



City of Dallas

2011 Retiree Benefits & Enrollment Guide



City of Dallas

Important Health Plan Updates (Pre-65 Only)

Effective October 1, 2010

New Prescription Drug Program through Prescription Solutions

Beginning October 1, 2010, Prescription Solutions through UnitedHealthcare will begin managing your pharmacy benefit.

The City of Dallas asked UHC to determine additional cost avoidance strategies for the budget year 2010-2011 without sacrificing quality, care or the adherence to evidence-based medicine.

UHC recommended a change in pharmacy benefits management from their subcontractor partnership with Medco to Prescription Solutions, their whole-owned pharmacy benefits management company (PBM).

The change to Prescription Solutions represents better discounts on most medications at the pharmacy; both retail and through home delivery, mail order services. Better discounts will provide our employees/retirees savings in out of pocket expenses and save the City in claims cost.

What the change means for you:

- You will receive a new Medical ID card prior to October 1 that contains important information that your pharmacist will need to fill your prescriptions (BIN 610494 Group UHC PCN 9999).
- You'll have a new Prescription Drug List (PDL), or list of medications covered under your pharmacy benefit. The PDL also includes some information and new programs that may help you save money on future prescriptions.
- Minimal medication tiering changes will occur, however please check the PDL to determine if your medication or the amount you pay may change.
- A new Specialty Pharmacy Program is being introduced to support members using injections or infusion medications that are used to treat rare and complex conditions.

More information about your pharmacy program can be located on page 22 of this guide. Also, please check the City's website to obtain a copy of the new PDL, a mail order form for new mail order prescriptions, and other important information including the new Specialty Pharmacy Program.

Personal Health Support

Also effective October 1, 2010 a new program called Personal Health Support is being made available to all employees enrolled in a UnitedHealthcare medical plan. Personal Health Support programs give you access to services and clinical support to help manage chronic diseases such as Diabetes and Heart Disease, as well as give you access to tools and resources to help you at whatever health stage you are in. Whether you are staying healthy, getting healthy or living with an illness, there is information available to you.

One important component of this program is that members with certain chronic conditions, such as diabetes, may receive a call from a UnitedHealthcare registered nurse to assist with the management of your disease. The program is completely voluntary and you can be assured that your personal privacy is protected.

You might also receive a HealthNote (pronounced "healthy note") in the mail to remind you to have an important test or screening, or invite you to contact UnitedHealthcare about an important message about your health.

Outbound calls and HealthNotes from UnitedHealthcare are just a few of the ways that they are offering help and assistance to you to better manage your health.

For additional information, please contact UHC at 800-736-1364

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Welcome to Benefits 2011

Dear Retirees,

The City of Dallas offers Retirees an enrollment period to review current benefits and if necessary, make new elections. This year's annual enrollment will be held from September 7th thru October 29th with an effective date of January 1, 2011. The pre-65 retiree's benefits enrollment will be active, meaning you must re-elect the benefit plans you intend to participate in during 2011. The enrollment process will include calling the Benefits Service Center (BSC) to elect or waive coverage and provide documentation for all dependents to validate their eligibility for participating in the City of Dallas' benefit plans. However, this year our post-65 retiree benefits enrollment will be passive, meaning you may continue your existing coverage during 2011 without calling the BSC.

What's new for 2011 for Pre-65 Retirees?

Medical Plan Changes for 2011:

The City of Dallas will continue to offer two medical plans:

- **Plan Option 1 – 75/25 plan with Health Reimbursement Account**
 - *There will be a reduction in the HRA allocation to \$700 for retiree only coverage and \$1700 for retirees with dependents covered.* However, retirees can take an online Health Assessment to earn an additional \$300 in their Health Reimbursement Account (see the Healthy Rewards section of this letter for additional information.)
- **Plan Option 2 – The 70/30 PPO plan**
 - The prescription deductible will be increasing from \$75 to \$150 per person

Also, the City has adopted In-Network benefits only for both plans, with exceptions made in emergency situations. (See 2011 Summary Plan Description (SPD) for more details)

Healthy Rewards for HRA Enrolled Retirees

City of Dallas is introducing a Healthy Rewards program that will begin in January 2011. Retirees and their spouses enrolled in the HRA Medical plan will be invited to take an online Health Assessment on www.myuhc.com. Retirees can earn an additional \$300 in their HRA account to pay for eligible medical or prescription expenses. Once you complete the assessment, dollars will be deposited into your existing HRA account for you to begin using immediately for eligible health care expenses.

Every day, you make decisions. When you have improved information, you make better decisions, and understanding your current health status is a good start. This short online Health Assessment questionnaire will take about 15 minutes to complete and will provide you with immediate feedback on your current state of health as well as give you access to some personalized health improvement tools and resources. Look for more information later this year about a Health Assessment campaign that will begin in January 2011.

Non-Tobacco User Premium Rebate and Smoking Cessation Medications Covered

People who smoke are at higher risk of cardiovascular disease, stroke, and hypertension. Whether you smoke cigarettes, cigars, pipes or use chewing tobacco, it isn't easy to quit using tobacco. Sometimes we need help to break that habit.

This year during your enrollment session, your counselor will ask you to attest to whether you are a tobacco user or non-tobacco user. Non-tobacco user retirees that enroll in one of the City of Dallas medical plans will receive a \$20 per month non-tobacco user premium rebate that will be applied to the medical plan they choose in 2011.

Retirees who do not receive the non-tobacco user premium rebate can participate in up to \$240 worth of Nicotine Replacement Therapy at no cost to them. The smoking cessation products that are eligible under the plan include nicotine replacement gum, patches and prescription medications such as Chantix or Zyban with a prescription from a doctor. We encourage you to talk to your doctor and about which course of treatment would be the best smoking cessation plan for you.

Diabetes and Personal Health Support

Pre-diabetes and diabetes are major health problems facing more than 80 million Americans today, and City of Dallas is no exception. If not managed properly, pre-diabetes can lead to diabetes and serious health complications such as

heart disease, kidney disease, amputations and blindness. City of Dallas is working to bring programs and resources to employees and their dependents to help support you and the cost for these services.

New Voluntary Benefits Offered by Colonial Life

In addition to your medical, dental and vision benefits, pre-65 retirees are eligible to enroll in the following voluntary benefits offered by Colonial Life (not sponsored by the City of Dallas) to enhance your benefits package:

- **Accident Insurance** helps offset the direct and indirect expenses such as co-payments, deductibles and other costs not covered by traditional health care plans.
- **Cancer Insurance** helps offset the out-of-pocket medical and indirect, non-medical expenses related to cancer treatment.

What's new for 2011 for Post-65 Retirees?

75/25/HRA Plan No Longer Available

If you are currently enrolled in the 75/25/HRA plan, you must contact the BSC to enroll in the 70/30/3000 or contact AARP to enroll in one of the supplemental plans (C, F or K) and if applicable the BSC to enroll in Medicare Part D (prescription drug coverage) effective January 1, 2011.

70/30/3000 Plan Subsidy will Discontinue

Effective **July 1, 2011**, retirees enrolled in the 70/30/3000 plan will not be subsidized. If you would like to enroll in an AARP supplemental plan please contact the vendors directly and/or Medicare Part D, please contact the vendors directly.

Two Medicare Part D Plans (Rx) Available

Effective January 1, 2011, there will be two Medicare Part D plans available, they are as follows:

Option 1 Buy-up Plan: Retirees may participate in the current Part D plan which has coverage both brand and generic through the Coverage Gap (Donut Hole).

Option 2 Part D Plan: This option covers generics through the Coverage Gap but brand drugs will be covered on a cost sharing basis with Pharmaceutical Companies. While in the Coverage Gap, the retiree will be responsible for 50% of the negotiated cost for the brand name medications.

What's new for 2011 for All Retirees?

Dental Plan Changes for 2011:

We will continue to offer the two current dental plan offerings; however, due to feedback from retirees we are adding a third dental *Exclusive Provider Organization* (EPO) Plan option. The Dental EPO plan offers the flexibility and network of dentists of a PPO plan with the fixed co payment structure of an HMO plan.

Your three dental plan options for 2011 are:

- **Dental HMO plan (Health Maintenance Organization)**
- **Dental EPO plan (Exclusive Provider Organization)**
- **Dental PPO plan (Preferred Provider Organization)**

Please see your 2011 Enrollment Guide for more details about the dental plan benefits.

Concentra Total Health and Wellness Clinic

Also, remember in addition to the medical plan offerings, the City of Dallas' Onsite Clinic located at **City Hall**

1C-South provides treatment to employees, spouses and dependents who have access to the facility for the following:

- Common Illnesses
- Preventive Screenings
- Physical Exams and Vaccinations

Benefits Service Center

Beginning September 7, 2010 the Benefits Service Center (BSC) will be located at **City Hall 1D-South**. Participants may access the BSC Monday – Friday, 8 am to 5 pm CST in person or via phone at **888-752-9122** for benefits customer service.

This Benefits and Enrollment Guide provides details about your benefit options. Reviewing the material contained in this guide will help you make informed decisions about your benefits for 2011. If you have any questions, refer to the vendor contact information section to access our service providers. As always, I hope you will continue to be pleased with these programs and services as we endeavor to maintain a competitive benefits package for you and your family.

Sincerely,

Molly McCall, Interim Director
Human Resources Department

Who Can I Call with Questions?

- The City Of Dallas is committed to providing you with quality customer service. Contact the Benefits Service Center between the hours of 8 a.m. and 5 p.m. Central Standard Time at 888-752-9122 beginning September 7, 2010.

The Benefits Service Center can assist you with questions regarding enrollment, health plan options, or making changes to your health plan.

- In the event that you are prompted to leave a voicemail message, please include your name, employee number, nature of your concern, and the insurance plan in which you are enrolled. Your message will be responded to within 24 to 48 hours.

Who Is Eligible?

You may elect health care coverage for you and your eligible dependents during the Annual Enrollment Period and through special enrollments as a result of a qualifying status change. Eligible dependents include the following persons:

Type of Eligible Dependent	Required Documentation
<p>Spouse Person of opposite gender</p>	<ul style="list-style-type: none"> ● Copy of marriage license, and ● Copy of Social Security Card, and ● Date of Birth <p>If Common-Law-Marriage applies, please provide the common-law form* and copies of documentation showing that you and your spouse have lived together for at least six months (provide two documents from list below).</p> <p>Examples include copies of:</p> <ul style="list-style-type: none"> ○ Lease or deed naming both partners ○ Joint checking account statement ○ Utility bills and/or Credit accounts ○ Will and or life insurance policies
<p>Domestic Partner Person of same gender</p>	<ul style="list-style-type: none"> ● Domestic Partner form** and copies of documentation showing that you and your partner have lived together for at least six months (provide two documents from list below). <p>Examples include copies of:</p> <ul style="list-style-type: none"> ○ Lease or deed naming both partners ○ Joint checking account statement ○ Utility bills and/or Credit accounts ○ Will and or life insurance policies <ul style="list-style-type: none"> ● Copy of Social Security Card, and ● Date of Birth
<p>Dependent Child Child who is married or unmarried, under age 26 and is the biological child, legally adopted child, or stepchild of you and/or your spouse, domestic or common law partner</p>	<ul style="list-style-type: none"> ● Copy of birth certificate showing you as a parent, or ● Copy of adoption agreement, or ● Copy of court custody or guardianship documents, or ● Copy of the portion of the divorce degree showing the dependent, or ● Copy Qualified Medical Court Support Order (QMCSO), and ● Copy of Social Security Card

*The common-law form may be accessed at: <http://www.dallascounty.org/department/countyclerk/marriage-license.html>

**The Domestic Partner form may be accessed at <http://www.cod/HumanResources/pdf/DomesticPartner.pdf>

Please note: Your dependents (spouse and children) cannot be covered on a plan if you are not covered.

Making Changes to Your Benefits During the Year

The IRS requires elections made during the Annual Enrollment Period to be effective for the upcoming plan year, January 1st through December 31st. You may not change your benefit elections after the annual open enrollment period unless you experience a Qualifying Life Event. Qualifying Life Events may include:

- Marriage
- Divorce, Legal Separation, or Annulment
- Birth or Adoption of an Eligible Child
- Change in you or your Spouse's work status (full-time to part-time) that effects benefits eligibility
- A change in your child's eligibility for benefits
- A Qualified Medical Child Support Order

You must notify the Benefits Service Center within 30 days of your Qualifying Life Event and provide all required documentation below. If you fail to notify the Benefits Service Center of your Qualifying Life Event and do not provide documentation, you must wait until the next Annual Enrollment period to change your benefit elections.

Special Note: If you elect to waive medical coverage as a retiree, you or your dependents may not re-enroll in any City-Sponsored medical plans in the future.

Type of Family Status Change	Required Documentation
<p>Add or lose other coverage Through another employer or government sponsored plan</p>	<ul style="list-style-type: none"> ● Copy of Employer/Government letter with an effective date and the name of the dependent(s) who gained or lost coverage, or ● Copy of Insurance letter with an effective date and the name of the dependent(s) who gained/lost coverage, or ● Copy of HIPAA certificate of Credible, or Coverage with the effective date and the name of dependent(s) who lost coverage, or ● Copy of insurance ID card with the effective date and the name of the dependent(s) who gained coverage ● Copy of birth certificate, and ● Copy of Social Security Card
<p>Add or lose an eligible dependent Birth, adoption, placement of adoption or death of spouse or child</p>	<ul style="list-style-type: none"> ● Copy of birth certificate showing you as a parent, or ● Copy of adoption agreement, or ● Copy of court custody or guardianship documents, or ● Copy of the portion of the divorce degree showing the dependent, or ● Copy Qualified Medical Court Support Order (QMCSO), and ● Copy of Social Security Card ● Copy of death certificate (if applicable)
<p>Qualified Medical Child Support Order For a dependent child</p>	<ul style="list-style-type: none"> ● Copy Qualified Medical Court Support Order (QMCSO)
<p>Marriage, Divorce, Legal Separation or Annulment</p>	<ul style="list-style-type: none"> ● Copy of the legal documents with effective dates and name of dependent, and ● Copy of SSN and Date of Birth if adding due to marriage

Your response is required in the following situations:

- During open enrollment (fourth quarter of calendar year)
- Family Status Change (30 days of qualifying event)

If your dependent does not meet the current eligibility rules during the specified time period and/or you do not provide the required documentation, your dependent(s) will not be added to the plans.

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Non-Medicare Eligible Retiree Benefits Information

How to Enroll

(Non-Medicare Eligible Retiree Information)

Enrollment information

During the annual enrollment period, you must re-elect coverage for 2011. It's important to make your choices carefully, as you will not be able to change your elections until the next annual enrollment period, unless you have a qualified status change.

Enrollment period: September 7, 2010 through October 29, 2010

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

Enrollment types

The pre-65 retiree's benefits enrollment will be active, meaning you must re-elect the benefit plans you intend to participate in during 2011. The enrollment process will include calling the Benefits Service Center to elect or waive coverage and participate in an eligibility verification process, which requires all participants to verify all dependents to be insured on our plans effective January 1, 2011.

Enrollment method and instructions

- If you are a pre-65 retiree, you are eligible to enroll in medical, dental and vision as well as Voluntary Benefits (sponsored by Colonial Life).
- To enroll in your benefits, you must contact the Benefits Service Center to speak with a benefits counselor. Simply call 888-752-9122 between 8 am and 5 pm CST during the enrollment period.
- Elections made by calling the Benefits Service Center will be treated as an agreement to pay any required premium through payroll deduction.
- You may also enroll by scheduling an appointment with a benefits counselor at City Hall by calling the Benefits Service Center at 888-752-9122 between 8 am and 5 pm CST during the enrollment period.
- When speaking with a benefits counselor, you'll need to verify information about your dependents, so be prepared with the following documentation if applicable: marriage license (if necessary, domestic or common-law partnership documentation), Social Security Numbers (all dependents), birth certificates (dependent children only) and spouse's date of birth. **Note: You do not have to mail or fax the documentation.**
- Should you experience a long hold time, leave a voicemail message with a daytime telephone number where you can be reached and your call will be returned within 24 to 48 hours. Spanish-speaking assistance is available.

Review of benefit elections

- After making enrollment elections, a confirmation statement will be mailed by the Benefits Service Center showing your 2011 benefit elections.
- Review the confirmation statement that you receive in the mail from the Benefits Service Center and retain it for your records as proof of your timely enrollment. If there are errors on your confirmation statement, you must contact the Benefits Service Center to make the corrections. Also, make sure you review your January 2011 pension check to verify your benefit elections and insurance deductions are correct.

Verification of personal information

To receive your identification cards promptly, make sure that your current mailing address is correct in the City's Human Resource Information System. You can call the Benefits Service Center for enrollment changes, or to report an address change or other corrections as necessary.

