CITY OF TYLER

Enrollment Guide

Benefits Year 2020

The information in this enrollment guide is intended to help you enroll in your 2020 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern.

The City of Tyler reserves the right to change or terminate benefits at any time. Neither the benefits, nor this enrollment guide, should be interpreted as a guarantee of future benefits.

Your 2020 Benefits

2020 Enrollment Guide

The Employee Benefit Enrollment Guide for 2020 was designed with you and your family in mind. In this valuable reference guide, we have included brief explanations of each benefit program, important plan information, comparison charts, contact information, phone numbers, and web addresses. This document is not just an enrollment guide, but it is an important resource for services and benefits provided to you as an employee with the City of Tyler. You will find the information you need to make informed decisions regarding the selection and continued management of your benefits.

How to Use This Guide

The Employee Benefit Guide is divided into sections, each covering a specific benefits program or option.
You will find important information regarding:

- **Medical Plan**
- **Dental Plan**
- **Vision Plan**
- **Basic, Supplemental and Dependent Life Insurance**
- **Short Term Disability**
- **Flexible Spending Account**
- **COBRA**
- **HIPAA**

Glossary of Terms

This section of definitions has been added to assist you with the terminology used by certain benefit plans as referred to in this guide. Refer to page 5.

IMPORTANT NOTE:

Please review your selected benefits carefully because the benefits that you select will be effective through the next plan year which begins January 1, 2020. Unless you have a HIPAA qualifying life event.

A HIPAA qualifying life event allows you to make changes to your current coverage by adding or deleting dependents; or, changing benefit plans as appropriate. Please see your Human Resources representative regarding more information about qualifying events.

How to Enroll Online?

All Employees will register and enroll at:
https://enroll.hfbenefits.com

To Register:

1. Click “New user registration” on the welcome screen.
2. Select “Employee Registration”
3. User Type: Employee
4. Enter group number: 0070053
5. Enter Social Security Number
6. Create a username and password
7. Follow all instructions and click next. Your account will be created and you are ready to enroll.

To Enroll or Change Benefits:

1. Click on the Next button under your status
2. Enter corporate code: 7005318
3. Enter Enrollment Personal Information; fields marked by a blue diamond are required.
4. Select Plan information.
5. Add your spouse and dependents.
6. Complete spouse/dependent plan elections.
7. Click next to continue to the New Enrollment Review page.
8. From that page, all employees must follow the link to complete the Coordination of Benefits form.
9. Also from that page, employees adding or removing a dependent, or changing a status should follow the link to complete the Eligibility form.

Everyone

- Group number 0070053
- Corporate Code 7005318
- Social security number for yourself and dependents

Add or Delete Spouse

- Marriage license
- Divorce decree

Adding Dependent

ONE or more of the following:

- Birth certificate
- Qualified child support order
- Adoption papers
- Court documentation for foster child
- Proof of income tax deduction

IMPORTANT NOTE:

- Open Enrollment starts November 11th through November 22nd. The system will close November 22nd at midnight.

Glossary of Terms

Allowed Fees
Term used by some dental plans for their participating dentist fees and/or maximum payable for a non-participating dentist.

Annual Deductible
The amount you must pay for covered health services based on contracted rates (also referred to as eligible charges/expenses) in a year before the plan will begin paying certain benefits in that year.

COBRA
Consolidated Omnibus Budget Reconciliation Act of 1985. This Act requires that continuation of group insurance be offered to covered persons who lose health, dental or vision coverage due to a qualifying life event as defined in the Act.

Co-insurance
The portion of covered health care costs for which the covered person is financially responsible, usually according to a fixed percentage. Co-insurance may be applied after a deductible requirement is met.

Co-payment
The charge you are required to pay for certain covered health services, such as a prescription or office visit.

Eligibility
Eligibility for benefits will begin following a 90 day waiting period after regular full-time employment hire date.

Explanation of Benefits (EOB)
A summary of claims processed which will be provided to you after a claim is processed for you or for a dependent. This statement outlines year-to-date deductible and out-of-pocket amounts met during the year. This statement is available online. Some carriers mail them to your house, if requested.

Incurred Expense
An expense is considered incurred on the date services were rendered or supplies were received.

Initial Enrollment Period
The first 31 days of full-time employment or 30 days from a covered life event.

Out-of-Pocket Maximum
The maximum amount of co-insurance you pay every year. Once you reach the out-of-pocket maximum, as an individual or family, benefits for those covered health services that apply to the out-of-pocket maximum are paid at a percent of eligible charges during the rest of that year. Deductibles and co-pays do not always apply to the out-of-pocket maximum. Check with your carrier or plan description for specific details.

Plan Year
January 1, 2020 through December 31, 2020.

Tips

Important Tips:

- Take the time to carefully review the guide for any changes or updates.
- Visit each vendor's website for additional information. Don't forget to review each plan's provider directory.
- If your physician or doctor's office is not considered in-network, you cannot change or drop plans mid-year without a qualifying life event. For additional questions, feel free to contact Customer Service as listed.
- Be sure to choose the right coverage level, such as Employee Only, Employee/Spouse, Employee/ Children or Employee/Family.
- Gather the correct information for your dependents such as social security numbers and birth dates. If adding children you will need a copy of their birth certificate. If adding a spouse you will need a copy of your marriage license.
- Make sure your address and personal information is current. If your information is not up-to-date, you may miss out on important information such as insurance cards, plan documents, health notices, etc. You must fill out an address change form in order to change your address.
- Do you need to change your beneficiary due to divorce, marriage or other life event? Open Enrollment is an excellent time to ensure that the person designated as your beneficiary is correct regarding your life insurance and retirement benefits.
- Make sure your physician is In-Network.
- Your cannot change or drop plans or add a dependent mid-year without a qualifying event.

Getting Started

Employee Eligibility

If you are a full-time employee regularly scheduled to work 40 hours or more a week or a part-time employee scheduled to work 30 hours or more a week you are eligible to enroll in the benefit plans described in this Employee Benefit Guide.

If enrollment is not completed within 30 days, you will have no coverage for the remainder of the plan year for the following voluntary plans:

- Medical Plan for yourself or dependents;
- Dental Plan;
- Vision Plan;
- Supplemental Life Insurance Plan;
- Accidental Death & Dismemberment Plan; and
- Flexible Spending Account.; and
- Short Term Disability

Eligible employees are automatically enrolled in the basic term life and accidental death and dismemberment. You must designate your beneficiary for your basic term life and accidental death and dismemberment insurance coverage upon your enrollment.

Dependent Eligibility

Dependent: the employees legal spouse or a dependent child of the employee or the employee's spouse. The term child includes:

- A natural child;
- A stepchild;
- A legally adopted child; or,
- A child for whom legal guardianship has been awarded.

Dependent children are eligible for insurance until age 26. Please keep in mind, you may be required to furnish evidence of dependency during random eligibility audits conducted by an outside consultant.

New Hire Coverage and Waiting Period by Benefit Coverage:

The waiting period for medical, dental, vision, short term disability, and basic life is 90 days following the date of employment.

