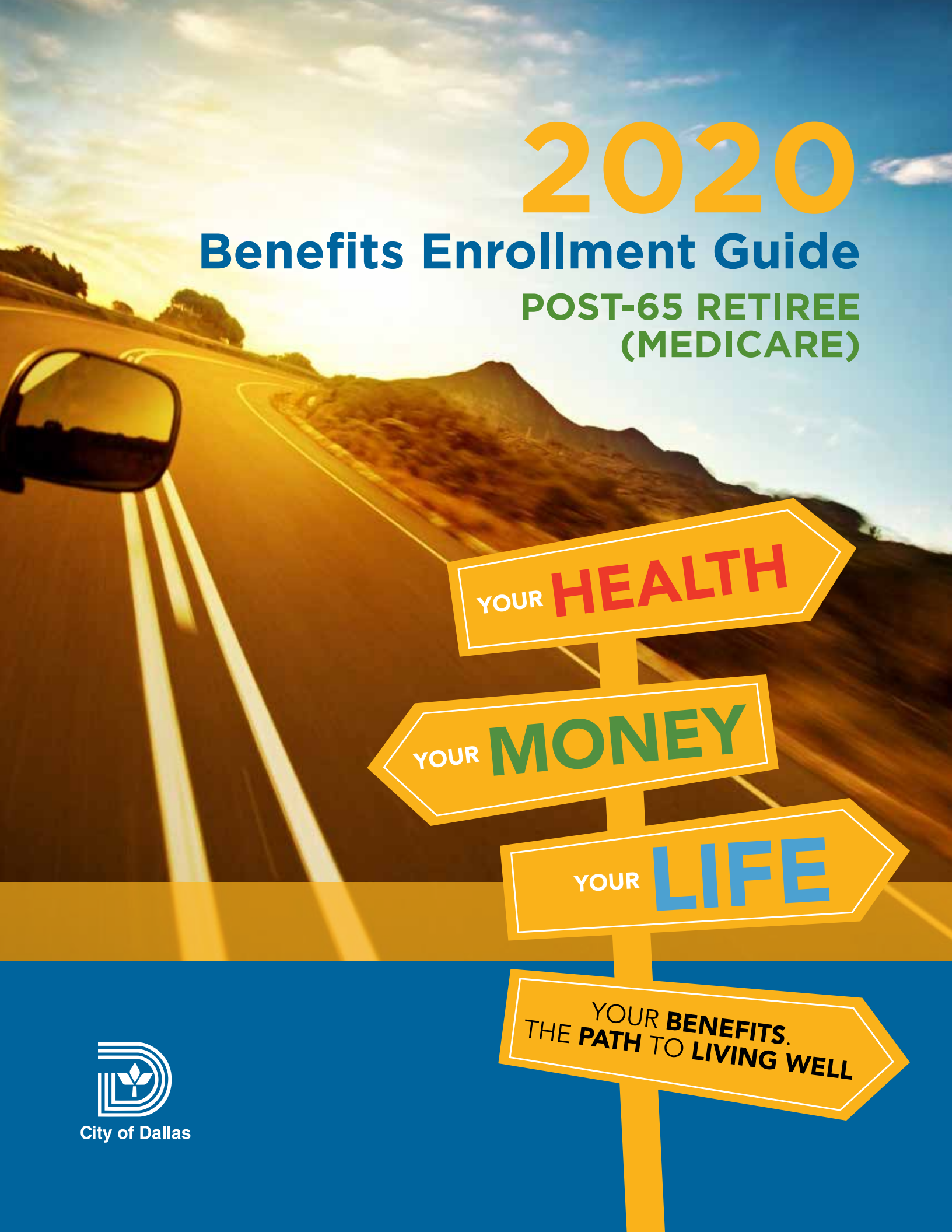
2020
Benefits Enrollment Guide
POST-65 RETIREE (MEDICARE)



City of Dallas

This guide highlights the main features of many of the benefit plans sponsored by the City of Dallas. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. The City of Dallas reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time.

TABLE OF CONTENTS

Important: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Advantage PPO plans give you more choices about your prescription drug coverage. Please see page 16 for more details.

Evidence of Coverage

The benefits information provided in this guide is a summary of what the UnitedHealthcare (UHC) medical plans cover and what you pay. It does not list every service that UHC covers or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of covered services. You can see it online at www.UHCRetiree.com, or you can call UHC's Customer Service line at 1-800-457-8506 for help. If you enroll in the plan, you will get information that tells you where you can go online to view your Evidence of Coverage.

Health Benefits Coverage Under State and Federal Laws

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

GREETINGS CITY OF DALLAS RETIREE:

It is our pleasure to welcome you to your 2020 Open Enrollment. The City of Dallas provides an annual open enrollment period for retirees to review their benefits coverage and make new elections for the upcoming year.

Exciting news for all Post-65 Retirees!

Starting in 2020, the City of Dallas will offer two new Medicare Advantage PPO Plans that will provide you with medical **and** pharmacy coverage—and lower premiums! Both plans are administered by UnitedHealthcare (UHC). These plans provide national coverage and include any provider that accepts Medicare and the plan.

We are proud to offer our Retirees enhanced medical and pharmacy benefits at lower rates in 2020.

Enhanced benefits include:

- Combined medical and pharmacy coverage
- One ID card and one premium amount
- Access to the vast UnitedHealthcare National Provider Network
- Access to any provider (in-network or out-of-network) at the same cost share, as long as they have not opted out of or been excluded from Medicare
- Additional programs at no extra cost
  - Silver Sneakers
  - Nurse Line
  - HouseCalls
  - Renew rewards program
  - Hearing impairment devices
  - Preferred diabetes supply program
- And more!

