CITY OF SAN ANTONIO EMPLOYEE BENEFIT GUIDE

BENEFIT Matters | 2016

We've Got You Covered!

INSIDE THIS EDITION

2016 Premiums
Health Plans
Helpful Tools

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Quick Look

- The Consumer Choice and New Value medical plan options will be offered in 2016. There are no changes to your plan options. **More information is available on page 5.**
- Good News!
  The 2016 retiree monthly premiums for your medical, dental, and vision coverage are the same as what you paid in 2015.
- Your current tobacco use status will continue in 2016. Tobacco users will be assessed a $40 monthly fee. **Learn how you can stop the fee on page 7.**
- Throughout this year's Benefit Matters guide, you will see different icons next to information that we would like to draw your attention to. **A legend has been provided below for your reference.**

Annual Enrollment: October 12 - November 6

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Non-Medicare Retirees

In 2016, non-Medicare retirees will have the option of selecting either the Consumer Choice or New Value medical plan option.

Medical Plans At-A-Glance

Here is a side-by-side comparison of the two medical plan options available to you in 2016. As you can see in the chart below, both medical plan options cover the same health care services. However, the amount you pay out-of-pocket will vary between options.

Plan Benefit	Consumer Choice		New Value PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
City Contribution to Health Savings Account (Retiree Only / Family)	$500 / $1,000 Health Savings Accounts are funded by City and retiree contributions. They are medical savings accounts.		N / A	
Preventive Care	100%	60% after deductible	100%	60% after deductible
Annual Deductible (Retiree Only / Family)	$1,300 / $2,600	$2,600 / $5,200	$1,250 / $2,500	$2,500 / $5,000
Annual Out-of-Pocket Maximum (Retiree Only / Family)	$4,000 / $8,000*	$8,000 / $16,000	$3,000 / $6,000	$6,000 / $12,000
Co-insurance (After Deductible)	80% / 20%	60% / 40%	80% / 20%	60% / 40%
Office Visit Co-pays: Primary Care / Premium Designation Specialist / Urgent Care / Specialist	20% after deductible	40% after deductible	$30 / $35 / $50 / $55	40% after deductible
Emergency Care and Ambulance Services	20% after deductible			
In-Patient Hospital Admissions, Out-Patient Surgery, Durable Medical Supplies, and Radiology	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Physical, Occupational, & Speech Therapy	20% after deductible	40% after deductible	20% after deductible	40% after deductible

**For family coverage, beginning in 2016, the maximum amount to be paid by any one individual on the plan will not exceed $6,850.*

Non-Medicare Retiree Contributions

Retiree contributions comprise a portion of the actual cost of the retiree medical plan. The City pays approximately 67% of the cost for retiree medical coverage. In order to maintain your coverage, it is critical that you pay your premiums promptly. Any retiree with a past due account of more than 60 days will be subject to termination of medical coverage with no opportunity for re-enrollment into the plan. Retirees participating in the City's non-Medicare medical plans are required to pay for their coverage using an automated bank draft.

Non-Medicare Premiums (Monthly)

The table below features the monthly premium amounts for non-Medicare retirees, which are the same as what you pay now, for both medical care plan options. Included in this table is the amount the City contributes toward the cost of each option. For example, if you select the Consumer Choice plan, are in the Retiree Only category, and had 30+ years of service, you pay $187 monthly and the City pays $502.55 monthly to cover the total cost of the monthly premium.

Years of Service	30+		25-29		20-24		19 & Under		5-9 (Hired on or after 10/1/2007)
Consumer Choice									
	Retiree	City	Retiree	City	Retiree	City	Retiree	City	Retiree
Retiree Only	$187	$502.55	$204	$485.55	$221	$468.55	$278	$411.55	$689.55
Retiree + 1	$375	$915.59	$394	$896.59	$435	$855.59	$579	$711.59	$1,290.59
Retiree + 2 or More	$535	$1,204.99	$566	$1,173.99	$626	$1,113.99	$836	$903.99	$1,739.99
New Value PPO									
Retiree Only	$254	$848.03	$281	$821.03	$304	$798.03	$368	$734.03	$1,102.03
Retiree + 1	$479	$1,583.59	$515	$1,547.59	$566	$1,496.59	$714	$1,348.59	$2,062.59
Retiree + 2 or More	$664	$2,116.83	$716	$2,064.83	$789	$1,991.83	$998	$1,782.83	$2,780.83

Note: The monthly premium amounts do not include the $40 monthly tobacco surcharge.

Notes

Two Medical Plans - Choose The One That Is Best For You

Of the two non-Medicare medical plan options, Consumer Choice is the only Consumer-Driven Health Plan (CDHP). As you will recall, a CDHP allows you to have more control over how your health care dollars are spent. Here are some key elements of Consumer Choice that make it different from New Value.

Consumer Choice and New Value - How Are They Different?

