2012
Benefits Enrollment Guide

For Retirees and Surviving Spouses

Medical
Vision
Dental
Life Insurance
Wellness

Important Information for Retirees and Surviving Spouses

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

This Guide is designed to help you understand your benefits. Review this material carefully before making your enrollment decisions. Keep this Guide to refer to during the 2012 Plan Year.

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

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The City of Austin is committed to compliance with the Americans with Disabilities Act.

Call Human Resources Department at 512-974-3400 (Voice) or 800-735-2985 (Relay Texas TTY Number) for more information.

Contact Information

City of Austin
Human Resources Department
Employee Benefits Division

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

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

Retirees should make an appointment before they visit our office.

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

Online Information

You can access benefits information and download forms online at: www.cityofaustin.org/benefits/enrollment

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

UnitedHealthcare HMO and PPO

Medical Plans

Medical Phone Number: 800-430-7316
Medical Providers: www.myuhc.com
Prescription Information: www.myuhc.com or www.365wellst.com
Vision Providers: www.uhcvision.com
Vision Phone Number: 800-203-4317
Mental Health Providers: www.ubhprovider.com

To find a medical provider go to ***View Directory*** at the main page of the UHC website, www.myuhc.com. Click on ***Find Physician or Facility*** and follow the steps. Be sure you select ***UnitedHealthcare Choice*** for the HMO or ***UnitedHealthcare Choice Plus*** for the PPO from the drop down menu.

You must register at www.myuhc.com to print a temporary ID card or print an explanation of benefits.

1. Click the ***Register Now*** button.
2. Enter ID card information or your Social Security Number and birth date as requested.
3. Enter the UnitedHealthcare group number – **704244**
4. Enter email address or sign up for a free email account.
5. Create a ***User Name*** and ***Password*** – then start using the www.myuhc.com website.

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

Davis Vision

Vision Plan

Toll-Free Number: 888-445-2290

Vision benefits offered through the Davis Vision plan are in addition to the vision benefits offered under your UHC medical plan. Members can verify eligibility and benefits, locate a provider, place an order, check claim status, and download forms at: www.davisvision.com

To register, follow these steps:

1. From the main page, select the ***Members*** link.
2. Click the ***Register Now*** button.
3. Enter the policy holder's information.
4. Create a ***username***, ***password***, and ***security question***.
5. Click the ***Register*** button.

Delta Dental

Dental Plan

Toll-Free Number: 800-336-8264
Office Hours: 6:15 a.m. to 6:30 p.m. Monday through Friday
Website: www.deltadentalins.com

Assurant Employee Benefits - Heritage Plus with Specialty Benefit Plan

Dental Plan

Toll-Free Number: 800-443-2995
Office Hours: 7 a.m. to 5:30 p.m. Sunday through Saturday
Website: www.assurantemployeebenefits.com

CompuSys/Erisa Group, Inc. (Erisa)

Retiree Self Pay
COBRA Administration

Manual payments and COBRA Administration are managed by the City's third party administrator, Erisa. If you have questions contact Erisa at:

Phone Number: 512-250-9397
Toll-Free Number: 800-933-7472
FAX Number: 512-250-2937

Austin Fire Fighters Relief and Retirement Fund

4101 Parkstone Heights Dr., Suite 270
Austin, TX 78746
Call 512-454-9567, FAX Number: 512-453-7197
or go to: www.afrs.org

City of Austin Police Retirement System

2520 South IH-35, Suite 205
Austin, TX 78704
Call 512-416-7672, FAX Number: 512-416-7138
go to: www.ausprs.org

City of Austin Employee Retirement System (COAERS)

418 E. Highland Mall Blvd.
Austin, TX 78752-3720
Call 512-458-2551, FAX Number: 512-458-5650
or go to: www.coaers.org

Open Enrollment Information

If you are not making any changes to your benefits, you do not need to participate in Open Enrollment.

2011 Coverage Information Statement

Attached to the front of your Benefits Packet is your 2011 Coverage Information Statement. This statement is not available if you retired in September or later, or if you are not currently enrolled in City benefits. Your statement contains:

- Your Personal Identification Number (PIN) for enrolling.
- Your current 2011 benefits with 2012 rates.
- Your current coverage level for each benefit, i.e. Retiree Only, Retiree and Spouse, along with the name of each covered dependent.

September, October, November, and December 2011 Enrollment Changes

If you made a change to your benefits that will be effective in September through December of 2011, verify that the change is listed on your 2011 Coverage Information Statement. If the change is not listed, you will need to participate in Open Enrollment and make the change again in order for the change to remain in effect for 2012.

Retiree Open Enrollment Presentations

If you are considering making changes to your benefits or have questions about Open Enrollment, make plans to attend one of the two retiree presentations listed below. At these presentations you will be able to:

- Listen to representatives from UnitedHealthcare, Davis Vision, Assurant Employee Benefits, and Delta Dental.
- Ask benefits questions.
- Make your Open Enrollment changes.
- Update your COA Retiree Beneficiary Designation form.
- Receive a free flu shot.

Presentation 1

When: October 27
8 a.m. until 12 noon
Where: Learning & Research Center
2800 Spirit of Texas Drive, Austin Texas

Presentation 2

When: November 4
8 a.m. until 12 noon
Where: Learning & Research Center
2800 Spirit of Texas Drive, Austin Texas

Presentations will be held at 8 a.m. and 10 a.m. during both Retiree Open Enrollment sessions. Vendors and Employee Benefit Division staff will be available for enrollment assistance and to answer questions at both sessions.

Identification Cards

All participants enrolled in UnitedHealthcare will receive new identification cards by January 1, 2012. Only new participants enrolling in Davis Vision, Assurant Employee Benefits, or Delta Dental, will receive identification cards.

