials that follow carefully and choose the combination of benefits that are best suited for you and your family.

During Annual Enrollment You May.....

- Add or drop coverage for dependents
- Choose different medical and dental plans, or drop dental or vision coverage
- Make no changes to dental and vision benefits, your coverage will rollover for 2007
- Do nothing for your medical benefits and your current coverage will continue for 2007

Make Informed Decisions

Read this Enrollment Guide carefully. Learn about the various options available before you make your enrollment decisions. It's up to you to choose the benefits that best meet your need. So take the time to use the available resources.

General Enrollment Information

Employees should make sure that they have completed and on file current beneficiary designation forms with Standard for life insurance, Human Resources for final paycheck distribution, the Employee Retirement Fund or Dallas Police and Fire Pension System for retirement benefits and Fidelity for 401K and 457 participants.

Employees who *DO NOT* want to make any elections changes for 2007:

Your benefit elections will roll over for 2007 and any premiums will be adjusted, if there has been a change in premiums for 2007. However, employees who want to participate in the DCAP or EMSP for 2007, you must re-enroll in these plans.

If you have noticed that your address is incorrect:

Active employees can update their addresses by contacting their department HR Assistant or Generalist to have your address corrected or on-line through the Human Resources Information System (HRIS).

If you are adding a spouse or dependent to your coverage:

Documentation will be required when you are adding a spouse or a dependent child to your coverage. 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.

About This Guide (cont)

Benefit Elections and Changes

Any benefits that you select or any changes you make during annual enrollment will be effective for a 12-month period, January 1, 2007 through December 31, 2007. You **will not** be allowed to make any changes during the 12 months unless you have a qualifying change in status.

Leaves 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 prior to the start of your leave.

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 non-payment 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 Benefit Service Center within 31 days. The employee returning from Military Leave must call the Benefits Service Center, for medical and life insurance coverage and Marsh for dental and vision coverage, within 31 days of return to work in order to reinstate coverage.

Other Significant Reminders:

- Corrections or changes to benefit elections made during the annual enrollment period can be made up to 5:00 pm CTS Friday, December 8th**.** It is important that you verify the accuracy of your payroll deduction when you receive your January pension check. Your payroll deduction amount should match your benefit elections.

- Confirmation statements will be mailed by the Benefits Service Center that will show your 2007 Medical Benefit Elections, whether you made any changes or not. To confirm you're dental or vision elections, contact Marsh@Work Solutions at 1-800-557-1046 from 8:00 AM. to 5:00 PM. CST, Monday through Friday.

Other Important Highlights

For 2007, there will be **no premium increases** for employees who are participating in the City's self-insured PPO plans and fully-insured HMO plan that will be replace by a new self-insured EPO plan for 2007.

For "Same Sex Domestic Partners", who meet the eligibility requirements and who complete an Affidavit of Domestic Partnership Form. The form can be found on the City's intranet or internet under publications Affidavit of Domestic Partnership, or phone (214) 670-3120 for information. **Under current Internal Revenue Service tax codes there may be severe tax liabilities. Premiums for a domestic partner maybe considered as an after tax deduction.** When considering enrollment and the potential tax liabilities please consult with a competent tax code attorney to consider your potential tax liability.

Accessing Customer Service

The City of Dallas Employee Benefits staff and its partner Deloitte Outsourcing, who manages the City's Benefits Service Center is committed to provide you with quality customer service when it comes to your health benefits. In order to ensure that we are able to provide you the service that you need and to respond to as quickly as possible, **WE NEED YOUR HELP.** You can help us to serve you better by following the steps outlined below to access customer service:

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

- Medical Coverage
- Prescription Coverage
- Spouse Status
- Eligibility
- Insurance Rate
- Student Status
- Premium Payroll Deductions
- Updating Your Benefits
    - Dropping coverage
    - Adding a new born or spouse
    - Spouse dies
    - Changing job
    - Turning age 65
    - Dependent child is no longer eligibility for coverage (age 25)
- Personal information (address change, phone # or relocation)
- Vendor complaint

Please contact the appropriate vendor directly if you have general questions concerning before calling the Benefits Service Center:

- Claims Issues or you want appeal how a claim was paid
- Prescription Drugs
- Dental Coverage
- Vision Coverage
- Membership ID Card

(See Vendor Contact Information in this Guide)

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

- **Your Name**
- **Social Security #**
- **The nature of your concern**
- **The insurance plan you are enrolled in**

2007 Plan Changes and Highlights

City Sponsored Health Plans

PPO Plans

- The City will continue to offer its six self-insured PPO plans for 2007. There are no plan design or benefit changes. The $1,000 (80/20 and 70/30) and $3,000 (80/20 and 70/30) deductible plans will continue to offer preventive care benefits from an in-network provider which will not be subject to the deductible. The participant is responsible for 20% or 30% of costs. Preventive care benefits are not available out-of-network.
- For 2007, there will be **no premium increases** for employees' participating in the City's self-funded PPO plans, for a second year.

HMO Plan

- For plan year 2007, the City **will not** offer its fully-insured HMO Plan, administered by Blue Cross Blue Shield. The City will replace the HMO plan and offer a self-insured Exclusive Provider Organization (EPO) plan to eligible employees. The new EPO plan will be administered by UnitedHealthcare Insurance Company
- The City will terminate its contract with Blue Cross Blue Shield of Texas, effective December 31, 2006 to administer the fully-insured Health Maintenance Organization (HMO) plan.

Exclusive Provider Organization (EPO) Plan

- For the plan year 2007, the City will offer a new self-insured Exclusive Provider Organization (EPO) plan to eligible employees. The EPO will look like the HMO plan; however it will offer full access to the same local and national network as the City's current PPO plan members. **Some of the enhanced benefits the EPO will offer are:**
- **Networks**: Full access to the same local and national network as PPO members. Currently HMO participants are limited to a small network. The change will allow the employees to utilize the larger network current PPO participants' use.
- **Referrals**: No referrals required. Not required to see Primary Care Physician before seeing a specialist. This non-referring system allows employees to visit their physician without delay to various specialists.
- **Pharmacy:** Full access to same local and national Pharmacy Network as PPO members. (Mail Order and Retail)
- **Nurseline:** 24/7 free access to UHC nurses. This benefit is currently not offered to HMO participants yet, it is a benefit to employees participating within the PPO. Encouraging employees to use the nurse line may increase the education of employees and thus reduce utilization and cost.
- **Health and Wellness**: Full access to UHC wellness websites, resources, tools and the City's robust wellness activities. It also allows the City to have one data base of information, which also allows better management.
- **Customer Service:** Telephonic support, full access to myuhc.com and Tina Adams, UHC onsite service coordinator at 214-670-3556.
- **Care Coordination**: Disease Management, Inpatient Care, and Critical Indicators, monitored by dedicated staff of UnitedHealthcare nurses. Nurses are only assigned to City of Dallas members. **See the UnitedHealthcare Section of this Guide for more details.**

2007 Plan Changes and Highlights (cont)

Prescription Drug Program

- Effective January 1, 2007, the City will increase the retail prescription minimum co pays of its PPO Prescription Drug Program as show below:
  - Generic drug co-payment will increase from $ 5 to $10
  - Preferred drug co-payment will increase from $10 to $20
  - Name brand drug co-payment will increase from $20 to $30
- The annual individual deductible of $75 and annual out of pocket maximum of $2,500 will remain the same for 2007.

Voluntary Benefits

- For the plan year 2007, there will be no changes to the City's Voluntary Benefits Program. Marsh@WorkSolutions, the City Third-Party Administrator, will continue to provide enrollment services and customer support for all voluntary benefits, including dental and vision.
- To enroll for voluntary benefits, including dental or vision, you must contact Marsh's Enrollment Service Center at 1-800-557-1046. To make changes or waive coverage, you can contact either Marsh's Enrollment Service Center or visit their website at: **www.personal-plans.com/cod** . During the 2007 open enrollment period all other voluntary benefits are still available to you:
  - Long Term Care Insurance
  - Short Term (STD) Paycheck Protector
  - Long Term (LTD) Paycheck Protector

Life Insurance

- There **are no** life insurance rate increases for the plan year 2007. Your supplemental life insurance rate could be higher, as a result of change in age. Supplement rates are age banded. **See the section on Standard Life Insurance in the Guide**.
- The City will continue to provide $40,000 of basic term life insurance coverage to eligible full-time employees at no cost. No enrollment action is necessary for this coverage. Employees will also be able to purchase voluntarily:
  - ? Supplemental Term Life Insurance, which allows you to elect from one to three times your annual salary (rounded to the next higher $1,000) for yourself. This product's cost increases as you age. New employees can elect one, two or three times their annual salary. Employees who are currently enrolled in supplemental life can only increase their coverage by one increment.
  - ? Dependent term life insurance can be purchase in the amount of $15,000 for a spouse and $5,000 for a dependent child. An employee may not be insured as both an employee and a dependent. A child may not be insured by more than one employee.
  - ? You may purchase twenty-four hour Accident Death and Dismemberment (AD&D) protection. Individual or 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. If you need to change your life insurance beneficiary information, please contact The Standard Insurance Company at 1-877-474-4250 or use the form found on the City's websites (internet or Intranet). Return the completed form to The Standard Insurance Company.

Enrollment Information

During the annual enrollment period, you can choose to change or keep your same benefit coverage for the year ahead. 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: November 6, 2006 through November 17, 2006. 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: November 20, 2006 through December 8, 2008. This period has been identified to allow employees to make correction to any benefits elections that have been 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.

Type of Enrollment

This year's annual enrollment is a ***PASSIVE*** enrollment. These means, if you are satisfied with your 2006 coverage and wish to keep the same coverage for 2007, then no action is required on your part. Your 2006 coverage will roll over as your coverage for 2007. Employees, who are enrolled in one of the flexible spending accounts (DCAP or EMSP) and wish to continue for 2007, **MUST** re-enroll for 2007. **Coverage will not continue automatically.**

Review of Benefit Elections

Review the confirmation statement that you will receive in the mail from the Benefits Service Center or your computer printout statement. Retain it for your records as proof of your timely enrollment. Contact the Benefits Service Center at 1-888-873-7692 between November 20th through December 8th if there are any errors on your confirmation statement or printout. Changes will not be permitted after this period. Contact Marsh@Work Solutions to confirm you're dental and vision elections.

Verification of Personal Information

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

Changing Your Benefits Mid-Year (Qualified Status Change):

You may only change your benefits during the plan year if you undergo a qualified status change as defined by IRS guidelines. Your enrollment **MUST** be completed within 31 days of the qualifying event. If you fail to enroll within 31 days of your event, you will wait until the next year's Annual Enrollment period. **Qualified changes in status include:**

- ⇒ You get married; You get divorced, or legally separated, or your marriage is annulled
- ⇒ A child is born to you, or placed with you for adoption;
- ⇒ Your spouse or dependent dies;
- ⇒ Your spouse or dependent begins or ends employment;
- ⇒ You, your spouse, or dependent have a change in employment status that impacts your hours and you lose or gain eligibility;
- ⇒ Your eligible dependent child loses eligibility status due to age or student status;
- ⇒ You, your spouse, or dependent change where you live or work and this change affects your eligibility for benefits under the Plan.

Enrollment Information (cont)

Consistency Rules

If you have a qualified change in status during the year, and you request a change in your benefit election, your election change must satisfy the appropriate consistency rules:

For Medical and Dental Coverage:

If a qualified change in status causes you, your spouse or a dependent to lose or gain eligibility for coverage under the Health Plan or under a plan sponsored by your spouse's or dependent's employer, you may make a change in your medical and/or dental coverage as long as the change is because of, and is consistent with, that change in status. For example, if a dependent dies or is no longer eligible for coverage, you may elect to cancel coverage for that dependent; however, you would not be allowed to cancel coverage for any other individual.

Reporting Eligibility Changes during the Year

You must report changes in dependent eligibility to the Benefit Service Center at 1-888-873-7692 within 31 days of the change (for example divorce, marriage, or loss of dependent child's student status). All status changes must be made within 31 days of the status change. If you are adding a spouse or dependent to your coverage: Documentation will be required when you are adding a spouse or a dependent child to your coverage. 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 status change. Any change in deductions will go into effect at the next available pay period.

Dependent and Disable Children up to Age 25

Children may be covered up cover up to age 25 and are not required to be full-time students. Children must also be unmarried and dependent upon the employee for support. When your child loses eligibility for coverage, you must notify the Benefit Service Center for medical coverage at 1-888-873-7692 and Marsh at 1-800-557-1046 for dental and vision coverage, within 31days of the change in eligibility.

Paying for Medical Coverage

Medical premiums are paid on a before-tax basis for employees and on a after-tax basis for domestic partners. Your annual cost of medical coverage depends on the plan you choose and the level of coverage you need. Premium costs for 2007 can be found in this Enrollment Guide.

Duplicate Medical Coverage by Employees

Due to coordination of benefits, no employee may be simultaneously covered as both a member and a dependent under the city medical plans. In the case where there are two city employees and both employees are eligible for coverage, only one may enroll for dependent coverage. Both employees **cannot cover** each other. In the case where there are eligible dependents of both the employees, only one employee can cover the dependents. Both employees **cannot cover** their eligible dependents. If and employee and their spouse are employed by different employers and are covered by the same insurance carrier, the health plan will pay only up to the 80% allowable.

Enrollment Choices

The health plan choice that is right for you and your family depends on your own situation. Health care protection brings peace of mind when everyday and unexpected medical expenses occur. For the plan year 2007, the following health plan choices will be available.

Default Coverage

If you fail to either waive coverage, or make benefit election changes, you will remain in the plan that you are currently enrolled in for 2007. Other existing coverages will continue, with the exception of the Employee Medical Spending Plan (EMSP) and Dependent Care Assistance Program (DCAP). **Annual enrollment for EMSP and DCAP is required for participation in 2007.**

City Sponsored Health Plans

PPO Plans

For 2007, eligible employees will still have a choice of six PPO plans to choose from that are administer by UnitedHealthcare (UHC). The $1,000 and $3,000 deductible PPO plans will allow participants to receive preventive care benefits from an in-network provider, which will not be subject to the deductible; the participant is responsible for 20% or 30% of costs. **Preventive care benefits are not available out-of-network.** The prescription drug program will be integrated with the City's medical plans and will be administered by UHC. For more information, refer to the UHC section of this Guide.

HMO Plan

The fully-insured HMO plan administered by Blue Cross Blue Shield of Texas **will not** be offered for 2007. The HMO plan will be replaced by a new self-insured Exclusive Provider Organization (EPO) plan administered by UHC. The City's contract with Blue Cross Blue Shield of Texas will be terminated effective December 31, 2006. For more information on the EPO plan, refer to the UnitedHealthcare section in this Guide.

Exclusive Provider Organization (EPO) Plan

For the plan year 2007, the City will offer a new self-insured Exclusive Provider Organization (EPO) plan to eligible employees. The EPO will look like the HMO plan; however it will offer full access to the same local and national network as the City's current PPO plan members**. ALL employees who are currently enrolled in the HMO plan will be automatically enrolled in the new self-insured EPO plan for 2007. HMO participants' rate will not change for 2007.**

Dental Plans

Marsh@WorkSoultions, the City's voluntary benefits third-party administrator will continue to provide enrollment services for the City's Dental plans that are administered by Safeguard Dental. Safeguard will continue to offer a Dental HMO and a Dental Indemnity plan. HMO plan participants must receive services from their primary care Safeguard 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. The Safeguard indemnity plan allows participants 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. See summary of benefits for both dental plans in Safeguard section of this Enrollment Guide.

Enrollment Choices (cont)

Vision Plan

Marsh@WorkSolutions, the City's voluntary benefits third-party administrator will continue to provide enrollment services for the City's Vision plan that is administered by Spectera Insurance Company. For 2007 to enroll, waive coverage or change your level of vision coverage you must contact Marsh@WorkSolutions at the toll-free number 1-800-557-1046 or visit their website at: www.personal-plans.com/cod. You **WILL NOT** be able to enroll, waive or make changes via the HRIS SEA website or the Benefits Service Center. Spectera's Vision Care Program provides access to a nation-wide network of private-practice optometrists and ophthalmologists, as well as conveniently located retail stores. The election you make will be in effect for the entire 2005 plan year. A summary of benefits on the Vision Care Program can be found in this Enrollment Guide.

Life Insurance

Standard Insurance Company will continue to provide life insurance to employees in 2007. You have the opportunity to design your own package of life insurance coverage based on your financial objectives and personal situation. The life insurance benefits available to eligible employees are:

Basic Life

The City of Dallas provides $40,000 basic term life insurance coverage to eligible full-time employees at no cost. No enrollment action is necessary for this coverage.

Supplemental Term Life

In addition to your Basic Life Insurance benefits, you may purchase Additional Term Life coverage for yourself. The Additional Term Life plan allows you to elect from one to three times your annual salary (rounded to the next higher $1,000) for yourself. This product's cost increases as you age.

New employees can elect one, two or three times their annual salary. Employees who are currently enrolled in supplemental life can only increase their coverage by one increment. 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 Term Life

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 twenty-four hour accident protection. Individual or family plans are available. 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.

