

IMPORTANT NOTICES 2016

COBRA

You are receiving this notice because you have recently gained coverage under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group coverage would otherwise end. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event, known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of any of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;

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- For retirees, commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 30 days after the qualifying event occurs. You must provide this written notice to: City of Fort Worth, Benefits Office 1000 Throckmorton, Fort Worth, TX 76102

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of ours of work. Certain qualifying events, or a second qualifying event during this initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in writing and in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact Pursuit of Excellence at 800-207-5432 within 60 days of the date of determination of disability.

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less the COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employment Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www/HealthCare.gov.

Keep Your Plan Informed of Address Changes

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

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COBRA Plan Contact Information

Pursuit of Excellence
Attn: COBRA Administrator
10440 N. Central Expressway Ste 1250
Dallas, TX 75231
Phone: 800-207-5432
Fax: 214-242-2295

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

TEXAS – Medicaid
Website: <https://www.gethipptexas.com/>
Phone: 1-800-440-0493

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 **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it

has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

You may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility to see if any more States have added a premium assistance program since July 31, 2013 or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 6156

HIPAA Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll

yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

If you or your dependents lose eligibility for Medicaid or a Children's Health Insurance Program, or if you become eligible for a state premium assistance subsidy, you must request enrollment within **60 days** after such event.

To request special enrollment or obtain more information, contact Maria Gray, Benefits Manager at 817/392-7787.

www.cms.hhs.gov

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NOTICE OF PRIVACY PRACTICES

REVISED DATE: AUGUST, 2013

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 describes how your group health plan, the City of Fort Worth Employee Health Benefits Plan (the "Plan"), may use and disclose your health information to carry out payment, health care operations and other purposes that are permitted or required by law. This health information may be recorded in your medical record, invoices, payment forms, videotapes or other ways. This notice also describes your rights to limit access to your health information and the Plan's responsibilities under federal and state laws. Health Information is any information (whether oral or recorded in any form or manner) that is created or received by a health care provider, the Plan, a public health authority, a health care clearing house, or The City ("Employer") and relates to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

THE PLAN'S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of your health information and to provide you with this Notice of its legal duties and privacy practices. In addition, the Plan is required to abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make those changes applicable to all health information that the Plan maintains. Any

changes to this Notice will be posted in the Benefits department of the Plan Sponsor, and will be available upon request.

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In certain circumstances, the Plan is allowed or may be required to use or disclose your health information without obtaining your prior authorization and without offering you the opportunity to object. The most common uses or disclosures of your protected health information include:

- **Treatment.** The Plan may use or disclose your health information for the purpose of providing, or allowing others to provide, treatment to you. An example would be if your primary care physician discloses your health information to another doctor for the purposes of a consultation. Also, the Plan may contact you with appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Payment.** The Plan may use or disclose your health information to allow the Plan or other companies to pay claims or receive payment for the health care services provided to you. For example, the Plan may disclose your protected health information when a provider requests information regarding your eligibility for coverage under the Plan.
- **Health Care Operations.** The Plan may use or disclose your information for the purposes of the Plan's day-to-day operations and functions including, but not limited to quality assessment, reviewing provider performance, licensing, and stop-loss underwriting. For example, the Plan may (1) compile

your health information, along with that of other patients, in order to allow a team of the Plan's health care professionals to review that information and make suggestions concerning how to improve the quality of care provided by the Plan; (2) the Plan may disclose or use your health information to answer a question from you, or (3) the Plan may use your information to determine if a treatment that you received was medically necessary.

- **Plan Sponsor.** The Plan may disclose your protected health information to the Plan Sponsor of the Plan, The City, to administer the Plan or if you sign an authorization to do so.

OTHER POSSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

- **Required by Law.** The Plan may use or disclose your health information when required to do so by federal, state or local law. Examples include:
- **Public Health Activities.** The Plan may use or disclose your protected health information for public health purposes that are allowed or required by law. For example, we may use or disclose information to a public health authority to report diseases, injuries, or vital statistics, or reactions to medications or problems with products or to notify people of recalls of products they may be using, or who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- **Abuse or Neglect.** The Plan may use or disclose protected health information to a government authority about victims of abuse, neglect, or domestic violence;

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- **Health Care Oversight Agency.** The Plan may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, but not limited to, audits, investigations, inspections, licensing procedures, or civil, administrative, or criminal proceedings or actions. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws;
- **Legal Proceedings.** The Plan may disclose your protected health information for judicial or administrative proceedings, such as any lawsuit in which your health information is relevant to the proceedings. This includes responding to a subpoena or discovery request;
- **Law Enforcement.** Under certain conditions, the Plan may disclose your protected health information to law enforcement officials as part of law enforcement activities, in investigations of criminal conduct or victims of crime, in response to court orders, in emergency circumstances, or when required to do so by law;
- **Coroners, Medical Examiners.** Funeral Directors, and Organ Donation. The Plan may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties; Further, the Plan may disclose protected health

information to organizations that handle organ, eye, or tissue donation and transplantation;