How to Enroll for New Retirees after Open Enrollment

If you are planning to retire in 2011, call or make an appointment with the Benefits Service Center before your retirement to discuss retiree enrollment options and payroll deductions. You must enroll within 30 days after your date of retirement. You may be asked to pay the first two months' retiree health premiums in advance, depending on the date of retirement. Call the Benefits Service Center at 1-888-752-9122 from 8 a.m. to 5 p.m., Monday through Friday, within 30 days following your retirement to enroll. If you do not enroll within 30 days, you will be considered to have waived retiree coverage and **will not be eligible for future coverage**.

Retirees who have waived coverage will not be eligible to participate in the City's plan in the future. Your retiree coverage is effective on the first day of the month following your termination date with the City.

Upon retirement, all life insurance benefits will end unless you exercise your right to convert. To convert your life insurance, contact UnitedHealthcare Specialty Benefits within 30 days after your retirement date toll-free at 1-866-615-8727.

How to Enroll When Turning Age 65

When turning age 65, you should follow four steps:

1 Notify the Benefits Service Center within 30 days

Within 30 days before reaching age 65, retirees and/or their covered spouses must report their change in age to the Benefits Service Center at 1-888-752-9122. If a rate adjustment is required as a result of the retiree and/or his or her covered spouse turning age 65, the adjustment/reduction in rate will be made in the month following the month the retiree and/or his or her covered spouse turned age 65, providing the age change is reported to the Benefits Service Center before the first day of the month in which you turn age 65. The retiree and/or his or her covered spouse rate will not be adjusted or reduced in the month they turned age 65. The effective rate, before turning age 65 will be charged for the month the retiree and/or his or her covered spouse turned 65.

2 Enrollment in Medicare Part A and B

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

- Retirees and/or their covered spouses must enroll in Medicare Parts A and B at age 65 as a requirement of medical coverage through the City's benefit programs. Contact the Benefits Service Center at 1-888-752-9122 if you or your spouse is not otherwise qualified for premium-free Medicare Part A coverage due to quarters earned through employment or spouse's employment.
- Retirees must pay the full cost of the monthly premium for Medicare Part B. Medicare may charge a penalty to retirees who delay enrollment in Medicare Part B at the time of initial eligibility. If a retiree waives coverage in a city sponsored health plan, the retiree will not be eligible for inclusion of Medicare Part A premium payments to be made on his or her behalf by the City of Dallas. Contact your local Social Security Administration office or go online at www.ssa.gov to enroll and determine your eligibility.

3 Enrollment in Medicare Supplement plans

Once you have enrolled in Medicare Parts A and B and become Medicare-eligible, **you are no longer eligible** to participate in the City's health plans. You must enroll in a medical supplement plan offered by the City. We suggest that you consider adding drug coverage since the Medicare Supplement plan does not include prescription drug coverage. You have an option to either enroll in the City's Medicare Part D plan or one of the Medicare Part D plans offered by various private insurance carriers. **We strongly suggest that you consider your personal needs before selecting any drug coverage option plan.**

4 Enrollment in one of the Medicare Supplement plans is a two-step process

Enroll in Medicare Supplement plans C, F or K, contact the Medicare Supplement Enrollment Center at 1-800-392-7537 to request an enrollment kit and let them know you are City of Dallas retiree. Read and sign the application and mail it back to the Medicare Supplement Provider within 14 days. Your application will not be complete until it is received by the Medicare Supplement provider. They will provide an enrollment card once your application has been approved. Contact the City's Benefits Service Center at 1-888-752-9122 to inform them that you are enrolling in the Medicare Supplement plan C, F or K. If you wish to enroll in the City's Medicare Part D plan, you will need to provide your Medicare claim number in order to complete the Medicare Part D enrollment.

Important Disclaimers

Paying for Medical Coverage

Medical premiums are paid on a post-tax basis for all retirees. Your annual cost of medical coverage depends on the benefit options you choose and the level of coverage you need. Premium costs for 2011 can be found in this benefits and enrollment guide.

- Contributions shall be paid by pension check deduction by all Members who receive pension checks in sufficient amount to permit deduction for the contributions. For each regular pension check during the plan year a member will pay the monthly rates indicated in this enrollment guide. If for any reason a Member's pension check is not reduced by the amount of a contribution or does not receive pension check with a sufficient amount to permit deduction for the contributions, contributions must be paid by check or money order on a monthly basis.
- If a Member joins the plan or changes coverage during the plan year, deductions from the member's pay shall begin as soon as administratively feasible.
- A grace period of thirty days shall be allowed for the payment of each contribution paid directly by the member. If any contribution is not paid within the grace period, the coverage shall terminate on the last date for which contributions are paid.
- Dropping Coverage - If the notice for dropping coverage is received by Employee Benefits prior to the 15th of the month, deductions will not be taken and coverage will end the last day of the previous month. If the notice for dropping dependent coverage is received by Employee Benefits after the 15th of the month, deductions and coverage will be discontinued the first day of the following month.

Duplicate medical coverage by retiree

In the case where two city retirees both are eligible for coverage, only one may enroll for dependent coverage. Both retirees **cannot cover** each other. In the case both retirees have eligible dependents, only one retiree can cover the dependents. Both retirees **cannot cover** their eligible dependents. If a retiree and his or her spouse are employed or retired from different employers and are covered by the same insurance carrier, the health plan will pay only up to the allowable.

Medical Plans Overview (with Prescriptions)

PPO 75/25 HRA Medical Plan Comparison Chart (In-Network Benefits Only effective 1/1/2011)

	HRA Plan Non-Tobacco User Rate	HRA Plan Tobacco User Rate
Without Health Risk Assessment		
Total Deductible	\$2500 (single)	\$2500 (single)
HRA Allocation (City \$\$)	\$700 (single)	\$700 (single)
Deductible (Your \$\$)	\$1800 (single)	\$1800 (single)
Total Deductible	\$5000 (with dep(s))	\$5000 (with dep(s))
HRA Allocation (City \$\$)	\$1700 (with dep(s))	\$1700 (with dep(s))
Deductible (Your \$\$)	\$3300 (with dep(s))	\$3300 (with dep(s))
With Health Risk Assessment		
Total Deductible	\$2500 (single)	\$2500 (single)
HRA Allocation (City \$\$)	\$1000 (single)*	\$1000 (single)*
Deductible (Your \$\$)	\$1500 (single)	\$1500 (single)
Total Deductible	\$5000 (with dep(s))	\$5000 (with dep(s))
HRA Allocation (City \$\$)	\$2000 (with dep(s))*	\$2000 (with dep(s))*
Deductible (Your \$\$)	\$3000 (with dep(s))	\$3000 (with dep(s))
Coinsurance	Member pays 25% Plan pays 75%	Member pays 25% Plan pays 75%
Primary Care Physician	Plan pays 100%	Plan pays 100%
Preventive Services (See SPD for Injections)	(in-network only) doesn't reduce HRA	(in-network only) doesn't reduce HRA
Out-Patient Services	Plan pays 75% after deductible	Plan pays 75% after deductible
In-Patient Services	Plan pays 75% after deductible	Plan pays 75% after deductible
ER Services at hospital (See SPD for Ambulance services)	Plan pays 75% after deductible	Plan pays 75% after deductible
Specialist Services & Urgent Care Services	Plan pays 75% after deductible	Plan pays 75% after deductible
Out-of-Pocket Max	\$6000 (single) \$12000 (with deps)	\$6000 (single) \$12000 (with deps)
Rx Coverage (31 days):		
Deductible	Same as (Your \$\$) Deductible above	Same as (Your \$\$) Deductible above
Generic	10%	10%
Preferred	25%	25%
Non-Preferred	40%	40%
Out-of-Pocket Max	N/A	N/A
Full-Time Rates		
EE Only	\$408	\$428
EE + Spouse	\$1,025	\$1,045
EE + Child(ren)	\$693	\$713
EE + Family	\$1,282	\$1,302
Spouse Only	\$667	\$687
Spouse + Child(ren)	\$924	\$944

*Please complete Health Risk Assessment between 1/1/2011 - 2/28/2011 to receive the increased HRA Allocation.

PPO 70/30 Plan Comparison Chart
(In-Network benefits only effective 1/1/2011)

	70/30 Plan Non-Tobacco User Rate	70/30 Plan Tobacco User Rate
Total Deductible	\$3000 (single) \$9000 (with dep(s))	\$3000 (single) \$9000 (with dep(s))
HRA Allocation (City \$\$)	N/A	N/A
Deductible (Your \$\$)	Same as Total Deductible	Same as Total Deductible
Coinsurance	Member pays 30% Plan pays 70%	Member pays 30% Plan pays 70%
Primary Care Physician Preventive Services (See SPD for Injections)	Plan pays 70% no deductible	Plan pays 70% no deductible
Out-Patient Services	Plan pays 70% after deductible	Plan pays 70% after deductible
In-Patient Services	Plan pays 70% after deductible	Plan pays 70% after deductible
ER Services at hospital (See SPD for Ambulance services)	\$100 Copay plus Plan pays 70% after deductible	\$100 Copay plus Plan pays 70% after deductible
Specialist Services & Urgent Care Services	Plan pays 70% after deductible	Plan pays 70% after deductible
Out-of-Pocket Max	\$7500 (single) \$15000 (with dep(s))	\$7500 (single) \$15000 (with dep(s))
Rx Coverage (31 days):		
Deductible	\$150/person	\$150/person
Generic	10% or \$10 minimum	10% or \$10 minimum
Preferred	25% or \$25 minimum	25% or \$25 minimum
Non-Preferred	40% or \$40 minimum	40% or \$40 minimum
Out-of-Pocket Max	\$2500/person	\$2500/person
Retiree Rates		
EE Only	\$314	\$334
EE + Spouse	\$896	\$916
EE + Child(ren)	\$540	\$560
EE + Family	\$1,115	\$1,135
Spouse Only	\$632	\$652
Spouse + Child(ren)	\$851	\$871

Pharmacy deductible is not included in the out-of-pocket max for the PPO 70/30/\$3000 plan.



Understanding your HRA plan

A medical plan with an account to help pay your medical expenses

The Definity Health Reimbursement Account (HRA) plan includes a special account that you can use for health care expenses. The City of Dallas owns the account and puts money in it for you to use on eligible medical bills and pharmacy.

You have control over how the money is spent. And, you get personal support and online tools to help you spend it wisely and find care when you need it.

The plan is made up of two parts:

Medical Plan

- You have network coverage with an annual deductible and coinsurance. You are also protected from major expenses with an out-of-pocket maximum.
- Up to 100% coverage for preventive care. Please see your official benefit plan information for details.

Health Reimbursement Account:

- The City of Dallas puts money into your account each plan year.
- You use it to pay for eligible medical and pharmacy expenses and to help meet your annual deductible.
- The amount you don't use carries over to the next year.



Want more information on HRAs? Visit Campbell's Auto Care at www.healthcarelane.com/cod

HRA Plan Advantages

- You choose how your health care dollars are spent
- There is a limit on how much you will pay each year
- Generally, emergencies are covered anywhere in the world
- Unused HRA dollars carry over to next year's plan, and your employer will again fund your HRA, further reducing the out-of-pocket portion of your annual deductible
- Tools on myuhc.com help you:
 - check eligible expenses
 - check costs for treatment before doctor visits
 - find the best doctors and hospitals
 - manage your claims



How your HRA plan works

1

Your health expenses are paid by your HRA first

The City of Dallas contributes money to your account each year:

- \$700 - Employee • \$1,700 - Employee+Spouse • \$1,700 - Employee+Child(ren) • \$1,700 - Family
- ▶ Your HRA pays your eligible medical and pharmacy expenses as long as there are funds in it.
- ▶ These payments apply toward your annual deductible.
- ▶ You usually make no copayments at the doctor's office.

Employees can earn an additional \$300 in HRA dollars if they complete the Health Assessment on www.myuhc.com after January 1, 2011. Look for more information later in 2010 on how to earn this incentive.

2

After your HRA is used, you pay the rest of your deductible

Your annual deductible is the amount you need to pay before your medical plan pays. The annual deductible is:

- \$2,500 - Employee • \$5,000 - Employee+Spouse • \$5,000 - Employee+Child(ren) • \$5,000 - Family
- ▶ If you use all of your HRA, you pay the rest of the deductible amount out of your own pocket.
- ▶ Preventive care is covered up to 100% by the medical plan whether or not you have met your deductible.

3

After your deductible is met, then, you pay only coinsurance

Once you have met your deductible, you and the medical plan share expenses. This is called coinsurance. The percentage you owe is:

In-Network
25%

For your protection, there is a limit on how much you need to pay out of your own pocket. Once you reach the amounts shown below, you are covered 100% for the rest of the year.

	Employee	Employee+Spouse	Employee+Child(ren)	Family
Out of pocket maximum	In: \$6,000	In: \$12,000	In: \$12,000	In: \$12,000

- ▶ After you reach your out-of-pocket maximum, all eligible expenses are covered up to 100% for the rest of the year. (See your Summary Plan Description for specific out-of-pocket information.)

A Flexible Spending Account helps you save even more

You may choose to open a health care and dependent care Flexible Spending Account (FSA) to reimburse yourself for eligible medical and dependent care (i.e. day care) expenses not covered by your plan. An FSA can help you save on taxes because the money you put into your FSA comes out of your paycheck before taxes.

Examples of eligible expenses include:

Deductibles and coinsurance - Travel costs for certain health care services - Out-of-pocket medical and dental costs - Charges for eyeglasses, contacts and radial keratotomy - Out-of-pocket psychiatric care - Vaccines and immunizations not covered by a medical plan (See IRS Publication 502 for a complete list of eligible expenses. You can access IRS Publication 502 at www.irs.gov and searching for "Publication 502" Contact your employer if you want to open a FSA.



Want more information on FSAs? Visit Alex Jackson, CPA at www.healthcarelane.com/cod





Understanding your HRA plan

A medical plan with an account to help pay your medical expenses

The Definity Health Reimbursement Account (HRA) plan includes a special account that you can use for health care expenses. The City of Dallas owns the account and puts money in it for you to use on eligible medical bills and pharmacy.

You have control over how the money is spent. And, you get personal support and online tools to help you spend it wisely and find care when you need it.

The plan is made up of two parts:

Medical Plan

- You have network coverage with an annual deductible and coinsurance. You are also protected from major expenses with an out-of-pocket maximum.
- Up to 100% coverage for preventive care. Please see your official benefit plan information for details.

Health Reimbursement Account:

- The City of Dallas puts money into your account each plan year.
- You use it to pay for eligible medical and pharmacy expenses and to help meet your annual deductible.
- The amount you don't use carries over to the next year.



Want more information on HRAs? Visit Campbell's Auto Care at www.healthcarelane.com/cod

HRA Plan Advantages

- You choose how your health care dollars are spent
- There is a limit on how much you will pay each year
- Generally, emergencies are covered anywhere in the world
- Unused HRA dollars carry over to next year's plan, and your employer will again fund your HRA, further reducing the out-of-pocket portion of your annual deductible
- Tools on myuhc.com help you:
 - check eligible expenses
 - check costs for treatment before doctor visits
 - find the best doctors and hospitals
 - manage your claims

How your HRA plan works

- 1** Your health expenses are paid by your HRA first

The City of Dallas contributes money to your account each year:

 - \$700 - Employee • \$1,700 - Employee+Spouse • \$1,700 - Employee+Child(ren) • \$1,700 - Family
 - Your HRA pays your eligible medical and pharmacy expenses as long as there are funds in it.
 - These payments apply toward your annual deductible.
 - You usually make no copayments at the doctor's office.

Employees can earn an additional \$300 in HRA dollars if they complete the Health Assessment on www.myuhc.com after January 1, 2011. Look for more information later in 2010 on how to earn this incentive.
- 2** After your HRA is used, you pay the rest of your deductible

Your annual deductible is the amount you need to pay before your medical plan pays. The annual deductible is:

 - \$2,500 - Employee • \$5,000 - Employee+Spouse • \$5,000 - Employee+Child(ren) • \$5,000 - Family
 - If you use all of your HRA, you pay the rest of the deductible amount out of your own pocket.
 - Preventive care is covered up to 100% by the medical plan whether or not you have met your deductible.
- 3** After your deductible is met, then, you pay only coinsurance

Once you have met your deductible, you and the medical plan share expenses. This is called coinsurance. The percentage you owe is:

In-Network
25%

For your protection, there is a limit on how much you need to pay out of your own pocket. Once you reach the amounts shown below, you are covered 100% for the rest of the year.

	Employee	Employee+Spouse	Employee+Child(ren)	Family
Out of pocket maximum	In: \$6,000	In: \$12,000	In: \$12,000	In: \$12,000

 - After you reach your out-of-pocket maximum, all eligible expenses are covered up to 100% for the rest of the year. (See your Summary Plan Description for specific out-of-pocket information.)

A Flexible Spending Account helps you save even more

You may choose to open a health care and dependent care Flexible Spending Account (FSA) to reimburse yourself for eligible medical and dependent care (i.e. day care) expenses not covered by your plan. An FSA can help you save on taxes because the money you put into your FSA comes out of your paycheck before taxes.

