

December 1, 2011 - November 30, 2012
Benefit Summary



Medical

Dental

Life/AD&D

Disability

**Flexible Spending
Accounts**

Worksite Benefits

Working together to benefit all.

City of Texas City is the official sponsor of your benefits program. As an active employee, you are eligible to participate in City of Texas City's competitive benefits program.

At City of Texas City, our employees are the foundation of our success. To reward you and reflect our commitment to you, City of Texas 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 December 1, 2011 to November 30, 2012 benefits program gives you the opportunity to select the coverage you need.

This December 1, 2011 to November 30, 2012 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.

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.

Every employee must meet with a benefits specialist at our Annual Enrollment Meetings the week of October 24 – 28, 2011 in order to have coverage in the December 1, 2011 to November 30, 2012 Plan Year.

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 Summary Plan Description (SPD). The SPDs are available by request from the Human Resources Department.

If you have any questions, please call the **Human Resources Department** direct at 409-643-5912.

— Contact Information —

Refer to this list when you need to contact one of your benefit vendors.

MEDICAL: _____ PG 4

UnitedHealthcare
Customer Service
1-877-250-8186
www.myuhc.com

DENTAL: _____ PG 7

UnitedHealthcare
Customer Service
1-877-816-3596
www.myuhcdental.com

VISION: _____ PG 8

UnitedHealthcare Specialty Benefits (formerly Spectera)
Service Center
800-638-3120
www.myuhcspecialtybenefits.com

LIFE & ACCIDENTAL DEATH & DISMEMBERMENT: _____ PG 9

Standard
Claims Customer Service
1-800-628-8600

LONG TERM DISABILITY: _____ PG 9

Standard
Customer Service
1-800-368-1135

FLEXIBLE SPENDING ACCOUNTS (FSA): _____ PG 10

UnitedHealthcare
Customer Service
877-311-7849
www.myuhc.com

SUPPLEMENTAL INSURANCE: _____ PG 11

Allstate
Critical Illness/Accident
Customer Service
800-521-3535
www.allstateatwork.com/mybenefits

NOTIFICATIONS AND DISCLOSURES: _____ PG 12

— Who Is Eligible? —

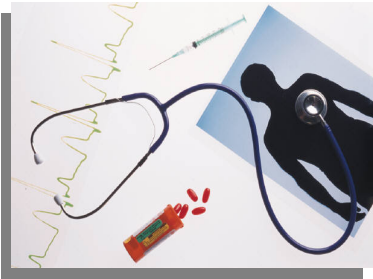
This brochure summarizes the coverage that is available during the upcoming 2011 – 2012 plan year. You may sign up during the Annual Enrollment period. You are not eligible to make changes outside of Annual Enrollment unless:

- a) You are a new employee and have completed 90 days of continuous service.
- b) You have a qualified family status change as outlined below.

Qualified Family Status Changes include:

- Marriage or divorce;
- You or your spouse give birth or adopt a child;
- A covered dependent no longer meets the plan’s definition of eligibility;
- You become disabled;
- You or a dependent dies;
- You end your employment with City of Texas City;
- You or a covered dependent loses coverage through another plan; or
- There is a significant change in the health coverage of you or your spouse attributable to your spouse’s employment.

Who is Eligible?	
Family Member	Requirements
You	Must be a regular, full-time, active employee that consistently works 40 hours per week and has completed 3 months of continuous service.
Your Spouse	Must be your legal spouse
Your Dependent Children	<ul style="list-style-type: none"> • Under the age of 26; regardless of student status <p>Coverage terminates at the end of the birthday month in which the student/child attains maximum covered age.</p>



— Medical Insurance —

UnitedHealthcare Medical

Medical Plan Changes Effective December 1, 2011:

Preventive Services:

- Covered at 100% if you utilize a Network Provider
- Deductible/Coinsurance apply if you utilize a Non-Network Provider

Medical Plan Enhancements/Additional Services Effective December 1, 2011:

Introduction of A.C.N. – Chiropractic Management

- You will be required to complete a Patient Health Questionnaire on your first visit to a Network Provider for chiropractic care beginning December 1, 2011.
- Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met.

NurseLine Services

- Access NurseLine: 1-800-401-7396
- NurseLine can help you:
 - Find a doctor or hospital.
 - Understand treatment options.
 - Ask medication questions.
 - Choose appropriate medical care.
 - Locate available resources.

