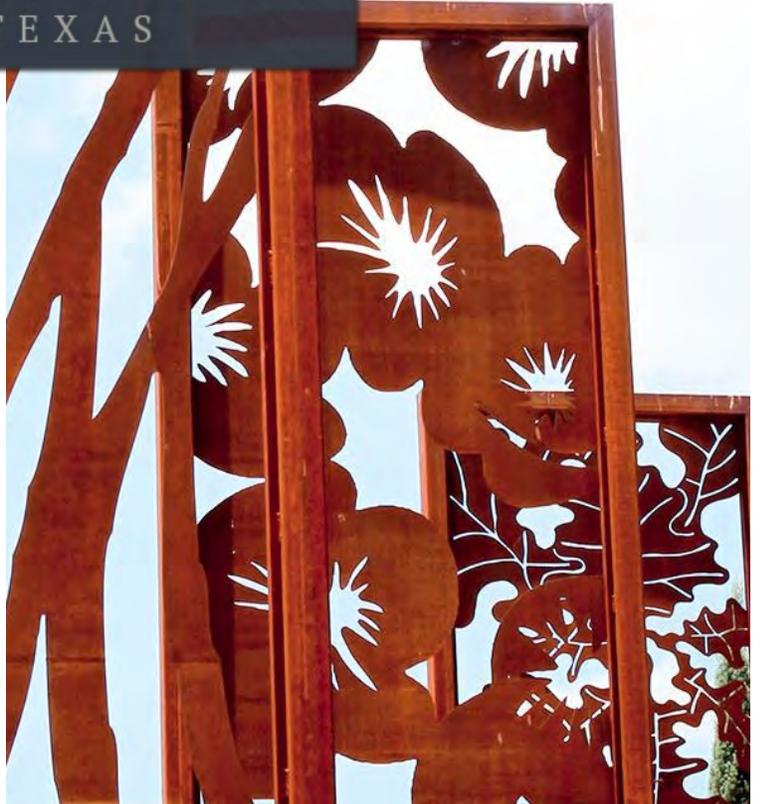


 **DESOTO**
TEXAS



2020 Employee Benefits Guide

EFFECTIVE 1.1.2020 — 12.31.2020



The information in this enrollment guide is intended to help you enroll in your 2020 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern.

The City of DeSoto reserves the right to change or terminate benefits at any time. Neither the benefits, nor this enrollment guide, should be interpreted as a guarantee of future benefits.

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Welcome

The City of Desoto is proud to provide you and your family with valuable and significant benefits. This Employee Benefits Guide was designed with you and your family in mind. This valuable reference guide, is an overview of the services and benefits available to you as an employee of the City of Desoto. Please take the time to carefully review the guide for any changes or updates. Inside you will find the information you need to make informed decisions regarding the selection and continued management of your benefits for the 2020 Plan Year.

Important Contacts

Coverage	Company	Phone Number	Website
Medical Plan	Blue Cross Blue Shield Group PPO #170332 Group HSA #170333	1.800.521.2227	www.bcbstx.com
Dental Plan	CIGNA Group #3336204	1.800.CIGNA24 (1.800.244.6224)	www.cigna.com
Flexible Spending Account	Newport Group	1.877.859.5735	www.healthcareadmin.com flex@newportgroup.com
Life/AD&D & Long Term Disability	Dearborn National Group #G32481	1.800.778.2281	www.dearbornnational.com
Other Resources	Dearborn National	1.800.769.9187 - Beneficiary Resource	www.beneficiaryresource.com (see page 17)
EAP	Deer Oaks	866.327.2400	www.deeroakseap.com
Vision Plan	The Standard/VSP Vision Care Group #160-755859	1.800.877.7195	www.vsp.com www.standard.com/services
Deferred Compensation & Roth Plans	Mass Mutual (formerly Hartford)	1.800.528.9009	retire.hartfordlife.com
Health Savings Account	Payflex	1.844.PAYFLEX	www.payflex.com
Deferred Compensation Plans	ICMA Nationwide	1.800.326.7272 1.877.677.3678	www.icmarc.org www.nationwide.com
City Employee Retirement	Texas Municipal Retirement System (TMRS)	1.800.924.8677	www.tmrs.com
Supplemental Insurances	Aflac Mickey Shuler - Account Representative	972.247.3009 1.800.992.3522 (billing questions)	www.aflac.com



You may contact Human Resources with any questions at: 972-230-9601

**Human Resources Department
211 East Pleasant Run Road
Desoto, TX 75115-3939**

Getting Started

FAQs

When Does Coverage Begin?

The elections you make during Open Enrollment are effective January 1, 2020 - December 31, 2020.

New Hires: Coverage starts 1st day of month following date of hire. (example: start date January 10th - effective date of coverage February 1st.) You have 31 days to select coverage.

If I Am Already Enrolled and Not Making Any Changes, Do I Have to Complete the Open Enrollment Process?

No, this is a passive enrollment. If you do not want to make changes to your current elections, your previous plan year elections will rollover to the next plan year. The exception is your FSA elections - you have to login and make an active election.

If I Want to Decline Coverage, Do I still Need to Complete the Open Enrollment Process?

Yes, it is important that Human Resources has a record of your decision.

Can I Enroll My Spouse or Dependent on One Plan and Myself on Another?

No, all covered dependents, including spouse, must be on the same plan as the employee.

Can I Drop or Change Plans During the Plan Year?

No, changes can only be made if there has been a qualifying life event or personal life change. Examples include marriage, divorce, birth of a child, or change in employment status. All changes must be completed within the first 31 days of the life event.

Eligibility

Who is Eligible?

If you are a full-time employee of the City of Desoto who is regularly scheduled to work 30 hours a week or more, you are eligible to enroll the benefit plans described in this employee benefits guide. **You are required to enroll no later than 31 days after your first day of regular, fulltime work with the City.** If enrollment is not completed in this time period, you will have no coverage for the remainder of the plan year for the following voluntary plans:

- Medical Plan for yourself or dependents
- Dental Plan
- Vision Plan
- FSA-Health Account
- FSA—Dependent Care Account
- Supplemental Life Insurance Plan
- Accidental Death & Dismemberment Plan

Eligible employees are automatically enrolled in the basic term life, accidental death and dismemberment, long term disability, and employee assistance (EAP) plans. Please note, you must designate your beneficiary for these plans upon your enrollment.

Eligible Dependents

Dependents eligible for coverage include:

- Your legal spouse.
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26.

You may be required to furnish evidence of dependency during random eligibility audits.



Enrollment

Online enrollment is easy! You will access the BenefitFirst website to submit or confirm your benefit elections.

How to enroll for benefits:

Just follow these simple steps:

1. Review your 2020 Enrollment Guide carefully. Choose the plan option or options that are right for you.
2. Have you and your dependent's dates of birth and social security numbers ready.
3. When you are ready to enroll, visit: www.benefitfirst.com.
4. Login:

Company ID is 429

User ID is your social security number without dashes and password.

5. At the homepage, choose **enrollment wizard**.
6. Select the **Enroll** or **Decline** benefits as **Newly Eligible** option.
7. Add any eligible dependents to the dependent screen and click next.
8. Starting with the medical screen, complete your selections. Choose the level of coverage, the plan desired, and the dependents to be added.
9. When you get to the last enrollment screen, you will be asked to review your elections and certify them by re-entering your password.
10. The final step is to click the **submit** button.

That's it! The entire process can take as little as four minutes to complete!