How These Changes Affect You

- **Your current medical and prescription drug plans will no longer be offered by City of Dallas, and your coverage will end effective December 31, 2019.**
- **During Open Enrollment (October 2 – 25, 2019), you MUST elect a <u>new</u> plan option for 2020 if you want your medical coverage to continue to be deducted from your pension check.**
- For 2020, you must take action to enroll or decline City of Dallas medical and prescription drug coverage. If you decline coverage, you will not be eligible to enroll in the City of Dallas plans at a later date and will lose any applicable subsidy.
- You will automatically be disenrolled from your UnitedHealthcare Medicare Advantage HMO plan or UnitedHealthcare Group Prescription Drug plan coverage effective December 31, 2019.
- You will NOT be automatically disenrolled from your current UnitedHealthcare AARP® Medicare Supplement Plan.
  - After you have enrolled in the new UnitedHealthcare® Group Medicare Advantage (PPO) plan you **MUST** call 1-800-545-1797 to disenroll from the AARP Medicare Supplement Plan.
  - If you do not disenroll from the AARP Medicare Supplement plan by 12/31/2019, you will be billed directly for 100% of your Medicare Supplement Insurance policy premium.
  - The City of Dallas is **NOT** able to do this on your behalf.
- Your current dental and vision elections will remain the same for 2020 if no action is taken during Open Enrollment.

Your Medical Plan Options for 2020

The following table and the rest of this 2020 Benefits Enrollment Guide provide details about your benefit options. Reviewing the material contained in this guide will help you make informed decisions about your benefits.

Enroll in a New City of Dallas Plan

- The City will offer two new post-65 retiree plans for 2020: Medicare Advantage PPO Low and Medicare Advantage PPO High.
- Both plans offer improved benefit levels and include both medical and pharmacy coverage.
- Your premiums will be deducted through the Pension Department.

Can I stay in my current plan?

- Your current Medicare Advantage HMO and/or Prescription Drug plan coverage will end on December 31, 2019.
- You may choose to continue your coverage with the UnitedHealthcare (UHC) AARP Medicare Supplement plan, but you will be required to pay your full premium directly to UHC.
- This means that your coverage **will no longer be associated with the City of Dallas** and subsidies will not be available.

Do I have alternative coverage options?

- Both the public and private marketplaces offer a variety of medical plan options. Government subsidies may be available.
- **Alternative Coverage Options**
  - healthcare.gov (public) **Call: 1-800-318-2596**
  - healthcompare.com (private) **Call: 1-888-956-7735**
- Contact a local agent at Benefit Solutions By Design to assist with your search at no cost to you: benefitsbd.com or **(214) 579-0045**.

Questions?

If you have any questions, please reach out to UHC directly at (877) 647-9423 (TTY 711), 8:00 a.m. – 8:00 p.m. 7 days a week, or visit www.uhcretiree.com.

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

Sincerely,
City of Dallas Benefits Team

ENROLLMENT OVERVIEW

Dependent Eligibility

If you are covered by a plan, in most cases, you may also cover your eligible dependents as outlined below. Your dependents (spouse and/or children) cannot be covered on a plan if you are not covered. Please note: Only those enrolled in Medicare Parts A and B are eligible to enroll in the UHC Medicare Advantage PPO medical plan options outlined in this guide.

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

Type of Eligible Dependent	Required Documentation
Spouse	• Copy of Marriage License, copy of Social Security Card and Date of Birth • If Common-Law Marriage applies, please provide copies of two documents showing that you and your spouse live together. – Lease or deed naming both partners – Joint checking account statement – Utility bills and/or credit accounts – Will and/or life insurance policies
Domestic Partner	• Copy of Social Security Card and Date of Birth **-AND-** • Copies of two documents showing that you and your partner live together. – Lease or deed naming both partners – Joint checking account statement – Utility bills and/or credit accounts – Will and/or life insurance policies
Dependent Child Child who is married or unmarried up to age 26* and is the biological child, legally adopted child, grandchildren or stepchild of you and/or your spouse, domestic partner or common-law spouse. Note: Dependent children will become insured on their date of birth if you elect Dependent Insurance no later than 30 days after the birth. If you do not elect to insure your newborn child within such 30 days, coverage for that child will end on the 30th day.	• Copy of Birth Certificate showing you as a parent, or • Copy of Verification of Birth Form (accepted for up to 3 months post-birth only) • Copy of Adoption Agreement, or • Copy of court custody or guardianship documents, or • Copy of the portion of the divorce decree showing the dependent, or • Copy of Qualified Medical Court Support Order (QMSCO) **-AND-** • Copy of Social Security Card **Additional documentation required for disabled dependents:** • Physician affirmation of such condition and dependence
Dependent Grandchild Grandchild who is married or unmarried up to age 26* and is the biological grandchild of you and/or your spouse, domestic partner or common-law spouse. You must have guardianship or cover the child to cover a grandchild.	

*Dependent children and dependent grandchildren are covered until the end of the month of their 26th birth month for dental and vision coverage and until the age of 25 for life insurance. Disabled children are eligible to be covered past their 26th birthday if they are unmarried, primarily supported by you, and incapable of self-sustaining employment by reason of mental or physical disability.

NOTE: All members are enrolled in the Medicare Advantage PPO plans as individuals with no dependents listed on their account. Each individual enrolled will have his or her own account and own unique member ID number.

Making Changes to Coverage

Once you enroll, you cannot change your benefit choices until the next annual enrollment period. This is an IRS rule. However, you may make certain changes if you have a qualifying event that affects your benefits — and the event is consistent with your requested change. Typical qualifying events include:

- Marriage
- Divorce, legal separation, or annulment
- Birth, adoption, or legal guardianship of a child
- Death of a spouse/domestic partner or eligible dependent
- A change in the employment status of yourself, your spouse/domestic partner, or a dependent
- A dependent qualifies or no longer qualifies due to age
- Significant cost increases for benefit coverage
- Enrollment in or loss of state or federal medical coverage
- You move out of your health plan's service area that requires a change in plans
- A spouse or dependent gains or loses coverage in another qualified health plan

You must notify the Benefits Service Center and provide proof of your qualifying event as soon as possible and before 30 days have passed. Coverage will be effective based on the date of the event. If you wait longer than 30 days, you must wait until the next annual enrollment to make a change.