Examples of eligible expenses include:

Deductibles and coinsurance - Travel costs for certain health care services - Out-of-pocket medical and dental costs - Charges for eyeglasses, contacts and radial keratotomy - Out-of-pocket psychiatric care - Vaccines and immunizations not covered by a medical plan (See IRS Publication 502 for a complete list of eligible expenses. You can access IRS Publication 502 at www.irs.gov and searching for "Publication 502" Contact your employer if you want to open a FSA.

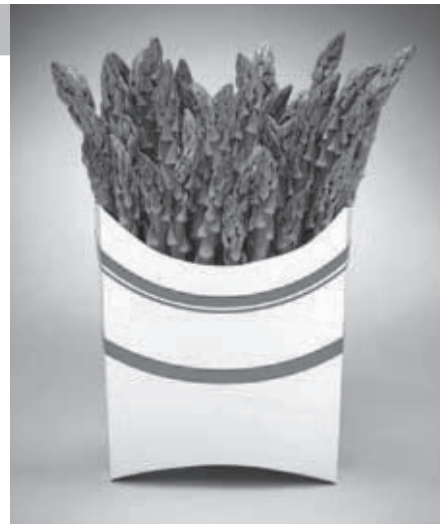


Prorated HRA funds (based on the month of enrollment):

If you enroll in the HRA plan or experience a Qualifying Life Event (QLE) after January 31, the funds allocated to your account balance will be reduced based on the table below. However, you will be responsible for your annual deductible.

Month	Employee Only	Employee & Dependents
January	\$700.00	\$1,700.00
February	\$658.33	\$1,558.33
March	\$616.66	\$1,416.66
April	\$574.99	\$1,274.99
May	\$533.32	\$1,133.32
June	\$491.65	\$991.65
July	\$449.98	\$849.98
August	\$408.31	\$708.31
September	\$366.64	\$566.64
October	\$324.97	\$424.97
November	\$283.30	\$283.30
December	\$241.63	\$147.63

What's the best way to improve your health?



Find out by taking a free confidential health assessment

A healthier life could be just a few clicks away. By taking a free online confidential Health Assessment, you can identify your personal health needs, learn healthy habits and compare your "lifestyle score" to others of the same age and gender. Plus, you'll have access to several health improvement resources.

It's easy to get started:

1. Go to www.myuhc.com[®]
2. If you already registered, log in to your account with your user name and password. If you are not registered, you must register with myuhc.com to access the Health Assessment. Follow the easy steps under Register Now.
3. After you are logged into myuhc.com, click on the Health Assessment box on the right side > then click on Launch University of Michigan Health Assessment and follow the instructions for completing the confidential Health Assessment.

Reach Your Goals

Health Assessment & Improvement helps you track progress toward your health goals. After you have completed the Health Assessment, you can review your assessment report and begin to take steps to improve your overall health and well-being. Once you have reached your goals, pat yourself on the back for a job well done!

HRA Enrolled Employees

Earn an additional \$300 HRA dollars in 2011 for completing the CONFIDENTIAL Personal Health Assessment after January 1, 2011. Look for more details later this year!



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

M48126 7/10 Consumer © 2010 United HealthCare Services, Inc.

On-Site Clinic Services For Employees Enrolled in City of Dallas Medical Plans

Visit Description	HRA Plan	70/30 \$3000 Deductible Plan
Preventive Care Services <ul style="list-style-type: none"> • Services provided on-site at the Clinic • Lab services that are sent out to LabCorp will be processed according to your medical plan benefits. 	<ul style="list-style-type: none"> • No cost to the employee or dependents. • Paid at 100%. 	<ul style="list-style-type: none"> • No cost to the employee or dependents. • \$3000 deductible is waived, services are subject to 30% coinsurance.
Injury or Illness Care - Diagnostic Services <ul style="list-style-type: none"> • Service provided on-site at the Clinic. • Lab services that are sent out to LabCorp will be processed according to your medical plan benefits. 	<ul style="list-style-type: none"> • No cost the employee or dependents. • Services are subject to 25% coinsurance, after \$2500 deductible is met. HRA funds will be used, if still available. 	<ul style="list-style-type: none"> • No cost the employee or dependents. • Services are subject to 30% coinsurance, after \$3000 deductible is met.

Any referrals made by the clinic to providers outside of the clinic (physicians or other facilities) are subject to the network status of the provider and your specific plan benefits.

Please visit www.myuhc.com to search for network providers and view your medical plan benefits.

On-site Clinic Services For Employees NOT Enrolled in City of Dallas Medical Plans

Visit Description	
Preventive Care Services <ul style="list-style-type: none"> • Services provided on-site at the Clinic 	<ul style="list-style-type: none"> • \$25.00 fee at point of service • Labs taken and sent to an outside laboratory are processed at full cost to employee.
Injury or Illness Care - Diagnostic Services <ul style="list-style-type: none"> • Service provided on-site at the Clinic. • Lab services 	<ul style="list-style-type: none"> • \$25.00 fee at point of service • Labs taken and sent to an outside laboratory are processed at full cost to employee.

Pricing for Employees, Dependents and Retirees
(determined by insurance coverage)

covered under City of Dallas UHC plan

Free All center visits and “in-house” lab services and treatments

At cost All “outside” lab services and xrays (billed through your UHC plan)

no insurance plan through City of Dallas *

\$25 Urgent Care

\$25 Preventive Care

At cost All lab services

** Employees and Dependents only. Retirees without a plan through the City of Dallas cannot use the center*

Note: We do NOT provide prenatal, obstetric, or pediatric care (children under 5 years)

If you are experiencing any of the following conditions or symptoms, seek treatment immediately at an emergency department:

- Eye or head trauma
- Dizziness or confusion
- Chest pain
- Shortness of breath
- Severe allergic reaction
- Seizure
- Severe abdominal pain
- Severe cuts or burns
- Suspected poisoning

Services include:

Urgent Care

- Allergies
- Athletes foot and nail fungus
- Bladder infection
- Minor burns and wound care
- Bronchitis
- Eye and ear infections
- Colds and influenza
- Cough and sore throat
- Cuts and bruises
- Diarrhea and vomiting
- Fungal infections
- Insect bites and stings
- Poison oak and poison ivy
- Sinus infections
- Skin rashes and infections
- Sprains and strains
- Splinter removal
- Strep throat/tonsillitis
- Upper respiratory infections
- Urinary tract infections
- Viral illnesses

Onsite Testing and Treatments

- Rapid Strep
- Rapid Flu
- Urinalysis
- Cholesterol, glucose
- TB tests (PPD)
- EKGs
- Nebulizer treatments for asthma/COPD

Preventive Care

- Health education and counseling
- Blood pressure screening
- Cholesterol and blood sugar screening
- Cancer screening (pap, psa, fecal blood)
- Preventive health exams
- Gender health (reproductive choices, healthy sexual practices, health screenings, etc.)
- Oral contraception for family planning
- HIV and hepatitis counseling and testing
- Dietary and fitness counseling
- Tobacco use counseling and treatment

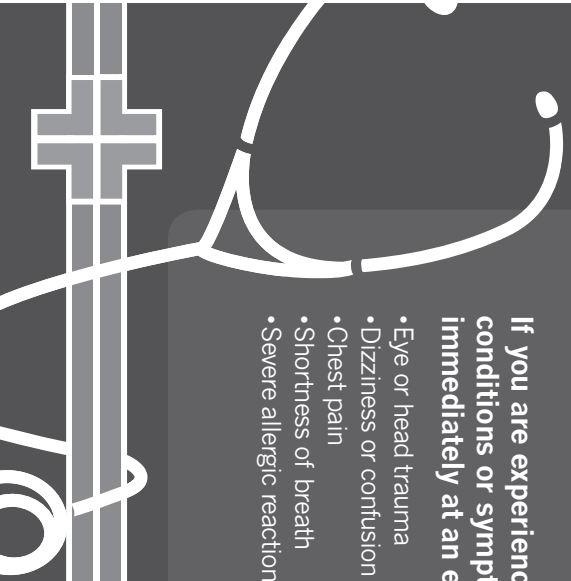
Interim Care for Chronic Conditions *

** In coordination with your primary care physician or specialist*

- Acne
- Arthritis
- Asthma
- Colitis and diverticulitis
- Diabetes
- Eczema
- Emphysema and COPD
- Gastritis and GERD
- Headaches (migraine)
- Hemorrhoids
- High blood pressure
- High cholesterol
- Psoriasis
- Weight management

Vaccinations

- Diphtheria/Tetanus/Pertussis (T/d/Tdap)
- Hepatitis A and hepatitis B
- Meningococcal
- MMR
- Pneumococcal
- Reduced cost flu shots during flu season



Personal Health Support



Personal Health Support programs give you access to services and clinical support across the range of health and wellness goals. From staying healthy and getting healthy to managing a chronic condition, there is a program or service to meet your unique health care needs.

If you are with UnitedHealthcare, you have access to a wealth of Personal Health Support resources and programs at no extra charge to you. They are included with your benefits and all of your personal health information is treated with the highest level of confidentiality.

A number of health care programs are available to you.

If you don't need this support right now, know that UnitedHealthcare Personal Health Support is there if you ever do. Your UnitedHealthcare benefit also includes a number of health improvement programs and resources on myuhc.com[®]. Programs that range from weight loss to fitness to smoking cessation are available to all members. Simply go to myuhc.com today and click "Health & Wellness".

Care 24[®]

Care24 services offer you access to a wide range of health and well-being information – seven days a week, 24 hours a day. Using one toll-free phone number, you can speak with registered nurses and master's-level counselors who can help with almost any problem ranging from medical and family matters to personal, legal, financial and emotional needs.

Call the number on the back of your member ID card for access to:

- Registered nurses
- Master's-level counselors
- Legal and financial professionals
- Community resources

Support for a wide range of topics

- Childhood illnesses
- Minor illnesses and injuries
- Medication safety
- Relationship worries
- Choosing appropriate medical care
- Stress and anxiety
- Coping with grief and loss
- Personal legal and financial issues
- Self-care information
- Help finding a doctor
- Information on medications
- General health information

Call 1-800-586-6875

HealthNotes

UnitedHealthcare has a new way we want to communicate with you.

The messages are called HealthNotes (pronounced "healthy notes"), and we designed them to provide you with personalized care opportunities to improve your health.

One of the best things about a HealthNote is you don't have to do a thing to receive one. We'll send them to you automatically when we have a message or recommendation we think would benefit you. For example, if you are a diabetic and our evidence-based medicine guidelines suggest lab tests twice a year, we may send you a HealthNote message in the mail to remind you to schedule your tests. Or maybe you have a chronic kidney disorder; so we may send you opportunities we have found to help you better manage your condition, such as reminders to take your medications the way your doctor has prescribed them.

So be on the lookout for a HealthNote message that might arrive in your mailbox. If you receive one, please take a few moments to read it and consider how you can apply the health care recommendations and tips to your life.

We want you to be as healthy as you can be and we're here to help.

Treatment Decision Support

If you are considering treatment decisions for a specific condition, Treatment Decision Support (TDS) is available to help you make informed decisions. TDS can help you:

- Select the treatment option that best meets your needs
- Choose a physician and hospital for your treatment
- Prepare you for your upcoming treatment and for a successful recovery

Call 1-800-586-6875

Coronary Artery Disease (CAD) Program

The Coronary Artery Disease program is designed to reduce unnecessary hospitalizations and health care costs, and improve your quality of life. The program gives you information and resources to help you:

- Reduce or eliminate your risk factors, such as high cholesterol, high blood pressure, diabetes, excess weight, obesity, cigarette smoking, and lack of physical activity
- Maintain a healthy lifestyle and follow your doctor's treatment plans and medication recommendations including proper use of beta blockers, ACE inhibitors, statins and antiplatelet medications
- Effectively manage your coronary artery disease with other conditions, including depression

Diabetes Management Program

- The Diabetes Disease Management program helps you manage the “ABCs” of diabetes – A1C (or blood sugar control), blood pressure and cholesterol – and learn how to best manage your condition.
- The program provides wide-ranging benefits that focus on medication, diet and exercise tips to help you live a healthy life and get the best value from every dollar you will spend on your care.
- A registered nurse will call you if your medical condition qualifies you for this program. Your nurse will keep in touch with you and help you set up a diabetes self-management plan.
- The program is entirely voluntary and you can be assured your personal privacy will be protected. There is no additional cost to you and your family.

Heart Failure Program

The Heart Failure Disease Management program seeks to reduce unnecessary hospitalizations and health care costs and works to improve your health. The program provides information and resources to help you:

- Manage your condition through daily monitoring of key findings, including weight and symptom changes, and symptom-specific management
- Follow physician treatment plans and drug therapy
- Manage your risk factors including hypertension, asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease and depression
- Understand your condition and how to receive the most clinically appropriate, cost-effective and timely tests and procedures



Because of the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against OptumHealth or its affiliates, or any entity through which the caller is receiving OptumHealth services directly or indirectly (e.g. employer or health plan).

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, Inc. or their affiliates.

The Care24® program integrates elements of traditional employee assistance and work-life programs with health information lines for a comprehensive set of resources. Program components may not be available in all states or for all groups. Care24 is a registered trademark of UnitedHealth Group, Inc., used by permission. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against OptumHealth or its affiliates, including UnitedHealthcare, or any entity through which the caller is receiving OptumHealth services directly or indirectly (e.g. employer or health plan).

Care24 may not be available in all states or for all group sizes. Components are subject to change.

HealthNotes messages are based on information we've received from your care providers and pharmacies. But due to possible delays in receiving data, and because your situation is unique, we may not have all your information. If we have incorrect information, please disregard those messages. Our goal is to provide you with all the information we have to help ensure you receive the best care possible. Rest assured, our suggestions are kept private in accordance with your health plan's privacy policy and are not used when determining benefits, reviewing claims or making other insurance decisions. HealthNotes messages are not a substitute for a doctor's or professional's care.



Printed on paper containing recycled material.

Ten great reasons to use myuhc.com[®]



The tools and information at myuhc.com are both practical and personalized so you can get the most out of your benefits. Register at myuhc.com and connect to current information about your plan benefits and health care interests.

- 1. Compare costs for different health plans.** Choose a plan that's right for you and your family needs. **Select *Plan Cost Estimator*** located under Links and Tools
- 2. Ask health care professionals.** Communicate one-on-one online 7 days a week with a registered nurse who can help answer your questions and give you advice. **Select *Live Nurse Chat*** located on the Home page
- 3. Organize your medical claims online.** View processed claims, remaining balances for deductibles and out-of-pocket expenses via your Health Statements. Download claims to a spreadsheet, set-up automatic payments, direct deposits and more. **Select *Claims & Accounts***
- 4. Get information about hospitals and physicians.** Find information on network doctors and health care professionals. You can even find out what physicians are recognized in the UnitedHealth Premium[®] designation program, a free informational tool that evaluates physician and facilities using national quality and cost efficiency standards in their specialty. **Select *Physicians & Facilities***
- 5. Order and renew prescriptions online.*** See information about your pharmacy benefits, prescription history and drug coverage. Order prescriptions or check order status. Learn more about medications, including interactions and side effects.

