



**CITY OF AUSTIN
2011 COBRA GUIDE**

HELPFUL RESOURCES

<p>City of Austin Human Resources Department Employee Benefits Division 505 Barton Springs, Suite 600 Austin, TX 78704</p> <p>Phone number: 512-974-3284 TTY number: 512-974-2445 Relay Texas: 800-735-2989 Fax number: 512-974-3420</p> <p>Hours: Monday – Friday, 7:30 a.m. to 5:00 p.m.</p> <p>Call for: Benefits information including Life claims; enrollment; changing coverage; and adding/dropping dependents.</p>	<p>Davis Vision Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110</p> <p>Toll-free number: 888-445-2290</p> <p>www.davisvision.com</p> <p>Call for: Eligibility verification, claims, and vision program providers.</p>
<p>CompuSys/Erisa Administrative Services 12325 Hymeadow Drive #4 Austin, TX 78750</p> <p>Phone number: 512-250-9397 Toll-free number: 800-933-7472 Relay Texas: 800-735-2989</p> <p>Hours: Monday – Friday, 7:30 a.m. to 5:30 p.m.</p> <p>Call for: Dental; FLEXTRA Health Care; and COBRA Administration.</p>	<p>UnitedHealthcare HMO and Choice Plus Plan P. O. Box 30555 Salt Lake City, UT 84130-0555</p> <p>Medical and Prescription Customer Service: 800-430-7316 Vision Customer Service: 800-203-4317</p> <p>Hours: Monday – Friday, 7:00 a.m. to 7:00 p.m.</p> <p>www.myuhc.com - Medical Providers www.uhcvision.com - Vision Program Providers www.ubhprovdirect.com - Mental Health Providers www.365wellst.com - Prescription Coverage</p> <p>Call for: Eligibility verification; pre-notification; utilization review; medical claims; prescription benefits, and benefits information.</p>

VENDOR ONLINE RESOURCES

You can access provider directories, check the status of a claim, print Explanation of Benefits, request ID cards or print a temporary card, and find pharmacy locations using the Internet. Follow the steps below:

UnitedHealthcare HMO or Choice Plus

The website for UnitedHealthcare participants is www.myuhc.com. To view the directory from the main page of the website, click on “View Physician and Facility” and follow the steps. Note: You do not have to register to view the directory. Be sure you select **UnitedHealthcare Choice Plus** from the drop down menu. You will be able to view prescription coverage information at www.365wellst.com or www.myuhc.com. For all other options, follow these steps to register:

1. On the Internet, type in www.myuhc.com.
2. Click on “Register Now” on the right hand side of the screen.
3. Enter your Social Security Number or Subscriber Number.
4. Enter your Date of Birth.
5. Click on “Continue.”
6. Follow the steps for these items:
 - Choose User Name.
 - Choose Password.
 - Security Question.
 - Answer Security Question.
 - Email Address.
7. Choose “Agree with Privacy Statement.”
8. Click on “Submit.”
9. Click on “Start Using myuhc.com.”

Davis Vision

The website for Davis Vision is www.davisvision.com. To find Davis Vision care providers and for more plan information, go to: www.davisvision.com, or call 1-888-445-2290. If you are not a current member, click on the Member link and under the Open Enrollment/Discount Plan section enter the client code 2481.

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INTRODUCTION

About the *COBRA Guide*

Some information in this booklet comes from the *2011 Employee Benefits Guide* and may pertain only to active City employees. If you have questions, contact Erisa or Employee Benefits of the City of Austin Human Resources Department.

This *Guide* provides an overview of the coverage available to City of Austin (City) COBRA participants. For the key features of each plan refer to the Medical Plans Comparison section of this guide.

Each plan has a legal document that contains the complete provisions of the plan. Your rights are governed by the legal document, and not by the information in this *Guide*. If there is a conflict between the provisions in the legal document and this *Guide*, the terms of the legal document govern.

Notice: Federal Requirements

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 974-3284 or 974-2445 (TTY number). For any services in the guide for which a TTY number is not listed, use the Relay Texas TTY number 1-800-735-2989 for assistance. For more information, visit the website at: www.ci.austin.tx.us/ada

The Health Insurance Portability and 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 coverage the individual previously 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:
 - ❖ Reaching a lifetime limit on all benefits.
 - ❖ Termination of employer contributions towards 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. Plan provisions regarding limits on the number of visits or days of coverage are not affected by this requirement. If this requirement results in a one percent or more increase in plan costs or premiums, this rule does not apply.

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; therefore, the plan is already in compliance with this provision.
- ◆ 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 was 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.
- ◆ Prosthesis 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 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 copays and deductibles.

Prescription Drug Coverage and Medicare

Beneficiary Creditable Coverage Disclosure Notice. Please read this notice carefully. This notice provides information about your current prescription drug coverage through the City of Austin and prescription drug coverage available through Medicare.

Carefully review and evaluate the prescription drug coverage available through City health plans and through Medicare before making any enrollment decisions.

This notice also provides resources you can use to get additional information and assistance. Use these resources to help you make an informed decision.