Enrollment Choices (cont)

Flexible Spending Accounts (Employee Medical Spending Plan [EMSP] and Dependent Care Assistance Program [DCAP]

EMSP and DCAP provide you with an opportunity to save money by reducing taxable income subject to Federal withholding tax. All permanent full-time and part-time employees working twenty hours or more per week are eligible. You should estimate contributions carefully and conservatively, as benefits that are not used will be lost. Allow four weeks for reimbursements to be processed. The election you make will be in effect for the entire 2007 plan year. **Employees must enroll in these plans annually. Remember, that EMSP participants can now be reimbursed for covered over-the-counter medicines.**

DCAP - You may set aside money from each paycheck using pre-tax dollars to cover eligible dependent care expenses. The maximum contribution per year is $5,000 for single or married filing jointly and $2,500 for married filing separately. Allow three to four weeks to receive reimbursement. See the UHC section of this Guide for more details.

EMSP - You may set aside a portion of each paycheck using pre-tax dollars and file claims to obtain reimbursement for medical and dental out-of-pocket expenses incurred by you or your eligible dependents during the calendar year. The maximum contribution per year for 2007 is $5,000. Note: Employees who participate in EMSP and elect UHC PPO plan may choose automatic reimbursement to have out-of-pocket medical expenses from PPO claims automatically considered for benefits under the EMSP program.

UnitedHealthcare announces the Consumer Accounts Card !!!!!!!!!!!!!!!

New for 2007, UnitedHealthcare will offer access to a Consumer Account Card for all FSA participants. A welcome kit will be sent to your primary address with two cards, information on how to activate and additional Frequently Asked Questions.

What is the Consumer Accounts MasterCard® Card?

The Consumer Accounts MasterCard® Card is a special purpose financial debit card linked to your Health Care Flexible Spending Account (FSA), and/or Dependent Care Flexible Spending Account.

- A direct payment solution
- Providers and pharmacies receive direct payment from a consumer's Health Care FSA, Dependent Care FSA and HRA
- Part of an integrated payment strategy
- It works with auto-rollover to eliminate most paper claims
- Added convenience
- Cardholders no longer need to pay out-of-pocket for certain expenses
- A means to maximize benefits
- It's easy for consumers to access benefits for appropriate expenses
- A no-cost option
- No charge for the card

Enrollment Choices (cont)

Voluntary Benefit Products

Marsh@WorkSolutions will continue to provide enrollment services and customer support for all voluntary benefits, including dental and vision. **To enroll, waive or make changes to any voluntary benefit elections, you must contact Marsh@WorkSolutions**. **You will not be able to enroll, waive or makes changes to any voluntary benefit elections via the City's HRIS SEA website or the Benefits Service Center for 2007.** Your other voluntary benefit enrollment options are (1) Long Term Care Insurance, (2) Short Term Paycheck Protector and (3) Long Term Paycheck Protector. During the 2007 annual enrollment period, Long Term Care Insurance is available to you without submitting proof of good health. However, you will be required to go through the full underwriting process if you wish to enroll in one or both Paycheck Protector Programs. See the Marsh@WorkSolutions section of this Guide for more details**,**

Employees' Assistance Program (EAP)

The Employees' 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. To access services, interested persons should call Alliance Work Partners toll-free 1-800-343-3822. There is no charge for obtaining a referral or seeing an Alliance Work Partners EAP counselor. Discounted services for legal and family mediation are also available. The EAP helps employees achieve balance in both work and life. The program provides valuable services at no cost to employees and their families in the form of short-term counseling and legal and financial consultations. City of Dallas has chosen Alliance Work Partners (AWP) as its EAP service provider. It's easy to obtain help and guidance from AWP! Simply call the toll free number 1-800-343-3822 anytime, 24-hours a day, 365 days a year and speak confidentially with one of our Intake & Referral counselors to set up an appointment with an EAP counselor or to schedule a free 30-minute legal or financial consultation per problem, per year.

Short-term counseling includes up to three sessions per issue, per year. Issues include but are not limited to:

- Family
- Domestic violence
- Personal financial management
- Stress management
- Emotional health
- Bereavement
- Alcohol, tobacco, and drug
- abuse/dependency
- Family elder care
- Work-related issues and conflicts
- Literacy
- Compulsive gambling
- Sexual orientation
- Legal
- Marital
- Psychological distress
- Psychiatric disorders
- Adolescence
- Pre- and postretirement
- Health
- Disability-oriented

Online EAP Resources:

An extensive online library containing legal and financial articles and documents can be accessed from AWP's Web site. Go to www.alliancewp.com, click the LawAccess link and enter the User Name and Password: **DALLAS**

Enrollment Choices (cont)

Deferred Compensation

The City offers its permanent employees an opportunity to save for retirement by contributing to one or both of two tax-deferred, supplemental retirement plans: a 401(k) plan and a 457 plan. Employees authorize deductions from their paychecks and direct their deductions into one or more of a broad range of mutual funds and other investment options. You may contribute as little as 1% of your salary to either plan and as much as $15,000 to each plan in 2007 ($20,000, if you are 50 or older). The recordkeeper and administrator for both plans is Fidelity Investments. For information go to:

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

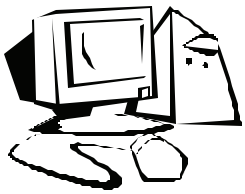
The Fidelity Retirement Counselor for the City of Dallas can be reached at 214-670-4954. The Deferred Compensation Office is located at City Hall, Room 2CS.

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 twelve digit/character personal identification number (PIN). If you need any assistance, call Fidelity at 1-800-343-0860.

Enrollment Methods



Enrolling via the Internet:

To enroll, access the HRIS Self Evident Application (SEA) via the Intranet or online at https://cod.dtolawsonportal.com/lawson/. You will need a User ID and HRIS Password to enroll via the Internet. Users 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 Lawson's SEA Screen. If you are experiencing technical difficulty you may call **1-866-804-3884** for assistance.

Remember: For 2007, to enroll or make changes to your dental or vision benefit elections, you must contact Marsh@WorkSolutions at the toll-free number 1-800-557-1046 or visit their website at: www.personal-plans.com/cod. You will not be able to enroll or make changes via the HRIS SEA website.

Enrolling via the Benefits Service Center:

To enroll by phone, call the Benefit Services Center at 1-888-873-7692 from 8:00 AM to 5:00 PM CST, Monday – Friday during the Annual Enrollment Period.

Remember: For 2007, to enroll or make changes to your dental or vision benefit elections, you must contact Marsh@Work Solutions at the toll-free number 1-800-557-1046 or visit their website at: www.personal-plans.com/cod. You will not be able to enroll or make changes via the Benefits Service Center.

If you experience a long hold time due to heavy call volume during the Annual Enrollment period, please feel free to leave a voice mail message regarding your enrollment and we will return your call within 24 to 48 hours. It is important that you leave a daytime phone number or cell phone number where you can be reached so that we may return your call in a timely manner. Spanish – speaking assistance is available.

In order to handle each enrollment call in a timely manner, we request that when calling, you have thoroughly read through your 2007 Benefits and Enrollment Guide and that you have the following information available: (election plan choices, social security numbers on all dependents that you are adding who were not on your 2005 benefits, along with dates of birth).

Confirmations will be mailed by the Benefits Service Center showing your 2007 Benefit Elections. To confirm your dental or vision elections contact Marsh Work Solutions.

Enrollment Methods (cont)

New Hire Enrollment Procedures

For all new hires that are eligible to participate in the City of Dallas Health Benefits Plan are automatically defaulted into the City's PPO 70/30 $3,000 Deductible plan, with employee-only coverage. This is to ensure that all eligible new hires are provided with health coverage Insurance and that there is coverage is effective on date of hire. New employees will have 31 days from their date of hire to change their default benefit election and enroll for other benefits or waiver their coverage. If the default medical election is not changed within 31 days, new employees must wait until the next Annual Enrollment to make changes, unless there is a change in status.

- To enroll, access the HRIS Self Evident Application (SEA) via the Intranet or online at 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 DTO Help Desk at 1-866-804-3884 for assistance).
- Or, enroll by calling the Benefit Service Center at 1-888-873-7692 between 8 AM and 5 PM CST. No special User ID or password is required to enroll via the Benefits Service Center. Spanish-speaking assistance is available. To enroll in voluntary benefits, including dental and vision, you must contact Marsh@WorkSoutions at the toll-free number 1-800-557-1046.
- Premium deductions, retroactive to your date of hire, will begin on the next available pay period.

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 30 days of employment**. Topics include introduction to quality customer service, the City's organizational structure, personnel rules and policies, employee benefits, and more.

In addition, all employees attending this orientation will undergo Harassment Prevention, Workplace Violence and Customer Service/Diversity Training for employees. These are usually separate mandatory courses, but upon successful completion of the full day of training, employees will be considered to have met the training requirement.

The Human Resources Assistant for each department will schedule new employees for New Employee Orientation.

City Wellness Program Update

In January this year the City partnered with UnitedHealthcare, Pfizer and The Wellness Group to developed a 2006 Worksite Wellness Plan. The following services and/or resources were offered by Wellness Partners:

UnitedHealthcare

- First year funding of project
- Care coordination/outreach services
- Sponsor a health risk assessment campaign
- On-line Personal Health Support Tools
- Full Time, On-Site wellness promotion/educator

The Wellness Group

- Conduct wellness interest survey
- Facilitate on-site health screenings
- Sponsor wellness awareness workshops

Pfizer

- Conduct Wellness Inventory

The following wellness achievements have been accomplished by the City and its Wellness Partners towards this very important City initiative:

- Develop a 12 month Worksite Wellness Plan
- HR will hire a Wellness Coordinator to manage the program
- Established a Wellness committee, which include both employees and retirees
- Wellness logo and motto chosen by employees
- Conducted wellness interest & needs survey (2,068 employees and retirees participated)
- Sponsored educational seminars/clinics on: stress management, lifting techniques, diabetes
- Sponsored health screenings (coordinated and administered by Wellness Partners)
    - 1,500 employees and retirees participated. 32 city facilities were utilized
- Developed proposed fitness options and initiated health assessment campaign

Wellness Next Steps

- Sponsor additional health screenings
- Screenings offered by Pfizer Pharmaceuticals
- Continue health assessment campaign
- Utilize data from wellness survey, health screenings and health assessments and clinical claims data to:
    - Identify and customize interventions and programs targeting at- risk populations and employees needs based on survey results
    - Refer at-risk participants identified via the health screenings to UHC Care Management Program
- Develop Worksite Health Improvement Strategic plan for 2007 & sequence years
- Develop a comprehensive communication plan to encourage members' participation.

Health and Wellness is an individual choice that can reap huge dividends. Not only does it reduce your healthcare out of pocket expenses, but it allows you to be better equip to feel successful in your job. We encourage you to take advantage of this integrated wellness approach, join with other employees and reach your personal health goals for 2007. You can enroll at myuhc.com for health and wellness tips.

Vendor Contact Information

City of Dallas Customer Service
Benefits Service Center (BSC) ……..…… 1-888-873-7692

HEALTH

PPO & EPO Plan - UnitedHealthcare

Membership Services ……..… 1-800-736-1364
Pharmacy Services……..…….. 1-877-842-6048
PPO/EPO Nurseline…….. 1-800-586-6875
Website ……..www.myuhc.com

DENTAL

Marsh@Work Solutions - Dental & Vision Enrollment Services

Membership Services……..……1-800-557-1046
Safeguard – Dental Indemnity……..1-800-962-9633
Safequard – Dental HMO……..……1-800-880-1800
Spectera……..……...…1-800-638-3120
Website ……www.personal-plans.com/cod

EAP – Alliance Work Partners
Membership Services……1-800-343-3822

Life Insurance – The Standard
Membership Services……..……1-877-474-4250

COBRA – UnitedHealthcare
Membership Services……1-866-747-0048

Employee Retirement Fund…….…..…214-580-7700

Dallas Police & Fire Pension……..…. 214-638-3863
Toll-Free……..…. 1-800-638-3861

Deferred Compensation (401K and 457 Plans) ……..… 214-670-4861
Toll-Free……..…. 1-800-343-0860

City of Dallas Website . . . . . .…….. www.dallascityhall.com

To locate employee health benefits on the City website enter the about web address. Look for the link "City Department" on right side of the page and click. Next look under the city department link for "Human Resources" and click. Finally, when the Human Resources page appear, look to the left side of the page for the link "Employee Benefits"

2007 Health Plan Rates (Monthly)

80/20 COINSURANCE PPO MONTHLY RATES

	$300 Deductible	$1,000 Deductible	$3,000 Deductible
Active Employees			
Member Only	$ 131	$ 58	$ 39
Member + Spouse	$ 518	$ 371	$ 330
Member + Child(ren)	$ 268	$ 140	$ 105
Member + Family	$ 656	$ 453	$ 396
Permanent Part-Time			
Member Only	$ 242	$ 169	$ 150
Member + Spouse	$ 629	$ 482	$ 441
Member + Child(ren)	$ 448	$ 320	$ 285
Member + Family	$ 836	$ 633	$ 576
Council Members			
Member Only	$ 352	$ 279	$ 260
Member + Spouse	$ 739	$ 592	$ 551
Member + Child(ren)	$ 627	$ 499	$ 464
Member + Family	$1,015	$ 812	$ 755
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
Active Employees			
Member Only	$ 111	$ 36	$ 16
Member + Spouse	$ 460	$ 325	$ 282
Member + Child(ren)	$ 218	$ 100	$ 65
Member + Family	$ 575	$ 388	$ 331
Permanent Part-Time			
Member Only	$ 222	$ 147	$ 127
Member + Spouse	$ 571	$ 436	$ 393
Member + Child(ren)	$ 398	$ 280	$ 245
Member + Family	$ 755	$ 568	$ 511
Council Members			
Member Only	$ 332	$ 257	$ 237
Member + Spouse	$ 681	$ 546	$ 503
Member + Child(ren)	$ 577	$ 459	$ 424
Member + Family	$ 937	$ 747	$ 690
COBRA			
Member Only	$ 339	$ 262	$ 242
Member + Spouse	$ 695	$ 557	$ 513
Member + Child(ren)	$ 589	$ 468	$ 432
Member + Family	$ 953	$ 762	$ 704

2007 Health Plan Rates (Monthly)

EXCLUSIVE PROVIDER ORGANIZATION (EPO)
REPLACES HMO PLAN

Active Employees	Monthly Rates
Member Only	$ 180
Member + Spouse	$ 701
Member + Child(ren)	$ 511
Member + Family	$1,043
Permanent Part-Time	
Member Only	$ 291
Member + Spouse	$ 812
Member + Child(ren)	$ 691
Member + Family	$1,223
Council Members	
Member Only	$ 401
Member + Spouse	$ 922
Member + Child(ren)	$ 870
Member + Family	$1,402
COBRA	
Member Only	$ 409
Member + Spouse	$ 940
Member + Child(ren)	$ 887
Member + Family	$1,430

2007 DENTAL AND VISION MONTHLY RATES

	Safeguard Dental		Spectera Vision
	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

2007 LIFE INSURANCE MONTHLY RATES

1. BASIC LIFE – NON CONTRIBUTORY

Basic Life Insurance will remain at $40,000 for 2004. There is no cost to full-time employees. Permanent part-time employees have to pay 50% 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 $540,000. Age banded rates are as follows

Age	Monthly Rate: Per $1,000
< 29	0.07
30-34	0.07
35-39	0.09
40-44	0.14
45-49	0.24
50.54	0.40
55-59	0.59
60-64	0.85
65-69	1.49
70-74	2.81
> 75	2.81

DEPENDENT LIFE

Monthly Rate: $2.85

For Spouse: $15,000
For Child or Children: $5,000

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Principal Sum Amount of Coverage	Employee Only	Employee + Family
$ 25,000	$.75	$1.13
50,000	1.50	2.26
75,000	2.25	3.39
100,000	3.00	4.52
125,000	3.75	5.65
150,000	4.50	6.78
175,000	5.25	7.91
200,000	6.00	9.04
225,000	6.75	10.17
250,000	7.50	11.30


UnitedHealthcare®
A UnitedHealth Group Company
SM

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Welcome !

We're glad you have chosen UnitedHealthcare for your health coverage.

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. To this end, we provide you with a wealth of informational tools and clinical approaches designed to support you through the entire health care process.

- **www.myuhc.com®** – Online Access to Benefits, Claim Review, Pharmacy, Physician Finder, Health and Wellness programs/tools/information.
- **NurseLine℠** – 24/7 access to registered nurses to discuss your health care needs.
- **Pharmacy Management Program** – Provides clinical pharmacy services that promote choice, accessibility and value.
- **Health Pregnancy Program** - Supports expectant mothers through all stages of pregnancy and delivery.
- **UnitedHealthwellness℠ Programs** – Health Assessments, Information, Tools, and Programs to help you improve your total health and wellbeing.
- **Care Coordination℠** – Care Solutions Team assigned only to the City of Dallas employees and families to provide disease management, inpatient advocacy and outreach education.

