



2016 Employee Benefit Guide

Welcome!

The information in this Benefit Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Benefit Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefit Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Benefit Summary, contact the Benefits Department.

At the City of Texas City, our employees are the foundation of our success. To reward you and reflect our commitment to you, The City provides a comprehensive benefits program as an important part of your total compensation package.

Your benefit needs are unique – and those needs may change over time. So, our benefits program is designed to be flexible to fit your personal situation.

Our 2016 benefits program gives you the opportunity to select the coverage you need.

This 2016 Benefit Summary:

- Gives an overview of your benefits as an employee of City of Texas City
- Helps you choose the coverage that is right for you and your family

Every employee may meet with a benefits specialist at our Open Enrollment Meetings the week of November 16th through November 20th. Please consider your benefits carefully before choosing. Your choices will remain in effect for the entire Plan year, unless you have a qualified family status change.

Even if you make no changes, you will be required to review your personal and dependent information and verify birth dates and social security numbers.

This Benefit Summary does not provide all of the details about all of the benefit programs. Additional information is available in each program's Certificate of Coverage (COC). The COC's are available by request from the Human Resources Department.

If you have any questions, please contact:
Human Resources Department
409-643-5912

Note: Employees are reminded that under Health Care Reform you are required to have Minimum Essential Health Coverage in 2016. The penalty for not having coverage in 2016 is the higher of 2.5% of your yearly household income, or \$695 per person (\$347.50 per child under 18). The maximum family penalty using the per person method is \$2,085. For more information about your responsibilities to obtain coverage go to www.healthcare.gov.

Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information, contact Human Resources.

Plan	Carrier	Group Number	Phone Number	Website	Page
Medical	Cigna	3339490	1-800-244-6224	www.mycigna.com	5
Dental	Cigna	3339490	1-800-244-6224	www.mycigna.com	7
Vision	Cigna	3339490	1-800-244-6224	www.mycigna.com	8
Life/AD&D	The Standard	615401-A	1-800-628-8600	www.thestandard.com	10
Group AD&D	The Standard	615401-F	1-800-628-8600	www.thestandard.com	10
LTD	The Standard	615401-C	1-800-368-1135	www.thestandard.com	10
EAP	The Standard	615401	1-888-293-6948	www.thestandard.com	11
FSA - 2016 Elections	Stanley, Hunt, Dupree & Rhine		1-800-768-4873	www.shdr.com	12
FSA - 2015 Elections	UnitedHealthcare	713205	1-877-311-7849	www.myuhc.com	12
Supplemental Benefits	Allstate		1-866-781-1871	www.allstateatwork.com/mybenefits	14



Who is Eligible

As an employee of the City of Texas City you are eligible for benefits on the first day of the month after completing 3 months of continuous service. You must be a regular, full-time employee who works at least 40 hours per week.

Eligible Dependents:

You may cover your eligible dependents under any of the benefit options offered under our plans. Your eligible dependents may include:

- Your legal spouse
- Your children up to age 26, regardless of full-time student or marital status
- Your unmarried children over age 26, who are incapable of self-support due to physical or mental disability, if they became disabled while an otherwise eligible dependent
- A child whose age is less than the limiting age and for whom the employee has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage

Dependent Documentation

In order to add a dependent to the City of Texas City Health Plan, you must provide one of the required documents listed below:

- Copy of the official state marriage certificate and/or official certificate of informal marriage
- Copy of the dependent child's official state birth certificate (must show employee or spouse as the parent)
- Copy of the final adoption decree signed by the judge (must show employee or spouse as the parent)
- Copy of court order confirming the employee has permanent legal custody
- Copy of the official state marriage certificate and birth certificate for a stepchild
- Copy of official medical findings of child incapable of self-support due to physical or mental disability

You can only change your coverage during the year when you experience a qualified change in status, such as:

- Marriage or divorce
- Birth or adoption
- Death of a dependent child or spouse
- Loss of coverage (e.g., spouse loses coverage through his or her employer's plan)
- Change in your or your spouse's employment status that affects benefits eligibility
- Dependent child no longer meets the definition of dependent under the Plan

Any changes you make to your coverage must be made within 30 days of the event and must be consistent with the event. For example, if your dependent child no longer meets eligibility requirements (e.g., he or she reaches age 26), you can drop coverage only for that dependent. A new enrollment form and supporting documentation of the qualifying change are required.

