

2016 Employee Benefits Overview



Employee benefits

Employee benefits are provided to employees in salaries. In instances where wages for some other for

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EMPLOYEE BENEFITS

At the City of Grapevine, employee benefits are an integral part of our comprehensive compensation program. We are pleased to offer a robust package of benefits and programs for you and your eligible dependents. This booklet was created to provide you with an easy-to-read overview of your benefit options to help you make an informed decision. The coverage you choose during this period will remain effective until September 30, 2016. You will not be able to make changes until the next open enrollment, unless you experience a Qualifying Life Event.

WHO IS ELIGIBLE

Elected officials, full-time and regular part-time employees regularly scheduled to work at least 20 hour per week are eligible for benefits. Employees are eligible for all benefits on the first of the month following date of hire. Your eligible dependents may also be enrolled for coverage. Eligible dependents include:

- Your legal, opposite-sex, spouse
- Your dependent children under age 26

Dependent Verification

Please note that the City of Grapevine requires employees enrolling dependents to submit documentation to substantiate their eligibility. A marriage license is required for a spouse and birth certificates for any child(ren).

QUALIFYING LIFE EVENTS

The benefits you choose at hire or during Open Enrollment must stay in place until September 30, 2016 unless you have a Qualifying Life Event, which includes the following:

- You have a change in marital status
- You have a baby, adopt a child, or have a child placed with you for adoption
- You become disabled
- You or a dependent dies
- You end your employment with the Company
- Your spouse gains or loses employment
- Your dependent child gains or loses eligibility due to age

If you experience a Qualifying Life Event and wish to change your benefits, you must complete the change in SmartBen and submit the necessary documentation to Risk Management within 30 days of the status change. If you do not return the necessary paperwork within 30 days, your coverage will remain until the following open enrollment window.

SPOUSE SURCHARGE

If your working spouse is eligible to participate in or be covered by another health plan, benefits under this plan will be paid on a secondary basis whether or not the other coverage is in force. An additional premium of \$300 per month is assessed. Prescription benefits are excluded if other coverage is available.

KNOW YOUR BENEFITS.



BENEFITS AT A GLANCE

City of Grapevine Benefit	Enrollment Optional or Automatic	Coverage
Compass Professional Health Services	Automatic - City of Grapevine pays the cost	Compass is a patient advocate and concierge service for all employees
Medical/Rx	Optional - You and the City share the cost	City of Grapevine provides two different plans: HDHP with HSA and a Buy-Up with HRA
Dental	Optional - You and the City share the cost	City of Grapevine provides comprehensive dental coverage through Cigna. Employees have access to a Cigna PPO network
Vision	Optional - You and the City share the cost	City of Grapevine provides a vision plan through VSP
Flexible Spending Account (FSA)	Optional - You pay the cost	Two separate accounts let you use pretax dollars to pay IRS-eligible out-of-pocket Healthcare and Dependent Care expenses
Voluntary Life	Optional - You pay the cost	You may elect coverage in \$10,000 increments up to \$500,000. Spouse and child life coverage is available
Basic Life/AD&D	Automatic - City of Grapevine pays the cost	City of Grapevine pays for a basic life/AD&D benefit of 2 times base salary for active benefit eligible employees
Short-Term Disability	Optional - You pay the cost	STD provides coverage in the event you cannot work due to a covered accident or illness
Long-Term Disability	Automatic - City of Grapevine pays the cost	City of Grapevine pays for LTD coverage for all active employees. LTD provides coverage in the event you cannot work due to a covered accident or illness
Accident Insurance	Optional - You pay the cost	Accident insurance pays a specified amount for specific injuries resulting from a covered accident
Critical Illness Insurance	Optional - You pay the cost	Critical Illness pays a one-time, lump sum benefit amount upon the diagnosis of a covered disease or illness. You may elect up to \$20,000 in coverage
Employee Assistance Program (EAP)	Automatic - City of Grapevine pays the cost	City of Grapevine pays for (8) face-to-face counseling services per year and for 24/7 phone counseling

MEDICAL AND PRESCRIPTION DRUG PLANS

You may choose from two plans through UMR who participates in the United Healthcare Choice Plus Network. Search for doctors by accessing umr.com or contact UMR at 817.360.4503.