- ◆ 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.
- ◆ The City of Austin has determined that prescription drug coverage offered through City health plans will pay – on average – for all plan participants, as much as the standard Medicare prescription drug coverage. The coverages are considered to be “actuarially equivalent.” For this reason, an individual with City coverage is not penalized if he or she decides to enroll in Medicare Part D at a later time.
- ◆ If you currently have prescription drug coverage through a City health plan, you may choose to enroll in Medicare Part D annually, or when you first become eligible for Medicare Part D.

PLEASE READ THE FOLLOWING CAREFULLY:

- ◆ If you keep the City health plan and enroll in Medicare Part D, you will continue to use your prescription benefit under one of the City's medical plans and pay the appropriate copay.
- ◆ You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
- ◆ If you choose to enroll in Medicare Part D and drop your City health plan (which includes prescription drug coverage) be aware that you and your covered spouse may not be able to enroll in a City health plan in future years.
- ◆ If you drop your City health plan and enroll in Medicare Part D, you must also drop any dependents from your City health plan. Regardless of intervening events (such as a family status change) you will not be able to reinstate coverage in a City health plan until the next Open Enrollment.
- ◆ If you die, and you and your spouse are not enrolled in a City health plan, your spouse will not be eligible for Surviving Spouse Coverage through the City.
- ◆ If you are a Surviving Spouse and drop City coverage, you will not be able to reinstate City coverage.
- ◆ If you drop or lose your City coverage and do not enroll in Medicare Part D after your current City coverage ends, you may have to pay a higher premium to enroll in Medicare Part D at a later date.
- ◆ If 63 days or more pass without your having prescription drug coverage that is at least as good as Medicare Part D, your monthly Medicare Part D premium will increase at least 1% per month for every month past your initial enrollment period that you have no coverage or have lesser coverage. In addition, you may have to wait until the following November to enroll.

For more information about prescription drug coverage, contact the Employee Benefits Division of the Human Resources Department at 512-974-3284.

Detailed information about Medicare Part D is available in a handbook entitled "Medicare & You 2010." Medicare will mail you a copy of this handbook when eligible. In addition, you may be contacted directly by Medicare prescription drug plans.

Information and assistance on prescription drug plans is available as follows:

Visit www.medicare.gov for personalized help. Call the Health and Human Services Commission of Texas toll free at 1-888-834-7406, local number 1-800-252-9330. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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: www.socialsecurity.gov. Or call 1-800-772-1213. TTY users should call 1-800-325-0778.

If you are enrolled in Medicare Part D or a Medicare Advantage Plan and enrolled in the City of Austin's medical coverage, you may have duplicate prescription coverage. If you are interested in discussing your coverage, please call the City of Austin's Employee Benefits Division at 512-974-3284.

Summary of the COBRA Premium Reduction Provisions under American Recovery and Reinvestment Act (ARRA), as Amended

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives “Assistance Eligible Individuals” the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an “Assistance Eligible Individual” and get reduced premiums you:

- **MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through May 31, 2010 and elect the coverage;**
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time between September 1, 2008 through May 31, 2010;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer.*

◆ IMPORTANT ◆

- ◇ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.
- ◇ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◇ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For information regarding your plan’s COBRA coverage and administration of the ARRA Premium Reduction Act or to notify the plan of your ineligibility to continue paying reduced premiums, contact Erisa Administrative Services at 512-250-9397 or 12325 Hymeadow Drive, Austin, TX 78750.

If you are denied treatment as an “Assistance Eligible Individual” you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

www.dol.gov/COBRA or call 1-866-444-EBSA (3272)

COBRA CONTINUATION OF COVERAGE

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, dental, vision, and/or participation in the FLEXTRA Health Care Account at their own cost in the case of certain qualifying events.

Coverage not available under COBRA include: life insurance, short term disability, long term disability, FLEXTRA Dependent Care Account, or prepaid legal services.

Qualified Beneficiary

A *qualified beneficiary* is you or your family member who was covered under a City-sponsored medical or dental plan or vision or the FLEXTRA Health Care Account on the day before a qualifying event. A child who is born to or placed for adoption with a qualified beneficiary during the period of COBRA continuation coverage is himself or herself, a qualified beneficiary.

If more than one family member is eligible, each person may elect continued coverage separately. You may not change from one medical plan to another, except during Open Enrollment, unless you are covered by an HMO and you move outside the HMO service area.

Qualifying Events

As determined by Federal law, *qualifying events* include:

- ◆ Your termination of employment (including retirement) for any reason except gross misconduct.
- ◆ The loss of eligibility for coverage due to a change in your work status.
- ◆ Your divorce or legal separation.
- ◆ Your dependent child's loss of eligibility because he or she no longer meets the definition of an eligible dependent under the plan.
- ◆ Your becoming entitled to Medicare benefits.
- ◆ Your death.

Notice Requirements

Each employee or qualified beneficiary is required to notify the Employee Benefits Division of the Human Resources Department within 60 days of a divorce, legal separation, child no longer meeting the definition of dependent, or entitlement to Medicare benefits. Erisa, 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 employee is considered proper notification to all other qualified beneficiaries residing with the spouse or former spouse at the time the notification is made.