Price a Medication and find out whether there is a lower cost option. Locate a neighborhood pharmacy or even arrange home delivery of your order. **Select *Pharmacies & Prescriptions***
- 6. Learn more about your coverage.** Check your current eligibility, deductibles and out-of-pocket costs; confirm what's covered and what's not covered **Select *Benefits & Coverage***
- 7. Organize and store all of your health data in one convenient, confidential place.** Record your family health history, allergies and immunizations, and personal contacts. Review medical and pharmacy claims information, as well as lab results. Track your progress with important Health Trackers such as blood pressure, cholesterol, and weight. Print or download a historical claims summary known as the Personal Health Summary. **Select *Personal Health Record***
- 8. Improve your health habits.** Participate in Health Coaching Programs that help set goals to achieve health objectives. Find out the best way to improve your health by taking the online Health Assessment. **Select *Health & Wellness*** or click on the Health Assessment from the Home page
- 9. Learn about health conditions and treatment options.** Medical information from reliable resources recognized by physicians. **Select *Health & Wellness > Conditions AtoZ***
- 10. Request a medical ID card.** Print a temporary ID card or request a replacement card. **Select *Account Settings***

It's easy to register:

- 1 Visit myuhc.com and click "*Register Now*"
- 2 Enter the requested information
- 3 Begin using the site

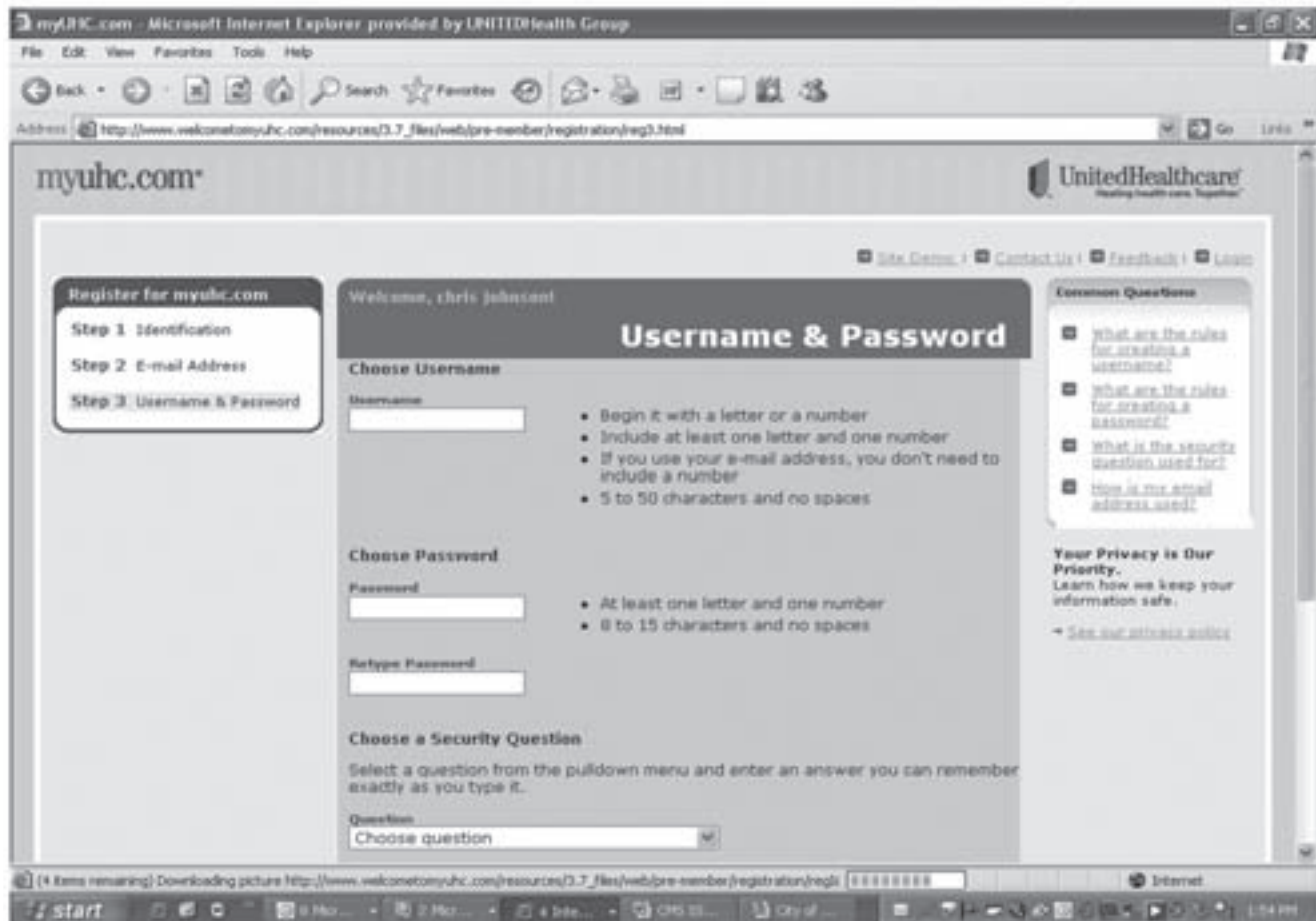
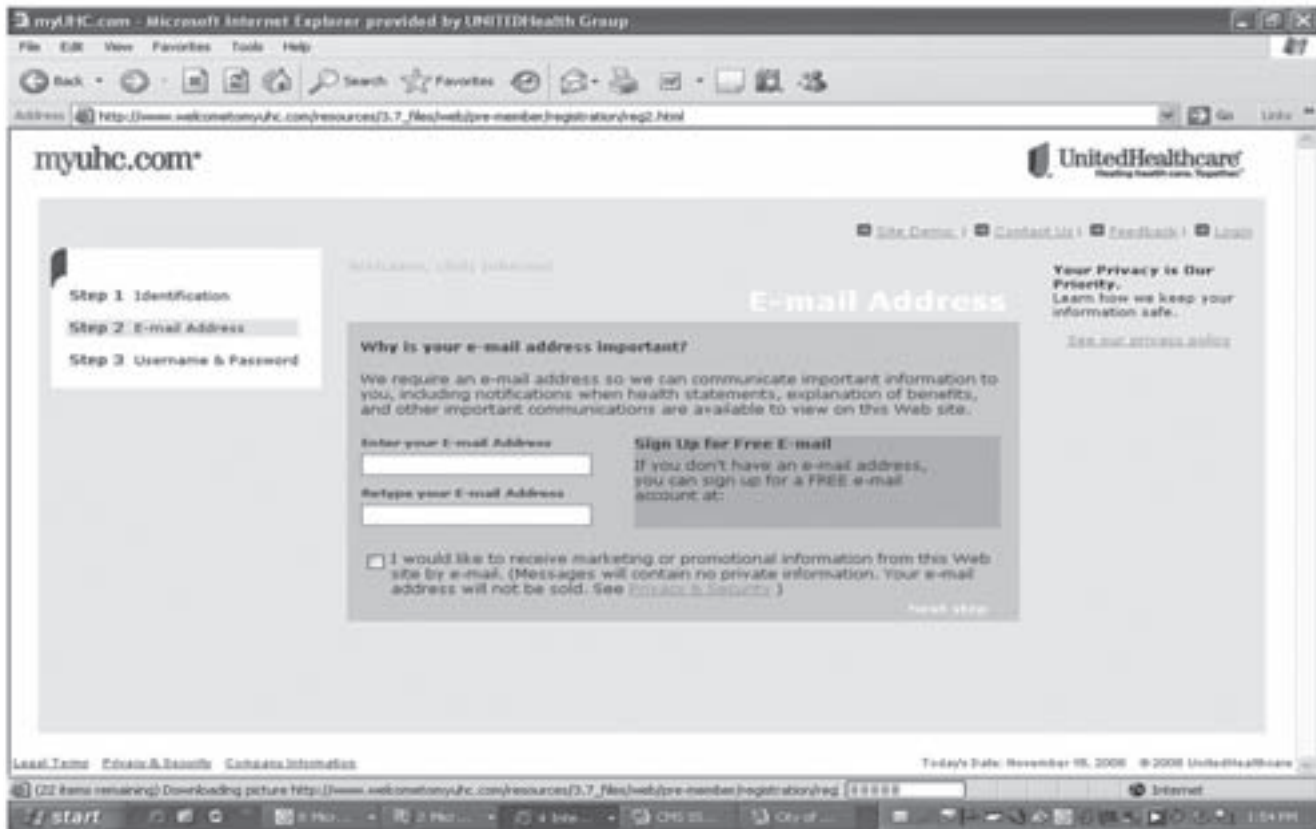


* You must have UnitedHealthcare pharmacy benefits to see pharmacy information on myuhc.com. Some plans do not include Home Delivery benefits.

For a complete description of the UnitedHealth Premium[®] Designation program, including details on the methodology used, geographic availability, program limitations and medical specialties participating, please see myuhc.com[®].

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

How to register on www.myuhc.com



Welcome to your UnitedHealthcare Pharmacy

Remember effective October 1, 2010, City of Dallas will use Prescription Solutions through UnitedHealthcare for your pharmacy benefit needs. You will need to present your new UnitedHealthcare ID Card that includes the Prescription Solutions logo when you fill prescriptions at your local network pharmacy. You will also need to use Prescription Solutions® Mail Service Pharmacy for future mail order refills or new mail order prescriptions.

Pharmacy Benefit Program

Your pharmacy benefit provides coverage for the majority of prescription medications approved by the U.S. Food and Drug Administration (FDA). Our goal is to support you and your doctor by providing access to a wide variety of medications and helping to make the medications you need more affordable. We offer programs and tools to help you make informed decisions, save money and get the most out of your pharmacy benefit.

Make informed decisions

When selecting a medication, you and your doctor should consult the UnitedHealthcare Prescription Drug List (PDL). The PDL includes most brand and generic medications approved by the FDA. Medications may be placed on different “tiers” based on their overall value, with tier 1 being the most affordable tier option. To determine if a medication is covered by your pharmacy benefit, its tier level and any available lower cost alternatives, visit www.myuhc.com and click on “Pharmacies and Prescriptions.”

Drugs may change tier levels throughout the plan year, but a change to a higher tier will only occur upon renewal. If you are going to be affected with a higher cost share, you will receive notification approximately 60 days in advance of the tier change effective date. This advance notice is provided to allow you time to consult with your physician on possible alternatives before your cost share increases.

Look for lower cost alternatives

Generic medications contain the same active ingredients — the chemicals that make a medication work — as brand medications, and they must meet the same strict FDA standards for quality, strength and purity as brand medications. Over 75% of brands have generic equivalents available, so ask your doctor if one is appropriate for you. While generics are typically less expensive than the brand, that may not always be the case, so be sure to check prices at myuhc.com® to determine your lowest cost option.

Specialty medications

Specialty medications are critical to improving the health and lives of individuals – and are some of the most expensive medications being used today. We want to make these medications accessible and affordable for you and for your employer. Specialty medications typically cost greater than \$250 per prescription, are frequently administered by injection or infusion, treat rare, unusual or complex conditions and require additional clinical oversight and expertise.

Members currently taking a designated specialty product will be required to use a designated specialty network pharmacy after the second fill. **If you continue to fill your specialty medication at a non-designated specialty pharmacy, you will be responsible for paying for the entire cost of the medication after the second fill.** You will be notified via mail if you are taking a specialty medication that is part of this program which requires a specific pharmacy for continued coverage. You can continue to fill your non-specialty prescriptions at your regular retail network or mail order pharmacy.

In addition, specialty drugs are limited to a 31 day supply, which allows the physician to assess the drug's effectiveness and eliminate waste.

Through our specialty pharmacies, you will receive comprehensive education and clinical support to help improve your medication outcomes. Call our Specialty Team, at 1-866-218-7398 to locate a designated specialty pharmacy that works for you.

For new Specialty medication prescriptions, call our Specialty Team, at 1-866-218-7398 to locate a designated specialty pharmacy that works for you.

Using a participating retail pharmacy

Choose a pharmacy that's in the network

To get the most from your pharmacy benefit, you should use a participating retail pharmacy. More than 64,000 retail pharmacies are in our network, including both chain and independent stores located across the United States. Filling prescriptions at pharmacies outside our network will increase your cost.

To find participating retail pharmacies near you, visit our Web site at www.myuhc.com or call the toll-free Customer Care number on your ID card.

Fill prescriptions at a participating retail pharmacy

Simply show your ID card to the pharmacist. Your pharmacist will tell you how much you owe for the prescription.

Pharmacies and Prescriptions

Understanding your pharmacy benefit — and the choices it offers — can help you get the most out of your coverage and help you save money on prescription medications. Myuhc.com is convenient and secure and uses the latest technology and tools to let you compare and analyze medications and benefit options. Simply log in to myuhc.com and click on "Pharmacies and Prescriptions."

After you log in, you can access:

- Payment, pricing and coverage information about most prescription medications
- Information about lower cost medication alternatives
- A list of participating retail pharmacies by ZIP code
- Your prescription history

You may also call the Customer Care number listed on your ID card.

Using the mail order pharmacy

UnitedHealthcare's **Prescription Solutions® Mail Service Pharmacy** makes it easy to save money and time on maintenance medications you take every day. You could save money because we'll send you a 90-day supply of your maintenance medications. Your cost at mail-order will generally be lower, since our mail order pharmacy buys in bulk and is able to pass along greater discounts. Plus, shipping directly to your home is free.

As of October 1, 2010, your mail order pharmacy will be Prescription Solutions.

NOTE: **Existing prescriptions** at the current mail order will be transferred to Prescription Solutions Mail order. To refill your prescription after the transition, you simply need to call 1-800-562-6223 and provide your ID number to the representative.

Getting started on a new prescription with mail service is simple. Choose the method that works best for you:

1. Call 1-800-562-6223, 24 hours a day, 7 days a week. Be sure to have your medication name and dosage handy. You'll also need your doctor's name and phone number. We'll call your doctor to get a new prescription.
2. You can download a mail service order form at myuhc.com® - Click on Manage My Prescriptions. Mail your original prescription, payment and completed order form to the address listed on the form. Write your date of birth on each prescription.

For new medications: Ask your doctor for two prescriptions. The first should be for a 30-day supply. The second should be for a 90-day supply with three refills. Fill the 30-day prescription at your local pharmacy. You can start mail service as soon as your doctor confirms the medication is working well for you.

3. Your doctor can call in your prescription to 1-800-791-7658 or fax it to 1-800-491-7997. Faxed prescriptions will only be accepted from a doctor's office.

Your prescription should arrive in about seven days from the time we receive your completed order. Refills can be done by phone, mail or online at myuhc.com. Click on "*Pharmacies and Prescription*" and then "*Prescription Solutions*."

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Medicare Eligible Retiree Benefits Information

MEDICARE ELIGIBLE BENEFITS

How to Enroll

(Medicare Eligible Retiree Information)

Enrollment information

During the annual enrollment period, you can choose to change or keep your same benefit coverage for 2011. It's important to make your choices carefully, as you will not be able to change your elections until the next annual enrollment period, unless you have a qualified status change.

Enrollment period: September 7, 2010 through October 29, 2010

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

Enrollment types

- The post-65 retiree's benefits enrollment will be passive, meaning if you are satisfied with your 2010 coverage (AARP Plans C, F, K, Medicare Part D, dental and vision plans) and wish to keep the same coverage for 2011, then no action is required on your part to continue.
- If you are currently enrolled in the 75/25/HRA plan, you must contact AARP to enroll in a supplemental plan (800-449-4954) and contact the Benefits Service Center (888-752-9122) to enroll in Medicare Part D or the 70/30/3000 plan because post-65 members can not be enrolled in the HRA plan beginning 1/1/2011.
- Effective 7/1/2011, retirees enrolled in the 70/30/3000 plan will be responsible for 100% of the premium. If you would like to enroll in an AARP supplemental plan and/or Medicare Part D please contact the vendor at the number listed.

Enrollment method and instructions

- If you would like to enroll or make changes to your AARP Plans C, F or K, please call AARP directly at 800-449-4954 during open enrollment.
- If you would like to enroll or make changes to your Medicare Part D, dental and vision, please call the Benefits Service Center directly at 888-752-9122 during open enrollment.
- Elections made by calling the Benefits Service Center will be treated as an agreement to pay any required premium through payroll deduction.
- You may also enroll by scheduling an appointment with a benefits counselor at City Hall by calling the Benefits Service Center at 888-752-9122 between 8 am and 5 pm CST during the enrollment period.
- Should you experience a long hold time, leave a voicemail message with a daytime telephone number where you can be reached and your call will be returned within 24 to 48 hours. Spanish-speaking assistance is available.

Review of benefit elections

- After making enrollment elections, a confirmation statement will be mailed by the Benefits Service Center showing your 2011 benefit elections.
- Review the confirmation statement that you receive in the mail from the Benefits Service Center and retain it for your records as proof of your timely enrollment. If there are errors on your confirmation statement, you must contact the Benefits Service Center to make the corrections. Also, make sure you review your January 2011 pension check to verify your benefit elections and insurance deductions are correct.

Verification of personal information

To receive your identification cards promptly, make sure that your current mailing address is correct in the City's Human Resource Information System. You can call the Benefits Service Center for enrollment changes, or to report an address change or other corrections as necessary.

Changing your benefits mid-year (qualified status change)

You can only change your benefit elections during the plan year if you undergo a qualified status change as defined by Internal Revenue Service guidelines. Your enrollment changes must be completed within 30 days of the qualifying event. If you fail to change your elections within 30 days of your event, you will have to wait until the next year's annual enrollment period to change your elections.

- **Reporting eligibility changes during the year**

You must report changes in dependent eligibility to the Benefits Service Center at 1-888-752-9122 within 30 days of the change (such as divorce, marriage or dependent child becoming ineligible). All status changes must be made within 30 days of the status change. If you are adding a spouse or dependent to your coverage, appropriate documentation will be required.

- **Special Note: If you cancel your medical coverage as a retiree, you or your dependents may not re-enroll in any City-Sponsored medical plans in the future.**

Duplicate medical coverage by retiree

In the case where two city retirees both are eligible for coverage, only one may enroll for dependent coverage. Both retirees **cannot cover** each other. In the case both retirees have eligible dependents, only one retiree can cover the dependents. Both retirees **cannot cover** their eligible dependents. If a retiree and his or her spouse are employed or retired from different employers and are covered by the same insurance carrier, the health plan will pay only up to the allowable.

Important Disclaimers

Paying for Medical Coverage

Medical premiums are paid on a post-tax basis for all retirees. Your annual cost of medical coverage depends on the benefit option you choose and the level of coverage you need. Premium costs for 2011 can be found in this benefits and enrollment guide.