Benefits Changes for 2012

For the HMO and PPO:
- Increase Primary Care copay from $20 to $25, including Optometrists in the UHC Routine Vision Network.
- Introduce a $50 Pharmacy deductible for Tier 2 and Tier 3 drugs.
- Increase Emergency Room copay by $25 (PPO $125, HMO $175).
- Waive copays for diabetic counseling.

For the PPO:
- Decrease In-Network coinsurance from 85% to 80%.

How to Make Benefits Changes

There are two ways to participate in Open Enrollment. To assist you in the process, review the information below:

1. Online Enrollment (Available Monday, October 17 – Sunday, November 20)

- To make benefits changes, go to: www.coaopenenrollment.com. This system is available 24/7.
- To log in, use your PIN Number located on your 2011 Coverage Information Statement.

Retiree tab – Allows you to verify and update your address and marital status.
- To add a spouse or domestic partner to your benefits, you must change your marital status first.

Dependents tab – Allows you to add or drop dependents to or from your coverage.
- To drop a dependent from ALL benefits coverage, click in the square next to the dependent's name.
- To drop a dependent from a specific benefit, select that benefit tab. For example, to drop a dependent from medical only, choose the ***Medical*** tab and follow the prompts.
- To add a dependent for the first time, you must provide the required documentation to the City of Austin by Friday, November 18, 2011.

Save tab – Allows you to save your 2012 changes and print a copy of your 2012 online verification for your records.

2. Telephone Enrollment (Available Monday, October 17 – Thursday, November 10)

- To enroll or make benefits changes, call 512-493-1350, between the hours of 8:00 a.m. to 5:00 p.m., Monday – Friday.
- Spanish-speaking operators are available.

After Participating in Open Enrollment

- A 2012 Confirmation Statement will be mailed to your home address within two work days of participating.
- Verify that your benefits changes have been made.
- If your benefits changes are not correct, participate in Open Enrollment again or call Erisa at 512-250-9397. Keep your 2012 Confirmation Statement.
- Verify that deductions are correct on your first annuity paycheck (January 2012).
- If you notice a deduction error, call the Employee Benefits Division at 512-974-3284. You will need to provide a copy of your statement to have the error corrected.

Eligibility

As a City retiree or the surviving spouse of a City retiree, you are eligible to participate in medical, dental, and/or vision coverage.

Retirees may also elect to purchase coverage for dependents. The following is a list of eligible dependents for whom you may purchase coverage. Each of these individuals may or may not be your dependent for Federal tax purposes. That determination depends on Federal law.

Eligible Dependents

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

- **Spouse:** Your legally married spouse, including a declared common-law spouse. Only one spouse or domestic partner maybe covered at any time.
- **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. A domestic partner may be of the same or opposite gender as the retiree. Only one spouse or domestic partner may be covered at any time.
- **Children:** Your biological children, stepchildren, legally adopted children, children for whom you have obtained court-ordered guardianship or conservatorship, qualified children placed pending adoption, grandchildren, 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.

City of Austin skyline, 2011

- **Disabled Children:** To continue City coverage past the age limit, your disabled child must otherwise meet the requirements for eligible dependents and must also meet the following definitions:
  - 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 on 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 dependent 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.

Persons Not Eligible

Dependents do not include:

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

An individual is not eligible to be covered:

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

Changes in Family

When you add or drop a dependent during Open Enrollment, the change is effective January 1, 2012. For changes to be effective immediately, call the Employee Benefits Division at 512-974-3284 within 31 days of the status change to schedule an appointment with a Benefits representative.

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 are listed below for the following dependents:

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

Coverage Information

Enrollment Changes for Retirees

Certain events in your and your family's lives may occur during the year that may affect your medical, vision, and/or dental coverage. Examples of a family status change are:

- Marriage or divorce.
- A dependent's death.
- Termination of employment or reduction in work hours.
- Newly eligible dependent.
- Loss of dependent eligibility.
- Domestic partner no longer qualifies or domestic partnership is dissolved.
- Medicare coverage becomes effective.

You may change coverage as long as you submit an enrollment form within 31 days of the family status change to the Employee Benefits Division. The change will be effective the first day of the month after your enrollment form is submitted.

In the case of a newborn dependent, medical coverage is temporarily effective on the date of birth for any eligible child born while you are a covered retiree. Coverage continues for the child for 31 days. Coverage extends beyond that date only if you submit an enrollment form within 31 days of the child's birth.

Retiree Coverage Ending Dates

Coverage for you and your dependents will end on the earliest of the following:

- The date you fail to pay any required premium.
- The date the City ceases to offer coverage to retirees.
- The date the plan in question is terminated.
- The date the coverage in question is terminated or reduced.
- The last day of the month in which you voluntarily terminate your or your dependents' class of eligibility coverage.
- The date you voluntarily terminate your or your dependents coverage.
- The date in which you or your dependents no longer meet eligibility requirements.
- The date of your death.

Enrollment Changes for Surviving Spouses

As a Surviving Spouse, you are eligible for medical, dental, and/or vision benefits. If at any time you cancel all benefits, you cannot re-enroll in Surviving Spouse benefits.

You may request a change to your coverage only at the following times.

- During Open Enrollment.
- If you are enrolled in UnitedHealthcare HMO and move outside the plan's service area.
- If you are enrolled in Assurant Employee Benefits - Heritage Plus with Specialty Benefit Plan and move where there are no providers in your service area, you must change to the Delta Dental plan or drop coverage.
- Within 31 days of obtaining other coverage.
- Medicare coverage becomes effective.

