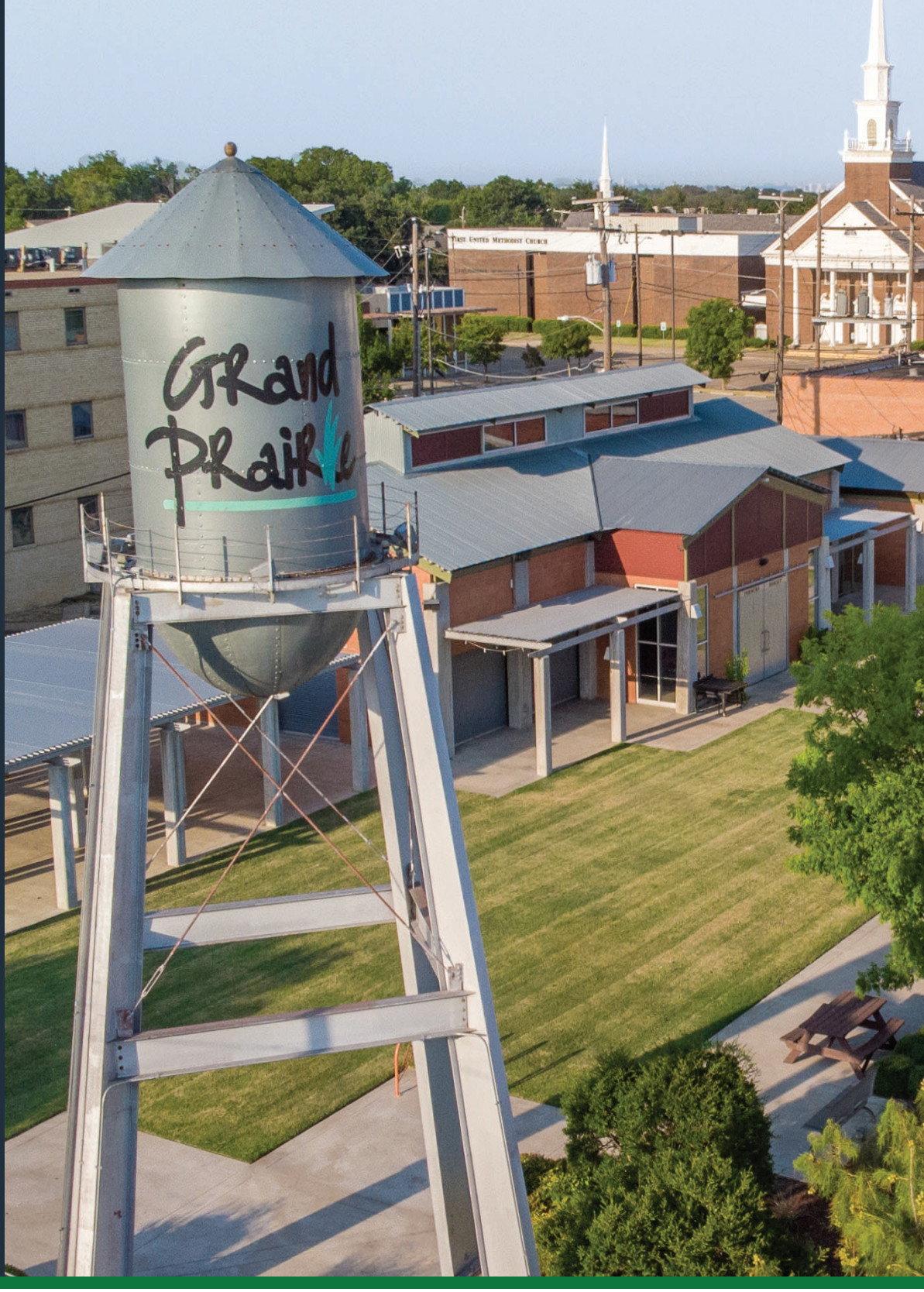
2025

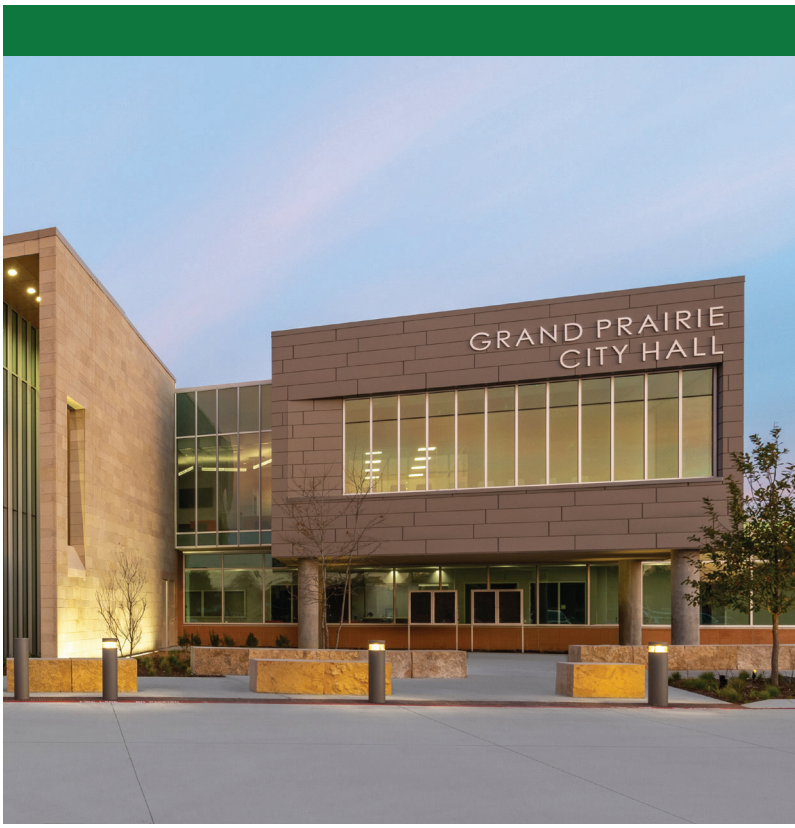


Retiree Benefits

Grand Prairie
TEXAS

2 Table of Contents

City of Grand Prairie is proud to support our retirees' overall wellbeing with a variety of benefit options. This guide offers details on our 2025 offerings for you and your family. Contact the Human Resources department with any questions.



See **page 29** for important information concerning Medicare Part D coverage.

In this guide, we use the term company to refer to the City of Grand Prairie. This guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

3 Welcome

City of Grand Prairie understands that the path to making healthcare decisions for you and your family can be difficult. To do our part, we are committed to keeping your benefits affordable and beneficial for you and your eligible family members.

City of Grand Prairie strives to provide benefits that:

- Meet your needs
- Are easy to understand and use
- Provide excellent value for affordable costs

To be your healthiest and help keep costs down, we ask that you take advantage of the provided wellness activities and preventive features.

This guide is designed to assist you and your family in making the best choices for your needs in 2025. It contains explanations of each benefit, contact information for benefits vendors, and costs you can expect for each benefit. Please review this guide in its entirety and keep as a resource throughout the year.

Any questions?

We're here to help. Contact Human Resources at 972-237-8192.

	COVERAGE ENDS ON THE LAST DAY OF EMPLOYMENT	COVERAGE ENDS ON THE LAST DAY OF THE MONTH OF THE QUALIFYING EVENT
MEDICAL, DENTAL, VISION		X

Note: If your coverage terminates, you may be eligible to continue medical, dental, vision, and Flexible Spending Account coverage under COBRA provisions.

4 Eligibility and Enrollment

The City of Grand Prairie's benefits are designed to support your unique needs.

Eligibility

Retiree rates, rules, structures, and benefits requirements are subject to change at any time as deemed necessary by the city. Plans, rates, and benefits are considered each year as part of the city's budget process.

Eligibility for retiree benefits with the city requires:

- Retiree must be eligible to retire through TMRS.
- The retiree must be under the age of 65 upon retirement from the city to be eligible for medical coverage but may continue dental and vision over the age of 65.
- Your dependents may be covered through retiree insurance into retirement only if they were covered for two full years immediately prior to retirement on the plan(s) selected and are eligible for coverage in accordance with plan guidelines.

Turning 65

Medicare has certain enrollment periods, deadlines and requirements to sign up for Part A, Part B, Part C, and Part D prior to turning 65.

Research your options regarding Medicare at https://hhs.texas.gov/services/health/medicare.