Medical Insurance Cigna

The City of Texas City is committed to providing you with comprehensive medical benefits to meet your needs. You pay the cost of your coverage through pre-tax payroll deductions. By paying on a pre-tax basis, your cost for coverage is lower because the earnings you use to pay premiums are not subject to federal tax withholding or Social Security (FICA) taxes. Cigna administers the medical and prescription drug plans for City of Texas City. Employees are free to use the physicians and health care providers of their choice, but the in-network providers offer added advantages for participants. To find participating providers, go to www.cigna.com and select the Open Access Plus network, or log in to your myCIGNA.com account and you will automatically be limited to seeing the participating doctors.

Core Plan

Plan Features	In-Network	Out-of-Network
Calendar Year Deductible	\$1,000 Individual / \$2,000 Family	No Out-of-Network Benefits Available
Coinsurance (Plan Pays)	80%	
Out of Pocket Maximum (Includes Deductible and all Copays)	\$3,000 Individual / \$6,000 Family	
Lifetime Maximum	Unlimited	
Primary Physician Office Visit	\$30 copay per visit	
Specialist Physician Office Visit	\$30 copay per visit	
Rehabilitation Services	\$30 per visit; 20 visit limit per calendar year for Rehabilitation & Chiropractic care, 36 days for Cardiac rehab services	
Preventive Care Services	\$0 copay*	
Urgent Care	\$35 copay per visit	
Hospital and Other Charges		
Inpatient	80% after deductible	No Out-of-Network Benefits Available
Outpatient	80% after deductible	
Emergency Room Charges	\$150 copay per visit if not admitted to hospital; copay waived if admitted within 48 hours	
Home Health Care (max 90 days)	80% after deductible	No Out-of-Network Benefits Available
Skilled Nursing Facility (60 days per Calendar Year)	80% after deductible	
Behavioral Health/Chemical Dependency		
Inpatient Serious Mental/Behavioral Health	80% after deductible	No Out-of-Network Benefits Available
Outpatient Serious Mental/Behavioral Health	\$30 copay per visit	
Inpatient Chemical Dependency	80% after deductible	
Outpatient Chemical Dependency	\$30 copay per visit	
Pharmacy		
Retail (up to a 90 day supply) Generic/Formulary/Non-Formulary)	\$10 / \$20 / \$40	No Out-of-Network Benefits Available
Mail (up to a 90 day supply) Generic/Formulary/Non-Formulary)	\$20 / \$40 / \$80	

Medical Insurance Cigna

Buy-Up Plan

Plan Features	In-Network	Out-of-Network
Calendar Year Deductible	\$1,000 Individual / \$2,000 Family	No Out-of-Network Benefits Available
Coinsurance (Plan Pays)	90%	
Out of Pocket Maximum (Includes Deductible and all Copays)	\$3,000 Individual / \$6,000 Family	
Lifetime Maximum	Unlimited	
Primary Physician Office Visit	\$15 copay per visit	
Specialist Physician Office Visit	\$15 copay per visit	
Rehabilitation Services	\$15 per visit; 20 visit limit per calendar year for Rehabilitation & Chiropractic care, 36 days for Cardiac rehab services	
Preventive Care Services	\$0 copay*	
Urgent Care	100% after \$35 copay per visit	
Hospital and Other Charges		
Inpatient	90% after deductible	No Out-of-Network Benefits Available
Outpatient	90% after deductible	
Emergency Room Charges	\$100 copay per visit if not admitted to hospital; copay waived if admitted within 48 hours	
Home Health Care (max 90 days)	90% after deductible	No Out-of-Network Benefits Available
Skilled Nursing Facility (60 days per Calendar Year)	90% after deductible	
Behavioral Health/Chemical Dependency		
Inpatient Serious Mental/Behavioral Health	90% after deductible; pre-certification required	No Out-of-Network Benefits Available
Outpatient Serious Mental/Behavioral Health	\$15 copay per visit	
Inpatient Chemical Dependency	90% after deductible; pre-certification required	
Outpatient Chemical Dependency	\$15 copay per visit	
Pharmacy		
Retail (up to a 90 day supply) Generic/Formulary/Non-Formulary)	\$5 / \$10 / \$20	No Out-of-Network Benefits Available
Mail (up to a 90 day supply) Generic/Formulary/Non-Formulary)	\$10 / \$20 / \$40	

*Some preventive services may be subject to cost sharing—refer to Cigna booklet for details.