Surviving Spouse Coverage Ending Dates

Surviving spouse medical coverage will end on the last day of the month following any of these dates:

- The date you fail to pay any required premium.
- The date you remarry.
- The date you are covered under another group plan, except for Medicare.
- The date the City ceases to offer coverage to surviving spouses.
- The date the plan in question is terminated.
- The date the coverage in question is terminated or reduced.
- The date you voluntarily terminate coverage.
- The date you no longer meet eligibility requirements.
- The date of your death.

Retirees & Surviving Spouses Canceling Coverage

You may cancel medical coverage for yourself and/or your dependents, if applicable, at any time during the calendar year. However, you may not drop dental or vision coverage during the calendar year unless it corresponds with a change in family status. Exception, if you are covered by Assurant Employee Benefits-Heritage Plus with Specialty Benefit Plan, you move where there are no plan providers in your service area.

Medicare Eligibility Requirements

A retiree, surviving spouse, or covered dependent that is eligible for Medicare due to age must enroll in Medicare Parts A and B. When you or your covered dependents are enrolled in Medicare, Medicare is considered primary and will pay benefits before the medical plan you have selected considers payment for covered services. If the Medicare-eligible retiree or dependent does not enroll in Parts A and B, benefits under a City-sponsored plan will be reduced to the amount that would have been payable had he or she enrolled in Medicare Parts A and B. To find out more about how each plan coordinates benefit payments with Medicare, contact the plans directly. For information about Medicare Part D, refer to the last page of this guide.

Coordination of Benefits

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

Medical Plans: HMO and PPO

UnitedHealthcare provides HMO (Choice) and PPO (Choice Plus) medical coverage. As a retiree you may choose the medical plan that best meets your needs. Provider information is available online at: www.myuhc.com

- Select UnitedHealthcare Choice for the HMO and UnitedHealthcare Choice Plus for the PPO.
- UnitedHealthcare Group No: **704244**

Things to consider when choosing a medical plan:

- Amount of out-of-pocket expenses.
- Amount of copays for Specialists.
- Predictability of inpatient hospital expenses.
- Mail Order copays for Prescription Drug coverage.

Do you need 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 UnitedHealthcare.

You will receive reimbursement for these expenses, minus the required copay. If you are enrolled in the PPO and utilize a non-network doctor or facility, the amount will be applied toward your out-of-network deductible. If you are enrolled in the HMO you must use network providers.

my**Nurse**Line

The UnitedHealthcare my**Nurse**Line is a resource for retirees and dependents covered by a City medical plan. This 24-hour service is designed to help you save time and money by helping you access the nearest and best level of medical care. When you call my**Nurse**Line you speak to a registered nurse who can guide you to the appropriate medical facility based on your immediate needs.

For your convenience enter the my**Nurse**Line number into your phone: 877-440-6011. This service is available 24 hours a day, seven days a week.

Consumer Tips

Understanding a Formulary

A formulary is a list of prescription drugs created by an insurance company, which lists the drugs covered under the plan and the level of coverage provided. Most formularies provide three categories of coverage, often referred to as "tiers."

- Tier One – Low copay for generic and some brand name drugs.
- Tier Two – A higher copay for preferred or brand name drugs.
- Tier Three – The highest copay for the most expensive brand name drugs (non-preferred).

Some drugs are excluded from formularies altogether. Make sure you review your enrollment materials to understand the costs of your prescription medication. To price a medication go to: www.myuhc.com

Generic Drugs

Generic drugs can save you money and are as effective as name brands. The Food and Drug Administration (FDA) regulates generics, just as it does name brands, to ensure safety and quality. Today, generics are available for about half of all prescription drugs. Talk to your doctor about whether a generic drug is right for you. Refer to the Prescription Drug Benefits section in the Schedule of Benefits for a comparison of prescription copays.

Getting Information About Generic Drugs

Consumer Reports Best Buy Drugs – www.crbestbuydrugs.org provides information about prescription medication available to treat specific illnesses and diseases, the differences among them, and their costs. Always ask your doctor about whether a particular medication is right for you. Finally, talk to your doctor about the role that dietary and lifestyle changes can play in helping to alleviate your condition.

What Your Medical Plan Does for You

As the cost of medical care and prescription drugs increases, medical plan copays change. However, City medical plans still provide valuable protection from the real costs of medical products and services. The charts below show examples of how the plans provide financial protection for some commonly-used products and services.

Medical Services	Cost Without Insurance	Retiree Cost	
		HMO	PPO
Primary Care Visit	$107	$25	$25
Specialist	$166	$45	$35
Inpatient Hospital (4 days)	$28,700	$1,000	$3,000
MRI Scan	$1,803	$100	$100
Ambulance Service	$1,246	$100	$612

Prescription Drugs			
	Cost Without Insurance	HMO	PPO
Tier 1	$31	$10	$10
Tier 2	$135	$35	$30
Tier 3	$210	$55	$50

How To Use Mail Order

Each medical plan has a mail order prescription drug benefit that offers home delivery and, in some instances, can save you money. Generally, these programs are designed to cover drugs used to treat chronic conditions and/or medications taken for more than 30 days.

To begin using mail order:

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

Within 7 to 14 days, your prescription will be delivered to you, postage paid. UnitedHealthcare **PPO** participants can receive 90 days of medication for ***two*** copays. UnitedHealthcare **HMO** participants receive 90 days of medication for ***three*** copays.

If your doctor allows you to take a generic drug, this should be indicated on the prescription. The mail order pharmacy will then fill your prescription using a generic form of your medication. Three weeks before your mail order supply runs out, you will need to request a refill.

For information about your plan's mail order pharmacy benefit or to order forms, call UnitedHealthcare at 800-430-7316.