The Texas Health Information, Counseling, and Advocacy Program through Medicare can help you enroll, find information, and provide counseling about your options. They partner with the Texas Health and Human Services system, Texas Legal Services Center, and the Area Agencies on Aging to train and oversee these counselors across Texas. Counselors through this program help you understand the fine print and apply for a plan that works best for you. Additionally, they advocate for you with these programs and help you get the services you need.

To obtain services through this agency as you are nearing 65, call 800-252-9240.

Benefit Rules

Plan rules are different for retirees and their covered dependents versus an active employee. It is important that you understand these rules on our plans.

RETIREE RULES	DEPENDENT RULES
If you meet the eligibility requirements, you may continue medical, dental, and/or vision benefits into retirement for you and any eligible dependents.	To carry dependents into retirement, they must have been covered by the employee on the selected plan(s) for at least two full years immediately prior to the retirement date.
Upon initial retirement, you may only select the current plans for which you are covered at the time of retirement. You may not add coverage that you did not have, nor can you add any dependents that weren't already covered.	Dependents who do not meet the two year requirement may select continuation coverage on their own through COBRA benefits. The COBRA benefits duration and guidelines are in accordance with federal law. COBRA rates and coverage are independent from retiree coverage and may be provided by Human Resources.
If you decline coverage for medical, dental, and/or vision, you can never re-elect that coverage at any time in the future.	Dependents may not be added to retiree coverage at any time in the future for any reason (i.e., marriage, adoption, gaining custody of grandchildren, etc.).
Coverage will continue as long as the premium is paid. Premiums that are more than 60 days delinquent are subject to coverage cancellation and may not be reinstated.	Spouses on the retiree's medical plan, who attain the age of 65, must move off of the medical plan on the first day of the month in which they turn 65. Spouses may remain covered on the retiree's dental and/or vision plan after 65.
If you are a retiree on the plan, and your spouse worked for the city and has retiree coverage on their own city plan, you may not combine in the future into one plan. Each remains covered separately based on their eligibility at the time of retirement, years of service, etc.	If a retiree moves off of the medical plan due to death or turning 65, and the spouse remains eligible (under 65), he/she may continue coverage on the city's medical plan as a spouse only, for themselves, or family only, if eligible children are also covered.
Retirees on the city's medical plan, who attain the age of 65, must move off of the medical plan on the first day of the month in which they turn 65. Dental and/or vision may be continued until death or cancellation of coverage.	

6 MyTMRS Account

How Does MyTMRS Work?

To use this secure online service, you must first register and set up your username, password, and security questions. After that, you may access account information, such as your beneficiary, retirement option chosen, and year-to-date annuity payment information. Also, 1099-R forms, account statements, and annuity verification letters may be viewed and printed through MyTMRS. With MyTMRS, you are also able to change your address, phone number, email address, beneficiary (in cases that do not require spousal consent), and withholding information.

To set-up a MyTMRS account, visit www.tmrs.com and click on MyTMRS.

How Do I Review or Change My Information?

The best way to keep up with your personal information is to register for MyTMRS. It is important to keep TMRS updated with your current address, beneficiary choice, and direct deposit information.

How Do I Obtain Forms?

If you need a TMRS form, you may call HR or download the form you need from the TMRS website. Direct deposit changes (account or institution) require a new TMRS Direct Deposit Authorization form. To change your beneficiary(ies), contact TMRS for directions, and we send you the proper form (in some cases, you may change your beneficiary on MyTMRS).

To obtain a form, visit www.tmrs.com and click on MyTMRS, or call 800-924-8677.

Visit www.tmrs.com so you can:

- See the balance of your TMRS account (does not include city contribution)
- View and update your beneficiaries
- See your total months of service
- View and update your address

Can I Change My TMRS Option After Retirement?

If you marry after retirement, you may be eligible to change your payment plan to provide a survivor benefit for your new spouse. To be eligible for this change, you must have selected the Retiree Life Only Benefit or a Guaranteed Term option at retirement. You only have one year after the date of your post-retirement marriage to notify TMRS in writing that you wish to change your retirement option. If you retired under a Lifetime Survivor Option, your beneficiary dies, and you remarry, you may also make this change. This change can be made only once and **cannot be made online**. Call TMRS for assistance.

Changing your option does not increase the total benefit you and your spouse will receive. Depending on the new option you choose and the age of your beneficiary, your monthly payment will be reduced to pay the cost of the additional survivor benefit.

If you divorce after retirement, you may be eligible to change your retirement option. Please contact TMRS regarding eligibility for option reselection.

What If My Beneficiary Dies?

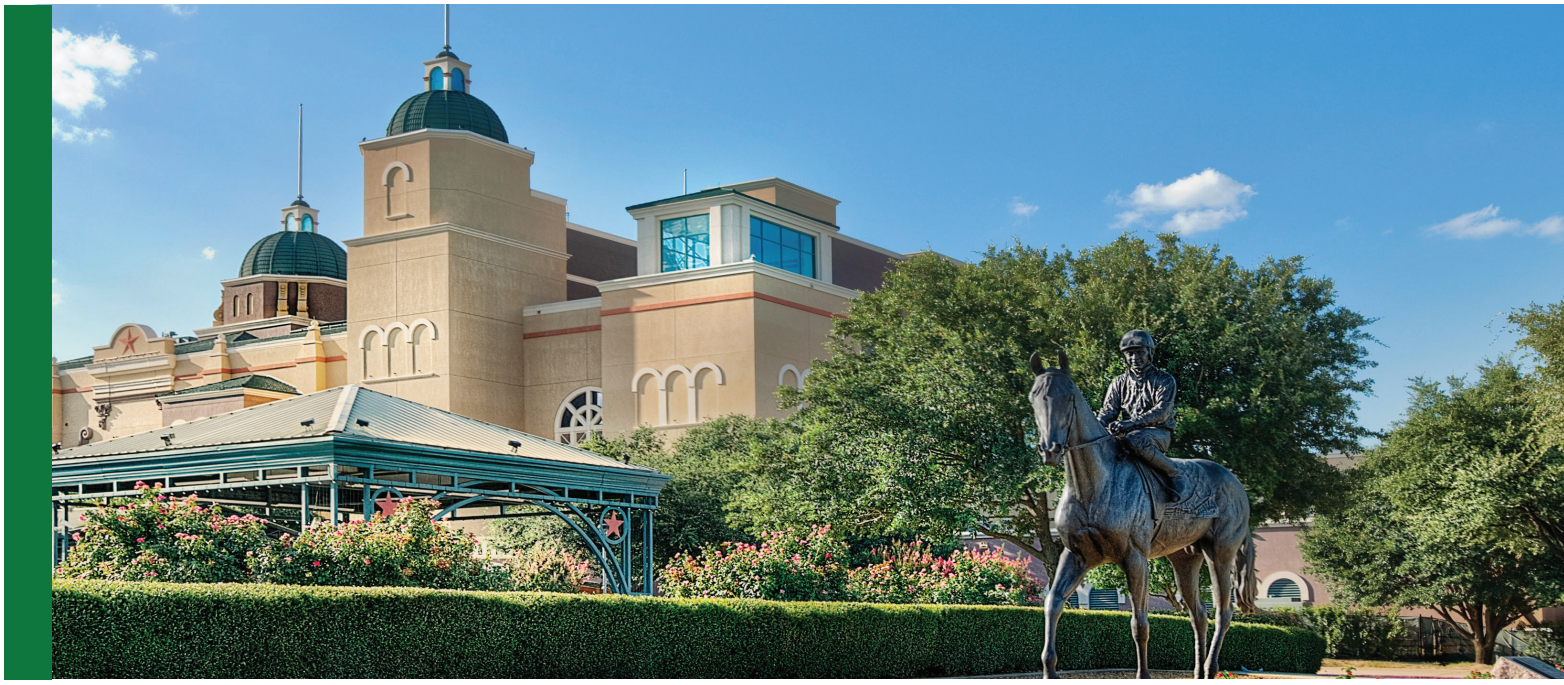
If your beneficiary dies, contact TMRS as soon as possible. Some retirement options that provide a lifetime survivor benefit include a “pop-up” feature. If your designated beneficiary dies before you, your benefit will “pop up” to the amount of the Retiree Life Only benefit. It is always important to keep your beneficiary information current with TMRS.

What Happens to My TMRS Benefit When I Die?

At your death, your retirement benefits will be paid to your chosen beneficiary, depending on the retirement option you chose. Your personal representative or a family member needs to notify TMRS at the time of your death. They will advise your designated beneficiary in writing of the proper forms to submit.