You are required to enroll no later than 30 days after your first day of regular, full-time or eligible part-time work with the City.

Qualifying Events

Personal Life Changes / Family Status Changes

The City of Tyler Benefits Plan is regulated by federal laws that may restrict you when changing your elections. You may request a benefit change during the year under the Medical, Dental, Vision, Flexible Spending Account, Supplemental Life, Dependent Life or Voluntary. Accidental Death and Dismemberment plans only if you have any of the following life changes that affect eligibility or coverage:

- Your marital status changes due to marriage, death of your spouse, divorce, or annulment;
- The number of your dependents for federal income tax purposes changes due to birth, adoption, placement for adoption, or death. If you gain a new dependent and already have family coverage, you still must submit a status change request within 30 days of your change to add the new dependent to any coverage.
- **Having existing family coverage DOES NOT automatically enroll the new dependent.**
- You or your eligible dependent begin or end employment;
- You or your eligible dependent experience a change in employment status that affects eligibility for benefits;
- You or your dependent become entitled to coverage or lose coverage under Medicare or Medicaid; or
- Your spouse's employer offers benefit plans with a different plan year that affects your coverage.

The Benefits Administrator will determine whether your requested change is a qualified life event.

Contact Human Resources within 30 days of the qualifying event.

They are referred to as life changes, qualifying events, family status changes, IRS changes. Regardless of the terminology, your new election must be consistent with your status change. Consistent means the change must result in the gain or loss of coverage by you, your spouse, or any of your dependents and the new election must reflect that gain or loss. An employee with current coverage may add or delete dependents to or from that coverage.

Medical Plan Costs

Plan	Semi- Monthly Employee Contribution	Monthly Employee Contribution
Employee Only	$27.65	$55.30
Employee + Spouse	$145.71	$291.42
Employee + Child(ren)	$113.22	$226.44
Employee + Family	$197.43	$394.86

** Cost for up to 3 children - An additional premium of $15.15 semi-monthly or $30.30 per month will be added for each additional child over 3.

Medical Benefits Summary

	Benefit By Type of Network		
	Platinum Access Direct In-Network	**Wrap In-Network**	**Out-Of-Network**
Maximum Benefit - maximum dollar amount that your insurance company will pay out during your lifetime for non-essential healthcare services.	Unlimited	Unlimited	Not Covered
Coinsurance- the portion you pay of the share of the payment made against a claim.	20%	30%	Not Covered
Individual Deductible - The amount you pay for covered health care services before your insurance plan starts to pay.	$1,000	$1,600	Not Covered
Family Deductible - Coverage begins for the entire family, even those family members who haven't met their individual deductibles yet, as soon as the family deductible is met.	$3,000	$4,800	Not Covered
Individual Out-of-Packet Maximum- - The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.	$6,350	$6,350	Not Covered
Family Out-of-Pocket Maximum- The maximum amount that an entire family unit on a health insurance plan will be responsible for.	$12,700	$12,700	Not Covered
Physician Office Copay- A fixed amount you pay for a covered health care service at a regular office visit after you've paid your deductible.	$30 copay	30% after deductible	Not Covered
Specialist Office Copay- A fixed amount you pay for a covered health care service at an office visit with a specialist after you've paid your deductible.	$30 copay	30% after deductible	Not Covered
Preventive Care- the care you receive to prevent illnesses or diseases.	Covered at 100%	Covered at 100%	Not Covered
Emergency Room Copay- A fixed amount you pay for an emergency room visit	$250 copay/visit True Emergency 20% coinsurance In-network NOT true Emergency	$250 copay/visit True Emergency 30% coinsurance In-network NOT true Emergency	$250 copay/visit True Emergency; Not Covered if NOT true Emergency
Urgent Care Copay- A fixed amount you pay for a walk-in clinic visit focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency room. Urgent care centers primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an ER visit.	$30 copay per visit	30% after deductible	Not Covered

Medical Benefits Summary

	Benefit By Type of Network		
	Platinum Access Direct In-Network	**Wrap In-Network**	**Out-Of-Network**
Hospital Inpatient - the portion you pay of the share of the payment made against a claim care of patients whose condition requires admission to hospital.	20% after deductible*	30% after deductible*	Not Covered
Outpatient - the portion you pay of the share of the payment made against a claim care of patients whose condition does not require admission to a hospital	20% after deductible	30% after deductible	Not Covered
Home Health Care - services that can be given in your home for an illness or injury.	20% after deductible	30% after deductible	Not Covered
Skilled Nursing Facility - a health-care institution that meets federal criteria for Medicaid and Medicare reimbursement for nursing care including especially the supervision of the care of every patient by a physician, the employment full-time of at least one registered nurse, the maintenance of records concerning the care and condition of every patient, the availability of nursing care 24 hours a day, and the presence of facilities for storing and dispensing drugs.	20% after deductible*	30% after deductible*	Not Covered
Mental Illness/Substance Abuse Inpatient - 24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.	20% after deductible (services must be precertified)	30% after deductible (services must be precertified)	Not Covered
Outpatient - includes services that are usually provided outside a hospital, like in these settings: A doctor's or other health care provider's office, hospital outpatient department, a community mental health center	$30 copay per visit	30% after deductible	Not Covered
Telemedicine - Refers to the practice of caring for patients remotely when the provider and patient are not physically present with each other. Only covered through Teladoc.	$0 copay when using Teladoc		Not Covered

***Services must be pre-certified.**

Prescription Drug Benefits

Prescription drug coverage provided by CerpassRX is included for employees enrolled the City's medical plan.

	30 Day Supply	90 Day Supply	Mail order
Specialty:	$125 copay	Not Covered	Not Covered
Non-Preferred Brand:	$100 copay	$250 copay	$300 copay
Preferred Brand:	$60 copay	$150 copay	$180 copay
Generic:	$15 copay	$37.50 copay	$45 copay

How do I search for in-network pharmacy?

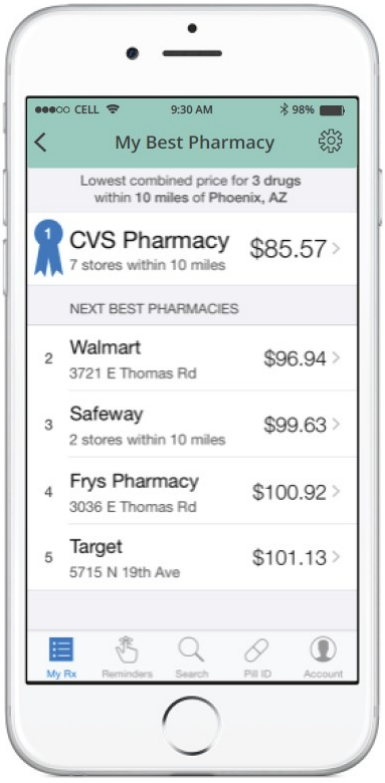
Access your private, secure member portal today. Visit www.cerpassrx.com - Member Portal

MEMBER PORTAL

This private, secure website is designed just for you. All of your pharmacy plan information is available and kept up-to-date in real time.