How to Enroll for Coverage

You have 60 days in which to elect coverage under COBRA from the later of:

- ◆ The date coverage ends.
- ◆ The date you are notified of your rights under COBRA.

Payment Due Dates

You have 45 days from the date you elect COBRA coverage to pay the amount owed to Erisa Administrative Services. Your payment must be received in Erisa's office by the 45th day. If you make your election and pay on time, coverage under COBRA will begin the day after your group benefits otherwise would have ended. Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. Contact Erisa Administrative Services to confirm the correct amount of your first payment. After the initial payment, payments for COBRA coverage must be made on a

monthly basis and are due on the first day of the month of coverage. Payments must be received within 30 days of the due date or coverage will be cancelled.

Your Cost for Coverage

If you choose to continue medical, vision, and/or dental coverage under COBRA, you will be responsible for paying the total premium, plus a 2% administrative fee. The total premium includes the amount you paid as an active employee plus the amount the City contributed toward the cost of your coverage. If you qualify for 29 months of COBRA coverage due to disability, your cost will equal 102% of the total premium for the first 18 months and 150% for the 19th through the 29th months of COBRA coverage.

If premiums for City employees increase, the new premiums also apply to members who have elected coverage under COBRA. You will be notified of new rates prior to the effective date.

If you choose to continue your FLEXTRA Health Care Account under COBRA, you will pay 102% of the monthly contribution you designated for the plan year. If you elect COBRA coverage, your contributions must be mailed directly to Erisa.

American Recovery and Reinvestment Act of 2009 as Amended – if you are eligible for the 65 percent COBRA subsidy under the American Recovery Reinvestment Act, your medical, dental, and vision premiums will be 35 percent of the total COBRA premium. After nine months of the 65 percent subsidy COBRA premiums will return to the entire cost of coverage as indicated on page 12, 19, and 21.

How Long Coverage Continues

Depending on the qualifying event, medical, vision, or dental coverage may be continued under COBRA either 18, 29, or 36 months past the qualifying event.

You and covered family members may elect to continue coverage for up to 18 months if coverage ends due to:

- ◆ Your termination of employment.
- ◆ A change in your work status.

If an employee or covered family member is determined to be disabled under the Social Security Act either at the time of a qualifying event, or at any time during the first 60 days of COBRA coverage, the disabled individual and all covered family members may be eligible for up to 29 months of COBRA coverage, rather than 18 months. In order for the disabled individual and any qualified family members to be eligible for the 29 months of COBRA coverage, the disabled family member must meet the requirements listed below before the first 18 months expires.

The individual must:

- ◆ Be determined to be disabled by the Social Security Administration.
- ◆ Notify the City within 60 days of the Social Security Administration's determination of disability.

A covered family member may elect to continue coverage for up to 36 months if coverage ends due to:

- ◆ Your dependent child's loss of eligibility due to restrictions of the plan.
- ◆ Your divorce or legal separation from your spouse.
- ◆ Your becoming entitled to Medicare benefits.
- ◆ Your death.

It is possible that a qualified beneficiary may experience a second qualifying event while enrolled in COBRA coverage. In that case, the maximum period of COBRA coverage will be the longest period for which the qualified beneficiary is eligible.

COBRA coverage under the FLEXTRA Health Care Account may be continued through the end of the calendar year in which you originally elected coverage, regardless of the qualifying event.

When Coverage Ends

Your continued coverage under COBRA generally ends after the expiration of the period described above in “How Long Coverage Continues”. However, under certain circumstances, COBRA coverage may end before the full period of eligibility. Coverage will end on the earliest of the following dates, if any of these dates occur before the end of the applicable COBRA period:

- ◆ The date you fail to pay any required premiums when due.
- ◆ The date you become covered under another group health plan or Medicare.
- ◆ The date the City ceases to offer medical or dental benefits or FLEXTRA Health Care Account to employees.

If you or a covered dependent becomes covered under another group benefit plan, you normally are not eligible to continue coverage under COBRA. However, if the new coverage has a pre-existing condition exclusion or limitation that limits your coverage under the new plan, you may keep your COBRA coverage for the remainder of the time you are eligible, or until the limitation expires, whichever comes first.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If the other group medical plan’s pre-existing condition rule does not apply to you, your COBRA coverage through the City may be terminated.

COBRA and Dependents

COBRA participants may add or maintain coverage for eligible dependents according to the same provisions as active employees. If you have questions about COBRA and dependents, refer to the appropriate Medical Plan Document or contact Erisa.

ELIGIBILITY

Eligible Dependents

Your spouse and children who meet the descriptions listed below can be enrolled as dependents.

