City of Dallas

2021 Post-65 Retiree (Medicare) Benefits Enrollment Guide

Contents

Evidence of Coverage

The benefits information provided in this guide is a summary of what the Blue Cross and Blue Shield of Texas (BCBSTX) medical plans cover and what you pay. It does not list every service that BCBSTX covers or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of covered services. You can see it online at **www.cityofdallasbenefits.org**, or you can call (855) 855-2871. If you enroll in the plan, you will get information that tells you where you can go online to view your Evidence of Coverage.

Important: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Blue Cross Group Medicare Advantage Open Access (PPO) plans gives you more choices about your prescription drug coverage. Please see page 22 for more details.

Greetings City of Dallas Retiree

It is our pleasure to welcome you to your 2021 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!

The City of Dallas will offer two new Medicare plan choices, administered by Blue Cross and Blue Shield of Texas (BCBSTX), for 2021. These new BCBSTX plans are called the Blue Cross Group Medicare Advantage Open Access (PPO)[SM] plans and will replace our current UnitedHealthcare offerings.

Your covered benefits will stay the same. The new premiums will be lower than if we had stayed with the previous plans. Your out-of-pocket costs will be less or stay the same. And, you will be able to choose any providers in the nation that accept Medicare – most doctors and hospitals across the United States do.

Open Enrollment is October 19 – November 1, 2020. You MUST take action and choose a plan during this time if you wish to be covered under the City of Dallas health insurance benefits for 2021. If you do not choose a plan and enroll by the deadline, you will lose your group health plan coverage with no option to return.

Carefully review the plan options and choose the one that best meets your needs and budget. If you have any questions about plan choices, or if you need assistance enrolling in a plan, please call (855) 855-2871.

Enhanced benefits include:

- Combined medical and pharmacy coverage
- One ID card and one premium amount
- Access to the vast BCBSTX 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
  - SilverSneakers® Fitness Program
  - 24/7 Nurseline
  - Virtual Visits
  - Rewards Program
  - Hearing impairment devices
  - Preferred diabetes supply program
- And more!

How These Changes Affect You

- **Your current medical, prescription drug, dental, and vision plans will no longer be offered by the City of Dallas, and your coverage will end effective December 31, 2020.**
- **During Open Enrollment (October 19 – November 1, 2020), you MUST elect new plan options for 2021 if you want your benefits coverage to continue to be deducted from your pension check.**
- **If you decline coverage or take no action, 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 be automatically disenrolled from your UnitedHealthcare Medicare Advantage PPO plan coverage effective December 31, 2020.**

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.

Your Medical Plan Options for 2021

The following table and the rest of this 2021 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 through Blue Cross and Blue Shield of Texas (BCBSTX) for 2021: Medicare Advantage PPO Low and Medicare Advantage PPO High.
- Both plans offer comprehensive benefits and include both medical and pharmacy coverage.
- Your premiums will be deducted through the Pension Department.

Can I stay in my current plan?

- No. Your current UHC Medicare Advantage PPO plan, which includes prescription drug coverage, will end on December 31, 2020.

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) 576-0045**.

Questions?

If you have any questions, please call (855) 855-2871.

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 Blue Cross Group Medicare Advantage Open Access (PPO) medical plan options outlined in this guide.

If you need to add dependents not previously covered, you must provide supporting documentation during your enrollment period. Please be prepared to provide supporting documentation as outlined below. Documentation can be provided via fax to (513) 371-5559, through the My Selerix app, online through the enrollment process, or by e-mailing **yourenrollment@ebcoh.com**.

Type of Eligible Dependent	Required Documentation

Spouse	– Copy of Marriage License and Date of Birth
	– If Common-Law Marriage applies, please provide copies of two documents showing that you and your spouse live together.
	  – Lease or deed naming both partners
	  – Joint checking account statement
	  – Utility bills and/or credit accounts
	  – Will and/or life insurance policies

Domestic Partner	– Copies of two documents showing that you and your partner live together.
	  – Lease or deed naming both partners
	  – Joint checking account statement
	  – Utility bills and/or credit accounts
	  – Will and/or life insurance policies

Dependent Child Child who is married or unmarried up to age 26* and is the biological child, legally adopted child, 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 (QMCSO)
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.	**Additional documentation required for disabled dependents:** – Physician affirmation of such condition and dependence

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

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

How to Enroll

The City of Dallas offers two convenient ways for you to enroll in benefits.