Helpful Tips and Reminders

- Take the time to carefully review the guide for any changes and updates. Be sure to choose the right coverage level, such as individual or family.
- Gather the correct information for your dependents such as social security numbers and birth dates.
- Make sure your address and personal information is current. If your information is not up-to-date, you may miss out on important information such as insurance cards, plan documents, health notices, etc.
- Open Enrollment is an excellent time to ensure that the person designated as your beneficiary is correct regarding your insurance and retirement benefits.
- Visit each vendor's website for additional information. Don't forget to review each provider directory.
- Benefits premiums are deducted on a pre-tax basis, which lessens your tax liability.
- Avoid making quick decisions — **enroll early!**
- **If you fail to complete enrollment during the specified enrollment eligibility period, the City will carry over your previous plan year elections, excluding Flexible Spending Accounts (FSA) information. During Open Enrollment, you may select different plan options, make plan changes, and add or delete dependents for your benefit plans without a special enrollment event.**

THINGS TO CONSIDER

Take the following situations into account before you enroll to make sure you have the right coverage.

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? If so, do you need to add or remove any dependent(s) and/or update your beneficiary designation?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria.

Online Enrollment can be completed any time between October 24 and November 10.

Qualifying Life Events

Due to IRS regulations, once you have made your choices for the 2020 Plan Year, you won't be able to change your benefits until the next enrollment period unless you experience a Qualifying Life Event. Benefits that can be changed include: Medical, Dental, Vision, Supplemental Life, Dependent Life or Voluntary Accidental Death and Dismemberment plans, or the Health Care and Dependent Care Spending Accounts.

Personal Life & Status Changes

When one of the following events occurs, you have **31 days** from the date of the event to request changes to your coverage. **Any changes must be completed through www.benefitfirst.com.** **Human Resources will review for approval.**

- Change in your legal marital status (marriage, divorce, annulment, legal separation or death).
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent) or your dependent becomes eligible or loses eligibility for coverage due to age.
- Change in your dependent or spouse's employment status or your spouse's employer offers benefit plans with a different plan year that affects your coverage.
- Change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of coverage.
- You or your eligible dependent take or return from an unpaid leave of absence that affects coverage.
- Entitlement to Medicare or Medicaid (or loss of).
- Change in your address or location that may affect the coverage for which you are eligible.

Your change in coverage must be consistent with your change in status. The change must result in the gain/loss of coverage by you, your spouse, or any of your dependents and the new election must reflect that gain/loss. Please direct questions regarding specific life events to Human Resources.

TIP: Having existing family coverage DOES NOT enroll the new dependent

In the case of a qualifying event allowing you to add or delete dependents from your coverage, that includes current coverage only. Changing plan types is not allowed under the Plan.

Qualifying Event	Dependent Verification Documentation
Marriage	Government issued Marriage Certificate
	Government issued Birth Certificate naming you as parent
Birth	OR
	(if under six months of age only) Hospital documentation reflecting the child's birth, naming you as parent
Adoption	Legal documentation of the adoption
Loss of Other Coverage	Letter indicating the loss of coverage from the prior plan sponsor, including name(s) of the insured, specific coverages that were lost, and date that coverage(s) were lost
Divorce	Government issued Divorce decree showing date of divorce
Gain of Other Coverage	Letter indicating the gain of coverage from the new plan sponsor, including name(s) of the insured, specific coverages that were elected, and date that coverage(s) are effective
Death	Government issued Death Certificate





**BlueCross
BlueShield**

Medical Benefits

Blue Cross Blue Shield offers three plan designs that consist of traditional Preferred Provider Organization (PPO) plans and a High Deductible Health Plan. Your Blue Cross Blue Shield plan booklet will detail these plans for you. Additional information and booklets are available online and in Human Resources.

Continuing in 2020, employees will have access to an innovative health plan offered through Blue Cross Blue Shield. This plan, referred to as a High Deductible Health Plan, is supported by a Health Savings Account (HSA). Similar to Flexible Spending Accounts, an HSA allows employees to save for non-insurance covered health related expenses with pre-tax dollars. However, an HSA account allows participants to roll over remaining funds and earn interest on account balances.

Both you and the City can share in the cost of this health contribution coverage. To assist those who select the High Deductible Health Plan (HDHP), the City will contribute the following amounts to your HSA Account. The first payment will be in January (half of below), after bank accounts have been established. The second payment will be in July of 2020.

Employer HSA Contribution	
Employee Only	\$1,000
Employee + Dependent	\$1,500
Employee + Family	\$2,000

To assist with your deductible, the City will contribute two lump sum deposits into your HSA account based on your enrollment election.

Note: City contributions will be prorated for newly hired employees enrolling after January 2020 or July 2020.

When choosing the right medical plan for you and your family, please remember:

- Selection of only one medical plan is permitted.
- Employee and participating dependents must all be on the same plan.
- If adding or deleting dependents to a plan due to a qualifying event (page 7), your plan changes have to be consistent.

Health Savings Account (HSA)

Contributions to the HSA are limited by the amount established by IRS guidelines. Employees can contribute additional funds pre-tax. **See *maximum contributions chart***.

– Unused funds stay in your bank account and roll over year to year.

– HSAs serve as a pre-tax and pre-FICA fund that can be used to save for the day medical expenses are actually incurred. Funds compound tax free. The account is owned and controlled by you.

– In addition, individuals can use tax-free HSA dollars for qualified medical expenses not covered by the high deductible health plan, along with dental and vision expenses. If the HSA funds are not used for qualified medical expenses, then the amount is included as income and a 20% penalty is applied by the IRS.

–Your spouse or dependents do not need to be covered by a high deductible health plan. Funds can only be used on qualified dependents. **See *eligible dependent chart***.

See HSA FAQ's on page 10 for additional information.

IRS Definition of Qualifying Dependent

Qualifying Child—daughter, son, stepchild, sibling, or step-sibling or any descendant of these who:

Has the same principal place or abode as the covered employee for more than one-half of the taxable year

Has not provided more than one-half of his or her own support during the taxable year

If not age 19, (or if a student, not yet 24) at the end of the tax year or is permanently and totally disabled

If an HSA Account holder cannot claim a child as a dependent on their tax return, they cannot spend HSA dollars on services provided to that child. This applies to all children, including those mentioned above.

2020 HSA Maximum Contributions*

Employee Only	\$3,550
Employee + Family	\$7,100
Catch-Up (55+ Years)	\$1,000

*Maximum contributions include City and Employee Contributions, combined.



Health Savings Account FAQ

What Are the Tax Advantages of a Health Savings Account?

Funds contributed to a Health Savings Account are triple tax advantaged:

- 1. Money goes in tax free:** Funded electronically through payroll deduction (required to receive City's matching contribution and pre-tax benefit) through a Section 125 Cafeteria Plan, allowing you to make contributions to your account on a pre-tax basis. The contribution is then deposited into your account before taxes are applied to your paycheck, making your savings immediate. You can also contribute after tax and get the same tax savings by claiming the deduction when filing your annual taxes. **You will need to report and claim direct deposits by you on your IRS tax form the following year. Be careful not to exceed the non-taxable IRS contribution level.**
- 2. Money comes out tax free:** Eligible health care purchases can be made tax free when you use your account. Purchases can be made directly either by using your Debit Card or you can pay out of pocket and reimburse yourself from the account.
- 3. Funds earn interest - tax free:** The interest on your funds grows on a tax free basis. And, unlike most savings accounts, interest earned on your health savings account is not considered taxable income when the funds are used for eligible health care expenses.

Who Administers the Account?