UHC – Choice Plus – BASE PLAN

Plan Features	In-Network	Out-of-Network
Calendar Year Deductible	\$250 Individual \$750 Family	\$500 Individual \$1,500 Family
Coinsurance (Plan Pays)	80%	60%
Out-of-Pocket Maximum	\$2,000 Individual \$4,000 Family	\$6,000 Individual \$12,000 Family
Lifetime Maximum	Unlimited	Unlimited
Primary Physician Office Visit	100% after \$30 copay	60% after deductible
Specialist Physician Office Visit	100% after \$30 copay	60% after deductible
Chiropractic Care <i>Subject to A.C.N. Chiropractic Management Program</i>	\$30 per visit; \$500 per calendar year maximum, combined network and non-network	60% after deductible to \$500 per calendar year maximum, combined network and non-network
Preventative Care	Preventive Services Covered at 100%	60% after deductible
Hospital and Other Charges		
Inpatient	80% after deductible	60% after deductible; pre-certification required
Outpatient	80% after deductible	60% after deductible
Emergency Room Charges	\$100 copay per visit if not admitted to Hospital; copay waived if admitted within 48 hours.	Same as network benefits. Notification is required if results in an inpatient stay.
Skilled Nursing Facility (100 Days per Calendar Year)	80% after deductible	60% after deductible; requires pre-certification
Mental Illness, Chemical Dependency		
Inpatient Serious Mental Illness	80% after deductible; pre-certification required	60% after deductible; pre-certification required
Outpatient Serious Mental Illness	\$30 copay per visit	60% after deductible
Inpatient Chemical Dependency	80% after deductible; pre-certification required	60% after deductible; pre-certification required
Outpatient Chemical Dependency	\$30 copay per visit	60% after deductible; pre-certification required
Pharmacy		
Retail (up to a 30 day supply) Generic/Formulary/Non-Formulary	\$10 / \$20 / \$40	50%
Mail Order (31 - 90 day supply) Generic/Formulary/Non-Formulary	\$20 / \$40 / \$80	50%

Mail Order Pharmacy

- Save money with a lower copay and /or a longer lasting supply!
- Enjoy the convenience of having your prescription(s) delivered right to you!
- Get your medication(s) fast! Your initial prescription will arrive in 7 to 14 days. If you utilize the phone-in refill service, your order will be processed and delivered within 5 days!

For more information, please contact Human Resources.

UHC – Choice Plus – UNION PLAN

Plan Features	In-Network	Out-of-Network
Calendar Year Deductible	None	\$ 500 Individual \$1,000 Family
Coinsurance (Plan Pays)	90%	70%
Out-of-Pocket Maximum	\$1,000 Individual \$2,000 Family	\$3,000 Individual \$6,000 Family
Lifetime Maximum	Unlimited	Unlimited
Primary Physician Office Visit	100% after \$15 copay	70% after deductible
Specialist Physician Office Visit	100% after \$15 copay	70% after deductible
Chiropractic Care <i>Subject to A.C.N. Chiropractic Management Program</i>	\$15 per visit; \$500 per calendar year maximum, combined network and non-network	70% after deductible to \$500 per calendar year maximum, combined network and non-network
Preventative Care	Preventive Services Covered at 100%	70% after deductible
Hospital and Other Charges		
Inpatient	90% after deductible	70% after deductible; pre-certification required
Outpatient	90% after deductible	70% after deductible; pre-certification required
Emergency Room Charges	\$100 copay per visit if not admitted to Hospital; copay waived if admitted within 48 hours.	Same as network benefits. Notification is required if results in an inpatient stay.
Skilled Nursing Facility (100 Days per Calendar Year)	90% after deductible	70% after deductible; requires pre-certification
Mental Illness, Chemical Dependency		
Inpatient Serious Mental Illness	90% after deductible; pre-certification required	70% after deductible; pre-certification required
Outpatient Serious Mental Illness	\$15 copay per visit	70% after deductible; pre-certification required
Inpatient Chemical Dependency	90% after deductible; pre-certification required	70% after deductible; pre-certification required
Outpatient Chemical Dependency	\$15 copay per visit	70% after deductible; pre-certification required
Pharmacy		
Retail (up to a 30 day supply) Generic/Formulary/Non-Formulary	\$5 / \$10 / \$20	50%
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For more information, please contact Human Resources.