Online

1. Log on to **https://standard.benselect.com/cityofdallas**. **Note:** You MUST have */cityofdallas* in your URL! The correct page has the City of Dallas logo in the upper-right corner and looks like the picture on this page.
2. At the ***Employee Login*** screen, enter your user name and PIN. Your user name is your first name.last name and your 4-digit birth year (Example: John Smith born in 1966 is ***john.smith1966***). Your PIN is 6 digits, composed of the last 4 digits of your Social Security number and the last 2 digits of your birth year. (Example: If the last 4 digits of your Social Security number are 1234 and you were born in 1966, your PIN would be *123466*). **Note:** You will be asked to change your PIN the first time you log in. Be sure to make note of your new secure PIN for future use.
3. Start your benefits enrollment by clicking ***Next*** to review your personal and dependent information. (Note: The ***My Benefits*** page provides a snapshot of your current benefit elections.)
4. Click ***Next*** to continue through each plan or click on the benefit plan names under ***My Benefits*** to enroll or waive coverage.
   - A check mark means "enrolled"
   - An X means "waived" or "not available to enroll"
   - A blank square means "not yet enrolled"
5. Once you have made your benefit elections, the ***Verify Your Benefits Election*** page will appear. Review your elections.
6. Click ***Next***, then sign the benefit confirmation form electronically using your PIN. You must complete this step for the system to process your elections.

If you have any questions about your 2021 benefits or need assistance with the enrollment process, please call (855) 855-2871.

By Phone

Benefit Specialists can enroll you over the phone as well. The call center is available to help you with questions, rates, and your enrollment. The call center is open during Open Enrollment, Monday – Friday, 8:15 a.m. – 5:15 p.m. To get started, just call (855) 855-2871.

MBI Number Required!

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

Supporting Documentation Required

Any selections that require evidence or documentation will not be accepted or finalized until documentation is provided. All required documentation must be provided prior to the close of the Open Enrollment period. (Example: If you wish to enroll a dependent child for the first time, you must provide the required supportive documentation at the time of enrollment and prior to the close of Open Enrollment, otherwise your dependent child will not be enrolled.)

You can provide dependent documentation in one of several ways:

- Upload it from your computer during the online enrollment process (follow the on-screen instructions)
- Send it from your Smartphone with the My Selerix app (available for free in the App Store and Google Play)
- Fax it to (513) 371-5559
- Email it to **yourenrollment@ebcoh.com**

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.

Reminders

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

1. **The Open Enrollment period for 2021 starts October 19, 2020 and ends on November 1, 2020**. If you want to continue to participate in the City of Dallas Retiree benefit plans for 2021, 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.**

How to Enroll for New Retirees after Open Enrollment

If you are planning to retire in 2021, call the Benefits Service Center before your retirement date to discuss retiree enrollment options and payroll deductions. You must enroll within 30 days of your date of retirement. You may be asked to pay half a month or one-half and a full month of retiree health premiums in advance, depending on the date of retirement. If you do not enroll within 30 days of your retirement date, the Benefits Service Center will presume that you have waived your retiree coverage with the City of Dallas. **You will not be eligible to participate in the City's health coverage in the future.**

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

Upon becoming Medicare eligible, you should follow 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.

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 2021, please call (855) 855-2871 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 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. You must also contact the City of Dallas Benefits Service Center at (214) 671-6947, option 1, or **hrbenefits@dallascityhall.com**.

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. You will no longer be eligible to continue dental and/or vision through the City of Dallas upon waiver of medical coverage.

Duplicate Medical Coverage by Retiree

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

Important Information

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

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

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

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

Benefits Information for Certain Medicare-Eligible Retirees

If you have any questions, please contact (855) 855-2871. In the next few months, you will receive a letter from your Medicare Part D provider to alert you of the following information.

- Welcome kit, which will include:
  - 2021 Formulary List
  - Summary of Benefits
  - Mail-order information
  - Pharmacy Directory
- Explanation of Coverage (EOC)

The documents listed above will require no action on your part because you are already enrolled. However, if you receive a Late Enrollment Penalty Letter, you are required to complete and return as instructed in the letter. 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 2021 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	
Tier	**High Option**	**Low Option**
Retiree Only	$328.70	$266.50
Retiree + Spouse	$657.40	$533.00
Spouse Only	$328.70	$266.50

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

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

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

If you decide to enroll in a Blue Cross Group Medicare Advantage Open Access (PPO) plan, BCBSTX will send you more plan details in the mail. Until then, please call (855) 855-2871 with any questions.