Liberty Health Bank, a chartered financial institution. Liberty Health Bank will provide you with tax forms at the end of the year to submit with a 1040. **All medical receipts need to be retained by employees to document eligible distributions. NOTE: Some reimbursement methods may require additional service fees charged by Liberty Health Bank.**

What Expenses Are Eligible for Reimbursement?

- Copays
- Deductibles / Coinsurance
- Vision
- Dental
- Certain Medical Supplies

For a complete list of eligible expenses, go to www.irs.gov/pub/irs-pdf/p502.pdf

You are responsible for ensuring the money is spent on qualified purchases only and maintain records to withstand IRS scrutiny. Funds used for non-qualified expenses are subject to income tax and an additional 20 percent tax.

Am I Eligible to Participate?

In order to contribute you must be:

- Enrolled in a qualified HDHP

In addition you must not be:

- Covered under a secondary health plan that is not a qualified HDHP, including a full purpose Flexible Spending Account through your employer, parent or spouse
- Enrolled in Medicare
- Another person's tax dependent

What if I am enrolled in Medicare?

If you are enrolled in Medicare Part A or B, you cannot enroll in the Health Savings Account due to IRS regulations. However, you can enroll in the High Deductible Health Plan. Have Questions? Call 877.859.5735.

Can I Change My Contributions Throughout the Year?

Yes, contact Human Resources.

Do I Have to Spend All of My Contributions by the End of the Plan Year?

No, unused money in your account rolls over and continues to grow tax free.

What Happens to the Money in My Account If I No Longer Have HDHP Coverage?

Once you discontinue coverage under an HDHP and/or get secondary coverage that disqualifies you, and/or terminate employment, you can no longer make contributions to your account. However, since you still own the account, you can continue to use the remaining funds for future health care expenses.



Medical Premiums

BCBS CORE PLAN

	Monthly Premium	City Monthly Contribution (\$)	Employee Monthly Contribution (\$)	Employee Semi-Monthly Contribution
CONTRIBUTIONS				
Employee Only	\$514.01	\$424.01	\$90.00	\$45.00
Employee + Spouse	\$1,121.34	\$721.34	\$400.00	\$200.00
Employee + Child(ren)	\$1,076.34	\$686.34	\$390.00	\$195.00
Employee + Family	\$1,662.05	\$1,174.05	\$488.00	\$244.00

BCBS BUY UP PLAN

	Monthly Premium	City Monthly Contribution (\$)	Employee Monthly Contribution (\$)	Employee Semi-Monthly Contribution
CONTRIBUTIONS				
Employee Only	\$577.67	\$475.67	\$102.00	\$51.00
Employee + Spouse	\$1,261.06	\$675.06	\$586.00	\$293.00
Employee + Child(ren)	\$1,210.42	\$634.42	\$576.00	\$288.00
Employee + Family	\$1,869.51	\$1,207.51	\$662.00	\$331.00

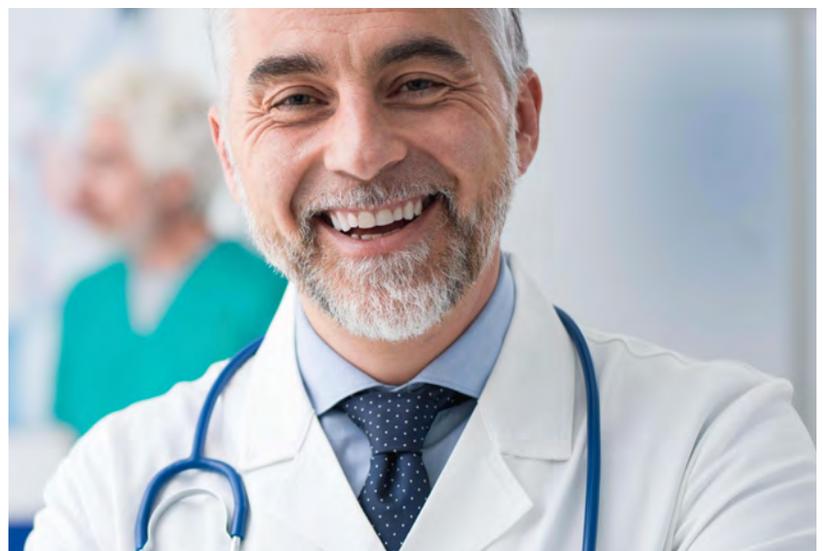
BCBS HDHP PLAN

	Monthly Premium	City Monthly Contribution (\$)	Employee Monthly Contribution (\$)	Employee Semi-Monthly Contribution
CONTRIBUTIONS				
Employee Only	\$515.55	\$515.55	\$0.00	\$0.00
Employee + Spouse	\$1,124.77	\$784.77	\$340.00	\$170.00
Employee + Child(ren)	\$1,079.77	\$759.77	\$320.00	\$160.00
Employee + Family	\$1,667.12	\$1,297.12	\$370.00	\$185.00

**Included in the premium is \$5.90 per month charge fee for the administration of your benefit plan.

Need to locate a network physician or hospital?

Log on to www.bcbstx.com or call customer service at 1.800.521.2227



Medical Benefits

Medical Plan Summary

The chart below gives a summary of the three benefit plan options available to you, so you can decide the right plan for you and your family. Deductibles and copays accumulate towards the out of pocket maximum.

	Buy-Up \$1,500 Option		Core \$2,500 Option		HDHP \$3,000 Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE						
Individual	\$1,500	\$2,000	\$2,500	\$4,000	\$3,000	\$4,000
Family	\$3,000	\$4,000	\$5,000	\$8,000	\$6,000	\$8,000
Coinsurance (You Pay)	20%	40%	20%	40%	100%	30%
ANNUAL OUT-OF-POCKET MAXIMUM (Includes Calendar Year Deductible)						
Individual	\$4,000	\$7,000	\$6,000	\$14,000	\$3,000	\$14,000
Family	\$8,000	\$14,000	\$12,000	\$28,000	\$6,000	\$28,000
OFFICE VISITS						
Preventive Care	No Cost	Ded. & Coins.	No Cost	Ded. & Coins.	No Cost	Ded. & Coins.
Physician Office	\$30 copay	Ded. & Coins.	\$30 copay	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.
Specialist Office	\$30 copay	Ded. & Coins.	\$30 copay	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.
HOSPITAL FACILITY						
Inpatient & Outpatient	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.
HOSPITAL PHYSICIAN						
Inpatient & Outpatient	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.	Ded. & Coins.
Emergency Room	\$100 copay & Coins.		\$100 copay & Coins.		Ded. & Coins.	
PRESCRIPTION DRUGS						
Retail (30 day supply)						
Generic	\$10 copay		\$10 copay		\$0 after Ded.	
Brand Formulary	\$25 copay		\$30 copay		\$0 after Ded.	
Brand Non-Formulary	\$50 copay		\$60 copay		\$0 after Ded.	
Mail Order (90 day supply)						
Generic	\$25 copay		\$25 copay		\$0 after Ded.	
Brand Formulary	\$62.50 copay		\$75 copay		\$0 after Ded.	
Brand Non-Formulary	\$125 copay		\$150 copay		\$0 after Ded.	
EMPLOYER HSA FUNDING						
Employee Only					\$1,000	
Employee + Spouse or Child	Not an HSA qualified plan, does not apply.		Not an HSA qualified plan, does not apply.		\$1,500	
Employee + Family					\$2,000	

Note: Please refer to Summary Plan Description for a full outline of your medical coverage.

Blue Access for MembersSM

Secure access to your personal health plan information



Get information about your health benefits, anytime, anywhere. Use your mobile phone, tablet or computer to access the Blue Cross and Blue Shield of Texas (BCBSTX) secure member website, Blue Access for Members (BAM).

