

2012 Active COBRA Guide



*Important Information
About Your Benefits*

*Medical
Vision
Dental*



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

Call Human Resources Department at [974-3400](tel:974-3400) (Voice) or [800-735-2985](tel: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
Outlook Email: HRD, Benefits
Internet Email: HRD.Benefits@austintexas.gov
FAX: 512-974-3420

Individuals 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 Resources

You can access benefits information by visiting:
www.cityofaustin.org/benefits/enrollment

You can also view eligibility requirements, plan choices, print the City's employee and retiree benefits guides.

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 online 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.

CompuSys/Erisa Group Inc. (Erisa)

Dental Assistance Plan

FLEXTRA Health Care Account

& Benefits Card

FLEXTRA Dependent Care Account

COBRA Administration

The programs above 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

INTRODUCTION

About the COBRA Guide

Some information in this booklet comes from the 2012 Employee Benefits Guide and may pertain only to active City employees. If you have questions, contact Erisa or Employee Benefits of the City of Austin Human Resources Department.

This Guide provides an overview of the coverage available to City of Austin (City) COBRA participants. For the key features of each medical plan refer to the Schedule of Benefits section of this guide.

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

COBRA CONTINUATION OF COVERAGE

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

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

Qualified Beneficiary

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

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

Qualifying Events

As determined by Federal law, qualifying events include:

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

Notice Requirements

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

How to Enroll for Coverage

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

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

Payment Due Dates

You have 45 days from the date you elect COBRA coverage to pay the amount owed to Erisa Administrative Services. Your payment must be received in Erisa's office by the 45th day. If you make your election and pay on time, coverage under COBRA will begin the day after your group benefits otherwise would have ended. Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. Contact Erisa Administrative Services to confirm the correct amount of your first payment. After the initial payment, payments for COBRA coverage must be made on a monthly basis and are due on the first day of the month of coverage. Payments must be received within 30 days of the due date or coverage will be cancelled.

Your Cost for Coverage

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

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

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

How Long Coverage Continues

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

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

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

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

The individual must:

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

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

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

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

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

When Coverage Ends

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

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

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

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

COBRA and Dependents

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

ELIGIBILITY

Eligible Dependents

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

- Spouse: Your legally married spouse, including a declared common-law spouse. Only one spouse may be covered at any time.
- Children: Your biological children, stepchildren, legally adopted children, children from whom you have obtained court-ordered guardianship or conservatorship, qualified children placed pending adoption, and grandchildren. To be eligible, your children must:
 - Be Dependent on you in a regular parent-child relationship as reasonably determined by the City, be the subject of a Qualified Medical Child Support Order, or be the subject of an Administrative Writ.
 - Be under 26 years of age.
 - Dependent grandchildren: Your unmarried grandchild must meet the requirements listed above, and must also qualify as a dependent (as defined by the IRS) on your or your spouse's Federal income tax return.

- Disabled children: To be eligible for coverage past the age limit listed above, your disabled child must otherwise meet the requirements for eligible dependents and must also meet the following definition:
- A disabled child is a child who, due to a mental or physical disability, is incapable of earning a living at the time he or she would otherwise cease to be a dependent, if the child is covered as a dependent at that time, and if at that time he or she depends on you for principal support and maintenance.
- A disabled child continues to be considered an eligible dependent as long as the child remains incapacitated, unmarried, dependent upon you for principal support and maintenance, and you continuously maintain the child's coverage as a dependent under the plan from the date he or she otherwise would lose dependent status.
- A child who loses eligibility and later becomes disabled is not eligible to be covered. A disabled child who was not covered as a dependent immediately prior to the time he or she would otherwise cease to be a dependent is not eligible to be covered.

Documentation

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

Acceptable documents include:

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

Persons Not Eligible

Dependents do not include:

- Individuals on active duty in any branch of military service, (except to the extent and for the period required by law).
- Residents of a country other than the United States.
- Parents, grandparents, or other ancestors.
- Grandchildren who do not meet the definition of dependent grandchildren.
- Domestic partners or their children.