For retirement benefits account information, please contact TMRS:

Texas Municipal Retirement System
Toll-Free: 1-800-924-8677
Monday – Friday
8:00 a.m. to 5:00 p.m. (CST)



8 Wellness

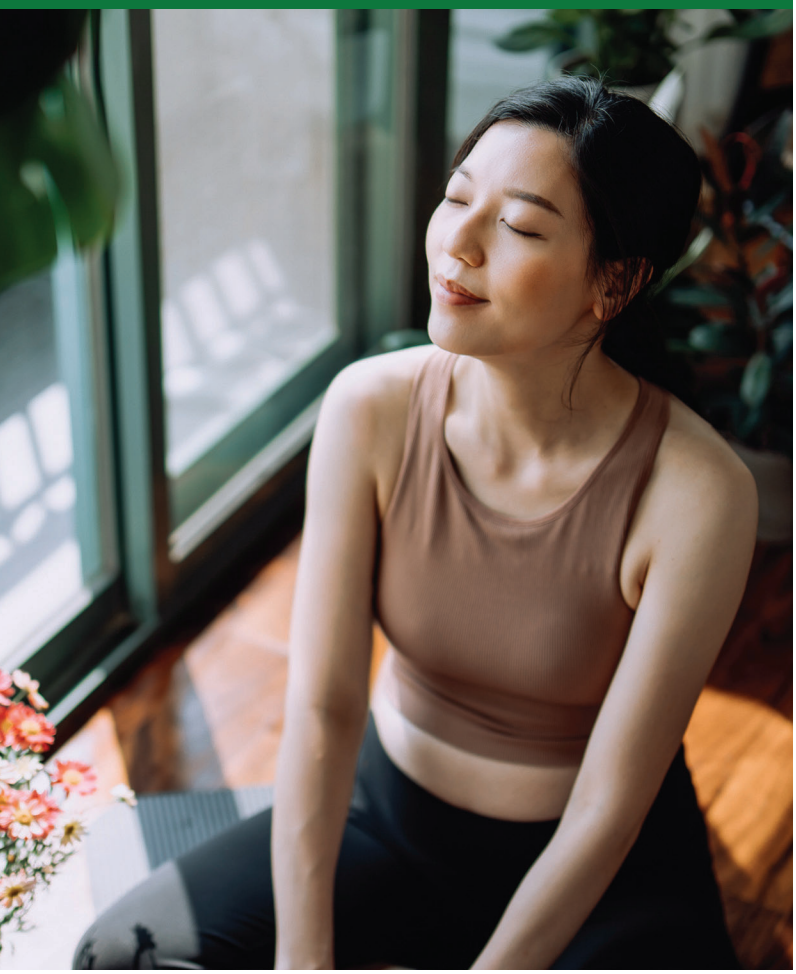
Do you make your good health a priority every day? The City of Grand Prairie is here to help. All medical plan enrolled retirees and dependents are welcome to participate, and the program is completely confidential.

Benefits Value Advisor

Benefits Value Advisors (BVAs) make it easier to use your health plan, while helping you save time and money. They will explain your benefits and provide guidance on how to use them. In addition, BVAs will also help you:

- Find a doctor of facility
- Get cost estimates for procedures and services
- Schedule appointments
- Set up prior authorizations (if needed)

Call the number on the back of your member ID card any time — day or night! Or connect via live chat in Blue Access for Members (bcbstx.com) or in the BCBSTX App, which you can quickly download by texting BCBSTXAPP to 33633.



Well onTarget

The Well onTarget Member Wellness Portal at wellontarget.com provides you with tools to help you set and reach your wellness goals. The portal is user-friendly, so you can find everything you need quickly and easily. Explore your wellness world to find a wide variety of health and wellness resources including:

Health Tools and Trackers

The tracker lets you record how much sleep you get, your stress levels, your blood pressure readings, and your cholesterol levels. It also offers a symptom checker and helps you decide if you should see a doctor.

Fitness Tracking

You can see where you are today compared to where you were when you started. You can also read the latest health news, check your activity progress, and more.

These programs are interactive and include learning activities and content that focus on behavioral changes to reinforce healthier habits. These educational programs inform you about symptoms, treatment options and lifestyle changes.

Blue Points Rewards

Well onTarget understands how hard it can be to maintain a healthy lifestyle. Sometimes, you may need a little motivation. That's why we offer the Blue Points program. This program may help you get on track and stay on track to reach your wellness goals.

With the Blue Points program, you will be able to earn points for regularly participating in many different healthy activities. You can redeem these points in the online shopping mall, which provides a wide variety of merchandise.

It's Easy to Get Started!

Contact Customer Service at 877-806-9380 or go to wellontarget.com.

9 Medical Benefits

Medical benefits are provided through BlueCross BlueShield of Texas. Consider the physician networks, premiums, and out-of-pocket costs for each plan when making a selection. Keep in mind your choice is effective for the entire 2025 plan year unless you have a Qualifying Life Event.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your monthly contributions.

Our Plans are Self-Funded

Our medical, and pharmacy plans are self-funded. What does that mean? Rather than paying fixed premiums to an insurance carrier as with fully insured plans, the City of Grand Prairie has more control over the plan we select for our employees. Together, the city and employees share the cost of healthcare.

Healthcare Cost Transparency

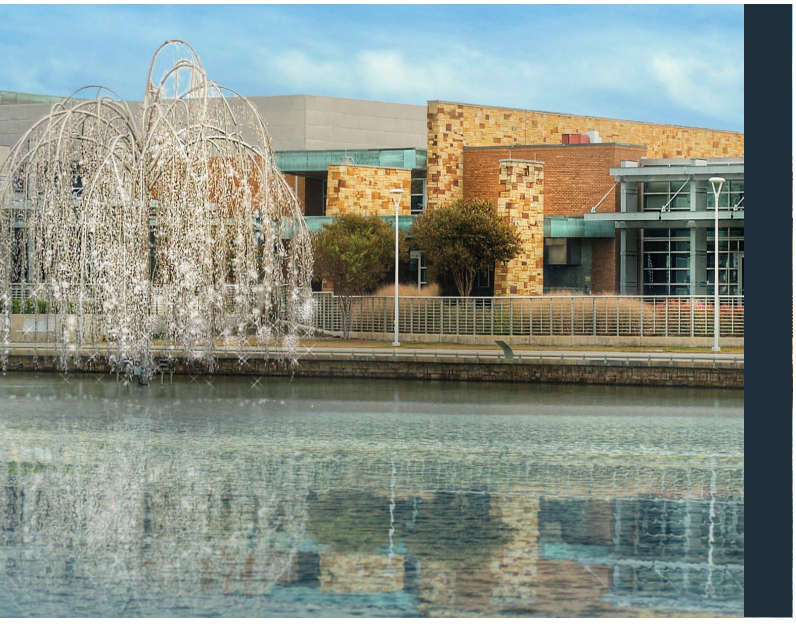
There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. Available through most health insurance carriers, these tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit bcbstx.com to learn more.

How to Find a Provider

Visit bcbstx.com or call Customer Care at 855-357-5229 for a list of BlueCross BlueShield of Texas network providers.

	HDHP	EPO
	IN-NETWORK	IN-NETWORK
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$3,300	$1,500
FAMILY	$6,600	$3,000
COINSURANCE (PLAN PAYS)	80%*	80%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)		
INDIVIDUAL	$6,000	$6,000
FAMILY	$12,000	$12,000
COPAYS/COINSURANCE		
PREVENTIVE CARE	No charge	No charge
PRIMARY CARE	Plan pays 80%/ You pay 20%*	$35 copay
SPECIALIST SERVICES	Plan pays 80%/ You pay 20%*	$60 copay
DIAGNOSTIC CARE	Plan pays 100%*	No charge
MENTAL HEALTH – INPATIENT	Plan pays 80%/ You pay 20%*	80%*
MENTAL HEALTH – OUTPATIENT	Plan pays 80%/ You pay 20%*	$35 copay
URGENT CARE	Plan pays 80%/ You pay 20%*	$75 copay
EMERGENCY ROOM	Plan pays 80%/ You pay 20%*	$300 copay, plus 20%*

*After deductible



Deductibles

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a “per individual” deductible amount will also be applied toward the “per family” deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the “per family” deductible amount. The same typically applies for the out-of-pocket maximum.

10 How to Pick a Plan

What plan is right for you? Consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How does an HDHP (High Deductible Health Plan) work?