EASY ACCESS ALLOWS YOU TO:

- Manage all your prescriptions on a single dashboard
- Update your information and complete health profile for home delivery
- Compare prices at local pharmacies
- Find your lowest prescription cost
- Locate your pharmacy and get driving directions
- Keep track of your health history
- Learn more about your drugs
- Take it all with you through the mobile app



WITH THE MOBILE APP IN YOUR POCKET:

- Stay on top of medication refills. See when refills are due, get refill reminders and quickly contact your pharmacy.
- Show your doctor exactly what medications you are taking.
- Pull up your medication history anytime.
- Learn about medication side effects and interactions.
- Find network pharmacies by ZIP code or location, then check and compare current prescription prices.
- Learn ways to save on your prescription by switching from brand name to generic or splitting a higher dosage pill.
- Track individual and family spend

HOW TO REGISTER

Visit http://www.cerpassrx.com/members-page/ and click on the member portal button. With your CerpassRx ID card handy, click"activate your account". From there, enter your member ID (as shown on your ID card) and proceed with completing your personal information to activate your account.

Questions? Call member services at 844-636-7506.

CERPASSRX

How to find an in-network provider:

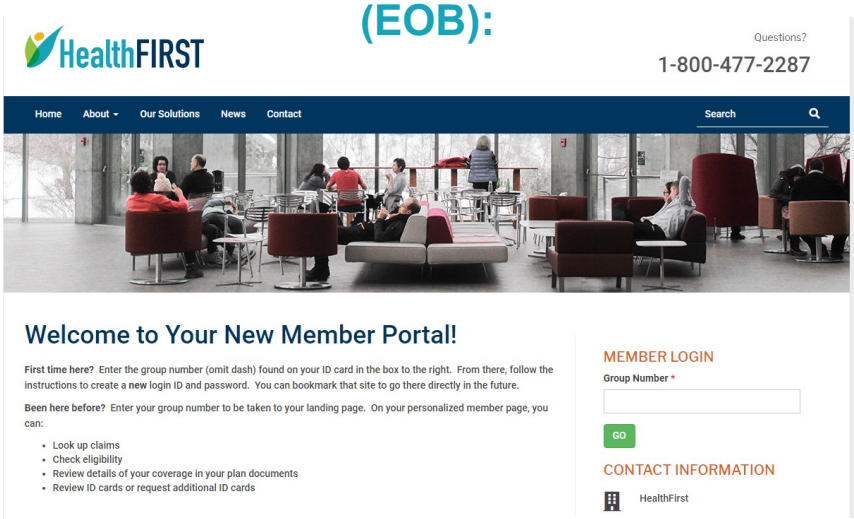
Platinum Access Direct

1. Go to www.adppo.com
2. Click “Find a Provider”
3. “Agree” to terms
4. Enter: 0070053 in the “please enter your group #” box - click “next step”
5. Enter your Zip Code or City and check whether you are looking for a “facility” or “physician”
6. You can search for a physician by name or specialty

Wrap In-Network

1. Go to www.uhss.welcometouhc.com/find-a-doctor
2. Click “UnitedHealthcare Options PPO”
3. Make sure to “change location” to your location

Downloading or viewing your explanation of benefits (EOB):

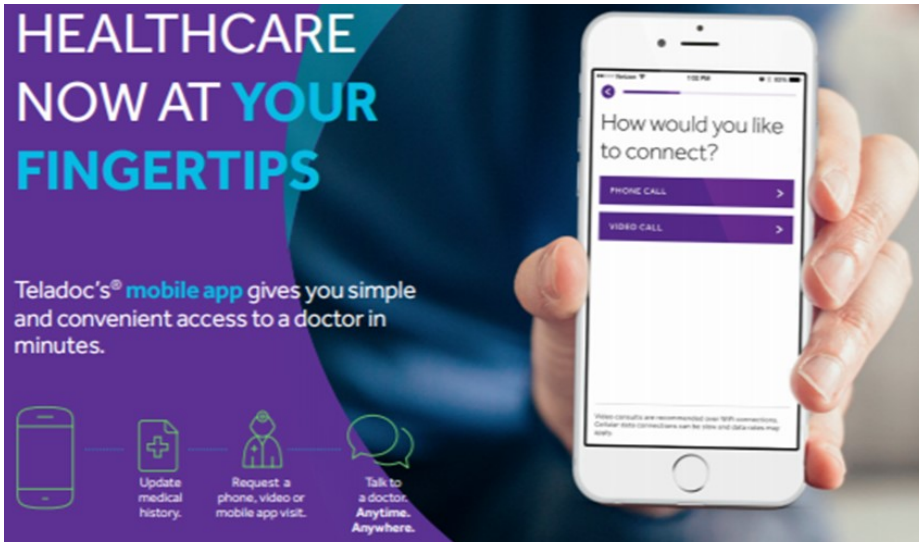


1. Go to www.hfbenefits.com/enrollment.
2. Enter: 0070053 into the “group number” box located on the right of the screen.
3. For new users, click “new user registration” to register, for returning users, enter your UserID and password or if forgotten click “I forgot my UserID or password”.
4. Once logged in, hover over “inquiry” at the top of the screen and choose “claims inquiry” from the drop down.
5. Enter your information and click “next”. The easiest way to sort is by name or Social Security Number.
6. Select the family member you would like to view from the “select a name” drop down box. Enter the date of service range you would like to view and click “submit”.
7. Select “view detail” for the EOB you would like to view. (far left column)
8. You will arrive on a new page specific to the claim selected. There will be a an “EOB/Checks” button in the middle of the page, located on the right side. This will allow you to view and print your EOB.

Teladoc gives you 24/7/365 access to U.S. board-certified doctors through convenience of phone, video or mobile app visits. City of Tyler is providing Teladoc with a $0 copay to health plan participants. It's a free alternative to costly urgent care and ER visits when you need care now.

WHY TELADOC?

- When you need care now
- If you're considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip or away from home
- For short term prescription fills



GET THE CARE YOU NEED

- Cold and Flu Symptoms
- Allergies
- Bonchitis
- Pink Eye
- Ear Infections
- Urinary Tract Infections
- Nasal Congestion
- Sinus Problems
- Sore Throat
- Respiratory Infection
- Skin Problems
- And more!

Create Account
Use your phones, the app, or our website to create an account and quickly complete your medical history.

Request a Visit
Use your device to request a visit and a Teladoc doctor will contact you at the requested time.

Feel Better
Your doctor will diagnose your symptoms and even prescribe medicine if needed.

Talk to a doctor anytime!

Teladoc.com
1-800-TELADOC (835-2362)

Available on the iPhone App Store
ANDROID APP ON Google play

Frequently Asked Questions

Q. When does coverage begin?

A. The coverage you select during Open Enrollment will begin January 1, 2020 and will remain in effect until December 31, 2020. **New Hires** coverage begins 90 days after hire date.