Dental Insurance Cigna

The Dental Plan helps you with the cost of many dental services, including child orthodontia. Preventive care, such as routine check-ups and cleanings, is covered at 100% with no deductible. You must first meet an annual deductible for basic and major services, and then the Plan pays a percentage of the cost for your dental care. It's always a good idea to ask for a pre-determination of costs for services over \$300. The in- and out-of-network benefits are covered at the same percentage; however, using in-network providers will save you money as the reimbursements will be based on a discounted rate. Out-of-network providers are based on Usual and Customary rates and may balance bill you for any amount over the allowed amount. Our dental coverage, administered by Cigna, includes coverage for preventive, basic, major and orthodontic care as shown in the table below. For a list of Cigna providers visit www.mycigna.com.

Type of Service	In-Network	Out-of-Network
Calendar Year Deductible Does not apply to Preventive Services	\$50 single /\$150 family	\$50 single /\$150 family
Calendar Year Maximum	\$1,000 per person	\$1,000 per person
Orthodontia Lifetime Maximum* (Under the age of 19)	\$750 lifetime maximum 50% coverage orthodontia	\$750 lifetime maximum 50% coverage orthodontia
Preventive Services Exams, Cleanings, X-rays	100%, deductible waived	100%, deductible waived
Basic Services Fillings, Simple extractions	80% after deductible	80% after deductible
Major Services* Oral Surgery, Root Canal, Crowns	50% after deductible	50% after deductible

*Benefit is reduced to 50% for Late Entrants during their first 12 months of coverage



Vision Insurance Cigna

The Vision Plan offers you and your family an optional vision program that reduces the cost of eye exams, eyeglasses and contact lenses. To receive the highest level of benefits, you must use a vision care provider in the Cigna networks. If you use an out-of-network provider, you will pay full fees to the provider and be reimbursed for services rendered up to a maximum allowance. For a list of Cigna providers visit www.mycigna.com.

Major features of the Vision Plan include:

- **Eye Exams** - The plan offers a yearly eye exam at 100% at a participating provider after a \$10 copay
- **Eyeglasses** - The plan offers frames every 2 years (lenses every year) at 100% after a \$25 materials copay
- **Contact Lens Benefits (in lieu of eyeglasses)** - The plan offers \$110 allowance towards contact lens fitting, evaluation exam (in lieu of eyeglasses exam) and contact lenses when using a participating provider.

Plan Feature	UHC Vision Plan	
	In Network	Out of Network
Examination	100%	Up to \$45
Lenses		
Single Vision	100%	Up to \$40
Bifocal	100%	Up to \$65
Trifocal	100%	Up to \$75
Progressive	100%	Up to \$75
Lenticular	100%	Up to \$100
Frames	100%; up to \$130	Up to \$71
Contact Lenses		
Necessary	100%	Up to \$210
Elective	Up to \$110	Up to \$98
Exam Copay	\$10	Subject to allowable reimbursement as stated above
Materials Copay	\$25	
Service Frequency		
Examination		12 months
Lenses		12 months
Frames		24 months

Rate Sheet

Cigna Medical Core Plan				
Election	Funding Rate	City Cost	Employee Cost	Retiree Cost
EE	\$636.61	\$606.61	\$30.00	\$636.61
EE + FAM	\$1,412.91	\$1,022.89	\$390.02	\$1,412.91

Cigna Medical Union Buy-Up Plan				
Election	Funding Rate	City Cost	Employee Cost	Retiree Cost
EE	\$864.64	\$834.64	\$30.00	N/A
EE + FAM	\$2,658.65	\$1,797.98	\$860.67	N/A

Cigna Dental Plan				
Election	Funding Rate	City Cost	Employee Cost	Retiree Cost
EE	\$25.41	\$25.41	\$0.00	\$25.41
EE + FAM	\$63.53	\$45.38	\$18.15	\$63.53

Cigna Vision Plan				
Election	Funding Rate	City Cost	Employee Cost	Retiree Cost
EE	\$5.82	\$5.82	\$0.00	\$5.82
EE + FAM	\$12.46	\$9.43	\$3.76	\$13.19

2016 COBRA Funding Rates				
Election	Core	Buy-Up	Dental	Vision
EE	\$649.34	\$881.93	\$25.92	\$5.93
EE + FAM	\$1,441.17	\$2,711.82	\$64.80	\$13.30

Life & AD&D Insurance Standard

Basic Life/AD&D Insurance:

The City of Texas City provides an employer paid Basic Life insurance equal to three times your annual earnings, to a \$150,000 maximum (\$50,000 minimum). In the event of Accidental Death, your beneficiaries would receive an additional accidental death benefit equal to your Basic Life benefit.