— Dental Insurance —

UnitedHealthcare – PPO Dental Plan

The Dental Plan helps you with the cost of many dental services, including child orthodontia. Preventive care, such as routine checkups 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.

NETWORK BENEFITS	United Healthcare	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$50	\$50
Family	\$150	\$150
Co-Pay	N/A	N/A
Preventative	100%	100%
Basic	80%	80%
Major	50%	50%
Calendar Year Maximum (Combined)	\$1,000	\$1,000
Orthodontia	50%	50%
Orthodontia Lifetime Maximum	\$750 Children only	\$750 Children only

This Benefit Summary does not provide all of the details about all of the benefit programs. Additional information is available in the Dental Summary Plan Description (SPD). The SPDs are available by request from the Human Resources Department.

If you have any questions, please call the **Human Resources Department** direct at 409-643-5912.

— Vision Insurance —

UnitedHealthcare Specialty Benefits - Vision Plan

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 UHC specialty benefits network. If you use an out-of-network provider, you will pay full fees to the provider, and you will be reimbursed for services rendered up to a maximum allowance.

Major features of the Vision Plan Include:

- **Eye Exams** – The plan covers a yearly eye exam at 100% after a \$10 copayment.
- **Eyeglasses** – The plan offers frames every 2 years (lenses every year) at 100% after a \$25 materials copayment.
- **Contact Lens Benefits (in lieu of eye glasses)** - The plan offers a contact lens fitting and evaluation exam (in lieu of eye glasses exam) every year at 100% after a \$10 copayment. This exam is in addition to your vision exam to ensure proper fit of contacts.

Schedule of Benefits	UHC Specialty Benefits	
	In-Network	Out-of Network
Examination	100%	up to \$40
Single Vision	100%	up to \$40
Bifocal	100%	up to \$60
Trifocal	100%	up to \$80
Lenticular	100%	up to \$80
Frame	100%	up to \$45
Contact Lenses Necessary:	100%	up to \$210
Elective:	up to \$105	up to \$105
Exam Co-pay:	\$10	Subject to allowable reimbursement as stated above
Materials Co-pay:	\$25	
Service Frequency		
Examination:		12 Months
Lenses:		12 Months
Frames:		24 Months



— Life & AD&D Insurance —

Life Insurance & AD&D for You

City of Texas City provides a mandatory Basic Life insurance and Accidental Death & Dismemberment (AD&D) coverage equal to three times your annual earnings, to a \$150,000 maximum (\$50,000 minimum). If you die, the beneficiary you have designated will receive the amount of your life insurance. If you have AD&D coverage and suffer a covered injury, such as the loss of a limb or an eye, you would receive a portion of your AD&D benefits. All life premiums are after tax deductions.

— Disability Insurance —

Disability Income Benefits

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

LTD Plan Features	
Eligibility Requirement	Full-time active - after 3 months of continuous employment
Benefits Waiting Period	180 Days
Percentage of Income Replaced	60% of base salary
Maximum Benefit	\$6,000/month
Duration of Benefits	As long as you remain disabled, or until you reach Social Security Normal Retirement Age



— Flexible Spending — Accounts (FSA)

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses not covered by their insurance plan with pre-tax dollars. You decide how much to contribute to the account, up to **\$2,500** per plan year. The money can be used to reimburse yourself for eligible health care expenses not covered by any insurance, such as plan deductibles, coinsurance, or copayments. The account can be used to receive tax-free reimbursement of expenses for you, your spouse, your children and anyone you claim as a dependent on your federal income tax return, regardless of whether you cover the dependent on your insurance.

Dependent Care FSA

The Dependent Care FSA lets employees use pre-tax dollars towards qualified dependent care such as caring for children under the age 13 or caring for elders. You decide how much to contribute, up to **\$5,000** per year per household. You may use the account for reimbursement for any dependent that lives with you and relies on you for more than half of his or her financial support. You must claim the person as a dependent on your federal income tax return. You may only be reimbursed for care that enables you to work, not occasional babysitters. If you are married, your spouse must also work, be a full-time student or be disabled. Eligible care includes care in your home, someone else's home, or a licensed day care facility, and includes care provided by a relative as long as the person is not your spouse, child under age 19, or someone you claim as your dependent.