How to Enroll for New Retirees after Open Enrollment

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

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

Reminders

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

1. The Open Enrollment period for 2020 starts October 2, 2019 and ends on October 25, 2019. If you want to continue to participate in a City of Dallas Retiree Medical Plan for 2020, you **MUST** take action during our Open Enrollment period.
2. You must report a Qualifying Life Event within 30 days of that event to change your benefits coverage.
3. New retirees must enroll in a benefits plan within 30 days of their retirement date; otherwise, they forfeit coverage.

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

Upon becoming Medicare eligible, you should follow these steps:

1. Enroll in Medicare Parts A and B

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

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

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

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

Important Information

To be eligible for coverage under the UHC Group Medicare Advantage (PPO) plans, you must be enrolled in Medicare Parts A and B. You must also continue paying your Medicare Part B premium.

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

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

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

3. Enroll in a Medical Supplement Plan

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

Dependent Information

To enroll dependents or update dependent information for 2020, please call the Benefits Service Center and speak with a representative to add or remove a dependent(s). Please provide documentation as listed on the Eligible Dependent chart in this guide.

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

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

Verification of Personal Information

To receive your identification cards promptly, it is important to make sure your current mailing address is correct. To confirm your mailing address, report an address change, or make other corrections, please contact UHC at (877) 647-9423. **To report address changes only,** please contact the Employees' Retirement Fund of the City of Dallas Pension Office (civilian) at (214) 580-7700 or Dallas Police and Fire Pension Office (uniform) at (800) 638-3861.

Special Note

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

Duplicate Medical Coverage by Retiree

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

Benefits Information for Certain Medicare-Eligible Retirees

If you have any questions, please contact UHC at (877) 647-9423. In the next few months, you will receive a letter from your Medicare Part D provider to alert you of the following information.

- Annual Notice of Change (ANOC), which will include:
  - 2020 Formulary List
  - Summary of Benefits
  - Mail-order information
  - Pharmacy Directory
- Explanation of Benefits (EOB)
- Explanation of Coverage (EOC)

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

Important Disclaimers

Paying for Medical Coverage

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

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

MEDICARE ADVANTAGE PPO PLANS

Medicare Advantage PPO Plan Rates

	Retiree Monthly Rates		Retiree Monthly Rates Hired After 1/1/2010 (not eligible for City subsidy)	
Tier	**High Option**	**Low Option**	**High Option**	**Low Option**
Retiree Only	$291.46	$263.48	$388.61	$351.30
Retiree + Spouse	$680.07	$614.78	$777.22	$702.60
Spouse Only	$388.61	$351.30	$388.61	$351.30

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

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

- One ID card for Medical and Prescription Drugs. No need to show Medicare Card.
- The plan travels with you and allows access to services throughout the U.S. and all U.S. territories with no referrals.
- You can see any provider (in-network or out-of-network) at the same cost share, as long as they have not opted out of or been excluded from Medicare.
- Choose from over 67,000 pharmacies across the United States, including national chain, regional, and independent local retail pharmacies. OptumRx is an affiliate of UnitedHealthcare and will continue to be an option for home delivery.
- SilverSneakers® offers access to exercise equipment, classes, and more at over 15,000+ fitness locations.
- UnitedHealthcare® HouseCalls provide in-home visits designed to complement your doctor's care. A licensed and knowledgeable health care practitioner will review your health history and current medications, perform a health screening, identify health risks, and provide health education. HouseCalls is a choice available to you if you are interested.
- Renew, the members-only health and wellness experience, offers access to inspiring lifestyle tips, learning activities, videos, recipes, interactive health tools, rewards and more — all designed to help you live your best life at no additional cost to you.
- NurseLine is available to answer health questions at any time. Registered nurses answer your call 24 hours a day, 7 days a week.