- You'll pay less in premiums.
- You'll pay for the full cost of non-preventive medical services until you reach your deductible.
- You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.
- If you expect to mostly use preventive care (which is covered), this plan could be for you.

How does an EPO (Exclusive Provider Organization) plan work?

An EPO is an exclusive provider organization that does not cover out-of-network care except in the case of a true emergency.

- You'll pay more in premiums, but you will pay less out of pocket when you need medical care.
- You will have a fixed copay, so that you know exactly what you'll have to pay at the time of your visit.
- Fixed copays do not apply toward your deductible.
- If you do not want to pay the full cost for medical care up front, this plan could be for you.

11 Out-of-Pocket Costs

These are the types of payments you're responsible for:

Copay

The fixed amount you pay for healthcare services at the time you receive them.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

12 Health Savings Account

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in an HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

WEX will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse's or parent's non-HDHP.
- You or your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Note

Because HSA funds never expire, contributing your annual maximum to your HSA can help you save to pay for healthcare expenses tax-free after retirement.

You Own Your HSA

Your HSA is a personal bank account that you own and manage. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements (you own all contributed HSA funds immediately) or forfeiture provisions (you keep all HSA funds whether you leave the company or retire).

How to Enroll

The City of Grand Prairie will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with WEX. The money in your HSA (including interest and investment earnings) grows tax-free. When the funds are used for qualified medical expenses, they are spent tax-free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where you spend your HSA funds.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2025, contributions are limited to the following:

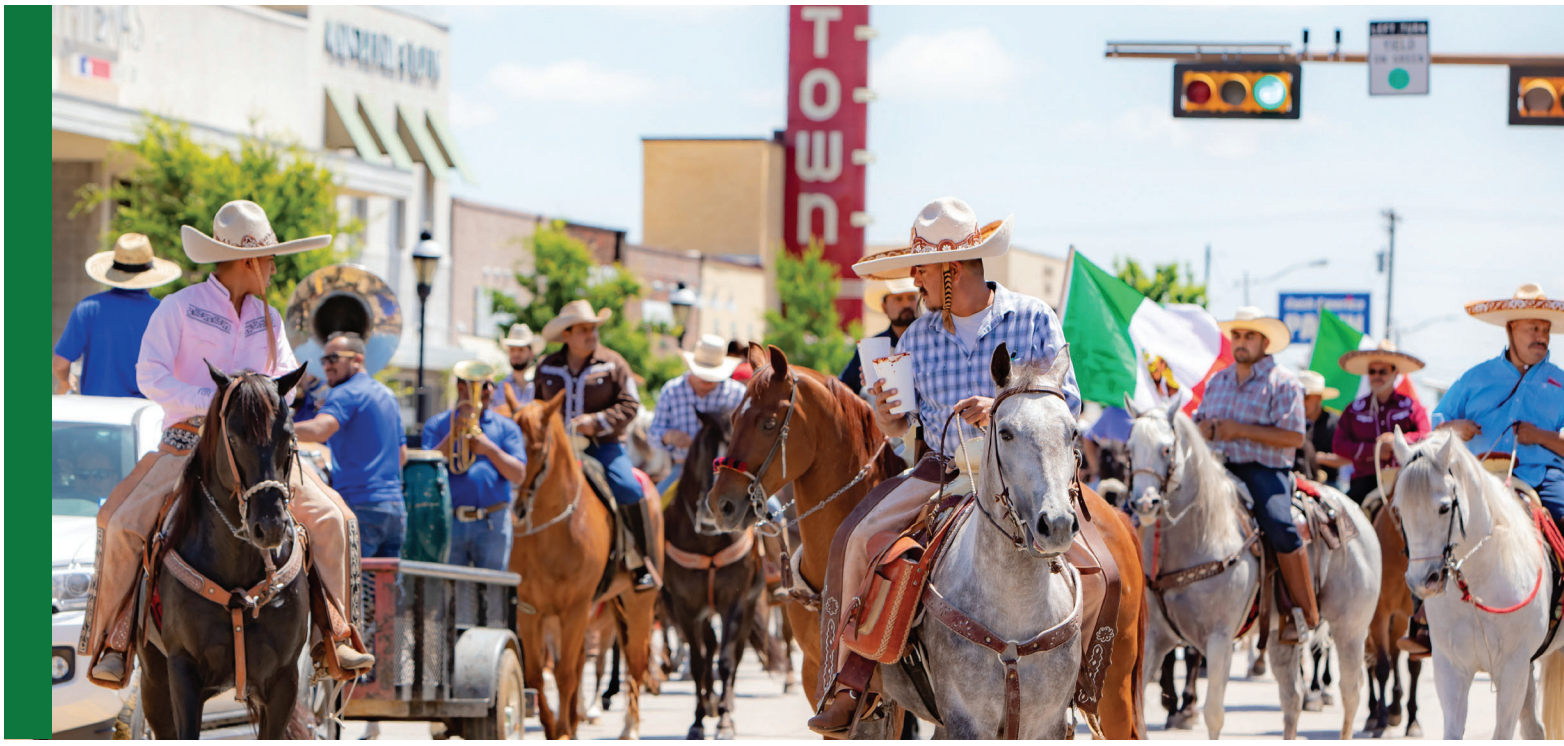
HSA FUNDING LIMITS	
EMPLOYEE	$4,300
FAMILY	$8,550
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

HSA contributions over the IRS annual contribution limits ($4,300 for individual coverage and $8,550 for family coverage for 2025) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed but won't have to pay a penalty tax.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The City of Grand Prairie HSA is established with WEX. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit wexinc.com.



14 BCBS Added Benefits

The BCBS added benefits are no additional cost to the members covered on the City's plan.

Livongo for Diabetes

The Livongo for Diabetes program is a health benefit that combines advanced technology with coaching to support you with your diabetes. Those enrolled into one of the City's medical plans that meet certain medical criteria will receive a connected glucose meter, unlimited strips and lancets, personalized insights with each reading, and access to Certified Diabetes Educators. The program is provided to you and your eligible family members with diabetes and coverage on the City's medical plan.

To learn more about Livongo for Diabetes, visit www.livongo.com/diabetes.

Livongo for Hypertension

The Livongo for Hypertension program is a health benefit that helps you easily manager your high blood pressure with advanced technology and personalized coaching. Those enrolled into one of the City's medical plans that meet certain medical criteria will receive a connected blood pressure monitor with a sleek carrying case, mobile application to keep track of all of your readings, personalized insights with each reading, and access to Livongo's expert health coaches when you need it. This program is provided to you and your eligible family members with high blood pressure and coverage on the City's medical plan.

To learn more about Livongo for Hypertension, visit www.livongo.com/hypertension.

Omada

The Omada program helps you reduce your risk of prediabetes and chronic disease through nutrition guidance, weight loss, and customized health coaching. This program will help you build healthy routines around what you love to do and where you want the most support. You will receive a wireless smart scale, mobile application to track your health progress, access to peer groups, and a dedicated health coach for the support you need to get going and keep going. This program is provided to you and your eligible family members with coverage on one of the City's medical plans.

To learn more about Omada, visit www.omadahealth.com/gptx.

Hinge Health

Say goodbye to traditional physical therapy with the Hinge Health program. Hinge Health goes beyond traditional physical therapy to help you take control of back and joint pain, recover from injuries, prepare for surgery, or stay healthy and pain free. You will receive app-guided exercise therapy that includes 15-minute sessions to reduce pain and increase strength and mobility, free tablet, and wearable sensors that provide live feedback on your form in the Hinge Health app, and access to a personal health coach or physical therapist at any time. Your Hinge Health care plan can be done from anywhere and whenever works best for your schedule in their convenient app. That means never rushing to an appointment or worrying about copays.

To learn more about Hinge Health, call 855-902-2777, visit www.hingehealth.com/gptx or email hello@hingehealth.com.

SmartER

SmartER Care helps guide you to know where to go for medical care and can make a big difference in cost and time. The 24/7 Nurseline helps identify options when you or a family member has a health problem or concern.

Urgent Care or Freestanding Emergency Room

Urgent care centers and freestanding ERs can be hard to tell apart. Freestanding ERs treat most major injuries, except for trauma, but costs may be higher. Unlike urgent care centers, freestanding ERs are often out of network and may charge patients up to 10 times more for the same services.

Ways to know if you are at a freestanding ER:

- Look like urgent care centers, but have the word "Emergency" in their name or on the building
- Are open 24 hours a day, seven days a week
- Are not attached to and may not be affiliated with a hospital
- Are subject to the same ER member share which may include a copay, coinsurance, and applicable deductible

Need to Find an Urgent Care?