Included in this section:

- Medical ID Cards
- www.myuhc.com®
- Pharmacy - Frequently Asked Questions
- Pharmacy Retail Providers
- How to Choose a Physician
- NurseLine℠ and Healthy Pregnancy Program
- UnitedHealth Wellness℠ Programs
- Care Coordination and Personal Health Assessment
- Flexible Spending Accounts – Frequently Asked Questions
- PPO and EPO Plans

UnitedHealthcare®
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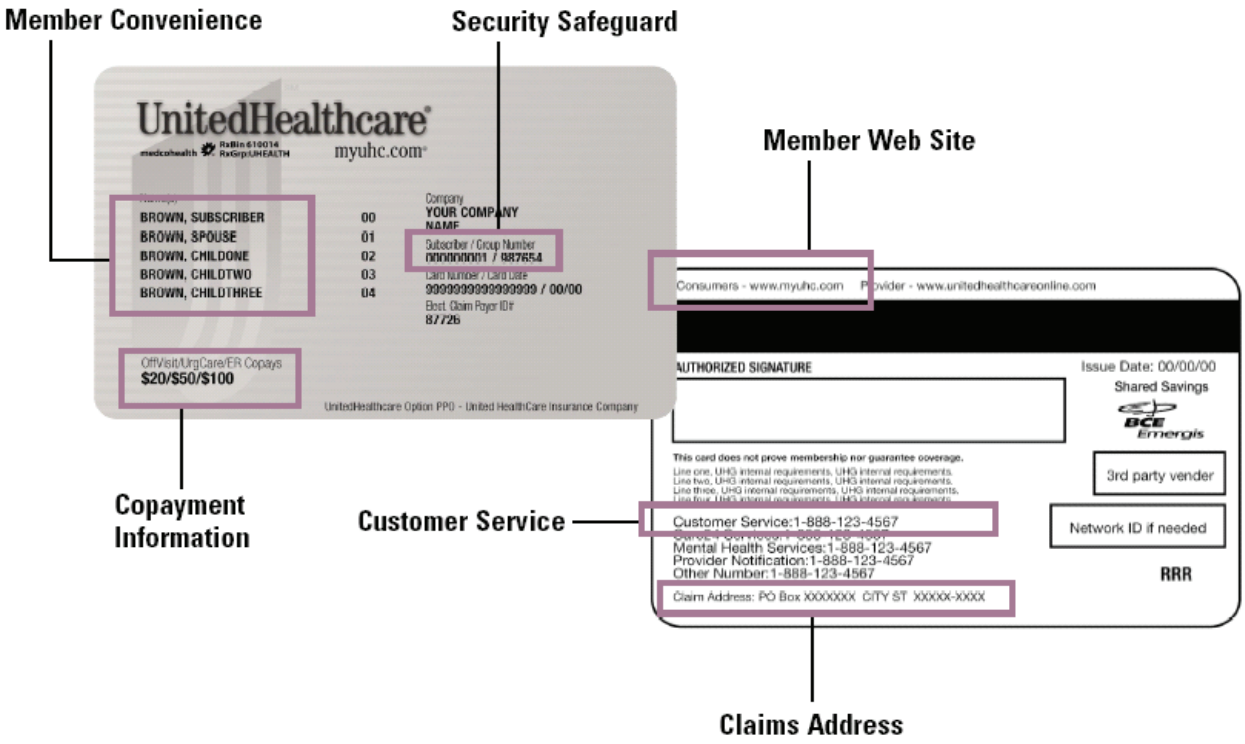
Your Medical ID Card

Be sure to present your ID card each time you or your covered family members receive services from a physician or health care professional. It also contains customized phone numbers and addresses, as well as online information. The new medical ID card lists your name and the names of any covered dependents, so you don't need separate cards for each family member. To increase the security of your personal information, the card doesn't use your Social Security Number to identify you. Your ID card(s) will be mailed directly to you. If you need to print a temporary ID card, you can visit our Web site, **www.myuhc.com®**.



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

1. To make the most of your health care benefits, establish a relationship with a physician.

2. Your physician makes it easier for you to get the care you need, when you need it.

3. Remember that you choose your physician and/or health care professional. We simply provide you with information to help you make informed choices. However, this information — including credentials, range of services offered, fees charged, and performance on quality measures and surveys — is not intended as an endorsement of a particular physician or health care professional's suitability to your needs.

4. Typically, you will have lower out-of-pocket expenses by visiting a physician or health care professional who participates in the UnitedHealthcare® network. These physicians and health care professionals have contracted with us at discounted rates and participate in programs that facilitate and enhance your health care experience. You can find the most up-to-date information about participating network physicians and other health care professionals by consulting our online directory at **www.myuhc.com®**.

UnitedHealthcare®
A UnitedHealth Group Company

Choosing a Physician

Choice (EPO) and Choice Plus (PPO) Network

- **The advantage of one super-sized network**

UnitedHealthcare® has one of the largest direct-contracted networks in the nation, with **440,000 physicians** and specialists at **617,000 locations** in **50 states**. The roster includes some of the most renowned and respected professionals in the industry. Our network also includes more than **3,900 hospitals** (out of the nation's 5,500) and **56,000 pharmacies** — including all major national and regional pharmacy chains and most independent local pharmacies.

This means it should be easy to find a physician in your area.
To make the most of your health care benefits, establish a relationship with a physician. Your physician makes it easier for you to get the care you need, when you need it. Remember that you choose your physician and/or health care professional. We simply provide you with information to help you make informed choices. However, this information — including credentials, range of services offered, fees charged, and performance on quality measures and surveys — is not intended as an endorsement of a particular physician or health care professional's suitability to your needs. For resources on how to make an informed decision, go to **myuhc.com®** and select

In-network vs. out-of-network (if part of your plan benefits) care
Selecting a physician or health care professional within the UnitedHealthcare® network provides you with the maximum coverage for your benefit plan. If you seek non-emergency care outside the network — from a non-network physician, facility, or other health care professional — your choice will result in a higher deductible and coinsurance.

Additionally, if you choose to seek care **outside the network**, the Plan only applies and pays out of network benefits to a percentage of billed charges, and it is your responsibility to pay the remainder. You are required to pay the amount that exceeds the allowable amount, which could be significant.

Greater cost savings using UHC Network Lab / Imaging services
During the course of receiving outpatient health care, you and your doctor may determine that lab testing and/or diagnostic imaging services (MRI, CT scan, etc.) are needed. For lab services, sometimes the nurse will draw the sample while you are at the physician's office and send it to an outside lab. In other cases, you may be referred to another lab or diagnostic imaging center.
UnitedHealthcare® enrollees receive the greatest cost savings when using in-network outpatient services, including lab diagnostic imaging services. Claims submitted by non-contracted facilities will be processed at non-network benefit levels, even if a network physician referred your service.
To avoid being billed personally for your next lab or diagnostic imaging service, make sure it's referred to a network facility. During an inpatient hospital stay, your lab and diagnostic services are always covered at network benefit levels.

Choosing a Physician - Continued

Finding a physician or health care professional

For the most up-to-date listing of physicians and hospitals based on your eligibility, visit our online directory, **myuhc.com®**, or call the Customer Care telephone number printed on your ID card.

UnitedHealth Premium℠ Program

The UnitedHealth Premium℠ program identifies leading physicians and hospitals across three important specialty areas of medicine – cardiac care, orthopedic care and cancer care. Specialists and hospitals are evaluated against quality and efficiency criteria. Quality criteria for each specialty area of medicine are built on evidence-based medical standards, clinical society guidelines and independent, expert physician advice. Only those network physicians and facilities that apply and meet the strict program criteria for their specialty area of medicine receive UnitedHealth Premium designation.

NCQA Physician Recognition Programs

The National Committee for Quality Assurance (NCQA) Physician Recognition Programs help you identify physicians that have met NCQA's quality-based criteria across three important specialty areas of medicine – diabetes care, cardiac care, and stroke care. In addition, the NCQA Physician Practice Connection (PPC) program recognizes physician practices that use up-to-date information and systems to enhance patient care. NCQA is an independent non-profit organization that has developed these programs in association with the American Diabetes Association, the American Heart Association and American Stroke Association. You may also visit www.liveandworkwell.com for additional information on mental health and substance abuse services, plus a directory for locating a behavioral health clinician in your area. The site also links to the UBH Preventive Health Program, which provides exclusive information and resources for those dealing with a major depression disorder, alcohol abuse/dependence and Attention Deficit Hyperactivity Disorder.

Finding a Leading Physician or Hospital

Simply visit **www.myuhc.com®**, search the physician directory and look for symbols next to your search results that denote the following designation:

- ★ ★ 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)

Or call a Customer Care Professional at the phone number listed on the back of your ID card.

UnitedHealthcare
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Nurseline[SM] 24/7

Connecting People with Information They Need

Nurseline[SM] provides reliable information and support regarding a wide range of health concerns – 24 hours a day, 365 days a year. One toll-free number gives you access to registered nurses to assist you and your family with health care questions and concerns. Nurseline[SM] services also offer audio messages on more than 1,100 health and well-being topics. More than 600 audio messages are recorded in Spanish. Translation services are available for 140 languages. Services are also available to callers with hearing impairments.

Experienced Professionals

NurseLine[SM] nurses have an average of 15 years clinical nursing experience. They are an excellent resource when you and your family have minor health needs or questions. Nurses help identify and address a variety of health related concerns.

Features:

- **Childhood illnesses**
- **Minor illnesses and injuries**
- **Medication questions**
- **Chronic conditions**
- **Nutrition**

Healthy Pregnancy Program

Support. Resources. Healthy Babies and Moms.

That's what you can expect from the UnitedHealthcare® Healthy Pregnancy Program. Our program offers you personal support through all stages of pregnancy and delivery. Whether this is your first pregnancy or you have other children, we want to give you information you need to make healthy choices during your pregnancy and delivery. This program is offered at no extra charge to you, and enrolling is easy. We hope you'll take advantage of it during this very special time in your life.

Personal Attention

When you call our Healthy Pregnancy Program, a maternity nurse will fill out a pregnancy assessment with you over the telephone. They'll ask questions about your health, lifestyle and other factors that may affect your pregnancy. The maternity nurse will review your completed assessment and determine if you have special pregnancy needs. If you are identified as a mother-to-be with special health needs, we have additional resources to help you. A maternity nurse will offer to work with you to provide individualized support throughout your pregnancy. We want to give you all the support and resources you need to work closely with your doctor so that you can have a healthy pregnancy and delivery.

Enroll at Your Convenience

To get the best possible benefit from this program, we encourage you to enroll in the first 12 weeks of pregnancy. But you can enroll anytime it's convenient through the 33rd week of pregnancy. **To enroll,** simply call **1-800-411-7984** (toll-free) between 8 a.m. and 11 p.m. Central Time, Monday through Friday.

Useful Information

Everyone who enrolls in the program will receive important educational information covering a wide variety of topics, such as proper nutrition, preparing for childbirth, and exercise during pregnancy, warning signs and things to avoid. After your delivery, you will continue to have access to experienced nurses who can help answer your questions.

UnitedHealthcare
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UnitedHealth Wellness℠

Resources and tools to help you stay healthy.

Feel Good. Be Healthy. Live Well.

To help you improve your total health and well-being, we are pleased to bring you UnitedHealth Wellness – a comprehensive portfolio of on-site (workplace) and online wellness programs and services from UnitedHealthcare.

• **Total Well-Being Program – myRenewell℠** – organizes information on the five areas of total well-being: Physical, Intellectual, Social, Spiritual and Emotional.
Features interactive online tools and resources based on individual needs, and wellness product discounts.
• **Health Value Program – UnitedHealth Allies℠** – provides up to 50 percent savings on certain health care services not covered by your medical, dental or vision plan. Includes discounted rates on complementary care (chiropractic, acupuncture and massage therapy), cosmetic dentistry, laser eye vision correction and more.
• **Online Health Assessment and Personalized Report** – helps assess your overall current state of health, and sends you an immediate online Personalized Report with results and suggestions to improve your health.
• **Online Health Improvement Programs** – helps you make lifestyle changes and achieve health objectives in targeted areas like losing weight, gaining energy or improving overall health through various six-week online programs.
• **Online Personal Health Manager** – allows you to securely and confidentially manage your health information – all in one place.
• **Healthy Pregnancy Program** – features a pregnancy assessment to identify special needs and risk factors, a 24-hour toll-free phone number to experienced nurses, and customized educational materials.
• **Health and Wellness Educational Information** – includes healthy living articles and general information via our consumer medical Web sites. Samples topics: *nutrition/weight management, fitness, smoking cessation, stress management and more*.
• **Other Wellness Programs and Services** – features nurse and counselor helplines; on-site/workplace wellness programs, training seminars and health fairs; mental health programs; preventive care reminders, self-care materials; and employer-sponsored wellness programs.

Visit **unitedhealthwellness.com**

UnitedHealthcare
A UnitedHealth Group Company

Custom 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 the following:

- **An assigned Care Coordination nurse** for each high-risk employee and their family members.
- **Integration** with Nurseline, UnitedBehavioralHealth and HealthPartners EAP services.
- **Disease Management**, to include broader intervention for coronary artery disease, diabetes and congestive heart failure.
- **A longitudinal behavior change model for members with high-intensity to complex conditions**, which includes an assigned disease management nurse who stays with the member for six to 12 months, a high level of clinical contacts per case, and on-site medical director engagement for complex case review and ongoing education
- **An educational model for members with low-intensity conditions**, which includes program participation letters, quarterly disease-specific newsletters, disease-specific Web resources and behavior modification programs via **myuhc.com**®
- **Inpatient Advocacy –** we work with hospitals to make sure the physician's orders and treatment plan are carried out in a timely manner and work with family members and other service providers to coordinate post-discharge needs.
- **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.

Personalized Health Assessment

Make a commitment to improving your health today!

You keep promising yourself to live a healthier lifestyle and only you have the ability to improve your health. Now is the time! Take the first step to better health today with your personalized Health Assessment. Get information about your current health habits and resources and where to begin a healthier lifestyle. It's fun and easy and available through myuhc.com®. UnitedHealthcare provides you with a personalized Health Assessment tool to help keep you healthy and fit.

- Receive a personalized report outlining your current health habits with suggestions on how to improve.
- Get your health report card – an assessment of your health habits.
- Confidential results.

The Health Assessment and results are not a substitute for medical care and should not be used to diagnose health problems. You should consult your physician before making decisions about medical care.

UnitedHealthcare
A UnitedHealth Group Company

Eight great reasons to use myuhc.com®

1. Learn about health conditions, treatments and procedures.
Medical information in plain English gets right to the point. Plus, it's from reliable resources recognized by physicians.
• **Select** Health Topics & Tools

2. Compare costs for treatments and health plan options. Choose a plan that's right for your needs.
Compare in- and out-of-network costs for particular procedures.
• **Select** Treatment Cost Estimator or Plan Comparison Calculator

3. Get information about hospitals and physicians. Evaluate hospitals on quality-of-care and patient safety measures. Identify in network physicians and hospitals.
• **Select** Hospital Comparison Tool or Find a Physician

4. Organize your medical claims online. View and print copies of your medical claims.
• **Select** Claims Center

5. Ask health care professionals now.
Connect online with a registered nurse who can answer your questions. See postings from nurses, physicians, counselors and other health professionals who answer questions submitted by myuhc.com users.
• **Select** Live Nurse Chat or Ask a Professional

6. Learn more about your coverage. Check your current eligibility, coinsurance, deductibles and out-of-pocket information.
• **Select** Plan Summary

7. Request a medical ID card.
Print a temporary ID card or request a replacement card anytime.
• **Select** Manage My Account

8. Order and renew prescriptions online.* See information about your pharmacy benefits, prescription history, drug coverage and coinsurance.
Learn about side effects and interactions.
Locate a neighborhood pharmacy.
Even arrange mail order - home delivery of your order.
• **Select** Pharmacy Online

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UnitedHealthcare Pharmaceutical Solutions

What is a Prescription Drug List?

A Prescription Drug List (PDL) is a list of prescription medications. The PDL includes brand name and generic medications that have been approved by the United States Food and Drug Administration (FDA) as safe and effective.

This approach helps to ensure access to a wide range of medications and controls health care costs for you and your employer or health plan. You and your doctor decide which medication is appropriate for you.

The tier placement of a medication on the PDL may change. While medications change tiers infrequently, such changes may occur up to four times per calendar year, depending on your benefit. Additionally, when a brand name medication becomes available as a generic, that brand name medication may move to a higher tier. When a medication changes tiers, you may be required to pay more or less for that medication. These changes may occur without prior notice to you. However, you may visit our Web site, www.myuhc.com®, or call the Customer Service number on your ID card for Coinsurance information about a particular medication.

The PDL does not restrict what your physician can prescribe or what a pharmacist can dispense. You and your physician decide which medications you should take.

What are tier designations and how do they affect what I actually pay at the pharmacy?

Prescription medications (generic and brand) are categorized within three tiers. Each tier is assigned a Coinsurance Level, which is an amount you pay when you visit the pharmacy or order your medications through our mail order service. The City of Dallas sets the actual Coinsurance amounts for the medications covered under your pharmacy benefit. Consult the benefit plan documents for more information about specific Coinsurance, out of pocket maximums, and deductibles.

- Tier 1 is your lowest coinsurance option. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your doctor decide they are appropriate for your treatment. Most generic medications are found in Tier 1.