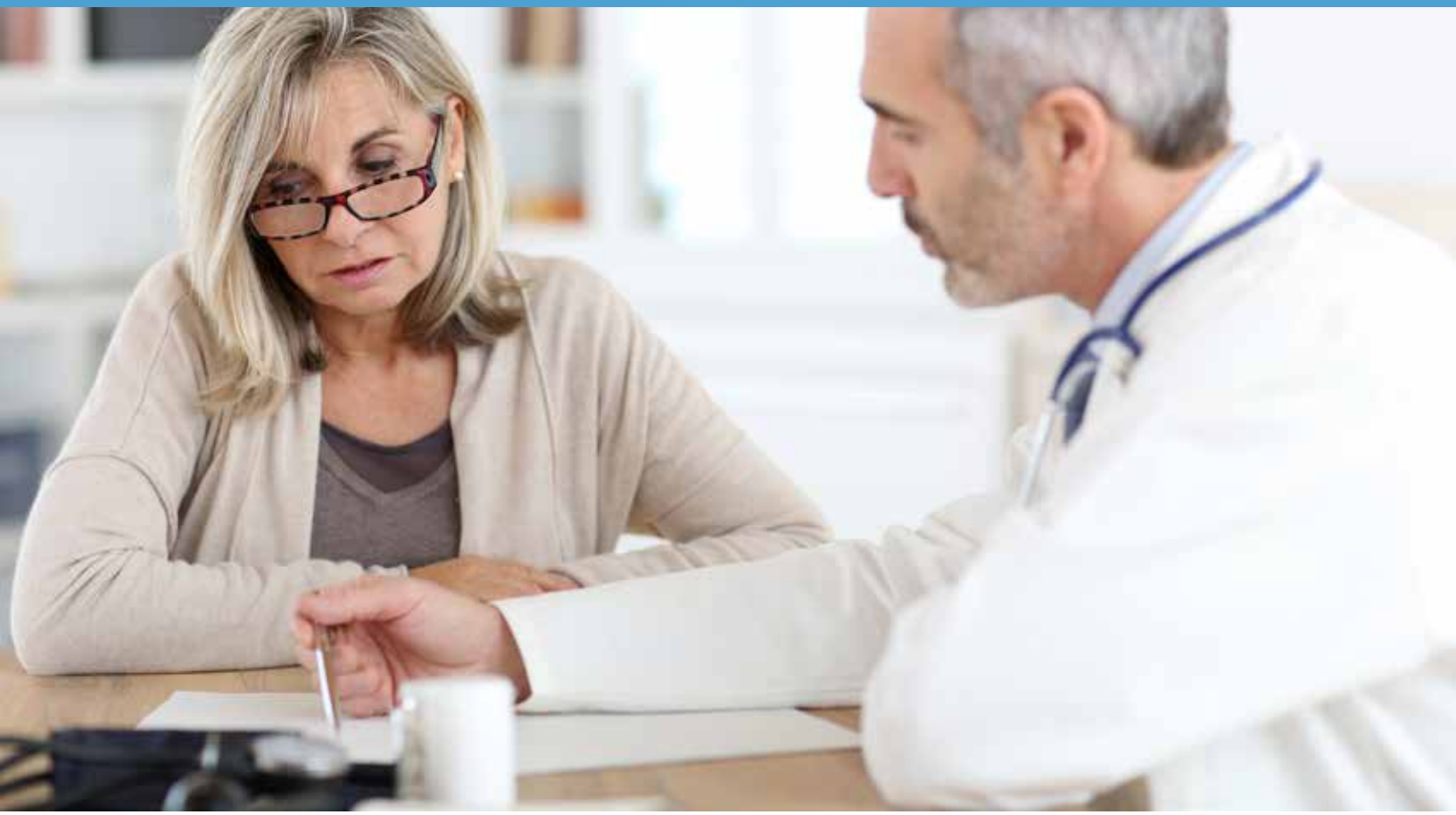
If you decide to enroll in a UHC Medicare Advantage plan, UHC will send you more plan details in the mail. Until then, UnitedHealthcare is ready for any Group Medicare Advantage (PPO) plan questions you may have. Call Customer Service toll-free at 1-877-647-9423, TTY 711, 8:00 a.m. – 8:00 p.m. local time, 7 days a week.

UnitedHealthcare® Medicare Advantage PPO Plans

Benefits & Coverage	Medicare Advantage PPO High Plan	Medicare Advantage PPO Low Plan
Physician Services/Basic Health Services • Consultation, Diagnosis and Treatment, Primary Care Physician • Specialist	 $0 copayment per office visit $0 copayment per office visit	 $10 copayment per office visit $20 copayment per office visit
Annual Physical Examination (Includes Pap smears)	$0 copayment	$0 copayment
Immunizations • Flu Shots, Pneumococcal Vaccine and Hepatitis B Injections • All other Medicare-approved Immunizations	Covered in Full Covered in Full	
Hospitalization	$0 copayment per admission*	$250 copayment per admission*
Non-network/ Out-of-Area Urgent Care	$0 copayment	$10 copayment, waived if admitted to hospital within 24 hours for the same condition
Ambulance Services Medically Necessary Ambulance Transport	$0 copayment	$50 copayment
Outpatient Surgical Services • Certified Ambulatory Surgical Center • Outpatient Hospital Facility	 $0 copayment $0 copayment	 $100 copayment $100 copayment
Outpatient Mental Health Care/Substance Abuse Treatment • Individual Visit • Group Visit • Day Treatment	 $0 copayment $0 copayment $0 copayment	 $20 copayment $10 copayment $55 copayment per day
Inpatient Psychiatric Care/Inpatient Substance Abuse Treatment	$0 copayment per admission, up to 190 days lifetime maximum in a psychiatric hospital	$250 copayment per admission, up to 190 days lifetime maximum in a psychiatric hospital
Emergency Services (Covered worldwide) You may go to any emergency room if you reasonably believe you need emergency care	$0 copayment	$120 copayment, waived if admitted to hospital within 24 hours for the same condition
Renal Dialysis	$0 copayment	
Radiation Therapy	$0 copayment	$20 copayment
Radiology Services • Standard X-ray Films • Specialized Scanning & Imaging Procedures: CT, SPECT, PET, MRI (with or without contrast media)	$0 copayment	 $10 copayment $20 copayment
Skilled Nursing Facility Care	$0/day for days 1-100; up to 100 days per benefit period**	$0/day for days 1-20; $80/day for days 21-100; up to 100 days per benefit period**
Vision Care Examination for Eyeglasses (Refraction)	$0 per visit for Medicare-covered eye exams	$20 per visit for Medicare-covered eye exams
Hearing Services Routine Hearing Examination	Plan pays up to a $500 allowance for hearing aids every three years	
Chiropractic Services	$0 copayment for Medicare-covered services	$20 copayment for Medicare-covered services

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

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



UnitedHealthcare Medicare Advantage PPO Prescription Drug Coverage

If you enroll in one of the City-sponsored UHC Medicare Advantage PPO plans, you will automatically receive prescription drug coverage.

- There are no deductibles or out-of-pocket maximums; you'll start saving with the first prescription you fill.
- The National Pharmacy Network includes more than 65,000 convenient locations, so you are covered at home or while you are traveling across the United States.
- With this comprehensive prescription drug coverage, **there is no need to worry about the coverage gap or "doughnut hole"** – you are fully covered.

Outpatient Prescription Drug Benefits	UHC Medicare Advantage PPO High Plan	UHC Medicare Advantage PPO Low Plan
Retail (30-day supply)		
• Tier 1: Preferred Generic	$10 copay	
• Tier 2: Preferred Brand	$25 copay	
• Tier 3: Non-Preferred Drug	$50 copay	
• Tier 4: Specialty	$50 copay	
Mail Services (90-day supply)		
• Tier 1: Preferred Generic	$20 copay	
• Tier 2: Preferred Brand	$50 copay	
• Tier 3: Non-Preferred Drug	$100 copay	
• Tier 4: Specialty	$100 copay	

DENTAL PPO PLAN

With The City of Dallas' Dental PPO Plan, you may use any dentist you wish. When you choose a MetLife Dentist, though, you receive service at discounted prices.