With BAM, you can:

- Check the status or history of a claim
- Locate a doctor or hospital in your plan's network
- Find Spanish-speaking providers
- Request a new ID care - or print a temporary one
- Visit [Health Care School](#) to see articles and videos to help you make the most of your benefits

Any covered dependent age 18 and older can have his or her own BAM account.

It's easy to get started

From your mobile phone, tablet or computer:

1. Go to bcbstx.com/member
2. Click Register Now
3. Use the information on your BCBSTX ID care to complete the registration process.



Text* BCBSTXAPP to 33633 to get the BCBSTX app that lets you use BAM while you're on the go.

* Message and data rates may apply.
Terms and conditions and privacy policy at bcbstx.com/mobile/text-messaging.



Care When and Where You Need It Just Got Easier

Virtual Visits

Convenient health care at your fingertips



Getting sick is never convenient, and finding time to get to the doctor can be hard. Blue Cross and Blue Shield of Texas (BCBSTX) provides you and your covered dependents access to care for non-emergency medical issues through MDLIVE.

Whether you're at home or traveling, access to a board-certified doctor is available 24 hours a day, seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits can also be a better alternative than going to the emergency room or urgent care center.¹

MDLIVE doctors can help treat the following conditions and more:

General Health

- Allergies
- Asthma
- Nausea
- Sinus infections

Pediatric Care

- Cold/flu
- Ear problems
- Pinkeye

Telephone:

- Call MDLIVE (888-680-8646)
- Speak with a health service specialist
- Speak with a doctor



Connect²
Access via telephone
24/7/365



Interact
Real-time consultation with a board-certified doctor or therapist



Diagnose
Prescriptions sent electronically to pharmacy of your choice (when appropriate)

Medical Benefits

WHERE TO GO GUIDE

The cost for care and time you wait can vary greatly depending on where you go. Below is a simple guide to choosing the right place to go for health care. In addition to clinical settings, you have access to virtual visits.



	Conditions Treated*	Your Cost & Time
Emergency Room		
For the immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room. Open 24/7.	<ul style="list-style-type: none"> Sudden numbness, weakness Uncontrolled bleeding Seizure or loss of consciousness Shortness of breath Chest pain Head injury/major trauma Blurry or loss of vision Severe cuts or burns Overdose 	<ul style="list-style-type: none"> Costs are highest No appointment needed Wait times may be long, averaging over 4 hours
Urgent Care Center		
For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	<ul style="list-style-type: none"> Minor cuts, sprains, burns, rashes Fever and flu symptoms Headaches Chronic lower back pain Joint pain Minor respiratory symptoms Urinary tract infections 	<ul style="list-style-type: none"> Costs are lower than an ER visit No appointment needed Wait times vary
Doctor's Office		
The best place to receive routine or preventive care, track medications, or get a referral to see a specialist.	<ul style="list-style-type: none"> General health issues Preventive services Routine checkups Immunizations and screenings 	<ul style="list-style-type: none"> May include coinsurance and/or deductible Appointment usually needed May have little wait time
Convenience Care Clinic		
Staffed by nurse practitioners and physician assistants. Treat minor medical concerns that are not life threatening. Located in retail stores and pharmacies, they're often open nights and weekends.	<ul style="list-style-type: none"> Common cold/flu Rashes or skin conditions Sore throat, earache, sinus pain Minor cuts or burns Pregnancy testing Vaccinations 	<ul style="list-style-type: none"> Costs are same or lower than office visit No appointment needed Wait times typically 15 minutes or less
Virtual Medicine		
Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or smartphone mobile app.	<ul style="list-style-type: none"> Cold and flu symptoms such as a cough, fever and headaches Allergies Sinus infections Family health questions 	<ul style="list-style-type: none"> Cost is the same as an office visit** No appointment needed Immediate, private, and secure visits



*List is not all inclusive. To find a specific health care facility or doctor, go to your medical carrier's website or call the number on your ID card. The listing of a health care professional or facility in the online directory does not guarantee that the services rendered by that professional or facility are covered under your specific medical plan. Check your official plan document for information about the services covered under your plan benefits. The information provided here is for informational purposes only. During a medical emergency, you should always visit the nearest hospital or call 911 for assistance.

**Virtual Visits on HDHP are subject to deductible.

Deer Oaks EAP Services Fact Sheet



The Deer Oaks Employee Assistance Program (EAP) is a free service provided for you and your dependents by your employer. This program offers a wide variety of counseling, referral, and consultation services, which are all designed to assist you and your family in resolving work/life issues in order to live happier, healthier, more balanced lives. These services are completely confidential and can be easily accessed by calling the toll-free Helpline listed below.

DEER OAKS EAP IS A RESOURCE YOU CAN TRUST.

Eligibility: All employees and their household members/dependents are eligible to access the EAP. Employees who have recently separated from their employer will continue to have access to services for up to six (6) months post-employment. Retirees will continue to have access for the life of the contract.

In-person Counseling & Assessments: A network of 54,000+ mental health providers throughout the United States are available to provide in-person assessment and counseling services to members wherever they may reside.

Telephonic Assessments & Support: All clinical EAP cases receive a thorough telephonic clinical assessment. In-the-moment telephonic support and crisis intervention are also available 24/7.

Tele-Language Services: Deer Oaks has the ability to provide therapy in a language other than English if requested. Services are available for telephonic interpretation in 200 of the most commonly spoken languages and dialects.

Referrals & Community Resources: Counselors provide referrals to community resources, member health plans, support groups, legal resources, and child/elder care services.

Advantage Legal Assist: Free 30-minute telephonic or in-person consultation with a plan attorney; 25% discount on hourly attorney fees if representation is required; unlimited online access to a wealth of educational legal resources, links, tools and forms; interactive online Simple Will preparation; access to state agencies to obtain birth certificates and other records.

Advantage Financial Assist: Unlimited telephonic consultation with a financial counselor qualified to advise on a range of financial issues such as bankruptcy prevention, debt reduction and financial planning; supporting educational materials available; objective, pressure-free advice; unlimited online access to a wealth of educational financial resources, links, tools and forms (i.e. tax guides, financial calculators, etc.).

ID Recovery: Free telephonic consultation with an Accredited Financial Counselor; information on steps that should be taken upon discovery of identity theft; referral to full-service credit recovery agencies; free credit monitoring service.

Monthly Electronic Newsletters: Employees and supervisors receive monthly e-newsletters covering a variety of topics including health and wellness, work/life balance issues, conflict resolution, leadership, and more.

Disaster Assistance Program: Educational articles on how to help children cope with disasters; consultation to Employer Group Management Personnel regarding disaster readiness; and tools for developing workplace violence prevention plans.

Online Tools & Resources: Log on to www.deeroakseap.com to access an extensive topical library containing health and wellness articles, videos, archived webinars, child and elder care resources, and work/life balance resources. The Deer Oaks website also includes a wealth of information for supervisors with topics covering conflict resolution, leadership, motivation, and more.

Work/Life Services: Work/Life Consultants are available to assist members with a wide range of daily living resources such as pet sitters, event planners, home repair, tutors and moving services. Simply call the Helpline for resource and referral information.

Find-Now Child & Elder Care Program: This program assists participants caring for children and/or aging parents with the search for licensed, regulated, and inspected child and elder care facilities in their area. Work/Life Consultants assess each member's needs, provide guidance, resources, and referrals within 3 business days of the call. Searchable databases and other resources are also available on the Deer Oaks website.

Critical Incident Stress Management: Traumatic events can be extremely disruptive to the well-being and productivity of employees. Deer Oaks will respond quickly when asked to provide Critical Incident Stress Management Services for any major company incident.