Diabetic Bundling – What Your Medical Plan Does for You

Participants who are required to take insulin, can realize significant savings if they utilize the mail order services offered through the PPO and HMO. If you submit a 90-day prescription for the insulin and related diabetic supplies at retail pharmacies, you will incur a copay for ***each*** 30-day prescription.

However, if you submit the 90-day prescriptions through the mail order program, you will incur only ***two*** copays if enrolled in the PPO Plan or ***three*** copays if enrolled in the HMO Plan. The copay incurred is for the insulin prescription; the other supplies are included at no cost to you.

PPO Plan Example

Refer to the chart below for an example of the cost savings.

Item (90-day supply)	Total Cost	Plan Pays	You Pay PPO
Insulin (Tier 2)	$ 1,100	$ 1,040	$ 60
Lancets	$ 65	$ 65	$ 0
Syringes/Needles	$ 110	$ 110	$ 0
Test Strips	$ 850	$ 850	$ 0
Total	$ 2,125	$ 2,065	$ 60

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. Includes deductible.	$12,000 per covered person, per calendar year. Includes deductible.
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.	The maximum allowable charge is the maximum fee for a particular service or supply that the Plan will consider eligible for payment. 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.	
Selection of Doctor	Members must select a network doctor.	Members select an in-network doctor.	Members select an out-of-network doctor.
Service Locations	Services are provided at in-network doctors' offices, hospitals, and other facilities. If a required service is not available in-network, pre-approval is required.	Services are provided at in-network doctors' offices, hospitals, and other facilities. If a required service is not available in-network, pre-approval is required otherwise the service will be paid as an out-of-network expense.	Services are provided in out-of-network doctors' offices, hospitals, and other facilities.
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 service 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, except in case of an emergency.	$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. 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.	

Medical Benefits

	HMO	PPO In-Network
Preventive Exams	Plan pays 100%, no copay.	Plan pays 100%, no copay.
Doctor's Charges for Office Visits	$25 Primary Care Physician copay per visit. $45 Specialist copay per visit.	$25 Primary Care Physician copay per visit. $35 Specialist copay per visit.
Doctor's Charges for Maternity Office Visits	$25 copay for first office visit. Plan pays 100% thereafter.	$25 copay for first office visit. Calendar year deductible applies. Plan pays 80%.
Urgent Care and Non-Hospital Minor Emergency Centers	$45 copay per visit.	$35 copay per visit.
Convenience Care Clinics	$25 copay per visit.	$25 copay per visit.
Outpatient Surgery Facility Fee Doctor's Charges Colonoscopies	 $600 copay. $25 Primary Care Physician copay. $45 Specialist copay. Plan pays 100% for preventive screenings, no copay.	Calendar year deductible applies. $75 copay. Plan pays 80%. Plan pays 100% for preventive screenings, no coinsurance.
Hospital Inpatient Facility Fee	$1,000 copay per confinement. Limited to semi-private room rate. Pre-notification is required unless hospitalization is the result of an emergency.	Calendar year deductible applies. Plan pays 80%. Limited to semi-private room rate. Pre-notification required unless hospitalization is the result of an emergency.
Hospital Emergency Room Services	$175 copay per visit.	$125 copay per visit.
Ambulance Service	$100 copay.	Calendar year deductible applies. Plan pays 80%.
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.
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 rehabilitory speech therapy.	$35 copay per visit.
Registered Dietician	$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.
Acupuncture	Not covered.	$35 copay per visit. Limited to $1,000 per covered person, per calendar year.

Medical Benefits

	HMO	PPO In-Network
Outpatient Diagnostic X-Ray and Laboratory	Plan pays 100%.	Plan pays 100%.
CT, MRI, PET Scans	$100 copay. Pre-notification required.	$100 copay. Pre-notification required.
Mental Health Care Outpatient	$25 copay per visit.	$25 copay per visit.
Mental Health Care Inpatient	$1,000 copay per confinement. Pre-notification required.	Calendar year deductible applies. Plan pays 80% per calendar year. Pre-notification required.
Chemical Dependency	$1,000 copay per confinement. Pre-notification required.	Calendar year deductible applies. Plan pays 80% per calendar year. 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 80%. 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-notification required.	Plan pays 100%. Pre-notification required.
Durable Medical Equipment	Plan pays 100%. Pre-notification required.	Calendar year deductible applies. Plan pays 80%. Pre-notification required for any item over $1,000.
Disposable Medical Supplies	Plan pays 80%	Calendar year deductible applies. Plan pays 80%. Pre-notification required for any item over $1,000.
Prosthetic-Orthotic Devices	Plan pays 80%, Pre-notification required.	Calendar year deductible applies. Plan pays 80%. Pre-notification required for any item over $1,000.
Diabetic Equipment Insulin pumps and related supplies.	Plan pays 80%, Pre-notification required.	Calendar year deductible applies. Plan pays 80%. Pre-notification required for any item over $1,000.
Diabetic Supplies At a durable medical equipment provider.	Plan pays 80%.	Calendar year deductible applies. Plan pays 80%.
Diabetic Counseling	Plan pays 100%	Plan pays 100%.
Other Covered Medical Expenses	Refer to your Medical Plan Document or contact UnitedHealthcare.	

Vision Benefits Provided by Medical Plan

	Routine Vision Network	HMO/PPO In-Network
Annual Routine Vision Exam	$25 copay for eyeglass vision exam or contact lens exam. Members must use the Routine Vision Network.	$45 copay Choice (HMO) $35 copay Choice Plus (PPO)
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.	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.	Not available at private practices. Retail chain providers may offer a discount.

Prescription Drug Benefits

A $50 Annual Deductible will apply for Tier 2 and Tier 3 prescription drugs. Once the deductible is met the below copays apply.