When you use a non-MetLife dentist, you pay more out of your own pocket since you're responsible for 100% of the amount the dentist charges that exceeds MetLife's network-negotiated fee.

	In-Network % of Negotiated Fee*	Out-of-Network % of Negotiated Fee*
Deductible (Per Person)**	$50	$50
Annual Maximum Benefit (Per Person)	$1,750	$1,750
Orthodontia Lifetime Maximum (Per Person)	$1,750	$1,750
Coverage Type		
Type A – Preventive		
• Two cleanings every 12 months • Two exams every 12 months • Two fluoride treatments per calendar year for dependent children up to 16th birthday • Full mouth X-rays: one per 36 months • Bitewing X-rays: one set per calendar year for adults; one per calendar year for children	100%	100%
Type B – Basic Restorative		
• Fillings • Extractions • General Anesthesia: When dentally necessary in connection with oral surgery, extractions or other covered dental services	80%	80%
Type C – Major Restorative†		
• No waiting period for major services • Crown, Denture, and Bridges • Endodontics • Periodontics • Oral Surgery †Implants not covered	50%	50%
Type D – Orthodontia		
• All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia	50%	50%

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

* Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

** Subject to the section titled Dental Benefits: Limitations and Additional Charges and Dental Benefits: Exclusions.

Note: Child(ren)'s eligibility for dental coverage is from birth up to age 26.

DENTAL HMO PLAN

The DHMO Plan offers a wide range of dental benefits through a network of participating dentists. With this plan, you are responsible for copayments associated with each covered procedure.

This plan offers lower out-of-pocket costs on more than 400 procedures.

Here are some of the services in this plan, all of which will help you lower your dental care costs.

	Co-payment
Office Visit	$5 per visit (including all fees for sterilization and/or infection control)
Preventive Services Visit	$0 exams $5 cleaning $0 X-rays
Crowns	$255 porcelain, metal and titanium
Orthodontics	$2,600 adults* $2,400 children*
Osseous surgery	$200 – $300
Root canals	$95 – $225
Extractions	$15 – $110 (higher cost for impacted tooth)
General anesthesia & nitrous oxide	$0
Dentures	$300 – $350
Implants	See fee schedule

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

Please note, if you elect the MetLife Dental HMO Plan, you MUST select a dental provider to be able to use your benefits. You will not be able to see a dentist until you elect a provider.

To locate a participating dentist and the most current MetLife dental information visit www.metlife.com/dental. If you are already registered you can go directly to www.metlife.com/mybenefits.

- Click on "Find a Dentist"
- Enter your ZIP Code
- Select "Dental HMO/Managed Care" for the Network Type
- Complete all required information (CITY OF DALLAS should be used for the plan name)

*Additional charges for initial exam ($250), removable appliance therapy and fixed appliance therapy.

VISION COVERAGE

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan through Davis Vision helps you care for your eyes while saving you money[5]. Choose from a national network of independent, private practice doctors or select retail partners in 50 states. Visit www.davisvision.com/Member (client code: *7955*) to find providers in your network.

In-Network Benefits	
Eye Examination	
Every 12 months. Covered in full after $10 copayment	
Eyeglasses (One-year eyeglass breakage warranty is included on plan eyewear)	
Spectacle Lenses (Every 12 months)	• Covered in full after $10 copayment • Clear plastic lenses in any single vision, bifocal, trifocal, or lenticular prescription; tinting; scratch-resistant coating; UV coating; standard and premium ARC; polycarbonate lenses; and standard progressives
Frames (Every 12 months)	• Covered in full: Any Fashion, Designer or Premier frame from Davis Vision's Collection[1] (retail value up to $195) **OR** • $140 retail allowance toward any frame from provider, plus 20% off balance[2] **OR** • Receive a **FREE frame at Visionworks**[3]
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care (Every 12 months)	• Collection Contacts: Covered in full after $10 copay **OR** • Non Collection Contacts covered in full after $10 copay • Standard & Specialty Contacts[4]: $60 allowance with 15% off balance[2] less • $10 copay
Contact Lenses – if you do not choose eyeglasses (Every 12 months)[4]	• Covered in full: Any contact lenses from Davis Vision's Contact Lens Collection[1] **OR** • $130 retail allowance toward provider supplied contact lenses, plus 15% off balance, no copay required[2]

1 The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.

2 Additional discounts not applicable at Walmart, Sam's Club or Costco locations.

3 The free frame benefit is available at all Visionworks locations nationwide and includes all frames except Maui Jim eyewear.

4 Including, but not limited to toric, multifocal and gas permeable contact lenses.

5 Refer to the plan summary for a complete list of lens options and applicable member charges.

Out-Of-Network Vision Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement. The out-of-network claim form can be found on the member portion of the website at www.davisvision.com/Member, using client code *7955*. Out-of-network claims may also be submitted directly through the Davis Vision Mobile App.