- ◆ Spouse: Your legally married spouse, including a declared common-law spouse. Only one spouse may be covered at any time.
- ◆ Children: Your biological children, stepchildren, legally adopted children, children from whom you have obtained court-ordered guardianship or conservatorship, qualified children placed pending adoption, and grandchildren.
To be eligible, your children must:
 - ❖ Be Dependent on you in a regular parent-child relationship as reasonably determined by the City, be the subject of a Qualified Medical Child Support Order, or be the subject of an Administrative Writ.
 - ❖ 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 IRS) on your or your spouse’s Federal income tax return.
- ◆ Disabled children: To be eligible for coverage past the age limit listed above, your disabled child must otherwise meet the requirements for eligible dependents and must also meet the following definition:
 - ❖ A disabled child is a child who, due to a mental or physical disability, is incapable of earning a living at the time he or she would otherwise cease to be a dependent, if the child is covered as a dependent at that time, and if at that time he or she depends on you for principal support and maintenance.
 - ❖ A disabled child continues to be considered an eligible dependent as long as the child remains incapacitated, unmarried, dependent upon you for principal support and maintenance, and you continuously maintain the child’s coverage as a dependent under the plan from the date he or she otherwise would lose dependent status.
 - ❖ A child who loses eligibility and later becomes disabled is not eligible to be covered. A disabled child who was not covered as a dependent immediately prior to the time he or she would otherwise cease to be a dependent is not eligible to be covered.

Documentation

To provide coverage for a dependent under any of the City's benefits programs, you must submit documentation that supports your relationship to the dependent.

Acceptable documents include:

- ◆ For a spouse: A marriage certificate or declaration of informal (common-law) marriage which has been recorded as provided by law.
- ◆ For a child: A birth certificate or court order establishing legal adoption, guardianship, or conservatorship.
- ◆ For a stepchild: A birth certificate or court order establishing legal adoption, guardianship, conservatorship, and a marriage certificate or declaration of informal marriage indicating the marriage of the child's parent and stepparent.
- ◆ For a dependent grandchild: A birth certificate or court order establishing legal adoption, guardianship, or conservatorship for your child and grandchild and (if applicable) a marriage certificate or declaration of informal marriage that supports the relationship between you and your grandchild.
- ◆ For a disabled child: A completed Dependent Eligibility Questionnaire verifying an ongoing total disability. If requested, written documentation from a physician verifying ongoing total disability.
- ◆ For a qualified child placed pending adoption: An agreement executed between you and a licensed child-placing agency or TDPRS, which meets the requirements listed above under Qualified Children Placed Pending Adoption.

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).
- ◆ Residents of a country other than the United States.
- ◆ Parents, grandparents, or other ancestors.
- ◆ Grandchildren who do not meet the definition of dependent grandchildren.
- ◆ Domestic partners or their children.

An individual is not eligible to be covered:

- ◆ As both a City employee and a COBRA participant.
- ◆ As both a COBRA participant and as a dependent of a COBRA participant or as a dependent of a City employee.

CHANGING COVERAGE

Open Enrollment

During Open Enrollment, you may make changes to your coverage. Allowable changes include:

- ◆ Adding or dropping a dependent.
- ◆ Changing from one medical plan to another.
- ◆ Canceling coverage.

Changes During the Year

When already enrolled in COBRA coverage and you need:

- ◆ To drop coverage for a spouse due to divorce, you must submit a corrected COBRA Enrollment Form to Erisa. In addition, you must provide a copy of the portion of the divorce decree that indicates the names of the parties involved, as well as the judge's signature, and the date the divorce was final. Erisa will automatically send a COBRA notification to your ex-spouse.
- ◆ To drop coverage for a dependent who is no longer eligible, you must submit a corrected COBRA Benefits Enrollment Form to Erisa. This step is necessary to drop the dependent. If applicable Erisa will send you a new

coupon book with adjusted premium payments. The City will not refund premiums paid for dependents that should have been dropped because they were no longer eligible for coverage.

- ◆ To add or drop coverage due to a change in the health coverage attributable to employment, you must submit documentation within 31 days from the employer or health insurance carrier confirming the date coverage was lost or became effective with a corrected COBRA Enrollment Form to Erisa.
- ◆ Newly acquired dependents may be added to your coverage within 31 days following the qualifying event (for example, birth, adoption, or marriage).
- ◆ Coverage may be cancelled at any time on any individual by notifying Erisa.

At times other than Open Enrollment, you are not permitted to add dependents not previously covered, except in the case of a newly acquired dependent or a loss of health coverage that results from employment.

You cannot change between the HMO and PPO during the year, unless you move outside the service area or as allowed by HIPAA *Special Enrollment*. If you want to change your medical plan, you must wait until the next Open Enrollment.

American Recovery and Reinvestment Act of 2009, as Amended

If you are eligible for COBRA coverage under the American Recovery and Reinvestment Act of 2009 (due to involuntary termination between 9/1/08-12/31/09) you may switch from the HMO plan to the PPO plan. The Act allows individuals to switch medical plans if the premium is the same or lower than the plan they were previously covered under. However, you are not eligible to switch from the PPO to the HMO since the COBRA premium is higher for the HMO than the PPO.

Premium Errors

Entry Error/Delay. If a data entry error occurs or if data entry is delayed, it will not invalidate the coverage reflected on your COBRA Enrollment Form. Upon discovery of any such error or delay, an adjustment will be made to reflect the correct premium. 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.