Q. If I am already enrolled and not making any changes, do I have to complete the Open Enrollment process?

A. No, if you are not making any changes, you do not need to complete open enrollment. Please see page 4 of this guide for instructions.

Q. If I want to decline coverage, must I still complete the Open Enrollment process?

A. Yes, only if you are currently enrolled. It is important that Human Resources has a record of your decision to cancel those coverages. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special qualifying event such as a marriage, divorce, birth or adoption of a child, or loss of other coverage.

Q. Can I drop or change plans during the plan year?

A. Changes can only be made if there has been a qualifying event or personal life change. Examples include marriage, divorce, birth of a child, or change in employment status. All changes must be completed within the first 30 days of the life event.

Need to locate a network physician or hospital?

Call Direct: 866-219-1592
Or visit www.adppo.com for Platinum Access Direct or
www.uhss.welcometouhc.com/find-a-doctor for Wrap In-Network

See page 12 for additional instructions

Dental Plan

Benefits	Delta Dental PPO Plan
Network	**DPO / Premier**
Deductible	$50 Individual $150 Family
Deductible Waived for Preventive	Yes
Diagnostic/Preventive	100%
Restorative/Basic	80%
Major	50%
Endodontics and Periodontics	Basic
Waiting Period	New Hires: 90 days
Calendar Year Maximum	$1,200
R&C Percentage	90%
Orthodontia Coverage	50%
Orthodontia Maximum	$1,000

QUICK INDICATORS

- ✓ Free to visit a dentist of your choice
- ✓ No balance bill if services are provided in-network
- ✓ Must meet a Deductible—$50
- ✓ Maximum annual Benefit—$1,200
- ✓ Includes Child Orthodontic Benefits

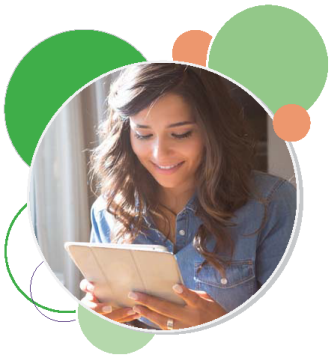
Enrollment Tier	Semi- Monthly Employee Contributions	Monthly Employee Contribution
Employee Only	$4.91	$9.82
Employee + Spouse	$18.05	$36.10
Employee + Child(ren)	$17.48	$34.96
Employee + Family	$27.17	$54.34

Need to locate a network dentist or orthodontist?

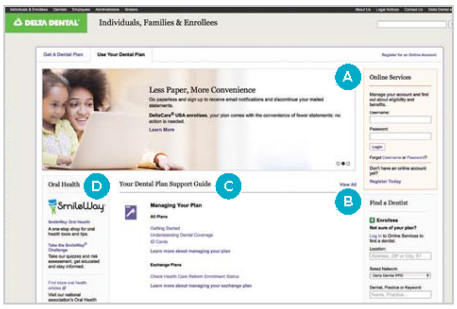
Log on to www.deltadentalins.com or Call customer service at 1-800-521-2651.

DELTA DENTAL

Stay Connected



Check the site



1. Enter **deltadentalins.com/enrollees** on your computer's browser.
2. Browse the features listed below. If you haven't already done so, register for Online Services. Already got an account? Log in!

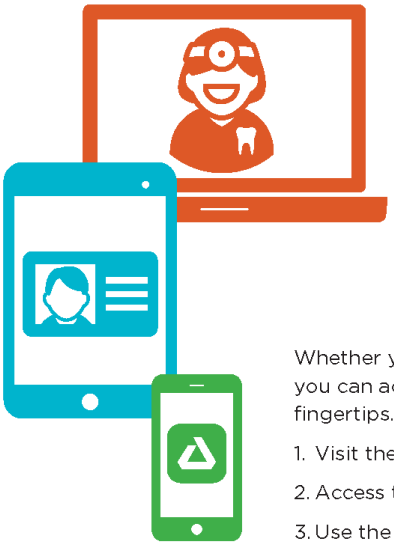
Features:

A. **Online Services** (register or log in): See benefits, eligibility, deductibles and maximums; check claims; view or print an ID card

B. **Find a dentist**

C. **Dental Plan Support Guide**

D. **SmileWay® Wellness site**



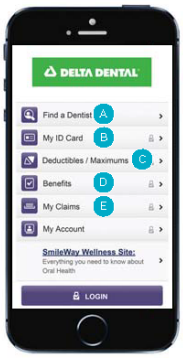
Want information about your dental plan? Take advantage of our web and mobile resources to:

- **check your eligibility**
- **look up coverage details**
- **check claims**
- **find a network dentist**
- **improve your oral wellness**
- **and more**

Whether you're on a computer, tablet or smartphone, you can access all the information you need at your fingertips.

1. Visit the **website**
2. Access the **mobile-optimized site**
3. Use the **free app**

Go mobile[1]



1. Enter **deltadentalins.com** on your smartphone's browser.
2. Click the **Visit Mobile Site** button.

Features:

A. **Find a dentist**

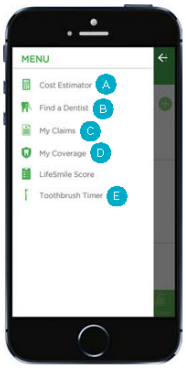
B. **View your electronic ID card**

C. **Check deductibles and maximums**

D. **See your benefits and eligibility**

E. **Check claims**

Get the app[2]



1. Open the **App Store** or **Google Play**.
2. Search for "**Delta Dental.**"
3. Download the free app titled **Delta Dental** by Delta Dental Plans Association.

Features:

A. **Get a cost estimate**

B. **Find a dentist**

C. **Check claims**

D. **See your benefits, eligibility, deductibles and maximums**

E. **Use a musical timer to brush for 2 minutes**

¿Habla español?

es.deltadentalins.com

We keep you smiling®
deltadentalins.com/enrollees

Vision Plans

Vision coverage is provided through Superior Vision. The plan pays benefits for annual exams and corrective lenses. You pay a co-payment for exams, and the plan pays benefits for frames and lenses up to certain limits. Under this plan, you may use in-network or out-of-network vision care providers, but you receive greater benefits when you use in-network providers.

The plan will pay for a comprehensive exam, lenses, frames once every 24 months, and contact lenses once every 12 months.

SUPERIOR VISION
See yourself healthy.