- Tier 2 is your middle coinsurance option. Consider Tier 2 medications if you and your doctor decide that no Tier 1 medication is appropriate to treat your condition.

- Tier 3 is your highest coinsurance option. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

Our National Pharmacy and Therapeutics (P&T) Committee, comprised of physicians and pharmacists, reviews new and existing medications and makes recommendations to the PDL Management Committee. Recommendations are based on the clinical role the medication plays in treating a given disease or condition.

How does the PDL work?

Physicians are encouraged to consult the PDL when prescribing medicines. When a member presents a prescription at a retail pharmacy, the pharmacist receives an electronic message advising of the applicable Coinsurance based on the medication prescribed by the physician. The Coinsurance will be applied based on the Tier 1, 2, or 3 status of the medication.

How do doctors know which medications are on the PDL?
Physicians participating in the UnitedHealthcare® physician network receive a copy of the PDL every year from UnitedHealthcare®.

How can I be sure that my doctor prescribes medicine on the PDL for me?
You and your doctor make important decisions about your health care together. It is important that you talk to your doctor about the best treatments, including medication treatments, for your condition. In order that your physician makes decisions that include information about your out of pocket costs, you may want to take a copy of the PDL (or information from the Web site at www.myuhc.com® to your next appointment. You and your physician can then discuss options to any medications you are currently taking. The lowest cost option will usually be the Tier 1 version of a medicine. However, your doctor may want you to take a higher tier medication for specific reasons related to your health.

What is the difference between brand name and generic medications?
Generic medications are medications that contain the same active ingredients as brand name medications, but they often cost less. Generic medications become available after the patent on the brand name medication expires. At that time, other companies are permitted to manufacture a chemically equivalent medication. Many companies that make brand name medications also produce and market generic medications that are equivalent to the branded products. Before a generic medication can be sold, the FDA must be satisfied that the medication contains the same active ingredients in the same strength as the brand name equivalent. It must also meet the same quality standards.

Why do generics cost less than brand name medications?
A multi-year patent is granted on new prescription medications, which the original manufacturer researches, develops, advertises, and sells under its own brand name. After the patent expires, other manufacturers may begin producing and selling the medication using the chemical or "generic" name. Generic medications cost less because they do not require the same level of sales, marketing, research, and development as brands.

What are therapeutic alternatives?
"Therapeutic alternative" is a term that we use to describe two or more chemically different medications that may be used to treat the same medical condition. A therapeutic alternative may cost you less than the medication your doctor may prescribe. Some therapeutic alternatives may also be available without a prescription, i.e., "over-the-counter." If you are interested in pursuing therapeutic alternatives, please talk to your doctor to see if a therapeutic alternative may be right for you.

Why might the medication that I am used to taking no longer be covered?
Periodically, medications may be excluded from coverage under your pharmacy benefit. For example, a prescription medication may be excluded from coverage when the FDA approves an over-the-counter (non-prescription) equivalent to the prescription medication. The prescription version of the medication is excluded from coverage under your pharmacy benefit and removed from the PDL because your pharmacy benefit excludes coverage for over-the-counter medications. Your doctor can recommend either over-the-counter or prescription medications for your treatment. You can purchase an over-the-counter medication at your local pharmacy without a prescription.

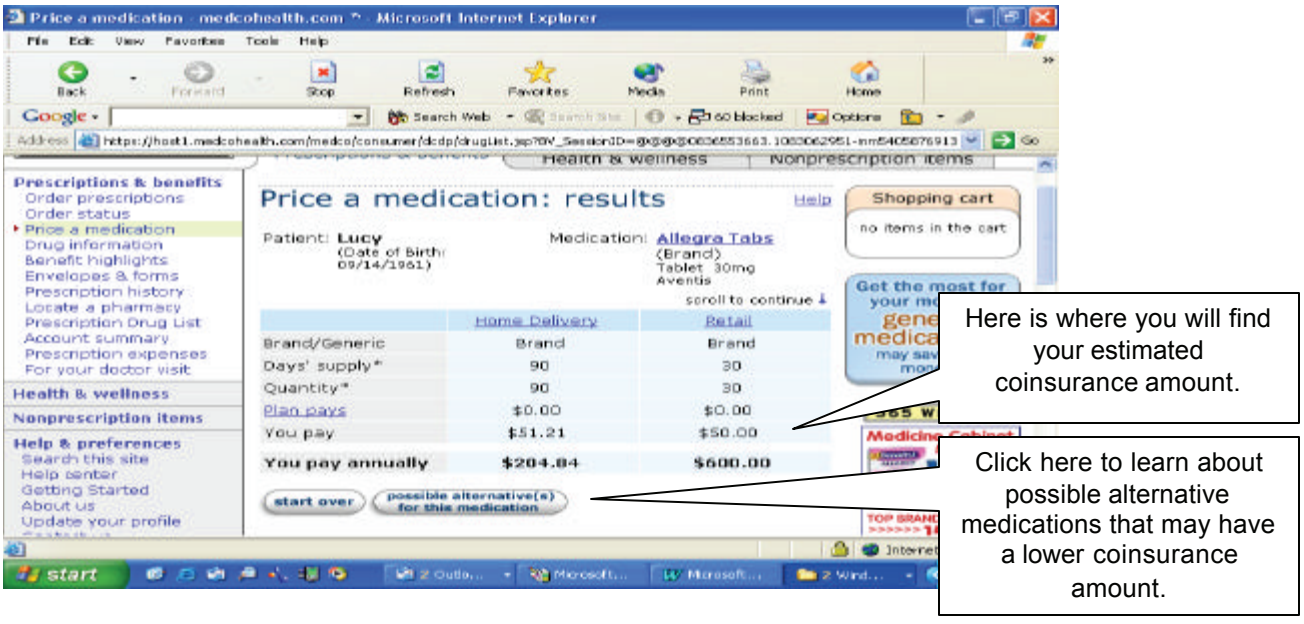
When should I consider "over-the-counter" or non-prescription medications?

An over-the-counter medication can be an appropriate treatment for many conditions. Consult with your doctor about over-the-counter alternatives to treat your condition. These medications are not covered under your pharmacy benefit, but they can cost less than your out-of-pocket expense for prescription medications.

How do I find information on myuhc.com®?

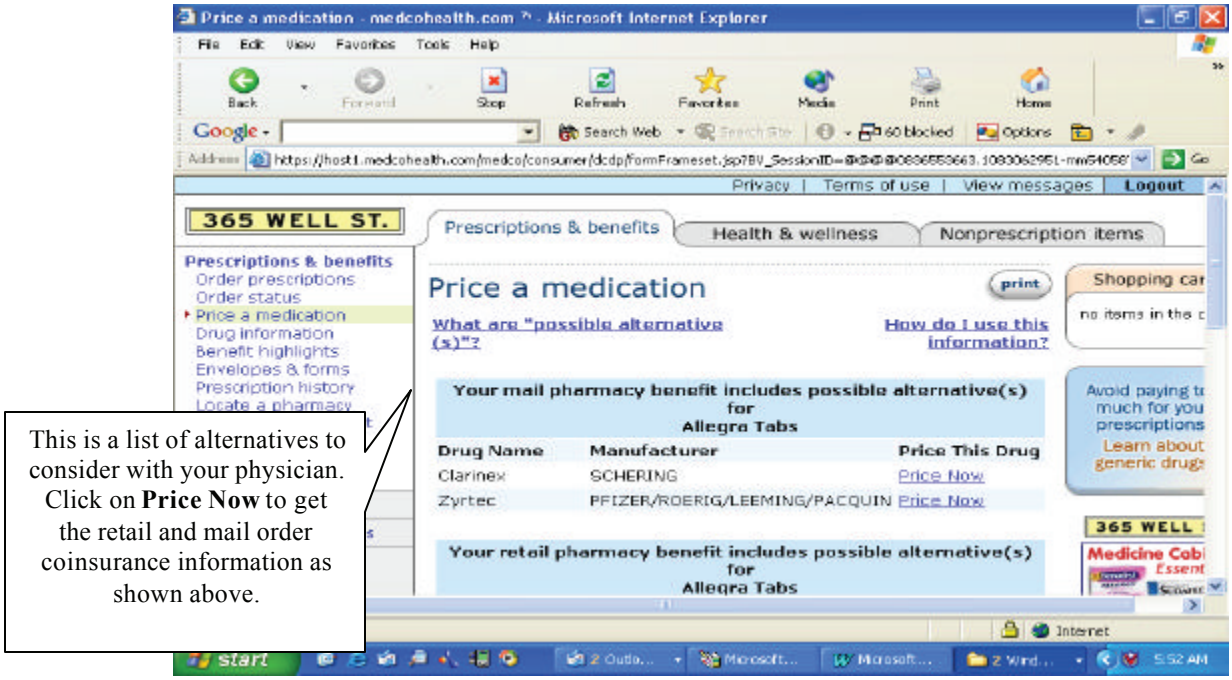
To learn more about your pharmacy benefit coverage, please visit www.myuhc.com®. Registering is easy. From there, you just need to click on the Prescriptions tab and then on Drug Pricing / Coverage, and you will have access to Coinsurance, pricing, and coverage information on most prescription medications. You will also have access to the following information.

- Pharmacy benefit and coverage information
- Your Coinsurance amounts for prescription medications
- Information about lower-cost medication alternatives
- A list of medications based on a specific medical condition
- Medication interactions, side effects, etc.



At www.myuhc.com®, you will also be able to:

- Locate a participating retail pharmacy by zip code
- Order ongoing prescriptions through the mail order pharmacy
- Review your prescription history
- Set up e-mail reminders for prescription refills



KEY POINTS TO REMEMBER!

Your doctor may be able to help you save money by prescribing medications in Tier 1 and Tier 2 of the PDL. You and your doctor always make the decisions regarding your treatment. Here are some practical suggestions for getting the most out of your pharmacy benefit:

1. *Ask your doctor to refer to the PDL when prescribing medications. It is a tool that helps guide you and your doctor in choosing medications that allow the most effective and affordable use of your pharmacy benefit.*
2. If you would like to view a more complete version of the PDL and information about your specific benefit plan, please visit www.myuhc.com®. Once you have logged in, click on "Prescriptions."
3. Inquire about the availability of a cost-saving Tier 1 alternative. Some Tier 1 medications may be used to treat the same medical condition as medications classified in Tiers 2 and 3, but are less expensive. As a result, Tier 1 medications are available to you for the lowest out-of-pocket expense.
4. *Ask your doctor or pharmacist if there is an over-the-counter medication available to treat your condition.*
5. Always refer to your benefit plan materials to determine your coverage for medications and Coinsurance, coinsurance, and deductibles.

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How do I use MAIL ORDER – HOME DELIVERY?

UnitedHealthcare® partners with Medco Health to provide mail order – home delivery. **Medco By Mail** sends your prescription medicines directly to you by mail -- a great convenience for medications you take on an ongoing basis, such as those used to treat chronic diseases like heart disease and diabetes.

To set up your mail order pharmacy service simply follow the steps below.

Step 1:

- The first time your doctor prescribes a medication that you will take on a regular basis, ask for two prescriptions.
- The first prescription should be written for a one-month supply that can be immediately filled at a participating retail pharmacy.
- The second prescription should be written for a 90-day supply of the medication with refills (instead of a one-month supply with refills). Use the 90-day prescription to obtain your medication from the mail order pharmacy. The mail order pharmacy cannot alter your prescription, which must be dispensed as written by your doctor. You will be charged a mail order Coinsurance on any prescription you submit to the mail order pharmacy.

Step 2:

- Complete the Medco By Mail Order Form. Order form can be found on **www.myuhc.com®**.

Step 3:

- The first time you order medication by mail, please complete the Health, Allergy & Medication Questionnaire. The information that you supply on this form is kept confidential. It helps the pharmacist check for potential medication interactions and medication allergies.

Step 4:

- Mail the order form with your prescription, payment, and questionnaire to the address provided.

What if I still have questions?
If you have additional questions about your pharmacy benefit, please call the Customer Service number on your ID card.

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Retail Network Pharmacy Participating Chains.

A

A & P Pharmacy
ACME Pharmacy
AHS - Providence Pharmacy
Accredo Therapeutics
Albertson's Pharmacy
Allscripts
Arbor Drug Store
Arrow Pharmacy & Nutrition Center
Arrow Prescription Center
Aurora Pharmacy

B

B & B Pharmacy
Baker Pharmacy
Baker's Supermarkets
Bartell Drugs
Bashas United Drug
Bel Air
Bi-Lo Pharmacy
Bi-Mart
Big B
Bigg's Pharmacy
Brooks Pharmacy
Brookshire Brothers Pharmacy
Brookshire Pharmacy
Brunos

C

CVS Pharmacy
Carnival Pharmacy
Carrs Quality Center
Cashwise Pharmacy
City Market
Coborn's Pharmacy
Costco Pharmacy
Cub Pharmacy

D

Dillions Pharmacy
Discount Drug Mart
Dominicks Pharmacy
Drug Barn
Drug Emporium
Drug Fair
Drug Mart
Drug Town
Drug Warehouse
Drugs for Less
Duane Reade

E

Eckerd Drugs
Econo Foods Pharmacy

F

Fagen Pharmacy
Fairview
Family Fare Pharmacy
Familymeds Pharmacy
Farm Fresh Pharmacy
Farmacia El Amal
Farmer Jack Pharmacy
Food 4 Less
Food City Pharmacy
Food Emporium
Food Lion Pharmacy
Food Town
Food World Pharmacy
FoodMax Pharmacy
Fred Meyer
Fred's Pharmacy
Fred's Xpress
Fry's Food & Drug

G

Gerbes
Giant Eagle Pharmacy
Giant Pharmacy
Glen's Pharmacy

H

HEB Pharmacy
Hannaford Food & Drug
Happy Harry's
Harp's Pharmacy
Harris Teeter Pharmacy
Hen House Pharmacy
Homeland Pharmacy
Hy-Vee Pharmacy
Hypermart

I

Ingles Pharmacy

J

Jewel-OSCO

K

K Mart Pharmacy
Kash N Karry Pharmacies
Keltsch Pharmacy
Kerr Drug Store
Kessel
King Soopers Pharmacy
King's
Kinney Drugs
Kohl's Pharmacy
Kroger Pharmacy

L

Longs Drug Store
Lucky

M

Marc's Pharmacy
Marsh Drugs
Martin's Pharmacy
May's Drug Store
Med-X
Medic Drugs
Medicap Pharmacy
Medistat Pharmacy
Meijer Pharmacy
Metro Pharmacy
Minyard Pharmacy
More 4 Family Pharmacy
Mr. Z's Pharmacy

N

Neighborcare
Network Pharmacy
Nob Hill Pharmacy
Nova Factor

O

OSCO

P

P & C Pharmacy
Pamida Pharmacy
Pathmark Pharmacy
Payless Pharmacy
Pharm
Pharmacare Pharmacy
Price Chopper Pharmacy
Price Cutter Pharmacy
Publix Pharmacy

Q

QFC Pharmacy
Quality Markets

R

Raley's
Ralph's Pharmacy
Randalls Pharmacy
Rite Aid

S

Sack 'N Save
Safeway Pharmacy
Sam's Pharmacy
Sav-A-Center Pharmacy
Sav-On
Sav-On Pharmacy
Save Mart Pharmacy
Schnucks Pharmacy
Shaw's Pharmacy
Shop 'N Save
Shop N Save Pharmacy
Shopko
Shoppers Pharmacy
Shoprite
Smiths Pharmacy
Snyder's Drug Store
St John Pharmacy
Star Pharmacy
Stop & Shop
Sun Mart Pharmacy
Super 1 Pharmacy
Super D Drugs
Super Foodmart Pharmacy
Super Fresh Pharmacy
Super G Discount Drug
Super Sav-on Drugs

T

Talbert
Target
The Medicine Shoppe
Thriftway
Thirft-White Drug
Tom Thumb Pharmacy
Tops Pharmacy
Tops Pharmacy Services

U

USA Drug
United Pharmacy

V

Vix Pharmacy
Vons Pharmacy

W

Wal*Mart Pharmacy
Waldbaum's Pharmacy
Walgreens
Wegmans Pharmacy
Weis Pharmacy
White Drug
Winn-Dixie Pharmacy

X

Xpect Discounts

* With 25 or more stores

as of 02/16/05

100-3699 2/05

Subject to change without notice.

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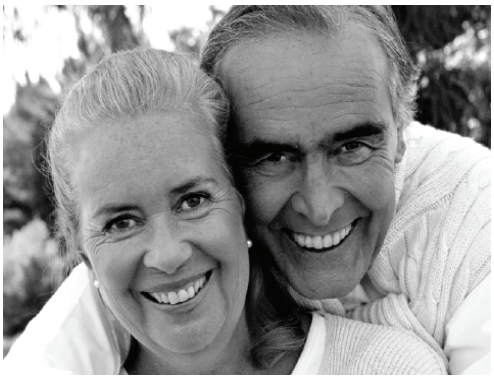

Flexible Spending Accounts and Consumer Account Cards.