An individual is not eligible to be covered:

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

CHANGING COVERAGE

Open Enrollment

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

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

Changes During the Year

When already enrolled in COBRA coverage and you need:

- To drop coverage for a spouse due to divorce, you must submit a corrected COBRA Enrollment Form to Erisa. In addition, you must provide a copy of the portion of the divorce decree that indicates the names of the parties involved, as well as the judge's signature, and the date the divorce was final. Erisa will automatically send a COBRA notification to your ex-spouse.
- To drop coverage for a dependent who is no longer eligible, you must submit a corrected COBRA Benefits Enrollment Form to Erisa. This step is necessary to drop the dependent. If applicable Erisa will send you a new coupon book with adjusted premium payments. The City will not refund premiums paid for dependents that should have been dropped because they were no longer eligible for coverage.
- To add or drop coverage due to a change in the health coverage attributable to employment, you must submit documentation within 31 days from the employer or health insurance carrier confirming the date coverage was lost or became effective with a corrected COBRA Enrollment Form to Erisa.
- Newly acquired dependents may be added to your coverage within 31 days following the qualifying event (for example, birth, adoption, or marriage).
- Coverage may be cancelled at any time on any individual by notifying Erisa.

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

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

Premium Errors

Entry Error/Delay. If a data entry error occurs or if data entry is delayed, it will not invalidate the coverage reflected on your COBRA Enrollment Form. Upon discovery of any such error or delay, an adjustment will be made to reflect the correct premium. If underpayment of premium occurs, the City has the right to collect any additional premium owed by you. Conversely, if overpayment occurs, the City will reimburse you any amount overpaid.

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

MEDICAL COVERAGE

Medical Plans

For 2012, the medical plans offered by the City are UnitedHealthcare HMO (Choice) and UnitedHealthcare PPO (Choice Plus).

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

For complete coverage information, refer to the materials provided by UnitedHealthcare, or contact them directly at 800-430-7316. The provisions of the plan document(s) always govern in case of conflict with this 2012 COBRA Guide.

UnitedHealthcare HMO (Choice Plan)

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

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

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

UnitedHealthcare PPO (Choice Plus Plan)

The UnitedHealthcare Choice Plus Plan offers:

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

Medical Rates For 2012

The 2012 COBRA monthly medical rates for current or former employees and/or their covered dependents are listed below. The term Insured refers to a COBRA qualified beneficiary who has elected coverage for himself or herself and/or his or her eligible dependents.

	UnitedHealthcare HMO	UnitedHealthcare PPO
Insured Only	\$ 501.12	\$ 463.06
Insured and Spouse	\$ 1,124.51	\$ 1,039.05
Insured and Child(ren)	\$ 960.15	\$ 887.40
Insured and Family	\$ 1,547.47	\$ 1,430.06
Spouse Only	\$ 501.12	\$ 463.06
Spouse and Child(ren)	\$ 960.15	\$ 887.40
Child(ren) Only	\$ 501.12	\$ 463.06

Coordination of Benefits

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

Appeal of a Claim

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

Subrogation

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

MEDICAL PLANS COMPARISON

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

Things to consider when selecting a medical plan:

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

Schedule of Benefits - UnitedHealthcare

	HMO	PPO	
		In-Network	Out-of-Network
Individual Deductible	None.	\$500 per covered person per calendar year.	\$1,500 per covered person per calendar year.
Family Deductible Maximum	None.	Three individual deductibles.	Three individual deductibles.
Out-of-Pocket Maximum	\$3,500 per covered person or, \$7,000 per family, per calendar year.	\$3,000 per covered person, per calendar year. 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 a medical 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	Included in Hospital Services. \$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 rehabilitatory 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.
	<i>Lifetime maximum benefit of three series of treatments per covered person.</i>	
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 routine vision exam including contact lens fitting. 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 100% 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