Text URGENTTX to 33633.

SurgeryPlus™

Have an upcoming surgery? The City of Grand Prairie offers a supplemental benefit for planned non-emergency surgeries. SurgeryPlus™ provides a personalized concierge experience with a dedicated Care Advocate, as well as access to high-quality care through a network of providers. By using SurgeryPlus™, you may save money through waived coinsurance. SurgeryPlus™ is a part of the City of Grand Prairie's medical benefits for you and your dependents. When you call SurgeryPlus™, a Care Advocate can help you:

- Choose the right surgeon
- Schedule appointments
- Coordinate medical record transfers and travel arrangements
- Provide all the information you need as you make your healthcare decisions

Covered procedures may include orthopedics, spine, general surgery, gynecology, ear nose and throat, gastrointestinal, cardiac, and pain management. To learn more about SurgeryPlus, visit gptx.surgeryplus.com. Click "Register Now" and then complete all necessary fields along with the access code: Raving Fans!

Airrosti

The city invites medical plan members who suffer from back, neck, or other chronic pain or injures to try Airrosti for aches, pains, and muscle pulls. This may reduce the likelihood of surgery, pharmaceuticals, or injections. Airrosti is a non-surgical rapid recovery treatment designed to eliminate pain and soft tissue injuries in an average of three treatments (based on historical outcomes). For City of Grand Prairie employees, dependents, and retirees on the BCBSTX health plan, Airrosti visits are set at a $20 copay for EPO plan members and subject to deductible and coinsurance for HDHP members.

To learn more about Airrosti, call 800-404-6050 or visit www.airrosti.com.

16 Preventive Care

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance. Some common covered services include:

- **Wellness visits, physicals, and standard immunizations**
- **Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes**
- **Depression screenings and resources**
- **Lung cancer screenings for adults 50 to 80 at high risk for lung cancer due to heavy smoking or who have quit smoking in the past 15 years**
- **Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk**

It's important to take advantage of these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What vaccines are covered 100% under preventive care?

Many vaccines are covered under preventive care when delivered by a doctor or provider in your plan's network. These include chickenpox, flu, shingles and tetanus. For a full list, visit www.healthcare.gov/preventive-care-adults.

17 Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Or you're on vacation and are under the weather. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

SmartER 24/7 Nurse Line: 800-581-0939

When to Use
You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

Types of Care*
Answers to questions regarding:
- Symptoms
- Self-care/home treatments
- Medications and side effects
- When to seek care

Costs and Time Considerations
- Available 24 hours a day, 7 days a week
- No cost to you as part of the SmartER Care Program

Virtual Visit With MDLive ($): 800-400-MDLIVE

When to Use
You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*
- Cold & flu symptoms
- Bronchitis
- Urinary tract infection
- Sinus problems

Costs and Time Considerations
- EPO Plan – $25 Copay | HDHP – Deductible & Coinsurance
- Typically immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states

In-Network Primary Care Center ($)

When to Use
You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*
- Routine checkups
- Immunizations
- Preventive services
- Managing your general health

Costs and Time Considerations
- EPO Plan – $35 Copay HDHP – Deductible & Coinsurance
- Normally requires an appointment
- Short wait time with scheduled appointment

*This is a sample list of services and may not be all inclusive.

In-Network Urgent Care Center ($$)

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns

Costs and Time Considerations

- EPO Plan – $75 Copay
  HDHP – Deductible & Coinsurance
- Walk-in patients welcome, but urgency determines order seen and wait time

Need to find an Urgent Care? Text URGENTTX to 33633.

Emergency Room/Standalone ER ($$$)

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- Heavy bleeding
- Chest pain
- Major burns
- Severe head injury

Costs and Time Considerations

- EPO Plan – $300 Copay + Deductible & Coinsurance | HDHP – Deductible & Coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

*This is a sample list of services and may not be all inclusive.

Do Your Homework

What may seem like an urgent care center might actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word “emergency” appears in the company name.

19 Virtual Medicine

When you're under the weather, there's no place like home, and if you're busy with work and family, scheduling an in-person doctor's appointment can be a pain. Virtual medicine is a convenient and easy way to connect with a doctor on your time.

The City of Grand Prairie provides a virtual medicine benefit through BCBS MDLive for you and your dependents. This service offers on-demand access to board-certified doctors through online video, telephone, or secure email.

BCBS MDLive doctors can share information with your primary care physician with your consent. Please note that some states do not allow physicians to prescribe medications via telemedicine. For more information, visit MDLive.com/bcbstx.

The cost for each MDLIVE visit varies based on your plan. If you are enrolled in the EPO plan, you will pay a copay. If you are enrolled in the HDHP, the cost will be subject to deductible and coinsurance, but the cost is usually less than an office visit. Check with MDLIVE to confirm your specific cost.

BCBS MDLive doctors can treat many medical conditions, including:

- Cold & flu
- Allergies
- Bronchitis
- Bladder infection/urinary tract infection
- Respiratory infection
- Pink eye
- Sore throat
- Stomachache
- Sinus problems

Access Virtual Visits

Visit MDLive.com/bcbstx to request a virtual visit. After you register and request an appointment, you'll pay your portion of the service costs and enter a virtual waiting room. During your visit, you can talk to a doctor about your health concerns, symptoms, and treatment options.

Note

A virtual visit directly with your primary care physician (vs. BCBS MDLive) might also be an option — and typically costs the same as an office visit.

20 Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through BlueCross BlueShield of Texas. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at bcbstx.com and or by calling the Customer Care number on your ID card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, Non-Preferred, or Specialty Drugs.

Specialty Drugs

Specialty medications can be obtained through Accredo. You can order a new prescription or transfer your existing prescription for a specialty medication to Accredo. To start using Accredo, call 833-721-1619 and an Accredo representative will work with your doctor on the rest.

	HDHP	EPO
	IN-NETWORK	IN-NETWORK
RX DEDUCTIBLE	Included with Medical Deductible	$100 Individual/$300 Family
RETAIL RX (30-DAY SUPPLY)		
GENERIC	Plan pays 80%/You pay 20%*	$10 copay
PREFERRED	Plan pays 80%/You pay 20%*	$40 copay
NON-PREFERRED	Plan pays 80%/You pay 20%*	$65 copay
SPECIALTY DRUGS	Plan pays 80%/You pay 20%*	$150 copay
MAIL ORDER RX (90-DAY SUPPLY)		
GENERIC	Plan pays 80%/You pay 20%*	$30 copay
PREFERRED	Plan pays 80%/You pay 20%*	$120 copay
NON-PREFERRED	Plan pays 80%/You pay 20%*	$195 copay
SPECIALTY DRUGS	Not covered	Not covered