Gold $150 Buy Up Plan 1		
Coverage Level	**Employee Semi-Monthly Contributions**	**Cost per Month**
Employee Only	$3.07	$6.15
Employee + Spouse	$5.25	$10.50
Employee + Children	$5.57	$11.15
Employee + Family	$8.35	$16.70

Gold $100 Base Plan 2		
Employee Only	$2.75	$5.50
Employee + Spouse	$4.65	$9.30
Employee + Children	$4.95	$9.90
Employee + Family	$7.40	$14.80

Benefits	**Gold $150 Buy Up Plan 1**		**Gold $100 Base Plan 2**	
Exams	In Network	Out of Network	In Network	Out of Network
With Dilation	$10 co-pay	Up to $35 reimbursed	$10 co-pay	Up to $35 reimbursed
Lenses: Standard	Once every 12 months		Once every 12 months	
Single Vision	$25 co-pay	Up to $25 reimbursed	$25 co-pay	Up to $25 reimbursed
Bifocal	$25 co-pay	Up to $40 reimbursed	$25 co-pay	Up to $40 reimbursed
Trifocal	$25 co-pay	Up to $45 reimbursed	$25 co-pay	Up to $45 reimbursed
Frame	Once every 24 months		Once every 24 months	
	$150 allowance after $25 co-pay + 20% discount	Up to $70 reimbursed	$100 allowance after $25 co-pay + 20% discount	Up to $55 reimbursed
Contacts	Once every 12 months		Once every 12 months	
Elective Contact Lenses	$150 allowance after $25 co-pay + 20% discount	Up to $80 reimbursed	$125 allowance after $25 co-pay + 20% discount	Up to $65 reimbursed
Medically Necessary	$25 co-pay	Up to $150 reimbursed	$25 co-pay	Up to $150 reimbursed
Laser Vision Correction	$200 allowance		$200 allowance	

Basic Life Plans

Paid for you by City of Tyler

Benefits	Securian administer by Ochs
Employee Life Amount- Sum paid to beneficiary upon the insured's death	$10,000
Employee AD&D Amount- Benefits to the beneficiary if the cause of death is an accident	$10,000
Accelerated Benefit- Enables the policy holder to receive cash advances against the death benefit in the case of being diagnosed with a terminal illness	24 months expectancy 100% to $1,000,000
Age Reduction Formula– Amount life insurance starts reducing in face amount by percentage	35% at age 65 50% at age 70 70% at age 75+
Line of Duty– An additional amount of basic AD&D for public safety officers that suffer a loss while he or she is performing his or her customary duties for the City.	$10,000
Retiree Life Amount—Sum paid to beneficiary upon the insured's death	$5,000

Accidental Death and Dismemberment (AD&D) Insurance Coverage

If you are injured or die as a result of an accident, you or your beneficiary will receive a benefit based on the extent of the injury. AD&D pays benefits if death or dismemberment occurs within 365 days following the covered accident. AD&D insurance pays benefits in addition to any other benefits you receive under your life insurance coverage if you die as a result of an accident. The City of Tyler provides basic AD&D insurance coverage at no cost to you.

Voluntary Life & Accidental Death and Dismemberment for Employee and Dependents

Benefits	Securian administer by Ochs Employee Coverage
Employee Benefit - Sum paid to beneficiary upon the insured's death	$10,000 Increments
Employee Voluntary AD&D- Benefits to the beneficiary if the cause of death is an accident	Same as Life
Maximum Benefit - maximum dollar amount your beneficiary can expect to receive	$500,000
Guarantee Issue Amount- benefit amount offered to an applicant regardless of health. Note: Newly eligible employees only.	$250,000
Conversion - option which allows the insured to switch to a different type of policy without submitting to a physical examination	Included
Portability - allows eligible insureds to continue their insurance coverage when they are in danger of losing that coverage because their employment is being voluntarily or involuntarily terminated	Included
Accelerated Death Benefit - enables the policy holder to receive cash advances against the death benefit in the case of being diagnosed with a terminal illness	24 Months Expectancy 100% to $1,000,000
Waiver of Premium if disabled - a clause that waives the policyholder's obligation to pay any further premiums should you become seriously ill or disabled	9 Months Elimination To age 70
Age Reduction Formula- amount life insurance starts reducing in face amount by percentages	None
Line of Duty– An additional amount of basic AD&D for public safety officers that suffer a loss while he or she is performing his or her customary duties for the City.	Principal Sum up to $100,000

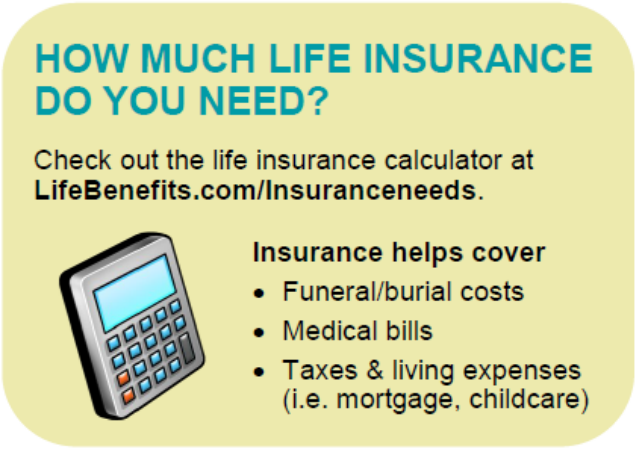
You may choose additional coverage for yourself, in $10,000 increments, up to $500,000. Premiums are paid on an after-tax basis, so any insurance benefits paid are not taxable when your beneficiary receives them.

Voluntary Life & Accidental Death and Dismemberment for Employee and Dependents cont.

Benefits	Securian administer by Ochs Dependent Coverage
Spouse Benefit	$5,000 Increments
Spouse Voluntary AD&D	Same as Life
Spouse Maximum	Up to $250,000
Spouse Guarantee Issue	$50,000
Child Benefit Child Maximum and Guaranteed Issue	Choice of $5,000, $10,000, $15,000 or $20,000
Age Reduction Formula- amount life insurance starts reducing in face amount by percentage	None

Child Life Insurance Monthly Rates

All Children Premium Table Monthly Rates (one premium insures all eligible children)			
$5,000	**$10,000**	**$15,000**	**$20,000**
$0.65	**$1.30**	**$1.95**	**$2.60**



