2022 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 and assist you in making your enrollment decisions. Your rights are overseen by each Plan. The terms of the Plan and detailed coverage information are included in the document made available by the Plan, which may be a plan document, evidence of coverage, certificate of coverage, contract, etc.

In the case of a conflict between information presented in this Guide and the Plan, the Plan's terms take over.

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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 *800-735-2989* (Relay Texas TTY number) for more information.

Contact Information

City of Austin
Human Resources Department
Employee Benefits Division

Benefits staff are available by phone or in person to discuss benefits questions. For your convenience, please make an appointment before visiting our office.

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

Office Hours: 8 a.m. to 5 p.m.
Office Location: 505 Barton Springs Road, Suite 600

Online Resources
To access benefits information, visit 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 website.

BlueCross BlueShield
Medical Plans & BlueCare Dental PPO

Toll-Free Number: *888-907-7880*
24/7 NurseLine Phone Number: *800-581-0368*

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

1. Click ***Log in***.
2. Click ***Register Now***.
3. Follow the prompts to register.
4. Enter information from your ID card. If you do not have your ID card, you can call the Internet Help Desk at *888-907-7880.*

To find a medical provider, visit bcbstx.com/coa.
1. Click on ***Doctors and Hospitals*** tab.
2. Under ***Find a Provider*** click on ***HMO Plan, PPO Plan, or HRA Plan***.
3. Click ***Browse by Category*** and select the type of medical care you are searching for: Medical Care, Urgent Care Center, or Behavioral Health or ***Search for Names and Specialties***.

To find a dental provider, visit bcbstx.com/coa.
1. Click on ***Dental*** tab.
2. Click on ***Find a Dentist***.
3. Select the criteria by which you want to search for an in-network dentist:
   - Search by Dentist Name
   - Search by Location
   - Search by County
   - Search by Center Name

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

Avesis
Vision Plan

Toll-Free Number: *866-563-3589*

To view benefits, locate a provider, and check claim status, visit avesis.com. To register, follow these steps:

1. Click ***Member***
2. Click ***Sign Up to Register***.
3. Enter contact and account information.
4. Agree to Terms and Conditions.
5. Click ***Submit and Get Started***.

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

Sun Life Financial DHMO Plan

Toll-Free Number: *800-443-2995*
Website: sunlife.com/onlineadvantage

To register, follow these steps:
1. Website: sunlife.com/account
2. Click on *New User?* Create an account.

ComPsych GuidanceResources®
Employee Assistance Program

Toll-Free Number: *866-586-1456*

To view a list of free webinars, counseling services and more visit guidanceresources.com To access, follow these steps:

1. Click the ***Register*** tab.
2. Enter ***austintexas.gov*** as your ***Organization Web ID*** and click the ***Register*** button.
3. Enter a user name and password.
4. Confirm security questions.
5. Click the ***Submit*** button.

City of Austin
Employees' Retirement System (COAERS)

6836 Austin Center Blvd., Suite 190
Austin, TX 78731

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*
Email: dcaustin@empower-retirement.com

To view and manage your account, visit dcaustin.com. To enroll, click ***Register***.

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

- **Spouse:** Your legally married 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 26, 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.

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.

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 the Texas Department of Family and Protective Services (TDFPS), which meets the requirements listed in Dependent Eligibility.

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 extended family members not listed under the Eligible Dependents section.
- Grandchildren who do not meet the definition of dependent grandchildren and who are not claimed on your or your spouse's federal tax return.

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 schedule an appointment to complete a Benefits Enrollment Form.

Benefits Enrollment for Surviving Dependents

To be eligible, the dependent must have been enrolled in the retiree's medical, dental, or vision coverage at the time of the retiree's death. As a surviving dependent, you are eligible to continue your medical, dental, or vision benefits. If at any time you cancel all benefits, you cannot re-enroll in surviving dependent benefits.

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

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 Qualifying Life 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 Retiree and Children or 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 ended or is reduced.
- You voluntarily drop 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.
- The coverage in question ended or is reduced.
- You voluntarily drop your or your dependent's coverage.
- You or your dependents no longer meet eligibility requirements.