- **To Prevent a Serious Threat to Health or Safety.** When instances of imminent and serious threat exist as to your health or safety or that of the public or another person, the Plan may disclose your protected health information;
- **Military Activity and National Security, Protective Services.** Under certain conditions, the Plan may disclose your protected health information for specialized governmental functions, such as military, national security, criminal corrections, or public benefit purposes; and
- **Worker's Compensation.** As allowed by Texas law, the Plan may disclose your protected health information to comply with worker's compensation laws and similar programs that provide benefits for work-related injuries or illnesses

Disclosure to Family or Others Involved in Your Care

To the extent authorized by law, the Plan may disclose your health information to your family or other individuals identified by you when they are involved in your care or the payment for your care. It will only disclose the health information directly relevant to their involvement in your care or payment. The Plan may also use or disclose your health information to notify a family member or another person responsible for your care of your location, general condition or status. The Plan will determine whether a disclosure to your family or friends is in your best interest, and then, to the extent allowed by law, it will disclose only the health information that is

directly relevant to their involvement in your care.

Except as described above, disclosures of your health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless the Plan has taken action in reliance upon your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

Breach of Unsecured Protected Health Information

You must be notified in the event of a breach of unsecured protected health information. A "breach" is the acquisition, access, use, or disclosure of protected health information in a manner that compromises the security or privacy of the protected health information. Protected health information is considered compromised when the breach poses a significant risk of financial harm, damage to your reputation, or other harm to you. This does not include good faith or inadvertent disclosures or when there is no reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

YOUR RIGHTS

The following is a description of your rights with respect to your protected health information.

- **To Request Restrictions.** You have the right to request restrictions on the use and disclosure of your health information for treatment, payment or health care operations purposes or notification purposes. The Plan is not required to agree to your request (except as described below). If the

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Plan does agree to a restriction, it will abide by that restriction unless you are in need of emergency treatment and the restricted information is needed to provide that emergency treatment. To request a restriction, obtain the Plan form and submit that form to the Contact Person listed on the final page of this Notice. In addition, you have the right to restrict disclosure of your health information to the Plan for payment or health care operations (but not for carrying out treatment) in situations where you have paid the healthcare provider out-of-pocket in full. In this case, the Plan is required to implement the restrictions that you request.

- **To Confidential Communications.** You have the right to receive confidential communications about your own health information. This means that you may, for example, designate that the Plan contact you only via e-mail, or at work rather than home. To request communications via alternative means, or at alternative locations, obtain a Plan form and submit that form to the Contact Person listed on the final page of this Notice.
- **To Access and Copy Health Information.** You have the right to inspect and copy most health information about you, including your health information maintained in an electronic format. To arrange for access to your records, or to receive a copy of your records, obtain a Plan form and submit that form to the Contact Person listed on the final page of this Notice. If your health information is available in an electronic format, you may request access electronically or you may request that this information be

transmitted directly to someone you designate. If you request copies, you will be charged the Plan's regular fee for copying and mailing the requested information. But, this fee must be limited to the cost of labor involved in responding to your request if you requested access to an electronic health record.

- **To Request Amendment.** You may request that your health information be amended. Your request may be denied under certain circumstances. If your request to amend your health information is denied, you may submit a written statement disagreeing with the denial, which the Plan will keep on file and distribute with all future disclosures of the information to which it relates. To amend any information, obtain a Plan form and submit that form to the Contact Person listed on the final page of this Notice.
- **To an Accounting of Disclosures.** You have the right to an accounting of any disclosures of your health information made during the six-year period preceding the date of your request (three years in the case of a disclosure involving an electronic health record). However, the following disclosures will not be accounted for:
 - Disclosures made for the purpose of carrying out treatment, payment or health care operations (Note: Does not apply to electronic health records.);
 - Disclosures made to you;
 - Disclosures of information maintained in the Plan's patient directory, or disclosures made to persons involved in your care, or for the purpose of notifying your

family or friends about your whereabouts;

- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure;
- Disclosures that occurred prior to April 14, 2003;
- Disclosures made pursuant to an authorization signed by you,
- Disclosures that are incidental to another permissible use or disclosure; or
- Disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks the Plan not to account to you for such disclosures and only for the limited period of time covered by that request.

The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure. To request an accounting of disclosures, obtain a Plan form and submit that form to the Contact Person listed on the final page of this Notice.

- **Right to a Paper Copy of this Notice.** You have the right to obtain a paper copy of this Notice upon request.

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- **Law Pertaining to Notice.** The Plan is required by law to maintain the privacy of protected health information and provide the individual with notice of legal duties and privacy practice with respect to the information. The Plan is required to abide by the terms of this Notice as it is currently in effect.
- **Amendment to Notice.** The Plan reserves the right to revise, amend, and change this Notice and the Plan can make the changes, revisions, and amendments effective for all protected health information that the Plan maintains. A revised notice will be distributed to all Plan participants within sixty (60) days after the revision, amendment, or change.

Effective April 20, 2005, the City Employee Health Benefits Plan (the "Plan") conforms with the requirements of the Security and Privacy requirements of the Health Insurance Portability and Accountability Act ("HIPAA Security Rule"), by establishing the extent to which the City (the "Employer") will receive, use, and/or disclose Electronic Protected Health Information ("EPHI").