Eligible dependents include: children under age 13, and disabled dependents of any age (such as your disabled spouse, older child, or parents).

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.

— Supplemental Insurance —

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

Compliments 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.*

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

**— December 1, 2011 to November 30, 2012
Rate Sheet —**

MEDICAL - CORE	Funding Rate	City Cost*	Employee Cost	Retiree Cost
Employee only	\$490.75	\$490.75	\$0.00	\$490.75
Employee & Family	\$1,150.79	\$820.77	\$330.02	\$1,150.79
MEDICAL - BUY-UP	Funding Rate	City Cost*	Employee Cost	Retiree Cost
Employee only	\$697.71	\$697.71	\$0.00	\$697.71
Employee & Family	\$2,299.05	\$1,498.38	\$800.67	\$2,299.05
DENTAL	Funding Rate	City Cost*	Employee Cost	Retiree Cost
Employee only	\$24.20	\$24.20	\$0.00	\$24.20
Employee & Family	\$60.50	\$42.35	\$18.15	\$60.50
VISION - CORE	Rate (Fully insured)	City Cost*	Employee Cost	Retiree Cost
Employee only	\$6.40	\$6.40	\$0.00	\$6.40
Employee & Family	\$13.71	\$10.16	\$3.55	\$13.71
VISION - BUY-UP	Rate (Fully insured)	City Cost	Employee Cost	Retiree Cost
Employee only	\$6.40	\$0.00	\$6.40	\$6.40
Employee & Family	\$13.71	\$0.00	\$13.71	\$13.71

* City cost includes 100% of employee only cost and 50% of dependent cost.

COBRA RATES		
100% of the Medical, Dental and Vision rate. Does not include 2% admin fee.		
	CORE	BUY-UP
Employee only	\$521.35	\$728.31
Employee & Family	\$1,225.00	\$2,373.26

— Notifications/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.

To request special enrollment or obtain more information, please see your location's Benefit Contact.

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.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)

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).

NOTICE OF THE GROUP HEALTH PLAN'S PRE-EXISTING CONDITION LIMITATION

This health plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should provide a copy of any certificates of creditable coverage you have. If you do not have a certificate but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact your location's Benefit Contact if you need help demonstrating creditable coverage.

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 the City of Texas City Group Health Plan. Individuals may request enrollment for such children for 30 days from the date of the notice. Enrollment will be effective retroactively to January 1, 2011. For more information contact City of Texas City Human Resources.

GRANDFATHERED HEALTH PLAN DISCLOSURE

This City of Texas City Group Health Plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 409-643-5912. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

LIFETIME LIMIT NO LONGER APPLIES AND ENROLLMENT OPPORTUNITY

The lifetime limit on the dollar value of benefits under the City of Texas City Group Health 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. For more information contact City of Texas City Human Resources at 409-643-5912.

COBRA

If your employment terminates for any reason, other than gross misconduct, you and/or your covered dependents may be able to continue medical and dental coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You are eligible for COBRA continuation when you terminate employment with City of Texas City. Your covered dependents are eligible for COBRA continuation when you terminate employment, divorce, die, or when your dependent children are no longer eligible due to age. Details will be provided if you or your dependents become eligible for COBRA. When you elect COBRA coverage, you pay the entire cost of coverage plus an administrative fee.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP 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.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtprecovery.com/ Phone: 1-877-357-3268
CALIFORNIA – Medicaid	GEORGIA – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	MONTANA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-8183
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561
MAINE – Medicaid	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839	

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nc.gov Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	VERMONT – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml Phone: 1-888-564-9669	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtml Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: www.dhr.wv.gov/bms/ Phone: 304-558-1700
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531
UTAH – Medicaid and CHIP	
Website: http://health.utah.gov/upp Phone: 1-866-435-7414	

To see if any more States have added a premium assistance program since July 31, 2011, or for more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