- Contributions shall be paid by pension check deduction by all Members who receive pension checks in sufficient amount to permit deduction for the contributions. For each Regular pension check during the plan year a member will pay the monthly rates indicated in Article IV of the Master Plan Document. If for any reason a Member's pension check is not reduced by the amount of a contribution or does not receive pension check with a sufficient amount to permit deduction for the contributions, contributions must be paid by check or money order on a monthly basis.
- For each regular pension check during the plan year a member will pay the monthly rates indicated in this enrollment guide.
- A grace period of thirty days shall be allowed for the payment of each contribution paid directly by the member. If any contribution is not paid within the grace period, the coverage shall terminate on the last date for which contributions are paid.
- Dropping Coverage - If the notice for dropping coverage is received by Employee Benefits prior to the 15th of the month, deductions will not be taken and coverage will end the last day of the previous month. If the notice for dropping dependent coverage is received by Employee Benefits after the 15th of the month, deductions and coverage will be discontinued the first day of the following month.

Benefits information for certain Medicare-eligible retirees

Medical benefit options

For certain Medicare-eligible retirees, the City will continue to offer its Medicare Supplements, Medicare HMO and Medicare Part D benefit options. If you have any questions, please contact the benefits provider.

In the next few months, you will receive a letter from your Medicare Part D provider to alert you of the following information.

- Annual Notice of Change (ANOC), which will include:
 - 2011 Formulary List
 - Summary of Benefits
 - Mail-order information
 - Pharmacy Directory
- Explanation of Benefits (EOB)
- Explanation of Coverage (EOC)

The documents listed above will require no action on your part because you are already enrolled. **However**, if you receive a **Late Enrollment Penalty Letter**, you are required to *complete and return* as instructed in the letter. For help in completing this letter, please call the City of Dallas Benefits Service Center at 1-888-752-9122.

Post-65 Rates –2011 Plan Year

Post-65 AARP Supplement Plan Rates

Tier	Plan C	Plan F	Plan K
Retiree Only	\$110.88	\$110.88	\$54.88
Retiree + Spouse	\$320.76	\$321.82	\$158.76
Spouse Only	\$209.88	\$210.94	\$103.88

United Medicare Rx

Tier	Part D [^] (Option I)	Part D [^] (Option II)
Retiree Only	\$128.04	\$64.05
Retiree + Spouse	\$327.32	\$203.10
Spouse Only	\$199.28	\$139.05

Option I - Has full gap coverage for Brand and Generic drugs.

Option II - Has full gap coverage for Generics only, donut hole would apply to Brand name drugs only.

Post-65 Medicare Complete HMO Plan Rates

Tier	Individual	High Option	Low Option
Retiree Only	\$0.00	\$128.80	\$84.00
Retiree + Spouse	\$0.00	\$372.60	\$243.00
Spouse Only	\$0.00	\$243.80	\$159.00

*Medicare supplement plans: monthly cost for Texas residents

Rates are for Texas residents only. Rates for other states will vary. All rates subject to change during 2011. Actual rates, which may contain discounts or surcharges, are subject to change and will be provided in the enrollment kits provided to prospective insured. Retirees also will pay Medicare Part B monthly premiums.

[^]Medicare Part D prescription-only plan

No medical included. Purchase with or without Medicare Supplement plan. This plan **cannot** be purchased with the PPO plans.

Plan C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

- * A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
- ** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* - Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
61 st through 90 th day	All but \$267 a day	\$267 a day	\$0
91 st day and after:			
– While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
– Once lifetime reserve days are used:			
▪ Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
▪ Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD – First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE – Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

- *** Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$135 of Medicare-approved amounts***	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare-approved amounts)	\$0	\$0	All costs

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Plan C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (continued)

*** Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
BLOOD – First 3 pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts***	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment:			
▪ First \$135 of Medicare-approved amounts***	\$0	\$135 (Part B Deductible)	\$0
▪ Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Plan F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

- * A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
- ** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* - Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
61 st through 90 th day	All but \$267 a day	\$267 a day	\$0
91 st day and after:			
– While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
– Once lifetime reserve days are used:			
▪ Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
▪ Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD – First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE – Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

- *** Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$135 of Medicare-approved amounts***	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare-approved amounts)	\$0	100%	\$0

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.
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Plan F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (continued)

*** Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
BLOOD – First 3 pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts***	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment:			
▪ First \$135 of Medicare-approved amounts***	\$0	\$135 (Part B Deductible)	\$0
▪ Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Plan K

◆ You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4620 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of the Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay◆
HOSPITALIZATION** - Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$534 (50% of Part A Deductible)	\$534 (50% of Part A Deductible)◆
61 st through 90 th day	All but \$267 a day	\$267 a day	\$0
91 st day and after:			
– While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
– Once lifetime reserve days are used:			
▪ Additional 365 days (lifetime)	\$0	100% of Medicare Eligible Expenses	\$0***
▪ Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE** - You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$133.50 a day	Up to \$66.75 a day	\$66.75 a day◆
101 st day and after	\$0	\$0	All costs
BLOOD –			
First 3 Pints	\$0	50%	50%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE – Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments◆

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Plan K

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

◆ This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$4620 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**** Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay◆
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$135 of Medicare-Approved Amounts****	\$0	\$0	\$135 (Part B Deductible)****◆
Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare- approved amounts	Remainder of Medicare- approved amounts	All costs above Medicare- approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
PART B EXCESS CHARGES (Above Medicare-Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$4620)
BLOOD – First 3 Pints	\$0	50%	50%◆
Next \$135 of Medicare-Approved Amounts****	\$0	\$0	\$135 (Part B Deductible)****◆
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
▪ First \$135 of Medicare-Approved Amounts****	\$0	\$0	\$135 (Part B Deductible)****◆
▪ Remainder of Medicare-Approved Amounts	80%	10%	10%◆

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

United Medicare Rx™ - Option I

United MedicareRx Enhance Medicare Part D Prescription Drug Plan

The City of Dallas is pleased to be offering you a Medicare Part D prescription drug plan, called United MedicareRx, offered through UnitedHealthcare Insurance Company. Coverage will be effective beginning January 1, 2011. With United MedicareRx, you will have prescription drug insurance you can count on to protect you and to meet your prescription drug needs today and in the future.

Here are some of the key features of this prescription drug coverage:

No annual deductible or out of pocket maximum – start saving with the first prescription you fill

Predictable and **affordable flat co-pays**- as low as \$10.00 for generic drugs

No need to worry about the coverage gap or “doughnut hole” – you’re fully covered

A **formulary** that includes 100% of the drugs covered by Medicare Part D

National pharmacy network with over 60,000 convenient locations so you are covered at home or while you are traveling across the United States.

Part D Benefits

The United MedicareRx plan has three different levels of co-pays for a 31-day supply of prescription drugs. The United MedicareRx plan formulary covers 100% of the drug covered by Medicare Part D. Effective on or after October 1, 2010. A complete formulary listing will be available on request or online at www.UnitedMedicareRx.com.

Your Co-pays beginning January 1, 2011 for the three tiers are:

Contracted retail Pharmacy Co-pay Levels	Type of Medication
Tier 1 - \$10	Most generic drugs, lowest co-pay
Tier 2 - \$25	Preferred brand-name drugs, medium co-pay
Tier 3/Specialty - \$50	Non-preferred or unique drugs, higher co-pay

Summary of Prescription Drug Benefits Effective January 1, 2011 to December 31, 2011		
Drug Benefit	2011 Out-of-Pocket Costs	You Pay
Outpatient Prescription Drugs	\$0 - \$4,550 (a) in Enrollee/Plan Out-of-Pocket	<p>Retail</p> <p>\$10 co-pay for a one month (31 day) Supply of Tier 1 drugs</p> <p>\$25 co-pay for a one month (31 day) Supply of Tier 2 drugs</p> <p>\$50 co-pay for a one month (31 day) Supply of Tier 3 or Specialty Tier drugs</p> <p>Mail Services</p> <p>\$20 co-pay for a three month (90 day) Supply of Tier 1 drugs you get through Our contracted Mail Service Pharmacy</p> <p>\$50 co-pay for a three month (90 day) Supply of Tier 1 drugs you get through Our contracted Mail Service Pharmacy</p> <p>\$100 co-pay for a three month (90 day) Supply of Tier 1 drugs you get through Our contracted Mail Service Pharmacy</p>
Catastrophic Care	Over \$4,550 (a) in Enrollee Out-of-Pocket	You pay the greater of \$2.50 or 5% co-insurance for generic or a preferred Brand name drug that is a multi-source Drug, and \$6.30 for all other drugs, or 5% Once your total out-of-pocket costs reach \$4,550

(a) The above out-of-pocket and catastrophic coverage dollars were established by CMS and the amounts shown in the exhibits were by CMS for 2010 and subject to change as of January 1, 2011. Please refer to www.medicare.gov for additional info.

United Medicare Rx™ - OPTION II

United MedicareRx Enhance Medicare Part D Prescription Drug Plan

The City of Dallas is pleased to be offering you a Medicare Part D prescription drug plan, called United MedicareRx, offered through UnitedHealthcare Insurance Company. Coverage will be effective beginning January 1, 2011. With United MedicareRx, you will have prescription drug insurance you can count on to protect you and to meet your prescription drug needs today and in the future.

Here are some of the key features of this prescription drug coverage:

No annual deductible or out of pocket maximum – start saving with the first prescription you fill
Predictable and **affordable flat co-pays** until you reach the gap.

Coverage Gap (donut hole): Generic drugs covered at copays in the gap. Medicare Part D covered brand medications in the gap @ 50% co-insurance.

A **formulary** that includes 100% of the drugs covered by Medicare Part D

National pharmacy network with over 60,000 convenient locations so you are covered at home or while you are traveling across the United States.

Part D Benefits

The United MedicareRx plan has three different levels of co-pays for a 31-day supply of prescription drugs. The United MedicareRx plan formulary covers 100% of the drug covered by Medicare Part D. Effective on or after October 1, 2010. A complete formulary listing will be available on request or online at www.UnitedMedicareRx.com.

Your Co-pays prior to reaching the gap (donut hole) beginning January 1, 2011 for the three tiers are:

Contracted retail Pharmacy Co-pay Levels	Type of Medication
Tier 1 - \$10	Most generic drugs, lowest co-pay
Tier 2 - \$25	Preferred brand-name drugs, medium co-pay
Tier 3/Specialty - \$50	Non-preferred or unique drugs, higher co-pay

Summary of Prescription Drug Benefits Effective January 1, 2011 to December 31, 2011		
Drug Benefit	2011 Out-of-Pocket Costs	You Pay
Outpatient Prescription Drugs	\$0 - \$2,840 (a) in Enrollee/Plan Out-of-Pocket. (Until you reach the coverage gap/donut hole)	<p>Retail</p> <p>\$10 co-pay for a one month (31 day) Supply of Tier 1 drugs</p> <p>\$25 co-pay for a one month (31 day) Supply of Tier 2 drugs</p> <p>\$50 co-pay for a one month (31 day) Supply of Tier 3 or Specialty Tier drugs</p> <p>Mail Services</p> <p>\$20 co-pay for a three month (90 day) Supply of Tier 1 drugs you get through Our contracted Mail Service Pharmacy</p> <p>\$50 co-pay for a three month (90 day) Supply of Tier 1 drugs you get through Our contracted Mail Service Pharmacy</p> <p>\$100 co-pay for a three month (90 day) Supply of Tier 1 drugs you get through Our contracted Mail Service Pharmacy</p>

Coverage Gap (Donut Hole)	\$2,841 - \$4,550 (a) in Enrollee/Plan/Manufacturer Out of Pocket Expense	<p>Retail \$10 co-pay for a one month (31 day) Supply of Generic drugs</p> <p>50% co-insurance for a one month (31 day) Supply of Medicare Coverage Brand drugs. (Tier 2 and 3)</p> <p>Mail Services \$20 co-pay for a three month (90 day) Supply of Generic drugs you get through Our contracted Mail Service Pharmacy</p> <p>50% co-insurance for a three month (90 day) Supply of Medicare Coverage Brand drugs. (Tier 2 and 3)</p>
Catastrophic Care	Over \$4,550 (a) in Enrollee Out-of-Pocket	<p>You pay the greater of \$2.50 or 5% co-insurance for generic or a preferred Brand name drug that is a multi-source Drug, and \$6.30 for all other drugs, or 5%</p> <p>Once your total out-of-pocket costs reach \$4,550</p>

(a) The above out-of-pocket and catastrophic coverage dollars were established by CMS and the amounts shown in the exhibits were by CMS for 2010 and subject to change as of January 1, 2011. Please refer to www.medicare.gov for additional info.

SecureHorizons® by UnitedHealthcare®

SecureHorizons Medicare Complete – Low Option HMO Plan-18410	
Benefits and Coverage	Member's Costs
Physician Services/Basic Health Services Consultation, diagnosis, and treatment Primary Care Physician Specialist	\$15 co-payment per office visit \$25 co-payment per office visit
Annual Physical Examination Includes Pap smears	Covered in full
Immunizations Flu shots, pneumococcal vaccine and Hepatitis B injections All other Medicare-approved immunizations	Covered in full Covered in full
Hospitalization	\$500 co-payment per admission*
Non-network/out-of-Area Urgent Care	\$25 co-payment
Ambulance Services Medically necessary ambulance transport	\$50 co-payment
Outpatient Surgical Services Certified Ambulatory Surgical Center Outpatient Hospital Facility	\$250 co-payment \$250 co-payment
Outpatient Mental Health Care/ Outpatient Substance Abuse Treatment	\$25 co-payment
Inpatient Psychiatric Care/ Inpatient Substance Abuse Treatment	\$500 co-payment per admission, up to 190 Days lifetime maximum in a psychiatric hospital
Emergency Services You may go to any emergency room if you Reasonably believe you need emergency care	Covered Worldwide \$50 co-payment, waived if admitted to hospital Within 24 hours for the same condition
Prescription Drugs – Retail (up to 30 day-supply)	\$15 generic; \$25 brand-name; \$40 non-formulary
Prescription Drugs – Mail Order (90 day-supply)	\$30 generic; \$50 brand-name; \$80 non-formulary
Renal Dialysis	\$25 at network facility or Medicare Facility
Radiation Therapy	\$25 co-payment
Radiology Services Standard X-ray films Specialized scanning and imaging procedures CT, SPECT, PET, MRI—with or without contrast media	Covered in full
Skilled Nursing Facility Care	Covered \$0/day Days 1-20, \$50/day Days 21-100 up to 100 days per benefit period** in a Medicare-certified Skilled Nursing Facility
Vision Care Examination for eyeglasses (Refraction)	\$25 for Medicare covered eye exams, per visit
Hearing Services Routine hearing examination	\$25 for Medicare covered hearing exams, per visit
Chiropractic Services	\$25 co-payment, per office visit; Medicare Benefit only

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

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

SecureHorizons®

by UnitedHealthcare®

SecureHorizons Medicare Complete – High Option HMO Plan-18409	
Benefits and Coverage	Member's Costs
Physician Services/Basic Health Services Consultation, diagnosis, and treatment Primary Care Physician Specialist	\$10 co-payment per office visit \$20 co-payment per office visit
Annual Physical Examination Includes Pap smears	\$0 Primary Care Physician
Immunizations Flu shots, pneumococcal vaccine and Hepatitis B injections All other Medicare-approved immunizations	Covered in full Covered in full
Hospitalization	\$250 co-payment per admission*
Non-network/out-of-Area Urgent Care	\$25 co-payment
Ambulance Services Medically necessary ambulance transport	\$50 co-payment
Outpatient Surgical Services Certified Ambulatory Surgical Center Outpatient Hospital Facility	\$125 co-payment \$125 co-payment
Outpatient Mental Health Care/ Outpatient Substance Abuse Treatment	\$20 co-payment
Inpatient Psychiatric Care/ Inpatient Substance Abuse Treatment	\$250 co-payment per admission, up to 190 Days lifetime maximum in a psychiatric hospital
Emergency Services You may go to any emergency room if you Reasonably believe you need emergency care	Covered Worldwide \$50 co-payment, waived if admitted to hospital Within 24 hours for the same condition
Prescription Drugs – Retail (up to 30 day-supply)	\$10 generic; \$20 brand-name; \$40 non-formulary
Prescription Drugs – Mail Order (90 day-supply)	\$20 generic; \$40 brand-name; \$80 non-formulary
Renal Dialysis	\$20 at network facility or Medicare Facility
Radiation Therapy	\$20 co-payment
Radiology Services Standard X-ray films Specialized scanning and imaging procedures CT, SPECT, PET, MRI–with or without contrast media	Covered in full
Skilled Nursing Facility Care	Covered \$0/day Days 1-20, \$50/day Days 21-100 up to 100 days per benefit period** in a Medicare-certified Skilled Nursing Facility
Vision Care Examination for eyeglasses (Refraction)	\$10 Primary Care Physician/ \$20 Specialist co-payment, per office visit
Hearing Services Routine hearing examination	Medicare diagnostic hearing examinations - \$20 Specialist co-payment, per office visit
Chiropractic Services	\$10 Primary Care Physician/\$20 co-payment, per office visit

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

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

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***Dental and Vision
Benefits Information***

Dental Plan Overview

UnitedHealthcare is our provider for dental plan offerings for 2010. Your options for dental include the Dental HMO which provides in network benefits exclusively and the PPO (Indemnity) Plan which allows you to select your provider. You may access the fee schedule below.

