2019 Benefits Guide

For Retirees and Surviving Dependents

Medical

Vision

Dental

Life Insurance

Wellness

Important Information for Retirees and Surviving Dependents

City of Austin retirees and surviving dependents of City retirees have access to benefits approved by the City Council each year as part of the budget process. The benefits and services offered by the City may be changed or terminated at any time.

This Guide is designed to help you understand your benefits. Review this material carefully before making your enrollment decisions. Keep this Guide to refer to during the 2019 Plan Year.

Your rights are governed by each plan instrument, which may be a Summary Plan Description (SPD), evidence of coverage, or contract, and not by the information in this Guide. If there is a conflict between the provisions of the plan you selected and this Guide, the terms of the plan govern. For detailed information about the plans, refer to each plan instrument or contact the vendor directly.

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The City of Austin is committed to compliance with the Americans with Disabilities Act. Call the Human Resources Department at *512-974-3400* (voice) or *800-735-2985* (Relay Texas TTY number) for more information.

Contact Information

City of Austin
Human Resources Department
Employee Benefits Division

Benefits staff are available to answer questions you have about your benefits.

Phone Number: 512-974-3284
Email: HRD.Benefits@austintexas.gov
Fax Number: 512-974-3420

We recommend making an appointment before visiting our office.

Office Hours: 7:30 a.m. to 5:00 p.m.
Office Location: 505 Barton Springs Road, Suite 600

Online Resources
To access benefits information, go to austintexas.gov/retirees.

You can also view eligibility requirements, plan choices, print the City's retiree benefits guide, and find information about the City's other benefits.

Scan the QR code below for easy access to the Retiree Benefits webpage.

BlueCross BlueShield
Medical Plans

Member Service Phone Number: 800-521-2227
24/7 NurseLine Phone Number: 800-581-0368
Prescription Information: myprime.com

To find a medical provider, go to bcbstx.com.

1. Click ***Find a Doctor or Hospital***.
2. Click the ***Search as Guest***.
3. Click ***Search In-Network providers***.
4. Under "How do you get your insurance," select ***Through my employer or my spouse's employer***.
5. Under "Are you a member or are you shopping for an insurance plan," select ***I am a member***.
6. Under "Select type of care you are looking for," select ***Medical or Pharmacy***.
7. Under "Where you live?" Select your state.
8. Under "Select Plan/Network," select your medical plan.
   For PPO & CDHP members, select ***Blue Choice PPO***.
   For HMO members, select ***Blue Essentials***.

To view the prescription formulary, Explanation of Benefits, and print a temporary ID card, go to bcbstx.com. To register, follow these steps:

1. Go to bcbstx.com/member.
2. Click ***Sign Up*** or ***Log in*** button.
3. Click ***Register Now***.
4. Follow the prompts to register.
5. Enter information from your ID card. If you do not have your ID card, you can call the Internet Help Desk at 888-706-0583.

Contact each benefits vendor directly for identification cards, claims, benefits, and coverage information.

Davis Vision
Vision Plan

Toll-Free Number: 888-445-2290

To view benefits, locate a provider, and check claim status, go to davisvision.com. To register, follow these steps:

1. Click the ***Members*** link.
2. Click the ***Register*** link.
3. Enter information from your ID card.
4. Create a username, password, and security question.
5. Click the ***Register*** button.

For non-members, click on the ***Member*** link and enter **2481** for the Client Code.

Cigna Dental PPO Plan

Toll-Free Number: 800-244-6224
Office Hours: 24/7, seven days per week.
Website: mycigna.com

To register, follow these steps:

1. Click the ***Register Now*** button.
2. Enter your personal information.
3. Confirm your identity.
4. Create your security information and provide your primary email address.
5. Review and hit the ***Submit*** button.

Sun Life Financial

Toll-Free Number: 800-443-2995
Office Hours: 7 a.m. to 7 p.m. Monday through Thursday
7 a.m. to 6 p.m. Friday
Website: sunlife.com/onlineadvantage

To register, follow these steps:

1. Click the ***Register for Online Advantage*** link.
2. Enter your name and email.
3. You will receive an email from Sun Life Financial.
4. Select the link in the email to continue your registration.

City of Austin Employees' Retirement System (COAERS)

418 E. Highland Mall Blvd.
Austin, TX 78752-3720

Phone Number: 512-458-2551
Fax Number: 512-458-5650
Website: coaers.org

Austin Fire Fighters Relief and Retirement Fund (AFRS)

4101 Parkstone Heights Dr., Suite 270
Austin, TX 78746

Phone Number: 512-454-9567
Fax Number: 512-453-7197
Website: afrs.org

City of Austin Police Retirement System (PRS)

2520 South IH-35, Suite 100
Austin, TX 78704

Phone Number: 512-416-7672
Fax Number: 512-416-7138
Website: ausprs.org

Austin Deferred Compensation Plan
457 Plan (Empower Retirement)

Toll-Free Number: 866-613-6189

To view and manage your account, go to dcaustin.com. To enroll, click the ***Register*** button.

Eligibility

As a City retiree, you are eligible to enroll in medical, dental, and vision coverage. Retirees may also elect to enroll their eligible dependents. Below is a list of eligible dependents. Each of these individuals may or may not be your dependent for federal tax purposes. That determination depends on federal law.

Eligible Dependents

Your dependents who meet the descriptions listed below can be enrolled for benefits.

- **Spouse:** Your legally married spouse, including a common-law spouse.
- **Domestic Partner:** The individual who lives in the same household and shares the common resources of life in a close, personal, intimate relationship with a City retiree if, under Texas law, the individual would not be prevented from marrying the retiree on account of age, consanguinity, or prior undissolved marriage to another person. A domestic partner may be of the same or opposite gender as the retiree.
- **Children:** Your biological children, stepchildren, legally adopted children, children for whom you have obtained court-ordered guardianship or conservatorship, qualified children placed pending adoption, and children of your domestic partner if you also cover your domestic partner for the same benefit. Your children must be under 26 years of age.
- **Dependent Grandchildren:** Your unmarried grandchild must meet the requirements listed above, and must also qualify as a dependent (as defined by the Internal Revenue Service) on your or your spouse's federal income tax return.
- **Disabled Children:** To continue City coverage for an eligible dependent past the age limit, the child must be covered as a dependent at the time, unmarried, and must also meet the following definitions:
  - ❖ A disabled child must rely on you for more than 50 percent of support.
  - ❖ A child is considered disabled if they are incapable of earning a living at the time the child would otherwise cease to be a dependent and depend on you for principal support and maintenance, due to a mental or physical disability.
  - ❖ A disabled child continues to be considered an eligible dependent as long as the child remains incapacitated and dependent on you for principal support and maintenance, and you continuously maintain the child's coverage as a dependent under the plan from the time they otherwise would lose dependent status.
  - ❖ A dependent child who loses eligibility and later becomes disabled is not eligible for coverage. A disabled child who was not covered as a dependent immediately prior to the time the child would otherwise cease to be a dependent is not eligible for coverage.
  - ❖ A disabled child must be covered continuously on the medical and dental plans. If coverage is dropped, the disabled child will not be allowed to re-enroll.

Eligible surviving dependents of a City retiree may enroll in medical, dental, and vision coverage. Domestic partners and children of domestic partners are eligible for Continuation of Coverage of Domestic Partners only.

Covering dependents who are not eligible for the City's insurance programs unfairly raises costs for the City, as well as for all participants in the programs.

Persons Not Eligible

Dependents do not include:

- Individuals on active duty in any branch of military service (except to the extent and for the period required by law).
- Permanent residents of a country other than the United States.
- Parents, grandparents, or other ancestors.
- Grandchildren who do not meet the definition of dependent grandchildren and who are not claimed on your or your spouse's federal tax return.

An individual is not eligible to be covered:

- As both a City employee and a City retiree, for the same benefit.
- As both a City employee or City retiree and as a dependent of a City employee or City retiree, for the same benefit.
- As a dependent of more than one City employee or City retiree, for the same benefit.

Life Qualifying Event:

When you add or drop a dependent during Open Enrollment, the change is effective January 1, 2019. For changes to be effective immediately, call the Employee Benefits Division at *512-974-3284* within 31 days to schedule an appointment with a Benefits representative.

Dependent Documentation

If you are adding a dependent under any of the City's benefits programs, you must provide documentation that supports your relationship to the dependent. **Social Security Numbers must be provided for all eligible dependents**.