	Buy-up/HRA				HDHP/HSA				
	Network		Non-Network		Network		Non-Network		
Threshold Deductible (must meet before HRA will pay)									
Individual	\$1,000		\$2,000		N/A				
Family	\$2,000		\$4,000						
HRA City Contribution					HSA City Contribution				
Individual	\$750				\$1,000 w/ option for add't personal contribution				
Family	\$1,500				\$2,000 w/ option for add't personal contribution				
Deductible (Co-pays are not included)					Deductible (Co-pays included)				
Individual	\$1,750		\$3,500		\$2,600		\$5,200		
Family	\$3,500		\$7,000		\$5,000		\$10,000		
Out-of-Pocket-Maximum									
Individual	\$2,750		\$5,500		\$3,500		\$7,000		
Family	\$5,500		\$11,000		\$7,000		\$14,000		
Out-of-Pocket-Maximum (Prescription drugs)									
Individual	\$3,000		\$3,000		N/A				
Family	\$6,000		\$6,000						
Office Visit									
Physician	\$25 No referrals required		Subject to deductible then coinsurance rates		Subject to deductible then coinsurance rates				
Specialist									
Urgent Care									
Emergency Room	\$250 co-pay then 80% Co-pay waived if admitted		\$250 co-pay then 60% Co-pay waived if admitted		Subject to deductible then coinsurance rates				
Preventative	100%		100%		100%		100%		
Other Facility									
Inpatient/Outpatient	80%		60% Subject to deductible then coinsurance rates		80%		60%		
Lab Work	100%				Subject to deductible then coinsurance rates				
Retail (34-Day Supply)									
Generic	\$4				Subject to deductible then coinsurance rates				
Preferred Brand	20% min. \$15								
Nonpreferred Brand	30% min. \$30								
Mail Order (100-Day Supply)									
Generic	\$8				Subject to deductible then coinsurance rates				
Preferred Brand	\$30								
Nonpreferred Brand	30% min. \$60								
Premiums		Physical		Non-Physical		Physical		Non-Physical	
Employee Only	\$18	\$8.31	\$43	\$19.85	\$0	\$0	\$25	\$11.54	
Employee & Spouse	\$94	\$43.38	\$119	\$54.92	\$37	\$17.08	\$62	\$28.62	
Employee & Child(ren)	\$87	\$40.15	\$112	\$51.69	\$33	\$15.23	\$58	\$26.77	
Employee & Family	\$150	\$69.23	\$175	\$80.77	\$60	\$27.69	\$85	\$39.23	

If you're currently enrolled in the bronze plan, please know that you can continue in the plan for fiscal year 2016 and 2017, but the plan won't be offered in fiscal year 2018 due to new regulations put in place by the Affordable Care Act, so you'll need to eventually choose a new plan option. In addition, there is a \$15 per month increase premium for those that would like to continue on this plan.

	BRONZE (FROZEN)			
	Network		Non-Network	
Deductible (Co-pays are not included)				
Individual	\$500		\$1,000	
Family	\$1,000		\$2,000	
Out-of-Pocket-Maximum (includes Deductibles, Co-pays, Coinsurance)				
Individual	\$1,500		\$3,000	
Family	\$3,000		\$6,000	
Out-of-Pocket-Maximum (Prescription drugs)				
Individual	\$3,000		\$3,000	
Family	\$6,000		\$6,000	
Office Visit				
Physician	Subject to deductible then paid at coinsurance rates			
Specialist				
Urgent Care				
Emergency Room	\$250 co-pay then 80% Co-pay waived if admitted		\$250 co-pay then 60% Co-pay waived if admitted	
Preventative	100%		100%	
Other Facility				
Inpatient/Outpatient	80%		60%	
Lab Work	100%		Subject to deductible then coinsurance rates	
Retail (34-Day Supply)				
Generic	\$4			
Preferred Brand	20% min. \$15			
Nonpreferred Brand	30% min. \$30			
Mail Order (100-Day Supply)				
Generic	\$8			
Preferred Brand	\$30			
Nonpreferred Brand	30% min. \$60			
Speciality Drug (30-Day Supply)				
Generic	\$4			
Preferred Brand	20% min. \$40			
Nonpreferred Brand	40%			
Monthly Premiums				
	Physical		Non-Physical	
Employee Only	\$43.00	\$19.85	\$68.00	\$31.38
Employee & Spouse	\$163.00	\$75.23	\$188.00	\$86.77
Employee & Child(ren)	\$148.00	\$68.31	\$173.00	\$79.85
Employee & Family	\$255.00	\$117.69	\$280.00	\$129.23