Plan Features	UHC PPO		UHC DHMO	UHC EPO
	In-Network	Out-of-Network	In-Network Only	
Calendar Year Deductible *Individual *Family	\$50 \$150		\$0 \$0	\$50 \$150
Maxium *Calendar Year *Orthodontic Lifetime	\$1000 per person N/A		\$0 *****	\$1250 \$1500
Visits and Exams *Office visit *Oral Exam *X-rays	You pay 0%	You pay any charges in excess of Allowed Amount*	Office visit: \$5 Oral exam \$0 X-rays: \$0	Copays vary by service according to Patient Charge Schedule*
Basic Services *Filings *General Services *Space Maintainers	You pay 0%	You pay 20% and any charges in excess of Allowed Amount*	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*
Major Services *Crowns *Dentures/bridges	You pay 50%	You pay 50% and any charges in excess of Allowed Amount*	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*
Orthodontic Services	Not Covered	Not Covered	Copays vary by service according to Patient Charge Schedule*	Copays vary by service according to Patient Charge Schedule*

**The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.

2011 Dental Monthly Rates for Retirees			
	UHC PPO	UHC DHMO	UHC EPO
Member Only	\$24.37	\$7.84	\$18.20
Member + Spouse	\$48.76	\$14.43	\$33.48
Member + Child(ren)	\$49.73	\$14.51	\$33.66
Member + Family	\$74.13	\$20.40	\$47.33

Dental PPO Information

UnitedHealthcare

dental plan

Voluntary Options PPO/covered dental services for CITY OF DALLAS

Custom Option p5527

	NON-ORTHODONTICS			
	NETWORK	NON-NETWORK		
Individual Annual Calendar Year Deductible	\$50	\$50		
Family Annual Calendar Year Deductible	\$150	\$150		
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	\$1000 per person per Calendar	\$1000 per person per Calendar		
New enrollee's waiting period:	Network: - 12 months Major		Non Network: - 12 months Major	
Annual deductible applies to preventive and diagnostic services			No	
COVERED SERVICES	NETWORK PLAN PAYS*	NON-NETWORK PLAN PAYS**	BENEFIT GUIDELINES	
PREVENTIVE & DIAGNOSTIC				
Oral Evaluations (Diagnostic)	100%	100%	Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per consecutive 12 months.	
X Rays (Diagnostic)	100%	100%	Bite-wing: Limited to 1 series of film per calendar year. Complete/Panorex: Limited to one time per consecutive 36 months.	
Lab and Other Diagnostic Tests	100%	100%		
Prophylaxis (Preventive)	100%	100%	Limited to 2 times per consecutive 12 months.	
Fluoride Treatment (Preventive)	100%	100%	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months. Treatment should be done in conjunction with dental prophylaxis.	
Sealants	100%	100%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	
BASIC SERVICES				
Restorations (Amalgams and Resin Based Only)	80%	80%	Multiple restorations on one surface will be treated as a single filling. Composite: for anterior teeth only.	
General Services (Emergency Treatment and Anesthesia)	80%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: when clinically necessary.	
Space Maintainers	80%	80%	Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.	
Simple Extractions	50%	50%		
Oral Surgery (includes surgical extractions)	50%	50%		
Periodontics	50%	50%	Perio Surgery: Limited to once every consecutive 36 months per surgical area. Root Planning: Limited to one time per quadrant per consecutive 24 months. Perio Maintenance: Limited to 2 times per consecutive 12 months period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.	
Endodontics	50%	50%		
MAJOR SERVICES				
Inlays/Onlays/Crowns	50%	50%	Limited to one time per tooth per consecutive 60 months. Covered only when silver fillings cannot restore the tooth.	
Dentures and other Removable Prosthetics	50%	50%	Once every 60 months. No additional allowances for over-dentures or customized dentures.	
Fixed Prosthetics	50%	50%	Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.(alternate benefits for a partial denture may be applied)	

*The network percentage of benefits is based on the discounted fee negotiated with the provider.

**The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.

Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the fee for the service actually rendered and the fee for the service upon which the plan benefit is based.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; or United HealthCare Services, Inc.
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UnitedHealthcare/Dental Exclusions and Limitations

General Limitations

ORAL EXAMINATIONS Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months.

BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

DIAGNOSTIC CASTS Limited to one time per consecutive 24 months.

FLUORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months. Treatment should be done in conjunction with dental prophylaxis.

SEALANTS Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.

SPACE MAINTAINERS Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months. Treatment should be done in conjunction with dental prophylaxis.

AMALGAM RESTORATIONS Multiple restorations on one surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to Cast Restoration.

GOLD INLAYS AND ONLAYS Limited to one time per tooth per consecutive 60 months. Covered only when silver fillings cannot restore the tooth.

CROWNS Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy.

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than X-rays and exam, were done during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.

FULL DENTURES Once every 60 months. No additional allowances for over-dentures or customized dentures.

PARTIAL DENTURES No additional allowances for precision or semi precision attachments.

RELINING DENTURES Limited to relining done more than 6 months after the initial insertions. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES,

BRIDGES Limited to repairs or adjustments done more than 12 months after the initial insertion.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

OCCUSAL GUARDS Limited to one guard per consecutive 36 months. Only covered for habitual grinding.

General Exclusions

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Dental Services provided in a foreign country, unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for 12 continuous months.
15. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of dental implants, implant-supported abutments and prostheses {(D6010-D6079) & (D6090-D6194)}. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
20. Placement of fixed partial dentures (D6210- D6793, D6920) solely for the purpose of achieving periodontal stability.
21. Billing for incision and drainage (ADA Code D7510, D7520) if the involved abscessed tooth is removed on the same date of service.
22. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision. (D7413-D7415, D7440-D7441, D7485-D7490).
23. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue (D7610-D7780).
24. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral (D7810-D7899). Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery (D7920-D7949), jaw alignment or treatment for the temporomandibular joint.
25. Acupuncture; acupressure and other forms of alternative treatment.
26. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
27. Occlusal guard used as safety items or to affect performance primarily in sports-related activities (D9941).
28. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
29. Services of a participating provider than can be effectively treated by a less costly, clinically acceptable alternative procedure in accordance with the "Standards of Care" established by DBP with its participating providers. These services, if appropriate, will be covered under the less costly clinically acceptable alternative procedure.

Dental HMO Information

**NATIONAL PACIFIC DENTAL
CENTURY SELECT
PLAN SE350
Benefit and Copayment Schedule**

CDT-5 Code	Procedure Description	Member Co-Pay	CDT-5 Code	Procedure Description	Member Co-Pay
Diagnostic (00100-00999): Exams; x-rays; and related tests.			Restorative (02000-02999): Continued		
09999	Unspecified Adjunctive Procedure, By Report ² Office Visit (Infection Control Included)	\$5.00	02934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth ³	\$55.00
00120	Periodic Oral Evaluation	No Co-Pay	02940	Sedative Filling	\$10.00
00140	Limited Oral Evaluation - Problem Focused (Emergency)	No Co-Pay	02950	Core Build-Up, Including Any Pins	\$40.00
00150	Comprehensive Oral Evaluation - New or Established Patient	No Co-Pay	02951	Pin Retention - Per Tooth, in Addition to Restoration	\$36.00
00160	Detailed and Extensive Oral Evaluation - Problem Focused, By Report	No Co-Pay	02952	Cast Post Core In Addition to Crown	\$75.00
00170	Re-Evaluation - Limited, Problem Focused (Established Patient; not Post-Operative Visit)	No Co-Pay	02953	Each Additional Cast Post - Same Tooth	\$15.00
00180	Comprehensive Periodontal Evaluation - New or Established Patient	No Co-Pay	02954	Prefabricated Post and Core in Addition to Crown	\$65.00
00210	Intraoral - Complete Series (Including Bitewings) (x-ray)	No Co-Pay	02955	Post Removal (Not in Conjunction with Endodontic Therapy)	\$15.00
00220	Intraoral - Periapical First Film (x-ray)	No Co-Pay	02957	Each Additional Prefabricated Post - Same Tooth	\$16.00
00230	Intraoral - Periapical Each Additional Film (x-ray)	No Co-Pay	Endodontics (03000-03999): Pulp caps; root canals; apical surgery; retrogrades; hemisections and related procedures.		
00240	Intraoral - Occlusal Film (x-ray)	No Co-Pay	03110	Pulp Cap - Direct (Excluding Final Restoration)	\$12.00
00250	Extraoral - First Film (x-ray)	No Co-Pay	03120	Pulp Cap - Indirect (Excluding Final Restoration)	\$3.00
00260	Extraoral - Each Additional Film (x-ray)	No Co-Pay	03220	Therapeutic Pulpotomy (Excluding Final Restoration) - Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament	\$20.00
00270	Bitewings - Single Film (x-ray)	No Co-Pay	03221	Pulpal Debridement, Primary and Permanent Tooth	No Co-Pay
00272	Bitewings - Two Films (x-ray)	No Co-Pay	03230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	\$20.00
00274	Bitewings - Four Films (x-ray)	No Co-Pay	03240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	\$20.00
00277	Vertical Bitewings - Seven to Eight Films (x-ray)	No Co-Pay	03310	Root Canal Therapy - Anterior (Excluding Final Restoration)	\$95.00
00330	Panoramic Film (x-ray)	No Co-Pay	03320	Root Canal Therapy - Bicuspid (Excluding Final Restoration)	\$150.00
00415	Collection of Microorganisms for Culture and Sensitivity	No Co-Pay	03330	Root Canal Therapy - Molar (Excluding Final Restoration)	\$225.00
00416	Viral Culture	No Co-Pay	03410	Apicoectomy/Periradicular Surgery - Anterior	\$125.00
00421	Genetic Test for Susceptibility to Oral Diseases	No Co-Pay	03421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	\$175.00
00425	Caries Susceptibility Tests	No Co-Pay	03425	Apicoectomy/Periradicular Surgery - Molar (First Root)	\$185.00
00460	Pulp Vitality Tests	No Co-Pay	03426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$90.00
00470	Diagnostic Casts	No Co-Pay	03430	Retrograde Filling - Per Root	\$60.00
Preventive (01000-01999): Prophylaxis (cleanings); fluoride; and related maintenance procedures.			Periodontics (04000-04999): Includes root planing/curettage; gingival and osseous surgery; and related procedures; includes pre-op and post-op evaluations and local anesthetic; charting must be performed in conjunction with these procedures.		
01110	Prophylaxis - Adult	No Co-Pay	04210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	\$140.00
01120	Prophylaxis - Child ¹	No Co-Pay	04211	Gingivectomy or Gingivoplasty - One to Three Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	\$94.00
01201	Topical Application of Fluoride (Including Prophylaxis) - Child ¹	No Co-Pay	04240	Gingival Flap Procedure, Including Root Planing - Four or More Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	\$200.00
01203	Topical Application of Fluoride (Prophylaxis Not Included) - Child ¹	No Co-Pay	04241	Gingival Flap Procedure, Including Root Planing - One to Three Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	\$134.00
01204	Topical Application of Fluoride (Prophylaxis Not Included) - Adult	No Co-Pay	04260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	\$300.00
01205	Topical Application of Fluoride (Including Prophylaxis) - Adult	No Co-Pay	04261	Osseous Surgery (Including Flap Entry and Closure) - One to Three Contiguous Teeth or Bounded Teeth Spaces, Per Quadrant	\$200.00
01351	Sealant - Per Tooth ¹	\$6.00	04341	Periodontal Scaling and Root Planing - Four or More Teeth, Per Quadrant	\$50.00
01510	Space Maintainer - Fixed - Unilateral	\$55.00	04342	Periodontal Scaling and Root Planing, One to Three Teeth Per Quadrant	\$34.00
01515	Space Maintainer - Fixed - Bilateral	\$55.00	04355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	\$40.00
01520	Space Maintainer - Removable - Unilateral	\$60.00	04910	Periodontal Maintenance	\$30.00
01525	Space Maintainer - Removable - Bilateral	\$60.00	Prostodontics, Removable (05000-05899): Full and partial dentures; includes fabrication and/or repair of prosthesis and routine post-delivery care.		
01550	Re-Cementation of Space Maintainer	\$15.00	05110	Complete Denture - Maxillary	\$300.00
Restorative (02000-02999): Amalgams, resins, pins, and single crowns: includes bases; pulp caps; liners; and preparation, temporization and cementation of cast restorations; and cast crowns.			05120	Complete Denture - Mandibular	\$300.00
02140	Amalgam - One Surface, Primary or Permanent	\$12.00	05130	Immediate Denture - Maxillary	\$325.00
02150	Amalgam - Two Surfaces, Primary or Permanent	\$15.00	05140	Immediate Denture - Mandibular	\$325.00
02160	Amalgam - Three Surfaces, Primary or Permanent	\$16.00	05211	Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	\$320.00
02161	Amalgam - Four or More Surfaces, Primary or Permanent	\$18.00	05212	Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	\$320.00
02330	Resin-Based Composite - One Surface, Anterior	\$15.00	05213	Maxillary Partial Denture - Cast Metal Framework with Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	\$350.00
02331	Resin-Based Composite - Two Surfaces, Anterior	\$18.00	05214	Mandibular Partial Denture - Cast Metal Framework with Resin Base (Including Any Conventional Clasps, Rests, and Teeth)	\$350.00
02332	Resin-Based Composite - Three Surfaces, Anterior	\$23.00	05410	Adjust Complete Denture - Maxillary	\$10.00
02335	Resin-Based Composite - Four or More Surfaces, or Involving Incisal Angle (Anterior)	\$68.00	05411	Adjust Complete Denture - Mandibular	\$10.00
02390	Resin-Based Composite Crown, Anterior	\$30.00	05421	Adjust Partial Denture - Maxillary	\$10.00
02391	Resin-Based Composite - One Surface, Posterior	\$50.00	05422	Adjust Partial Denture - Mandibular	\$10.00
02392	Resin-Based Composite - Two Surfaces, Posterior	\$70.00	05510	Repair Broken Complete Denture Base	\$29.00
02393	Resin-Based Composite - Three Surfaces, Posterior	\$90.00	05520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	\$22.00
02394	Resin-Based Composite - Four or More Surfaces, Posterior	\$90.00			
02750	Crown - Porcelain Fused to High Noble Metal ³	\$255.00			
02751	Crown - Porcelain Fused to Predominantly Base Metal	\$255.00			
02752	Crown - Porcelain Fused to Noble Metal ³	\$255.00			
02780	Crown - 3/4 Cast High Noble Metal ³	\$255.00			
02781	Crown - 3/4 Cast Predominantly Base Metal	\$255.00			
02782	Crown - 3/4 Cast Noble Metal ³	\$255.00			
02790	Crown - Full Cast High Noble Metal ³	\$255.00			
02791	Crown - Full Cast Predominantly Base Metal	\$255.00			
02792	Crown - Full Cast Noble Metal ³	\$255.00			
02794	Crown - Titanium ³	\$255.00			
02910	Re-Cement Inlay, Onlay, or Partial Coverage Restoration	\$15.00			
02915	Re-Cement Cast or Prefabricated Post and Core	\$15.00			
02920	Re-Cement Crown	\$15.00			
02930	Prefabricated Stainless Steel Crown - Primary Tooth ¹	\$55.00			
02931	Prefabricated Stainless Steel Crown - Permanent Tooth ¹	\$55.00			