Acceptable documents are listed below for the following dependents:

- **Spouse:** A marriage certificate which has been recorded as provided by law.
- **Domestic Partner:** A Domestic Partnership Affidavit and Agreement form signed by the retiree and domestic partner. Also a Domestic Partnership Tax Dependent Status Form signed by the retiree.
- **Child:** A certified birth certificate, complimentary hospital birth certificate, Verification of Birth Facts issued by the hospital, or court order establishing legal adoption, guardianship, or conservatorship, or qualified medical child support order or the subject of an Administrative Writ.
- **Child of a Domestic Partner:** The documentation listed above must also be provided and the domestic partner must be covered for the same benefit in order to cover a child of a domestic partner.
- **Stepchild:** The documentation listed above must also be provided and a marriage certificate or declaration of informal marriage indicating the marriage of the child's parent and stepparent.
- **Dependent Grandchild:** The documentation listed above must also be provided and a marriage certificate or declaration of informal marriage that supports the relationship between you and your grandchild.
- **Disabled Child:** A completed Dependent Eligibility Questionnaire verifying an ongoing total disability, including written documentation from a physician verifying an ongoing total disability.
- **Qualified Child Pending Adoption:** For children already placed in your home, an agreement executed between you and a licensed child-placing agency or TDFPS, which meets the requirements listed in Dependent Eligibility.

Coverage Information

Changing your Benefits Coverage

To change your benefits coverage, you must call the Employee Benefits Division to schedule an appointment. You can request changes to your benefits:

- Within 31 days of a Qualifying Life Event.
- Within 31 days of the date you initially become eligible.
- If you are enrolled in the HMO and move outside the plan's service area.
- If you are enrolled in Sun Life Financial and move where there are no providers in your service area.

If you miss the deadlines listed above, you must wait until the next Open Enrollment. To drop coverage for your dependents who no longer meet eligibility requirements, you must call the Employee Benefits Division to complete a Benefits Enrollment Form.

Benefits Enrollment for Surviving Dependents

To be covered, the dependent must have been enrolled in a City-sponsored plan at the time of the retiree's death. As a surviving dependent, you are eligible for medical, dental, and vision benefits. If at any time you cancel all benefits, you cannot re-enroll in surviving dependent benefits.

Qualifying Life Events

You can add, drop, or change coverage for yourself and your dependents when you experience a Qualifying Life Event such as: marriage, divorce, birth, adoption of a child, death of a dependent, establishing a committed living arrangement as domestic partners, dissolution of domestic partnership, loss or gain of other coverage, or change in employment. You must call the Employee Benefits Division within 31 days of the Life Qualifying Event to schedule an appointment to complete a Benefits Enrollment Form.

In the case of a **newborn dependent**, your newborn is **temporarily covered** for medical for 31 days. After 31 days, if you do not complete a Benefits Enrollment Form and pay any required premiums to add your newborn, your newborn will no longer have coverage even if you have Employee and Family coverage.

Retiree Coverage Ending Dates

Coverage for you and your dependents will end on the last day of the month if:

- You fail to pay any required premium.
- The City ceases to offer coverage to retirees.
- The plan in question is terminated.
- The coverage in question is terminated or reduced.
- You voluntarily terminate your or your dependent's coverage.
- You or your dependents no longer meet eligibility requirements.

Surviving Dependent Coverage End Dates

Coverage for you and your dependents will end on the last day of the month if:

- You fail to pay any required premium.
- You remarry. (Only applies to retiree's surviving spouse).
- You are covered under another group plan, except for Medicare.
- The City ceases to offer coverage to surviving dependents.
- The plan in question is terminated or reduced.
- The coverage in question is terminated or reduced.
- You voluntarily terminate your or your dependent's coverage.
- You or your dependents no longer meet eligibility requirements.

Canceling Coverage

You may cancel medical coverage for yourself and your dependents, if applicable, at any time during the calendar year. However, you may not drop dental or vision coverage during the calendar year unless it corresponds with a change in family status.

Exception: If you are covered by Sun Life Financial, and you move where there are no plan providers in your service area.

Medicare Eligibility Requirements

A retiree or a surviving spouse/domestic partner eligible for Medicare due to age must enroll in Medicare Parts A and B. When you or your covered spouse/domestic partner are enrolled in Medicare, Medicare is considered primary and will pay benefits before the City's sponsored medical plan you have selected considers payment for covered services. If the Medicare-eligible retiree or surviving spouse/domestic partner does not enroll in Medicare Parts A and B, benefits will be reduced to the amount that would have been payable had he or she enrolled in Medicare Parts A and B. For information about Medicare Part D, refer to "Your Prescription Drug Coverage and Medicare" under "Important Benefits Information in this Guide."

Coordination of Benefits

Coordination of Benefits is a group health insurance policy provision that provides a method for determining which coverage will apply (primary or secondary) when an individual is covered under more than one plan. It also keeps benefits paid from exceeding the amount of expenses incurred. In most cases, medical coverage offered through the City is considered primary for you while you are under age 65. If you or your dependents have other coverage, refer to the appropriate plan document for information about Coordination of Benefits.

Medical Plans

As a retiree, you may choose the medical plan that best meets your needs. Provider information is available online at bcbstx.com. Pharmacy information is available online at myprime.com . Select ***Blue Choice PPO*** for the CDHP w/ HRA and PPO. Select ***Blue Essentials*** for the HMO.

BlueCross BlueShield of Texas

Things to consider when choosing a medical plan:

- Premium costs for dependent coverage.
- Amount of copays.
- Amount of out-of-pocket expenses.
- Future expenses and the predictability of inpatient hospital expenses.
- Freedom to not designate a Primary Care Physician.
- Freedom to seek services from a Specialist without a referral.

For treatment before your ID card arrives

You will need to pay for the services out-of-pocket, then submit a claim form and your receipt to BlueCross BlueShield.

If you are enrolled in the CDHP w/HRA or PPO and utilize a non-network doctor or facility, the amount will be applied toward your out-of-network deductible. If you are enrolled in the HMO, you must use the Primary Care Physician you designated.

CDHP w/HRA

CDHP w/HRA is the Consumer Driven Health Plan with a Health Reimbursement Account. Like the PPO and HMO medical plans, the CDHP w/HRA is administered by BlueCross BlueShield. The same network of doctors and facilities as those on the PPO and HMO plans are available. Despite these similarities, the plan works differently. Read on to see if the CDHP w/HRA plan is right for you.

Why the City is Offering the CDHP w/HRA

Research shows that many large employers offer some type of Consumer Driven Health Plan. The City is concerned with the rising costs of health care. The CDHP w/HRA features lower premiums when covering dependents, a Health Reimbursement Account, and higher out-of-pocket costs for non-preventive services, which enable you to be a wise consumer of health care. The City and BlueCross BlueShield provide you with tools to make the cost of health care more transparent. This allows you to consider the cost of a provider or facility before making the decision of where to seek care.

Plan Features

- Retiree Only in-network deductible is $1,500. For Retiree with Dependent coverage, the deductible is $3,000.
- Retiree Only in-network, out-of-pocket maximum is $5,000. For Retiree with Dependent coverage, the out-of-pocket maximum is $6,850.
- Out-of-network coverage is available at higher deductibles, coinsurance and maximum out-of-pocket charges.
- The City will contribute money into your HRA account on an annual basis based on your years of service.

City annual contributions to the HRA

Years of Service	Retiree Only	Retiree & Dependent
Less than 5	$ 200	$ 300
5 through 9	$ 400	$ 600
10 through 14	$ 600	$ 900
15 through 19	$ 800	$1,200
20 or more	$1,000	$1,500

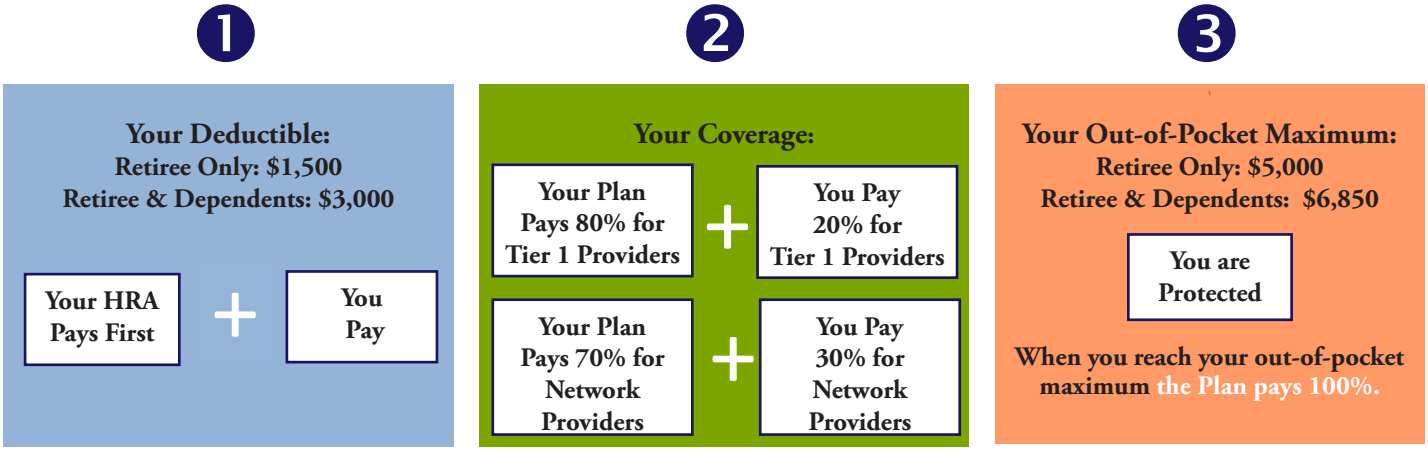
How the CDHP w/HRA Works

Before enrolling in the CDHP w/HRA, it is important to understand how the plan works. Here are a few things to know about this plan:

- Preventive services mandated by the Affordable Care Act continue to be covered at 100 percent.
- Except for preventive services, you must meet your calendar year deductible for medical services before the plan pays for any covered services.
- Once you meet your calendar year deductible, the plan will pay 80 percent of Tier 1 providers covered services and 70 percent for Network providers covered services.
- Once you meet your calendar year out-of-pocket maximum, the plan will pay 100 percent for all in network covered services and prescriptions.
- The CDHP w/HRA includes three prescription formularies:
  - ACA Preventive Drugs – The plan pays 100 percent, no deductible.
  - HSA Preventive Drug List – The plan will pay 80 percent, no deductible. The list of expanded preventive medications can be found on the Retiree Benefits web page at austintexas.gov/retirees.
  - Basic Drug List (Tier 1, 2, & 3 Drugs) – The plan will pay 80 percent after you meet your deductible.