PRESCRIPTION DRUG PLAN

UMR's medical plans include coverage for prescription drugs. You may fill your prescriptions at participating retail pharmacies or through the mail order service. The Buy-Up with HRA and Bronze plan include coverage for prescription drugs and those costs go towards the prescription drugs out-of-pocket maximum. All prescriptions on the HDHP with HSA will not have a prescription co-pay and will go toward the deductible and out-of-pocket maximum offered with that plan.

RETAIL PHARMACY

When you present your medical plan ID card at a participating pharmacy, you will be charged a co-payment based on the type of prescription you receive. Keep in mind that generic drugs cost significantly less than their brand name counterparts, yet they can be equally effective. If you request a brand name drug when a generic is available, you will be required to pay the difference between the cost of the generic and the formulary/nonformulary brand name drug plus the applicable co-payment.



MAIL ORDER

If you are taking a maintenance medication such as high blood pressure, asthma, or diabetes medication, as well as birth control pills, you will save money and save time if you utilize the mail-order service offered through Optum Rx. Optum Rx provides prescription drug mail service.

CONTACT INFORMATION

Optum Rx 877.559.2955

Website OptumRX.com

PREVENTIVE CARE

Preventive care is very important for adults and children. By making smart health choices, women and men can boost their own health and well-being. Below is a list of services covered at no cost to the employee and any covered dependents if the member visits an In-Network provider:

- An annual checkup
- Age and gender specific health screenings, including cholesterol, blood pressure, blood sugar and weight
- Routine immunizations based on your age, stage of life and health status including the annual flu shot

Did you know disclosure of aches and pains at a wellness visit could cause you to be responsible for a copay?

NURSE LINE

Provides round-the-clock telephone access to registered nurses who can offer assistance and answer questions on a variety of health topics.

Phone: 1-877.950.5083, Pin 197

SMOKING CESSATION

Enroll through UMR and receive smoking cessation Rx for free.

- Self-directed online courses
- Tobacco cessation resources to help you become tobacco and nicotine free
- To qualify for this benefit you must enroll in the smoking cessation counseling prior to filling your prescriptions

MATERNITY MANAGEMENT

Maternity Management helps expectant mothers understand and manage pregnancy. The program supports mothers through pregnancy: Pregnancy risk factor identification, educational materials, personal telephone contact, and assistance in managing high risk conditions. You must enroll within the first trimester of pregnancy.



ADVANTAGES OF A HEALTH SAVINGS ACCOUNT

- **Affordability:** Lower your health insurance premiums by switching to a health insurance plan with a higher deductible
- **Triple Tax Savings:** Tax deductions when you contribute to your account, tax-free earnings through investment, tax-free withdrawals for qualified medical expenses
- **Portability:** You keep the account even if you change Insurance plans/jobs or retire
- **Flexibility:** Use the funds to pay for current medical expenses or save the money for future needs
- **Savings:** Grow your account through investment earnings
- **Control:** You decide how much money to put into the account and when to use it to pay for medical expenses

Contributions to the HSA are limited by the amount established by IRS guidelines. For 2015 limits are \$3,350 for employee only and \$6,650 for employee + family. Individuals can use this tax-free money to pay for expenses covered under a high deductible plan until their deductible has been met. The insurance company pays covered medical expenses above the deductible except for any coinsurance. Individuals can pay coinsurance costs with tax-free money from their HSA account. In addition, individuals can use tax-free HSA dollars for qualified medical expenses not covered by the high deductible plan, such as dental and vision.

For individuals who are 55 years of age or older and not on Medicare, a catch-up contribution of \$1,000 is allowed.

Your contributions are pre-tax and can be funded:

- Electronically through payroll deduction (optional)
- Directly to the account by you:
 - At the end of the year
 - As claims are incurred
 - On a one time, monthly or quarterly basis

Note: You will need to report the claim direct deposits by you on your IRS tax form the following year. Please be careful not to exceed the non-taxable IRS contribution level.