Employee and Spouse Life & AD&D Insurance Monthly Rates

Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate per $1,000	$0.08	$0.09	$0.11	$0.12	$0.15	$0.24	$0.40	$0.64	$0.78	$1.34	$2.09	$4.10
Coverage Amount												
$10,000	0.80	0.90	1.10	1.20	1.50	2.40	4.00	6.40	7.80	13.40	20.90	41.00
$20,000	1.60	1.80	2.20	2.40	3.00	4.80	8.00	12.80	15.60	26.80	41.80	82.00
$30,000	2.40	2.70	3.30	3.60	4.50	7.20	12.00	19.20	23.40	40.20	62.70	123.00
$40,000	3.20	3.60	4.40	4.80	6.00	9.60	16.00	25.60	31.20	53.60	83.60	164.00
$50,000	4.00	4.50	5.50	6.00	7.50	12.00	20.00	32.00	39.00	67.00	104.50	205.00
$60,000	4.80	5.40	6.60	7.20	9.00	14.40	24.00	38.40	46.80	80.40	125.40	246.00
$70,000	5.60	6.30	7.70	8.40	10.50	16.80	28.00	44.80	54.60	93.80	146.30	287.00
$80,000	6.40	7.20	8.80	9.60	12.00	19.20	32.00	51.20	62.40	107.20	167.20	328.00
$90,000	7.20	8.10	9.90	10.80	13.50	21.60	36.00	57.60	70.20	120.60	188.10	369.00
$100,000	8.00	9.00	11.00	12.00	15.00	24.00	40.00	64.00	78.00	134.00	209.00	410.00
$110,000	8.80	9.90	12.10	13.20	16.50	26.40	44.00	70.40	85.80	147.40	229.90	451.00
$120,000	9.60	10.80	13.20	14.40	18.00	28.80	48.00	76.80	93.60	160.80	250.80	492.00
$130,000	10.40	11.70	14.30	15.60	19.50	31.20	52.00	83.20	101.40	174.20	271.70	533.00
$140,000	11.20	12.60	15.40	16.80	21.00	33.60	56.00	89.60	109.20	187.60	292.60	574.00
$150,000	12.00	13.50	16.50	18.00	22.50	36.00	60.00	96.00	117.00	201.00	313.50	615.00
$160,000	12.80	14.40	17.60	19.20	24.00	38.40	64.00	102.40	124.80	214.40	334.40	656.00
$170,000	13.60	15.30	18.70	20.40	25.50	40.80	68.00	108.80	132.60	227.80	355.30	697.00
$180,000	14.40	16.20	19.80	21.60	27.00	43.20	72.00	115.20	140.40	241.20	376.20	738.00
$190,000	15.20	17.10	20.90	22.80	28.50	45.60	76.00	121.60	148.20	254.60	397.10	779.00
$200,000	16.00	18.00	22.00	24.00	30.00	48.00	80.00	128.00	156.00	268.00	418.00	820.00
$210,000	16.80	18.90	23.10	25.20	31.50	50.40	84.00	134.40	163.80	281.40	438.90	861.00
$220,000	17.60	19.80	24.20	26.40	33.00	52.80	88.00	140.80	171.60	294.80	459.80	902.00
$230,000	18.40	20.70	25.30	27.60	34.50	55.20	92.00	147.20	179.40	308.20	480.70	943.00
$240,000	19.20	21.60	26.40	28.80	36.00	57.60	96.00	153.60	187.20	321.60	501.60	984.00
$250,000	20.00	22.50	27.50	30.00	37.50	60.00	100.00	160.00	195.00	335.00	522.50	1,025.00
$260,000	20.80	23.40	28.60	31.20	39.00	62.40	104.00	166.40	202.80	348.40	543.40	1,066.00
$270,000	21.60	24.30	29.70	32.40	40.50	64.80	108.00	172.80	210.60	361.80	564.30	1,107.00
$280,000	22.40	25.20	30.80	33.60	42.00	67.20	112.00	179.20	218.40	375.20	585.20	1,148.00
$290,000	23.20	26.10	31.90	34.80	43.50	69.60	116.00	185.60	226.20	388.60	606.10	1,189.00
$300,000	24.00	27.00	33.00	36.00	45.00	72.00	120.00	192.00	234.00	402.00	627.00	1,230.00
$350,000	28.00	31.50	38.50	42.00	52.50	84.00	140.00	224.00	273.00	469.00	731.50	1,435.00
$400,000	32.00	36.00	44.00	48.00	60.00	96.00	160.00	256.00	312.00	536.00	836.00	1,640.00
$450,000	36.00	40.50	49.50	54.00	67.50	108.00	180.00	288.00	351.00	603.00	940.50	1,845.00
$500,000	40.00	45.00	55.00	60.00	75.00	120.00	200.00	320.00	390.00	670.00	1,045.00	2,050.00

Spouse rates are based off of employee age.

Short-term Disability Insurance Benefits

All active regular non-civil service full-time employees are eligible to participate in this plan at a cost of $15.00 per month.

Benefits	HealthFirst
Basic Monthly Earnings– gross rate of pay used to determine benefit dollar amount	Average monthly base salary or hourly pay before taxes. Does not include commissions, bonuses, overtime pay, or any other extra compensation.
Benefit Percentage - percentage of your weekly salary	60%
Maximum Weekly Benefit - maximum dollar amount you can expect to receive	$1,200
Elimination Period - period of continuous disability which must be satisfied before you are eligible to receive short term disability benefit payments	7th Day Sickness/7th Day Accident
Definition of Disability - qualification for receiving the disability benefit	Unable to perform all the material duties of your regular occupation, and unable to earn 80% or more of your covered earnings.
Maternity - allows you to receive a portion of your pay if you are unable to work due to pregnancy/ maternity leave	6 weeks – Normal Delivery 8 weeks - C-section
Benefit Duration - length of time during which a benefit is paid	Up to 26 weeks

To File a Disability Claim Contact Human Resources:
903-531-1100

Flexible Spending Accounts

You can pay for eligible health care and dependent care expenses with pre-tax income through a Flexible Spending Account. You do not pay federal income tax on your deposit.

The Flexible Spending Account reimburses you for eligible health care expenses that are not covered by insurance. Expenses may be incurred by you, your spouse, and your dependent children, regardless of whether they are covered by the City's medical, dental or vision plans.

The Flexible Spending Account also reimburses you for certain dependent care expenses incurred while you and/or your spouse work.

How the Spending Accounts Work

You choose to contribute part of your earnings into the Medical Flexible Spending Account and/or the Dependent Care Flexible Spending Account. The accounts are maintained separately and you cannot make transfers between them. These accounts will reimburse you for eligible expenses that you submit throughout the year.

Health Care Flexible Spending Account

1. Estimate your annual health care expenditures on items not reimbursed by insurance.
2. Decide how much money you want to contribute to the account from $1 to **$2,700** per year. The money is deducted before taxes, so taxes are withheld on a lower amount of your earnings.
3. You may also file a paper or online claim when you have eligible health care expenses.

Dependent Care Flexible Spending Account

1. Estimate your dependent care expenses for the coming year.
2. Decide how much money you want to contribute to the account with a **$5,000** maximum per year. The money is deducted before taxes are taken out, so taxes are withheld on a lower amount of your earnings (pre-tax basis).
3. File a claim when you have eligible dependent care expenses.
4. You will be reimbursed for eligible claims up to the current contributed amount available in your account.

Note: Dependent care deposits must be received and posted to your individual account before they can be used.

WageWorks
everyone benefits

Medical Care Flexible Spending Account

Eligible Expenses

The following are examples of expenses eligible for reimbursement when they are not covered by a medical, dental or vision care plan. You cannot claim an expense as a federal income tax deduction if it is reimbursed through your Flexible Spending Account. (For a full list, go to www.irs.gov.)

- Amount applied to any medical, dental, or vision plan deductible, or copayment, or fees in excess of plan limits;
- Vision expenses not covered by a plan, including exams, eye glasses, contact lenses and solutions, optometrist and ophthalmologist fees and laser eye surgery;
- Dental expenses not covered by a plan including cleanings, fillings and orthodontia;
- Hearing aids;
- Prescription drugs;
- Diabetic supplies;
- Specialized equipment for disabled persons;
- Physical therapy, speech therapy, and psychotherapy; and
- Smoking cessation programs.
- Over-the-counter drugs, if to treat a medical condition. Prescription is required.