The City funds a Health Reimbursement Account (HRA) for you. An HRA is an account that helps pay for eligible health care expenses, including those that may apply to your annual deductible.

Even though the City owns the money in the HRA, think of it as yours. By doing so, you'll realize that spending your HRA wisely can help you save. As long as you have money in your HRA, that's less you have to pay out of your pocket for health care expenses. HRA money does not rollover each year.



Preventive care is covered at 100% in Blue Choice PPO network.

1. Your Deductible.
Your HRA pays first. When you have an eligible expense, like a doctor visit, the entire cost of the visit will apply to your deductible. The HRA will pay for all of your eligible expenses first, up to the amount contributed by the City. This means you won't have to pay anything until the money in the HRA is spent.

If you spend all of the HRA money, you will need to pay out of pocket. You will need to pay the full cost of your health care expenses until the remaining deductible is met.

2. Your Coverage.
Your plan pays a percentage of your expenses. Once the deductible is met, the CDHP w/HRA plan has coinsurance. With coinsurance, the plan shares the cost of expenses with you. The plan will pay 80 percent of each eligible expense and you pay 20 percent for Tier 1 Providers. The plan will pay 70 percent of eligible expenses and you pay 30 percent for Network Providers.

3. Your Out-of-Pocket Maximum.
You are protected from major expenses. The out-of-pocket maximum amount is the most you have to pay each year for covered services. The out-of-pocket maximum for the CDHP w/HRA plan is $5,000 for Retiree Only coverage. For Retiree with Dependent coverage, the out-of-pocket maximum is $6,850 for family. The plan will then pay 100 percent of all remaining covered expenses, including prescriptions, for the rest of the plan year. Your deductible and coinsurance will go toward your out-of-pocket maximums.

CDHP w/HRA Schedule of Benefits

Preventive services include annual physical, colonoscopy, mammogram, well woman exam, and well baby check. To find the CDHP Preventive Drug List go to austintexas.gov/retirees.

Medical Benefits	CDHP (BlueChoice PPO)		Out-of-Network
	Tier 1 Providers	Network Providers	
Deductible	$1,500 - Retiree Only $3,000 - Retiree & Dependents		$3,000 - Retiree Only $6,000 - Retiree & Dependents
Preventive Services	Plan pays 100%.		Plan pays 60% after deductible.
Eligible Covered Services & Facilities	Plan pays 80% after deductible.	Plan pays 70% after deductible.	Plan pays 60% after deductible.
Out-of-Pocket Calendar Year Maximum	$5,000 - Retiree Only $6,850 - Retiree & Dependents		$10,000 - Retiree Only $20,000 - Retiree & Dependents
Primary Care Physician (PCP)	PCP selection is not required.		
Referrals Required	No. A referral is not required to seek services from a Specialist.		
Virtual Visit Copay	Approximately $49		Not applicable.

Tier 1 Providers – Providers designated as providing higher quality of care and cost efficiency.

CDHP Vision Benefits

Routine Vision Eye Exam	CDHP (Blue Choice PPO)	Out-of-Network
Optometrists	Plan pays 80% after deductible.	Plan pays 60% after deductible.
Ophthalmologists	Plan pays 80% after deductible.	Plan pays 60% after deductible.
Frames, Standard Lenses, and Contact Lenses	For discounts, visit Blue365 at blue365deals.com/bcbstx.	For discounts, visit Blue365 at blue365deals.com/bcbstx.

CDHP Pharmacy Benefits

Plan Features (In-Network)	CDHP (Blue Choice PPO)
Affordable Care Act (ACA) Preventive Drugs	Plan pays 100%.
HSA Preventive Drug List	Plan pays 80%. No deductible.
Basic Drug List - Tier 1, 2 & 3	Plan pays 80% after deductible.
90-Day Supply - Mail Order	Plan pays 80% after deductible.

Pharmacy Drug Lists can be found at: austintexas.gov/benefits.

PPO & HMO Schedule of Benefits

	PPO (Blue Choice PPO)		HMO (Blue Essentials)	
	Tier 1 Providers	**Network Providers**	**Tier 1 Providers**	**Network Providers**
Individual Deductible	$500 per covered person.		None.	
Family Deductible Maximum	Three individual deductibles.		None.	
Out-of-Pocket Maximum	$4,000 per covered person or $12,700 per family, per calender year.		$4,500 per covered person or $8,000 per family, per calender year.	
Provider Selection	Members **may** select Tier 1, Network, or Out-of-Network Providers.		Members **must** select Tier 1 or Network Providers. Referrals are required to receive services from a Specialist. No benefits coverage without a referral.	
Primary Care Physician (PCP)	PCP selection is not required.		PCP selection is required. If a PCP is not selected, one will be assigned. You **will be** required to seek services from the assigned PCP. To change your PCP, call BlueCross BlueShield. You may change PCPs on a monthly basis.	
Referrals Required	No. A referral is not required to seek services from a Specialist.		Yes. A referral is required to seek services from a Specialist. No benefits coverage without a referral.	
Residency Requirements	None.		**Must** receive services in Bastrop, Blanco, Burnet, Caldwell, Hays, Travis, or Williamson counties. No benefits coverage outside of this area.	
Out-of-Network Benefits	$1,500 deductible per covered person. Plan pays 60%, up to maximum allowable charge. Out-of-network benefits are subject to network benefit plan limits, pre-approval, and pre-notification requirements. Outpatient Surgery and Inpatient Admissions are subject to a $250 per day facility fee.		None, except in case of a medical emergency.	

PPO & HMO Schedule of Benefits

	PPO (Blue Choice PPO)		HMO (Blue Essentials)	
	Tier 1 Providers	**Network Providers**	**Tier 1 Providers**	**Network Providers**
Preventive Exams	Plan pays 100%.		Plan pays 100%.	
Virtual Visit Copay	$10		$10	
Office Visit Copay Primary Care Specialist	$10 $25	$25 $45	$10 $35	$25 $55
Convenience Care Clinics Copay	$25		$25	
Urgent Care Copay	$35		$45	
Emergency Room Copay	$200		$250	
Ambulance Services	Plan pays 80% after deductible.		$200 copay	
Outpatient Surgery	Plan pays 80% after deductible.	Plan pays 70% after deductible.	$750 copay.	$1,000 copay.
Inpatient Admission	Plan pays 80% after deductible.	Plan pays 70% after deductible and $250 copay.	$1,500 copay.	$2,500 copay.
Allergy Services Immunizations	Plan pays 100%. Plan pays 100%. Office visit copays may apply.		Plan pays 50%. Plan pays 100%. Office visit copays may apply.	
Physical, Speech and Occupational Therapy Registered Dietitian Chiropractic Care Copay (20 visit limit)	$35		$45	
Acupuncture Copay (12 visit limit)	$35		Not covered.	
CT, MRI, PET Scans Copay	$100		$150	
Mental Health Care Outpatient Copay	$10		$10	
Durable Medical Equipment	Plan pays 80% after deductible.		Plan pays 100%.	
Disposable Medical Supplies Prosthetic-Orthotic Devices Insulin Pumps and Related Supplies	Plan pays 80% after deductible.		Plan pays 80%.	
Hearing Aids	Not covered.		One pair every 48 months.	
Other Covered Medical Expenses	Refer to your Medical Plan Document or contact BlueCross BlueShield.			

PPO & HMO Vision Benefits

Routine Vision Exam	PPO (Blue Choice PPO)	HMO (Blue Essentials)
Optometrists	$25	$25
Ophthalmologists	$35	$45
Frames, Standard Lenses, and Contact Lenses	For discounts, visit Blue365 at blue365deals.com/bcbstx.	For discounts, visit Blue365 at blue365deals.com/bcbstx.