Take the High Road: Deer Oaks reimburses members for their cab, Lyft and Uber fares in the event that they are incapacitated due to impairment by a substance or extreme emotional condition. This service is available once per year per participant with a maximum reimbursement of \$45.00 (excludes tips).

Other Resources

Beneficiary Resource Services™

Benefits Beyond a Check



When a loved one dies, families often face complex issues ranging from estate planning, legal questions, funeral planning and coping with grief and financial uncertainties. Beneficiary Resources Services is a program that combines family wellness and security at the most difficult of times. Services include grief counseling, funeral planning, legal support and online will preparation. Provided by Morneau Shepell.

Services for *Insured* and their Families

Online Will Preparation

Full Library of estate planning documents, including an online will. You can create your own will online in a safe and secure way, right from your home. The will can be saved and updated as family situations change. Creating a will provides security and peace of mind for several reasons:

- Appoints a Guardian for Children
- Controls where Property and Assets go
- Provides Family Security

Online Funeral Planning

You have access to an online funeral planning site that features a variety of helpful tools and information such as:

- A downloadable funeral planning guide to document vital information your loved ones need when making final arrangements
- Calculators to estimate and compare expenses for various types of funeral arrangements
- Information on funeral requirements and various religious customs
- Directories to locate funeral homes and cemeteries in your area



Services for *Beneficiaries* and their Families

The following services are available after a life claim or for those who qualify for an accelerated death benefit.

Face-to-Face Working Sessions

Five face-to-face working sessions are available to you or your beneficiaries. All five may be used with one grief counselor or legal advisor, or they may be split among the two types of counselors or advisors in geographically accessible locations. A one hour financial consultation on the phone is also available.

Unlimited Phone Contact

Available for up to one year with a grief counselor, legal advisor or financial planner.

Referrals and Support Services

Comprehensive directory of qualified and accessible grief counselors and legal and financial consultants.

Follow Up

Counselors will initiate follow up calls when necessary for up to one full year from the date of initial contact.

Counselors are available 24 hours a day, 365 days a year. All calls are completely confidential.

To Access the Valuable Resources:

Call: 866.769.9187

Online: BeneficiaryResources.com

– Username: beneficiary

Dental Benefits

Dental coverage is provided through Cigna. The dental plan gives you the freedom to choose any dentist in or out of network, including specialists. While participants may choose any dentist or specialist under the PPO Plan, selection of a contract network dentist will provide participants with the highest level of benefits and save on out of pocket costs.

	Benefit
ANNUAL DEDUCTIBLE	
Individual	\$75
Family	\$225
ANNUAL MAXIMUM BENEFIT	
Per Person	\$1,250
COVERED SERVICES	
Preventive Services Oral Exams, X-Rays, Routine Cleanings, Fluoride Treatments	100% of Cigna's allowed (UCR) amount Deductible is waived
Basic Services Fillings, Simple extractions, Endodontics, Periodontics	80% of Cigna's allowed (UCR) amount*
Major Services Bridges, Dentures, Crowns , Inlays, Onlays	80% of Cigna's allowed (UCR) amount*
Orthodontia Covers both adult and child(ren)	50% of Cigna's allowed amount Deductible does not apply
Orthodontia Lifetime Maximum	\$2,000

*After Deductible

Note: Please refer to Certificate of Coverage for a full outline of your dental coverage.

	Monthly Cost	Semi-Monthly Cost
Employee Only	\$4	\$2
Employee +Spouse	\$30	\$15
Employee + Child(ren)	\$24	\$12
Employee + Family	\$34	\$17



Need to locate a network dentist or orthodontist?

- Log on to www.mycigna.com, or call customer service at 1.800.CIGNA24



Vision Benefits

Vision coverage is provided through The Standard. The plan pays benefits for annual exams and corrective lenses. You pay a copayment for exams, and the plan pays benefits for frames and lenses up to certain limits. Under this plan, you may use in-network or out-of-network vision care providers, but you will receive greater benefits when you use in network providers. **The network is VSP Choice.**

The plan will pay for a comprehensive exam, lenses and contact lenses once ever 12 months and will pay for frames once every 24 months. A single copay covers both frames and/or eyeglass lenses, or contact lenses instead of eyeglass frames and/or lenses. **Discounts are available on additional pairs of eyewear and contact lenses.**



	In-Network	Out-of-Network
COPAY		
Comprehensive Eye (Optometrist & Ophthalmologist)	\$10 copay	\$45 Allowance
COVERED MATERIALS		
LENSES		
Single Vision	After \$10 copay	\$30 Allowance
Bifocal	After \$10 copay	\$50 Allowance
Trifocal	After \$10 copay	\$65 Allowance
FRAMES		
Standard	Up to \$150 Allowance	\$75 Allowance
CONTACTS		
Cosmetic (elective *)	\$60 fit & follow up; Up to \$150 Allowance	\$120 Allowance
Medically Necessary	Covered in Full	\$210 Allowance
FREQUENCY		
Examination	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contacts	12 Months	

*The frames & contact lens benefit is an either or benefit. For example, contact lens benefit in lieu of frames benefit.

Note: Please refer to Certificate of Coverage for a full outline of your vision coverage.



	Cost per Month	Cost Semi-Monthly
Employee Only	\$5.52	\$2.76
Employee + Spouse	\$9.38	\$4.69
Employee + Child(ren)	\$9.94	\$4.97
Employee + Family	\$14.90	\$7.45



Income Protection



Basic & Supplemental Life Insurance

The City provides Basic Life Insurance coverage at no cost to you. You may add to the life insurance provided by electing additional coverage. You pay premiums for the additional coverage elected on an after tax basis, so any insurance benefits paid are not taxable for your beneficiary. You can add dependent life insurance, this coverage will pay benefits to you in the event your covered spouse or child(ren) die.

Accidental Death & Dismemberment (AD&D)

The City provides Basic AD&D insurance coverage for you that matches your basic life volume. If you choose to elect additional life coverage, your AD&D benefit will match this election. AD&D benefits are payable if you die within 365 days after a covered accident and the cause of your death can be attributed to the covered accident. Accidental Dismemberment benefits are payable to you if you suffer a loss that is covered under the plan within 365 days of the covered accident.

If you:	This Policy:	Pays benefits to:
Die	Life Insurance	Your Beneficiary
Die in an accident	Life Insurance and AD&D Insurance	Your Beneficiary
Suffer a covered dismemberment	AD&D Insurance	You

Basic Life / AD&D (City of Desoto Provides)

Life and AD&D Benefit Amount	3 X Annual Salary up to \$150,000
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Employee Supplemental Life / AD&D (Employee Paid)

Life and AD&D Benefit Amount	Increments of \$10,000, up to 5 X Annual Salary
Guarantee Issue	\$150,000, not to exceed 5 X Annual Salary
Maximum Benefit	\$500,000, not to exceed 5 X Annual Salary

Dependent Supplemental Life^{1,3} (Employee Paid)

Spouse Life Benefit Amount	\$5,000 increments
Spouse Guarantee Issue	\$50,000
Spouse Maximum Benefit	\$250,000
Child Life Benefit Amount²	\$1,000 increments Live birth - 6 months: \$1,000 6 months - Age 26: Up to
Child Guarantee Issue	\$15,000
Child Maximum Benefit	\$2,000 - \$15,000

¹You must purchase coverage on yourself to purchase it for your family.
²If you elect coverage for your children, all of your eligible children are covered from live birth through age 25. You pay the same premium amount regardless of the number of children.
³Dependent elections cannot exceed employee election.