Duplicate Benefits Coverage

An individual is not eligible to be covered:

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

Any individual found to have duplicate benefits coverage for the same benefit (including life insurance) will automatically be dropped from the duplicate benefit.

Canceling Coverage

You may cancel medical coverage for yourself and your dependents, 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 Qualifying Life Event.
Exception: If you are covered by Sun Life Financial, and you move where there are no plan providers in your service area, you may switch to the BlueCare Dental PPO or drop coverage.

Medicare Eligibility Requirements

If you, your covered spouse/domestic partner, or surviving spouse are enrolled in a City medical plan and are eligible for Medicare due to age, the City requires that you enroll in Medicare Part A (Hospital Insurance) & B (Medical Insurance).

When enrolled in Medicare, Medicare is considered primary, and the City's medical plan is considered secondary. If you do not enroll in Medicare Parts A and B, the City's medical plan will pay claims as if you were enrolled in Medicare Parts A & B.

If enrolled in Parts A & B, the City requires you to send a copy of your Medicare Health Insurance card or verification of Medicare enrollment from the Social Security Administration Office indicating the coverage effective dates for Parts A & B. It is your responsibility to ensure that the City receives your Medicare information before your Medicare Coverage effective date. Your reduced medical premium will take effect the following month from the date received. If an incorrect premium deduction occurs, no refunds will be issued.

In addition to medical coverage, the City's medical plan provides prescription drug coverage. If you choose to continue your medical coverage through the City of Austin, you s**hould not** enroll in Medicare Part D (Drug coverage).

If you need assistance in enrolling in Medicare or have Medicare questions, please contact the Social Security Administration Office at *800-772-1213* or access their website at medicare.gov.

Coordination of Benefits

A group health insurance provision that determines which coverage will apply (primary or secondary) when an individual is covered under more than one plan. In most cases, medical coverage offered through the City is considered primary while under age 65. If you or your dependents have other coverage, refer to the appropriate plan document for information about Coordination of Benefits.

If enrolled in another employer's plan as an active employee and the City plan as a retiree, medical claims will be paid in the following order:

- **Primary -** your employer's medical plan.
- **Secondary -** Medicare.
- **Third -** City of Austin medical plan.

Medical Plans

As a retiree, you may choose the medical plan that best meets your needs. Provider and prescription information is available online at bcbstx.com/coa.

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 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 are available. Despite these similarities, the plan works differently. Read on to see if the CDHP w/HRA plan is right for you.

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	$ 100	$ 200
5 through 9	$ 200	$ 400
10 through 14	$ 300	$ 600
15 through 19	$ 400	$ 800
20 or more	$ 500	$1,000