Dismemberment Benefits:

If you suffer the loss of a hand, foot, or eye due to an accident, you may be eligible for a benefit up to the amount of your accidental death benefits. For details, please refer to The Standard policy #615401-A. Firefighters refer to #615401-D.

Group Accidental Death & Dismemberment:

Effective October 1, 2015, a new additional employer paid AD&D benefit has been added. This policy provides an additional accidental death benefit of \$250,000, with additional benefits payable for dismemberment as well. Details on this coverage are found in The Standard policy #615401-F.

Coverage for the Basic Life/AD&D and Group AD&D begins to reduce starting at age 70. Please refer to The Standard Basic Life/AD&D and Group AD&D certificates for detailed information.

Designating Your Beneficiary:

As part of receiving this life insurance coverage, you must designate a beneficiary to receive benefits upon your death. Your beneficiary can be more than one person, but it is important that you keep this information up-to-date. Change in marital status or the death of a loved one may impact your beneficiary designation. Check with the Human Resources Department if you need to verify or change your beneficiary. **You are advised to not name a minor as your beneficiary** unless a guardian has been appointed and named in your Last Will of Testimony or a Trust is used. Insurers generally will not make settlements directly to minors. Benefits payable to minors will be placed in a holding account until the state probates the estate, at which time proceeds will be awarded to the person whom the state appoints as the legal guardian if not specified in a Last Will of Testimony. You should consult with an attorney if you have questions.

Long Term Disability Standard

The City of Texas City understands the importance of having a steady income - especially during a disability. As a full-time active employee you receive long-term disability (LTD) coverage to protect a portion of your income should you become unable to work.

Long Term Disability Plan Summary	
Eligibility Requirement	Full-time active employee after 6 months of continuous employment
Benefits Waiting Period	180 days
Percentage of Income Replaced*	60% of base salary
Maximum Monthly Benefit	\$6,000
Maximum Duration of Benefits	Until you reach SSNRA (Social Security Normal Retirement Age). Benefits for mental illness/substance abuse and subjective illness are limited to 24 month maximum
Pre-existing Condition Limitation	No benefits are payable if due to a pre-existing condition starting in the first 12 months of coverage

*Benefits are reduced by other sources of disability income. Please see The Standard certificate #615401-E. Firefighters refer to #615401-D.

Employee Assistance Program Standard



Employee Assistance Program

Pointing You In The Right Direction

We all experience times when we need a little help managing our personal lives. Your employer understands this and is providing the Employee Assistance Program (EAP) to covered employees in connection with your group insurance from The Standard†, to offer support, guidance and resources to help you and your family find the right balance between your work and home life.

What Can The EAP Do For Me?

Experienced master's-degreed clinicians will confidentially consult with you over the telephone and direct you to the solutions and resources you need. You may also receive referrals to support groups, community resources, a network counselor or your health plan. These services are available for covered employees, their dependents, including children to age 26, and all household members.

The EAP Services Can Help With:

- Child care and elder care
- Alcohol and drug abuse
- Life improvement
- Difficulties in relationships
- Stress and anxiety with work or family
- Depression
- Goal-setting
- Emotional well-being
- Financial and legal concerns
- Grief and loss
- Identity theft and fraud resolution
- Online will preparation

How Do I Access EAP Services?

Follow the directions on the wallet card on this page.

Is It Confidential?

Your calls and all counseling services are confidential. Information will be released only with your permission or as required by law.

continued on reverse

This EAP service is not affiliated with The Standard. The EAP service is not an insurance product.

† The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Ore., in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of 360 Hamilton Avenue, Suite 210, White Plains, NY. Product features and availability vary by state and company, and are solely the responsibility of each subsidiary. Each company is solely responsible for its own financial condition. Standard Insurance Company is licensed to solicit insurance business in all states except New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

Call 888.293.6948 or visit

www.eapbda.com.