The HSA is administered through a chartered financial institution, HSA Bank . HSA Bank will provide you with tax forms at the end of the year to submit with a form 1040. All medical expense receipts need to be retained by you to document eligible distributions.

HSA distributions are tax-free for qualified expenses if taken by you, your spouse or dependent(s). Your spouse or dependents do not need to be covered by a high deductible health plan (HSA plans). If the HSA funds are not used for qualified medical expenses, then the amount is included as income and a 20% penalty is applied by the IRS. HSA funds can be withdrawn by using a debit card or a check.



HEALTHCARE REIMBURSEMENT ACCOUNT

A Healthcare Reimbursement Account (also referred to as an HRA) is an arrangement that is paid for by the City of Grapevine. This account will reimburse only Qualified Medical Care Expenses eligible for coverage under your medical benefit plan. Your HRA will be financed with an employer contribution as shown on the Schedule of Benefits for the 12-month benefit Plan Year.

The Healthcare Reimbursement Account is managed by UMR. All claims are paid directly from UMR once the employee threshold deductible is met for the plan year. This is an employee hands-off account, so no action is necessary on your part to access these funds.

These funds will not rollover each plan year, any funds remaining at the end of the plan year will be forfeited back to the City.*

*Any employee with grand-fathered HRA accounts will have a secondary account for those funds. Those funds are accessible after the threshold deductible is met for the plan year and the current HRA account is depleted. If you do not use the funds they will continue to rollover and can be taken with you if you have a qualified TMRS retirement from the City.

DENTAL PLAN

Dental coverage is an important component of the City of Grapevine's comprehensive benefit plan. Coverage is offered through Cigna Dental. Participants have access to a Cigna PPO network. Out-of-network provider costs will be reimbursed based on reasonable and customary fees. This reimbursement may not cover the full cost of services. In these cases, you may be balance-billed for the amount exceeding the reimbursement.

Cigna Dental Benefits		
Dental Provisions	In-Network	Out-of Network
Annual Deductible		
Individual	\$0	\$50
Family	\$0	\$150
Maximums		
Class I,II, III Combined Calendar Year Maximum Benefit	\$2,000	
Class IV: Lifetime Maximum	\$2,500	
Services		
Class 1: Preventive Services Oral Exams, X-Rays, Bitewing X-Rays, Sealants Prophylaxis/Cleanings, Topical Fluoride Application, Space Maintainers	100%	100% (deductible first)
Class 2: Basic Services Fillings, Extractions, Basic Oral Surgery, Anesthesia, Endodontic, Root Canal Therapy, Periodontics, Crowns	90%	80% (deductible first)
Class 3: Major Services Bridges, Dentures, Implants	60%	50% after ded.
Class 4: Orthodontia	50%	50% after ded.



DID YOU KNOW?

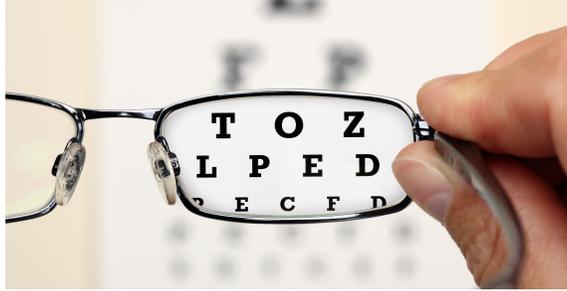
There is a positive relationship between periodontal diseases and psychological factors such as stress, distress, anxiety, depression, and loneliness 57 percent of the studies in a literary review published by the Journal of Periodontology revealed. Specifically, increased levels of the hormone cortisol can lead to more destruction of the gums and bone due to periodontal diseases. It is well known that periodontal diseases, left untreated, can ultimately lead to bone loss or tooth loss. Preston D. Miller, DDS and AAP President, advised "Patients should seek healthy ways to relieve stress through exercise, balanced eating, plenty of sleep, and maintaining a positive mental attitude."

Bi-Weekly Premiums	Dental
Employee Only	\$0.00
Employee & Spouse	\$6.92
Employee & Child(ren)	\$6.92
Employee & Family	\$9.23

Contact information for benefit questions, order cards, claim inquiries, dental providers etc.