	HMO			PPO In-Network		
Retail Pharmacy *Limited to a 30-day supply*	Generic/Preferred/Non-Preferred			Generic/Preferred/Non-Preferred		
	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
	$10	$35	$55	$10	$30	$50
Mail Order Pharmacy *Limited to a 90-day supply.*	$30	$105	$165	$20	$60	$100
Diabetic Supplies *See also Diabetic Equipment*	Retail Pharmacy – Supplies are covered at a participating pharmacy for the copays listed above. Mail Order Pharmacy – A participant's insulin and related diabetic supplies can be purchased through mail order with the insulin copay if prescriptions for the insulin and supplies are submitted at the same time.					

Speciality Prescription Drug – Patients who require a specialty prescription drug will be directed to a pharmacy designated by UnitedHealthcare for coverage.

Tobacco Cessation Program/Drugs – A participant can receive an FDA approved tobacco cessation drug at no cost, if the participant:

- Is covered under a City medical plan and attends one of the tobacco cessation programs.
- Obtains a prescription from his or her physician and contacts the Employee Benefits Division to receive approval.

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

Cost for Coverage

Retirees

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

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

Years of service – Your cost of coverage is determined by continuous years of employment with the City of Austin or creditable years of service, whichever is greater. Your years of creditable service are determined by your retirement system and include military or City retirement system buy backs or City-purchased service credit. If you withdrew any of your contributions from your retirement system prior to your retirement, your creditable service will not include any years for which contributions were withdrawn. Also, your years of creditable service will not include any years of employment accrued with an employer, other than the City, that participates in the Proportionate Retirement Program.

Medicare Rates – Apply only when you and/or a covered spouse or domestic partner are enrolled in both Medicare Parts A and B and provide a copy of your card to the Employee Benefits Division. See Medical Rates section of this Guide.

Surviving Spouses

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

- City established rates for surviving spouse medical coverage.
- Your spouse's years of service with the City.
- Medicare enrollment.

Years of service – Your cost of coverage is determined by your spouse's continuous years of employment with the City of Austin or creditable years of service, whichever is greater. Your spouse's years of creditable service are determined by his or her retirement system and include military or City retirement system buy backs or City-purchased service credit. If your spouse withdrew any contributions from a City retirement system prior to retirement, 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, that participates in the Proportionate Retirement Program.

Medicare Rates – Apply only when you are enrolled in both Medicare Parts A and B and provide a copy of your card to the Employee Benefits Division. See Medical Rates section of this Guide.

Deduction Errors

Premium Payments

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

Premium Deduction Errors

Data Entry Error/Delay

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

Enrollment Form Errors

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

Retiree Medical Rates for 2012

"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 card to the Employee Benefits Division.

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

	Years of Service	UnitedHealthcare HMO		UnitedHealthcare PPO	
Retiree without Medicare A & B	Less than 5	$ 555.22	(9A1)	$ 550.22	(8A1)
	5 through 9	$ 502.66	(9A2)	$ 497.66	(8A2)
	10 through 14	$ 397.58	(9A3)	$ 392.58	(8A3)
	15 through 19	$ 292.45	(9A4)	$ 287.45	(8A4)
	20 or more	$ 134.79	(9A5)	$ 129.79	(8A5)
Retiree with Medicare A & B	Less than 5	$ 323.49	(9B1)	$ 323.49	(8B1)
	5 through 9	$ 292.59	(9B2)	$ 292.59	(8B2)
	10 through 14	$ 230.81	(9B3)	$ 230.81	(8B3)
	15 through 19	$ 169.00	(9B4)	$ 169.00	(8B4)
	20 or more	$ 76.30	(9B5)	$ 76.30	(8B5)
Retiree and Spouse / Domestic Partner both without Medicare A & B	Less than 5	$1,112.39	(9C1/9C6)	$1,107.39	(8C1/8C6)
	5 through 9	$1,028.81	(9C2/9C7)	$1,023.81	(8C2/8C7)
	10 through 14	$ 861.65	(9C3/9C8)	$ 856.65	(8C3/8C8)
	15 through 19	$ 694.46	(9C4/9C9)	$ 689.46	(8C4/8C9)
	20 or more	$ 443.70	(9C5/9C0)	$ 438.70	(8C5/8C0)
Retiree and Spouse / Domestic Partner both with Medicare A & B	Less than 5	$ 803.55	(9D1/9D6)	$ 803.55	(8D1/8D6)
	5 through 9	$ 746.22	(9D2/9D7)	$ 746.22	(8D2/8D7)
	10 through 14	$ 631.58	(9D3/9D8)	$ 631.58	(8D3/8D8)
	15 through 19	$ 516.92	(9D4/9D9)	$ 516.92	(8D4/8D9)
	20 or more	$ 344.94	(9D5/9D0)	$ 344.94	(8D5/8D0)
Retiree without Medicare A & B, and Spouse / Domestic Partner with Medicare A & B	Less than 5	$1,035.28	(9E1/9E6)	$1,030.28	(8E1/8E6)
	5 through 9	$ 956.29	(9E2/9E7)	$ 951.29	(8E2/8E7)
	10 through 14	$ 798.35	(9E3/9E8)	$ 793.35	(8E3/8E8)
	15 through 19	$ 640.37	(9E4/9E9)	$ 635.37	(8E4/8E9)
	20 or more	$ 403.42	(9E5/9E0)	$ 398.42	(8E5/8E0)
Retiree with Medicare A & B, and Spouse / Domestic Partner without Medicare A & B	Less than 5	$ 880.66	(9F1/9F6)	$ 880.66	(8F1/8F6)
	5 through 9	$ 818.74	(9F2/9F7)	$ 818.74	(8F2/8F7)
	10 through 14	$ 694.88	(9F3/9F8)	$ 694.88	(8F3/8F8)
	15 through 19	$ 571.01	(9F4/9F9)	$ 571.01	(8F4/8F9)
	20 or more	$ 385.22	(9F5/9F0)	$ 385.22	(8F5/8F0)
Retiree with Medicare A & B and Children	Less than 5	$ 602.17	(9G1)	$ 602.17	(8G1)
	5 through 9	$ 555.80	(9G2)	$ 555.80	(8G2)
	10 through 14	$ 463.08	(9G3)	$ 463.08	(8G3)
	15 through 19	$ 370.32	(9G4)	$ 370.32	(8G4)
	20 or more	$ 231.23	(9G5)	$ 231.23	(8G5)