The EAP is always ready to assist you. We've also provided a handy reference card for your wallet.

How To Access EAP Online

1. Enter this address in your Web browser:
www.eapbda.com
2. Enter **standard** as the login ID (in all lowercase letters) when prompted.
3. Enter **eap4u** as the password (in all lowercase letters) when prompted.

Note: It is a violation of your company's contract to share this information with individuals who are not eligible for this service.

Fold

EAP For Policyholders of The Standard

Call this toll-free number for access to EAP services.

888.293.6948

TDD 800.327.1833

Available 24 hours a day, 365 days a year.

Standard Insurance Company

The Standard Life Insurance
Company of New York

www.standard.com

Employee Assistance Program-3
17201 (5/14) S/SNY EE

Flexible Spending Account (FSA) SHDR

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income. Please see the worksheet on the following page for examples of expenses that can be filed to your Health FSA.

Starting January 1, 2016, your FSA accounts will be administered by Stanley, Hunt, Dupree & Rhine (SHDR). UHC will administer any issues related to your 2015 FSA elections.

Health Care Reimbursement FSA:

This program lets City of Texas City employees pay for certain IRS-approved medical care expenses not covered by their insurance plan with pretax dollars. The annual maximum amount you may contribute to the Health Care FSA is \$2,550 per calendar year. (Note: the annual maximum has been reduced to \$2,550 to comply with the Affordable Care Act.) Some examples include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives

Dependent Care FSA:

The Dependent Care FSA lets City of Texas City employees use pretax dollars toward qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is \$5,000 (or \$2,500 if married and filing separately) per calendar year. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Employee Filing Deadline:

Employees have 90 days following the end of the plan year to request reimbursement for Eligible Expenses incurred during the Plan Year. Per IRS regulations, unused funds are forfeited at the end of the year. If you have unused funds from 2015, you must file with UHC by March 31, 2016 to be reimbursed.



Flexible Spending Account (FSA)

Use this page to estimate your contributions to the Health Care FSA and/or the Dependent Care FSA. You can include expenses on your spouse and/or dependent children under age 26 regardless whether you or they are covered under the City's medical, dental, or vision plans in 2016.

Prescription drug copays	_____
Chiropractic treatments	_____
Office Visit, Urgent Care, ER Copays	_____
Deductibles and coinsurance expenses	_____
Subtotal	_____
Dental Expenses not Covered by Insurance	
Annual Deductible	_____
Crowns/bridges/dentures	_____
Orthodontia	_____
Root canals	_____
Other	_____
Subtotal	_____
Vision/Hearing Expenses not Covered by Insurance	
Exams	_____
Frames/Lenses	_____
Prescription Sunglasses	_____
Contact Lenses & Cleaning Solutions	_____
Corrective Eye Surgery, e.g. LASIK	_____
Other	_____
Subtotal	_____
(A) TOTAL HEALTH CARE EXPENSES	_____
DEPENDENT DAY CARE EXPENSES	
January	_____
February	_____
March	_____
April	_____
May	_____
June	_____
July	_____
August	_____
September	_____
October	_____
November	_____
December	_____
(B) TOTAL DEPENDENT DAY CARE EXPENSES	_____
(C) TOTAL FSA CONTRIBUTIONS (ADD A + B)	_____
(D) SAVINGS ON SOCIAL SECURITY TAXES (0.0765 x C)	_____
(E) INCOME TAX SAVINGS (MARGINAL TAX RATE x C)	_____
(F) TOTAL TAX SAVINGS (D + E)	_____

Note: Remember to include expenses from eligible dependents, even if they are on another medical, dental or vision plan.

Supplemental Insurance Allstate

Accident Insurance

Under this policy benefits are payable directly to you for medical expenses related to treatment for an accident, such as hospital expenses, intensive care, fractures, burns, etc. For example, for a complete dislocation of a hip joint you could collect up to \$4,000. In addition to paying benefits for medical treatments, the policy also pays a lump sum benefit of up to \$40,000 for accidental death, with additional benefits payable for dismemberment.