Reimbursement Amount	Claims
Eye Examination up to $40, **Frame** up to $50 **Spectacle Lenses** (per pair) up to: Single Vision $40 Bifocal $60, Trifocal $80, Lenticular $100 **Elective Contacts** up to $105 **Visually Required Contacts** up to $225	Pay the provider directly for all charges and then submit a claim for reimbursement to: **Vision Care Processing Unit** **P.O. Box 1525** **Latham, NY 12110**

Value-Added Features and Extras

- **Mail Order Contact Lenses:** Replacement contacts (after initial benefit) through DavisVisionContacts.com
- **Laser Vision Correction:** Significant savings with discounts of up to 40 – 50 percent off the national average price of traditional LASIK. In addition, a one-time/lifetime allowance of $500 is available. For more information regarding Laser Eye Services, contact Davis Vision at (855) 502-2020
- **One Year Breakage Warranty:** Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a Visionworks location where the Collection is not displayed.
- **Greater Benefits:** By visiting a Visionworks family of store locations you will receive a free frame (excludes Maui Jim brands)
- **Additional Savings:** At most participating network locations, members receive up to 20% off additional eyeglasses, sunglasses and items not covered by the benefit and 15% off disposable contact lenses.
- **Mail Order Contact Lenses:** Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.
- **Low Vision Services:** Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.
- **Eye Health & Wellness:** Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

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

IMPORTANT NOTICES

Important Notice About Your Prescription Drug Coverage & Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Dallas and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Dallas has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage through no fault of your own — you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you are enrolled in the City's EPO health plan; that coverage pays for medical expenses in addition to prescription drug expenses which are included the plan's design. As a retiree, if you decide to join a non-City of Dallas sponsored Medicare drug plan, your current City of Dallas coverage will be affected as you cannot be enrolled in two plans. If you decide to join a Medicare drug plan as a retiree that is not sponsored by the City of Dallas and drop your current City of Dallas coverage, be aware that you and your dependents will not be able to get this coverage back. See pages seven through nine of the *CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance* (available at **http://www.cms.hhs.gov/CreditableCoverage**), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of Dallas and are eligible for Medicare and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Please contact the Benefits Service Center at (214) 671-6947 Option 1 or send written correspondence to the address listed at the end of this notice.

NOTE: This notice will be provided in each annual enrollment guide and if this coverage through the City of Dallas changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call (877) 486-2048.

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

Remember: If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty). To receive a copy of this notice, please use the contact information listed below.

August 2019
City of Dallas
Benefits Service Center
1500 Marilla Street, 1D South,
Dallas, TX 75201
(214) 671-6947 Option 1

Notice of Privacy Practices

Effective Date: April 14, 2003 Revised: August 31, 2015

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. This notice addresses the changes set forth in the Final HIPAA Omnibus Rule. Please review carefully. The Health and Wellness Organized Health Care Arrangement "OHCA" includes the following plans and wellness program of the City of Dallas:

3. City of Dallas Active Employee Health Benefits Plan;
4. City of Dallas Retiree Health Benefits Plan
5. City of Dallas Active Employee Prescription Drug Plan;
6. City of Dallas Retiree Prescription Drug Plan;
7. Employee Medical Spending Account that is part of the City of Dallas Cafeteria Plan;
8. City of Dallas Onsite Clinic;
9. City of Dallas Active Employee Vision Benefits Plan
10. City of Dallas Active Employee Dental Benefits Plan
11. City of Dallas Retiree Vision Benefits Plan
12. City of Dallas Retiree Dental Benefits Plan; and
13. City of Dallas Wellness Program

These plans and program will be working together purposes of healthcare operations, using common systems to provide benefits to you.

Our Privacy Principles

We are required by law to maintain the privacy of your protected health information and to inform you about

- Our practices regarding the use and disclosure of your protected health information
- Your rights with respect to your protected health information
- Our duties with respect to your protected health information
- Your right to file a complaint about the use of your protected health information
- Whom you may contact for additional information about our privacy practices and
- Any breach of your unsecured Protected Health Information (PHI)

This notice explains how we may use and disclose your health information to provide benefits to you and our promise to protect your health information. We understand the importance of maintaining the privacy of this information. We are guided by your rights to make inquiries about how we use or disclose your health information. This notice describes rights according to the Privacy Rule and our legal obligations regarding them. We shall abide by the terms of this notice for all health or medical information retained by the OHCA. In this notice the terms "we," "our," and "OHCA" are used interchangeably to refer to the separate plans and program listed above as part of the City of Dallas Health and Wellness OHCA. The term "health information" refers to the information about you, your spouse, or your dependent(s) that is used or disclosed to the OHCA concerning your physical or mental health or the medical services you received, your health benefits and payments. Health information includes all identifying information you provide to the any plans or program listed above to enroll for coverage, receive benefits,or participate in a program.

If you have any questions regarding this notice, please contact the Privacy Officer:

Privacy Officer: (214) 670-1208

Call Compliance Hotline: (855) 345-4022

Email: hipaacompliance@dallascityhall.com

How Your Protected Health Information May Be Used or Disclosed

We may access your health information at various times depending on the action required to be completed to your account to maintain your health benefits. We may also document your conversations with the Benefits Division or Wellness Staff. Employees and business associates will have access to view your health information to perform certain activities for the OHCA. They will be given access to your information to help you with your inquiries related to your plan(s) or program. They may also access your information to perform business or administrative functions for the plan(s) and program. At all times, we take steps to ensure that no use or disclosure is inconsistent with the Privacy Rule. Your health records pertaining to your mental health (e.g. psychotherapy notes), substance or drug abuse, and alcohol abuse histories and information relating to HIV test results are subject to stricter disclosure rules under Texas law. We require your written authorization or that of your authorized representative to release this information when requested. The City has certified that your health information will not be used for any employment-related actions or decisions or activities that deviate from managing the plans and program listed above. Violations of these rules are subject to disciplinary action. Below, we describe the different ways we may use and disclose your health information and provide examples for the different disclosures.

Treatment

When the plans and program in the OHCA do not provide treatment services, but your health care provider or physician does we (or the third-party plan administrator) may confirm your health benefits to a health care provider. For example, if your physician wishes to determine whether a plan covers a prospective treatment or medication, they may contact us (or our third-party administrator) for this information. We may also share your personal information (name, DOB, social security, address or other identifying information) with Cigna, or Caremark Pharmacy Services, or other business associates who update the information we have on file for you in the health plans database(s). For example, a business associate may have access to the plans' database(s) to add new or additional subscribers to your plan, to make changes to your benefits elections, or to update your profile information – in an effort to provide the most up-to-date information to facilitate the treatment activities of your health care provider.