PPO & HMO Pharmacy Benefits

Plan Features (In-Network)	PPO (Blue Choice PPO)		HMO (Blue Essentials)	
Affordable Care Act (ACA) Preventive Drugs	Plan Pays 100%.		Plan Pays 100%.	
Basic Drug List -Tier 1	$10 copay.		$10 copay.	
Basic Drug List - Tier 2 & 3	$50 annual deductible applies.		$50 annual deductible applies.	
	Tier 2: **$30** or 20% of cost (up to **$60**).	Tier 3: **$50** or 20% of cost (up to **$100**).	Tier 2: **$35** or 20% of cost (up to **$70**).	Tier 3: **$55** or 20% of cost (up to **$110**).
90-Day Supply - Mail Order	2 x's Tier 1, 2, or 3 copay.		3 x's Tier 1, 2, or 3 copay.	

Applies to the CDHP w/HRA, HMO, and PPO

Diabetic Supplies	
Retail	Supplies are covered at a participating pharmacy.
Mail Order	Copays for insulin needles/syringes and/or diabetic supplies are waived when dispensed on the same day as your insulin and oral agents, but only when the insulin or oral agent is dispensed first.

Diabetes Program/Drugs

A participant can receive approved diabetes medication and supplies for free if the participant is covered under a City sponsored medical plan, at least 18 years of age, and completes requirements of the HealthyConnections Diabetes Program.

This benefit does not include medications prescribed for related issues and durable medical equipment. Supplies for the continuous glucose monitors are covered if obtained through a retail pharmacy provider.

Tobacco Cessation Program/Drugs

A participant can receive FDA-approved tobacco-cessation drugs for free, if the participant is covered under a City sponsored medical plan, at least 18 years of age, and completes requirements of the HealthyConnections Tobacco
Cessation Program. Must obtain a prescription for tobacco cessation drugs from your physician.

This applies to prescription tobacco cessation drugs and over-the-counter nicotine replacement therapy (patches, gums, etc.) at a retail pharmacy or through the mail order service.

How To Use Mail Order

The pharmacy benefit offers home delivery through mail order. In some instances, mail order can save you money. Generally, these programs are designed to cover drugs used to treat chronic conditions and medications taken for more than 31 days.

To begin using mail order:

- Have your doctor write a prescription for a 90-day supply of your medication (ask for three refills).
- Complete the mail order form and attach your prescription.
- Provide a check or credit card information.
- Mail this information to the medical plan's mail order pharmacy.

Within 10 days, your prescription will be delivered to you, postage paid.

- **CDHP w/HRA** participants will pay 20 percent of the cost once the in-network deductible is met. Your HRA will pay first. If you do not have money in your HRA, you will pay out-of-pocket. If you have not met your in-network deductible, you will pay 100 percent of the cost. If the prescription is for a preventive care medication listed on the Expanded Preventive Drug List, no deductible is required and you will only pay 20 percent of the cost.
- **PPO** participants receive 90 days of medication for ***two*** copays/coinsurance.
- **HMO** participants receive 90 days of medication for ***three*** copays/coinsurance.

If your doctor allows you to take a generic drug, this should be indicated on the prescription. Three weeks before your mail order supply runs out, you will need to request a refill. For additional information, go to bcbstx.com or call BlueCross BlueShield at *800-521-2227.*

Diabetic Bundling – What Your Medical Plan Does for You

A participant's insulin/non-insulin medication and related diabetic supplies can be purchased through mail order for the cost of the insulin/non-insulin if prescriptions for the insulin/non-insulin and supplies are submitted at the same time.

- **CDHP w/HRA** participants will pay 20 percent of the cost once the in-network deductible is met. Your HRA will pay first. If you do not have money in your HRA, you will pay out-of-pocket. If you have not met your in-network deductible, you will pay 100 percent of the cost.
- **PPO** participants will pay ***two*** copays/coinsurance for a 90-day prescription.
- **HMO** participants will pay ***three*** copays/coinsurance for a 90-day prescription.

Consider participating in the HealthyConnections Diabetes Program to receive Tier 1 diabetes medication and supplies at no cost. This benefit is available to all participants enrolled in a City medical plan who are 18 years of age and older. See the "Wellness" section of this Guide for details.

Medical Programs

Cancer Support Program – Specialized cancer nurses offer needed support to participants throughout cancer treatment, recovery, and at end of life to assist with treatment decisions and improve a participant's health care experience. Experienced, caring cancer nurses from the cancer support program are available to support participants in several ways. They can:

- Find the right doctor for you.
- Explore your treatment options.
- Work with your doctors to make sure all your questions are answered.
- Help you manage symptoms and side effects.
- Talk to your spouse, family, children, and employer.
- Keep your doctors informed about how you're feeling.

Comprehensive Kidney Program – Specialized nurses offer education, motivation, and reinforcement to ensure integration with other programs. BlueCross BlueShield offers access to the top-performing centers through their network of preferred dialysis centers. You'll also receive ongoing clinical expertise and help from specialized nurses who can help you:

- Understand your treatment options.
- Manage your symptoms and side effects.
- Work with your doctor and ask the right questions.
- With other health concerns, such as high blood pressure, anemia, or nutrition.

Special Beginnings – Program available to all expectant mothers. Provides guidance on preventive care, early risk detection, and education. Personalized support is offered for each participant's unique experience. If you're thinking about having a baby, or you already have one on the way, the Maternity Support Program can help. Enroll and get access to an experienced maternity nurse who can help with:

- Immediate answers to your health questions any time, anywhere - 24 hours a day, 7 days a week.
- Access to experience registered nurses.
- Trusted, physician-approved information to guide your health care decisions.

24/7 NurseLine Services – Coping with health concerns on your own can be tough. With so many choices, it can be hard to know whom to trust for information and support. 24/7 NurseLine services were designed specifically to help you get more involved in your own health care, and to make your health decisions simple and convenient.

They will provide you with:

- Immediate answers to your health questions any time, anywhere - 24 hours a day, 7 days a week.
- Access to experience registered nurses.
- Trusted, physician-approved information to guide your health care decisions.

When you call, a registered nurse can help you:

- Discuss your options for the right medical care.
- Understand treatment options.
- Develop a healthy lifestyle.
- Ask medication questions.

Call 24/7 NurseLine services any time for health information and support – at no additional cost. Registered nurses are available any time, day or night. Call NurseLine services at *800-581-0368*.

For more information about any of these programs, call BlueCross BlueShield at *800-521-2227*.

Cost for Coverage

Retirees

The amount you pay for medical coverage is based on the following:

- Years of service with the City.
- Level of coverage (i.e., retiree only, retiree and spouse, retiree and children, etc.).
- Medicare eligibility.
- Disability retirement.

Surviving Dependents

The amount you pay for surviving dependent medical coverage is based on the following:

- City established rates for surviving dependent medical coverage.
- The retiree's years of service with the City.
- Medicare eligibility. (Applies only to the retiree's spouse).

Years of Service for Retiree and Surviving Dependents – Your cost of coverage is determined by continuous years of employment with the City of Austin or creditable years of service, whichever is greater. Years of creditable service are determined by the retirement system and include military or City retirement system buybacks or City-purchased service credit. If any contributions were withdrawn from the retirement system prior to retirement, the creditable service will not include any years for which contributions were withdrawn. Also, years of creditable service will not include any years of employment accrued with an employer, other than the City.

Disability Retirement for Retirees – If you were approved for disability retirement by the retirement system, your cost of medical coverage will be based on 20 years of service.

Medicare Rates – Apply only when Medicare Parts A and B are in effect and a copy of the Medicare card is provided to the Employee Benefits Division. See "Medical Rates" section of this Guide.

Provide a copy of your Medicare card to the Employee Benefits Division two months prior to you or your spouse/domestic partner turning 65 years old.

Premium Payments

Premium payments for coverage must be deducted automatically from the check you receive from the retirement system. If the monthly retirement check is not enough to pay for coverage selections, you must make arrangements with the Employee Benefits Division at *512-974-3284* to pay the premium. Payment coupons will be provided and must be returned with the payment. Payments must be made on a monthly basis and are due on the first day of the month of coverage. If payment is not received within the required timeline, coverage will be terminated.

Premium Deduction Errors

Data Entry Error/Delay

If a data entry error occurs or if data entry is delayed, it will not invalidate the coverage reflected on your enrollment form. Upon discovery, an adjustment will be made to reflect the correct premium deduction. If underpayment of premium occurs, the City has the right to collect any additional premium owed by you. Conversely, if overpayment occurs, the City will reimburse you any amount overpaid, up to a maximum of one month of premiums.

Enrollment Form Errors

It is your responsibility to ensure that information on your enrollment form is correct. If a premium deduction error occurs, you must notify the Employee Benefits Division immediately. If an overpayment occurs due to an error you made when completing your enrollment form, the City will reimburse you up to a maximum of one month of premiums. Conversely, if underpayment occurs due to an error you made on your enrollment form, the City has the right to collect any additional premium owed.