1. How can I benefit from enrolling in a Flexible Spending Account (FSA)?
An FSA lets you use pre-tax dollars for certain eligible medical and dependent daycare expenses. By setting aside money from each paycheck, you pay less in taxes and have money available when you need it to pay for covered services.
There are two types of FSAs:
Health Care FSA: used to reimburse out-of pocket medical expenses incurred by you and your dependents
Dependent Care FSA: used to reimburse expenses related to care of eligible dependents while you and your spouse work

2. How can I determine if I will have enough out-of-pocket expenses to make a health care FSA worthwhile?
Even if you have medical, dental and/or vision benefits, you still may be responsible for expenses that are not covered by your plans, such as: copays/deductibles; eyeglasses; contact lenses; saline solution; certain over-the-counter drugs—e.g., allergy and cold medicines, antacids and pain relievers; chiropractic treatment; orthodontia and dental work. Your FSA works to fund these expenses on a tax-free basis.

3. Where can I find a list of eligible and ineligible expenses for reimbursement?
You can view eligible and ineligible expenses for both health care and dependent care accounts on myuhc.com®. Please note that your employer may have a customized list of eligible and ineligible expenses. Also, the Internal Revenue
Service (IRS) and/or your employer may modify the lists of eligible and ineligible expenses periodically. If you are unsure whether an expense is eligible or not, please contact customer service or refer to your employer's FSA plan document.

4. Are over-the-counter (OTC) drugs and items eligible for reimbursement?
IRS regulations allow reimbursement of certain OTC drug expenses; however, check your employer's Summary Plan Description or contact your benefits representative. A list of examples of eligible and ineligible OTC items is available on myuhc.com®.

5. How does contributing to an FSA reduce my taxes?
Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay federal income tax,
Social Security taxes, and (in most cases) state and local income taxes on the portion of your paycheck you contribute to your FSA.

6. How much will I really save on my health care expenses?
Depending on your individual income and tax filing status, you could save as much as 20-50 percent on eligible health care expenses by using an FSA.

7. How much should I contribute?
You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period.
You should consider:
• Last year's medical and/or dependent care expenses
• Any medical or dental care costs you foresee that might not be covered under your health care plans (e.g., deductibles, copayments and over-the-counter drugs)
• Any changes in your family status that might have an impact on your medical/dental or dependent care expenses
Your employer can identify the maximum amount that can be contributed to your health care FSA.

8. Wouldn't I save more by just taking a deduction on my income tax?
According to the IRS, only medical and/or dental expenses that exceed 7.5 percent of your adjusted gross income can be deducted from your income taxes. Most people do not have expenses high enough to qualify for this deduction.
For work-related dependent care expenses, the tax credit amount is determined by applying a percentage to your total dependent care expenses. According to current tax structure, generally the tax credit is more beneficial than a dependent care spending account if your family income is under $25,000.
Keep in mind that contributions for an FSA are taken out of your pay before taxes are applied, thus reducing your gross salary and your taxable income. Talk to your accountant or financial planner for more assistance.

9. Can I request FSA reimbursement for services I received before the plan year begins if I'm not billed until after the plan year starts?
According to IRS guidelines, a qualified expense is "incurred" at the time the service is provided, not when you are billed or when you actually pay for this service. Therefore, you can only file claims for eligible expenses incurred during the same plan year.

10. At the end of the year, do I get to keep any unused money in my FSA?
No. According to the IRS "use it or lose it" rule, if you do not use all the money in your FSA for expenses incurred during the plan year, you will forfeit the unused balance. Your unused balance cannot be carried over into the next year.
However, if you are like most FSA plan members, you will use all of the money in your account. If you leave some behind, your tax savings may outweigh the loss.
If you are unsure of how much to save, be conservative.

11. Can I change my election or stop contributing money to my spending account at any time throughout the year?
Federal regulations state that once you have designated the contribution amount, you cannot change your decision throughout the year unless you have a valid life status change event, such as the birth of a child. Your employer can provide you with a list of family status changes that allow you to alter your original account allotments.

12. How do I submit a claim to get reimbursed from my FSA?
a. Fill out an FSA claim form, available on myuhc.com® or by calling Customer Care. All dependent care claims must be submitted via claim form.
b. If you have both medical coverage and a health care FSA through UnitedHealthcare, your employer offers auto-rollover and the ability to manage it online at myuhc.com®. With auto-rollover, claims for medical and pharmacy are automatically submitted for reimbursement, practically eliminating the need to submit manual claims for these types of services.
Direct deposit is also offered to have funds deposited into the bank account of your choice. Go to myuhc.com® to enroll.

13. What happens if I submit a claim for an amount greater than what I have contributed to my FSA so far this year?

IRS regulations determine what happens in this case.

For Health Care Expenses:

When you submit an FSA claim for a health care expense, you will be reimbursed up to the full amount of your annual election, regardless of the amount of money that has been deposited into your account.

For Dependent Care Expenses:

If your dependent care FSA balance is less than the amount of your claim, you will only be reimbursed for the amount of money available in your account at that time. The remainder will be reimbursed once your future contributions are deposited into your dependent care FSA.

This process lets you submit a claim only once and receive funding as it becomes available, rather than be denied payment and be forced to resubmit the claim until it can be paid in full.

14. Can I transfer money from my health care FSA to my dependent care FSA or vice versa?

The health and dependent care spending accounts are two separate benefit plans. Per IRS regulations, you cannot transfer money between the two accounts.

15. Can I use a dependent care FSA for elder care?

Yes. You can use the spending account for eligible elder care expenses so that you (or you and your spouse) can work if:

a. You are responsible for at least 50 percent of the support of an elderly parent, or any person living with you who is physically or mentally incapable of self-care.

b. This person is noted on your income tax statements as a legal dependent.

You also can use the dependent care spending account if the elder care is needed because you work and your spouse is a full-time student.

16. If I have someone caring for my children in my home instead of at a daycare facility, do these expenses qualify for reimbursement from a dependent care FSA?

Yes. You can include wages paid to a babysitter in or outside your home if the services are necessary in order for you (or you and your spouse) to work. Expenses also will qualify for a dependent care FSA if you work and your spouse is a full-time student.

The services are not covered if the babysitter is someone you declare as a dependent.

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CONSUMER ACCOUNT CARD

New for 2007, UnitedHealthcare will offer access to a Consumer Account Card for all FSA participants. A welcome kit will be sent to your primary address with two cards, information on how to activate and additional Frequently Asked Questions.

1. What is the Consumer Accounts MasterCard® Card?
The Consumer Accounts MasterCard® Card is a special purpose financial debit card linked to your: Health Care Flexible Spending Account (FSA), and/or Dependent Care Flexible Spending Account.

2. How does the Consumer Accounts Card work?
Your Consumer Accounts Card allows you to access health or dependent care tax-advantaged funds at the time of purchase, eliminating the need to fill out claim forms for reimbursement of eligible expenses. Card transactions are validated at the time you pay for the expense) to ensure conformance with IRS guidelines and your employer's specific plan.

3. What expenses are eligible for use with my Consumer Accounts Card?
Generally, your Card can be used to pay for:
• Pharmacy prescriptions (copays, deductibles, full or discounted charges).
• Copayments at your doctor's office, hospital, or other health care center
• Certain over-the-counter health care items
• Dependent care expenses, if you have a Dependent Care FSA.
• Coinsurance, deductible or other out of pocket expenses for medical, dental and vision expenses if your employer has elected this functionality.

4. Who can use the Consumer Accounts Card?
You and any covered dependent(s) in your UnitedHealthcare plan can use your Consumer Accounts Card at approved locations that accept MasterCard®. Two cards are sent to you for your convenience and additional cards may be requested by calling Customer Service.

5. Can I use my Consumer Accounts Card at online pharmacies or for mail order prescriptions?
Yes. Enter your Consumer Account Card number online or on the order form.

6. Can I use my Consumer Accounts Card to purchase over-the-counter (OTC) healthcare items?
Yes, visit our online pharmacy on myuhc.com to purchase eligible over-the-counter items and conveniently pay for them with your Consumer Accounts Card. Although over-the-counter expenses may be eligible for reimbursement under your plan, only certain pharmacies or retailers can electronically substantiate your purchases with the Consumer Accounts Card. Go to myuhc.com for a list of pharmacies or retailers where you can go to purchase OTC health care items with your Card. To receive reimbursement for eligible OTC items purchased at non-participating locations, send your receipts along with a claim form to our claim center.

7. What if I use my Consumer Accounts Card to pay for a prescription, but I am also purchasing another non-eligible item, such as shampoo, at the same time?

For a transaction to authorize, we must be able to match a Card transaction amount to the exact amount you owe for a covered prescription at the pharmacy. Therefore, you cannot use your Card for ineligible items; you must pay for those items separately. Remember, the IRS requires that you use the Card only for qualified expenses covered by your tax-advantaged account(s) and that you keep all of your receipts. Each time you present your Consumer Accounts Card for a payment you will sign a receipt. Your signature acknowledges that the charges represent qualified FSA expenses.

8. What are some reasons why my Consumer Accounts Card transactions may be declined?

- Your Card has not been activated.
- Three (3) business day has not passed since activation.
- The transaction is not for an eligible service or it does not match a pre-defined benefit, copay amount, as required by your plan.
- The transaction is for a medical, dental, vision deductible or coinsurance charge and your employer has not elected this functionality.
- The transaction cannot be substantiated in real time at your pharmacy.
- There are insufficient funds in your tax-advantaged account(s) to cover the expense.
- There is a problem with the merchant's card terminal.
- You are attempting to swipe at an invalid location, e.g. a gas station or electronics store.
- **Member is attempting to swipe for a coinsurance/deductible amount at an out-of-network provider.**

9. What if my Consumer Accounts Card is lost or stolen or I suspect that my Card has been used fraudulently?

If your Card is lost or stolen, call us immediately at 1-866-755-2648. If you report the incident to us within four (4) business days, you will not be liable for fraudulent use. You may be liable, for a maximum of $50, if you fail to report the loss within four business days. It is your responsibility to monitor your account activity and report any unusual or fraudulent transactions to UnitedHealthcare and your employer.
When you report a lost or stolen Card, it will be deactivated immediately and new Cards will be reissued.

10. Can I have a negative balance in my FSA?

Yes. The transaction information for the Consumer Accounts Card is updated daily. However, there could be an instance when the Card is used on the same day that a manual claim is received and the total amount of both services results in a negative balance in your account.
If this occurs, we will advise you of overpayment procedures.

EXANTE FINANCIAL SERVICES℠

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2007 EPO Plan Design

Effective 1/1/2007

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	
PCP - Primary Care	**$20 copayment**
SCP - Specialist	**$45 copayment**
Hospital - Inpatient Stay	**$600 per Inpatient Stay**
Outpatient Surgery	**$300 copayment**
Emergency Room Svcs.	**$150 copayment**
Urgent Care Svcs.	**$45 copayment**
Pharmacy Benefits:	
RETAIL:	
Tier One	**$10 copayment**
Tier Two	**$25 copayment**
Tier Three	**$40 copayment**
MAIL ORDER: (3 months supply)	
Tier One	**$20 copayment**
Tier Two	**$50 copayment**
Tier Three	**$80 copayment**

UnitedHealthcare EPO offering….

Provider Networks: Full access to 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 PCP prior to 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)*.

* See section on UHC pharmacy to learn more at our pharmacy program, network and how to access mail order services.

Nurseline: 24/7 free access to UnitedHealthcare nurses.

Health and Wellness: Full access to the UHC wellness websites, resources tools and onsite UHC wellness coordinator.

Customer Services: Telephonic support, www.myuhc.com and access to UHC onsite representative.

Care Coordination: Disease Mgmt, Inpatient Care, and Critical Indicators supported by dedicated staff of UnitedHealthcare nurses.

Summary Plan Document: Review/download a copy of the EPO Plan Document on the City's website.

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2007 PPO Plan Designs: 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 ****If the diagnosis is determined not to be a true emergency**	$100 copay per visit Plan Pays 80% after deductible	$100 copay per visit Plan Pays 60% after deductible	$100 copay per visit Plan Pays 80% after deductible	$100 copay per visit Plan Pays 60% after deductible	$100 copay per visit Plan Pays 80% after deductible	$100 copay per visit 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 2007 Summary Plan Description for detailed benefit information.

UnitedHealthcare
A UnitedHealth Group Company

PPO Plan Designs: 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%
ut-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 **** If the diagnosis is determined not to be a true emergency**	$100 copay per visit Plan Pays 70% after deductible	$100 copay per visit Plan Pays 50% after deductible	$100 copay per visit Plan Pays 70% after deductible	$100 copay per visit Plan Pays 50% after deductible	$100 copay per visit Plan Pays 70% after deductible	$100 copay per visit 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 2007 Summary Plan Description for detailed benefit information.

UnitedHealthcare
A UnitedHealth Group Company

Pharmacy Benefits: All PPO Plans

Retail	Mail Order - Home Delivery
Up to a 31 day supply	3 month supply
Tier One: 10% with a $10 minimum	Tier One: 10% with a $10 minimum
Tier Two: 20% with a $20 minimum	Tier Two: 20% with a $20 minimum
Tier Three: 30% with a $30 minimum	Tier Three: 30% with a $30 minimum
Annual Drug Deductible: $75 Combined Retail and Mail Order Deductible per individual **Out-of-Pocket Drug Max:** $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

- $1000 and $3000 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 & Female – Birth to 24 mo.	Well Visits up to 6 All Immunizations
Male & Female – Age 2 to 16 yrs.	Well Visits – 1 per year All Immunizations
Male & Female – Age 17 & up	Physical Exams – Once every 2 years
Male & Female – Age 50 & up	Colonoscopy Screening– Once every 5 years
Females – Age 35 & up	Annual Mammogram
Females – Age 20 & up	Annual Pap Smear
Males – Age 35 & up	Annual Prostate Antigen Testing

About Standard Insurance Company

Your employer has chosen Standard Insurance Company to provide group Additional Life coverage to eligible employees. The Standard has earned a solid reputation for its quality products, superior customer service, expert resources, steady growth, innovation and strong financial performance. Founded in 1906, The Standard has developed a nationwide presence in the employee benefits industry, providing customers with group and individual disability insurance and retirement plans, and group life and dental insurance. Just as others œount on you, you can count on The Standard for Additional Life insurance for your time of need. Talk with your employer's human resources representative for more information about group Additional Life insurance from The Standard.

Additional Life and Voluntary Accidental Death and Dismemberment (AD&D) Insurance

About This Guide

This guide is designed to provide some basic information about the group Additional Life and Voluntary Accidental Death and Dismemberment (AD&D) insurance coverage. It is not intended to provide a detailed description of the coverage.

The controlling provisions are in the group policies issued by Standard Insurance Company. Neither the certificate nor this information modifies the group policies or the insurance coverage in any way.

To be a member and eligible for the Additional Life and Voluntary AD&D coverage, you must be:

A regular employee of the City of Dallas excluding temporary and seasonal employees, full time members of the armed forces, leased employees and independent contractors.
Actively at work at least 20 hours each week.

For your spouse or dependent to be eligible for coverage, they must not be full-time members of the armed forces of any country nor a City of Dallas employee.

Life and AD&D Insurance Features

The time you spend with your family is priceless, and you wouldn't trade those special moments together for anything in the world. But what would happen if you suddenly died?

Would they have the funds to pay bills, your home mortgage, burial and funeral expenses? Would they be able to live on one income and maintain their current lifestyle? What about medical expenses associated with a terminal illness? Would your family be financially prepared? By sponsoring group Life and AD&D insurance from Standard Insurance Company, your employer offers you an excellent opportunity to help protect your loved ones.

The advantages to you and your family include:

- **Choice.** You decide how much coverage you need from the range of amounts available.
- **Flexibility.** If your needs change, you can request to change the amount of coverage. Increases in coverage require *evidence of insurability*.
- **Convenience.** With premiums deducted directly from your paycheck, you don't have to worry about
  mailing monthly payments.
- **Savings.** Typically, group insurance rates are lower than the rates of individual insurance plans, generally providing you with coverage at a lower cost.
- **Peace of Mind.** You can take comfort and satisfaction in knowing that you have done something positive for your family's future.

When does my insurance go into effect?

Your Voluntary AD&D insurance becomes effective on the later of either the date you apply or the date you become eligible.

The effective date of your Additional Life insurance depends on when you become an eligible member, when you apply and whether you are required to provide evidence of insurability. Please refer to your Certificate to determine whether you must provide evidence of insurability.

In every case, you must meet the active work requirement before your insurance becomes effective.

How much Life Insurance may I get for myself?

The City of Dallas provides $40,000 of Basic Life Insurance, at no cost to you.

You may elect Additional Life coverage in multiples of 1, 2, or 3 times your annual earnings, to a maximum of $500,000. All late applications and requests for coverage increases require you to provide satisfactory evidence of insurability.

How much Life Insurance may I get for spouse and children?

For your Spouse:	$15,000
For your Child (ren):	$5,000

Basic Life and Supplemental Term Life Insurance are based on your annual base salary on October 1st or at the time of enrollment, if new employee.

Is Accidental Death and Dismemberment (AD&D) coverage available?