Note: Please refer to Certificate of Coverage for a full outline of your life insurance coverage.

Long Term Disability

Disability helps you and your family meet financial obligations if injury or illness prevents you from working. This coverage is an important element in your financial planning because it provides a continuing source of income if you are unable to work because of a disability.

If you:	This Policy:	Pays benefits to:
Become disabled	Long-Term Disability and possibly AD&D if disability is due to dismemberment	You
Become disabled due to cancer, sickness or a short term disability	Supplemental Insurance	You

Coverage Paid by the City

Benefit Percentage	40% of your salary
Maximum Monthly Benefit	\$5,000
Elimination Period	180 Days
Own Occupation	24 Months

Buy-Up Coverage You Pay for

Benefit Percentage	60% of your salary
Maximum Monthly Benefit	\$7,000
Elimination Period	90 Days
Own Occupation	24 Months

Rates
See BenefitFirst for your specific rate and benefit during enrollment



Long Term Disability benefits are reduced by other sources of income during disability, such as, Workers' Compensation, Social Security, and/or retirement systems.

Employee - Monthly Rate

Age Band	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
0-24	\$0.40	\$0.80	\$1.20	\$1.60	\$2.00	\$2.40	\$2.80	\$3.20	\$3.60	\$4.00
25-29	\$0.40	\$0.80	\$1.20	\$1.60	\$2.00	\$2.40	\$2.80	\$3.20	\$3.60	\$4.00
30-34	\$0.40	\$0.80	\$1.20	\$1.60	\$2.00	\$2.40	\$2.80	\$3.20	\$3.60	\$4.00
35-39	\$0.50	\$1.00	\$1.50	\$2.00	\$2.50	\$3.00	\$3.50	\$4.00	\$4.50	\$5.00
40-44	\$0.85	\$1.70	\$2.55	\$3.40	\$4.25	\$5.10	\$5.95	\$6.80	\$7.65	\$8.50
45-49	\$1.35	\$2.70	\$4.05	\$5.40	\$6.75	\$8.10	\$9.45	\$10.80	\$12.15	\$13.50
50-54	\$2.30	\$4.60	\$6.90	\$9.20	\$11.50	\$13.80	\$16.10	\$18.40	\$20.70	\$23.00
55-59	\$4.15	\$8.30	\$12.45	\$16.60	\$20.75	\$24.90	\$29.05	\$33.20	\$37.35	\$41.50
60-64	\$5.95	\$11.90	\$17.85	\$23.80	\$29.75	\$35.70	\$41.65	\$47.60	\$53.55	\$59.50
65-69	\$9.45	\$18.90	\$28.35	\$37.80	\$47.25	\$56.70	\$66.15	\$75.60	\$85.05	\$94.50
70-74	\$16.25	\$32.50	\$37.80	\$65.00	\$81.25	\$97.50	\$113.75	\$130.00	\$146.25	\$162.50
75+	\$30.05	\$60.10	\$90.15	\$120.20	\$150.25	\$180.30	\$210.35	\$240.40	\$270.45	\$300.50

Spouse - Monthly Rate

Age Band	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
0-24	\$0.20	\$0.40	\$0.60	\$0.80	\$1.00	\$1.20	\$1.40	\$1.60	\$1.80	\$2.00
25-29	\$0.20	\$0.40	\$0.60	\$0.80	\$1.00	\$1.20	\$1.40	\$1.60	\$1.80	\$2.00
30-34	\$0.20	\$0.40	\$0.60	\$0.80	\$1.00	\$1.20	\$1.40	\$1.60	\$1.80	\$2.00
35-39	\$0.25	\$0.50	\$0.75	\$1.00	\$1.25	\$1.50	\$1.75	\$2.00	\$2.25	\$2.50
40-44	\$0.43	\$0.85	\$1.28	\$1.70	\$2.13	\$2.55	\$2.98	\$3.40	\$3.83	\$4.25
45-49	\$0.68	\$1.35	\$2.03	\$2.70	\$3.38	\$4.05	\$4.73	\$5.40	\$6.08	\$6.75
50-54	\$1.15	\$2.30	\$3.45	\$4.60	\$5.75	\$6.90	\$8.05	\$9.20	\$10.35	\$11.50
55-59	\$2.08	\$4.15	\$6.23	\$8.30	\$10.38	\$12.45	\$14.53	\$16.60	\$18.68	\$20.75
60-64	\$2.98	\$5.95	\$8.93	\$11.90	\$14.88	\$17.85	\$20.83	\$23.80	\$26.78	\$29.75
65-69	\$4.73	\$9.45	\$14.18	\$18.90	\$23.63	\$28.38	\$33.08	\$37.80	\$42.53	\$47.25
70-74	\$8.13	\$16.25	\$24.38	\$32.50	\$40.63	\$48.75	\$56.88	\$65.00	\$73.13	\$81.25
75+	\$15.03	\$30.05	\$45.08	\$60.10	\$75.13	\$90.15	\$105.18	\$120.20	\$135.23	\$150.25

Child(ren)- Monthly Rate

\$15,000
\$3.00

AD&D - Monthly Rate per \$1,000 of Coverage

Coverage Level	Rate
Employee	\$0.040
Family	\$0.060

Flexible Spending Account

Medical

–Employees enrolled in the **Core and Buy-Up PPO options** are eligible to open a Flexible Spending Account (FSA) each year, which allows tax free payroll deductions for certain types of unreimbursed medical and/or dependent care expenses.

–Employees enrolled in the **HDHP option** are eligible to open a *Limited* Flexible Spending Account (FSA). The Limited FSA can only be used on qualified dental and vision expenses.

–Estimate your annual health care expenditures on items not reimbursed by insurance. Accounts are pre-loaded with the annual election. You have access to all of your funds the first day of the new plan year.

– Employees have until December 31 to apply for reimbursement for incurred medical expenses that were incurred during the plan year. **Use it or lose it!**

–Participants receive a debit card that can be used for medical expenses up to the amount of their annual election. You can also file a claim online for reimbursement.

Dependent Care Spending Account

–**A maximum of \$5,000 per calendar year may be contributed to the dependent care account** (\$2,500 if an employee’s spouse also participates in a dependent care plan).

– You will be reimbursed for eligible claims up to the current contributed amount available in your account.

–**Money may not be transferred between medical and dependent care accounts.**



2020 FSA Maximum Contributions
\$2,700
2020 Dependent Care Maximum Contributions
\$5,000

Easily manage your healthcare benefit account from your mobile phone!

You will need the following information in order to register:

Employee ID = SSN with no dashes

Employer ID = LEGDESOTO

Getting Started!

Login credentials for Wealthcare Portal and Newport Flex Mobile are the same.

- If you already have a Wealthcare Portal or Newport Flex Mobile username, you can enter it and tap **sign in**. You may be asked some security questions, and then be prompted to enter your password.
- If needed, you can retrieve a forgotten username and reset a forgotten password from the password entry screen.
- If this is your first time logging into both Wealthcare Portal and Newport Flex Mobile, you must register before you can access the application.

Use the claims screen to enter new claims/ expenses, and view/edit pending ones. If you receipt(s) to substantiate claim(s), you can take a photo of it with your device and attach to a pending claim from this section of the app.

Flexible Spending Account Cont.



FSA Eligible Expenses

For a full list of eligible expenses please see IRS Publication 502.