Retiree Medical Rates for 2019

"With Medicare" rates apply only when the covered persons have both Medicare Parts A and B. If a retiree or spouse/domestic partner is eligible for Medicare due to age, the retiree or spouse/domestic partner must enroll in both Parts A and B and provide a copy of your Medicare card to the Employee Benefits Division.

The rates shown below are monthly rates for the medical plans.

	Years of Service	CDHP w/HRA	PPO	HMO
Retiree without Medicare	Less than 5	$ 760.83 (2A1)	$ 807.30 (8A1)	$ 817.30 (9A1)
	5 through 9	$ 676.29 (2A2)	$ 730.18 (8A2)	$ 740.18 (9A2)
	10 through 14	$ 507.22 (2A3)	$ 576.00 (8A3)	$ 586.00 (9A3)
	15 through 19	$ 338.15 (2A4)	$ 421.75 (8A4)	$ 431.75 (9A4)
	20 or more	$ 169.07 (2A5)	$ 190.43 (8A5)	$ 200.43 (9A5)
Retiree with Medicare	Less than 5	$ 389.18 (2B1)	$ 428.64 (8B1)	$ 428.64 (9B1)
	5 through 9	$ 345.94 (2B2)	$ 387.70 (8B2)	$ 387.70 (9B2)
	10 through 14	$ 259.45 (2B3)	$ 305.83 (8B3)	$ 305.83 (9B3)
	15 through 19	$ 172.97 (2B4)	$ 223.93 (8B4)	$ 223.93 (9B4)
	20 or more	$ 86.48 (2B5)	$ 101.11 (8B5)	$ 101.11 (9B5)
Retiree and Spouse/ Domestic Partner, both without Medicare	Less than 5	$1,369.53 (2C1/6)	$1,624.81 (8C1/6)	$1,634.81 (9C1/6)
	5 through 9	$1,251.18 (2C2/7)	$1,502.17 (8C2/7)	$1,512.17 (9C2/7)
	10 through 14	$1.048.29 (2C3/8)	$1,256.91 (8C3/8)	$1,266.91 (9C3/8)
	15 through 19	$ 811.58 (2C4/9)	$1,011.60 (8C4/9)	$1,021.60 (9C4/9)
	20 or more	$ 507.24 (2C5/0)	$ 643.68 (8C5/0)	$ 653.68 (9C5/0)
Retiree and Spouse/ Domestic Partner, both with Medicare	Less than 5	$ 896.36 (2D1/6)	$1,059.49 (8D1/6)	$1,059.49 (9D1/6)
	5 through 9	$ 824.94 (2D2/7)	$ 983.82 (8D2/7)	$ 983.82 (9D2/7)
	10 through 14	$ 710.28 (2D3/8)	$ 832.50 (8D3/8)	$ 832.50 (9D3/8)
	15 through 19	$ 567.45 (2D4/9)	$ 681.15 (8D4/9)	$ 681.15 (9D4/9)
	20 or more	$ 368.25 (2D5/0)	$ 454.12 (8D5/0)	$ 454.12 (9D5/0)
Retiree without Medicare and Spouse/ Domestic Partner with Medicare	Less than 5	$1,268.02 (2E1/6)	$1,438.16 (8E1/6)	$1,448.16 (9E1/6)
	5 through 9	$1,155.30 (2E2/7)	$1,326.31 (8E2/7)	$1,336.31 (9E2/7)
	10 through 14	$ 958.05 (2E3/8)	$1,102.67 (8E3/8)	$1,112.67 (9E3/8)
	15 through 19	$ 732.62 (2E4/9)	$ 878.96 (8E4/9)	$ 888.96 (9E4/9)
	20 or more	$ 450.84 (2E5/0)	$ 543.45 (8E5/0)	$ 553.45 (9E5/0)
Retiree with Medicare and Spouse/ Domestic Partner without Medicare	Less than 5	$ 957.00 (2F1/6)	$1,142.00 (8F1/6)	$1,142.00 (9F1/6)
	5 through 9	$ 882.21 (2F2/7)	$1,061.34 (8F2/7)	$1,061.34 (9F2/7)
	10 through 14	$ 764.18 (2F3/8)	$ 899.99 (8F3/8)	$ 899.99 (9F3/8)
	15 through 19	$ 614.61 (2F4/9)	$ 738.64 (8F4/9)	$ 738.64 (9F4/9)
	20 or more	$ 401.94 (2F5/0)	$ 496.61 (8F5/0)	$ 496.61 (9F5/0)
Retiree with Medicare and Children	Less than 5	$ 694.44 (2G1)	$ 784.95 (8G1)	$ 784.95 (9G1)
	5 through 9	$ 634.24 (2G2)	$ 724.23 (8G2)	$ 724.23 (9G2)
	10 through 14	$ 530.79 (2G3)	$ 602.81 (8G3)	$ 602.81 (9G3)
	15 through 19	$ 410.39 (2G4)	$ 481.34 (8G4)	$ 481.34 (9G4)
	20 or more	$ 256.07 (2G5)	$ 299.20 (8G5)	$ 299.20 (9G5)

Retiree Medical Rates for 2019

	Years of Service	CDHP w/HRA	PPO	HMO
Retiree without Medicare and Children	Less than 5	$1,065.19 (2H1)	$1,216.19 (8H1)	$1,226.19 (9H1)
	5 through 9	$ 963.74 (2H2)	$1,116.36 (8H2)	$1,126.36 (9H2)
	10 through 14	$ 777.76 (2H3)	$ 916.81 (8H3)	$ 926.81 (9H3)
	15 through 19	$ 574.87 (2H4)	$ 717.14 (8H4)	$ 727.14 (9H4)
	20 or more	$ 338.16 (2H5)	$ 417.75 (8H5)	$ 427.75 (9H5)
Retiree and Spouse/ Domestic Partner, both without Medicare and Family	Less than 5	$1,673.89 (2I1/6)	$2,033.70 (8I1/6)	$2,043.70 (9I1/6)
	5 through 9	$1,538.63 (2I2/7)	$1,888.35 (8I2/7)	$1,898.35 (9I2/7)
	10 through 14	$1,318.83 (2I3/8)	$1,597.71 (8I3/8)	$1,607.71 (9I3/8)
	15 through 19	$1,048.30 (2I4/9)	$1,306.99 (8I4/9)	$1,316.99 (9I4/9)
	20 or more	$ 676.33 (2I5/0)	$ 871.00 (8I5/0)	$ 881.00 (9I5/0)
Retiree without Medicare and Spouse/ Domestic Partner with Medicare and Family	Less than 5	$1,572.37 (2J1/6)	$1,847.04 (8J1/6)	$1,857.04 (9J1/6)
	5 through 9	$1,442.75 (2J2/7)	$1,712.49 (8J2/7)	$1,722.49 (9J2/7)
	10 through 14	$1,228.59 (2J3/8)	$1,443.48 (8J3/8)	$1,453.48 (9J3/8)
	15 through 19	$ 969.35 (2J4/9)	$1,174.35 (8J4/9)	$1,184.35 (9J4/9)
	20 or more	$ 619.93 (2J5/0)	$ 770.77 (8J5/0)	$ 780.77 (9J5/0)
Retiree with Medicare and Spouse/Domestic Partner without Medicare and Family	Less than 5	$1,262.26 (2K1/6)	$1,498.31 (8K1/6)	$1,498.31 (9K1/6)
	5 through 9	$1,170.51 (2K2/7)	$1,397.87 (8K2/7)	$1,397.87 (9K2/7)
	10 through 14	$1,035.52 (2K3/8)	$1,196.97 (8K3/8)	$1,196.97 (9K3/8)
	15 through 19	$ 852.03 (2K4/9)	$ 996.05 (8K4/9)	$ 996.05 (9K4/9)
	20 or more	$ 571.53 (2K5/0)	$ 694.71 (8K5/0)	$ 694.71 (9K5/0)
Retiree and Spouse/ Domestic Partner, both with Medicare and Family	Less than 5	$1,201.62 (2L1/6)	$1,415.81 (8L1/6)	$1,415.81 (9L1/6)
	5 through 9	$1,113.24 (2L2/7)	$1,320.35 (8L2/7)	$1,320.35 (9L2/7)
	10 through 14	$ 981.62 (2L3/8)	$1,129.48 (8L3/8)	$1,129.48 (9L3/8)
	15 through 19	$ 804.87 (2L4/9)	$ 938.56 (8L4/9)	$ 938.56 (9L4/9)
	20 or more	$ 537.84 (2L5/0)	$ 652.21 (8L5/0)	$ 652.21 (9L5/0)