Blue Cross Group Medicare Advantage Open Access (PPO) Plans

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

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

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

Blue Cross Group Medicare Advantage℠ Prescription Drug Coverage

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

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

Description of Benefit	Retail Pharmacy Preferred/Standard			Mail-Order Preferred/Standard		
	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Deductible	$0 deductible					
The following copays will apply up to the Initial Coverage Limit (ICL) amount of $4,130						
Tier 1 — Preferred Generic	$5/$10	$10/$20	$15/$30	$5/$10	$10/$20	$10/$20
Tier 2 — Generic						
Tier 3 — Preferred Brand	$20/$25	$40/$50	$60/$75	$20/$25	$40/$50	$40/$50
Tier 4 — Non-Preferred Brand	$45/$50	$90/$100	$135/$150	$45/$50	$90/$100	$90/$100
Tier 5 — Specialty						
The following copays will apply for the Coverage Gap until member reaches the True Out-of-Pocket (TrOOP) amount of $6,550						
Tier 1 — Preferred Generic	$5/$10	$10/$20	$15/$30	$5/$10	$10/$20	$10/$20
Tier 2 — Generic						
Tier 3 — Preferred Brand	$20/$25	$40/$50	$60/$75	$20/$25	$40/$50	$40/$50
Tier 4 — Non-Preferred Brand	$45/$50	$90/$100	$135/$150	$45/$50	$90/$100	$90/$100
Tier 5 — Specialty						
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the greater of: – 5% of the cost, or – $3.70 copay for generic (including brand drugs treated as generic) and a – $9.20 copayment for all other drugs						

PLEASE NOTE:

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

Dental Coverage

The City of Dallas offers two dental plans through Delta Dental – Dental PPO and Dental HMO. Both plans offer valuable features to save you money on dental care.

Dental Plan Comparison	Dental PPO	Dental HMO
Choice of Dentist	You may use any dentist you wish. When you choose a Delta Dentist, though, you receive service at discounted prices. When you use a non-Delta dentist, you pay more out of your own pocket since you're responsible for 100% of the amount the dentist charges that exceeds Delta Dental's program allowance.	Plan requires you to pre-select in-network dentists at the time of enrollment.[1] You MUST pre-select a dental provider to be able to use your benefits. You will not be able to see a dentist until you select a provider.
Specialty Care	No referral needed	Your dentist will provide you with a referral to an in-network specialist.
In-Network Discount	Participating dentists have agreed to accept negotiated fees as payment in full for in-network services.	Plan provides access to hundreds of dental services that may be lower than your cost would be without the plan.[2]
Benefits	Plan covers a percentage of an in-network dentists negotiated fee or the program allowance for non-Delta Dental dentists.	Plan has no annual maximums, deductibles or claims. You are responsible for the copayments for each covered procedure performed.

Finding a Delta Dental Participating Dentist

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

[1] If your first-choice provider is no longer accepting DHMO patients or is no longer a part of the DHMO network, you must select another in-network provider before plan benefits can begin.

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

* If you do not locate a provider in the PPO network, your next best option is to search for a Delta Dental Premier dentist before selecting a non-Delta dentists.

Create an Online Account with Delta Dental

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

Dental PPO Plan

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

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

	In-Network % of Negotiated Fee*	Out-of-Network % of Program Allowance*
Deductible (Per Person)**	$50	$50
Annual Maximum Benefit (Per Person)	$1,750	$1,750
Orthodontia Lifetime Maximum (Per Person)	$1,750	$1,750
Coverage Type	**Plan Pays**	**Plan Pays**
Preventive[1]		
– Exams – Cleanings (2 per calendar year) – X-rays – Sealants [1] Services do not apply to annual maximum	100%	100%
Basic		
– Fillings – Extractions – Oral surgery – Non-surgical Periodontics – General Anesthesia: When administered by a provider for covered oral surgery or selected endodontic and periodontal surgical procedures.	80% after deductible	80% after deductible
Major†		
– Crowns, dentures, bridges – Endodontics – Surgical Periodontics †Implants not covered	50% after deductible	50% after deductible
Type D – Orthodontia (Adults and Dependent Children up to Age 26)		
– All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia	50%	50%

Dental PPO Monthly Rate	
Retiree Only	$44.54
Retiree + Spouse	$81.94
Retiree + Child(ren)	$83.00
Retiree + Family	$115.78

* 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 limitations, additional charges, and 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.

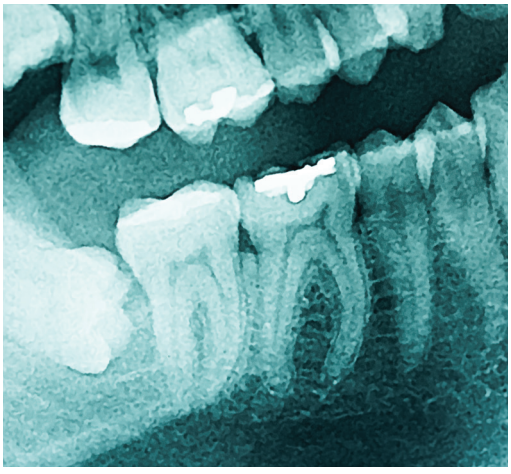
Here are some of the services in this plan, all of which will help you lower your dental care costs.