Member services: 1.800.244.6224

Website: mycigna.com



VISION PLAN

Vision coverage is provided through Vision Service Provider (VSP). VSP provides an extensive network of vision optometrists and ophthalmologists. Eye care is essential to a person's health and well-being. Members receive benefits for many eye care services and products including eye exams, eyeglasses, and contact lenses.

PPO		
Vision Provisions	Network	Non-Network
Standard Eye Exam (every 12 months)	100%	Up to \$45
Materials		
Single Vision Lenses	100%	Up to \$30
Bifocal Lenses	100%	Up to \$50
Trifocal Lenses	100%	Up to \$65
Frames (every 12 months)	\$150 Retail Allowance + 20% off balance	Up to \$70
Contacts (instead of glasses)	100% to \$135 allowance	Up to \$105

Bi-weekly Premiums	Vision
Employee Only	\$0.00
Employee & Spouse	\$4.62
Employee & Child(ren)	\$4.62
Employee & Family	\$6.92

Contacts

Member Services
1.800.877.7195

Website: vsp.com

NO ID CARD NECESSARY:
Employees use their social security number and date of birth when utilizing benefits.

CITY OF GRAPEVINE EMPLOYEE AND FAMILY CLINIC

- No co-pay for clinic visits for all City of Grapevine employees that are benefit eligible
- Clinic visit is an acute care need such as coughs, colds, flu, sinus infections, sore throats, ear aches, and other minor illnesses
- These providers are in the United Healthcare Choice Network, so employees can be treated for other medical conditions at a separate visit. Regular plan benefits will apply
- Call office and make appointment for a same day clinic visit. You must identify yourself as a City of Grapevine employee
- If you have any trouble while at the clinic, ask to speak with the Office Manager, as they will know the rules and can resolve any issues

The following Doctors can be seen for a clinic visit:

Dr. Chad Hogan

Location: 1280 S. Main Street, Suite 100, Grapevine 76051

Phone: 817.310.0898

Hours: Monday –Thursday 7:30 A.M. to 5:00 P.M. (Doctor takes lunch from 1:00-2:00 P.M.)

Friday 7:30 A.M. to 12:00 P.M. (you must be there by 11:30 to be seen)

Dr. Eric Futscher

1600 W. College St, #130, Grapevine 76051

Phone: 817.912.0442 (Located in the Professional Building at Baylor Hospital)

Hours: Monday - Friday 8:00 A.M. to 5:00 P.M.

North Country Family Practice

1050 E. Hwy 114, Suite 100, Southlake 76092

Phone: 817.329.8364

Hours: Monday- Friday 8:30 A.M. to 5:00 P.M. (Closed for lunch 12:00-1:30)

COMPASS PROFESSIONAL HEALTH SERVICES

- Compass is a patient advocate and concierge service, contact them for any of the following and more:
 - Pricing estimates for health procedures
 - Doctor recommendation
 - Assistance with reviewing your EOB's
 - Questions on your health insurance and more
- Contact information: 1.800.513.1667, compassphs.com/getconnected, email answers@compassphs.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)

City of Grapevine has partnered with Interface to provide an Employee Assistance Program (EAP) at no cost to you and your dependents. The EAP provides support and guidance for matters that range from personal issues you might be facing to providing information on everyday topics that affect your life. The free confidential service is available to you and your family members - 24 hours a day, seven days a week. A toll-free phone line is staffed by experts trained to help you find the help you need, when you need it. You or a family member can call 1.800.324.4327 anytime, day or night. The EAP provides up to eight(8) free counseling sessions per incident. The EAP is designed to assist with a wide array of issues, including work/life balance, stress, anxiety, depression, family issues, legal, and financial concerns.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to set aside money pretax to pay for qualified healthcare and dependent care expenses. FSA accounts are administered by UMR.

Paying for these expenses through a pretax spending account is like getting a discount on something you would have purchased at full price. You will be surprised at how quickly your savings add up.

Your contributions are deducted from your paycheck in equal amounts during the year. Because contributions are not subject to federal income tax, FICA tax, and, in most cases, state and local income taxes, you save money.