COBRA Enrollment Form Error. It is your responsibility to ensure that information on the COBRA Enrollment Form is correct. If a premium error occurs, you must notify Erisa immediately. If an overpayment occurs due to an error you made when completing the COBRA Enrollment Form, the City will reimburse you up to a maximum of 31 days of premium. Conversely, if underpayment occurs due to an error you made on the COBRA Enrollment Form, the City has the right to collect any additional premium owed.

American Recovery and Reinvestment Act of 2009

If you have paid the entire cost of your COBRA premium and later find out you or your dependents are eligible for the 65 percent subsidy, a credit will be taken against future COBRA premiums. Reimbursements will only be given if you terminate COBRA coverage before the credit is taken.

MEDICAL COVERAGE

Medical Plans

For 2011, the medical plans offered by the City are UnitedHealthcare HMO and Choice Plus Plan.

As a COBRA participant, you may choose the medical plan that best meets your needs. To help you compare the features of the two medical plans, refer to the Medical Plans Comparison section of this document.

For complete coverage information, refer to the materials provided by UnitedHealthcare, or contact them directly at 800-430-7316. The provisions of the plan document(s) always govern in case of conflict with this *2011 COBRA Guide*.

UnitedHealthcare HMO

As a member of an HMO, you must follow the rules and regulations of the HMO.

If you choose to enroll in the HMO, you must:

- ◆ Reside within the HMO service area. If you are court ordered to cover dependents who live outside the HMO service area contact UnitedHealthcare for coverage information.
- ◆ Use a UnitedHealthcare HMO provider.
- ◆ Pay a copay when you receive services.

UnitedHealthcare Choice Plus Plan

The UnitedHealthcare Choice Plus Plan offers:

- ◆ Comprehensive medical coverage for illness and injury.
- ◆ Freedom to choose your own doctors, including specialists.
- ◆ Access to a national network.
- ◆ UnitedHealthcare offers two levels of benefits. The benefits you receive depend on whether you:
 - ❖ Use providers that are part of UnitedHealthcare Choice Plus Plan (in-network).
 - ❖ Use providers that are not part of UnitedHealthcare Choice Plus Plan (out-of-network). Covered medical expenses are subject to the Maximum Allowable Charge.
 - ❖ Prescription benefits are also provided by UnitedHealthcare.

Medical Rates For 2011

The 2011 COBRA monthly medical rates for current or former employees and/or their covered dependents are listed below. The term *Insured* refers to a COBRA qualified beneficiary who has elected coverage for himself or herself and/or his or her eligible dependents.

	UnitedHealthcare HMO	UnitedHealthcare Choice Plus Plan
Insured Only	\$ 469.34	\$ 428.96
Insured and Spouse	\$ 1,053.21	\$ 962.54
Insured and Child(ren)	\$ 899.26	\$ 822.04
Insured and Family	\$1,449.35	\$1,324.74
Spouse Only	\$ 469.34	\$ 428.96
Spouse and Child(ren)	\$ 899.26	\$ 822.04
Child(ren) Only	\$ 469.34	\$ 428.96

Medical Rates for Individuals Eligible for the 65 percent Subsidy due to involuntary termination between 9/1/08 and 5/31/10. Maximum subsidy is fifteen months.

	UnitedHealthcare HMO	UnitedHealthcare Choice Plus Plan
Insured Only	\$ 164.27	\$ 150.14
Insured and Spouse	\$ 368.62	\$ 336.89
Insured and Child(ren)	\$ 314.74	\$ 287.71
Insured and Family	\$ 507.27	\$ 463.66
Spouse Only	\$ 164.27	\$ 150.14
Spouse and Child(ren)	\$ 314.74	\$ 287.71
Child(ren) Only	\$ 164.27	\$ 150.14

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. If you or your dependents have other coverage, refer to the appropriate plan document for information about Coordination of Benefits.

Appeal of a Claim

If you have questions about a claim, you should contact UnitedHealthcare. If you do not agree with their determination of benefits, you may file an appeal. For information on how to appeal a claim, including time limits, refer to the appropriate Plan Document.

Subrogation

If you or your dependents are injured or become ill under circumstances in which another individual or insurance company may be legally obligated to pay expenses, the medical plan you are enrolled in has the right to recover expenses paid by the plan. Refer to the appropriate plan document for information about subrogation.

MEDICAL PLANS COMPARISON

On the following pages you will find a Schedule of Benefits for UnitedHealthcare HMO and UnitedHealthcare Choice Plus Plan.

Things to consider when selecting a medical plan:

- ◆ Amount of out-of-pocket expenses.
- ◆ Ability to select doctor(s) of your choice.
- ◆ Predictability of inpatient hospital expenses.
- ◆ Prescription Drug coverage.

