

2013 Active COBRA Guide



Medical Vision Dental FLEXTRA

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

Cover Photos (counterclockwise): City Hall needle extending over 2nd Street, Felicia Molina, Austin Convention Center, Bill Stauber, Austin Water Utility at Water Treatment Plant #4. Photo credits: Jim Linton, Human Resources Department.

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

Please make an appointment before visiting our office.

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

Online Resources

To access benefits information, go to:
www.austintexas.gov/benefits/enrollment

You can also view eligibility requirements and plan choices.

CompuSys/Erisa Group Inc. (Erisa)

Dental Assistance Plan FLEXTRA Health Care Account COBRA Administration

These programs 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

Mailing Address: 13706 Research Blvd., Ste. 308
Austin, TX 78750

UnitedHealthcare HMO and PPO Plans

Medical Phone Number: 800-430-7316
Medical Providers: www.myuhc.com
Prescription Information: www.myuhc.com
NurseLine: 877-440-6011
Vision Phone Number: 800-203-4317
Vision Providers: www.uhcvision.com
Mental Health Providers: www.ubhprovider.com

To find a medical provider, go to: www.myuhc.com. Click on **Find Physician, Laboratory, or Facility**. Select **UnitedHealthcare Choice** for the HMO or **UnitedHealthcare Choice Plus** for the PPO.

Register at: www.myuhc.com to view prescription formulary, print a temporary ID card, or an Explanation of Benefits.

Davis 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 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 find a provider, go to: www.davisvision.com, click on **Members** and follow these steps. Select **Open Enrollment** and enter Client Code, **2481** Then select **Find a Provider**.

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

COBRA Guide Information

City of Austin benefits are 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. Some information in this guide comes from the 2013 Employee Benefits Guide and may pertain only to active City employees. Review this material carefully before making your enrollment decisions. 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.

For detailed information about the plans, refer to each plan instrument, contact Erisa, the vendor, or the Employee Benefits Division of the Human Resources Department.

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, and vision at their own cost in the case of certain Qualifying Events. If you have money remaining in your FLEXTRA Health Care Account, you may continue your participation through COBRA for the remainder of the calendar year.

Continuation of your life insurance, short term disability, long term disability, FLEXTRA Dependent Care Account, and group legal plan is not available under COBRA.

Qualified Beneficiary

A Qualified Beneficiary is you or your family member who was covered under a City-sponsored medical plan, dental plan, vision plan, or the FLEXTRA Health Care Account on the day before a Qualifying Event. If more than one family member is eligible, each person may elect continued coverage separately. 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.

Qualifying Events for COBRA Continuation of Coverage

As determined by Federal law, Qualifying Events include:

- Termination of employment (including retirement) for any reason except gross misconduct.
- Divorce or legal separation from employee.
- Death of employee.
- Entitlement to Medicare
- The loss of eligibility for coverage due to a change in work status.
- Dependent child's loss of eligibility because he or she no longer meets the definition of an eligible dependent under the plan.

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, a 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.

Initial Enrollment

How to Enroll for Coverage

You have 60 days in which to complete a COBRA enrollment form electing coverage 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. 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 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 contributed 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 change, the new premiums also apply to COBRA participants who have elected coverage under COBRA. You will be notified of new rates prior to the effective date.

If you have money remaining in your FLEXTRA Health Care Account, you may continue your participation through COBRA, however you will pay 102% of the monthly contribution you designated for remainder of the calendar 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 (including retirement) for any reason except gross misconduct.
- The loss of eligibility for coverage due to 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 Erisa within 60 days of the Social Security Administration's determination of disability.

A Qualified Beneficiary may elect to continue coverage for up to 36 months if coverage ends due to:

- Divorce or legal separation from an employee or former employee.
- Death of employee or former employee.
- Entitlement to Medicare of former employee.
- Dependent child's loss of eligibility because he or she no longer meets the definition of an eligible dependent under the plan.

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 FLEXTRA coverage.

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:

- Any required premium is not paid in full on time.
- The date you become covered under another group health plan or entitled to Medicare.
- The date the City ceases to offer medical, dental, vision or FLEXTRA Health Care Account to employees.
- The end of the calendar year in which you originally elected FLEXTRA Health Care.

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 pre-existing condition 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.

Dependent Eligibility

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 contact Erisa or the City.

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 may be covered at any one 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, and grandchildren. Your children must be under 26 years of age.
- **Dependent Grandchildren:** Your unmarried grandchild must meet the requirements listed above, and must also qualify as a dependent (as defined by the Internal Revenue Service) on your or your spouse's Federal income tax return.

- **Disabled Children:** To continue City coverage past the age limit, your disabled child must 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 tax return.

An individual is not eligible to be covered:

- As both a City employee and a COBRA participant, for the same benefit.
- As both a COBRA participant and as a dependent of a COBRA participant, for the same benefit.
- As dependent of a City employee or a COBRA participant, for the same benefit.