To Pay Your Health Insurance Premiums, Health Plan Contributions or Benefit

The plans and program may use and disclose your health information to obtain premiums for the health insurance, to pay for the health care services you receive (claims paid by third-party administrator) or to subrogate a claim. For example, we may need to provide your health information to a different insurance company to obtain reimbursement for health care benefits provided under the health plans to you, your spouse, or your dependents. The OHCA may also provide your health information to business associates (e.g. billing companies, claims processing companies) that participate in billing and payment activities for the plans and program in the OHCA.

Plan Operations

We may use and disclose your protected health information for our health care operations activities. This interaction is needed to run the plans more efficiently and provide effective coverage. Health care operation activities could include: administering and reviewing the health plans, underwriting health plan benefits, determining coverage policies,performing business planning, arranging for legal and auditing services, customer service related training activities, or determining plan eligibility criteria, etc. Your information may be shared with business associates that perform a service for the plans and program in the OHCA. Note, however, the health plans will never use genetic PHI for underwriting purposes. The health plans will only disclose the minimum information necessary with respect to the amount of health information used or disclosed for these purposes. In other words, only information relating to the task being performed will be used or disclosed. Information not required for the task will not be used or disclosed. The health plans may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

To Business Associates

We may share your health information with third-party business associates who perform certain business activities for the health plans. Examples include consultants, attorneys, billing or claims processing companies, interpreters, and auditors. Business associates are required through contract with us and by law to appropriately safeguard your PHI.

The health plans are also allowed to use or disclose your health information without your written authorization as required by law.

Disposal of Protected Health Information

Once we no longer need your protected health information we will either destroy it, return it, or if neither is feasible, we will store it securely and prohibit further uses and disclosures except to the extent use or disclosure is unavoidable for up to seven (7) years.

Other Uses and Disclosures Requiring Your Authorization

We are prohibited from using or disclosing your health information if the use or disclosure is not covered by a situation above. We will ask for your written authorization for other uses or disclosures. If you give us your written authorization to use or disclose your protected health information, you may revoke that permission, in writing, at any time, but not for any actions we have already taken. If you revoke your permission, you must be specific about which entity's permission is being revoked.

Rights You Have Regarding Your Health Information

Right to Inspect and Copy

You have the right to inspect and copy your health information that the Health Plan maintains for enrollment, payment, claims determination, or case or medical management activities, or that the Plan uses to make enrollment, coverage or payment decisions (the "designated record set"). However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. You must submit your request in writing to the Benefits Division. You may be charged a fee for the related costs, such as copying and mailing. If your request to inspect or copy your health information has been denied, you will be notified in writing of your rights of appeal at that time.

Right to Access Electronic Records

You may request access to your electronic health records (usually compiled by health care providers) or electronic copies of your PHI held in a designated record set, or you may request in writing or electronically that another person receive an electronic copy of these records. The electronic PHI will be provided in a mutually agreed-upon format, and you may be charged for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Amend

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

Right to an Accounting of Disclosures

You may seek an accounting of certain disclosures by requesting a list of the times we have shared your health information. Your request must be in writing. Your request should indicate in what form you want the list (for example, paper or electronically). The first list you request within a 12-month period will be free. Fr additional lists, you may be charged for the costs of providing the list. Your will receive a response no later than 60 days from when we receive your request, unless a written notice of a 30-day extension is provided.

Right to Request Restrictions

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

Right to Request Confidential Communications

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

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

Right to Receive Notice of A Breach

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

Receive a Copy of This Notice

You may ask for a paper copy of this notice by calling the Benefits Division at (214) 671-6947 Option 1. You may also view this notice at the health plans website at **www.cityofdallasbenefits.org**.

Changes to This Notice

We reserve the right to change this notice and will distribute as required. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. We will post the revised copy on the health plans' websites and distribute information about the update as required by the regulations.

Complaints and Questions

If you have questions regarding your privacy rights, please call the City of Dallas Privacy Officer at (214) 670-1208. If you believe your privacy rights have been violated, you may file a complaint by contacting the City of Dallas Privacy Officer at (214) 670-1208, by calling the Confidential Hotline at (855)345-4022, by email at hipaacompliance@dallascityhall.com or with the Department of Health and Human Services. You will not be penalized for filling a complaint.

Human Resources Department	ATTN: Benefits Service Center 1500 Marilla Street, Room 1D South Dallas, TX 75201-6390 Phone: (214) 671-6947 Option 1 Fax: (214) 659-7098
Human Resources Department	**UHC Plans** (Medicare Advantage PPO Low and High plans) Phone: (877) 647-9423 **UHC** – Prescription Services Phone: (877) 647-9423 **Davis Vision** – Vision Plan Phone: (800) 999-5431 **MetLife** – Dental Plan Phone: (855) 676-9442
U. S. Department of Health and Human Services	**Centers for Medicare and Medicaid Services** Website: www.cms.hhs.gov Phone: (877) 267-2323, Ext. 61565

60-Day Special Enrollment Period

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

- You or your dependent Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP

Women's Health Cancer Rights Act (WHCRA) Enrollment Notice

If you have had or plan to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

The benefits provided are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like additional information on WHCRA benefits, call your plan administrator at (800) 736-1364.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

Notice of Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for your other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or place for adoption, you may be able to enroll yourself and your dependents.

However, you must request enrollment within 30 days following the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact the Benefits Service Center at (214) 671-6947 Option 1.