Schedule Of Benefits - UnitedHealthcare

	HMO	PPO	
		In-Network	Out-of-Network
Individual Deductible	None.	\$500 per covered person, per calendar year.	\$1,500 per covered person, per calendar year.
Family Deductible Maximum	None.	Three Individual Deductibles.	Three Individual Deductibles.
Out-of-Pocket Maximum	\$3,500 per covered person or \$7,000 per family, per calendar year.	\$3,000 per covered person, per calendar year.	\$12,000 per covered person, per calendar year.
Lifetime Maximum	Unlimited.	Unlimited.	Unlimited.
Maximum Allowable Charge	The maximum allowable charge is the maximum fee for a particular service or supply that the Plan will consider eligible for payment.	<p>The maximum allowable charge is the maximum fee for a particular service or supply that the Plan will consider eligible for payment.</p> <p>In the case of Out-of-Network benefits, the covered person may be responsible for paying charges in excess of the maximum allowable charge in addition to any deductible, coinsurance, copays, or facility fee required by the Plan.</p>	
Selection of Doctor	Members must select a network doctor.	Members select a network doctor.	Members select a non-network doctor.
Service Locations	<p>Services are provided at in-network doctors' offices, hospitals, and other medical facilities.</p> <p>If a required service is not available in-network and you obtain the service from an outside provider, pre-approval is required.</p>	<p>Services are provided at in-network doctors' offices, hospitals, and other medical facilities.</p> <p>If a required service is not available in-network and you obtain the service from an outside provider, pre-approval is required.</p>	<p>Services are provided in non-network doctors' offices, hospitals, and other medical facilities.</p>
Residency Requirements	Must live or work in the service area (Bastrop, Blanco, Burnet, Caldwell, Hays, Travis and Williamson counties). Children for whom you have been court-ordered to provide medical support are not required to live in the area.	None. UnitedHealthcare is a national network; contact UnitedHealthcare directly for a list of doctors and/or facilities in your area.	None.
Out-of-Network Benefits	None unless a medical emergency.	<p>\$1,500 deductible. Plan pays 60%, up to maximum allowable charge. Out-of-Network benefits are subject to In-Network benefit plan limits and Pre-approval and Pre-notification requirements.</p> <p>In addition to the above, Outpatient Surgical Facility subject to a \$250 facility fee. Inpatient Hospital Services subject to a \$250 per day facility fee.</p>	

Medical Benefits - UnitedHealthcare

	HMO	PPO - In-Network
Doctor's Charges <u>Office</u>	\$20 Primary Care Physician copay per visit. \$45 Specialist copay per visit.	\$20 Primary Care Physician copay per visit. \$35 Specialist copay per visit.
Well Women & Well Child Exam	Plan pays 100%, no copay.	Plan pays 100%, no copay.
Doctor's Charges <u>Maternity</u>	\$20 copay for first office visit. Plan pays 100% thereafter.	\$20 copay for first office visit. Calendar year deductible applies. Plan pays 85%.
<u>Urgent Care/Non- Hospital Minor Emergency Centers</u>	\$45 copay per visit.	\$35 copay per visit.
Convenience Care Clinics	\$20 copay visit.	\$20 copay visit.
Outpatient Surgery <u>Doctor's Charges</u> <u>Facility Fee</u> <u>Colonoscopies</u>	\$20 Primary Care Physician copay. \$45 Specialist copay per visit. \$600 copay. Plan pays 100%, no copay.	Calendar year deductible applies. Plan pays 85%. \$75 copay. Plan pays 100%, no coinsurance.
Hospital Inpatient Services <u>Doctor's Charges</u> <u>Facility Fee</u>	Included in Hospital Services. \$1,000 copay per confinement. Limited to semi-private room rate. Other than emergency room, pre-notification required.	Calendar year deductible applies. Plan pays 85%. Limited to semi-private room rate. Pre-notification required.
Hospital Emergency Room Services	\$150 copay per visit.	\$100 copay for an emergency.
Ambulance Service	\$100 copay.	Calendar year deductible applies. Plan pays 85%.
Allergy and other Covered Injections	Injections are covered at 50%. Plan pays 50% for allergy serum and allergy testing. Plan pays 100% for all other injections. If charged for an office visit, office visit copays apply.	Injections are covered at 100%. Plan pays 100% for allergy serum and allergy testing. If charged for an office visit, office visit copays apply.
Immunizations	Plan pays 100%, if charged for an office visit, office visit copays apply.	Plan pays 100%, if charged for an office visit, office visit copays apply. 30% coinsurance for Shingles vaccination if under age 60.
Physical and Occupational Therapy	\$45 copay per visit.	\$35 copay per visit.
Chiropractic	\$45 copay per visit. Limited to 20 visits per covered person, per calendar year.	\$35 copay per visit. Limited to 20 visits per covered person, per calendar year.
Speech Therapy	\$45 copay per visit. Limited to rehabilitary speech therapy.	\$35 copay per visit. Limited to 48 visits per covered person, per calendar year.
Nutrition Consultation	\$45 copay per visit. Limited to three visits per covered person, per calendar year.	\$35 copay per visit. Limited to three visits per covered person, per calendar year.