Each year, you decide how much you want to contribute to either or both accounts for the calendar year. All healthcare FSA accounts are capped at \$2,550 as mandated through health reform legislation. Participants can still elect up to \$5,000 for dependent care FSA (up to \$2,550 if you are married and file separate tax returns). You will only be able to enroll in these benefits during annual open enrollment unless you experience a Qualifying Life Event.

HEALTHCARE ACCOUNT

Eligible expenses include office visit and prescription drug co-pays, medical deductibles, and coinsurance. Qualified dental and vision expenses are also eligible, including eye exams, prescription eye wear, and orthodontic services. If you are enrolled in the HDHP with HSA you are eligible to enroll in a limited FSA account that can be used to cover vision and dental expenses only.

DEPENDENT CARE ACCOUNT

Eligible dependent care expenses include licensed day care or elder care providers, before and after-school care through age 12, day camps, and care for a disabled dependent.

For a complete list of eligible expenses, go online to www.irs.gov/publications and find publications 502 and 503.

In order to get reimbursed, participants can either submit a claim form accompanied by a receipt or use their Benny card . Just swipe your card to pay for a covered item. The amount will be automatically deducted from your FSA account. Using the card eliminates paperwork and delays in being reimbursed. It is recommended that you retain your receipts in the event they are requested for documentation.

FILING A CLAIM

When you have an eligible expense, you submit a claim to UMR, the FSA administrator, for reimbursement. You must file your claims by the filing deadlines for each plan year.

CONTACTS

Member Services

Phone: 1.800.826.9781

Email: umr-fsa@umr.com

Website: umr.com

BASIC LIFE AND AD&D COVERAGE

City of Grapevine provides all full-time and regular part-time employees with a Basic Life/AD&D benefit. The benefit is 100 percent employer paid. Eligible employees are covered at 2 times annual base salary with a maximum of \$350,000. If you suffer a covered loss due to an accident, AD&D coverage pays you a portion of the full benefit.

City of Grapevine provides all elected officials with a Basic Life/AD&D benefit. The benefit is 100 percent employer paid. The elected officials have a \$50,000 policy.

Coverage amounts automatically reduce at ages 65, 70 and 75. Upon your attainment of the specified age below, the amount of Basic Life Insurance will be reduced to the applicable percentage.

Age	Percentage of available or in-force amount
65-69	65%
70	50%
75	35%

VOLUNTARY GROUP LIFE COVERAGE

If you need additional life insurance, you may purchase Voluntary Life/AD&D coverage for yourself and your eligible dependents. You may elect coverage for yourself and your spouse in \$10,000 increments. You may also elect coverage for your child(ren) up to the amount of \$15,000. The child(ren) coverage does not include an AD&D policy.

As long as you elect at least \$10,000 in coverage on yourself during the initial enrollment period, you are eligible to increase up to the guarantee issued amount at any time without having to complete additional paperwork.

	Employee	Spouse	Child
Minimum	\$10,000	\$10,000	\$2,000
Maximum	\$500,000	\$250,000	\$15,000
Guarantee Issue	\$200,000	\$50,000	6 months to 26 years \$15,000

Unum phone number: 1.800.421.0344



SHORT-TERM AND LONG-TERM DISABILITY

Disability Insurance provides protection in the event you experience a non-work related injury or illness that prevents you from working. The City of Grapevine pays for the Long Term Disability coverage and the Short Term Disability coverage can be voluntarily elected and paid for through payroll deductions. Both plans are administered by Unum.

SHORT-TERM DISABILITY (STD)

Your benefits will begin on the eighth day following a nonoccupational accidental injury, sickness, or pregnancy. STD pays 60 percent of basic weekly predisability earnings (not including overtime, commissions, bonuses, and other extra compensation) up to a maximum of \$1,000 a week, less deductible sources of income. The maximum benefit duration is 180 days.

LONG-TERM DISABILITY (LTD)

In the event your disability continues after STD ends, then LTD is available. LTD benefits will be 60 percent of predisability earnings (not including overtime, commissions, bonuses, and other extra compensation) up to a maximum of \$5,000 per month, less deductible sources of income. Benefits can last up to Social Security Normal Retirement Age.