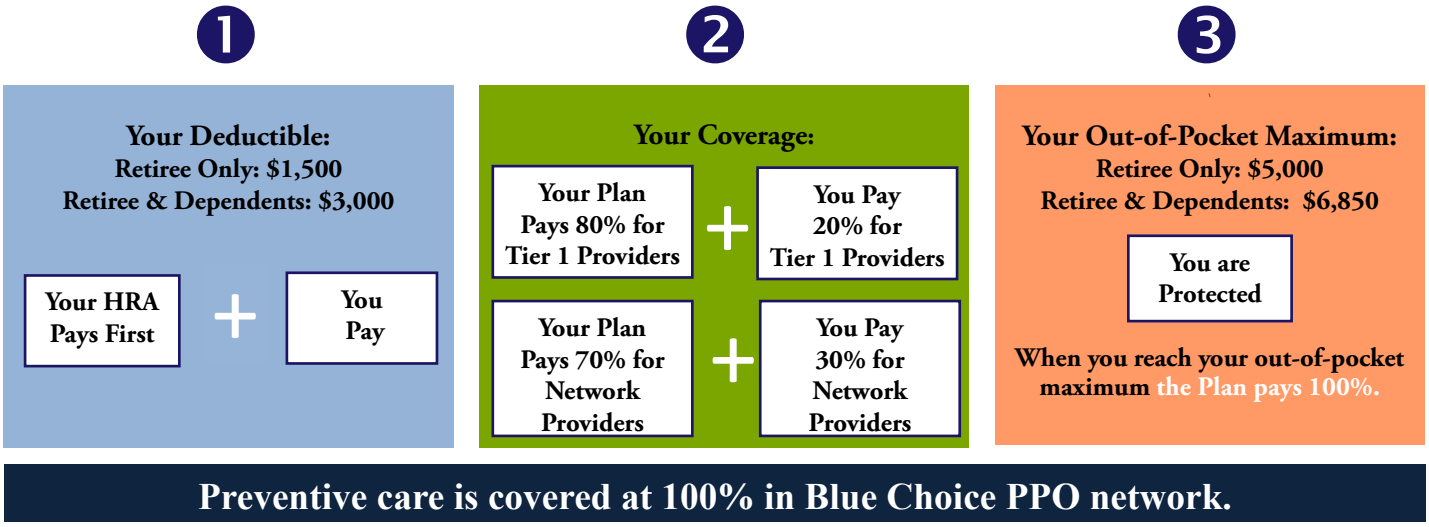
How the CDHP w/HRA Works

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 (ACA) continue to be covered at 100 percent.
- You must meet your calendar year deductible for medical services before the plan pays for any covered services (except for preventive 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 for the remainder of the calendar year.
- The CDHP w/HRA includes three prescription formularies:
  - ❖ ACA Preventive Drug List – The plan pays 100 percent, no deductible.
  - ❖ CDHP w/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 website 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. BlueCross BlueShield will automatically draw the funds from your HRA account when medical or prescription claims are processed.

Even though the money in the HRA is City money, 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 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 deductible is met.

2. Your Coverage.
Your plan pays a percentage of your expenses after the deductible is met. 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. The plan will then pay 100 percent of all remaining in-network 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 w/HSA Preventive Drug List visit 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 for general health, $100 per session for therapy counseling, and $175 per session for psychiatry.		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	Not covered. For discounts, visit Blue365 at blue365deals.com/bcbstx.	Not covered. For discounts, visit Blue365 at blue365deals.com/bcbstx.

CDHP Pharmacy Benefits

Plan Features (In-Network)	CDHP (Blue Choice PPO)
Affordable Care Act (ACA) Preventive Drug List	Plan pays 100% no deductible.
CDHP w/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 drugs covered can be found at: bcbstx.com/coa.

PPO & HMO Schedule of Benefits

	PPO (Blue Choice PPO)		HMO (Blue Essentials)	
	Tier 1 Providers	**Network Providers**	**Tier 1 Providers**	**Network Providers**
Individual Deductible	$600 per covered person.		None.	
Family Deductible Maximum	Three individual deductibles.		None.	
Out-of-Pocket Maximum	$4,250 per covered person or $13,250 per family, per calender year.		$4,750 per covered person or $9,500 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 from your PCP to seek services outside of your PCP including Specialists. 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 your PCP on a monthly basis. The change is effective the first day of the following month.	
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	$2,000 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. Inpatient Admissions are subject to a $500 copay per admission.		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/Telemedicine Visit Copay Primary Care Specialist	 $15 $30	 $30 $50	 $15 $40	 $30 $60
Convenience Care Clinics Copay	$25		$25	
Urgent Care Copay	$40		$50	
Emergency Room Copay	$300		$350	
Ambulance Services	Plan pays 80% after deductible.		$300 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.	$1,750 copay.	$3,000 copay.
Allergy Services	Plan pays 100%.		Plan pays 50%.	
Immunizations	Plan pays 100%. Office visit copays may apply.		Plan pays 100%. Office visit copays may apply.	
Physical, Speech & Occupational Therapy Registered Dietitian Chiropractic Care Copay (20 visit limit)	$40		$50	
Acupuncture Copay (12 visit limit)	$40		Not covered.	
CT, MRI, PET Scans Copay	$100		$150	
Mental Health Care Outpatient Copay	$15		$15	
Durable Medical Equipment	Plan pays 80% after deductible.		Plan pays 100%.	
Disposable Medical Supplies & Prosthetic-Orthotic Devices	Plan pays 80% after deductible.		Plan pays 80%.	
Insulin Pumps Copay	$100		$150	
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	Not covered. For discounts, visit Blue365 at blue365deals.com/bcbstx.	Not covered. 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%.
Deductible	$50 annual deductible applies to Tier 2 and Tier 3 drugs.	$50 annual deductible applies to Tier 2 and Tier 3 drugs.
Basic Drug List - Tier 1 (Generic)	$10 copay.	$10 copay.
Basic Drug List - Tier 2 (Preferred)	Tier 2: **$30** or 20% of cost (up to **$60**).	Tier 2: **$35** or 20% of cost (up to **$70**).
Basic Drug List - Tier 3 (Non-preferred)	Tier 3: **$50** or 20% of cost (up to **$100**).	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 participating pharmacies.
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 testing supplies for free if the participant is covered under a City sponsored medical plan, at least 15 years of age, and completes requirements of the HealthyConnections Diabetes Program.