Medical Benefits - UnitedHealthcare

	HMO	PPO - In-Network
Acupuncture	Not covered.	\$35 copay per visit. Limited to \$1,000 per covered person, per calendar year.
Outpatient Diagnostic X-Ray and Laboratory CT, MRI, PET Scans	Plan pays 100%. \$100 copay. Pre-notification required.	Plan pays 100%. \$100 copay. Pre-notification required.
Mental Health Care <u>Outpatient</u>	\$45 copay per visit.	\$35 copay per visit.
Mental Health Care <u>Inpatient</u>	\$1,000 copay per confinement. Pre-notification required.	Calendar year deductible applies. Plan pays 85%. Pre-notification required.
Chemical Dependency	\$1,000 copay per confinement. Pre-notification required.	Calendar year deductible applies. Plan pays 85%. Pre-notification required.
	Lifetime maximum benefit of three series of treatments per covered person.	
Extended Care/Skilled Nursing Facility	\$25 copay per day. Limited to 30 days per covered person, per calendar year. Pre-notification required.	Calendar year deductible applies. Plan pays 85%. Limited to 60 days per covered person, per calendar year. Pre-notification required.
Home Health Care	\$30 copay per visit.	Plan pays 100%. Limited to 120 visits per covered person, per calendar year.
Hospice Care	Plan pays 100%. Calendar Year maximum benefit of \$20,000 per covered person. Pre-approval required.	Plan pays 100%. Pre-approval required.
Durable Medical Equipment	Plan pays 100%. Pre-notification required.	Calendar year deductible applies. Plan pays 85%. Pre-notification required for any item over \$1,000.
Medical Supplies	Plan pays 80%.	Calendar year deductible applies. Plan pays 85%. Pre-notification required for any item over \$1,000.
Prosthetic/Orthotic Devices	Plan pays 80%. Pre-notification required.	Calendar year deductible applies. Plan pays 85%. Pre-notification required for any item over \$1,000.
Diabetic Equipment Insulin pumps/related supplies	Plan pays 80%. Pre-notification required.	Calendar year deductible applies. Plan pays 85%. Pre-notification required for any item over \$1,000.
Diabetic Supplies	See Prescription Drug Benefits.	
Other Covered Medical Expenses	Refer to your Medical Plan Document or contact UnitedHealthcare.	

Prescription Drug Benefits- UnitedHealthcare

	HMO	PPO - In-Network
Retail Pharmacy <i>Limited to a 30-day supply.</i>	<u>Generic/Preferred/Non-Preferred</u> Tier 1 / Tier 2 / Tier 3 \$10 / \$35 / \$55 copay per prescription.	<u>Generic/Preferred/Non-Preferred</u> Tier 1 / Tier 2 / Tier 3 \$10 / \$30 / \$50 copay per prescription.
Mail Order Pharmacy <i>Limited to a 90-day supply.</i>	\$30 / \$105 / \$165 copay per prescription.	\$20 / \$60 / \$100 copay per prescription.
Diabetic Supplies See also Diabetic Equipment	Supplies are covered at a participating pharmacy for copays listed above. Insulin and related diabetic supplies can be purchased with one copay using mail order. Preferred (Tier 2) or non-preferred (Tier 3) copays apply. Insulin pumps and supplies are covered under Durable Medical Equipment. PPO participants must meet annual deductible. Co-insurance will apply on both plans for Diabetic Equipment.	
<p>Smoking Cessation Program/Drugs – An individual can receive an FDA approved smoking cessation drug at no cost, if the individual:</p> <ul style="list-style-type: none"> • Is covered under a City medical plan. • Attends one of the smoking cessation programs conducted by the City’s Employee Assistance Program. • Obtains a prescription from his or her physician. • Contacts the Employee Benefits Division. <p>This provision applies to prescription smoking cessation drugs and to over-the-counter nicotine replacement therapy drugs (patch, gum, etc.) at a retail pharmacy or through mail order.</p>		

Vision Benefits Provided - UnitedHealthcare

	HMO	PPO- In-Network	
		Routine Vision Network	Choice Plus Plan In-Network
Annual Routine Vision Exam	\$10 copay for eyeglass vision exam or contact lens exam. Members must use the Routine Vision Network.	\$20 copay.	\$35 copay.
Annual Contact Lens Fitting Fee	Amount charged is due at time service is rendered. Submit a vision claim form for reimbursement of contact lens fitting fee, less a \$10 copay.	Amount charged is due at time service is rendered. Submit a vision claim form for full reimbursement of contact lens fitting fee.	Included in Annual Routine Vision Exam copay.
Frames, Standard Lenses and Contact Lenses	Preferred Pricing at participating private practices. Preferred Pricing discounts at participating retail chain providers.	Preferred Pricing at participating private practices. Preferred Pricing discounts at participating retail chain providers.	Not available at private practices. Retail chain providers may offer a discount.

DENTAL COVERAGE

The following information is a *summary* of dental benefits. In the case of a conflict between the information provided in this section of the *Guide* and the Dental Plan Document, the Dental Plan Document governs.

If you have specific questions about your dental coverage, contact Erisa Administrative Services, claims administrator for the dental plans, or the Employee Benefits Division of the Human Resources Department.

Features of the Plan

The plan allows you to choose your own dentist and provide coverage for the following types of dental care:

◆ Preventive	◆ Major
◆ Basic	◆ Orthodontia

There is no deductible for preventive care. For other services, each covered member must meet a \$50 deductible each calendar year before the plans pay any expenses. Reimbursement of all covered dental expenses is subject to a calendar year maximum and orthodontic lifetime maximum.