Documentation

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

Acceptable documents are listed below for the following dependents:

- **Spouse:** A marriage certificate or declaration of informal (common-law) marriage, which has been recorded as provided by law.
- **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.
- **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

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

- 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 signed by a judge showing the date the divorce was final. Erisa will automatically send a COBRA notification to any Qualified Beneficiary.
- To drop coverage for a dependent who is no longer eligible, you must submit a corrected COBRA enrollment form to Erisa. 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 drop coverage due to a change in other coverage attributable to employment, you must submit 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. You must submit a corrected COBRA enrollment form to 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 HMO service area or as allowed by HIPAA Special Enrollment.

Premium Errors

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, a credit will be given for future premiums. If underpayment occurs due to an error you made on the COBRA enrollment form, the City has the right to collect any additional premiums owed.

Entry Error/Delay

If a data entry error occurs or if data entry is delayed, it will not invalidate the coverage on your COBRA enrollment form. Upon discovery, 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. If overpayment occurs, a credit will be given for future premiums.

Medical Plans: HMO and PPO



UnitedHealthcare provides HMO (Choice) and PPO (Choice Plus) medical coverage. Provider and prescription 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**

For complete coverage information, refer to the materials provided by UnitedHealthcare, or contact them directly at 800-430-7316. If there is a conflict between the provisions of the plan and this Guide, the terms of the plan govern.

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 this expense, 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.

myNurseLine

The UnitedHealthcare myNurseLine is a resource for employees 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 myNurseLine 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 myNurseLine number into your phone: *877-440-6011*. This service is available 24 hours a day, seven days a week.

Medical Rates - Monthly

The monthly COBRA medical rates 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	\$ 509.63	\$ 488.07
Insured & Spouse	\$ 1,143.62	\$ 1,095.15
Insured & Child or Children	\$ 976.47	\$ 935.32
Insured & Family	\$ 1,573.78	\$ 1,507.29
Child Only	\$ 509.63	\$ 488.07
Children Only	\$ 509.63	\$ 488.07

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.	

Schedule of Benefits – UnitedHealthcare

	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	\$600 copay. \$25 Primary Care Physician copay. \$45 Specialist copay.	Calendar year deductible applies. \$75 copay. Plan pays 80%.
Colonoscopies	Plan pays 100% for preventive screenings.	Plan pays 100% for preventive screenings.
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	Allergy injections are covered at 50%. Plan pays 50% for allergy testing and serum. 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 testing and serum. 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.

Schedule of Benefits – UnitedHealthcare

	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.
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 for any item over \$1,000.	Calendar year deductible applies. Plan pays 80%. Pre-notification required for any item over \$1,000.
Disposable Medical Supplies	Plan pays 80%. Pre-notification required for any item over \$1,000.	Calendar year deductible applies. Plan pays 80%. Pre-notification required for any item over \$1,000.
Breast Pumps	Plan pays 100%.	Plan pays 100%. No coverage for out-of-network providers.
Prosthetic-Orthotic Devices	Plan pays 80%. Pre-notification required for any item over \$1,000.	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 for any item over \$1,000.	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 – UnitedHealthcare

	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 Benefits – UnitedHealthcare

A \$50 deductible will apply for Tier 2 & Tier 3 prescription drugs per covered person. Once the deductible is met the copays listed below apply.

	HMO		PPO	
	Retail Pharmacy (limited to a 31-day supply)	Mail Order Pharmacy (limited to a 90-day supply)	Retail Pharmacy (limited to a 31-day supply)	Mail Order Pharmacy (limited to a 90-day supply)
Tier 1 (Generic Drug)	\$ 10	\$ 30	\$ 10	\$ 20
Tier 2 (Preferred Drug)	\$ 35	\$ 105	\$ 30	\$ 60
Tier 3 (Non-Preferred Drug)	\$ 55	\$ 165	\$ 50	\$ 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.

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 1 – Low copay for generic and some brand name drugs.
- Tier 2 – A higher copay for preferred brand name drugs.
- Tier 3 – 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. Talk to your doctor about whether a generic drug is right for you.

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. Remember you can use your FLEXTRA Health Care Benefits Card to purchase these medications.

What Your Medical Plan Does for You

City medical plans 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	Participant Cost	
		HMO	PPO
Preventive Care Visit	\$ 114	\$ 0	\$ 0
Primary Care Visit	\$ 114	\$ 25	\$ 25
Specialist Visit	\$ 178	\$ 45	\$ 35
Inpatient Hospital (4 days)	\$ 26,767	\$ 1,000	\$ 3,000
MRI Scan	\$ 1,652	\$ 100	\$ 100
Ambulance Service	\$ 932	\$ 100	\$ 586

Prescription Drugs		Participant Cost	
	Cost Without Insurance	HMO	PPO
Tier 1	\$ 68	\$ 10	\$ 10
After a \$50 Deductible			
Tier 2	\$ 147	\$ 35	\$ 30
Tier 3	\$ 242	\$ 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 mail order 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, if available.

Three weeks before your mail order supply runs out, you will need to request a refill.

For additional information, go to: www.myuhc.com or 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.