	Years of Service	UnitedHealthcare HMO		UnitedHealthcare PPO	
Retiree without Medicare A & B and Children	Less than 5	$ 833.90	(9H1)	$ 828.90	(8H1)
	5 through 9	$ 765.86	(9H2)	$ 760.86	(8H2)
	10 through 14	$ 629.85	(9H3)	$ 624.85	(8H3)
	15 through 19	$ 493.77	(9H4)	$ 488.77	(8H4)
	20 or more	$ 289.72	(9H5)	$ 284.72	(8H5)
Retiree and Spouse / Domestic Partner both without Medicare A & B and Family	Less than 5	$1,391.07	(9I1/9I6)	$1,386.07	(8I1/8I6)
	5 through 9	$1,292.01	(9I2/9I7)	$1,287.01	(8I2/8I7)
	10 through 14	$1,093.92	(9I3/9I8)	$1,088.92	(8I3/8I8)
	15 through 19	$ 895.78	(9I4/9I9)	$ 890.78	(8I4/8I9)
	20 or more	$ 598.63	(9I5/9I0)	$ 593.63	(8I5/8I0)
Retiree without Medicare A & B, and Spouse / Domestic Partner with Medicare A & B and Family	Less than 5	$1,313.95	(9J1/9J6)	$1,308.95	(8J1/8J6)
	5 through 9	$1,219.49	(9J2/9J7)	$1,214.49	(8J2/8J7)
	10 through 14	$1,030.63	(9J3/9J8)	$1,025.63	(8J3/8J8)
	15 through 19	$ 841.69	(9J4/9J9)	$ 836.69	(8J4/8J9)
	20 or more	$ 558.35	(9J5/9J0)	$ 553.35	(8J5/8J0)
Retiree with Medicare A & B, and Spouse / Domestic Partner without Medicare A & B and Family	Less than 5	$1,159.34	(9K1/9K6)	$1,159.34	(8K1/8K6)
	5 through 9	$1,081.94	(9K2/9K7)	$1,081.94	(8K2/8K7)
	10 through 14	$ 927.15	(9K3/9K8)	$ 927.15	(8K3/8K8)
	15 through 19	$ 772.34	(9K4/9K9)	$ 772.34	(8K4/8K9)
	20 or more	$ 540.14	(9K5/9K0)	$ 540.14	(8K5/8K0)
Retiree and Spouse / Domestic Partner both with Medicare A & B and Family	Less than 5	$1,082.22	(9L1/9L6)	$1,082.22	(8L1/8L6)
	5 through 9	$1,009.42	(9L2/9L7)	$1,009.42	(8L2/8L7)
	10 through 14	$ 863.86	(9L3/9L8)	$ 863.86	(8L3/8L8)
	15 through 19	$ 718.24	(9L4/9L9)	$ 718.24	(8L4/8L9)
	20 or more	$ 499.87	(9L5/9L0)	$ 499.87	(8L5/8L0)

Surviving Spouse Medical Rates for 2012

	Years of Service	UnitedHealthcare HMO		UnitedHealthcare PPO	
Surviving Spouse without Medicare A & B	Less than 5	$561.37	(9Y1)	$556.37	(8Y1)
	5 through 9	$511.85	(9Y2)	$506.85	(8Y2)
	10 through 14	$412.90	(9Y3)	$407.90	(8Y3)
	15 through 19	$313.94	(9Y4)	$308.94	(8Y4)
	20 or more	$165.53	(9Y5)	$160.53	(8Y5)
Surviving Spouse with Medicare A & B	Less than 5	$331.82	(9Z1)	$331.82	(8Z1)
	5 through 9	$305.09	(9Z2)	$305.09	(8Z2)
	10 through 14	$251.67	(9Z3)	$251.67	(8Z3)
	15 through 19	$198.19	(9Z4)	$198.19	(8Z4)
	20 or more	$118.02	(9Z5)	$118.02	(8Z5)

Vision Plan

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

To find a Davis Vision Plan provider and for more information go to www.davisvision.com, or call 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**.

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 – in lieu of contact lenses. Once per calendar year. Up to $125 retail allowance toward provider-supplied frame plus 20% off cost exceeding the allowance.* ***OR*** Any Fashion or Designer frame from Davis Vision's exclusive Collection (with retail values up to $175), **Covered in Full**. ***OR*** Any Premier frame from Davis Vision's exclusive Collection (with retail values up to $225), **Covered in Full** after an additional $25 copay. One year eyeglass breakage warranty included at no additional cost.	**Contacts** – in lieu of frames. Once per calendar year. Up to $120 allowance toward provider-supplied contacts plus 15% off cost exceeding the allowance.* Standard Contacts – Evaluation, fitting fees, and follow-up care, $25 copay applies. Speciality Contacts – Evaluation, fitting fees, and follow-up care, up to a $60 allowance plus 15% off cost exceeding allowance.* $25 copay applies. **OR** Davis Vision Collection contact lenses, evaluation, fitting fees, and follow-up care, **Covered in Full** after $25 copay. (Up to 4 boxes of disposable lenses). **OR** Medically necessary with prior approval, **Covered in Full**.