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

Using Mail Order

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

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.

Your cost:

- **CDHP w/HRA** participants will pay 20 percent of the cost once the in-network deductible is met. Your HRA will pay first. If the prescription is for a preventive care medication listed on the CDHP w/HSA 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.

For additional information, visit bcbstx.com/coa or call BlueCross BlueShield at *888-907-7880.*

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.
- **PPO** participants will pay ***two*** copays/coinsurance for a 90-day prescription.
- **HMO** participants will pay ***three*** copays/coinsurance for a 90-day prescription.

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

HEB Prescription Delivery Service

Free prescription delivery is available to your home in the following Texas areas: Austin, San Antonio, Waco, Houston, Corpus Christi, and Border areas within 10 miles of an HEB store.

How does it work?

- Call your HEB Pharmacy and ask for prescription delivery.
- Pay the applicable prescription copay/coinsurance by a credit card, debit card, or your HRA.
- Have someone 18 years or older at home to sign for the delivery.
- Provides delivery of prescriptions filled Monday—Friday by 4 p.m. except for major holidays.
- Delivers medications as late as 8 p.m.

For more information, call your local HEB Pharmacy.

Medical Programs

BlueCross BlueShield of Texas

Cancer Services – 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 Disease – 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.
- Assist with other health concerns, such as high blood pressure, anemia, or nutrition.

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 experienced registered nurses.
- Trusted, physician-approved information to guide your health care decisions.

When you call, a registered nurse can:

- Discuss your options for the right medical care.
- Help you understand treatment options.
- Answer medication questions.
- Assist in guiding you to the correct treatment facility (i.e., Urgent Care, Emergency Room, etc.).

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*.

Virtual Visits

Talk to a board-certified physician for both general health and behavioral health conditions from the comfort of your home or work. There's no driving, no crowded waiting rooms, and it's available 24 hours a day, 7 days a week. Common services treated include, cold/flu, allergies, asthma, sinus/ear infections, and pink eye. Behavioral health services include, online counseling, child behavior/learning issues, and stress management.

For the PPO and HMO Plan, virtual visits are a $10 copay for general or behavioral health. For the CDHP Plan, virtual visits are approximately $49 for general health, $100 per session for therapy counseling, and $175 per session for psychiatry.

Log in to bcbstx.com/coa or download the BCBSTX app on your smartphone to access Virtual Visits powered by MDLIVE. You will need your BlueCross BlueShield medical ID number and your banking/credit card information readily available to charge your copay.

For more information about any of these programs, call BlueCross BlueShield at *888-907-7880*.

Cost for Coverage

Retirees

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

- Creditable 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 creditable years of service with the City.
- Medicare eligibility. (Applies only to the retiree's spouse).

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

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.