Coverage for preventive, basic, and major dental care is determined by a fixed fee schedule as listed in the Dental Plan Document. For each dental procedure listed under the *Table of Allowances* in the Dental Plan Document, the plan pays up to the amount listed.

Dental Assistance Plan	
Calendar Year Maximum	\$1,800
Orthodontia Lifetime Maximum	\$1,800
Orthodontia Treatments	Covered at 50%
Amalgam, resin-based composite fillings – ADA Code 2140	Maximum allowable amount \$114.46
Night guards, splints, implants, and over dentures – ADA Code 9940	Not Covered
Crowns – ADA Code 6740	Maximum allowable amount \$519.94
Periodontal Scaling – ADA Code 4341	Maximum allowable amount \$169.24
Tooth Extraction – ADA Code 7140	Maximum allowable amount \$103.56

The *Table of Allowance* for orthodontia care lists the type of service and the maximum allowable amount for that service. Reimbursement for orthodontia care is provided only if the member's treatment plan began after he or she became covered under either plan. Orthodontia care expenses are paid only as the work progresses and receipts are submitted for reimbursement. All orthodontia benefits paid by the plan is applied toward the calendar year maximum.

Rates

The COBRA monthly dental rates are listed below. The term *Insured* refers to a COBRA qualified beneficiary who has elected COBRA coverage for himself or herself and/or his or her eligible dependents.

Dental Assistance Plan	
Insured Only	\$33.97
Insured and Dependents	\$95.10
Dependents Only	\$61.14

Dental Rates for Individuals Eligible for the 65 percent Subsidy due to involuntary termination between 9/1/08 and 5/31/10. Maximum subsidy is fifteen months.

Dental Assistance Plan	
Insured Only	\$11.89
Insured and Dependents	\$33.29
Dependents Only	\$21.40

Filing a Claim

You may obtain City of Austin Dental Claim forms from Erisa or by downloading the form at: www.cityofaustin.org/benefits/enrollment. Claims must be filed for services received more than 90 days after the end of the year in which services were incurred.

Appeal of a Claim

If you have questions about a claim, you should contact Erisa. If you do not agree with Erisa's determination of benefits, you may file an appeal. For more information on how to appeal a claim, including time limits, refer to the Dental Assistance Plan Document.

Subrogation

If you or your dependents are injured or become ill under circumstances in which another individual or insurance company may be legally obligated to pay expenses, the City has the right to recover expenses paid by the Plan. Refer to the Dental Assistance Plan Document for information about subrogation.

VISION PLAN

This plan provides coverage for annual eye exams, lenses, glasses, contacts, and a discount on refractive surgery. The Plan is separate from the vision coverage offered under UnitedHealthcare.

Plan Design

The following is a Schedule of Benefits for the Davis Vision Plan. To find Davis Vision care providers and for more plan information, go to: www.davisvision.com, or call 1-888-445-2290. If you are not a current member, click on the Member link under the Open Enrollment/Discount Plan section and enter the client code 2481.

- Eyeglass lenses and frames are a \$25 combined copay, one pair per calendar year. In lieu of glasses, individuals may purchase contact lenses. Some restrictions apply to glasses and contact lenses.
- Out-of-network benefits are available.

Covered Service	Benefit
Eye Exams – include dilation	\$10 copay
Lenses	
Standard single-vision, lined bifocal, or trifocal	\$25 copay
Lens Options	
UV Coating	\$12
Standard Scratch-Resistance	\$0
Standard Polycarbonate	\$30 or \$0 for children up to age 19
Standard Anti-Reflective	\$35
Frames Once per calendar year In lieu of contacts	Any Fashion or Designer frame from Davis Vision’s Collection, covered in full Or Any Premier frame from Davis Vision’s exclusive Collection; after an additional \$25 copay Or \$120 retail allowance toward any frame from provider
Contact Lenses Once per calendar year In lieu of glasses	Any contact lenses from Davis Vision’s Contact Lens Collection (up to 4 boxes of disposables); Covered in Full Or \$120 retail allowance toward provider supplied contact lenses
Contact Lens Evaluation, Fitting & Follow-Up Care In lieu of glasses	Davis Vision’s Collection: Covered in full, after \$25 copayment Or NON-Davis Vision’s Collection contact lenses: \$60 allowance after \$25 copayment

Vision Rates for 2011

Vision	Davis Vision
Insured Only	\$ 4.45
Insured and Spouse	\$ 8.81
Insured and Child(ren)	\$ 8.65
Insured and Family	\$13.16
Spouse Only	\$ 4.45
Spouse and Child(ren)	\$ 8.65

Vision Rates for Individuals Eligible for the 65 percent Subsidy due to involuntary termination between 9/1/08 and 05/31/10. Maximum subsidy is fifteen months.

Vision	Davis Vision
Insured Only	\$ 1.56
Insured and Spouse	\$ 3.08
Insured and Child(ren)	\$ 3.03
Insured and Family	\$ 4.61
Spouse Only	\$ 1.56
Spouse and Child(ren)	\$ 3.03