Disability benefits will not be paid for disability that begins during the first 12 months of coverage due to a preexisting condition. A preexisting condition is an injury or sickness for which you received treatment, consultation, diagnostic measures, or prescribed drugs or medicines or followed treatment recommendations during the six months prior to your effective date of coverage.

ACCIDENT AND CRITICAL ILLNESS

- Administered by Voya
- Critical Illness Insurance is a limited benefit policy. Critical illness insurance pays a one-time, lump sum benefit amount upon the diagnosis of a covered disease or illness*. You may be eligible to purchase up to \$20,000 in coverage
- Accident Insurance is a limited benefit policy. Accident insurance pays a specified amount for specific injuries resulting from a covered accident. See the brochure or certificate of coverage for a schedule of your available benefits
- Neither of these coverage's are considered health insurance and will not satisfy the requirement of minimum essential coverage under the Affordable Care Act
- Coverage is available without medical questionnaire for both policies
- Dependent coverage is also available and the coverage is portable

ACCIDENT RATES

Bi-Weekly Rates			
Employee	Employee and Spouse	Employee and Children	Family
\$4.48	\$7.40	\$8.54	\$11.46

CRITICAL ILLNESS RATES

Employee Coverage Bi-Weekly Rates (26 pay periods) Includes Wellness Benefit Rider				
Attained Age	\$5,000	\$10,000	\$15,000	\$20,000
Under 25	\$1.98	\$3.97	\$5.95	\$7.94
25-29	\$1.98	\$3.97	\$5.95	\$7.94
30-34	\$2.28	\$4.57	\$6.85	\$9.14
35-39	\$2.28	\$4.57	\$6.85	\$9.14
40-44	\$3.97	\$7.94	\$11.91	\$15.88
45-49	\$3.97	\$7.94	\$11.91	\$15.88
50-54	\$8.19	\$16.38	\$24.58	\$32.77
55-59	\$8.19	\$16.38	\$24.58	\$32.77
60-64	\$11.33	\$22.66	\$33.99	\$45.32
65-69	\$13.59	\$27.18	\$40.78	\$54.37
70+	\$21.02	\$42.05	\$63.07	\$84.09

CRITICAL ILLNESS CONT.

Spouse Coverage* Bi-Weekly Rates (26 pay periods) Includes Wellness Benefit Rider		
Attained Age	\$5,000	\$10,000
Under 25	\$1.80	\$3.60
25-29	\$1.80	\$3.60
30-34	\$2.12	\$4.25
35-39	\$2.12	\$4.25
40-44	\$3.95	\$7.89
45-49	\$3.95	\$7.89
50-54	\$7.80	\$15.60
55-59	\$7.80	\$15.60
60-64	\$11.86	\$23.72
65-69	\$13.36	\$26.72
70+	\$16.27	\$32.54

*Spouse rates are based on spouse age

Children Coverage Bi-Weekly Rates (26 pay periods) Includes Wellness Benefit Rider	
Coverage Amount	Rate
\$1,000	\$0.38
\$2,500	\$0.96
\$5,000	\$1.92
\$10,000	\$3.83

ANNUAL REQUIRED NOTICES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 23, 2013 and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information for the following plan[s] [(referred to herein as the "Plan") OR (collectively referred to herein as the "Plan")] create[s] or receive[s] about you:

City of Grapevine Employee Health Benefit Plan

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information, including "genetic information" (as defined in Section 105 of GINA), that is created or received by the Plan (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan's privacy practices.

How the Plan Will Use or Disclose Your PHI

Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Effective for uses and disclosures on or after February 17, 2010 until the date the Secretary of HHS issues guidance on what constitutes the "minimum necessary" for purposes of the privacy requirements, the Plan shall limit the use, disclosure or request of PHI (1) to the extent practicable, to the limited data set or (2) if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to HHS;
- uses or disclosures that are required by law;
- uses or disclosures that are required for the Plan's compliance with legal regulations; and
- uses and disclosures made pursuant to a valid authorization

The following uses and disclosures of your PHI may be made by the Plan:

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above. Uses and disclosures of PHI for payment purposes are limited by the minimum necessary standard.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your doctor requests information on what other drugs you are currently receiving during the course of treating you.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes. Uses and disclosures of PHI for health care operations are limited by the minimum necessary standard.