Premium Payments

Your benefits premium will automatically be deducted from your monthly retirement annuity. If your annuity is not enough to cover your premium, 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 your monthly payment that is 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

It is your responsibility to ensure that information on your enrollment form, your annual Open Enrollment Coverage Statement and Confirmation Statement is correct. If a premium deduction error occurs, you must notify the Employee Benefits Division.

If an overpayment occurs due to a City data entry error or an error you made when completing your enrollment form or participating in Open Enrollment, the City will reimburse you up to a maximum of one month of premiums. Conversely, if an underpayment occurs due to the City data entry error or the error you made, the City has the right to collect any additional premiums owed. The data entry error will not invalidate the coverage reflected on your enrollment form.

Retiree Medical Rates for 2022

"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 2022

	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 2022

	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

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

To view benefits and locate a provider, visit avesis.com or call *866-563-3589*.

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 frame plus 20% off cost exceeding the allowance.* ***OR*** Up to $175 retail allowance if purchased at Vision Works plus 20% off cost exceeding the allowance. ***OR*** Up to $200 retail allowance toward frames if purchased using UVP Online. One year eyeglass breakage warranty included at no additional cost.		**Contacts** – Once per calendar year in lieu of frames. Up to $120 allowance toward provider supplied contacts plus an additional discount off the cost exceeding the allowance*– 10% for disposable contacts and 15% for standard contacts. ***OR*** Medically necessary contact lenses are **covered in full** with prior approval. Standard & Specialty Contacts - Evaluation, fitting fees, and follow-up care; $25 copay applies.	
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, Sam's Club, and Costco.			

Vision Rates – Monthly Premiums

Retiree Only	$ 3.96	V1
Retiree & Spouse or Domestic Partner	$ 8.56	V2
Retiree & Children	$ 8.12	V3
Retiree & Family or Domestic Partner & Children	$ 12.94	V4
Surviving Spouse Only	$ 3.96	V6
Surviving Spouse & Children	$ 8.12	V8
Surviving Children Only	$ 3.96	V9

Dental Plans

BlueCare Dental PPO

BlueCare Dental PPO provides you the option of seeking services from in-network and out-of-network dentists. Selecting a dentist from the BlueCare Dental PPO network will offer you the greatest savings. When contacting a dentist, ask whether the dentist participates in the BlueCare Dental PPO network. To find a dentist, view claims activity, or for more information visit bcbstx.com/coa or call BlueCare Dental at *888-907-7880*.

Plan features include:

- Freedom to choose dentist of your choice.
- Coverage for in and out-of-network dentists.
- Preventive Care – no deductible.
- Basic, Major, and Orthodontia Care – $50 annual deductible, per covered person.
- Calendar Year Maximum – $1,000 per covered person (includes Orthodontia Treatment).
- Orthodontia Lifetime Maximum – $1,000 per covered person.

In-network and out-of-network dentists:

- If you seek services from an in-network dentist:
  - ❖ Claim will be paid in full up to the Calendar Year Maximum, you will not be balance billed.
  - ❖ Based on reduced contracted rates, it will take you longer to reach your Calendar Year Maximum of $1,000.
  - ❖ For covered services and exclusions refer to the BlueCare Dental PPO Plan Document online at austintexas.gov/retirees.
- If you seek services from an out-of-network dentist:
  - ❖ Claim will be paid based on the Table of Allowance.
  - ❖ Orthodontia services are covered up to the Table of Allowance as work progresses.
  - ❖ For covered services, exclusions, and the Table of Allowance, refer to the BlueCare Dental PPO Plan Document online at austintexas.gov/retirees.

Sun Life Financial DHMO

The Sun Life Financial Plan is a prepaid dental plan that offers benefits and a network of plan dentists. Members must select a network general dentist if enrolled in this plan, and 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 https://www.sunlife.com/us/Resources/Tools/Find+a+dentist/.