You may also buy Voluntary AD&D insurance. With Voluntary AD&D insurance, you or your beneficiaries may be eligible to receive an additional benefit amount in the event of death or dismemberment as a result of an accident. The amount of the AD&D insurance benefit for loss of life is equal to the amount of AD&D insurance in effect on the date of the accident. The amount of the AD&D insurance benefit for other covered losses is a percentage of the amount of AD&D insurance in effect on the date of the accident, as shown below:

Loss:	**Percentage:**
Life	100%
One hand, one foot, sight in one eye, speech, or hearing in both ears	50%
Two or more of the above Losses	100%
Thumb and index finger of same hand	25%*
Quadriplegia	100%
Hemiplegia	50%
Paraplegia	50%

*This benefit is not payable if an AD&D insurance benefit is payable for the loss of the entire hand. The loss must occur due to an accident and independently of all other causes, and within 365 days after the accident.

How much AD&D Insurance may I get for my spouse and children?

You may also elect to insure your Dependents. The amount of AD&D Insurance for your Dependents is equal to a percentage of your AD&D Insurance, as follows:

Spouse only:		50%
Children only:	15% for each Child, not to exceed	$25,000
Spouse and Children:		40% for your Spouse 10% for each Child

Conversion Option

Term basic, supplemental and dependent life coverage as well as Accidental Death and Dismemberment (AD&D) terminate at retirement or when employment ends. You and your covered dependents are eligible to convert coverage to a private, individual policy with the life insurance carrier by making application within thirty days following termination. Contact the Standard Insurance for more information.

How are benefits paid?

For benefit amounts less than $25,000, The Standard issues a check to each designated beneficiary. The Standard pays amounts of $25,000 or more to each designated beneficiary by depositing funds into Standard Secure Access — a convenient, no fee, interest-bearing draft account.

With Standard Secure Access, each beneficiary receives a personalized checkbook and has complete control of the account. Beneficiaries can write checks as needed or for the full amount. This arrangement allows beneficiaries to earn competitive interest rates on their benefits while they take the necessary time to consider financial decisions and evaluate their choices.

What happens if I become terminally ill?

Under the Accelerated Benefit provision, you may be eligible to receive up to 75 percent, or a maximum of $500,000, of your Life insurance coverage if you become terminally ill, have a life expectancy of less than 12 months and meet other eligibility requirements.

This benefit allows you to use the proceeds as you desire — whether to cover medical expenses or to maintain your quality of life. The amount of Life insurance payable upon your death is reduced by the Accelerated Benefit paid and an interest charge.

What are the exclusions?

Voluntary Life Insurance includes exclusion for death resulting from suicide or other intentionally self-inflicted injury while sane or insane. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

AD&D insurance benefits are not payable for death or dismemberment caused or contributed to by:

- War or act of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature
- Suicide or other intentionally self-inflicted injury while sane or insane
- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot
- Voluntary use or consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a physician
- Sickness or pregnancy existing at the time of the accident
- Heart attack or stroke
- Medical or surgical treatment for any of the above
- Boarding, leaving, or being in or on any kind of aircraft. However, this exclusion will not apply if the person who incurs the loss is a fare-paying passenger on a commercial aircraft.

How do I apply for Additional Life and Voluntary AD&D insurance coverage?

To apply for Additional Life or Voluntary AD&D insurance, contact the Benefits Service Center at the toll-free number 1-888-873-7692. If you have any additional questions, please contact the Benefits Service Center or refer to the Group Life Insurance and Group AD&D certificates available online at:

or

http://www.dallascityhall.com/dallas/eng/html/employee_benefits.html .

MARSH

Voluntary Benefits Program — City of Dallas Employees

As a City of Dallas employee, you have choices when it comes to your voluntary benefits!

The voluntary benefits program offered to City of Dallas employees by Marsh @WorkSolutions provides many advantages over coverage or services you might be able to buy on your own. These quality insurance products and plans enable you to receive special pricing because you are an employee of the City of Dallas. Plus, when you enroll in any of the voluntary benefits, you will receive:

- The convenience of payroll deduction as a payment method.
- Access to a comprehensive Web site where you can get all the information you need regarding plan details, options and enrollment.
- A dedicated customer service center to answer any questions or assist you in enrolling.
- High quality, reputable programs and services that were chosen specifically for City of Dallas employees.
- And much more!

In this section, you will find a comprehensive overview of all your voluntary benefit options as well as detailed instructions on how to enroll in the various plans. If you would like more information, we encourage you to visit www.personal-plans.com/cod. Or, if you prefer, call 1-800-557-1046 and a Marsh @WorkSolutions customer service representative will be happy to assist you.

Current Voluntary Benefits Overview		
Benefit Plan	**What's Happening**	**For More Information**
Dental	• Enroll via the Web or phone. • No plan changes. • Have two plans to choose from: Indemnity Plan and DHMO Plan. • Payroll deductions continue.	Refer to the SafeGuard section in the Enrollment Guide
Vision	• Enroll via the Web or phone. • No plan changes. • Payroll deductions continue.	Refer to the Spectera section in the Enrollment Guide
Long Term Care	• New hires receive guaranteed acceptance within 90 days of hire as long as they are actively at work on their effective date of coverage. • Full medical underwriting required for ongoing employees and eligible family members. • Request information via the Web or phone; enrollment materials will be sent to you. • Payroll deduction as payment method.	Refer to the MetLife section in the Enrollment Guide
Short Term Disability	• Also known as Paycheck Protector. • Enroll by mailing application located in this booklet. • No plan changes. • Full medical underwriting required. • Payroll deduction as payment method.	Refer to The Hartford section in the Enrollment Guide
Long Term Disability	• Also known as Paycheck Protector. • Two plans to choose from: Long Term Paycheck Protector and Long Term Paycheck Protector PLUS. • Enroll by mailing application located in this booklet. • No plan changes. • Full medical underwriting required. • Payroll deduction as payment method.	Refer to The Hartford section in the Enrollment Guide

Group Dental Plans

Offered by SafeGuard®

Consistent care of your teeth is important. Keeping your teeth healthy goes a long way toward your total well being. But good dental care can be expensive. That's why the Group Dental Plans will continue, and are now part of the streamlined and comprehensive Voluntary Employee Benefits Program.

SafeGuard Dental has two plans to choose from, and both offer affordable rates and excellent coverage for you and your family. Plan benefits remain unchanged from last year.

SafeGuard Indemnity Plan

This plan provides you the option of receiving treatment from any licensed dental care professional or through a contracted dentist who has agreed to reduce standard fees for SafeGuard participants. Features include:

- A "calendar year maximum" (the amount SafeGuard will pay in claims for you and each of your enrolled dependents for that year).
- A deductible, which must be met before SafeGuard pays claims.
- Claims payment is determined by the percentage shown on your Summary of Benefits. Treatment procedures are categorized into three or four different types (i.e., Preventive, Basic, Major, and Orthodontia, if covered) and percentages vary by category.

SafeGuard DHMO Plan

Care under this plan is provided through a network of dental care professionals. The plan provides preventive and diagnostic care at low or no cost, which should reduce the need of more costly treatment in the future. Monthly rates are two percent lower than last year.

- Low out-of-pocket costs and no confusing percentages to calculate.
- No calendar year maximums, deductibles or waiting periods.
- Each covered procedure is listed along with the amount for which the member is responsible.
- No claim forms are required.
- Each insurer can choose his or her own SafeGuard dentist.

For more detailed information on dental plans or enrollment instructions, refer to the SafeGuard section in this Enrollment Guide.

Group Vision Plan

Offered by Spectera® Insurance Company, Inc., A UnitedHealth Group Company

The Group Vision Plan will continue, and is now part of the streamlined and comprehensive Voluntary Employee Benefits Program.

Spectera offers vision care benefits to you and your family. The plan design remains the same as the previous year.

The Spectera plan offers a wide variety of benefits to participants. If an in-network provider is used, participants pay co-payments for services such as a standard eye exam or for the purchase of contact lenses or eyeglasses. If a non-network provider is used, Spectera will reimburse participants, up to pre-established reimbursement levels.

For more detailed information on vision plans or enrollment instructions, refer to the Spectera section in this Enrollment Guide.

Long Term Care Insurance

Underwritten by MetLife®

MetLife Group Long Term Care (LTC) insurance is available to you and your eligible family members. This voluntary benefit is not only valuable insurance, but it can also be an essential part of your overall financial plan. Why is that? 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, or for instructions on how to request an information packet, refer to the MetLife section in this Enrollment Guide.

MARSH

Short Term and Long Term Disability
Paycheck Protector

Underwritten by The Hartford

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 to choose from:

- **Short Term Paycheck Protector —** Disability benefits start on the 30th day of disability or illness and may continue for up to 22 weeks. This plans 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 the181st 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 worker's compensation, your pension or any other coverage.

For more detailed information or enrollment instructions, refer to The Hartford section in this Enrollment Guide.

For more information, please contact Marsh @WorkSolutions at:
800-557-1046
www.personal-plans.com/cod

Marsh @WorkSolutions℠ is a service of Seabury & Smith

MMC Marsh & McLennan Companies

SafeGuard® | City of Dallas

We're Here For You!

As a City of Dallas employee, SafeGuard understands the importance of your well being when it comes to dental care needs. That's why you have a choice between a SafeGuard Meridian dental plan that allows you to see any licensed dentist, and a dental HMO plan, which provides comprehensive benefits through SafeGuard's large network of dentists.

If you are a member of our dental HMO plan, please visit our web site at **www.safeguard.net** for the most current dentist listing information … or call us on our toll-free line at **800.880.1800.**

If you wish to enroll in either SafeGuard Dental Plan, visit www.personal-plans.com/cod. There you will find detailed, easy-to-follow instructions on how to enroll. Or, if you prefer, call toll-free at 1-800-557-1046 and a Marsh @WorkSolutions customer service representative will be happy to assist you in the enrollment process.

Compare us to any other company and see for yourself who provides the best in service and the best dental coverage.

Thank you for your continued support.

Member Services 800.880.1800

www.safeguard.net

COL-CD-EB-F

SafeGuard® | City of Dallas

Dental Plans

Dental HMO Plan – CDC-680-TX

This plan provides dental care through a network of contracted dentists, with a schedule of co-payments determining your costs.

- **No deductibles. No annual maximums.**
- **Each family member can select their own SafeGuard Dentist**
- **No waiting period. No claim forms.**
- **Adult and child orthodontics**

CODE	DESCRIPTION	CO-PAYMENT
D9491	Office visit	$0
D0210	X-rays intraoral - complete series	$0
D1110	Cleaning - adult	$0
D2150	Filling, two surfaces, permanent	$13
D2751	Crown porcelain*	$185
D3310	Root canal, per tooth	$95
D5110	Complete upper denture (plus lab fee)	$250
D7140	Extraction	$10

*Porcelain on molars extra
Note: The above co-payments apply only if you receive services from a SafeGuard Selected General Dentist.

SafeGuard Meridian Plan – VC2320W

This plan allows you to receive treatment from any dentist and provides you and each of your enrolled dependents with annual benefit coverage.

- **Freedom to choose any licensed dentist**
- **Coverage for a wide variety of dental procedures**
- **Claims processed quickly**

DESCRIPTION	BENEFIT
Maximum Benefit per year	$1,000
Your Deductible per year	$50 per individual/ $150 per family
THE PLAN PAYS:	
Preventive Services	100%, no deductible
Basic Services	80%, after deductible
Major Services (12 month wait* on Major)	50%, after deductible
Orthodontics	Not a covered benefit

Monthly Rates - CDC-680-TX

Member Only	$7.99
Member + Spouse	$14.78
Member + Child(ren)	$14.78
Member + Family	$20.77

Monthly Rates - VC2320W

Member Only	$23.23
Member + Spouse	$46.46
Member + Child(ren)	$47.38
Member + Family	$70.62

Please review the Evidence of Coverage, Schedule of Benefits and Exclusions & Limitations for full plan details.

Benefits provided by SafeGuard Health Plans, Inc.

*If you are changing from the Dental HMO to the SafeGuard Meridian plan, the waiting period will be waived. If you have not been on the dental HMO plan for a full 12 months, credit will be given for the number of months you were enrolled.

Please review the Certificate of Insurance, Summary of Benefits and Exclusions & Limitations for full plan details. Benefits underwritten by SafeHealth Life Insurance Company.

COL-CD-PC-F

Self-Referral Dental HMO Plan CDC-680-TX

This Schedule of Benefits lists the services available to you under your SafeGuard plan as well as the co-payments associated with each procedure. There are other factors that impact how your plan works and those are included here in the Exclusions & Limitations; please review them before your first dental appointment.

The following co-payments apply only when services are performed by your selected SafeGuard general dentist. If you choose to receive services from a SafeGuard contracted dentist whose practice is limited to specialty care (periodontics, oral surgery, endodontics, pedodontics, orthodontics), your co-payment will be 70% of that dentist's usual fee for those services. A list of these contracted dentists may be found through SafeGuard's online directory at www.safeguard.net.

Benefits provided by SafeGuard Health Plans, Inc.

Code	Service	Co-payment
Diagnostic Treatment		
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D9491	Office visit fee - per visit	$0
D0210	X-rays intraoral - complete series - including bitewings (once every 3 years)	$0
D0220	X-rays intraoral - periapical - first film	$0
D0230	X-rays intraoral - periapical - each additional film	$0
D0240	X-rays intraoral - occlusal film	$0
D0250	X-rays extraoral - first film	$0
D0260	X-rays extraoral - each additional film	$0
D0270	X-rays bitewing - single film	$0
D0272	X-rays bitewings - two films	$0
D0274	X-rays bitewings - four films	$0
D0330	X-rays panoramic film	$0
D0350	Oral/facial photographic images	$0
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination	$0
D0502	Other oral pathology procedures, by report	$0
Preventive Services		
Procedures identified with an asterisk (*) are limited to twice a year, unless medically necessary.		
D1110	Prophylaxis - adult*	$0
D1120	Prophylaxis - child*	$0
D1201	Topical application of fluoride (including prophylaxis) - child*	$0
D1203	Topical application of fluoride (excluding prophylaxis) - child*	$0
D1204	Topical application of fluoride (excluding prophylaxis) - adult*	$0
D1205	Topical application of fluoride (including prophylaxis) - adult*	$0
D1310	Nutritional counseling for control of dental disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$5
D1510	Space maintainer - fixed unilateral	$50
D1515	Space maintainer - fixed bilateral	$50
D1520	Space maintainer - removable unilateral	$50
D1550	Recementation of space maintainer	$0

Restorative Treatment

D2140	Amalgam - one surface, primary or permanent	$11
D2150	Amalgam - two surfaces, primary or permanent	$13
D2160	Amalgam - three surfaces, primary or permanent	$15
D2161	Amalgam - four or more surfaces, primary or permanent	$17
D2330	Resin-based composite - one surface, anterior	$15
D2331	Resin-based composite - two surfaces, anterior	$18
D2332	Resin-based composite - three surfaces, anterior	$23
D2335	Resin-based composite - four or more surfaces or involving incisal angle, anterior	$42
D2390	Resin-based composite crown, anterior	$35
D2391	Resin-based composite, one surface, posterior	$35
D2392	Resin-based composite, two surfaces, posterior	$45
D2393	Resin-based composite, three surfaces, posterior	$55
D2394	Resin-based composite, four or more surfaces, posterior	$55

Crowns

An additional charge will be applied for any procedure using noble or high noble metal.