Standard Eyeglass Lenses – Single, Bifocals, Trifocals, Lenticular, and Standard Scratch Coating.
$25 copay, once per calendar year.
Polycarbonate lenses for children are covered in full up to age 19.

Lens Options	Copay		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	Photochromic glass lenses	$20
Standard anti-reflective (AR) coating	$35	Plastic photosensitive lenses	$65

* **Additional Discounts** – Are not available at Wal-Mart and Sam's Club.

Davis Vision Plan Rates – Monthly Premiums

Retiree Only	$ 4.36
Retiree and Spouse or Domestic Partner	$ 8.64
Retiree and Children	$ 8.48
Retiree and Family or Domestic Partner and Children	$ 12.90
Surviving Spouse	$ 4.36

Dental Plans

The City of Austin offers retirees and surviving spouses two dental coverage options. The following information briefly describes the two dental plans. For detailed information about the plans, refer to the information provided.

Delta Dental

If you enroll in Delta Dental, you can select any dentist to provide dental services; however, if you select a dentist in one of Delta Dental's networks (DPO or Premier), you will have lower out-of-pocket costs. The DPO Program allows you the greatest reduction in your out-of-pocket expenses, since this select group of dentists in your area will provide dental benefits at a charge which has been contractually agreed upon between Delta Dental and the DPO Dentist. These charges are generally lower than those charged by the majority of dentists in the same area. If you select a dentist in the Premier Network, you will not be balanced billed for amounts over the Usual, Customary and Reasonable (UCR) fee. If you select a Non-Delta dentist, you will be responsible for any extra amount charged by the dentist over the benefits that Delta Dental will pay, in addition to any deductibles and maximums specified by the Plan. When contacting a dentist, ask whether the dentist participates in Delta DPO Network or Premier Network. For detailed information call Delta Dental at 800-336-8264.

Plan features include:
- Diagnostic and Preventive Services covered at 100%.
- Basic Services covered at 80%.
- Major Services covered at 50%.
- Orthodontia Services covered at 50%.
- $50 Deductible per covered person (does not apply to Diagnostic and Preventive Services).
- $150 Deductible per family, per calendar year.
- $50 Deductible for Orthodontia Services per covered person.
- $1,000 per patient maximum per covered person, per calendar year.
- $1,000 lifetime orthodontia maximum per covered person.

Assurant Employee Benefits - Heritage Plus with Specialty Benefit Plan

The Assurant Employee Benefits Plan is a prepaid dental plan that offers benefits through a network of plan dentists. If enrolled in this plan, you are responsible for specific copay amounts when services are provided by a network dentist. Members must select a network general 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. See the plan documents for details.

Plan features include:
- No deductibles.
- 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 copay schedule. Refer to your plan document for copays.

To find a dentist call 800-443-2995, or visit www.assurantemployeebenefits.com. At the Website, click on ***For Members*** section, choose ***Find a Dentist*** – then under Prepaid/Managed Care Plans, select ***Heritage Series***. Services provided by an SBA Plan Specialty Dentist, and services provided by a Plan Specialty Dentist (a specialty dentist who is a part of the plan provider network but does not accept the SBA copay schedule), will be provided to you at a rate lower than the specialist's normal retail charges.

	Delta Dental			Assurant Employee Benefits - Heritage Plus with Specialty Benefit Plan
	DPO Network	**Premier Network**	**Out-of-Network**	**In-Network**
Selection of Dentist	Member can go to general dentist or specialist in network.	Member can go to general dentist or specialist in network.	Member can go to any general dentist or specialist.	Members must select a network general dentist. Members can use the Specialty Plan to obtain services from network and non-network specialists.
Annual Deductible	$50 per person/$150 per family per calendar year. Deductible does not apply to Diagnostic or Preventive Services.	$50 per person/$150 per family per calendar year. Deductible does not apply to Diagnostic or Preventive Services.	$50 per person/$150 per family per calendar year. Deductible does not apply to Diagnostic or Preventive Services.	None.
Covered Services (other than Orthodontia)	Diagnostic and Preventive – covered at 100% of DPO fee schedule. Basic – covered at 80% of DPO fee schedule. Major – covered at 50% of DPO schedule.	Diagnostic and Preventive – covered at 100% of Premier fee schedule (UCR). Basic – covered at 80% of Premier fee schedule (UCR). Major – covered at 50% of Premier fee schedule (UCR).	Diagnostic and Preventive – covered at 100% of UCR. Basic – covered at 80% of UCR. Major – covered at 50% of UCR. Also responsible for amounts above Usual, Customary and Reasonable (UCR).	Member pays applicable copays according to the schedule of benefits when services are provided by a network dentist.
Annual Maximum Benefit	$1,000 per person per calendar year.	$1,000 per person per calendar year.	$1,000 per person per calendar year. Also responsible for amounts above UCR.	No maximum for network dentist. $2,000 annual maximum for nonplan specialty dentist.
Orthodontia	50% of DPO fee schedule.	50% of Premier fee schedule (UCR).	50% of UCR. Also responsible for amounts above UCR.	25% discount when services are received from a network specialist. No age limitations (adults and children are both covered).