Surviving Dependents Medical Rates for 2019

	Years of Service	CDHP w/HRA	PPO	HMO
Surviving Spouse without Medicare	Less than 5	$ 760.83 (2Y1)	$ 816.32 (8Y1)	$ 826.32 (9Y1)
	5 through 9	$ 676.29 (2Y2)	$ 743.67 (8Y2)	$ 753.67 (9Y2)
	10 through 14	$ 507.22 (2Y3)	$ 598.48 (8Y3)	$ 608.48 (9Y3)
	15 through 19	$ 338.15 (2Y4)	$ 453.29 (8Y4)	$ 463.29 (9Y4)
	20 or more	$ 169.07 (2Y5	$ 235.54 (8Y5)	$ 245.54 (9Y5)
Surviving Spouse with Medicare	Less than 5	$ 389.18 (2Z1)	$ 439.68 (8Z1)	$ 439.68 (9Z1)
	5 through 9	$ 345.94 (2Z2)	$ 404.26 (8Z2)	$ 404.26 (9Z2)
	10 through 14	$ 259.45 (2Z3)	$ 333.47 (8Z3)	$ 333.47 (9Z3)
	15 through 19	$ 172.97 (2Z4)	$ 262.61 (8Z4)	$ 262.61 (9Z4)
	20 or more	$ 86.48 (2Z5)	$ 156.38 (8Z5)	$ 156.38 (9Z5)
Surviving Children Only	Less than 5	$ 321.26 (2V1)	$ 431.74 (8V1)	$ 431.74 (9V1)
	5 through 9	$ 312.81 (2V2)	$ 420.39 (8V2)	$ 420.39 (9V2)
	10 through 14	$ 304.36 (2V3)	$ 397.70 (8V3)	$ 397.70 (9V3)
	15 through 19	$ 287.45 (2V4)	$ 374.99 (8V4)	$ 374.99 (9V4)
	20 or more	$ 253.63 (2V5)	$ 340.96 (8V5)	$ 340.96 (9V5)
Surviving Spouse without Medicare and Surviving Children	Less than 5	$1,082.10 (2W1)	$1,248.06 (8W1)	$1,258.06 (9W1)
	5 through 9	$ 989.10 (2W2)	$1,164.06 (8W2)	$1,174.06 (9W2)
	10 through 14	$ 811.58 (2W3)	$ 996.18 (8W3)	$1,006.18 (9W3)
	15 through 19	$ 625.59 (2W4)	$ 828.28 (8W4)	$ 838.28 (9W4)
	20 or more	$ 422.70 (2W5)	$ 576.50 (8W5)	$ 586.50 (9W5)
Surviving Spouse with Medicare and Surviving Children	Less than 5	$ 688.87 (2X1)	$ 816.42 (8X1)	$ 816.42 (9X1)
	5 through 9	$ 637.74 (2X2)	$ 771.10 (8X2)	$ 771.10 (9X2)
	10 through 14	$ 543.37 (2X3)	$ 680.51 (8X3)	$ 680.51 (9X3)
	15 through 19	$ 441.11 (2X4)	$ 589.83 (8X4)	$ 589.83 (9X4)
	20 or more	$ 323.08 (2X5)	$ 453.90 (8X5)	$ 453.90 (9X5)

Vision Plan

DAVIS VISION℠
EYECARE REFRAMED

Healthy eyes and clear vision are an important part of your overall health and quality of life. Davis Vision will help you care for your sight while saving you money.

To view benefits and locate a provider, go to davisvision.com, call *888-445-2290*, or download the Davis Vision Member app on your smartphone or tablet. For non-members, click on ***Member*** and enter **2481** as the client code. Enrollment for Davis Vision is for the calendar year.

Plan Design

Covered Service – In-network benefits (limited out-of-network benefits are available).

Comprehensive Eye Exam – $10 copay, one exam per calendar year.

Frames – Once per calendar year in lieu of contact lenses.
Up to $125 retail allowance toward provider-supplied frames plus 20% off cost exceeding the allowance.* Up to $175 retail allowance if purchased at Vision Works.

OR

Any Fashion or Designer frame from Davis Vision's Collection (with retail values up to $195), **covered in full**.

OR

Any Premier frame from Davis Vision's Collection (with retail values up to $225), **covered in full** after an additional $25 copay.

One-year eyeglass breakage warranty included at no additional cost.

Contacts – in lieu of frames.
Once per calendar year.
Up to $120 allowance toward provider-supplied contacts plus 15% off cost exceeding the allowance.*
Standard Contacts – Evaluation, fitting fees, and follow-up care; $25 copay applies.
Specialty Contacts – Evaluation, fitting fees, and follow-up care, up to a $60 allowance plus 15% off cost exceeding allowance.* $25 copay applies.

OR

Davis Vision Collection contact lenses, evaluation, fitting fees, and follow-up care, **covered in full** after $25 copay. (Up to four boxes of disposable lenses).

OR

Medically necessary with prior approval, **covered in full**.

Standard Eyeglass Lenses – Single, bifocals, trifocals, lenticular, and standard scratch coating.
$25 copay, once per calendar year. Polycarbonate lenses for children are covered in full up to age 19.

Lens Options	Copay	Lens Options	Copay
Standard progressive addition lenses	$50	Premium AR Coating	$48
Premium progressives (i.e. Varilux, etc.)	$90	Ultra AR Coating	$60
Intermediate-vision lenses	$30	High-index lenses	$55
Blended-segment lenses	$20	Polarized lenses	$75
Ultraviolet coating	$12	Glass photochromic lenses	$20
Standard anti-reflective (AR) coating	$35	Plastic photosensitive lenses	$65

***Additional Discounts** – Not available at Wal-Mart or Sam's Club.

Vision Rates – Monthly Premiums

Retiree Only	$ 4.48	V1
Retiree & Spouse or Domestic Partner	$ 8.88	V2
Retiree & Children	$ 8.72	V3
Retiree & Family or Domestic Partner & Children	$ 13.28	V4
Surviving Spouse	$ 4.48	V6
Surviving Spouse & Children	$ 8.72	V8
Surviving Children Only	$ 4.48	V9

Dental Plans

Cigna Dental PPO

Cigna Dental PPO offers you the choice to choose a DPPO Advantage dentist, a PPO dentist, or an out-of-network dentist. Selecting a DPPO Advantage dentist in the Cigna Dental PPO network will offer you the greatest savings. If you select a DPPO Advantage dentist or PPO dentist, copays and coinsurance apply. If you select an out-of-network dentist, Cigna reimburses out-of-network dentists an amount up to their Maximum Allowable Charge (MAC). You should know that you may be balanced billed (responsible for any additional amount).When contacting a dentist, ask whether the dentist participates in the Cigna DPPO Advantage Network. To find a dentist or for more information, call Cigna Dental at *800-244-6224* or visit mycigna.com.

Cigna Dental PPO Plan features include:

- Diagnostic and Preventive Services covered at 100 percent.
- Basic Services covered at 80 percent.
- Major Services covered at 50 percent.
- Orthodontia Services covered at 50 percent.
- $50 deductible per covered person (does not apply to Diagnostic and Preventive Services).
- $150 deductible per family, per calendar year.
- $50 deductible for Orthodontia Services per covered person.
- $1,000 per patient maximum per covered person, per calendar year.
- $1,000 lifetime Orthodontia maximum per covered person.

Sun Life Financial DHMO

The Sun Life Financial Plan is a prepaid dental plan that offers benefits through a network of plan dentists. Members must select a network general dentist if enrolled in this plan, you are responsible for specific copay amounts when services are provided by a network dentist. Members can use the Specialty Plan to obtain services from network or non-network specialists for specific services listed in the member plan documents. Plan limitations and exclusions apply. If you move out of the service coverage area, you have the option to drop or change coverage. See the plan documents for details.

Plan features include:

- No deductible.
- No waiting periods.
- Coverage for pre-existing conditions.
- No claim forms to file for plan dentist and plan specialty dentist services.
- No referrals required for specialty dentist services.
- No annual maximum for plan dentist and plan specialty dentist services.

Plan specialty benefits have a copay schedule. Refer to your plan document for copays.

To find a dentist or for more information, call *800-443-2995* or visit sunlife.com/onlineadvantage.

	Cigna Dental PPO Network	Out-of-Network	Sun Life Financial DHMO In-Network
Selection of Dentist	Member can go to general dentist or specialist in network. When selecting a dentist, if you choose a DPPO Advantage dentist, you will receive greater savings.	Member can go to any general dentist or specialist; however, the customer is responsible for the difference in what the dentist charges and the amount that Cigna pays.	Member must select a network general dentist. Member can use the Specialty Plan for services from network and non-network specialists.
Annual Deductible	$50 per person/$150 per family, per calendar year. Deductible does not apply to Diagnostic or Preventive Services.		None.
Covered Services (other than Orthodontia)	Diagnostic and Preventive – covered at 100% of DPO fee schedule. Basic – covered at 80% of DPO fee schedule. Major – covered at 50% of DPO fee schedule.	Diagnostic and Preventive – covered at 100% of Maximum Allowable Charge (MAC).* Basic – covered at 80% of MAC. Major – covered at 50% of MAC. Also responsible for amounts above MAC.	Member pays applicable copays according to the schedule of benefits when services are provided by a network dentist.
Annual Maximum Benefit	$1,000 per person, per calendar year.	$1,000 per person per calendar year. Also responsible for amounts above MAC.	No maximum for network dentist. $2,000 annual maximum for nonplan specialty dentist.
Orthodontia	50% of DPO fee schedule	50% of MAC. Also responsible for amounts above MAC.	25% discount when services are received from a network specialist. No age limitations (adults and children are both covered).