D2410	Gold foil - one surface	$50
D2420	Gold foil - two surfaces	$130
D2430	Gold foil - three surfaces	$170
D2510	Inlay - metallic - one surface (plus lab fee)	$40
D2530	Inlay - metallic - three or more surfaces (plus lab fee)	$60
D2542	Onlay - metallic - two surfaces (plus additional lab fee)	$150
D2543	Onlay - metallic - three surfaces (plus additional lab fee)	$150
D2544	Onlay - metallic - four or more surfaces (plus additional lab fee)	$150
D2610	Inlay - porcelain/ceramic - one surface	$150
D2620	Inlay - porcelain/ceramic - two surfaces	$200
D2630	Inlay - porcelain/ceramic - three or more surfaces	$200
D2642	Onlay - porcelain/ceramic - two surfaces	$220
D2643	Onlay - porcelain/ceramic - three surfaces	$220
D2644	Onlay - porcelain/ceramic - four or more surfaces	$220
D2650	Inlay - resin - based composite - one surface	$75
D2651	Inlay - resin - based composite - two surfaces	$85
D2652	Inlay - resin - based composite - three or more surfaces	$115
D2662	Onlay - resin - based composite two surfaces	$115
D2663	Onlay - resin - based composite three surfaces	$115
D2664	Onlay - resin - based composite four or more surfaces	$115
D2710	Crown - resin-based composite (indirect)	$155
D2720	Crown - resin with high noble metal	$155
D2721	Crown - resin with predominantly base metal	$100
D2722	Crown - resin with noble metal	$100
D2740	Crown - porcelain/ceramic substrate	$185
D2750	Crown - porcelain fused to high noble metal	$185
D2751	Crown - porcelain fused to predominantly base metal	$185
D2752	Crown - porcelain fused to noble metal	$185
D2780	Crown - 3/4 cast high noble metal	$185
D2781	Crown - 3/4 cast predominantly base metal	$185
D2782	Crown - 3/4 cast noble metal	$185
D2790	Crown - full cast high noble metal	$185
D2791	Crown - full cast predominantly base metal	$185
D2792	Crown - full cast noble metal	$185
D2794	Crown - titanium	$185
D2910	Recement inlay, onlay, or partial coverage restoration	$5
D2915	Recement cast or prefabricated post and core	$5
D2920	Recement crown	$5
D2930	Prefabricated stainless steel crown - primary tooth	$30
D2931	Prefabricated stainless steel crown - permanent tooth	$50
D2932	Prefabricated resin crown	$0
D2940	Sedative filling	$0
D2950	Core build up, including any pins	$35
D2951	Pin retention - per tooth, in addition to restoration	$0

D2952	Cast post and core in addition to crown	$50
D2954	Prefabricated post and core in addition to crown	$35
D2961	Labial veneer (resin laminate) - laboratory	$195
D2962	Labial veneer (porcelain laminate) - laboratory	$240
D2980	Crown repair, by report	$25

Endodontics

All procedures exclude final restoration

D3110	Pulp cap - direct (excluding final restoration)	$0
D3120	Pulp cap - indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy	$20
D3310	Root canal - anterior, per tooth	$95
D3320	Root canal - bicuspid, per tooth	$118
D3330	Root canal - molar, per tooth	$190
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$50
D3351	Apexification/recalcification - initial visit	$0
D3410	Apicoectomy/periradicular surgery - anterior	$100
D3421	Apicoectomy/periradicular surgery - bicuspid, 1st root	$100
D3425	Apicoectomy/periradicular surgery - molar, 1st root	$125
D3426	Apicoectomy/periradicular surgery - each additional root	$60
D3430	Retrograde filling - per root	$25
D3450	Root amputation - per root	$50
D3470	Intentional replantation (including necessary splinting)	$50
D3910	Surgical procedure for isolation of tooth with rubber dam	$3
D3920	Hemisection (including any root removal), not including root therapy	$60

Periodontics

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces - per quadrant	$95
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces - per quadrant	$71
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	$220
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces - per quadrant	$165
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces - per quadrant	$190
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces - per quadrant	$143
D4263	Bone replacement graft - first site in quadrant	$150
D4320	Provisional splinting - intracoronal	$60
D4321	Provisional splinting - extracoronal	$60
D4341	Periodontal scaling and root planing - four or more teeth - per quadrant	$35
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$26
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$35
D4910	Periodontal maintenance procedures - following active therapy	
D4920	Unscheduled dressing change (other than treating dentist)	$0
D4999	Unspecified periodontal procedure, by report	$75

Removable Prosthodontics

D5110	Complete upper denture - plus lab fee	$250
D5120	Complete lower denture - plus lab fee	$250
D5130	Immediate upper denture - plus lab fee	$275
D5140	Immediate lower denture - plus lab fee	$275
D5211	Upper partial - resin base (including clasps, rests and teeth) - plus lab fee	$300
D5212	Lower partial - resin base (including clasps, rests and teeth) - plus lab fee	$300
D5213	Upper partial - cast metal base with resin saddles (including clasps, rests and teeth) - plus lab fee	$375
D5214	Lower partial - cast metal base with resin saddles (including clasps, rests and teeth) - plus lab fee	$375
D5410	Adjust complete denture - upper	$0
D5411	Adjust complete denture - lower	$0
D5421	Adjust partial denture - upper	$0
D5422	Adjust partial denture - lower	$0
D5510	Repair broken complete denture base	$35

D5520	Replace missing or broken teeth	$20
D5610	Repair resin denture base (plus lab fee)	$30
D5620	Repair cast framework (plus lab fee)	$30
D5630	Repair or replace broken clasp	$30
D5640	Replace broken teeth - per tooth	$20
D5650	Add tooth to existing partial denture	Lab Fee
D5660	Add clasp to existing partial denture	Lab Fee
D5710	Rebase complete upper denture	Lab Fee
D5711	Rebase complete lower denture	Lab Fee
D5720	Rebase partial upper denture	Lab Fee
D5721	Rebase partial lower denture	Lab Fee
D5730	Reline complete upper denture (chairside)	$60
D5731	Reline complete lower denture (chairside)	$60
D5740	Reline upper partial denture (chairside)	$60
D5741	Reline lower partial denture (chairside)	$60
D5750	Reline complete upper denture (laboratory)	$75
D5751	Reline complete lower denture (laboratory)	$75
D5760	Reline upper partial denture (laboratory)	$75
D5761	Reline lower partial denture (laboratory)	$75
D5810	Interim complete denture, upper	$60
D5811	Interim complete denture, lower	$60
D5820	Interim partial denture - upper	$90
D5821	Interim partial denture - lower	$90
D5850	Tissue conditioning - upper	$20
D5851	Tissue conditioning - lower	$20
D5862	Precision attachment, by report	$150

Crowns/Fixed Bridges - Per Unit

An additional charge will be applied for any procedure using noble or high noble metal.

D6010	Surgical placement of implant body: endosteal implant	$825
D6210	Pontic - cast high noble metal	$185
D6211	Pontic - cast predominantly base metal	$185
D6212	Pontic - cast noble metal	$185
D6214	Pontic - titanium	$185
D6240	Pontic - porcelain fused to high noble metal	$185
D6241	Pontic - porcelain fused to predominantly base metal	$185
D6242	Pontic - porcelain fused to noble metal	$185
D6250	Pontic - resin with high noble metal	$185
D6251	Pontic - resin with predominantly base metal	$185
D6252	Pontic - resin with noble metal	$185
D6720	Crown - resin with high noble metal	$155
D6721	Crown - resin with predominantly base metal	$100
D6722	Crown - resin with noble metal	$100
D6750	Crown - porcelain fused to high noble metal	$185
D6751	Crown - porcelain fused to predominantly base metal	$185
D6752	Crown - porcelain fused to noble metal	$185
D6780	Crown - 3/4 cast high noble metal	$185
D6781	Crown - 3/4 cast predominantly base metal	$185
D6782	Crown - 3/4 cast noble	$185
D6790	Crown- full cast high noble metal	$185
D6791	Crown- full cast predominantly base metal	$185
D6792	Crown- full cast noble metal	$185
D6794	Crown - titanium	$185
D6930	Recement bridge	$15
D6940	Stress breaker	Lab Fee
D6950	Precision attachment	$145
D6970	Cast post and core in addition to bridge retainer	$50
D6971	Cast post as part of bridge retainer	$50
D6972	Prefabricated post and core in addition to bridge retainer	$35
D6973	Core build up for retainer, including any pins	$35
D6975	Coping - metal	Lab Fee

D6999	Bonded Maryland bridge (per unit)	$225
Oral Surgery		
D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$10
D7210	Surgical removal of erupted tooth	$25
D7220	Extraction - removal of impacted tooth - soft tissue	$45
D7230	Extraction - removal of impacted tooth - partially bony	$55
D7240	Extraction - removal of impacted tooth - completely bony	$60
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$80
D7250	Surgical extraction - removal of residual tooth roots	$35
D7280	Surgical access of an unerupted tooth	$35
D7283	Placement of device to facilitate eruption of impacted tooth	$25
D7285	Biopsy of oral tissue - hard	Lab Fee
D7286	Biopsy of oral tissue - soft	Lab Fee
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$30
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$15
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$40
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$20
D7471	Removal of lateral exostosis	$50
D7472	Removal of torus palatinus	$50
D7473	Removal of torus mandibularis	$50
D7510	Incision and drainage of abscess - intraoral soft tissue	$20
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$20
D7520	Incision and drainage of abscess - extraoral soft tissue	$20
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$20
D7950	Osseous, osteoperiosteal, periosteal, or cartilage graft of the mandible	$150
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$30
D7963	Frenuloplasty	$30
D7970	Excision of hyperplastic tissue (per arch)	$35

Orthodontics

Orthodontic treatment is available from any SafeGuard contracted orthodontist at 70% of the usual and customary charge for the procedures. A listing of contracted dentists whose practice is limited to orthodontic care can be found online at www.safeguard.net or you may call Member Services

Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedures	$10
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$10
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$0
D9430	Office visit - after regularly scheduled hours	$0
D9440	Office visit - after regularly scheduled hours	$10
D9940	Occlusal guard, by report	$90
D9942	Repair and/or reline of occlusal guard	$60
D9951	Occlusal adjustment - limited	$0
D9952	Occlusal adjustment - complete	$20

Dental Terminology Definitions

These definitions are designed to give you a "layman's understanding" of some dental terminology in order for you to better understand your plan; they are not full descriptions.

Amalgam: A silver filling

Anterior: Teeth that are in the front of the mouth

Bicuspid: Most people have four bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.

Bridge: A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).

Crown: A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials (noble, high noble), base metal, porcelain or porcelain and metal.

Endodontics: Procedures that treat disease and injury to the inside of the tooth (the nerve or pulp).

Oral Surgery: Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.

Orthodontics: Braces and other procedures to straighten the teeth.

Periodontics: Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).

Posterior: Teeth that set towards the back of the mouth.

Primary Teeth: The first set of teeth ("baby" teeth).

Prophylaxis: Teeth cleaning

Prosthodontics: Procedures related to the replacement of teeth with removable appliances like dentures or partial dentures.

Quadrant: One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).

Resin-based Composite: Tooth-colored (white) fillings

Exclusions and Limitations

Principal Exclusions and Limitations of Benefits

The following services are **NOT COVERED** or **EXPRESSLY LIMITED** by this:

1. All services the provider does not deem reasonable and/or necessary for diagnosis and treatment.
2. Any service not specifically listed on the schedule of benefits.
3. Treatment for malignancies or neoplasms.
4. Drugs for treatment of oral disease, not normally supplied in a dental office.
5. Hospitalization, Out Patient Center, I.V. Sedation, General Anesthetic, or any procedures not performed at the Providers office.
6. Lab fees: The amount a laboratory charges to make prosthetic work. In-lays $97; Dentures (upper or lower) $187; Partials $193; All removable prosthetic repairs $78; Rebase denture (upper or lower) $164; Bridges per unit $148; Bridge repair per unit $123; Biopsy $150; and Habit appliance $175.

SafeGuard

SUMMARY OF BENEFITS

MERIDIAN DENTAL PLAN VC2320W

Benefits Description	Plan Coverage
Calendar Year Maximum	$1,000
Calendar Year Deductible	$50 per person / $150 per family
Preventive Services Initial/Routine Oral Exam, Teeth Cleaning & Routine Scaling, Fluoride Treatment, Sealant, X-rays as part of a general exam, Emergency Exam	100% no deductible
General Services Fillings, General Anesthetics, Space Maintainers	80% after deductible
Major Services Crowns, Removable & Fixed Bridges, Complete & Partial Dentures, Oral Surgery, Periodontics, Endodontics There is a 12-month waiting period for Major Services on this plan unless you were previously covered on this Employer's indemnity plan for the last continuous 12 months. If you were covered for less than 12 continuous months, your waiting period will be pro-rated.	50% after deductible 12 month wait

Network Access: This plan includes access to SafeGuard's network. Contracted dentists have agreed to accept a reduced fee as payment in full, less any deductibles and/or coinsurance requirements, with no "Balance Billing". The reduced fee is lower than the dentist's customary fee and could save you money.

Your Costs: Payment from SafeGuard is based on a Maximum Allowable Amount ("MAA"), which is the amount that will be allowed by SafeGuard for a covered procedure. The MAA is determined by SafeGuard based on either charges billed for the same service by dentists in the same geographic area with similar training and experience, or determined by negotiated rates with dentists who have contracted with SafeGuard.

Balance Billing: If you choose to receive treatment from a non-contracted dentist, and your dentist charges more than the MAA for a procedure, you are responsible for the difference between what is charged and the MAA. This is called "Balance Billing".

Limitations:

⇨ Initial/Routine Oral Exam	2 per calendar year
⇨ Bitewings (x-rays)	2 per calendar year
⇨ Teeth Cleaning	2 per calendar year
⇨ Fluoride Treatment	1 per calendar year
⇨ Sealants	1 per 36 months, children 17 years and under on permanent molars only
⇨ Emergency Treatment	Relief of acute pain, bleeding or infection only

Additional Exclusions and Limitations are listed on the following page.

Underwritten by SafeHealth Life Insurance Company

EXCLUSIONS AND LIMITATIONS

Exclusions – No benefits are payable under this Policy for any expenses incurred for:

1. Any service or supply not listed in the Summary of Benefits or defined in your Employer's Master policy.
2. Any procedure or appliance started before the effective date or after the termination date of the Covered Person's insurance.
3. An appliance delivered or placed more than ninety days after termination of the Covered Person's insurance.
4. Treatment by anyone other than a Dentist or Physician, except where performed by a duly qualified hygienist under the direction of a Dentist or Physician.
5. Dental services that do not have uniform professional endorsement by the American Dental Association.
6. Services or materials that are experimental, cosmetic, or not medically necessary.
7. Services and supplies related to the change of vertical dimension, restoration or maintenance of occlusion, re-implantation, splinting and stabilizing teeth, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for myofascial pain disorders (MPD) or temporomandibular joint dysfunction (TMJ).
8. Replacement of lost or stolen appliances or replacement of any appliance, prosthesis, crown, or bridge placed less than five (5) years before (temporary prosthetics are considered permanent and subject to this exclusion if not replaced by the permanent prosthetic within six (6) months.
9. Initial placement of any bridge or denture unless such placement is necessitated by the extraction of one or more natural teeth while insured under this Policy or is due to irreparable damage caused as a result of injury received while insured under this Policy.
10. Periodontal maintenance, unless following active periodontal therapy.
11. Periodontal scaling or root planning for children under the age of 14.
12. Partial dentures for children under the age of 14 to replace extracted or lost primary or permanent teeth.
13. Prescribed drugs, medications or analgesia, or training in or supplies used for dietary counseling, oral hygiene or plaque control; nitrous oxide or sterilization charges; pulp caps or medicaments.
14. Care rendered within any facility of, or provided by: (1) the United States Government or any agency thereof; (2) any hospital or institution that does not require the Covered Person to pay for such services in the absence of insurance.
15. Any expenses paid by any Workers' Compensation law or act, Employers' Liability law or by any governmental program, law or agency, except for Medicare or Medicaid.
16. Treatment of congenital malfunctions or malformations.
17. Treatment or service not recommended by a dentist.
18. Expenses resulting from injuries sustained or sickness contracted as a result of any war or act of war or participation in a riot or civil disturbance or while committing or attempting to commit a felony.
19. Charges for professional services rendered by any individual who is related to the Covered Person by blood or marriage.
20. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
21. Orthodontic services unless orthodontics is a covered benefit under this Policy or any applicable rider.
22. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.

Limitations - Benefits under this Policy are limited as follows:

1. Panorex or full mouth x-ray series – once every 36 months
2. Porcelain, porcelain with metal, or full gold crowns – must be 14 years or older and on permanent teeth.
3. General anesthetics – for oral surgery and periodontics only
4. Replacement of crowns, gold restorative or cast posts - once every five years (If the tooth can be restored with less expensive materials, the benefit will be based on those materials.)
5. To restore injured or decayed posterior teeth, the benefit is an amalgam filling.
6. Replacement of dentures – once every five years and only if the original is unserviceable. When a permanent denture replaces a temporary one, charges for both are limited to the charge for the permanent one.

(Additional Limitations can be found on the Summary of Benefits.)

$10 Exam Copay / $25 Materials Copay
Exam once every 12 months / Lenses once every 12 months / Frames once every 24 months
Plan Year Effective 1/1/07

Dear Spectera Member:

Thank you for choosing Spectera to provide your vision care benefits coverage. We are excited for the opportunity to provide vision care benefits to the employees, retirees and eligible dependents of the **City of Dallas**. This letter contains important information for you to understand as a Spectera member.

Spectera does not provide ID Cards, as they are not required for receiving services. Simply call a participating provider to schedule an appointment. Identify yourself as a **City of Dallas** member and inform the provider that you are covered by Spectera's vision care program. The provider will confirm eligibility and benefits with the primary insured's Social Security number in addition to the patient's name and date of birth.

Participating providers can be located by visiting Spectera's website at www.spectera.com or by calling our Provider Locator Service tollfree at (800) 839-3242.

If you wish to enroll in Spectera Group Vision insurance, visit www.personal-plans.com/cod. There you will find detailed, easy-to-follow instructions on how to enroll. Or, if you prefer, call toll-free at 1-800-557-1046 and a Marsh @WorkSolutions customer service representative will be happy to assist you in the enrollment process.

RECEIVING BENEFITS FROM A NETWORK PROVIDER

A $10 copay covers a standard exam (Examination for pathology & abnormalities, Refraction, Diagnosis & prescription, Visual skill testing, and Case History). Please verify with the provider what your additional out-of-pocket expenses are should you choose to receive optional professional services (i.e. evaluation/fitting fees for contacts, etc.).

A $25 copay covers either eyeglasses (Frames & standard lenses) or contacts. Please be sure to ask the provider what materials are covered-in-full (plus applicable copay). Please verify with the provider what your additional out-of-pocket expenses are should you choose materials such as Frames in excess of the benefit allowance, Elective contact lenses not covered-in-full or Non-covered patient options (i.e. tints, coatings, progressive lenses, etc.)