<i>A \$50 Annual Deductible will apply for Tier 2 and Tier 3 prescription drugs per covered person. Once the deductible is met the below copays apply.</i>						
	HMO			PPO – In-Network		
	Generic/Preferred/Non-Preferred			Generic/Preferred/Non-Preferred		
	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Retail Pharmacy <i>Limited to a 30-day supply</i>	\$10	\$35	\$55	\$10	\$30	\$50
Mail Order Pharmacy <i>Limited to a 90-day supply.</i>	\$30	\$105	\$165	\$20	\$60	\$100
Diabetic Supplies <i>See also Diabetic Equipment</i>	Retail Pharmacy – Supplies are covered at a participating pharmacy for the copays listed above. Mail Order Pharmacy – A participants' 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:						
<ul style="list-style-type: none"> • 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.						

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*.		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		OR	
Any Fashion or Designer frame from Davis Vision’s exclusive Collection (with retail values up to \$175), Covered in Full .		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		OR	
Any Premier frame from Davis Vision’s exclusive Collection (with retail values up to \$225), Covered in Full after an additional \$25 copay.		Medically necessary with prior approval, Covered in Full .	
One year eyeglass breakage warranty included at no additional cost.			
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 – Not available at Wal-Mart or Sam’s Club.			

Davis Vision Rates – Monthly

Insured Only	\$ 4.45
Insured and Spouse or Domestic Partner	\$ 8.81
Insured and Children	\$ 8.65
Insured and Family or Domestic Partner and Children	\$ 13.16
Spouse Only	\$ 4.45
Spouse and Children	\$ 8.65

Dental Assistance Plan

This plan allows you to choose your own dentist. Covered benefits are indicated by dental codes. A fixed fee schedule indicates the maximum amount paid per code. For detailed information, refer to the 2012 Employee Dental Assistance Plan Document found online at www.cityofaustin.org/benefits/enrollment or call Erisa at 250-9397.

Plan Coverage

Preventive Care	No Deductible
Basic Care	\$50 Calendar Year Deductible, per covered person
Major Care	\$50 Calendar Year Deductible, per covered person
Calendar Year Maximum <i>Includes Orthodontia expenses</i>	\$1,800 per covered person
Lifetime Orthodontia Maximum Orthodontia Treatment	\$1,800 per covered person Covered at 50% of Maximum Allowable Charge
Night Guard, splints, implants, and over dentures	Not Covered

Orthodontia Treatment

Expenses are paid only as the work progresses. Receipts are submitted for reimbursement after you receive them from your dentist at each visit. Orthodontia benefits paid by the plan are applied toward the calendar year maximum.

The amounts reimbursable for orthodontia expenses are determined as claims are incurred throughout the course of treatment. This amount may not match the payment plan you have set up with your dentist.

Dental Rates – Monthly

Insured Only	\$ 33.97
Insured and Dependent	\$ 95.10
Dependents Only	\$ 61.14

Important Benefits Information

- ADA Compliance
- Governing Plan
- HIPAA
- Your Prescription Drug Coverage
and Medicare

ADA Compliance

The City is committed to complying with the Americans with Disabilities Act (ADA). Reasonable accommodation, including equal access to communications, will be provided upon request. For more information, call the Human Resources Department at 974-3284 or 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 employees 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. These benefits are not a guarantee of your employment with the City.

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 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.
- Prosthesis and physical complications of all stages of mastectomy, including lymph edemas.
- Secondary consultation whether such consultation is based on a positive or negative initial diagnosis.

The benefits required under the **Women's Health and Cancer Rights Act 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.

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 health 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 health plan, you may have duplicate prescription coverage. If you would like to review your coverage or for more information, contact the Employee Benefits Division of the Human Resources Department at [974-3284](tel: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** toll free at [888-834-7406](tel:888-834-7406), local number [800-252-9330](tel:800-252-9330).
- Call [800-MEDICARE \(800-633-4227\)](tel:800-MEDICARE).
- TTY users should call [877-486-2048](tel: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](tel:800-772-1213). TTY users should call [800-325-0778](tel:800-325-0778).