Please Call NPD For All Specialty Care Referrals 800-232-0990

**NATIONAL PACIFIC DENTAL
CENTURY SELECT
PLAN SE350
Benefit and Copayment Schedule**

CDT-5 Code	Procedure Description	Member Co-Pay	CDT-5 Code	Procedure Description	Member Co-Pay
Prosthodontics, Removable (05000-05899): Continued			Oral Surgery (07000-07999): Nonsurgical and surgical extractions and related procedures; includes pre-op and post-op evaluations and treatment under local anesthetic.		
		You Pay \$			You Pay \$
05610	Repair Resin (Partial) Denture Base	\$30.00	07111	Extraction, Coronal Remnants - Deciduous Tooth	\$15.00
05620	Repair Cast (Partial Denture) Framework	\$30.00	07140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	\$15.00
05630	Repair or Replace Broken Clasp (Partial Denture)	\$30.00	07210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	\$25.00
05640	Replace Broken Teeth (Partial Denture) - Per Tooth	\$30.00	07220	Removal of Impacted Tooth - Soft Tissue	\$50.00
05650	Add Tooth to Existing Partial Denture	\$30.00	07230	Removal of Impacted Tooth - Partially Bony	\$65.00
05660	Add Clasp to Existing Partial Denture	\$45.00	07240	Removal of Impacted Tooth - Completely Bony	\$110.00
05670	Replace All Teeth and Acrylic on Cast Metal (Partial) Framework (Maxillary)	\$288.00	07241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	\$110.00
05671	Replace All Teeth and Acrylic on Cast Metal (Partial) Framework (Mandibular)	\$288.00	07250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	\$40.00
05710	Rebase Complete Maxillary Denture	\$100.00	07270	Tooth Re-Implantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	\$65.00
05711	Rebase Complete Mandibular Denture	\$100.00	07280	Surgical Access of an Unerupted Tooth	\$65.00
05720	Rebase Maxillary Partial Denture	\$100.00	07310	Alveoloplasty in Conjunction with Extraction - Per Quadrant	\$45.00
05721	Rebase Mandibular Partial Denture	\$100.00	07311	Alveoloplasty in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant	\$30.00
05730	Reline Complete Maxillary Denture (Chairside)	\$60.00	07320	Alveoloplasty Not in Conjunction with Extractions - Per Quadrant	\$60.00
05731	Reline Complete Mandibular Denture (Chairside)	\$60.00	07321	Alveoloplasty Not in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant	\$40.00
05740	Reline Maxillary Partial Denture (Chairside)	\$60.00	07510	Incision and Drainage of Abscess - Intraoral Soft Tissue	\$35.00
05741	Reline Mandibular Partial Denture (Chairside)	\$60.00	07520	Incision and Drainage of Abscess - Extraoral Soft Tissue	\$35.00
05750	Reline Complete Maxillary Denture (Laboratory)	\$95.00	07910	Suture of Recent Small Wounds up to 5 cm	No Co-Pay
05751	Reline Complete Mandibular Denture (Laboratory)	\$95.00	07960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	\$60.00
05760	Reline Maxillary Partial Denture (Laboratory)	\$95.00	Orthodontics (08000-08999): Orthodontic treatment; related procedures to improve a patient's craniofacial dysfunction and/or dentofacial deformity.		
05761	Reline Mandibular Partial Denture (Laboratory)	\$95.00	08050	Interceptive Orthodontic Treatment of the Primary Dentition (Phase 1) ⁴ Up To	\$1,300.00
05820	Interim Partial Denture (Maxillary)	\$110.00	08060	Interceptive Orthodontic Treatment (Primary/Transitional Dentition) (Phase 1) ⁴ Up To	\$1,300.00
05821	Interim Partial Denture (Mandibular)	\$110.00	08070	Comprehensive Orthodontic Treatment of the Transitional Dentition (24 Month Case)	\$2,400.00
05850	Tissue Conditioning, (Maxillary)	\$30.00	08080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (24 Month Case)	\$2,400.00
05851	Tissue Conditioning, (Mandibular)	\$30.00	08090	Comprehensive Orthodontic Treatment of the Adult Dentition (24 Month Case)	\$2,600.00
Prosthodontics, Fixed (06200-06999): Abutments; pontics and related procedures. Includes diagnosis/models; preparation, temporization, fabrication and cementation of final restoration.			08210	Removable Appliance Therapy	\$560.00
06210	Pontic - Cast High Noble Metal ³	\$255.00	08220	Fixed Appliance Therapy	\$560.00
06211	Pontic - Cast Predominantly Base Metal	\$255.00	08660	Pre-Orthodontic Treatment Visit (Orthodontic Consultation)	\$150.00
06212	Pontic - Cast Noble Metal ³	\$255.00	08670	Periodic Orthodontic Treatment (In Conjunction With Comprehensive Orthodontic Treatment)	No Co-Pay
06214	Pontic - Titanium ³	\$255.00	08680	Orthodontic Retention - Per Arch (Removal of Appliances, Construction and Placement of Retainers(s))	\$95.00
06240	Pontic - Porcelain Fused to High Noble Metal ³	\$255.00	08999	Unspecified Orthodontic Procedure, By Report ² - Diagnostic Workup	\$250.00
06241	Pontic - Porcelain Fused to Predominantly Base Metal	\$255.00		Premium Transparent Brackets (Per Arch)	\$200.00
06242	Pontic - Porcelain Fused to Noble Metal ³	\$255.00	Adjunctive General Services (09110-09999):		
06250	Pontic - Resin with High Noble Metal ³	\$255.00	09110	Palliative (Emergency) Treatment of Dental Pain - Minor Procedure	No Co-Pay
06251	Pontic - Resin with Predominantly Base Metal	\$255.00	09211	Regional Block Anesthesia	No Co-Pay
06252	Pontic - Resin with to Noble Metal ³	\$255.00	09212	Trigeminal Division Block Anesthesia	No Co-Pay
06720	Crown - Resin with High Noble Metal ³	\$255.00	09215	Local Anesthesia	No Co-Pay
06721	Crown - Resin with Predominantly Base Metal	\$255.00	09230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	\$10.00
06722	Crown - Resin with Noble Metal ³	\$255.00	09310	Consultation (Diagnostic Service Provided by Dentist or Physician Other than Practitioner Providing Treatment)	No Co-Pay
06750	Crown - Porcelain Fused to High Noble Metal ³	\$255.00	09440	Office Visit After Regularly Scheduled Hours	\$35.00
06751	Crown - Porcelain Fused to Predominantly Base Metal	\$255.00	09450	Case Presentation, Detailed and Extensive Treatment Planning	No Co-Pay
06752	Crown - Porcelain Fused to Noble Metal ³	\$255.00			
06780	Crown - 3/4 Cast High Noble Metal ³	\$250.00			
06781	Crown - 3/4 Cast Predominantly Base Metal	\$250.00			
06782	Crown - 3/4 Cast Noble Metal ³	\$250.00			
06790	Crown - Full Cast High Noble Metal ³	\$255.00			
06791	Crown - Full Cast Predominantly Base Metal	\$255.00			
06792	Crown - Full Cast Noble Metal ³	\$255.00			
06794	Crown - Titanium ³	\$255.00			
06930	Recement Fixed Partial Denture	\$10.00			
06940	Stress Breaker	\$40.00			
06970	Cast Post and Core in Addition to Fixed Partial Denture Retainer	\$70.00			
06972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	\$70.00			
06973	Core Build-Up for Retainer, Including any Pins	\$40.00			
06980	Fixed Partial Denture Repair, By Report	\$45.00			

- 1 For children age 14 and under only
- 2 Other than those procedures listed, no other unspecified procedures are covered
- 3 Does not include the cost of noble metal, high noble metal, or titanium
- 4 Not to exceed the amount listed in the co-pay column; can be less than the amount listed

To be covered, all services and procedures must be considered dentally necessary by your Primary Care Dentist.

The above procedures are performed as needed and deemed necessary by your attending Panel Dentist - subject to applicable Limitations, Exclusions and Governing Administrative Policies of the Program. Please refer to these sections for further clarification of benefits. (See Limitations and Exclusions)

UnitedHealthcare Dental

EPO - Plan Code PIN69

Deductible	\$50 / \$150
Annual Maximum	\$1,250
Lifetime Orthodontic Maximum	\$1,500
Waiting Period for Orthodontic Services	12 months waiting period
Eligibility for Orthodontic coverage (Network & Non-Network)	child (up to age 19)

(Standard Exclusions, Limitations and Alternate Benefit rules apply)

Enrollee Copay Schedule			
Service Code	Service Description	Enrollee Network Copay	Out of Network Plan Pays
Diagnostic & Preventive			
	Office Visit	\$5	\$0
D0120	Periodic Oral Evaluation	\$0	\$22
D0140	Limited Oral Evaluation - Problem Focused	\$0	\$32
D0145	Oral Evaluation - Patient under 3 years of age	\$0	\$36
D0150	Comprehensive Oral Evaluation - New or Established Patient	\$0	\$36
D0170	Re-evaluation - Limited, Problem Focused (Established Patient; Not Post-Operative Visit)	\$0	\$30
D0180	Comprehensive Periodontal Evaluation - New Or Established Patient	\$0	\$42
D0210	X-Rays Intraoral - Complete Series (including bitewings)	\$0	\$58
D0220	X-Rays Intraoral - Periapical First Film	\$0	\$12
D0230	X-Rays Intraoral - Periapical Each Additional Film	\$0	\$10
D0240	X-Rays Intraoral - Occlusal Film	\$0	\$21
D0250	Extraoral first film (by report)	\$0	\$28
D0260	Extraoral each additional film (by report)	\$0	\$27
D0270	X-Rays (Bitewing) - Single Film	\$0	\$13
D0272	X-Rays (Bitewings) - Two Films	\$0	\$19
D0273	X-Rays (Bitewings) - Three Films	\$0	\$28
D0274	X-Rays (Bitewings) - Four Films	\$0	\$28
D0277	X-Rays (Bitewing, Vertical) - 7 to 8 Films	\$0	\$50
D0330	X-Rays (Panoramic)	\$0	\$54
D0415	Bacteriologic Studies - Pathologic Agents	\$0	\$33
D0425	Caries Susceptibility Tests	\$0	\$33
D0460	Pulp Vitality Tests	\$0	\$27
D0470	Diagnostic Casts	\$0	\$56
D1110	Prophylaxis - Adult	\$0	\$46
D1120	Prophylaxis - Child	\$0	\$33
D1201	Topical Fluoride Including Prophy - Child	\$0	\$45
D1203	Topical Application of Fluoride - (prophylaxis not included) - Child	\$0	\$18
D1204	Topical Fluoride Including Prophy - Adult	\$0	\$18
D1205	Topical Application of Fluoride - (prophylaxis not included) - Adult	\$0	\$53
D1206	Topical Fluoride Varnish - Moderate to High Caries Risk Patient	\$0	\$18
D1351	Sealant - Per Tooth	\$6	\$23
D1510	Space Maintainer - Fixed - Unilateral	\$55	\$125
D1515	Space Maintainer - Fixed - Bilateral	\$55	\$185
D1520	Space Maintainer-Removable Unilateral	\$60	\$165
D1525	Space Maintainer-Removable Bilateral	\$60	\$245
D1550	Recement Space Maintainer	\$15	\$23
D1555	Removal of Fixed Space Maintainer	\$15	\$23
Restorative			
D2140	Amalgam - One Surface, Primary or Permanent	\$12	\$46
D2150	Amalgam - Two Surfaces, Primary or Permanent	\$15	\$57
D2160	Amalgam - Three Surfaces, Primary or Permanent	\$16	\$73
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	\$18	\$98
D2330	Resin-Based Composite - One Surface, Anterior	\$15	\$57
D2331	Resin-Based Composite - Two Surfaces, Anterior	\$18	\$71
D2332	Resin-Based Composite - Three Surfaces, Anterior	\$23	\$91
D2335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	\$68	\$62
D2390	Resin-Based Composite Crown, Anterior	\$30	\$100

UnitedHealthcare Dental

EPO - Plan Code PIN69

Deductible	\$50 / \$150
Annual Maximum	\$1,250
Lifetime Orthodontic Maximum	\$1,500
Waiting Period for Orthodontic Services	12 months waiting period
Eligibility for Orthodontic coverage (Network & Non-Network)	child (up to age 19)

(Standard Exclusions, Limitations and Alternate Benefit rules apply)

Enrollee Copay Schedule

Service Code	Service Description	Enrollee Network Copay	Out of Network Plan Pays
D2391	Resin-Based Composite - One Surface, Posterior	\$50	\$80
D2392	Resin-Based Composite - Two Surfaces, Posterior	\$70	\$60
D2393	Resin-Based Composite - Three Surfaces, Posterior	\$90	\$40
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	\$90	\$40
D2750	Crown - Porcelain Fused to High Noble Metal	\$255	\$315
D2751	Crown - Porcelain Fused to Predominantly Base Metal	\$255	\$275
D2752	Crown - Porcelain Fused to Noble Metal	\$255	\$285
D2780	Crown - 3/4 Cast High Noble Metal	\$255	\$335
D2781	Crown - 3/4 Cast Predominantly Base Metal	\$255	\$295
D2782	Crown - 3/4 Cast Noble Metal	\$255	\$315
D2790	Crown - Full Cast High Noble Metal	\$255	\$295
D2791	Crown - Full Cast Predominantly Base Metal	\$255	\$255
D2792	Crown - Full Cast Noble Metal	\$255	\$275
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	\$15	\$40
D2920	Recement Crown	\$15	\$40
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	\$55	\$90
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	\$55	\$110
D2940	Sedative Filling	\$10	\$46
D2950	Core Buildup, Including Any Pins	\$40	\$80
D2951	Pin Retention - Per Tooth, In Addition to Restoration	\$36	\$10
D2952	Cast Post and Core, In Addition to Crown	\$75	\$140
D2953	Each additional Cast Post Same Tooth (by report)	\$15	\$200
D2954	Prefabricated Post and Core In Addition to Crown	\$65	\$95
D2955	Post Removal (not in conjunction with endodontic therapy)	\$15	\$145
Endodontics			
D3110	Pulp Cap - Direct (Excluding Final Restoration)	\$12	\$27
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	\$5	\$25
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	\$20	\$72
D3310	Anterior Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$105	\$256
D3320	Bicuspid Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$165	\$265
D3330	Molar Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$248	\$323
D3410	Apicoectomy/Periradicular Surgery - Anterior	\$125	\$330
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	\$175	\$325
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	\$185	\$375
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$90	\$95
D3430	Retrograde Filling - Per Root	\$60	\$80
Periodontics			
D4210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	\$154	\$226
D4211	Gingivectomy or Gingivoplasty - 1-3 Contiguous Teeth or Bounded Teeth Space (per quadrant)	\$94	\$16
D4240	Gingival Flap Procedure, Including Root Planing - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	\$220	\$230
D4241	Gingival Flap Procedure - 1-3 Contiguous Teeth or Bounded Teeth Space (per quadrant)	\$147	\$303
D4260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	\$330	\$300
D4261	Osseous Surgery (Including Flap Entry and Closure) - 1-3 Contiguous Teeth or Bounded Teeth Space (per quadrant)	\$220	\$410
D4341	Periodontal Scaling and Root Planing, Four or More Teeth Per Quadrant	\$58	\$63

UnitedHealthcare Dental EPO - Plan Code PIN69

Deductible	\$50 / \$150
Annual Maximum	\$1,250
Lifetime Orthodontic Maximum	\$1,500
Waiting Period for Orthodontic Services	12 months waiting period
Eligibility for Orthodontic coverage (Network & Non-Network)	child (up to age 19)

(Standard Exclusions, Limitations and Alternate Benefit rules apply)

Enrollee Copay Schedule

Service Code	Service Description	Enrollee Network Copay	Out of Network Plan Pays
D4342	Periodontal Scaling and Root Planing - One - Three Teeth Per Quadrant	\$39	\$81
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	\$40	\$27
D4910	Periodontal Maintenance	\$30	\$36
Prosthodontics, Removable			
D5110	Complete Denture - Maxillary	\$300	\$410
D5120	Complete Denture - Mandibular	\$300	\$410
D5130	Immediate Denture - Maxillary	\$325	\$455
D5140	Immediate Denture - Mandibular	\$325	\$455
D5211	Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests and Teeth)	\$320	\$285
D5212	Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests and Teeth)	\$320	\$305
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)	\$350	\$440
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)	\$350	\$440
D5410	Adjust Complete Denture - Maxillary	\$10	\$33
D5411	Adjust Complete Denture - Mandibular	\$10	\$33
D5421	Adjust Partial Denture - Maxillary	\$10	\$33
D5422	Adjust Partial Denture - Mandibular	\$10	\$33
D5510	Repair Broken Complete Denture Base	\$29	\$56
D5520	Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	\$22	\$50
D5610	Repair Resin Denture Base	\$30	\$62
D5620	Repair cast framework	\$30	\$81
D5630	Repair or Replace Broken Clasp	\$30	\$90
D5640	Replace Broken Teeth - Per Tooth	\$30	\$47
D5650	Add Tooth to Existing Partial Denture	\$30	\$77
D5660	Add Clasp to Existing Partial Denture	\$45	\$85
D5670	Replace All Teeth and Acrylic On Cast Metal Framework (Maxillary)	\$288	\$200
D5671	Replace all Teeth and Acrylic On Cast Metal Framework (Mandibular)	\$288	\$200
D5710	Rebase Complete Maxillary Denture	\$100	\$220
D5711	Rebase Complete Mandibular Denture	\$100	\$200
D5720	Rebase Maxillary Partial Denture	\$100	\$200
D5721	Rebase Mandibular Partial Denture	\$100	\$200
D5730	Reline Complete Maxillary Denture (Chair side)	\$60	\$120
D5731	Reline Complete Mandibular Denture (Chair side)	\$60	\$120
D5740	Reline Maxillary Partial Denture (Chair side)	\$60	\$105
D5741	Reline Mandibular Partial Denture (Chair side)	\$60	\$105
D5750	Reline Complete Maxillary Denture (Laboratory)	\$95	\$140
D5751	Reline Complete Mandibular Denture (Laboratory)	\$95	\$140
D5760	Reline Partial Maxillary Denture (Laboratory)	\$95	\$140
D5761	Reline Partial Mandibular Denture (Laboratory)	\$95	\$140
D5820	Interim Partial Denture - (Maxillary)	\$110	\$175
D5821	Interim Partial Denture - (Mandibular)	\$110	\$190
D5850	Tissue Conditioning - (Maxillary)	\$30	\$44
D5851	Tissue Conditioning - (Mandibular)	\$30	\$44
Prosthodontics, Fixed			
D6210	Pontic - Cast High Noble Metal	\$255	\$310
D6211	Pontic - Cast Fused to Predominantly Base Metal	\$255	\$280