	Copayment
Office Visit	$5 per visit (including all fees for sterilization and/or infection control)
Preventive Services Visit (cleanings, exams, fluoride, X-rays)	No cost
Crowns	$160 – $380 (resin, porcelain, metal, or titanium)
Orthodontics	$2,100 adults* $1,900 children*
Osseous surgery	$275 – $345
Root canals	$110 – $380
Extractions	$5 – $130 (higher cost for impacted tooth)
General anesthesia & IV sedation	$80
Cleanings (every 6 months)	No cost per 6-month period; Additional cleanings within the 6-month period: $45 adults/$35 children
Periodontal cleanings (every 6 months)	$40 per 6-month period; additional periodontal cleanings within the 6-month period: $55
Implants	Not covered

Dental HMO Monthly Rate	
Retiree Only	$12.34
Retiree + Spouse	$22.70
Retiree + Child(ren)	$22.82
Retiree + Family	$32.10

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

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



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** for High Plan or **9573** for Low Plan) to find providers in your network.

In-Network Benefits	High Plan	Low Plan
Frequency		
Eye exam	Once every calendar year	Once every calendar year
Contact lens evaluation and fitting	Once every calendar year	Once every calendar year
Frames	2 pairs per calendar year or mix and match with contacts	Once every other calendar year
Spectacle lenses	Once every calendar year or mix and match with contacts	Once every calendar year
Contact Lenses	2 pairs per calendar year or mix and match with glasses	Once every calendar year in lieu of glasses
Copay	YOU PAY	YOU PAY
Eye exam	$10	$10
Retinal imaging	$39	$39
Contact lens evaluation, fitting, and follow-up care	$10	$20
Spectacle lenses	$10	$20
Frames	YOU PAY	YOU PAY
Any frame in the eye care professional's office	20% off balance after $150 allowance[1] **OR** Covered-in-full frames at Visionworks locations[3]	20% off balance after $140 allowance[1] **OR** Covered-in-full frames at Visionworks locations[3]
Davis Vision Fashion/Designer/ Premier frame collection[1]	$0/$0/$0 (in lieu of allowance)	$0/$0/$25 (in lieu of allowance)
Spectacle Lenses	YOU PAY	YOU PAY
Single vision, lined bifocal, lined trifocal, lenticular, oversize	$10	$20
Gradient or solid tinting	$0	$15
Basic scratch-resistant coating	$0	$0
Polycarbonate lenses	$0	$0[3] or $35
UV coating	$0	$15
Standard AR coating	$0	$40
Standard progressive	$0	$65
Contacts		
Evaluation and Fitting – Davis Vision collection – Non-Davis Vision collection	$10 15% discount after $60 allowance[1, 4]	$20 15% discount after $60 allowance[1, 4]
Elective – Davis Vision collection[2] – Non-Davis Vision collection	$0 (up to 8 boxes) 15% discount after $130 allowance[1, 4]	$0 (up to 4 boxes) 15% discount after $130 allowance[1, 4]
Visually required (with prior approval)	$0	$0

How to Locate an In-Network Eye Care Professional

Visit **www.davisvision.com/members** or call 1 (877) 923-2847. Enter client code **7955** (High Plan) or **9573** (Low Plan), and then choose *Find an eye care professional*.

Out-of-Network Benefits	Reimbursement Amount		Claims
	HIGH PLAN	LOW PLAN	
Eye exam	Up to $40	Up to $45	Pay the provider directly for all charges and then submit a claim for reimbursement to: **Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110** Or, submit your claim via the Davis Vision mobile app.
Frames	Up to $50	Up to $50	
Spectacle lenses (single vision/bifocal/trifocal/lenticular)	Up to $40/$60/$80/$100	Up to $40/$60/$80/$90	
Contact lenses (elective/visually required)	Up to $105/$225	Up to $120/$225	

Value-Added Features and Extras

- **Paid-in-full eyeglasses and contacts.**
  - Frame collection[1]: The plans include a selection of designer, name-brand frames that are covered for no more than a $25 copay.
  - Contact lens collection [1, 4]: Select from the most popular contact lenses on the market today with Davis Vision's contact lens collection.
- **One-year eyeglass breakage warranty** included on plan eyewear at no additional cost.
- **A national network of top-notch eye care professionals** throughout the 50 states.
- **Use your in-network benefits to shop online** at 1-800-Contacts, **Befitting.com**, and **Glasses.com**.
- **Freedom of choice** with access to care through either Davis Vision's network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.
- **Additional value-added features.**
  - 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.
  - Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction through QualSight. For more information, visit **www.davisvision.com**. In addition, a one-time/lifetime allowance of $500 is available.
  - Hearing services receive discounts of up to 40% off with the Your Hearing Network.