	BlueCare Dental PPO In-Network	BlueCare Dental PPO Out-of-Network	Sun Life Financial DHMO In-Network
Selection of Dentist	Member can go to any in-network dentist. Member will realize greater savings when using in-network dentists.	Member can go to any dentist; however, the customer is responsible for the difference over the Table of Allowance.	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, per calendar year. Deductible does not apply to Preventive Care.		None.
Covered Services (other than Orthodontia)	Preventive Care – covered in full. Basic Care – covered in full. Major Care – covered in full.	Preventive Care – covered up to the Table of Allowance. Basic Care – covered up to the Table of Allowance. Major Care – covered up to the Table of Allowance. Also responsible for amounts over the Table of Allowance.	Member pays applicable copays according to the schedule of benefits when services are provided by a network dentist.
Orthodontia	Orthodontia Care – covered in full as work progresses up to Calendar/Lifetime Maximum. Orthodontia work already in progress is not covered prior to enrolling in a City-sponsored plan.	Orthodontia Care – covered up to the Table of Allowance as work progresses. Orthodontia work already in progress is not covered prior to enrolling in a City-sponsored plan.	25% discount when services are received from a network specialist. No age limitations (adults and children are both covered).
Annual Maximum Benefit	$1,000 per person, per calendar year.	$1,000 per person, per calendar year. Also responsible for amounts over the Table of Allowance.	No maximum for network dentist. $2,000 annual maximum for nonplan specialty dentist.

Table of Allowance – The most BlueCare Dental PPO will pay a dentist for a covered service or procedure when using an out-of-network dentist.

	BlueCare Dental PPO In-Network	BlueCare Dental PPO 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.
One Year Commitment	Allows members to cancel coverage only during Open Enrollment or within 31 days of a Qualifying Life Event.		
Identification Cards	Two cards		Two cards
Claim Forms	Dentists file claims for covered expenses.	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.

Dental Rates – Monthly Premiums

	BlueCare 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 Only	$ 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

Retiree Wellness Program

Why Engage in Wellness?

The goal of the Wellness program is to increase preventive screening rates and reduce preventable medical claims. Wellness programs are behavioral health interventions that are designed to improve health outcomes and reduce medical claims.

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

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/coa. 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.

Diabetes Control Program – Receive Diabetes Medications and Supplies at No Cost

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 retirees and dependents who are diabetic or prediabetic and enrolled in a City medical plan.

Participants Receive:

- Approved diabetes medications and testing supplies at no cost.
- Comprehensive Diabetes education.
- Quarterly screenings through a pharmacist (three visits per year required).
- Access to the Livongo Diabetes Management & Support Program.

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

New Livongo Heart Health Program

Get help managing your high-blood pressure and making lifestyle changes with Livongo. You'll receive a bluetooth connected blood pressure monitor that provides real-time insights. One-on-one support from expert coaches help you make lifestyle changes and better manage your high-blood pressure. The program is available at no-cost to members enrolled in a City medical plan. Members can enroll in the Livongo Program by registering at get.livongo.com/coa.

Maternity Support

This program is offered by BlueCross BlueShield and is available to pregnant, covered members enrolled in a City medical plan. The program is designed to provide the support and information needed for a healthy pregnancy. Participants will receive personalized maternity care and assistance in managing high-risk conditions including gestational diabetes and preeclampsia. To enroll, call BlueCross BlueShield at 888-907-7880. Participants of the Maternity Support program will also be referred to the Family Connects program through Austin Public Health. Family Connects offers in-home consultations with Registered Nurses to identify needs and connect families with available resources.

Wondr Online Weight Management Program

This simple, online program helps retirees 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, call HealthyConnections at *512-974-3284* and ask to speak to a Wellness Consultant.

Nationwide Fitness Program

Make it simple to go to the gym by joining the BlueCross BlueShield Fitness Program. Get access to more than 9,000 fitness centers with no contract required, making it easy to visit the gym at your convenience—near home, near work and while traveling. As a City of Austin retiree enrolled in a City medical plan, you and your covered dependents (age 18 and older) are eligible to join. Fitness Program members get unlimited access to a nationwide network of participating fitness centers. Visit bcbstx.com/coa for details and plan pricing.