RECEIVING BENEFITS FROM A NON-NETWORK PROVIDER

If a non-network provider is used, Spectera will reimburse the member up to the reimbursement levels established. Simply submit an itemized receipt, with the primary insured's Social Security number and the patient's name, date of birth and address to:

Spectera Claims Department
P.O. Box 26618
Baltimore, MD 21207-6618

VISION BENEFIT COMMUNICATION

City Of Dallas

Program Year Effective 1/1/07

Underwritten by UnitedHealthcare Insurance Company

BENEFITS AT A SPECTERA NETWORK PROVIDER	
COMPREHENSIVE VISION EXAM ($10 copay; Once Every 12 Months)	A vision examination is provided by a network optometrist or ophthalmologist, after applicable copay.
MATERIALS ($25 copay)	The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.
PAIR OF LENSES (for eyeglasses) (Once Every 12 Months) • Standard single vision • Standard lined bifocal • Standard lined trifocal • Standard lenticular	**Standard scratch-resistant coating is covered-in-full.** **Lens Options** - Options such as progressive lenses, polycarbonate lenses, tints, UV, and anti-reflective coating may be available at a discount.
FRAMES (Once Every 24 Months)	Receive a $50 wholesale frame allowance (approximate retail value of $120 to $150) at private practice providers, or a minimum $130 frame allowance at retail chain providers.
Contact Lenses (in lieu of eyeglasses) (Once Every 12 Months) • Covered-in-full elective contact lenses	The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered-in-full (after applicable copay) for many popular brands, such as Acuvue by Johnson & Johnson and Optima by Bausch & Lomb. If covered disposable contact lenses are chosen, up to 4 boxes (depending on prescription) are included when obtained from a network provider.It is important to note that Spectera's covered-in-full contact lenses may vary by provider.
• All other elective contacts	A $105 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of Spectera's covered-in-full contacts (materials copay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.
• Necessary contact lenses*	Covered-in-full (after applicable copay).
REFRACTIVE EYE SURGERY	Spectera participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit our Web site at www.spectera.com.

BENEFITS AT AN OUT-OF-NETWORK PROVIDER		
SERVICE	**AMOUNT**	
Exam		If you choose an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to: Spectera Claims Department P. O. Box 26618 Baltimore, MD 21207-6618 Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.
Optometrist	up to $40	
Opthalmologist	up to $40	
Lenses		
Single Vision	up to $40	
Bifocal	up to $60	
Trifocal	up to $80	
Lenticular	up to $80	
Frames	up to $45	
Contact Lenses (in lieu of eyeglasses)		
Elective	up to $105	
Necessary*	up to $210	

* Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact Spectera concerning the reimbursement that Spectera will make before you purchase such contacts.

Spectera's vision benefit is very affordable. The monthly premiums are:

Exam copay $10
Materials copay $25

Employee Only:	$6.04 per month
Employee + Spouse:	$11.03 per month
Employee + Child(ren):	$11.58 per month
Employee + Family:	$17.81 per month

2004-14

VISION BENEFIT COMMUNICATION

Sample Illustration of Savings

COST	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)*	EMPLOYEE + FAMILY**
Monthly Premium	$6.04	$11.03	$11.58	$17.81
Annual Premium	$72.48	$132.36	$138.96	$213.72
Approx. Pre-tax Savings (20%)	$14.50	$26.47	$27.79	$42.74
Annual Tax-Adjusted Premium	$57.98	$105.89	$111.17	$170.98
Plus Copays	$35	$70	$105	$140
Total Cost to Employee	**$92.98**	**$175.89**	**$216.17**	**$310.98**

	Estimated Cost Without a Vision Plan***	Less Employee Cost	TOTAL SAVINGS WITH SPECTERA
Employee Only Exam, Single Vision, & Covered-in-Full Frames	$265	$93	$172
Employee + Spouse Exam, Single Vision, & Covered-in-Full Frames	$530	$176	$354
Employee + Child(ren) Exam, Single Vision, & Covered-in-Full Frames	$795	$216	$579
Employee + Family** Exam, Single Vision, & Covered-in-Full Frames	$1,060	$311	$749

* For purposes of this sample calculation, Employee + Child(ren) is calculated with 3 members.

** For purposes of this sample calculation, Employee + Family is calculated with 4 members.

*** Approximate retail value illustrated: Exam & Refraction ($65), Single Vision Lenses ($80), and Frames ($120). Average retail costs may vary by location.
Actual tax savings will depend upon your individual tax bracket.
Upgrades and add-ons discounted between 20-40% off of retail costs.
Covered-in-full frames credit equivalent to approximately $120 to $150 U&C value.

Important to Remember:
• Always identify yourself as a Spectera participant when making your appointment. This will assist your provider in obtaining a claim authorization number prior to your visit.
• Benefits available every 12 or 24 months (depending on the benefit frequency), based on last date of service.

• Your $105 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $75 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

The following Services and Materials are excluded from coverage under the Policy:
1. Post cataract lenses
2. Non-prescription items
3. Medical or surgical treatment for eye disease, that requires the services of a physician
4. Worker's Compensation services or materials
5. Services or materials that the patient, without cost, obtains from any governmental organization or program
6. Services or materials that are not specifically covered by the Policy
7. Sunglasses, plain or prescription
8. Replacement or repair of lenses and/or frames that have been lost or broken
9. Cosmetic extras, except as stated in the Policy's Table of Benefits

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document.
Please retain this Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use the program. Customer Service is available toll-free at 1-800-638-3120 from 7:30 a.m. to 7:00 p.m. CST, Monday thru Friday, and from 8:00 a.m. to 4:00 p.m. CST on Saturdays.

2004-14

Metropolitan Life Insurance Company ("MetLife")

Get the Facts
About Long-Term Care Insurance

What is Long-Term Care?
Long-term care is the type of help you need when you're no longer able to do the things you take for granted every day. It's needed when simple things, such as getting out of bed, eating, or even taking a shower, become too difficult to do on your own.

Why think about Long-Term Care now?
People may think that they're too young to worry about this type of care, but the fact is, the need for long-term care can happen at any age and at any time, due to an unexpected accident or illness. Long-term care is an issue that's affecting more families than ever before, partly because people are living longer. And as we live longer, we're more likely to develop conditions (such as Alzheimer's) that require long-term care on a regular basis. Relying on your spouse or family member to provide this type of care may not be realistic. The type or frequency of care that is needed may be more than what he or she is able to provide. Increasingly, more and more families are having to rely on outside, paid help for routine long-term care needs.

You can't assume that you're already covered!
While your medical plan and Medicare are valuable, they often don't cover the high cost of long-term care. Unfortunately, many people don't find this out until they're actually faced with a long-term care situation. As a result, many individuals and their families end up paying for long-term care out of their own pockets and risk spending their life savings. Fortunately, protection is available to help fill the gap left by traditional health insurance. Long-Term Care Insurance is specifically designed to help protect you and your family from the high costs associated with long-term care.

Did you know?
• It is estimated that over 9,000,000 older adults will need long-term care in the year 2005.[1]
• Nearly half of all Americans will need long-term care at some point in their lives and one in five over the age of 50 is at a high risk of needing long-term care in the next 12 months.[2]
• The reported average cost of nursing home care (nationwide) is $61,600 per year.[3]

1 "Guide to Long-Term Care Insurance," Health Insurance Association of America, 2002.
2 "Consumer Information about Long-Term Care: A Guide for Families," National Center for Assisted Living, as of 2003.
3 "MetLife Market Survey on Nursing Home and Home Care Costs," The Mature Market Institute, September 2004.

To request enrollment materials or to learn more about LTC insurance, call 1-800-557-1046 or visit www.personal-plans.com/cod.
ADF#72.97

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Paycheck Protector Helps Guard Your Income and Your Family's Financial Future

As a permanent City of Dallas employee, Paycheck Protector helps protect your income and your family's financial future if an accident or serious illness leaves you disabled and keeps you from working and earning a paycheck.

Short Term Paycheck Protector:
Your First Defense Against Short Term Injuries or Serious Illnesses
You'll have valuable peace-of-mind with cash benefits that replace 60% of your weekly earnings up to $500.00 each week. Your Short Term Paycheck Protector benefits start the 30th day of your total disability and continues as long as you remain totally disabled up to a maximum of 22 weeks.

Long Term Paycheck Protector:
Your Back-Up Plan If A Disability Keeps You From Working
Long Term Paycheck Protector benefits pick up right where your Short Term Paycheck Protector ends. That's because your "Long-Term" cash benefit checks start on the 181st day of your total disability. You can choose between two "Long-Term" cash benefit options.

To help keep premiums as affordable as possible, we will subtract from your LTD benefit the amount of other disability income you may receive from other sources. Your combined benefit from The Hartford and other sources will not be less than 60% of your monthly earnings or $5,000, whichever is less.

Or, you can instead select Long Term Paycheck Protector PLUS. This exclusive plan gives you cash benefits equaling 30% of your earnings. However, benefits are NOT coordinated with other plans. That means your 30% disability cash benefit checks would be PAID ON TOP of any benefits you may receive through workers' compensation, your pension or any other coverage. In no event will you collect more than 100% of your pre-disability earnings when combining other income payments and your Long Term Paycheck Protector Plus benefit.

No matter which "Long-Term" option you select, you'll collect cash benefits for up to two full years if your disability prevents you from performing the regular duties of your current occupation. If you remain disabled during years three through five, you'll receive cash benefits if your disability prevents you from working in any occupation for which you are qualified by education and training.

PAYCHECK PROTECTOR BENEFITS ARE TAX-FREE
Under current tax law, when you pay your own disability premiums, your benefits are taxfree. Check with your accountant for full details. But in a nutshell, tax-free benefits are always better because you collect the full amount due to you … without worrying about sending a portion to the government for taxes.

CONVENIENT PAYROLL DEDUCT MEANS ONE LESS BILL FOR YOU
Premiums for your Paycheck Protector benefits are automatically handled through payroll deduction. That means no worries about writing extra checks. No making sure the bill's mailed on time. Once you set up your benefits, Paycheck Protector practically runs on autopilot – conveniently handled via payroll deduction.

HELPFUL HINT:
For seamless protection, enroll in both the Short Term Paycheck Protector and Long Term Paycheck Protector programs. These two important coverages pair up perfectly… giving you a strong back-up plan in case a disability keeps you from working and earning an income.

ENROLLMENT
You will be required to go through the full medical underwriting process if you wish to enroll in any Paycheck Protector plan. To enroll, please fill out the application in the Enrollment Guide and return to:

Marsh @WorkSolutions
Attn: City of Dallas Employee Benefit Administration
P.O. Box 9122, Des Moines, IA 50306-9905

Upon submitting your Enrollment Application located in the Enrollment Guide, you will receive a Personal Health Application in the mail to be completed and submitted within two weeks of receipt. The Hartford must approve, in writing, your Personal Health Application for coverage in order for you to become insured for disability coverage.

Questions? Call Toll-Free 1-800-557-1046
Or visit us at: www.personal-plans.com/cod

PAYCHECK PROTECTOR — FREQUENTLY ASKED QUESTIONS

Why do I need disability insurance?
Most people do not expect to suffer a long-term disability. However, if you're between the ages of 35 and 65, there's a 33 percent probability you could become seriously disabled. What's more, on average, a 35-year-old who's been disabled for 90 days is likely to remain disabled for almost three years.† These statistics should make all of us think about how we would cope if our income were interrupted because of a disability.

Your most valuable asset is your earning capacity. It's taken years of study and career advancement to achieve your position today. Yet a serious illness or injury could jeopardize your livelihood. Even if you're young and healthy, a serious illness or injury could put you out of work for months or even years.

† Life Insurers Fact Book, 2004, American Council of Life Insurers.

All permanent employees working 30+ hours may apply for this coverage.

When will benefits begin?
Short Term Paycheck Protector benefits begin on the 30th day of your covered disability and continue for the next 22 weeks. Long Term Paycheck Protector starts on the 181ST day of your covered disability and continues for up to 5 years.

Are disability benefit payments subject to federal income tax?
No. Benefits for which the employee pays 100% of the premium with post-tax dollars are not subject to federal income tax.

How much will this coverage cost?
Your premium is based on your age, your salary and the plan option you choose. Refer to the rate tables displaying the costs of these benefits.

When is the coverage effective?
Your coverage will become effective on the date you are approved by the insurance company.

How long can I continue this coverage?
The conversion privilege allows employees to convert their group Long Term Paycheck Protector coverage to a Long Term Paycheck Protector group conversion policy if their group Long Term Paycheck Protector coverage terminates under certain circumstances. If the conditions are met, the employee can enroll for personal insurance under this conversion policy, which will provide continuing coverage for disability.

Short Term Paycheck Protector cannot be converted. When employment is terminated, the disability coverage ceases.

How does the Return to Work provision work?
For the first 12 months after you return to work on a part-time basis, this benefit allows you to receive up to 100% of your pre-disability earnings. This means that you will continue to receive the full disability benefit in addition to your part-time earnings — as long as the combined amount does not exceed 100% of what you were making just prior to the disability. If the amount does exceed 100%, then the monthly benefit will be reduced by the excess.

How long will benefits be paid if I become disabled when I am covered under Long Term Paycheck Protector?
Long Term Paycheck Protector coverage continues up to the five-year benefit period — even if you leave your current employer.

What is a Pre-existing Conditions Limitation?
The disability plans define a pre-existing condition as any illness or injury for which you received medical treatment or consultation within 6 months before becoming covered under the plan. No benefits will be payable for a disability that results from that condition with the following exceptions:

The limitation ceases to apply after you go 6 months with no medical care for the pre-existing condition, or are continuously insured under the plan for 12 months.

Is pregnancy covered?
Yes. Pregnancy is treated like any other disability (subject to the pre-existing limitation).

What is the difference between the two Long Term Paycheck Protector plans?
To help keep premiums as affordable as possible, we will subtract from your LTD benefit the amount of other disability income you may receive from other sources. Your combined benefit from The Hartford and other sources will not be less than 60% of your monthly earnings or $5,000, whichever is less.

You can also elect an upgrade to your current City of Dallas disability benefits through Long Term Paycheck Protector PLUS. This exclusive plan gives you cash benefits equaling 30% of your earnings. However, benefits are not coordinated with other plans. That means your 30% disability cash benefit checks would be paid on top of any benefits you may receive through workers' compensation, your pension or any other coverage. In no event will you collect more than 100% of your pre-disability earnings when combining other income payments and your Long Term Paycheck Protector Plus benefit.

GROUP RATES MEAN LOWER PREMIUMS FOR YOU

The City of Dallas leveraged the group buying power of more than 12,000 permanent employees to negotiate money-saving group rates for you. That means you have an economic advantage over individual disability coverage you may find on your own. Take a look at your affordable group rates:

Short Term Paycheck Protector Monthly Rates	
Age	Rate per $1 of Monthly Payroll
< 45	$0.0118
45-54	$0.0119
55-59	$0.0144
60 And Up	$0.0165

Long Term Paycheck Protector Monthly Rates		
Age	PLUS Rate per $1 of Monthly Payroll	Base Plan Rate per $1 of Monthly Payroll
<35	$0.0014	$0.0027
35-39	$0.0024	$0.0045
40-44	$0.0039	$0.0077
45-49	$0.0060	$0.0120
50-54	$0.0093	$0.0183
55 And Up	$0.0120	$0.0237

Calculation Example

An employee earning $39,000 earns $3,250 of gross pay per month ($39,000 divided by 12 = $3,250). The employee's age is 48. The employee's Short Term Paycheck Protector and Long Term Paycheck Protector premiums are calculated as follows:

$3,250	X	$.0119	=	$38.70
Gross Monthly Pay		Short Term Paycheck Protector Monthly Rate		Short Term Monthly Premium
$3,250	X	$.0060	=	$19.50
Gross Monthly Pay		Long Term Paycheck Protector PLUS Monthly Rate		30% Long Term Monthly Premium
$3,250	X	$.0120	=	$39.00
Gross Monthly Pay		Long Term Paycheck Protector Monthly Rate		60% Long Term Monthly Premium

Rates are based on your age on your effective date and will increase as you enter a new age bracket on subsequent plan anniversary dates. Rates are subject to change. Due to rounding, your actual payroll deduction amount may differ slightly.

Other Important Information

What is COBRA?
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers with group health 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.

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; the 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.

Legislative Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ANNUAL NOTICE

Did you know that your 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)? Call your Plan Administrator for more information.

Continuation of Health Coverage during Family and Medical Leave (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires Employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible Employees for certain family and medical reasons. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See the Employer 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 return from a FMLA leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms. The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

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 provider (e.g., 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 provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Employer.

CITY OF DALLAS - 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 law – the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to:

- Make sure that your protected health information is kept private
- Give you this Notice of our legal duties and privacy practices with respect to your protected health information
- 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.

You're 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.

You're 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 60 days, unless a written notice of a 30-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.

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

e 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 website 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 RESOURCES DEPARTMENT	1500 Marilla Street, Rm. 6AS Dallas, Texas 75201-6390 Phone: 214-670-3120 Fax: 214-670-3764
UnitedHealthcare - PPO & EPO Plan	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 & DCAP	1-877-311-7849


Dallas-Together,
we do it better