Ineligible Expenses

The following expenses are examples of items not eligible for reimbursement through your Health Care Flexible Spending Account.

- Cosmetic expenses;
- Fees for exercise/athletic/health clubs;
- Premiums for health, dental, vision, or life insurance; and
- Weight-loss programs for general health purposes.

Dependent Care Flexible Spending Account

Eligible Expenses

You may claim dependent care expenses for any dependents who live with you and rely on you for more than half of their support as claimed on your taxes. Dependents include:

- Children under the age of 13.
- Persons of any age, if physically or mentally disabled, and claimed on your federal income tax return.
- You may be reimbursed for day care expenses only if this enables you to work. If married, your spouse must also work or be looking for work, be a full-time student, or be disabled.

The following are examples of eligible expenses for reimbursement.

- Expenses for child care;
- Care for a child under the age of 13 at a day camp, nursery school or private sitter; and
- Care for an incapacitated adult who lives with you at least eight hours a day.

Note: If you terminate employment or experience a change in employment status from full-time to part-time, you are eligible to access FSA funds up to your termination or employment status change date. This means that any services after the previous mentioned dates are ineligible for reimbursement.

Important Notices

Women's Health and Cancer Rights act

If you have had or are going 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; Prostheses; and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

Newborn's and Mother's health protection act (NMHPA)

Group health plans and health insurance issuers generally may not, under Federal law, 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 section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity Act (1996) (MHPA) and Mental Health Parity and Addiction Equity Act (2008) (MHPAEA)

The City of Tyler medical plan complies with the Mental Health Parity Act of 1996 ("MHPA"). Pursuant to such compliance, the annual and lifetime limits on Mental Health Benefits, if any, will not be less than the annual and lifetime plan limits on other types of medical and surgical services (if any limits apply). The plan does utilize cost containment methods, applicable for Mental Health Benefits, including cost-sharing, limits on the number of visits or days of coverage, and other terms and conditions that relate to the amount, duration and scope of Mental Health Benefits.

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, 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 1-866-444-EBSA (3272). To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefit Security Administration
www.dol.gov/agencies/ebsa - 1-866-444-EBSA (3272)
U.S. Department of Health and Human Services - Centers for Medicare & Medicaid Services
www.cms.hhs.gov - 1-877-267-2323, menu Option 4, Ext. 61565

Coverage After Termination (COBRA) Continuation of Health Coverage

If you or your dependents have coverage at the time of a qualifying event, you may be eligible to elect continuation of coverage under one or more of the following:

• Medical, Dental, Vision & FSA

You have a legal right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to purchase a temporary extension of your coverage at group rates. However, you must pay the full cost of the coverage, plus a 2% administrative fee.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect. COBRA continuation coverage must pay for COBRA continuation coverage. If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies; your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies; the parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

COBRA and Retirement

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the City of Tyler, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries

has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage. If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov. Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

HIPAA) Employee Health Plan Summary Notice of Privacy Practices:

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

Uses and Disclosures of Health Information: The City of Tyler uses health information about you for treatment, to pay for treatment, and for other allowable healthcare purposes. Health care providers submit claims for payment for treatment that may be covered by the group health plan. Part of payment includes ascertaining the medical necessity of the treatment and the details of the treatment or service to determine if the group health plan is obligated to pay. Information may be shared by paper mail, electronic mail, fax, or other methods. Subject to certain requirements, the City may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. The City provides information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and distribute the new notice. You can also request a copy of our full notice at any time. For more information about our privacy practices, contact the Human Resources Department.

Your Health Information Rights: In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you the normal copy fees that reflect the actual costs of producing the copies including such items as labor and materials. You also have the right to receive a list of instances where The City of Tyler has disclosed health information about you for reasons other than treatment, payment, healthcare operations, related administrative purposes, and when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that the City correct the existing information or add the missing information. You have the right to request that the City restrict the use and disclosure, then the City must abide by the request and may only reverse the position after you have been appropriately notified. You have the right to request an alternative means of communication with the City and are not required to explain why you want the alternative means of communication.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Privacy Complaints

If you are concerned that the City has violated your privacy rights, or you disagree with a decision the City has made about access to your records, you may address them to the Privacy Contact listed in this notice. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

City of Tyler's Responsibilities

The City of Tyler is required by law to protect the privacy of your information, provide this notice about the City's information practices,

follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice. For further details about your rights and the federal Privacy Rule, refer to the detailed statement of this Notice. You can ask for a written copy of the detailed Notice by contacting the Privacy Contact listed in this notice.

Notice of Opportunity to Enroll in Connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in The City of Tyler. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to 1/1/2020. If you would like more information, contact your Plan Administrator.

Notice Lifetime Limit No Longer Applies/Enrollment Opportunity

The lifetime limit on the dollar value of benefits under the City of Tyler benefit Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. If you would like more information, contact your Plan Administrator.

Special Enrollment Notice

Special Enrollment Notice: If you are declining 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 that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your 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 placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance. To request special enrollment or obtain more information, contact the Human Resources Department.

Important Notice from City of Tyler About Your Prescription Drug Coverage and 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 Tyler 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 Tyler has determined that the prescription drug coverage offered by the City of Tyler's Medical 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 decide to join a Medicare drug plan, your current coverage with the City of Tyler will not be affected. You and/or your dependents can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

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 Tyler 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% 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: Contact Human Resources for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Tyler 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 1-800-MEDICARE (1 -800-633-4227).

TTY users should call 1-877-486-2048. 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 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. 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).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new 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 new 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 new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2019 for coverage starting as early as January 1, 2020.

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 9.5% 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.

*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 Human Resources. 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.

*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.

Here is some basic information about health coverage offered by this employer. Eligible employees are Fulltime employees who work 40 hours per week and have completed the newly eligible 90 day waiting period. Eligible dependents include the employee's spouse and eligible dependent children up to age 26. 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. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

3. Employer name		4. Employer Identification Number (EIN)
City of Tyler		75-6000697
5. Employer address		6. Employer phone number
212 North Bonner		903-531-1100
7. City	8. State	9. ZIP code
Tyler	Texas	75710
10. Who can we contact about employee health coverage at this job?		
Jami Rogers		
11. Phone number (if different from above)	12. Email address	
	jrogers@tylertexas.com	

Notice Informing Individuals About Non Discrimination and Accessibility Requirements Discrimination is against the law:

The City of Tyler complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The City does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The City provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters;
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; Information written in other languages

If you need these services, contact the Human Resources Department. If you believe that the City has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The City of Tyler
212 N Bonner - Tyler, TX 75710

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Employee Rights and Responsibilities under the Family Medical Leave Act

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons: for incapacity due to pregnancy, prenatal medical care or child birth; to care for the employee's child after birth, or placement for adoption or foster care; to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings. FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service-member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*
*The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.
*Special hours of service eligibility requirements apply to airline flight crew employees.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

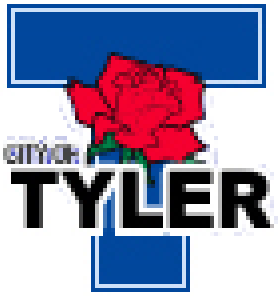
Contact Human Resources
at 903-531-1112

Important Contacts

City of Tyler
Human Resources Department
903-531-1100 or www.cityoftyler.org
Hours of Operation : Monday – Friday, 8 a.m. to 5 p.m.