Wellness Program Disclosure

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

Health Insurance Marketplace Notice

Through the Affordable Care Act, Health Insurance Exchanges have been established across the country. Each state had the option to set up a state-based insurance Marketplace that allows individuals and employers to easily compare and evaluate health insurance plans. The state of Texas elected not to implement a state exchange, so the Health Insurance Exchange is run by the Federal government. Enrollment in health coverage on the Marketplace will open in November, with plans effective on January 1, 2018. The Patient Protection and Accountable Care Act requires employers covered by the Fair Labor Standards Act (FLSA) to provide a notice to employees prior to the beginning date of the Exchange. On the following pages, you will find the Exchange Notice that notifies employees about the exchanges. Please be advised that the City of Dallas plans meet the minimum value required for health plans; therefore, City employees may not be eligible for a subsidy in the exchange. Specifically, the notice is designed to:

- Inform employees about the existence of the Exchange and give a description of the services provided by the Exchange
- Explain how employees may be eligible for a premium tax credit or a cost-sharing reduction if the employer's plan does not meet certain requirements
- Inform employees that if they purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer-provided coverage, and that all or a portion of this employer contribution may be excludable for federal income tax purposes and
- Include contact information for the Exchange and an explanation of appeal rights. Should you have any questions about your coverage, or to get additional information about this form, please contact the Benefits Service Center at (214) 671-6947 Option 1

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS-NOW or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at: **www.askebsa.dol.gov** or call (866) 444-EBSA (3272).

Texas Residents

Website: http://www.gethipptexas.com

Phone: (800) 440-0493

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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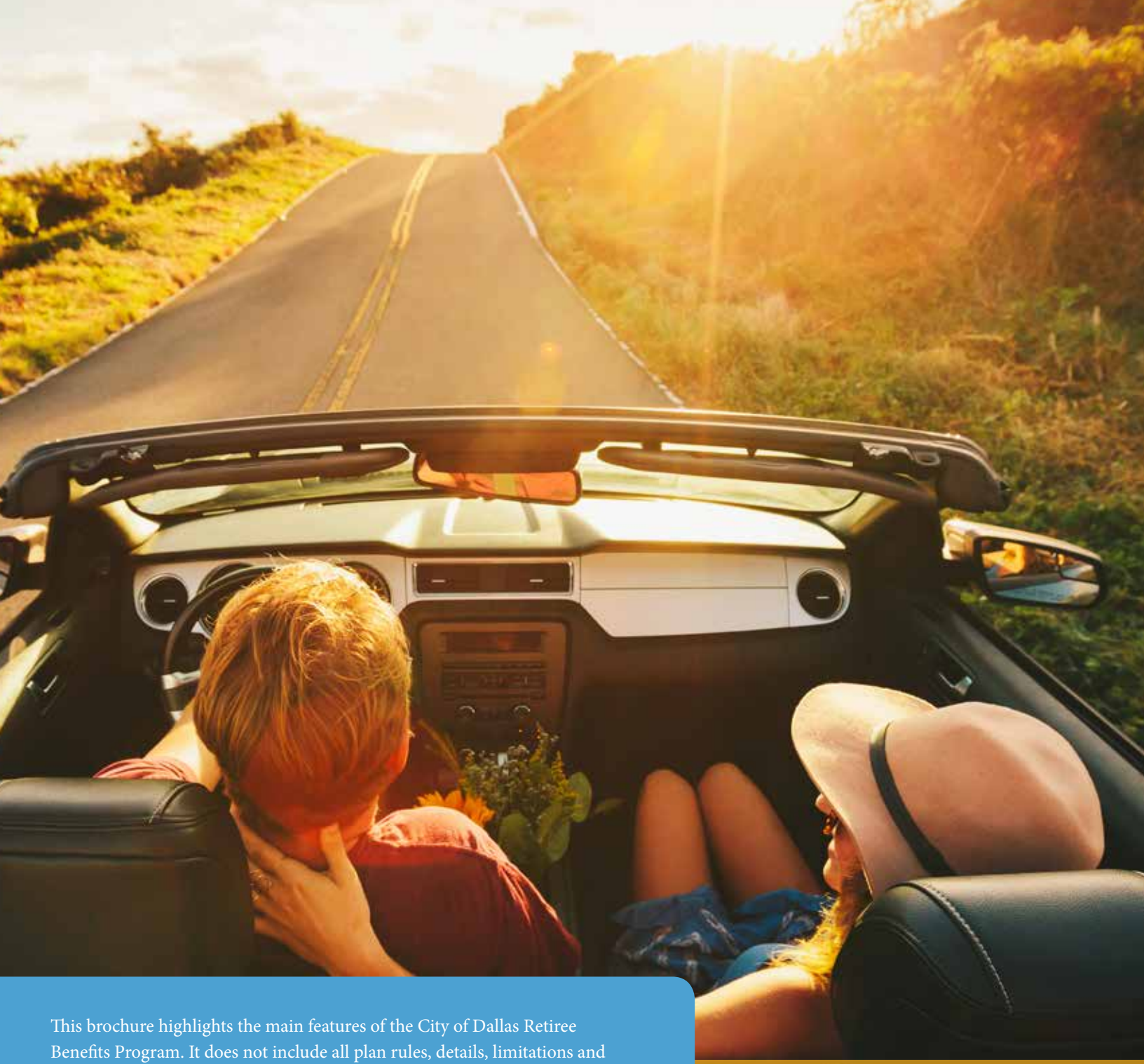
IMPORTANT CONTACTS

Resource	Carrier	Phone Number	Email/Web Address
City of Dallas Benefits Service Center	N/A	(214) 671-6947, Option 1	hrbenefits@dallascityhall.com
Medicare Parts A and B	N/A	Contact your local Social Security Administration office	www.ssa.gov
To disenroll from your Medicare Supplement Plan	AARP	(800) 545-1797	www.aarphealthcare.com
UnitedHealthcare Medicare Advantage PPO	UnitedHealthcare	(877) 647-9423	www.uhcretiree.com
Dental Plan	MetLife	(855) 676-9442	www.mybenefits.metlife.com
Vision Plan	Davis Vision	(800) 999-5431 Client code 7955	www.davisvision.com/member Client code 7955
Employee Retirement Fund (civilian)	N/A	(214) 580-7700	www.dallaserf.org
Dallas Police and Fire Pension (uniform)	N/A	(800) 638-3861	www.dpfp.org



This brochure highlights the main features of the City of Dallas Retiree Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. City of Dallas reserves the right to change or discontinue its retiree benefits plans at any time.

City of Dallas