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 GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of City of Texas City's Group Health Plan (the "Plan") to protect the privacy of your medical information. The Plan provides health, dental and flexible spending account benefits to you as described in your summary plan description and/or certificate of coverage for benefits. The Plan receives and maintains your medical information in the course of providing these benefits to you. The plan hires business associates (for example, insurance brokers and claims administrators) to help it provide these benefits to you. These business associates also receive and maintain your medical information in the course of assisting the Plan. The Plan is sponsored by City of Texas City (the "Plan Sponsor"). THE EFFECTIVE DATE OF THIS NOTICE IS APRIL 14, 2003. The Plan is required to follow the terms of this Notice until it is replaced. The Plan reserves the right to change the terms of this notice at any time. If the Plan makes changes to this notice, the Plan will revise it and send a new Notice to all employees and COBRA beneficiaries covered by the Plan at that time. The Plan and the Plan Sponsor reserve the right to make the new changes apply to all your medical information maintained by the Plan before and after the effective date of the new Notice.

Purposes for which the Plan May Use or Disclose Your Medical Information Without Your Consent or Authorization

The Plan may use and disclose your medical information for the following purposes and to the following people or businesses:

Health Care Providers' For Treatment: The Plan may disclose your medical information to your doctor or other health care treatment provider, at the provider's request, for your treatment by the provider.

For Payment: The Plan may use or disclose your medical information to pay claims for covered health care services or to provide eligibility information to your health care provider when you receive treatment.

For Health Care Operations: The Plan may use or disclose your medical information (i) to conduct quality assessment and improvement activities, (ii) for underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a contract of health insurance, (iii) to authorize business associates to perform data aggregation services, (iv) to engage in care coordination or case management, and (v) to manage, plan or develop the Plan's business.

For Health Services: The Plan may use your medical information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan may disclose your medical information to its business associates to assist the Plan in these activities.

As required by law: The Plan must allow the U.S. Department of Health and Human Services to audit Plan records. The Plan may also disclose your medical information as authorized by and to the extent necessary to comply with workers' compensation or other similar laws.

To Business Associates: The Plan may disclose your medical information to business associates the Plan hires to assist the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your medical information.

To Plan Sponsor: The Plan may disclose to the Plan Sponsor, in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also disclose to the Plan Sponsor the fact that you are enrolled in, or disenrolled from the Plan. The Plan may disclose your medical information to the Plan Sponsor for Plan administrative functions that the Plan Sponsor provides to the Plan if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your medical information. The Plan Sponsor must also agree not to use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor.

For Other Local Reasons: The Plan may also use and disclose your medical information as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or

with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this.

- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To a governmental agency authorized to oversee the health care system or government programs.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes.
- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.

Uses and Disclosures with Your Permission

The Plan will not use or disclose your medical information for any other purpose than those stated above unless you give the Plan your written authorization to do so. If you give the Plan written authorization to use or disclose your medical information for a purpose that is not described in this Notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information the Plan maintains, unless the Plan has already taken action in reliance on your prior authorization.

Your Rights

You may make a written request to the Plan to do one or more of the following concerning your medical information that the Plan maintains:

- To put additional restrictions on the Plan's use and disclosure of your medical information. The Plan does not have to agree to your request.
- To communicate with you in confidence about your medical information by a different means or at a different location than the Plan is currently doing. The Plan does not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plan to collect premiums and pay claims. Your request must specify the alternative means or location to communicate with you in confidence. Even though you request that we communicate with you in confidence, the Plan may give its subscribers cost information.
- To see and get copies of your medical information.
- To correct your medical information. In some cases, the Plan does not have to agree to your request.
- To receive a list of disclosures of your medical information that the Plan and its business associates made for certain purposes for the last six (6) years (but not for any disclosures before April 14, 2003).
- To send you a paper copy of this notice if you received this notice by e-mail or on the internet.

If you want to exercise any of these rights described in this notice, please contact the Privacy Officer at the address given below. The Plan will give you the necessary information and forms for you to complete and return to the Privacy Officer. In some cases, the Plan may charge you a nominal, cost-based fee to carry out your request.

Complaints

If you believe your privacy rights have been violated by the Plan, you have the right to complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Plan at the address listed below. We will not retaliate against you if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Contact Privacy Officer

If you need additional copies of this Notice, want to report a violation of this Notice, or to receive more information about our privacy practices or your rights, please contact us at the following Contact Office:

Human Resources: Human Resource Manager

Telephone: 409-643-5912

Address: 1801 9th Avenue North Texas City, Texas 77590-2608