Vendor and Type of Plan	Member Services Phone Number	Hours of Operation	Website
Medical Plan: HealthFirst TPA	1-866-219-1592	Monday - Friday ; 8 a.m. to 5 p.m. CST	www.hfbenefits.com
Pharmacy Benefit Manager: CerpassRX	844-636-7506	24/7	www.cerpassrx.com
Teladoc	800-835-2362	24/7	www.teladoc.com
Flexible Spending Account: Wage Works	866-279-8385	Monday - Friday ; 7 a.m. to 7 p.m. CST	www.wageworks.com
Dental Plan: Delta Dental	1-800-521-2651 Plan # 18474	Monday - Friday ; 6:15 a.m. to 6:30 p.m. EST	www.deltadentalins.com
Life & Supplemental Life Securian administer by Ochs	Customer Service:1-800-392-7295 Plan # 34638 Claims: 1-888-658-0193	Monday - Friday ; 8 a.m. To 4:30p.m. CST	www.securian.com
Vision Plan: Superior Vision	1-866-265-0517	Monday through Friday 8 a.m. to 5 p.m. CST	www.superiorvision.com
Short Term Disability: HealthFirst TPA	1-866-219-1592	Monday - Friday ; 8 a.m. to 5 p.m. CST	www.hfbenefits.com

Notes



The information in this enrollment guide is intended to help you enroll in your 2020 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern.

The City of Tyler reserves the right to change or terminate benefits at any time. Neither the benefits, nor this enrollment guide, should be interpreted as a guarantee of future benefits.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.hfbenefits.com or call 1-866-219-1592. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.dol.gov/ebsa/healthreform/ or call 866-219-1592.to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** person / **$3,000** family **Platinum** In Network **$1,600** person / **$4,800** family In-Network Other Counties, Out-Of-Network / **Not Covered** Doesn't apply to Platinum Network Services, Copayments or Benefits paid at 100%.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $400 for failure to pre-certify Inpatient admission, Dialysis, admission to Extended Care Facility or Physical Therapy with HMS at 1-800-625-6834.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. Preauthorization is required for Inpatient Hospital admissions, gender reassignment, Dialysis, admission to Extended Care Facility or Physical Therapy or an additional **$400** deductible shall be applied before the Plan benefits are determined. Benefits reduced to 50% if not medically necessary.
What is the out-of-pocket limit for this plan?	For network providers **$6,350** individual / **$12,700** family; for out-of-network providers - Not Covered	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. The In-Network Out-of-Pockets cross apply.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.hfbenefits.com.** For information outside of the Access Direct	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what

	service area visit **United Healthcare** at **www.hfbenefits.com or** call HealthFirst at **1-866-219-1592.**	your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit or 20% for other services in physician office - **Platinum**; 30% coinsurance **In-network UHC**	Not covered	Copay applies to Office Visit Only.
	Specialist visit	$30 copay/visit **Platinum**; 30% coinsurance **In-network UHC**	Not covered	Copay applies to Office Visit Only.
	Preventive care/screening/ immunization	100% Deductible Waived	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	100%, if medically necessary - **CPL Platinum**; 20% coinsurance- Other services **Platinum**; 30% coinsurance **In-network UHC**	Not covered	CPL Platinum - Covered at 100%, if medically necessary
	Imaging (CT/PET scans, MRIs)	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://cerpassrx.com/members-page/ or by calling	Generic drugs	$15 copay/**30 day retail**; $37.50 copay/**90 day retail** $45 copay/mail order		Covers up to a 30-day supply (retail prescription); 90-day supply (select 90-day retail or mail order prescription)
	Preferred brand drugs	$60 copay/**30 day retail**; $150 copay/**90 day retail** $180 copay/mail order		
	Non-preferred brand drugs	$100 copay/**30 day retail**; $250 copay/**90 day retail** $300 copay/mail order		
	Specialty drugs	$125 copay/**30 day retail**; Not Covered/**90 day retail** Not Covered /mail order		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
CerpassRx at (844) 636-7506				
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	None
	Physician/surgeon fees	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	None
If you need immediate medical attention	Emergency room care	$250 copay/visit True Emergency-**Platinum & In Network UHC** 20% coinsurance if NOT True Emergency-**Platinum**; 30% coinsurance if NOT True Emergency-**In-network UHC**; Not Covered - Out-of-Network	$250 copay/visit True Emergency; Not Covered if NOT True Emergency	Copay only applies to other In-network and out-of-network if TRUE Emergency
	Emergency medical transportation	20% coinsurance **Platinum;** 30% coinsurance **In-Network UHC**	30% coinsurance True Emergency; Not Covered if NOT True Emergency	Air ambulance is limited to a total benefit of $25,000.00 annually. Chartered air flights are excluded.
	Urgent care	$30 copay/visit **Platinum**; 30% coinsurance **In-network UHC**	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	Services must have Preauthorization at 1-800-625-6834.
	Physician/surgeon fees	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit **Platinum**; 30% coinsurance **In-network UHC**	Not covered	None
	Inpatient services	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	Services must be pre-certified at 1-800-625-6834.
If you are pregnant	Office visits	Initial Office Visit – 100% after $30 copay; 20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	$30 copay/visit **Platinum**; 30% coinsurance **In-network UHC**	Not covered	elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	Services must have Preauthorization at 1-800-625-6834 for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
If you need help recovering or have other special health needs	Home health care	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	None
	Rehabilitation services	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	Inpatient services or outpatient Physical Therapy must have Preauthorization at 1-800-625-6834.
	Habilitation services	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	None
	Skilled nursing care	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	Inpatient services must have Preauthorization at 1-800-625-6834.
	Durable medical equipment	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	None
	Hospice services	20% coinsurance **Platinum**; 30% coinsurance **In-network UHC**	Not covered	None
If your child needs dental or eye care	Children's eye exam	As defined under Preventive	Not Covered	Only as defined under Preventive
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered under Medical	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Acupuncture
- Bariatric surgery
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Hearing aids
- Routine eye care (Adult)
- Routine Foot Care
- Private-duty nursing
- Weight loss programs
- Chiropractic care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
N/A	N/A	N/A

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at **866-219-1592.** You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 866-219-1592.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-219-1592.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码866-219-1592.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-219-1592.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$120
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,660**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,000
Copayments	$1,545
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,973**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$859
Copayments	$90
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,164**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: HealthFirst 1-866-219-1592.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.