***Maximum Allowable Charge (MAC)** – The most Cigna Dental will pay a dentist for a covered service or procedure when using an out-of-network dentist.

	Cigna Dental PPO Network	Out-of-Network	Sun Life Financial DHMO In-Network
Orthodontia Maximum Benefit	$1,000 per person, per lifetime.		No Orthodontia maximum when services are received from a network specialist.
Benefit Waiting Period	None.	None.	None.
One Year Commitment	Allows members to cancel coverage only during Open Enrollment or within 31 days of a change in family status.		
Identification Cards	Two cards per retiree are issued.	Two cards per retiree are issued.	Two cards per retiree are issued.
Claim Forms	None.	Members file claims to be reimbursed for covered expenses. (Some dental offices may file claims and bill the balance after the plan has paid).	None.
Additional Information	For questions about eligibility, participating network dentist's, plan benefits, claim forms, etc., call *800-244-6224*.		For questions about eligibility, participating network dentist, plan benefits, claim forms, etc., call *800-443-2995*.

Dental Rates – Monthly Premiums

	Cigna Dental PPO		Sun Life Financial DHMO	
Retiree Only	$ 29.45	I1	$ 10.14	A1
Retiree & One Dependent	$ 61.96	I2	$ 16.64	A2
Retiree & Family or Domestic Partner & Children	$ 90.74	I3	$ 25.77	A3
Surviving Spouse	$ 29.45	I6	$ 10.14	A6
Surviving Spouse & One Child	$ 61.96	I7	$ 16.64	A7
Surviving Spouse & Children	$ 90.74	I8	$ 25.77	A8
Surviving Children Only	$ 61.96	I9	$ 16.64	A9

Additional Benefits

Life Insurance

Coverage Description
The City provides $1,000 of retiree life insurance at no cost to retirees. Coverage is effective the first day of the following month in which you retire. Retirees are automatically enrolled in this benefit. You must complete a Retiree Beneficiary Designation form.

Additional death benefits are available as follows:

- Employees' Retirement System – $10,000. For more information, call *512-458-2551*.
- Police Retirement System – $10,000. For more information, call *512-416-7672*.
- Austin Fire Fighters Relief and Retirement Fund – no death benefit offered.

Life insurance coverage is not available for dependents of retirees.

Choosing a Beneficiary
In the event of your death, life insurance benefits are paid to your named beneficiary or beneficiaries. The City provides a Beneficiary Designation form for this purpose. Unless prohibited by law, your life insurance benefits will be distributed as you indicated on your Beneficiary Designation form. If your named beneficiary is under 18 years of age at the time of your death, court documents appointing a guardian may be required before payment can be made. You should talk with an attorney to make sure that benefits to a minor will be paid according to your wishes.

Reviewing Your Beneficiary Designation Form
You can review your beneficiary designation for your life insurance coverage any time during the year. It is important that you keep this information current so that the person or persons you want to receive benefits are listed. To review your beneficiary information, you can visit the Employee Benefits Division or call *512-974-3284*.

Filing a Life Insurance Claim
Your beneficiary must file the life insurance claim with the Employee Benefits Division and submit the appropriate documents:

- Retiree death – one original death certificate.
- Vendor claim forms.

Retiree Discount Page – PerksConnect

The City of Austin has teamed up with PerksConnect to provide discounts to retirees. You can save at thousands of retailers in your neighborhood and around the country. Savings at Wyndham Hotels, Dell, Apple, Costco, Restaurant.com, AMC discount tickets and gift cards, Budget/Enterprise/Avis Car Rentals and TrueCar are just a small sampling of the partners that are offering you everyday savings. Whether it is local show & save, discounted gift cards or national deals, savings are just a click away. Activation is simple and FREE. Simply go to coadiscountpage.com on your computer, tablet or phone.

Retiree Wellness Program

Why Engage in Wellness?

The goal of the wellness program is to reduce preventable medical claims that account for about half of the City's medical spend. Wellness programs are behavioral health interventions that are designed to improve health outcomes and reduce medical claims.

According to claims data, employees engaged in wellness have lower average medical expenses and a higher utilization of both primary and preventive care services. Employees engaged in our wellness program also have shorter hospital stays and lower inpatient costs. These savings are beneficial to employees and the organization.

Wellness Newsletter

Retirees who are interested in receiving a newsletter about wellness opportunities and health information can email healthyconnections@austintexas.gov and request to be added to the distribution list for a monthly electronic newsletter. This is a good way to find out about the wellness programs described below. Retirees can also call the Employee Benefits Division at *512-974-3284* and ask to speak with a Wellness Consultant if they have questions about wellness opportunities.

Health Assessments

A Health Assessment provides a "snapshot" of an individual's health. Identifying health risks leads to early intervention, resulting in better health outcomes and less costly treatment.
Retirees and dependents can:

1. Complete a finger stick screening at a Health & Lifestyle Expo to get health numbers such as cholesterol, glucose, and triglycerides. To register for an appointment, call *877-366-7483.*

OR

2. Use lab results obtained through a doctor to get current health numbers.

These health numbers are then used to complete the health assessment at bcbstx.com. When the health assessment is completed, you will receive recommendations for improving your health. All personal health information is protected by HIPAA and will remain confidential.

New Naturally Slim - Online Weight Loss Program

Naturally Slim is a simple, online program that helps employees lose weight and improve their health. It's not a diet. There are no points to count, no starving, and no eating diet food! The program teaches participants *when* and *how* to eat the foods they love while losing weight, boosting their energy and improving their health. By learning new techniques about how and when you should eat, you can continue eating your favorite foods while improving your health, reducing your chance of developing chronic disease, and losing weight.

To enroll, contact HealthyConnections at *512-974-3284*.

Tobacco Cessation 101

Gain the resources and support needed to quit using tobacco products. Classes designed for all forms of tobacco use are available at worksites across the City. To successfully complete Tobacco Cessation 101, the individual must complete class 1 & 2.

Individuals who complete the class are eligible to receive cessation medication (including over-the-counter products) free for nine months with a doctor's prescription. Retirees, spouses and eligible dependents (age 18 years and older) who are enrolled in a City-sponsored medical plan are eligible for this benefit. Check the austintexas.gov website for the schedule of classes

Tobacco Premium

Retirees and spouses/domestic partners currently using tobacco products, including but not limited to cigarettes, cigars, chewing tobacco, snuff, pipes, snus, shisha and electronic cigarettes will be charged a tobacco premium.

Retirees and spouses/domestic partners enrolled in a City-sponsored medical plan who use tobacco will each pay $25 per month. To stop the tobacco premium, retirees and spouses using tobacco must complete the Tobacco Cessation 101 class. The scheduled classes can be found on austintexas.gov/retirees. Retiree and spouses/domestic partners can attend a class without registering.

Diabetes Control Program

Learn how to manage your diabetes, get personalized diabetes care, and receive approved diabetes medications and testing supplies at no cost. This program is offered to employees, retirees, and dependents who are diabetic or prediabetic and enrolled in a City-sponsored medical plan.

Participants Receive:

- Approved diabetes medications and testing supplies at no cost
- Comprehensive Diabetes education (required)
- Quarterly screenings through a pharmacist (3 visits per year required)

To enroll, call HealthyConnections at *512-974-3284* and ask to speak to a Wellness Consultant.

Special Beginnings - Maternity Support

The Maternity Support Program offered by HealthyConnections and BlueCross BlueShield (BCBS) is designed to help pregnant women get the support and information they need to have a healthy pregnancy. The program offers personalized maternity care including access to a dedicated maternity nurse, educational materials and assistance in managing high-risk conditions including gestational diabetes and preeclampsia. All pregnant women enrolled in a City medical plan are eligible. To enroll, call BCBS at *888-521-2227*.

City Olympics

HealthyConnections and the Parks and Recreation Department host the annual City Olympics at Krieg Sports Complex. Employees, retirees, and their families can watch the sports and golf tournaments, try out the extreme obstacle course, or run the Byron Johnson 5K run/walk. There will also be a number of health and lifestyle vendors at the mini-health expo and a brisket cook-off competition. Kid's activities will be provided and a kids 1K fun run will take place in the morning.

Health & Lifestyle Expos

HealthyConnections sponsors Citywide Health and Lifestyle Expos at Palmer Events Center. Expos offer Health Assessment screenings and an opportunity for retirees and family members to explore a number of booths focusing on health and lifestyle.

Five Wishes Program

This easy-to-complete living will addresses your medical, personal, emotional, and spiritual needs if you become seriously ill. The document is available free by contacting the Employee Benefits Division at *512-974-3284*.

Free Flu Shot Clinics

This benefit is free to retirees, spouses, and eligible dependents (age 18 and older). It is offered in the fall at the Health & Lifestyle Expo and at Retiree Open Enrollment meetings.