The following use and disclosure of your PHI may only be made by the Plan with your written authorization or by providing you with an opportunity to agree or object to the disclosure:

To Individuals Involved in Your Care. The Plan is permitted to disclose your PHI to your family members, other relatives and your close personal friends involved in your health care or the payment for your health care if:

- the PHI is directly relevant to the family or friend's involvement with your care or payment for that care;
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected; and
- the PHI is needed for notification purposes, or, if you are deceased, the PHI is relevant to such person's involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

For Workers' Compensation. The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

For Public Health Activities. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

To Report Abuse, Neglect or Domestic Violence. When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.

For School Records. The Plan may disclose immunization records for a student or prospective student to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.

For Public Health Oversight Activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

For Other Law Enforcement Purposes. The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

To a Coroner or Medical Examiner. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For Research. The Plan may use or disclose PHI for research, subject to certain conditions.

To Prevent or Lessen a Serious and Imminent Threat. When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

Your Privacy Rights With Respect to PHI

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person.

A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2004. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Notwithstanding the foregoing, if your Plan maintained electronic PHI as of January 1, 2009, effective January 1, 2013, you can request an accounting of all disclosures by the Plan of your electronic PHI during the three years prior to the date of your request.

Right to Receive Confidential Communications

You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties With Respect to Your PHI

The Plan has the following duties with respect to your PHI:

- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect to the PHI
- The Plan is required to abide by the terms of the notice that are currently in effect
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice
- The Plan is required to notify you of any "breach" (as defined in 45 CFR 164.402 of the Privacy Regulations) of you unsecured PHI

Your Right to File a Complaint

You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Complaint Official, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

Contact Information

If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact the Privacy Official and Complaint Official for the Plan, City of Grapevine Risk Manager at 817.410.3114.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires that mastectomy patients be provided additional benefits for breast reconstruction, surgery and reconstruction of the other breast to produce symmetry. Coverage should also be provided for prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

For Those Age 50 or Older

Senate Bill 1467 requires benefit plans that cover screening medical procedures to pay for colorectal examinations for enrollees who are age 50 or older and at normal risk for developing cancer of the colon. Your benefits are:

- An annual fecal occult blood test and a flexible sigmoidoscopy every five years, or
- A colonoscopy every 10 years

Newborn's and Mother's Health Protection Act (NMHPA)

The Newborn's and Mother's Health Protection Act (NMHPA) restricts limiting the length of a hospital stay in connection with childbirth for a mother or newborn child to less than 48 hours (or 96 hours for a cesarean delivery). The law does not prohibit earlier discharge if the mother and her attending physician are in agreement that an earlier discharge is appropriate. In addition, authorization of the hospital stay cannot be required for stays of 48 hours or less (or 96 hours) nor are early discharge incentives allowed. Hospital stays begin at delivery or upon hospital admission (whichever is later).

Medicaid and the Children's Health Insurance Program (CHIP) Offers Free or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1.877.KIDS NOW** or **insurekidsnow.gov** to find out how to apply.

Loss of Governmental Coverage

An individual who is eligible to enroll and who has lost coverage under Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) or under the Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a Late Enrollee provided appropriate enrollment application/change forms and applicable contributions are received by the Claims Administrator within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

Health Insurance Premium Payment (HIPP) Reimbursement Program

An individual who is eligible to enroll and who is a recipient of medical assistance under the Medicaid Program or enrolled in CHIP, and who is a participant in the HIPP Reimbursement Program may enroll with no enrollment period restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the month after the Claims Administrator receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from you, provided such forms and applicable contributions are received by the Claims Administrator within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

CONTACT INFORMATION

Coverage/Carrier	Phone Number	Website
Compass (Patient Advocate Service)	800.513.1667	compassphs.com/getconnected
UMR (Medical, FSA, HRA)	877.360.4503	umr.com
Optum Rx		optumrx.com
Cigna (Dental)	800.244.6224	mycigna.com
Vision Service Plan (VSP)	800.877.7195	vsp.com
Unum (Life, AD&D, Disability)	800.421.0344	
Voya (Accident/Critical Illness)	877.236.7564	
HSA Bank (HSA Account)	800.357.6246	hsabank.com
Interface (Employee Assistance Program)	800.324.4327	ieap.com

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.