Acupuncture
Chiropractor
Contact Lenses & Solutions*
Co-Payments
Dental Fees*
Medical Supplies
Glasses*
Hearing Devices
Lab Fees
Orthodontic Fees*
Prescriptions
Wheelchairs
X-Rays

*Also, Limited Care FSA eligible expenses

Non-Qualified FSA Expenses

Cosmetic Surgery/Procedures
Teeth Whitening
Marriage/Family Debt Counseling
Weight Loss Programs for General
General Health Items (vitamins,
Premiums



**Questions? Call
Newport Group at
877.859.5735**

Dependent Care Eligible Expenses

Dependent care expenses incurred for services outside your home provided they are:

- incurred for the care of a qualifying person who is under the age of 13 when the care was provided
- or
- incurred for the custodial care of your spouse or dependent who is physically or mentally unable to care for himself or herself. Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Also, persons who must have constant attention to prevent them from injuring themselves or others are considered not able to care for themselves.

Nanny expenses, for services provided inside your home are eligible to the extent they are attributable to dependent care expenses and expenses of incidental household services.

Employees (and your spouse if you are married) must have earned income during the year and you must pay for dependent care expenses so you can work or can look for work.

Payments must be made for a child and dependent care to someone you (or your spouse) cannot claim as a dependent. If you make payments to your child, he or she cannot be your dependent and must be age 19 or older by the end of the tax year.

Registration fees to a daycare facility are eligible as long as the fees are allocated to actual care and not described as materials or other fees.

Nursery school expenses are eligible even if the school also furnishes lunch and education services.

Food and incidental expenses (diapers, activities, etc.) may be eligible if part of dependent care charge.

Non-Qualified Dependent Care Expenses

Tuition fees for grades K-12
Meals*
Diapers*
Activity Fees
Late Fees
Overnight Camps
Sumer Camp Supplies

*Incidental fees are not eligible if broken out and billed separately by your provider.

Note: If you terminate employment or experience a change in employment status from full-time to part-time, you are eligible to access FSA funds up to your termination or employment status change date. This means that any services after the previous mentioned dates are ineligible for reimbursement.

Group Critical Illness with Cancer

Aflac can help ease the financial stress of surviving a critical illness.



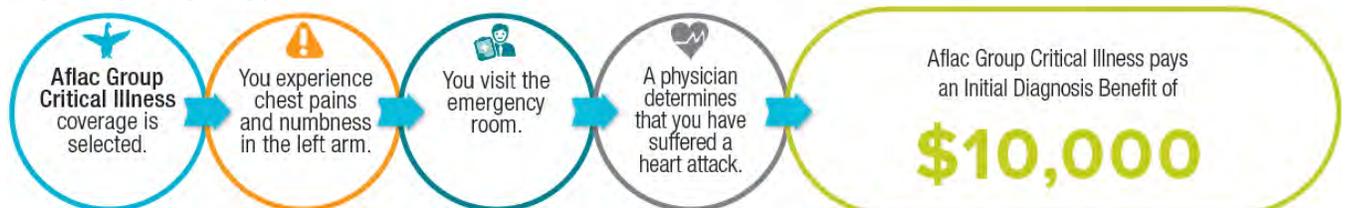
What you need, when you need it.

Group Critical Illness insurance pays cash benefits that you can use any way you see fit.

Base Benefits	
Benefit Amount Employee	Up to \$20,000
Benefit Amount Spouse/Child	50% of employee amount
Guarantee Issue	Employee - Up to \$20,000 Spouse - Up to \$10,000
Heart Attack (Myocardial Infarction)	100%
Sudden Cardiac Arrest	100%
Coronary Artery Bypass Surgery	25%
Major Organ Transplant, Bone Marrow Transplant (Stem Cell Transplant)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke (Ischemic or Hemorrhagic)	100%
Cancer Benefits	
Cancer (Internal or Invasive)	100%
Non-Invasive Cancer	25%
Skin Cancer	\$250 per calendar year
Health Screening Benefit	
Health Screening	\$50 per calendar year for employee & spouse only
Additional Benefits	
Note: Please refer to policy for a full outline of your critical illness coverage.	
Coma, Severe Burns, Paralysis, Loss of Sight, Loss of Speech and Loss of Hearing	100%
Additional Diagnosis	Benefit for each critical illness, after the first, when the two dates are separated by at least six consecutive months.
Reoccurrence	Benefit for the same critical illness, after the first, when the two dates of



How it Works:



Amount payable based on \$10,000 Initial Diagnosis Benefit.

Group Accident



Accident Insurance

Added protection for life's unexpected moments.

In the event of a covered accident, the plan pays cash benefits fast to help with the costs associated with out-of-pocket expenses and bills - expenses major medical might not take care of, including:

- Ambulance Rides
- Wheelchairs, crutches, and other medical appliances
- Emergency Room Visits
- Surgery and Anesthesia
- Bandages, stitches, and casts



Benefits

Note: Please refer to policy for full outline of your accident coverage.

Hospital Admission	\$900
Daily Benefit	\$225 per day, up to 365 days
Daily ICU	\$300 per day, up to 30 days
Initial Treatment (ER/Urgent Care)	
with X-Ray	\$200
without X-Ray	\$150
Fracture	Up to \$6,000
Dislocations	Up to \$4,500
Burns	Up to \$15,000
Outpatient Surgery	\$300
Inpatient Surgery	\$750
Transportation	\$150 - \$350
Prosthesis	\$2,000
Ambulance Air/Ground	\$900 / \$300
Vehicle Modification	\$1,500
Paralysis	\$3,500 - \$7,500
Traumatic Brain Injury	\$3,500
Dismemberment	\$87.50 - \$17,500
Coma	\$7,500
Concussion	\$350
Rehabilitation	\$75 per day, up to 31 days (up to 2x per year)
Wellness Benefit	\$25 - \$75
Emergency Dental Work	\$30 - \$120
Family Member Lodging	\$150 per day, up to 30 days
Back Brace	\$300
Wheelchair	\$300
Knee Scooter	\$300
Crutches	\$75

Voluntary Deferred Compensation Plans

A Deferred Compensation Plan permits you, on a voluntary basis, to authorize a portion of your salary to be withheld and invested for payment to you at a later date. These salary deferrals, or "contributions", are allocated to the Plan's investment choices at your instruction. Neither your contributions nor any investment earnings are subject to current federal and (in most cases) state income taxes. Taxes become payable when the deferred income plus earnings are distributed to you - generally at retirement, or separation from employment.



In today's environment, it is widely accepted that in order to have a comfortable retirement, you must rely on income sources other than your pension or Social Security. The City's voluntary deferred compensation plan is an important and valuable means for preparing for your retirement and supplementing your TMRS plan.

Additional information regarding the City's voluntary deferred compensation and Roth plans can be obtained from Human Resources.



Glossary

Allowed Fees

Term used by some dental plans for their participating dentist fees and / or maximum payable for a non-participating dentist.

Annual Deductible

The amount you must pay for covered health services based on contracted rates (also referred to as eligible charges/ expenses) in a year before the plan will begin paying certain benefits in that year.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985. This Act requires that continuation of group insurance be offered to covered persons who lose health, dental or vision coverage due to a qualifying life event as defined in the Act.

Coinsurance

The portion of covered health care costs for which the covered person is financially responsible, usually according to a fixed percentage. Co-insurance may be applied after a deductible requirement is met.

Copay

The charge you are required to pay for certain covered health services, such as a prescription or office visit.

Eligibility

Eligibility for benefits is the first of the month following regular full-time employment.

Explanation of Benefits (EOB)

A summary of claims processed, which will be provided to you after a claim is processed for you or for a dependent. This statement outlines year-to-date deductible and out-of-pocket amounts met during the year. This statement will be mailed unless it is turned off on the website.