*After deductible

MedsYourWay

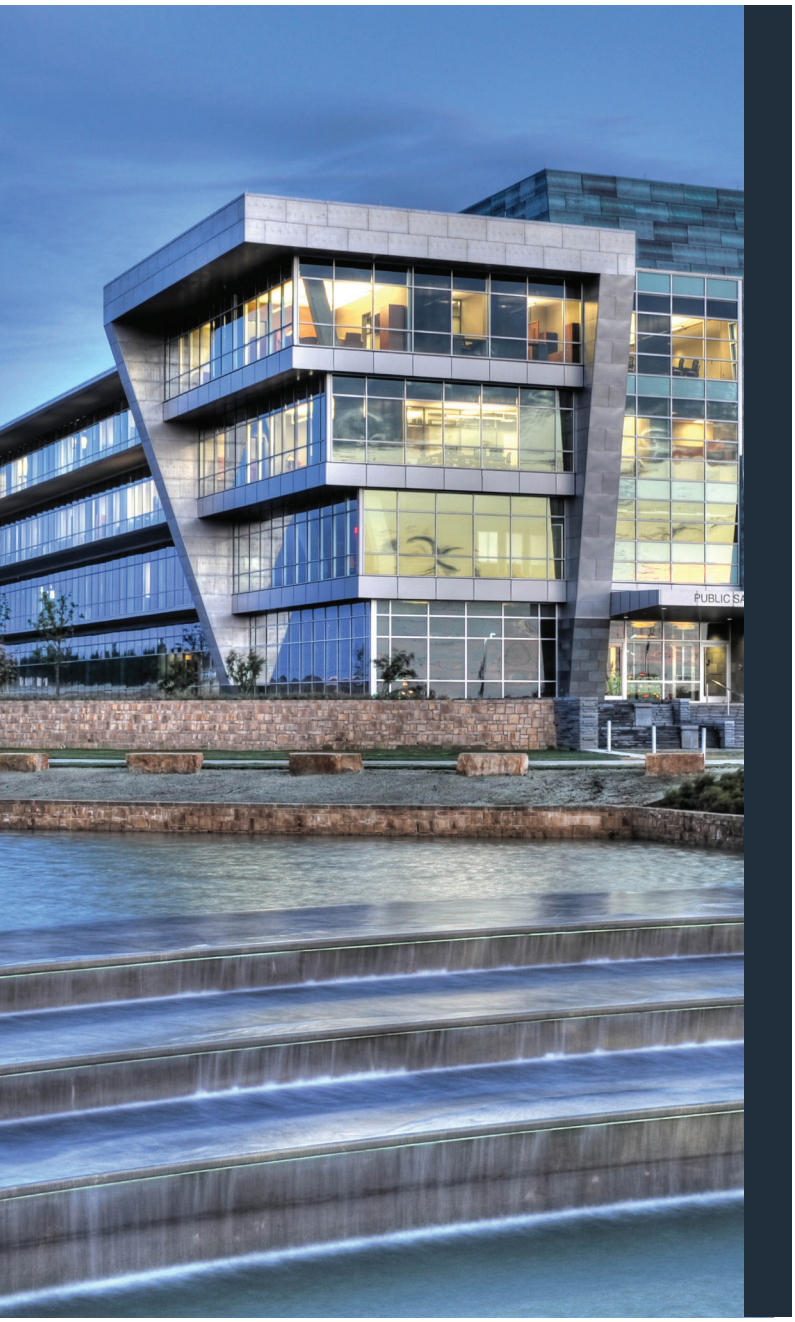
MedsYourWay is a drug discount card savings program for members enrolled in one of the City's health plans. It simplifies members' drugstore experience by automatically searching for and finding lower costs for eligible medicines.

How It Works

- Fill your prescription at a participating in-network retail pharmacy.
- When you pick up your prescription, show your BCBSTX member ID card to your pharmacist.
- MedsYourWay automatically compares prices from participating drug discount cards to your cost-share amount under your BCBSTX pharmacy benefits.
- You pay the drug discount card price or your member cost-share, whichever is lower, for an eligible medicine.
- Plus, what you pay will count toward your plan deductible and/or yearly out-of-pocket maximum amount if you have one.

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they are held to the same rigid FDA standards. But generic versions cost 80% to 85% less on average than the brand-name equivalent. To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.



Lowering Medication Costs

How do prescription discount programs work? These discounts can't be combined with your benefit plan's coverage, so make sure to check the price against the cost of using your insurance's prescription drug benefit. Something else to consider: If you choose to use a discount card and are therefore not tapping into your insurance's prescription drug benefit, the cash amount you pay for the prescription may not count toward your deductible or out-of-pocket maximum under the benefit plan.

GoodRx is a web- and app-based platform that allows you to search for prescription drug coupons and compare pharmacy prices. The company claims a savings of up to 80% on generics. **Optum Perks** also provides coupons for medications and a searchable database for drug cost comparison at participating pharmacies near you. The Optum Perks member card, which can be used at more than 64,000 pharmacies, is free to use and requires no personal data. Another discount option is the **Amazon Prime Rx Savings** discount card, which is included with an Amazon Prime membership and is administered by Inside Rx. It provides discounts of up to 80% for generics and up to 40% for brand-name medication at participating pharmacies. **Cost Plus Drug Company** is a web-based pharmacy that claims to keep costs low by buying directly from the manufacturer. It currently only offers a certain selection of medications and accepts a handful of prescription insurance providers, but it may be worth checking the price difference between Cost Plus and your regular pharmacy.

FlexAccess

Save money on your high-cost medicines with FlexAccess. Medicines for long-term health conditions can be expensive and hard to get when and where you need them. FlexAccess is here to help. Your health plan offers this program as part of your health insurance benefits. FlexAccess finds the best copay assistance (coupon) discounts for you — meaning your medicines may be cheaper and easier to get. Call the number on the back of your BlueCross BlueShield ID card to see if this program is right for you.

22 Do You Need Specialty Medications?

BlueCross BlueShield of Texas supports members who need self-administered specialty medication and helps them manage their therapy. Accredo® is the specialty pharmacy chosen to do just that.

Specialty drugs are often prescribed to treat complex and/or chronic conditions, such as multiple sclerosis, hepatitis C, and rheumatoid arthritis.

Specialty drugs often call for carefully following a treatment plan (or taking them on a strict schedule). These medications have special handling, or storage needs and may only be stocked by select pharmacies.

Some specialty drugs must be given by a healthcare professional, while others are approved by the FDA for self-administration (given by yourself or a caregiver). Medications that call for administration by a professional are often covered under your medical benefit plan. Your doctor will order these medications. Coverage for self-administered specialty drugs is usually provided through your pharmacy benefit plan. Your doctor should write or call in a prescription for self-administered specialty drugs to be filled by a specialty pharmacy.

Your plan may require you to get your self-administered specialty drugs through Accredo or another in-network pharmacy. If you do not use these pharmacies, you may pay higher out-of-pocket costs. Your doctor may also order select specialty drugs that must be given to you by a health professional through a contracted specialty pharmacy.

Note

Certain coverage exclusions and limits may apply based on your health plan. For some medicines, members must meet certain criteria before prescription drug benefit coverage may be approved. Check your benefit materials for details or call the customer service number listed on your BlueCross BlueShield ID card with questions.

Do You Need Specialty Medications?

Examples of Self-administered Specialty Medications

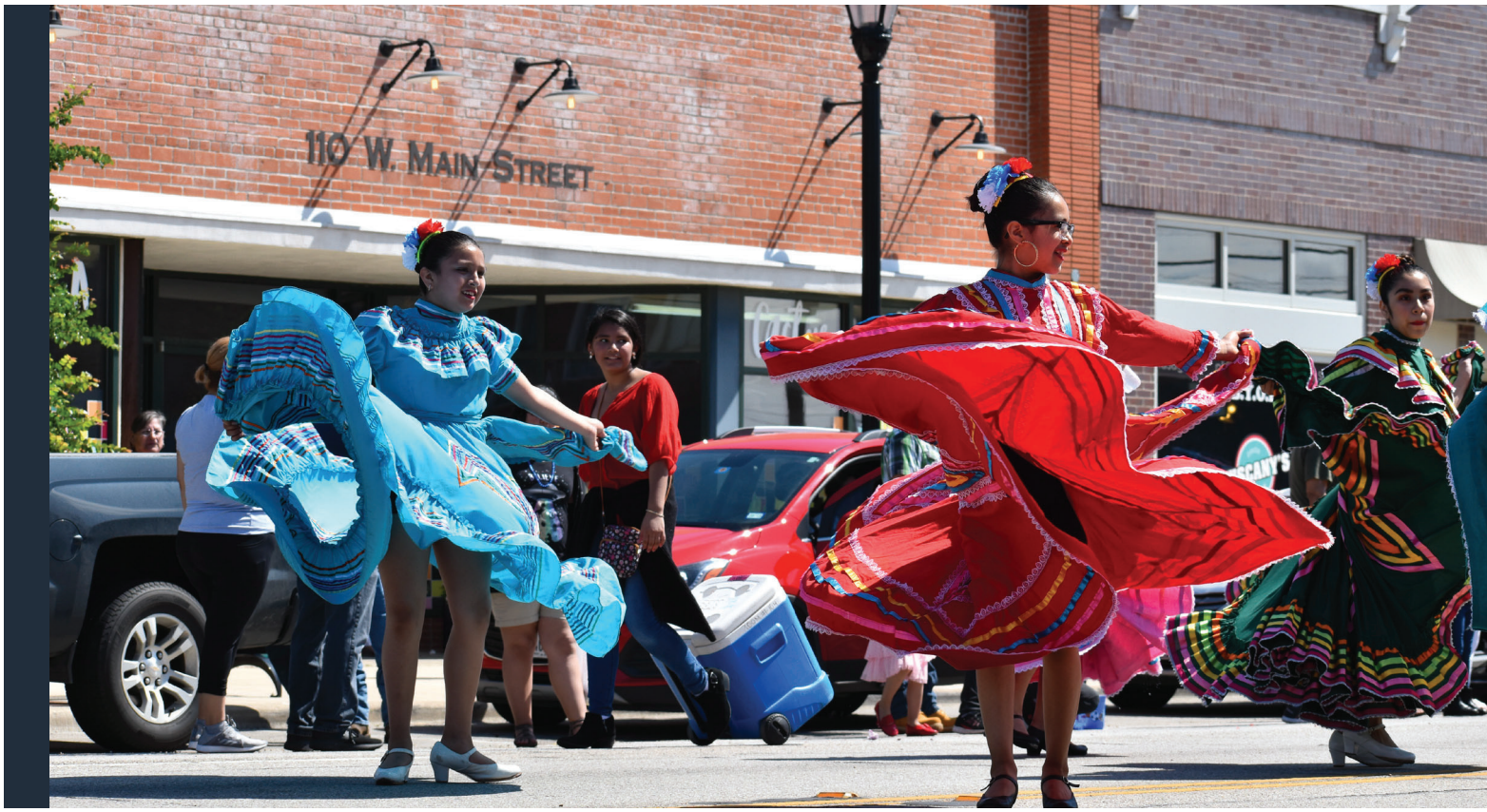
This chart shows some conditions self-administered specialty drugs may be used to treat, along with sample medications. This is not a complete list and may change from time to time. Visit bcbstx.com to see the up-to-date list of specialty drugs.