Important Benefits Information

Summary of Benefits and Coverage (SBC) and Uniform Glossary of Terms

Under the law, insurance companies and group health plans must provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary will help consumers better understand the coverage they have and allow them to easily compare different coverage options. It summarizes the key features of the plan and coverage limitations and exceptions. For a copy of the SBC of the City's medical plans, go to austintexas.gov/retirees or call *512-974-3284*.

Under the Patient Protection and Affordable Care Act (Health Reform), consumers will also have a new resource to help them understand some of the most common but confusing jargon used in health insurance. Retirees can access the Uniform Glossary of Terms online at austintexas.gov/retirees or call *512-974-3284* for a copy.

ADA Compliance

The City is committed to complying with the Americans with Disabilities Act (ADA). Reasonable accommodation, including equal access to communications, will be provided upon request. For more information, call the Human Resources Department at *512-974-3284* or use the Relay Texas TTY number *800-735-2989* for assistance. For more information, visit the website at austintexas.gov/ada.

Governing Plan

Your rights are governed by each plan instrument (which may be a plan document, evidence of coverage, certificate of coverage, or contract) and not by the information in this Guide. If there is a conflict between the provisions of the plan you selected and this Guide, the terms of the plan govern. City of Austin retirees have access to benefits approved by the City Council each year as part of the budget process. The benefits and services offered by the City may be changed or terminated at any time.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA)

This act imposes the following restrictions on group health plans:

Limitations on pre-existing exclusion periods: Pre-existing conditions can only apply to conditions for which medical advice, diagnosis, care, or treatment was recommended or received during a period beginning six months prior to an individual's enrollment date, and any pre-existing condition exclusion is not permitted to extend for more than 12 months after the enrollment date. Further, a pre-existing condition exclusion period may be reduced by any creditable previous coverage the individual may have had.

Special enrollment: Group health plans must allow certain individuals to enroll upon the occurrence of certain events, including new dependents and loss of other coverage. Loss of coverage includes:

- Termination of employer contributions toward other coverage.
- Moving out of an HMO service area.
- Ceasing to be a "dependent," as defined by the other plan.
- Loss of coverage to a class of similarly situated individuals under the other plan (e.g., part-time employees).

Additionally, individuals entitled to special enrollment must be allowed to enroll in all available benefit package options and to switch to another option if he or she has a spouse or dependent with special enrollment rights.

Prohibitions against discriminating against individual participants and beneficiaries based on health status: Plans may not establish rules for eligibility of any individual to enroll under the terms of the plan based on certain health status-related factors, including health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

Standards relating to benefits for mothers and newborns: Plans must provide for a 48-hour minimum stay for vaginal childbirth, and a 96-hour minimum stay for cesarean childbirth, unless the mother or medical provider shortens this period. No inducements or penalties can be used with the mother or medical provider to circumvent these rules.

Parity in the application of certain limits to mental health benefits: Plans must apply the same annual and lifetime limits (i.e., dollar amounts) that apply to other medical benefits to benefits for mental health. If this requirement results in a 1 percent or more increase in plan costs or premiums, this rule does not apply.

City of Austin Policy on HIPAA

HIPAA gives the City, as the plan sponsor of a non-federal governmental plan, the right to exempt the plan in whole or in part from the requirements described above. The City has decided to formally implement all of these requirements.

The effect of this decision, as it applies to each of the above requirements and the Plan, is as follows:

- The Plan does not currently have a pre-existing condition limitation and is in compliance.
- The Plan will provide special enrollment periods.
- The Plan will comply with the non-discrimination rules.
- The Plan will comply with the standards for benefits for mothers and newborn children.
- The Plan will comply with the rules on mental health benefits.

The HIPAA Privacy Rules for Health Information were established to provide comprehensive federal protection concerning the privacy of health information. The Privacy Rules generally require the City to take reasonable steps to limit the use, disclosure, and requests for Protected Health Information to the minimum necessary to accomplish the intended purpose. The City is committed to implementing the Privacy Rules.

The Women's Health and Cancer Rights Act of 1998 was enacted on October 21, 1998. It provides certain protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. Specifically, the act requires that health plans cover post-mastectomy reconstructive breast surgery if they provide medical and surgical coverage for mastectomies. Coverage must be provided for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications of all stages of mastectomy, including lymph edemas.
- Secondary consultation whether such consultation is based on a positive or negative initial diagnosis.

The benefits required under the **Women's Health and Cancer Rights Act of 1998** must be provided in a manner determined in consultation with the attending physician and the patient. These benefits are subject to the health plan's regular copay and deductible amounts.

Patient Protection and Affordable Care Act

As part of the Patient Protection and Affordable Care Act (Health Reform) effective January 1, 2020, medical plans which exceed a threshold level established by the Federal Government will have to pay a 40 percent excise tax. The City of Austin is committed to designing a medical plan that is below the threshold level. However, if the threshold is reached, the cost of the excise tax will be passed on to employees and retirees.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, is a federal law that requires employers to offer qualified beneficiaries the opportunity to continue medical coverage, vision coverage, and dental coverage, at their own cost in the case of certain qualifying events.

COBRA Notice Requirements: Each retiree or qualified beneficiary is required to notify the Employee Benefits Division of the Human Resources Department within 60 days of a divorce, legal separation, a child no longer meeting the definition of dependent, or entitlement to Medicare benefits. The City's COBRA administrator will then notify all qualified beneficiaries of their rights to enroll in COBRA coverage. Notice to a qualified beneficiary who is the spouse or former spouse of the covered retiree is considered proper notification to all other qualified beneficiaries residing with the spouse or former spouse at the time the notification is made.

Continuation of Coverage for Domestic Partners

The City offers covered individuals the opportunity to continue medical coverage, dental coverage, and vision coverage at their own cost in the case of certain qualifying events.

Each retiree or covered individual is required to notify the Employee Benefits Division of the Human Resources Department within 31 days of dissolution of the Domestic Partnership, a child no longer meeting the definition of dependent, or entitlement to Medicare benefits. The City's COBRA administrator will then notify all covered individuals of their rights to enroll in Continuation of Coverage for Domestic Partners coverage. Notice to a covered individual who is the Domestic Partner or former Domestic Partner of the covered retiree is considered proper notification to all other covered individuals residing with the Domestic Partner or former Domestic Partner at the time the notification is made.

Surviving Dependent Coverage

Your dependents may be eligible for Surviving Spouse Medical, Dental, and Vision Coverage only if you meet one of the following requirements, and your dependents complete a Surviving Dependent Benefits Enrollment Form within 31 days from the date of your death:

- You are a City retiree who retired under the City of Austin Employees' Retirement System, Austin Fire Fighters Relief and Retirement Fund, or City of Austin Police Retirement System.
- You are an active City employee who is eligible to retire with the City but chooses to continue to work for the City.
- You are a City retiree who has returned to active employment with the City.

If eligible, your dependents will be able to continue his or her coverage through the City after your death, provided your dependents were enrolled in a City-sponsored plan at the time of your death. The coverage offered is the same coverage offered to City retirees.

Domestic partners and children of domestic partners are eligible for Continuation of Coverage for Domestic Partners only.

Your Prescription Drug Coverage and Medicare

Beneficiary Creditable Coverage Disclosure Notice

This notice has information about your current prescription drug coverage with the City of Austin 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 a Medicare drug plan, 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 this area. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. On January 1, 2006, new prescription drug coverage became available to individuals with Medicare Part A. This coverage is available through Medicare prescription drug plans, also referred to as Medicare Part D. All such plans provide a standard, minimum level of coverage established by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Austin has determined that prescription drug coverage offered through City health plans 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.

Other Important Considerations

- If you currently have prescription drug coverage through a City medical plan, you may choose to enroll in Medicare Part D annually between October 15 and December 7, or when you first become eligible for Medicare Part D.
- If you decide to join a Medicare drug plan, your current City of Austin medical coverage will not be affected.
- If you do decide to join a Medicare drug plan and drop your current City of Austin coverage for your dependents, you may be able to get this coverage back during an Open Enrollment period.
- You should also know that if you drop or lose your current coverage with the City of Austin 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 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without Creditable Coverage, your premium may consistently be at least 19 percent 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.
- If you are enrolled in Medicare Part D or a Medicare Advantage Plan and are also enrolled in the City medical plan, you may have duplicate prescription coverage. If you would like to review your coverage or for more information, contact the Employee Benefits Division at *512-974-3284*.

More information about Medicare Part D 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. You can also:

- Visit medicare.gov for personalized help.
- Call the **Health and Human Services Commission of Texas** at *888-834-7406* or *800-252-9330*.
- Call *800-MEDICARE (800-633-4227)*. TTY users should call *877-486-2048*.

Financial assistance may be available for individuals with limited income and resources through the **Social Security Administration (SSA)**. For more information, visit the SSA website at socialsecurity.gov or call *800-772-1213*. TTY users should call *800-325-0778*.

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