We strongly encourage you to go to the website and select online notifications of EOBs, as this may be the only option available in the future and it helps us control your premium costs.

Flexible Spending Accounts (FSAs)

An option that allows participants to set aside pre-tax dollars to pay for certain qualified expenses during a specific time period (usually a 12-month period). There are two types of FSAs: the Health Care FSA and the Dependent Care FSA.

Guarantee Issue

The amount of coverage pre-approved by the Life Insurance Company regardless of health status.

Health Savings Account (HSA)

A personal health care bank account funded by your and/or your employer's tax-free dollars to pay for qualified Medical expenses. You must be enrolled in a CDHP / HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, meaning if you change jobs your account goes with you.

Incurred Expense

An expense is considered incurred on the date services were rendered or supplies were received.

Initial Enrollment Period

The first 31 days of fulltime employment or 31 days from a covered life event.

In-Network / Out-of-Network

In-network providers are doctors, hospitals and other providers that contract with your insurance company to provide health care services at discounted rates. **Out-of-network** providers are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.

Out-of-Pocket Maximum

The maximum amount of co-insurance you pay every year. Once you reach the out-of-pocket maximum, as an individual or family, benefits for those covered health services that apply to the out-of-pocket maximum are paid at a percent of eligible charges during the rest of that year. Deductibles and copays apply to the out-of-pocket maximum.

Plan Year

January 1st through December 31st of each year

Important Notices

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

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

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity Act (1996) (MHPA) and Mental Health Parity and Addiction Equity Act (2008) (MHPAEA): City of Desoto medical plan complies with the Mental Health Parity Act of 1996 ("MHPA"). Pursuant to such compliance, the annual and lifetime limits on Mental Health Benefits, if any, will not be less than the annual and lifetime plan limits on other types of medical and surgical services (if any limits apply). The plan does utilize cost containment methods, applicable for Mental Health Benefits, including cost-sharing, limits on the number of visits or days of coverage, and other terms and conditions that relate to the amount, duration and scope of Mental Health Benefits.

Medicaid and the Children's Health Insurance Program (CHIP):

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP, 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, 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, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't 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, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor - Employee Benefit Security Administration

www.dol.gov/agencies/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, menu Option 4, Ext. 61565

Coverage After Termination, Continuation of Health Coverage (COBRA):

If you or your dependents have coverage at the time of a qualifying event, you may be eligible to elect continuation of coverage under one or more of the following:

- Medical Plan, Dental, Vision & FSA

You have a legal right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to purchase a temporary extension of your coverage at group rates. However, you must pay the full cost of the coverage, plus a 2% administrative fee.

COBRA Continuation Coverage: COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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're an employee, you'll 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're the spouse of an employee, you'll 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 could 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.”

COBRA and Retirement: 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 City of Desoto 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 Continuation 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 the following qualifying events:

- The end of employment or reduction of hours of employment; death of the employee 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 within 60 days after the qualifying event occurs.

How is COBRA continuation 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 hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. **There are also ways in which this 18-month period of COBRA continuation coverage can be extended.**

Disability extension of 18-month period of COBRA continuation coverage: If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage. **Second qualifying event extension of 18-month period of continuation coverage:** If your family experiences another qualifying event during the 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 getting 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 qualifying 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 than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov. 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 Employee 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.

(HIPAA) Employee Health Plan Summary Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Uses and Disclosures of Health Information: City of Desoto uses health information about you for treatment, to pay for treatment, and for other allowable healthcare purposes. Health care providers submit claims for payment for treatment that may be covered by the group health plan. Part of payment includes ascertaining the medical necessity of the treatment and the details of the treatment or service to be obligated to pay. Information may be shared by paper mail, electronic mail, fax, or other methods. Subject to certain requirements, City of Desoto may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. City of Desoto provides information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and distribute the new notice. You can also request a copy of our full notice at any time. For more information about our privacy practices, contact the Office of the Privacy Officer or the Human Resources Department.

Your Health Information Rights: In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you the normal copy fees that reflect the actual costs of producing the copies including such items as labor and materials. You also have the right to receive a list of instances where City of Desoto has disclosed health information about you for reasons other than treatment, payment, healthcare operations, related administrative purposes, and when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that City of Desoto correct the existing information or add the missing information. You have the right to request that City of Desoto restrict the use and disclosure, then City of Desoto must abide by

the request and may only reverse the position after you have been appropriately notified. You have the right to request an alternative means of communication with City of Desoto and are not required to explain why you want the alternative means of communication. **Privacy Complaints:** If you are concerned City of Desoto has violated your privacy rights, or you disagree with a decision City of Desoto has made about access to your records, you may address them to the Privacy Contact listed in this notice. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

The City of Desoto Responsibilities: City of Desoto is required by law to protect the privacy of your information, provide this notice about City of Desoto's information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

Detailed Notice of Privacy Practices: For further details about your rights and the federal Privacy Rule, refer to the detailed statement of this Notice. You can ask for a written copy of the detailed Notice by contacting the Privacy Contact listed in this notice. **Privacy Contact:** Address any questions about this notice or how to exercise your privacy rights to the Human Resources Department at 972-230-9639.

Notice Of Opportunity To Enroll In Connection With Extension Of Dependent Coverage To Age 26: Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in City of Desoto. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to January 1st, 2020. If you would like more information, contact your Plan Administrator.

Notice Lifetime Limit No Longer Applies/ Enrollment Opportunity: The lifetime limit on the dollar value of benefits under City of Desoto benefit Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. If you would like more information, contact your Plan Administrator.

Your Prescription Drug Coverage and 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 City of Desoto 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. City of Desoto has determined that the prescription drug coverage offered by Blue Cross Blue Shield of Texas Medical 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 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 coverage with City of Desoto will not be affected. You and/or your dependents can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will 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 City of Desoto 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 plan administrator. 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 City of Desoto 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).

New Health Insurance Marketplace Coverage Options and Your Health Coverage: PART A: General Information: When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer. **What is the Health Insurance Marketplace?** The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2019 for coverage starting as early as January 1, 2020.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income. **Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?** Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.* Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. **How Can I Get More Information?** For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. *An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer: This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. **Here is some basic information about health coverage offered by this employer:** Eligible employees are Fulltime employees who work 30 hours per week and have completed the newly eligible 30 day waiting period. Eligible dependents include the employee's spouse and eligible dependent children up to age 26. This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages. **Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

3. Employer name City of Desoto		4. Employer Identification Number (EIN) 75-1102555	
5. Employer address 211 East Pleasant Run Road		6. Employer phone number 972.230.9619	
7. City Desoto	8. State Tx	9. ZIP code 75115	
10. Who can we contact about employee health coverage at this job? Rick DeOrdio			
11. Phone number (if different from above)		12. Email address rdeordio@desototexas.gov	

Special Enrollment Notice: 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. Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance. To request special enrollment or obtain more information, contact Human Resources at 972-230-9639.

Notice Informing Individuals About Non Discrimination and Accessibility Requirements **Discrimination is against the law:** City of Desoto complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The City does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The City:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters; written information in other formats (large print, audio, accessible electronic formats, other formats); provides free language services to people whose primary language is not English, such as: Qualified interpreters and Information written in other languages.

If you need these services, contact Human Resources at 972-230-9639. If you believe that City of Desoto has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The City of Desoto
211 East Pleasant Run Road
Desoto, TX 75115

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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.



The information in this benefits guide is intended to help you enroll in your 2019 - 2020 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern.

The City of Desoto reserves the right to change or terminate benefits at any time. Neither the benefits, nor this enrollment guide, should be interpreted as a guarantee of future benefits.