CONDITION	SAMPLE MEDICATIONS
AUTOIMMUNE DISORDERS	Cosentyx, Enbrel, Humira, Xeljanz
OSTEOPOROSIS	Forteo, Tymlos
CANCER (ORAL)	Sprycel, Imbruvica, Kisqali, Ibrance, Xtandi
GROWTH HORMONES	Norditropin Flexpro, Genotropin
HEPATITIS C	Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi
MULTIPLE SCLEROSIS	Betaseron, Rebif, Aubagio

Support in Managing Your Condition — Accredo

Through Accredo, you can have your covered, self-administered specialty drugs delivered straight to you. When you get your specialty drugs through Accredo, you get:

- One-on-one counseling from 500+ condition-specific pharmacists and 600+ nurses
- Simple communication, including refill reminders, by your choice of phone, email, text, or web
- An online member website to order refills, check order status and track shipments, view order and medication history, set profile preferences, and learn more about your condition
- A mobile app that lets you refill and track prescriptions, make payments, and set reminders to take your medicine
- Free standard shipping
- 24/7 support



Ordering Through Accredo

You can order a new prescription or transfer your existing prescription for a self-administered specialty drug to Accredo. To start using Accredo, call 833-721-1619. An Accredo representative will work with your doctor on the rest.

Once registered, you can manage your prescriptions on accredo.com or through the Accredo mobile app.

Receiving Specialty Medications

Since many specialty drugs have unique shipping or handling needs, shipments will be arranged with you through Accredo. Medications are shipped in plain, secure, tamper-evident packaging.

Before your scheduled fill date, you will be contacted to:

- Confirm your drugs, dose, and the delivery location
- Check any prescription changes your doctor may have ordered
- Discuss any changes in your condition or answer any questions about your health

One-on-One Support

Accredo has 15 Therapeutic Resource Centers® (TRCs), each focused on a specific specialty condition. Through your one-on-one counseling sessions, they'll discuss how to reduce your disease progression and achieve your treatment goals, manage any side effects from your drugs, help you stick to your regimen, and monitor your progress. They can also offer support with any financial or insurance concerns you may have.

24 Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. The City of Grand Prairie offers affordable plan options from Cigna for routine care and beyond.

Stay In-Network

If you enroll in the DHMO option, you must receive services from a network dentist. If you enroll in the PPO option, you can obtain services from an out-of-network dentist. If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Cigna at mycigna.com.

Dental Plan Summary

This chart summarizes the dental coverage provided by Cigna for 2025.

	DENTAL DHMO	DENTAL PPO
MONTHLY CONTRIBUTIONS		
EMPLOYEE ONLY	$7.26	$40.94
EMPLOYEE + SPOUSE	$13.78	$80.88
EMPLOYEE + CHILD(REN)	$15.98	$84.86
EMPLOYEE + FAMILY	$23.60	$146.74
	DENTAL DHMO	DENTAL PPO
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$0	$50
FAMILY	$0	$150
CALENDAR YEAR MAXIMUM		
PER PERSON	Unlimited	$1,500
COVERED SERVICES		
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, X-rays, Fluoride Applications, Sealants, Space Maintainers	Refer to Patient Charge Schedule	100%; no deductible
BASIC SERVICES Fillings, Endodontics, Periodontics, Oral Surgery, Anesthesia	Refer to Patient Charge Schedule	80%*
MAJOR SERVICES Inlays, Onlays, Crowns, Dentures, Bridges	Refer to Patient Charge Schedule	50%*
ORTHODONTICS Employee and All Dependents	Refer to Patient Charge Schedule	50%*
ORTHODONTIC LIFETIME MAXIMUM	N/A	$1,500

*After deductible

Note

In addition to keeping your teeth healthy, regular dental checkups can help dentists spot symptoms of other serious conditions such as osteoporosis, cancer, and diabetes.

25 Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. The City of Grand Prairie provides quality vision care for you and your family through Superior Vision.

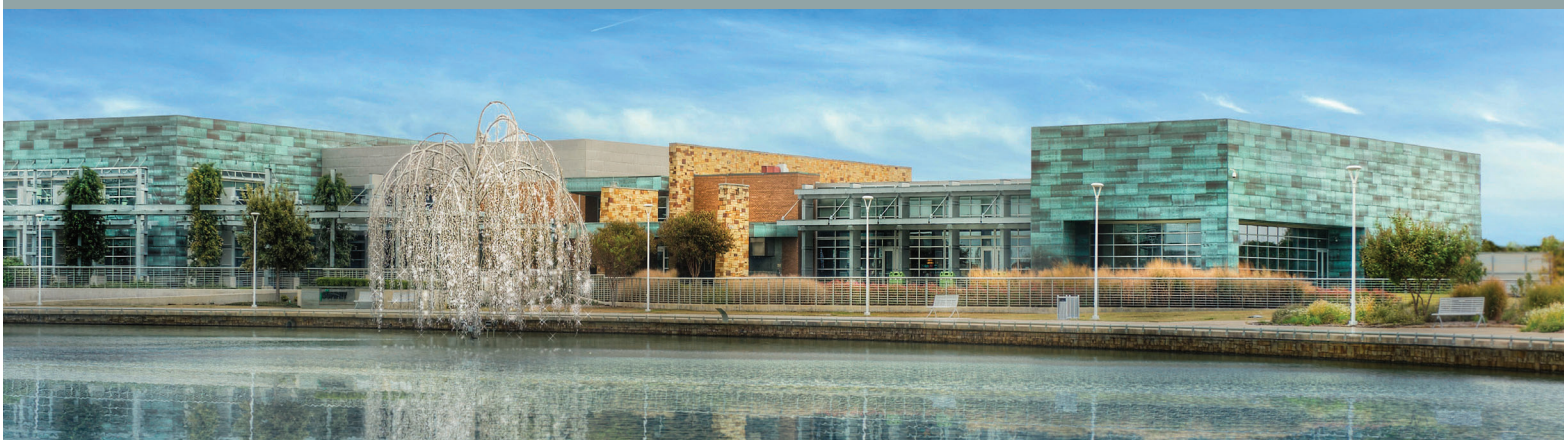
Vision Plan Summary

This chart summarizes the vision coverage provided by Superior Vision for 2025. The benefits listed on this page reflect in-network benefits. Refer to the Superior Vision benefit summary for out-of-network benefit information.