Cancer Insurance

If you are diagnosed and treated for cancer, in addition to your deductibles and copays, you will have many non-medical expenses related to your treatment, such as lost wages, travel, parking, and lodging. The Allstate Cancer Policy is designed to complement your medical coverage by providing benefits payable to you to offset those expenses. Additionally \$5,000 is payable to you upon an initial diagnosis of cancer (except skin cancer), and the policy will reimburse you up to \$100 per year for screening tests such as mammographies.

Short Term Disability Insurance

If you got sick or injured and could not work, would that create a financial hardship? The Allstate Short Term Disability plan pays you a weekly benefit to replace up to 60% of your income if you become disabled. Benefits begin on either the 8th or 15th day of disability, depending on which option you select, and are payable for up to six months.

Critical Illness

Complements your major medical coverage by providing a lump-sum benefit that you can use to pay the direct and indirect cost related to a covered critical illness. *Rates are based on age and tobacco status.*

Term Life Insurance

Term Life insurance for employees and spouse with guaranteed coverage. Spouses can apply for coverage without the employee. The term life policy is a 20 year term life policy with a fixed rate for 20 years or until age 70. The policy will renew every 20 years without evidence of insurability and must be converted to permanent coverage at age 70. This policy is portable at the same rate.

Universal Life (Permanent Coverage)

Universal Life is a Life insurance plan that accrues cash value. It is designed to cover you, your spouse and dependents to age 95. Spouses and dependents can be covered without the employee electing coverage. This policy is portable at the same rate.

Questions: If you have questions about your terms of coverage and/or rate information, please contact Allstate at 1-800-521-3535 or your Human Resources Department. Please also refer to the Allstate informational brochures for more detailed information about these coverages.



Legal Notices & Disclosures

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or 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 dependent's coverage. However, you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards 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/or your dependent(s). However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

On October 21, 1998 Congress passed the Women's Health and Cancer Rights Act. This law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include: Reconstruction of the breast upon which the mastectomy has been performed, Surgery/reconstruction of the other breast to produce a symmetrical appearance, Prostheses, and Physical complications during all stages of mastectomy, including lymphedemas. In addition, the plan may not: interfere with a woman's rights under the plan to avoid these requirements, or offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law. However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

EXPANDED WOMEN'S PREVENTIVE CARE SERVICES ON OR AFTER AUGUST 1, 2012

New coverage guidelines under the Patient Protection and Affordable Care Act (PPACA) require health plans to cover an expanded list of women's preventive care services with no cost-share (copayment, coinsurance or deductible) as long as services are received in the health plan's network. Coverage for the following expanded women's preventive care services becomes effective the first plan year beginning on or after Aug. 1, 2012:

- Breast-feeding support, supplies, and counseling, including costs for obtaining specified breast-feeding equipment from a network provider or national durable medical equipment supplier
- Domestic violence screening and counseling
- FDA-approved contraception methods, sterilization procedures and contraceptive counseling
- Gestational diabetes screening for all pregnant women*
- HIV counseling and screening for all sexually active women
- Human papilloma virus DNA testing for all women 30 years and older
- Sexually transmitted infection counseling for all sexually active women annually
- Well-woman visits including preconception counseling and routine, low-risk prenatal care

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT OF 1996

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

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.

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.

As a Texas resident, you may be eligible for assistance paying your employer health plan premiums by calling 1-800-440-0493 or visiting <http://gethiptexas.com>.

HIPAA PRIVACY NOTICE

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

This Notice is effective as of September 23, 2013 and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information the City of Texas City Health Plan (herein referred to as the "Plan") creates or receives about you.

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013.

HIPAA PRIVACY NOTICE

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.

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As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information, including "genetic information" (as defined in Section 105 of GINA), that is created or received by the Plan (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan's privacy practices.

How the Plan Will Use or Disclose Your PHI

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

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

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

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

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and

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

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

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

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

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

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

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

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

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

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

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

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

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

For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that

satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

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

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

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

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

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

Right to Request Restrictions on PHI Uses and Disclosures

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

Right to Inspect and Copy PHI

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

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

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

Right to Amend

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

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

Right to Receive an Accounting of PHI Disclosures

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

Right to Receive Confidential Communications

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

Right to Receive a Paper Copy of This Notice Upon Request

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

A Note About Personal Representatives

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

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

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

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

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

Your Right to File a Complaint

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

Contact Information

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