	Delta Dental			Assurant Employee Benefits - Heritage Plus with Specialty Benefit Plan
	DPO Network	**Premier Network**	**Out-of-Network**	**In-Network**
Orthodontia Maximum Benefit	$1,000 per person per lifetime.	$1,000 per person per lifetime.	$1,000 per person per lifetime.	No orthodontia maximum when services are received from a network specialist.
Benefit Waiting Period	None	None	None	None
One Year Commitment	Allows members to cancel coverage only during Open Enrollment or within 31 days of a change in family status.			
Identification Cards	Two cards per retiree are issued.			
Claim Forms	None	None	Members file claims to be reimbursed for covered expenses. (Some dental offices may file claims and bill the balance after the plan has paid.)	None
Additional Information	For questions about eligibility, participating network dentists, plan benefits, claim forms, etc., call 800-336-8264.			For questions about eligibility, participating network dentist, plan benefits, claim forms, etc., call 800-443-2995.

Dental Plan Rates – Monthly Premiums

	Delta Dental	Assurant Employee Benefits and Heritage Plus with Specialty Plan
Retiree Only	$ 27.33	$ 10.14
Retiree and One Dependent	$ 57.50	$ 16.64
Retiree and Family or Domestic Partner and Children	$ 84.20	$ 26.67
Surviving Spouse	$ 27.33	$ 10.14

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, provided you complete a Retiree Beneficiary 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.
- Fire Fighters Relief and Retirement Fund – no death benefit offered.

Life insurance coverage is not available for dependents of retirees.

Choosing a Beneficiary

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

Reviewing Your Beneficiary Designation Form

You can review your beneficiary designation for your life insurance coverage any time during the year. It is important that you keep this information current so that the person or persons you want to receive benefits are listed. To review your beneficiary information, you must visit the Employees Benefits Division and bring a photo ID.

Filing a Life Insurance Claim

Your beneficiary must file the life insurance claim with the Employee Benefits Division and submit the appropriate documents:

- Retiree death – one original death certificate.
- Vendor claim forms.
- All life insurance claims are paid in a lump sum, unless you request another method of payment in writing and the insurance carrier approves your request.

Wellness Resources

HealthyConnections: City of Austin Wellness Program

Retirees and their spouses are eligible to participate in some HealthyConnections programs, including:

- Tobacco Cessation.
- Free Flu Shot Clinics.
- Wellness Seminars and Classes.
- Group Exercise Classes.

Retirees who are interested in receiving email updates about wellness opportunities can email the program at healthyconnections@austintexas.gov and request to be added to the email notification list.
For more information call the Employee Benefits Division at 512-974-3284.

Health Assessments

UnitedHealthcare offers a free Health Assessment for its members. A Health Assessment is a handy "self test" that provides a personalized report with specific health recommendations just for you.

To complete your Health Assessment, go to: www.myuhc.com

1. Log in with your member ID and password.
2. Click on ***Health Assessmen***t on the right- hand side of the page.
3. Read the introduction page and select ***Spanish Health Assessment*** or ***English Health Assessment***.
4. Click on ***Launch University of Michigan Health Assessment***, then follow the instructions to complete the assessment.

The Health Assessment should take 10-20 minutes to complete. Once you are finished, click ***Submit*** for a comprehensive report. You may choose to print and share with your doctor or other health care provider.

LIVESTRONG Survivorship Notebook

If you or someone in your family has been diagnosed with cancer, the Lance Armstrong Foundation has provided the City of Austin a valuable resource, the *LIVESTRONG Survivorship Notebook*. This notebook includes information and tools to help you organize your care, keep all of your medical information in one place, and understand how to deal with the physical, emotional, and practical issues all cancer patients face. The accompanying Survivorship Stories booklet shares the very real stories of other cancer patients and how they LIVESTRONG.

The *LIVESTRONG Survivorship Notebooks* are available for free at the front desk of the City of Austin Human Resources Department in One Texas Center, 505 Barton Springs Road, Suite 600. You may also download or order your own hard copy at: www.livestrong.org (shipping charges will apply).

Important Benefits Information

ADA Compliance

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

Governing Plan

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

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

This act imposes the following restrictions on group health plans:

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

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

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

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

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

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

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

City of Austin Policy on HIPAA

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

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

The Plan does not currently have a pre-existing condition limitation; 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 were established to provide comprehensive Federal protection concerning the privacy of health information. The Privacy Rules generally require the City to take reasonable steps to limit the use, disclosure, and requests for Protected Health Information to the minimum necessary to accomplish the intended purpose. The City is committed to implementing the Privacy Rules.

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

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

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

Patient Protection and Affordable Care Act

As part of the Patient Protection and Affordable Care Act (Health Reform) effective January 2018, medical plans which exceed a threshold level established by the Federal government will have to pay a 40% excise tax. The City of Austin is committed to designing a medical plan that is below the threshold level; however, if the threshold is reached the cost of the excise tax will be passed on to employees and retirees.

COBRA

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

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, 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 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, vision coverage, and/or dental 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, child no longer meeting the definition of dependent, or entitlement to Medicare benefits. Erisa, 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 Spouse Coverage

Your spouse may be eligible for Surviving Spouse Medical, Dental, and Vision Coverage only if you meet one of the following requirements and your spouse completes a Surviving Spouse 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 spouse will be able to continue his or her coverage through the City after your death, provided your spouse was enrolled in a City-sponsored plan at the time of your death. Surviving Spouse Coverage is not available to any of your dependents other than a surviving spouse, regardless of whether the dependent was covered under a City-sponsored plan at the time of your death. The coverage offered is the same coverage offered to City retirees.

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 7 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% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.
- You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.
- If you are enrolled in Medicare Part D or a Medicare Advantage Plan and are also enrolled in the City medical plan, you may have duplicate prescription coverage. If you would like to review your coverage or for more information, contact the Employee Benefits Division at 512-974-3284.

More information about Medicare Part D prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. You can also:

- Visit: www.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: www.socialsecurity.gov or call 800-772-1213. TTY users should call 800-325-0778.