Tobacco Cessation 101 - Receive Cessation Medications

Gain the resources and support needed to quit using tobacco products. Classes designed for all forms of tobacco use are available online, by telephone or by webinar.

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 medical plan are eligible for this benefit. The scheduled classes can be found on austintexas.gov/retirees.

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 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. Retirees and spouses/domestic partners can attend a class without registering.

Health & Lifestyle Expos

HealthyConnections sponsors citywide Health & 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.

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.

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. Flu shots administered are standard dose quadrivalent flu shots.

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 calling the Employee Benefits Division at *512-974-3284*.

For more information on HealthyConnections programs, visit austintexas.gov/retirees.

Employee Assistance Program (EAP)

ComPsych GuidanceResources® services provides short-term confidential counseling to help you and members of your household deal with life's stresses. The EAP provides resources to help you address a wide variety of issues. Services are available 24 hours a day, seven days a week at no cost to you.

ComPsych® GuidanceResources® Worldwide

Your EAP benefits will give you and the members of your household confidential support, resources, and information for personal and work-life issues.

ComPsych GuidanceResources® can help you with:

- Marital/family problems
- Stress, Anxiety & Depression
- Grief & Loss
- Work/vocation issues
- Domestic violence
- Psychological issues

ComPsych Guidance Resources can also assist with work/life issues such as:

- Legal Guidance – Including a free 30-minute consultation
- Financial Guidance
- Child/elder care referral
- Home repair
- Online Support and more

Go Mobile! Access your GuidanceResources® program anytime, anywhere!
The GuidanceNowSM app gives you fast, easy access to Employee Assistance Program resources.

Guidance NOW℠

Check it out! Download the app from your smartphone or tablet.

- Search GuidanceResources (one word)
- Install GuidanceNow
- To register, click the Register link. Enter austintexas.gov as the Organization Web ID.

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 Retiree Beneficiary Designation form for this purpose. Unless prohibited by law, your life insurance benefits will be distributed to the beneficiaries you named. Current Texas law states a legally married spouse is entitled to 50 percent of the policy, and if not listed as a named beneficiary, the spouse may contest.

If you are legally married and designate less than 50 percent of your life insurance to your spouse, upon your death the life insurance carrier may contact your spouse for confirmation of this reduced percentage. If your spouse is not in agreement and an agreement is not reached between the beneficiaries listed, the Texas court will make the decision.

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 certified death certificate.
- Vendor claim forms.

Retiree Discount Page

You can save at thousands of retailers in your neighborhood and around the country. Whether it is the local show & save program, discounted gift cards or national deals, savings are just a click away. Visit austintx.perksconnection.com on your computer, tablet or smart phone. If registering with a tablet or smart phone, enter group code **AUSTINTX**.

Important Benefits Information

Summary of Benefits and Coverage (SBC)
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, visit austintexas.gov/retirees or call *512-974-3284*.

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,* use the Relay Texas TTY number *800-735-2989* for assistance, or visit 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)
Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, if the employer's group health plan is self-funded rather than provided through an insurance policy, these employers are permitted to elect to exempt their group health plan from the requirements listed below. The City of Austin has elected to exempt all its self-funded medical plans, CDHP, PPO, and HMO, from all the following requirements. However, while exempt from these provisions, the City of Austin medical plans do provide benefits to employees that are comparable to those required by the Public Health Service Act:

1. Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.

2. Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

3. Certain requirements to provide benefits for breast reconstruction after a mastectomy.

4. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these Federal requirements will be in effect for the plan year beginning January 1, 2022 and ending December 31, 2022. The City of Austin may renew this election for subsequent plan years.

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.

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 Dependent 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 medical 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 only eligible for Continuation of Coverage for Domestic Partners.

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, call 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*.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Texas, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or call *1-877 KIDS NOW* or insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

You may be eligible for assistance paying your employer health plan premiums. The following is current as of January 31, 2022. For more information on eligibility, visit gethipptexas.com/ or call *877-440-0493*.

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact:

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

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