	BASIC VISION	ENHANCED VISION
MONTHLY CONTRIBUTIONS		
EMPLOYEE ONLY	$1.98	$6.52
EMPLOYEE + SPOUSE	$3.94	$13.10
EMPLOYEE + CHILD(REN)	$3.58	$11.45
EMPLOYEE + FAMILY	$5.90	$19.22

	BASIC VISION	ENHANCED VISION	FREQUENCY
EXAMS			
COPAY	$10	$10	12 months
LENSES			
SINGLE VISION	Not covered	Covered in full*	12 months
BIFOCAL	Not covered	Covered in full*	
TRIFOCAL	Not covered	Covered in full*	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION	Not covered	$25 copay for Standard, $50 retail allowance for Specialty	12 months
ELECTIVE	Not covered	$150 retail allowance	
FRAMES			
COPAY	Not covered	$25	12 months
ALLOWANCE	Not covered	$150 retail allowance	

*After copay



26 Important Contacts

City of Grand Prairie Human Resources
300 W. Main Street
Grand Prairie, TX 75050
972-237-8192
benefits@gptx.org

Medical & Pharmacy
BlueCross BlueShield of Texas
855-357-5229
bcbstx.com
Group #: 271132 – EPO Plan
Group #: 271134 – EPO HDHP

Telemedicine
BCBS MDLive
888-680-8646
MDLive.com/bcbstx

Dental
Cigna
800-244-6224
mycigna.com
Policy #: 3341220

Vision
Superior Vision
800-507-3800
superiorvision.com

Health Savings Account
WEX
866-451-3399
wexinc.com

Retirement
Texas Municipal Retirement System (TMRS)
800-924-8677
tmrs.com

MissionSquare Retirement
800-669-7400
msqplanservices.org/myplan/300087

Nationwide Retirement Solutions
877-677-3678
nrsforu.com

27 Glossary

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in an HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered. These medications are usually required to be filled at a specific pharmacy.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to guide employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice From the City of Grand Prairie About Your Prescription Drug Coverage and Medicare Under the BlueCross BlueShield of Texas HDHP and EPO Plan(s)

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of Grand Prairie has determined that the prescription drug coverage offered by the BlueCross BlueShield of Texas HDHP and EPO plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current City of Grand Prairie coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with the City of Grand Prairie and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Grand Prairie changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227)
  TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	City of Grand Prairie
Contact—Position/Office:	Human Resources
Address:	300 W. Main Street Grand Prairie, TX 75050
Phone Number:	972-237-8192

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 972-237-8192.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 972-237-8192.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

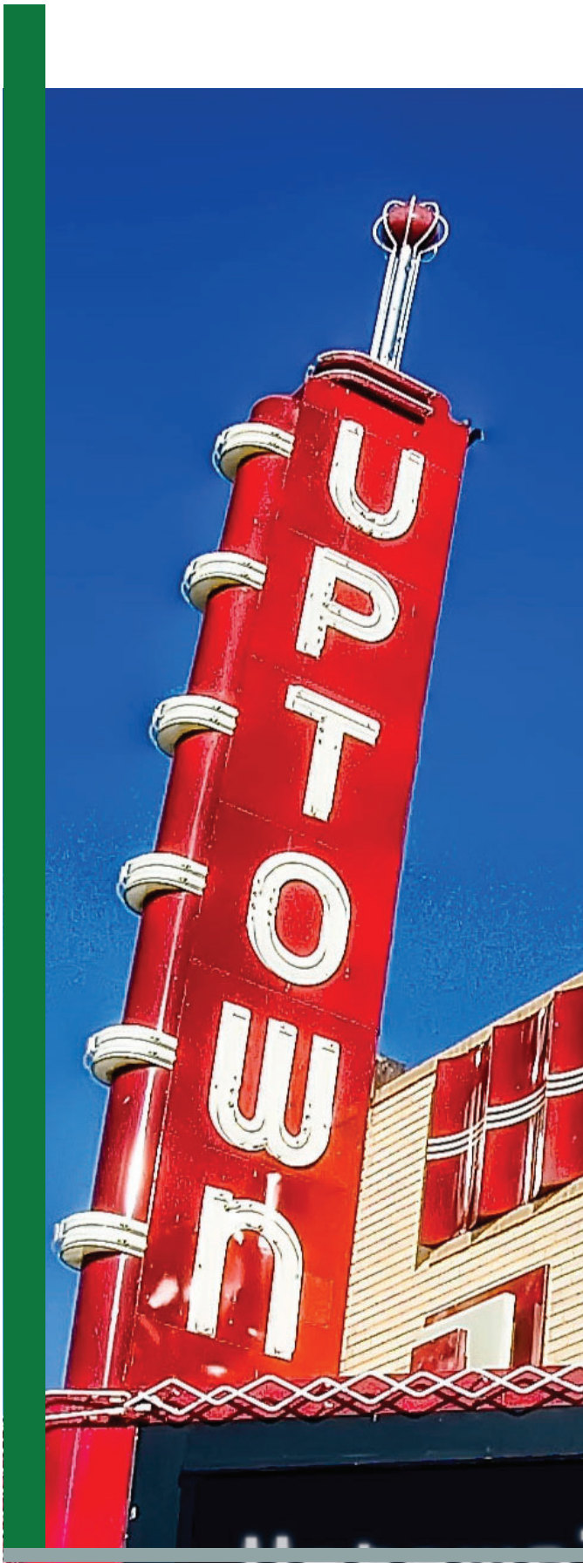
Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

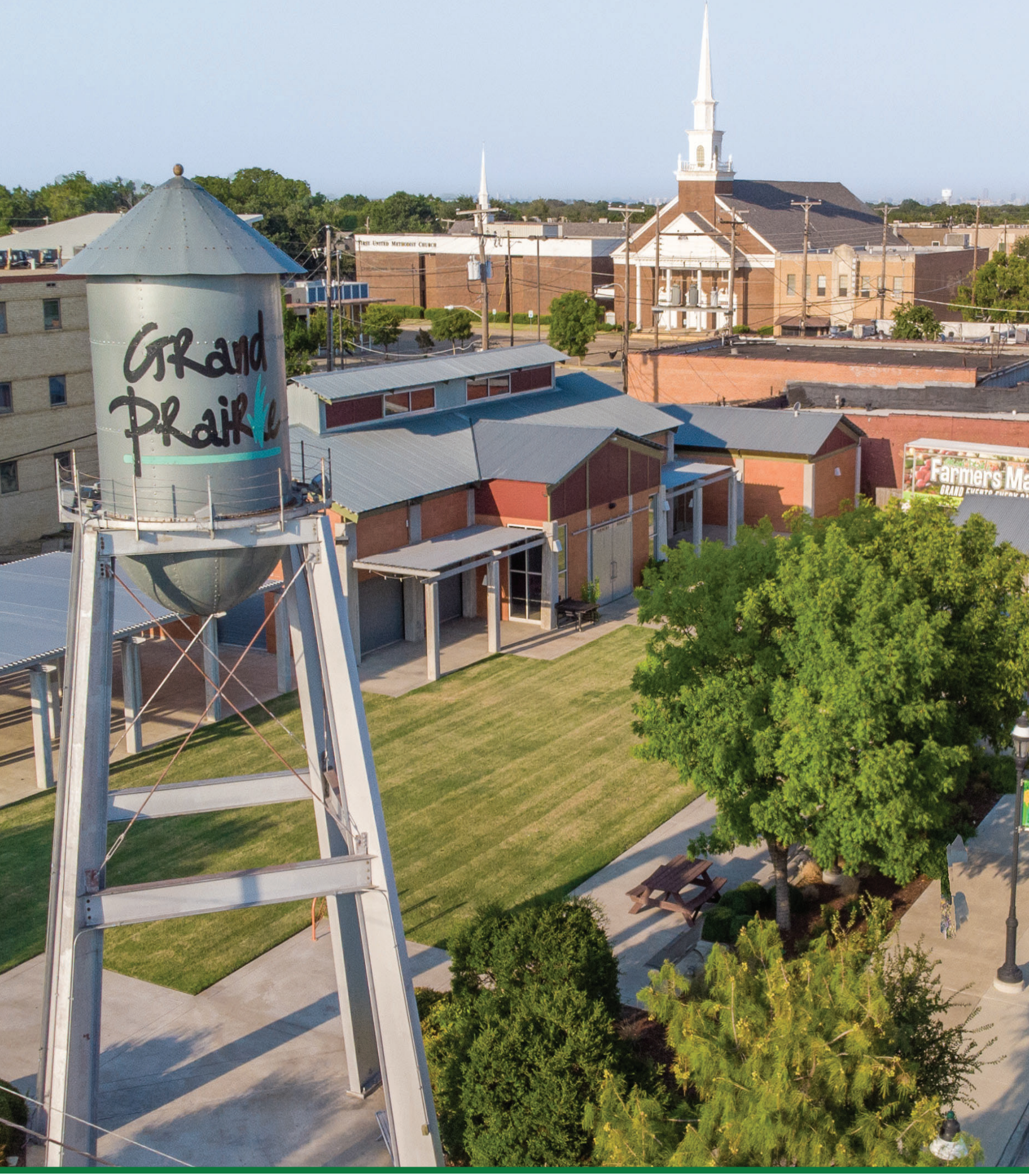
If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 972-237-8192.

31 Notes





Grand Prairie
TEXAS