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

HMO				
Item (90-Day Supply)	Cost	Plan Pays	Mail Order You Pay	Retail You Pay
Insulin (Tier 1)	\$ 933	\$ 903	\$ 30	\$ 30
Lancets	\$ 28	\$ 28	\$ 0	\$ 28
Syringes/Needles	\$ 55	\$ 55	\$ 0	\$ 30
Test Strips	\$ 367	\$ 367	\$ 0	\$ 30
Total	\$ 1,383	\$ 1,353	\$ 30	\$ 118
PPO				
Item (90-Day Supply)	Cost	Plan Pays	Mail Order You Pay	Retail You Pay
Insulin (Tier 1)	\$ 933	\$ 913	\$ 20	\$ 30
Lancets	\$ 28	\$ 28	\$ 0	\$ 28
Syringes/Needles	\$ 55	\$ 55	\$ 0	\$ 30
Test Strips	\$ 367	\$ 367	\$ 0	\$ 30
Total	\$ 1,383	\$ 1,363	\$ 20	\$ 118

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 **Members**, **Open Enrollment**, 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*.	
OR		OR	
Any Fashion or Designer frame from Davis Vision’s exclusive Collection (with retail values up to \$175), Covered in Full .		Standard Contacts – Evaluation, fitting fees, and follow-up care, \$25 copay applies.	
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.		Speciality Contacts – Evaluation, fitting fees, and follow-up care, up to a \$60 allowance plus 15% off cost exceeding allowance*. \$25 copay applies.	
One year eyeglass breakage warranty included at no additional cost.		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	Lens Options	Copay
Standard progressive addition lenses	\$50	Premium AR Coating	\$48
Premium progressives (i.e. Varilux, etc.)	\$90	Ultra AR coating	\$60
Intermediate-vision lenses	\$30	High-index lenses	\$55
Blended-segment lenses	\$20	Polarized lenses	\$75
Ultraviolet coating	\$12	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 & Spouse	\$ 8.81
Insured & Child or Children	\$ 8.65
Insured & Family	\$ 13.16
Child Only	\$ 4.45
Children Only	\$ 4.45

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 2013 Employee Dental Assistance Plan Document online at www.austintexas.gov/benefits/enrollment or call Erisa at 250-9397.

Plan Coverage

Preventive Care	No Deductible
\$50 Calendar Year Deductible, per covered person	
Basic Care	Deductible applies
Major Care	Deductible applies
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 Deductible applies
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	\$ 37.29
Insured & Spouse	\$ 104.43
Insured & Child or Children	\$ 104.43
Insured & Family	\$ 104.43
Child Only	\$ 37.29
Children Only	\$ 104.43

FLEXTRA

FLEXTRA Health Care Accounts

If you terminate employment with the City (or experience another COBRA Qualifying Event), you will have until May 31, 2014 to submit claims to Erisa for expenses that were incurred while you were employed with the City and you contributed to your FLEXTRA Health Care Account.

If you have money remaining in your FLEXTRA Health Care Account, you may continue your participation through COBRA, however you will pay 102% of the monthly contribution you designated for the remainder of the calendar year. For example, as a City employee, if you chose \$2,400 for the annual FLEXTRA Health Care election amount and you terminate on July 1, you have already paid \$1,200 into your FLEXTRA Health Care Account. If you have not incurred any claims, you will need to continue to contribute to the FLEXTRA Health Care Account in order to access those funds after termination.

FLEXTRA Health Care Carryover

If you are contributing to your FLEXTRA Health Care Account on December 31, 2013, you are eligible to incur expenses until March 15, 2014, and file against your 2013 funds. All 2013 claims must be received by May 31, 2014, by Erisa in order to be eligible for payment.

FLEXTRA Health Care Benefits Card

As a COBRA participant, the FLEXTRA Health Care Benefits Card is not available. You must complete a FLEXTRA Health Care claim form and submit the form along with your paid receipts and/or Explanation of Benefits directly to Erisa.

FLEXTRA Dependent Care Account

You are not eligible for COBRA continuation in your FLEXTRA Dependent Care Account. If you terminate employment with the City, you will have until March 15, 2014, to incur expenses and submit claims to Erisa by May 31, 2014, to receive reimbursement for funds accrued in your FLEXTRA Dependent Care Account.

Important Benefits Information

- Summary of Benefits and Coverage and Uniform Glossary of Terms
- ADA Compliance
- Governing Plan
- HIPAA
- Patient Protection and Affordable Care Act
- Your Prescription Drug Coverage and Medicare

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

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

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

ADA Compliance

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

Governing Plan

Your rights are governed by each plan instrument (which may be a plan document, evidence of coverage, certificate of coverage, or contract), and not by the information in this Guide. If there is a conflict between the provisions of the plan you selected and this Guide, the terms of the plan govern. City of Austin benefits are 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 (i.e., 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 is as follows:

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

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

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

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Protheses 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 participants.

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 15 and December 7, or when you first become eligible for Medicare Part D.
- If you decide to join a Medicare drug plan, your current City of Austin medical coverage will not be affected.
- If you do decide to join a Medicare drug plan and drop your current City of Austin coverage for your dependents, you may be able to get this coverage back during an Open Enrollment period.
- You should also know that if you drop or lose your current coverage with the City of Austin and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without Creditable Coverage, your premium may consistently be at least 19% 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).