Vision Monthly Rate	High Plan	Low Plan
Retiree Only	$6.64	$5.16
Retiree + Spouse	$12.16	$9.42
Retiree + Child(ren)	$12.74	$9.88
Retiree + Family	$19.58	$15.18

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.

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 a City 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 2020
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:

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

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

Our Privacy Principles

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

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

This notice explains how we may use and disclose your health information to provide benefits to you and our promise to protect your health information. We understand the importance of maintaining the privacy of this information. We are guided by your rights to make inquiries about how we use or disclose your health information. This notice describes rights according to the Privacy Rule and our legal obligations regarding them. We shall abide by the terms of this notice for all health or medical information retained by the OHCA. In this notice the terms "we," "our," and "OHCA" are used interchangeably to refer to the separate plans and program listed above as part of the City of Dallas Health and Wellness OHCA. The term "health information" refers to the information about you, your spouse, or your dependent(s) that is used or disclosed to the OHCA concerning your physical or mental health or the medical services you received, your health benefits and payments. Health information includes all 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 BlueCross BlueShield of Texas (BCBSTX), or BCBSTX-Prime Therapeutics, 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
Benefit Plans	**Blue Cross Group Medicare Advantage Open Access (PPO) Plans** (Medical and Prescription Drug) Phone: (888) 984-4103 TTY 711 **Davis Vision** – Vision Plan Phone: (800) 999-5431 **Delta Dental** – Dental Plan Phone: (800) 521-2651 (DPPO) (800) 422-4234 (DHMO)
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

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.

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

Continuation of Health Coverage During Family & 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 laws and any pertinent regulations, and its interpretation is governed by them. See the City of Dallas Personnel Rules to find out how this continuation applies to you. For the duration of 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 they 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.

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 typically opens in October or November, with plans effective on January 1, 2021. 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

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the City of Dallas Benefits Service Center at (214) 671-6947 Option 1.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name City of Dallas		**4. Employer Identification Number (EIN)** 75-6000508
5. Employer Address 1500 Marilla Street, 1DS		**6. Employer Phone Number** (214) 671-6947 Option 1
7. City Dallas	**8. State** TX	**9. ZIP Code** 75201
10. Who can we contact about employee health coverage at this job? The City of Dallas Benefits Service Center		
11. Phone Number (if different from above)		**12. Email Address** hrbenefits@dallascityhall.com

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

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

- Full-time permanent employees, permanent part-time employees and variable hour employees who are intended to work at least 30 hours per week on average

With respect to dependents, we do offer coverage. Eligible dependents are:

- A spouse, children up to age of 26 years, and grandchildren

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

Benefit Participation Upon Retirement

Per Article IV SEC. 34-32 (4) of the City of Dallas Personnel Rules, if a person is not participating in the city's health benefit program at the time the person retires from the city, the person is not eligible for continued health benefits coverage.

Notes

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Notes

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**
Blue Cross Group Medicare Advantage Open Access (PPO) Plans	Blue Cross and Blue Shield of Texas	(888) 984-4103 TTY 711	**www.getbluetx.com/mapd**
Benefits Enrollment	Enrollment Benefit Concepts (EBC)	(855) 855-2871	**https://standard.benselect.com/cityofdallas**
Dental Plan	Delta Dental	(800) 521-2651 (DPPO) (800) 422-4234 (DHMO)	**www.deltadentalins.com**
Vision Plan	Davis Vision	(800) 999-5431 Client code: 7955 (High), 9573 (Low)	**www.davisvision.com/member** **Client code:** **7955 (High), 9573 (Low)**
Employee Retirement Fund (civilian)	N/A	(214) 580-7700	**www.dallaserf.org**
Dallas Police and Fire Pension (uniform)	N/A	(800) 638-3861	**www.dpfp.org**

For 2021 benefits and enrollment questions, please call (855) 855-2871.

For all other benefits questions, please call the Benefits Service Center at (214) 671-6947, option 1.

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.

PPO plans provided by Blue Cross and Blue Shield of Texas, which refers to HCSC Insurance Services Company (HISC). PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC and HISC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and HISC are Medicare Advantage organizations with a Medicare contract. Enrollment in these plans depends on contract renewal.

City of Dallas