UnitedHealthcare Dental EPO - Plan Code PIN69

Deductible	\$50 / \$150
Annual Maximum	\$1,250
Lifetime Orthodontic Maximum	\$1,500
Waiting Period for Orthodontic Services	12 months waiting period
Eligibility for Orthodontic coverage (Network & Non-Network)	child (up to age 19)

(Standard Exclusions, Limitations and Alternate Benefit rules apply)

Enrollee Copay Schedule			
Service Code	Service Description	Enrollee Network Copay	Out of Network Plan Pays
D6212	Pontic - Cast Noble Metal	\$255	\$300
D6240	Pontic - Porcelain Fused to High Noble Metal	\$255	\$310
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	\$255	\$270
D6242	Pontic - Porcelain Fused to Noble Metal	\$255	\$300
D6250	Pontic - Resin with High Noble Metal	\$255	\$300
D6251	Pontic - Resin with Predominantly Base Metal	\$255	\$300
D6252	Pontic - Resin with Noble Metal	\$255	\$300
D6720	Crown - Resin w/ High Noble Metal	\$255	\$300
D6721	Crown - Resin w/ Pred. Base Metal	\$255	\$300
D6722	Crown - Resin w/ Noble Metal	\$255	\$300
D6750	Crown - Porcelain Fused to High Noble Metal	\$255	\$330
D6751	Crown - Porcelain Fused to Predominantly Base Metal	\$255	\$295
D6752	Crown - Porcelain Fused to Noble Metal	\$255	\$305
D6780	Crown - 3/4 Cast High Noble Metal	\$250	\$310
D6781	Crown - 3/4 Cast Predominantly Base Metal	\$250	\$310
D6782	Crown - 3/4 Cast Noble Metal	\$250	\$280
D6790	Crown - Full Cast High Noble Metal	\$255	\$315
D6791	Crown - Full Cast Predominantly Base Metal	\$255	\$285
D6792	Crown - Full Cast Noble Metal	\$255	\$295
D6930	Recement Fixed Partial Denture	\$10	\$60
D6940	Stress Breaker	\$40	\$30
D6970	Cast Post & Core in addt. to Bridge Ret	\$70	\$120
D6972	Pre-fab. Post & Core \ addt. to Bridge Ret	\$70	\$100
D6980	Fixed Partial Denture Repair, By Report	\$45	\$100
Oral Surgery			
D7111	Extraction, Coronal Remnants - Deciduous Tooth	\$15	\$28
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation and/or Forceps Removal)	\$15	\$51
D7210	Surgical Extraction Erupted Tooth	\$26	\$94
D7220	Removal of Impacted Tooth - Soft Tissue	\$51	\$99
D7230	Removal of Impacted Tooth - Partial Bony	\$66	\$134
D7240	Removal of Impacted Tooth - Completely Bony	\$111	\$129
D7241	Removal of Impacted Tooth - Completely Bony With Unusual Surgical Complications	\$111	\$229
D7250	Surgical Removal of Residual Tooth Roots	\$40	\$105
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	\$65	\$80
D7280	Surgical Access of Unerupted Tooth	\$65	\$210
D7310	Alveoplasty in Conjunction with Extractions - Per Quadrant	\$45	\$109
D7320	Alveoplasty Not in Conjunction with Extractions - Per Quadrant	\$60	\$265
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	\$36	\$114
D7520	Incision and Drainage of Abscess - Extraoral Soft Tissue	\$36	\$114
D7910	Suture of Recent Small Wounds up to 5 cm	\$5	\$40
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate procedure	\$61	\$274
Orthodontics			
D8010	Limited Trt Of Primary Dentition	50%	50%
D8020	Limited Trt Of Transitional Dentition	50%	50%
D8030	Limited Trt Of Adolescent Dentition	50%	50%
D8040	Lmtd Ortho Trt Adult Dentition	50%	50%
D8050	Interceptive Ortho Trt Of Primary Dentition	50%	50%

UnitedHealthcare Dental

EPO - Plan Code PIN69

Deductible	\$50 / \$150
Annual Maximum	\$1,250
Lifetime Orthodontic Maximum	\$1,500
Waiting Period for Orthodontic Services	12 months waiting period
Eligibility for Orthodontic coverage (Network & Non-Network)	child (up to age 19)

(Standard Exclusions, Limitations and Alternate Benefit rules apply)

Enrollee Copay Schedule

Service Code	Service Description	Enrollee Network Copay	Out of Network Plan Pays
D8060	Interceptive Ortho Trt Of Primary Dentition	50%	50%
D8070	Comprehensive Trt Of Transitional Dentition	50%	50%
D8080	Comp Ortho Trt Adolesc Dentit	50%	50%
D8090	Comp Ortho Trt Adult Dentition	50%	50%
D8210	Appli./Control Habit/Remv	50%	50%
D8220	Appli./Control Habit/Fixed	50%	50%
D8660	Pre-Ortho Trt Visit	50%	50%
D8670	Periodic Ortho Trt Visit As Part Of Contract	50%	50%
D8680	Ortho Retention	50%	50%
D8690	Ortho Treatment (Alternate Billing To Contract Fee)	50%	50%
D8691	Repair Of Ortho Appliance	50%	50%
D8693	Rebonding, Recementing and/or Repair of Fixed Retainers, As Needed	50%	50%
Adjunctive General Services			
D9110	Emergency Exam and Visit - Pain Relief Treatment During Regularly Scheduled Office Hours	\$5	\$43
D9120	Fixed Partial Denture Sectioning	\$10	\$100
D9211	Regional Block Anesthesia	\$5	\$43
D9212	Trigeminal Division Block Anesthesia	\$5	\$43
D9215	Local Anesthesia	\$5	\$12
D9230	Nitrous oxide inhalation	\$10	\$20
D9310	Consultation (Diagnostic Service Provided By Dentist or Physician Other Than Practitioner Providing Treatment)	\$5	\$80
D9440	Office Visit - After Regularly Scheduled Hours	\$35	\$35
D9450	Case Presentation, detailed and extensive treatment planning	\$5	\$65

Vision Plan Overview

Benefit/Service	UHC Network Provider	Out-of Network Reimbursement
Comprehensive Exam (every 12 months)	\$10.00 copay	\$40.00
Materials	\$25.00 copay	N/A
Spectacle Lenses (every 12 months) <i>Standard Scratch Resistant Coating</i>	\$25.00 copay	Single Vision \$40.00 Bifocal \$60.00 Trifocal \$80.00 Lenticular \$80.00
Frames (every 24 months)	\$130.00 retail frame allowance	\$45.00
Contact Lenses (every 12 months) Note: Covered in full contacts in lieu of eyeglasses. The covered-in-full contact lens benefit at network providers includes the fitting/evaluation, contacts, and two follow-up visits (after \$25 copay). For those who choose disposable lenses, up to 4 boxes are included when obtained from a network provider.	\$105.00 allowance	Elective \$105.00 Necessary \$210.00
Laser Vision Benefit	UHC has partnered with the Laser Vision Network of America (LVNA) to provide members with access to discounted laser correction providers at 877-28-SIGHT.	N/A

Important to Remember:

*Benefits available every 12 to 24 months (depending on the benefit frequency), based on last date of service.

*Your \$105 Contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of the contact lenses. For example, if the fitting/evaluation fee is \$30, you will have \$75 towards the purchase of contact lenses. The allowance maybe separated at some retail chain locations between the examining physician and the optical store. If you choose disposable contacts, you may receive up to 4 boxes of disposable contacts (depending on prescription). Toric, gas permeable and bifocal contacts are all examples that are outside of our covered-in-full selection.

*Out-of-Network Reimbursements: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UHC Vision ATTN: Claim Dept. PO BOX 30978 Salt Lake City, UT 84130

2010 Vision Monthly Rates for Retirees

	Vision
Member only	\$5.64
Member + spouse	\$10.29
Member + child (ren)	\$10.81
Member + family	\$16.63

Legislative Notices

What is COBRA?

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

How long must COBRA continuation coverage be available?

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

What plans are subject to COBRA?

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

What specific events can be qualifying events?

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

How much does COBRA cost for City of Dallas Sponsored plans?

COBRA	70/30/ PPO	75/25 PPO with HRA
Member only	\$154	\$366
Member + spouse	\$321	\$719
Member + child (ren)	\$291	\$647
Member + family	\$440	\$980

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

Did you know that your benefit plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy including lymphedema? Contact the Benefits Service Center at 1-888-752-9122 for more information.

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

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending health professional (such as your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care professional obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain physicians or facilities or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the Benefits Service Center at 1-888-752-9122.

Health Insurance Portability and Privacy Act

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

Protecting Your personal Health Information

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

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

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



MEDICARE SECONDARY PAYER STATUTE

SUMMARY

- The Medicare Secondary Payer (MSP) statute and associated regulations, issued by the Centers for Medicare and Medicaid Services (CMS), contain a series of rules for determining whether Medicare is the primary payer for an individual who has both Medicare and other health coverage (note, this only applies to medical coverage).
- The statute, which took effect on January 1, 2009, requires all employers, insurers and plan administrators to share active member eligibility data with CMS.
- The increased exchange of eligibility data will ultimately reduce coordination of benefits errors, allow for a more efficient process and help avoid unnecessary interest payments.

BACKGROUND

- Historically, CMS became aware of the existence of private coverage via a Voluntary Data Sharing Agreement (VDSA) it had with carriers. Through the VDSA, UnitedHealthcare and other health plans are legally permitted to provide eligibility data for their customers' employees to CMS.
- The MSP statute, which took effect on January 1, 2009, makes the previously voluntary eligibility data-sharing program into a mandatory requirement for all employers, insurers and plan administrators.

WHAT THIS MEANS

- As part of the MSP statute's eligibility data sharing mandate, CMS has required that carriers provide active (as of 1/1/09) member Social Security Numbers (SSN) within the following time frames:
 - Social Security numbers for current subscribers, including new subscribers and dependents with a 1/1/09 effective date (or post 1/1/09 effective date), are required by CMS as of January 1, 2009, and therefore need to be submitted to UnitedHealthcare as soon as possible – ready for our first quarterly feed to CMS.
 - Social Security numbers for dependents who were on file prior to 12/31/08 are required by CMS as of Jan. 1, 2011, however, should be submitted to UnitedHealthcare at your earliest convenience.
- Per the MSP statute, failure to report eligibility data and Social Security numbers as outlined above may subject the required reporting entity – insurers, third-party administrators, employers and/or plan administrators – to civil monetary penalties up to \$1,000 for each day of noncompliance for each individual for which data exchange is required.

UNITEDHEALTHCARE ACTIONS

- UnitedHealthcare is working hard to ensure full compliance with the MSP statute.
- Our Regulatory, Legal, Government Affairs and Compliance teams are also working directly with CMS and several industry organizations to keep close track of this issue and related updates.

FOR MORE INFORMATION

- For more information on the Medicare Secondary Payer program Statutory Language Section 111, P.L. 110-173, please visit cms.hhs.gov/EmployerServices/03_employervdsa.asp
- Please feel free to contact your UnitedHealthcare representative with any questions or concerns.

Legislative Highlights

The Federal Mental Health Parity Act was signed into law on Oct. 3, 2008 (the “2008 Act”) as part of the recently enacted economic recovery package (Sections 511 and 512 of HR 1424, PL 110-343). The new law, which amends ERISA, the Internal Revenue Code and the Public Health Service Act, requires insured and self-insured plans to provide “parity” between the financial requirements and treatment limitations applied to: (a) mental health and substance use disorder benefits, and (b) medical and/or surgical benefits.

This requirement will take effect for most plans on the first day of their plan year which begins or renews on or after Oct. 3, 2009.

New Requirements

- The new law does not allow either more restrictive or separate financial requirements for mental health and substance use disorder coverage. It specifically defines the ‘financial requirements’ that must be in parity as:
 1. Deductibles
 2. Co-payments
 3. Coinsurance
 4. Out-of-pocket expenses
- However, a plan may still have an aggregate lifetime limit and an aggregate annual limit that is applied to both medical and mental health and substance use disorder benefits.
- The law prohibits treatment limits on mental health and substance use disorder benefits that are more restrictive than those of medical/surgical benefits. The law specifically requires the following limitations to be in parity:
 1. Limits on frequency of treatment
 2. Limits on number of visits
 3. Limits on number of days of coverage
 4. Other similar limits on the scope or duration of coverage
- The law requires an explanation of a denial of benefits for mental health and substance use disorder treatment (if requested)
- The law also requires out-of-network (OON) coverage for mental health and substance use disorder treatment if OON coverage is available for medical/surgical benefits
- Employers who have behavioral health benefit limits or cost-sharing requirements will need to review those restrictions against their medical benefits coverage in order to assess whether they meet federal parity requirements of the 2008 Act and, if not, to determine what adjustments need to be made to your plan design to achieve compliance. This review will need to be completed well in advance of the effective date stated above.
- Under the new law, employers can choose which mental health and substance use diagnoses they want to cover. The parity requirements will apply to all diagnoses the employer chooses to cover (subject to applicable state law mandates; many states currently have limits on specific diagnoses such as autism, for example). An employer can not choose to cover some diagnoses at parity and others not at parity.

Complaints and Questions

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

Non-City Sponsored Benefits Voluntary Benefits

*Not sponsored by the City of Dallas;
available on an individual basis (Pre-65 Only)*

- Accident Insurance
- Cancer Insurance

The City of Dallas does not sponsor the Voluntary Benefits disclosed in the following pages.

Take Advantage of What Colonial Life Has to Offer!

You have the opportunity to apply for personal insurance products from Colonial Life! These benefits can enhance your current benefits portfolio and can be customized to fit your individual needs.

Also:

- Coverages are available for you and your family, with most products.
- You will enjoy the convenience of premium payment through pension deductions.
- You will have the ability to take most coverages with you if you change jobs or retire.

The following insurance plans will be offered during your enrollment:

Accident Insurance helps offset the direct and indirect expenses such as co-payments, deductibles and other costs not covered by traditional health care plans.

Cancer Insurance helps offset the out-of-pocket medical and indirect, non-medical expenses related to cancer treatment.

A Colonial Life benefits counselor will explain how these benefits can help protect you and your family. Your insurance needs can be reviewed in just a few minutes. With Colonial Life, you can select benefits that help meet your individual needs.

Products have exclusions and limitations that may affect benefits payable. See the Outline of Coverage for complete details.

Colonial Life & Accident Insurance Company,
1200 Colonial Life Boulevard, Columbia, SC 29210

Policyholder Services: **Phone: 800.325.4368**
 Website: coloniallife.com

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Colonial Life products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand.

Colonial Life[®]
Making benefits count.

Vendor Contact List

City of Dallas Customer Service Benefits Service Center (BSC)	1-888-752-9122
Health - UHC	
PPO and HRA Plans Membership services Pharmacy services PPO/HRA Care24 Web site	1-800-736-1364 1-877-842-6048 1-800-586-6875 www.myuhc.com
AARP Medicare Supplement - UHC	
Membership services (To ask questions, enroll or change plans) Web site	1-800-392-7537 www.aarphealthcare.com
Medicare Advantage HMO - UHC	
Membership services (To ask questions, enroll or change plans) Web site	1-800-950-9355 www.securehorizons.com
Medicare Part D Prescription Plan - UHC	
Membership services (To ask questions only) City of Dallas Benefits Service Center (To enroll or change plans) Web site	1-800-392-7537 1-888-556-6648 www.UnitedMedicareRX.com
Dental and Vision - UHC	
Vision services – UnitedHealthcare Web site Dental HMO – UnitedHealthcare Dental PPO and EPO – UnitedHealthcare Web site	1-800-638-3120 www.myuhcvision.com 1-800-232-0990 1-877-816-3596 www.myuhcdental.com
Employee Retirement Fund	
Web site	214-580-7700 www.dallaserf.org
Dallas Police & Fire Pension	
Toll-free Web site	1-800-638-3861 / 214-638-3863 www.dpfp.org
Wellness Website	http://www.cod/HumanResources/wellaware/wellaware.html
City of Dallas Website	www.dallascityhall.com

City of Dallas Publication No. 09/10-65
Additional copies may be obtained from:
The Benefits Service Center @ 888-752-9122

About This Guide

This 2011 Benefits & Enrollment Guide describes, in non-technical language, the essential features of the City of Dallas Health Benefits Plan (The Plan). This Guide has been prepared as a reference only. It is not an official Master Plan Document for the City of Dallas Health Benefits Plan, including dental, vision, life and voluntary benefits. The terms and conditions of coverage under The Plan are determined solely by the Master Plan Document as adopted by the City Council of the City of Dallas. If there is a difference between what you read in this Guide and what you read in the official SPD (Summary Plan Description), the official Master Plan Document will govern.