Employer's Requirements for Safeguarding EPHI. EPHI will be safeguarded as follows:

- The implementation of administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI created, received, maintained, or transmitted by the Employer on behalf of the Plan. These administrative, physical, and technical safeguards are implemented through the adoption of HIPAA Policies and Procedures.
- The Plan is allowed to disclose to the Employer information on whether the individual is participating in the Plan, or is

enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan. Except for such authorized disclosures, the Employer is required to ensure that adequate separation exists between the Employer and the Plan through the implementation of reasonable and appropriate security measures.

- The Employer must ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect EPHI.
- The Employer is required to report to the Plan any security incidents of which it becomes aware.

Exceptions to Employer's Safeguarding of EPHI.

The Employer will reasonably and appropriately safeguard EPHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan, except as disclosed pursuant to:

- A request for summary health information to obtain premium bids from health plans for providing health insurance coverage under the Plan or modifying, amending, or terminating the Plan.
- A request for information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.
- The following HIPAA Policies and Procedures:
 - Uses and Disclosures of PHI Based On Patient Authorization;
 - Uses and Disclosure of Psychotherapy Notes;
 - Uses and Disclosure of PHI for Marketing;
 - Revocation of Authorization to Release PHI; and

- Authorization Form.

COMPLAINTS

You may complain to the Plan if you believe that we have violated your privacy rights by completing a complaint form obtained from the Privacy Officer, Margaret Wise. You may also complain to the Secretary of the Department of Health and Human Services. No action will be taken against you for filing a complaint.

DESIGNATED CONTACT PERSON

Margaret Wise, the Privacy Officer, is the designated contact person for the Plan. You can contact her at 817-392-8058

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires your health care plan to provide benefits for mastectomy related services. These services include reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edemas). Coverage for these benefits or services will be provided in consultation with the participant's or beneficiary's attending physician.

If you are receiving, or in the future receive, benefits under a group medical contract in connection with a mastectomy, you are entitled to coverage for the benefits and services described above if you elect breast reconstruction. Your qualified dependents are also entitled to coverage for those benefits or services on the same terms. Coverage for the mastectomy related services or benefits required under the Women's Health law are subject to the same deductibles and coinsurance or copayment provisions that apply to other medical or surgical benefits your group medical contract provides.

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Maternity and Newborn Length of Stay

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery; or 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity and Addiction Equity Act

The City of Fort Worth Health Plan must apply annual, aggregate lifetime, or other applicable plan limits or requirements to mental health benefits that are comparable to the plan limits that apply to medical and surgical benefits. For this purpose, mental health benefits include benefits for the treatment of a substance use disorder or chemical dependency, except as otherwise provided by law.

Qualified Medical Child Support Order (QMCSO)

Employees and their dependents may obtain a copy of the Plan's QMCSO procedures from the plan administrator or from Maria Gray, Benefits Manager at 817-392-7787 free of charge.

Important Notice from City of Fort Worth about Your Prescription Drug

Coverage and Medicare- Consumer Choice Plan

Medicare Eligible Employees and Dependents who are enrolled in the **Consumer Choice Plan** for 2015 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 Fort Worth 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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 Fort Worth has determined that the prescription drug coverage offered by the **Consumer Choice Plan** is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the

Consumer Choice Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from the **Consumer Choice Plan**. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under the **Consumer Choice Plan**, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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

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may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 Consumer Choice Plan coverage will be affected. Coverage under the Consumer Choice Plan will end for the individual and all covered dependents. See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current **Consumer Choice Plan** coverage, be aware that you and your dependents will not be able to get this coverage back until you no longer have a Medicare drug plan.

For More Information about This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information at 817-392-7787. **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 Fort Worth Consumer Choice plan changes. You also may request a copy of this notice at any time.

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).

Date: September 2, 2013
Name of Entity: City of Fort Worth
Contact: Maria Gray, Benefits Office
Address: 1000 Throckmorton
Fort Worth, TX 76102
Phone Number: 817/392-7787

Important Notice from City of Fort Worth about Your Prescription Drug Coverage and Medicare- Basic Plan

This Notice pertains to those employees, dependents or retirees enrolling in the City of Fort Worth Health Benefit Plan the **Basic Plan**

who are on or eligible for Medicare. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Fort Worth Health Benefit Plan, the **Basic Plan** 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 has determined that the prescription drug coverage offered by the City of Fort Worth Health Benefit Plan, the **Basic Plan** is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is

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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 Fort Worth **Basic Plan** coverage will not be affected; however you may pay additional premium for the Medicare drug plan that will not benefit you. You cannot be reimbursed under both Medicare and the City of Fort Worth **Basic Plan** for prescription costs.

If you do decide to join a Medicare drug plan, you will not be able to drop your current City of Fort Worth Basic Plan prescription plan without dropping your current City of Fort Worth **Basic Plan** coverage, be aware that you and your dependents will 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 Fort Worth **Basic Plan** 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 below 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 Fort Worth **Basic Plan** changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

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

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: September 2, 2013
Name of Entity: City of Fort Worth
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