Plan Feature	Consumer Choice (CDHP) PPO	New Value PPO
Health Savings Account (HSA)	Allows you to pay for qualified medical, dental, and vision out-of-pocket expenses or save for future health care expenses with money that is yours to keep. City will contribute $500 for a retiree-only plan and $1,000 for a family plan. You own the funds, so whatever you do not use will carry over to the next year.	Does not apply.
Co-pays	Does not apply.	Co-pays apply in the amounts of $30, $35, $50, and $55 based on the type of provider you select.
Family Deductible NEW	The family deductible can be met by one family member or a combination of family members. For example, for a family of five, the family's $2,600 deductible can be met by one family member or a combination of any of the five family members. The maximum out-of-pocket to be paid by any one individual on the plan will not exceed $6,850.	A family would need at least two people to meet the individual deductible in order to meet the family deductible. For example, two family members would need to reach $1,250 each in health care expenses in order to meet the $2,500 family deductible. The maximum out-of-pocket to be paid by one individual on the plan will not exceed $6,850.
Prescription Drug Coverage	You are responsible for 100% of the discounted cost of your prescription medications (from in-network providers) until you meet your deductible. For IRS-approved maintenance medications, such as those used to manage high blood pressure, diabetes, osteoporosis, and cholesterol, you only pay 20% of their cost since they are not subject to the deductible.	Co-pays apply in the amounts of $10, $35, $65, and $100 based on the tier of medication you need. For those managing diabetes through medication, the City's Value-Based Co-pay Program offers no co-pays for Tier 1 medications, $10 for Tier 2, and $20 for Tier 3.

Tools & Resources for Non-Medicare Retirees

Tool	What it provides	Where to find it
UnitedHealthcare Health Plan Cost Estimator	• Helps you select the right health care plan • Compares cost differences between your plan and your spouse's / domestic partner's plan	pcestimator.com username: SanAntonio2016 password: Benefits2016
myHealthcare Cost Estimator	• Helps you budget for a medical treatment • Offers database of physicians and medical specialties • Compares network and non-network cost estimates • Shows how a procedure would affect your health account balances	myuhc.com

Non-Medicare Prescription Drug Plan

Make sure you consider your use of prescription medications when selecting your 2016 health care plan option. The City's prescription drug benefit provides you with access to a wide variety of medications, which helps to make the ones you need more affordable. You also have access to more than 60,000 in-network pharmacies to fill your next prescription.

With the 2016 prescription drug plan, four pricing tiers, reduced co-pays for prescription medications related to diabetes, and coverage for several popular tobacco cessation medications will continue to be offered. Also, the prescription drug plan will help you manage your pharmacy costs by encouraging the use of generic equivalents, when available.

Automatic Generics Program

This Program automatically provides you with a generic equivalent to your prescription medication, when available. You do not even have to ask for it. Generic prescription drugs, which are mostly found in Tier 1, contain the same active ingredients as brand name drugs typically found in Tiers 2 and 3. The majority of brand name drugs have an available generic equivalent. You still have the option of purchasing brand name prescription drugs; however, you will pay the difference between the generic cost and the brand name co-pay. If your doctor requires tha you only take brand name medications, make sure your prescription indicates "dispense as written." With "dispense as written" on your prescription, you will only pay the applicable co-pay for the brand name medication.

Value-Based Co-pays

It is important for retirees and their dependents with diabetes to follow their prescription drug regimen to effectively manage their condition. To continue assisting retirees and their eligible dependents who have diabetes with achieving a better quality of life, the City's Value-Based Co-pay plan offers prescription drugs related to diabetes at a reduced co-pay amount. For Tier 1 generic diabetes prescription drugs, there are no co-pays, and for Tiers 2 and 3, co-pays remain at their reduced prices from last year.

90-day Mail Order Prescriptions

Purchasing a 90-day supply of your prescription drugs is convenient, and it saves you money on the maintenance medications you take every day. The best part is you can have a 90-day supply of your medication delivered to you at home through the Mail Order Pharmacy Program.

2016 Prescription Drug Plan		
	Prescription Co-pays	Value-Based Co-pays
30-day Retail		
Tier 1	$10	$0
Tier 2	$35	$10
Tier 3	$65	$20
Tier 4	$100	--
90-day or Mail Order		
Tier 1	$20	$0
Tier 2	$70	$20
Tier 3	$130	$40
Tier 4	$200	--

Not only will you save yourself from having to wait in line at the pharmacy, but ordering your medications through the Mail Order Pharmacy Program is the best way to ensure that your 90-day supply is available when you need it. To begin using mail order, *visit myuhc.com.*

Prescriptions and Consumer Choice

Remember, Consumer Choice does not have co-pays. You are responsible for 100% of the discounted cost of your prescription medications until you reach your deductible. For IRS-approved preventive prescription drugs like those used to control high blood pressure, cholesterol, and diabetes, you only pay 20% of the cost since they are not subject to the deductible.

A complete list of IRS-approved maintenance medications can be found online, under the prescription drugs tab, at *sanantonio.gov/employeeinformation/retiredemployees/nonmedicarebenefits.*

Retiree Brown Bag Sessions

The City will continue to offer the Retiree Brown Bag Sessions in 2016. Through these sessions, you will continue to have the opportunity to learn more about topics including health care, fitness, mental wellness, and stress management. Remember, the Retiree Brown Bag Sessions are open and FREE to all City of San Antonio retirees and their spouses or domestic partners.

For more information about the Retiree Brown Bag Sessions, contact Human Resources Customer Service at 210-207-8705 or hrcustomerservice@sanantonio.gov.

Tobacco Use

Introduced in 2013, the City's $40 monthly tobacco surcharge for those non-Medicare retirees who use tobacco and are enrolled in a City medical plan will continue. The surcharge is in addition to the monthly medical premium. Your current tobacco use status will automatically roll over to 2016.

Remember, the City defines a "tobacco user" as a person who has used tobacco products within the past 60 days. Tobacco products include, but are not limited to: cigarettes, cigars, pipes, all forms of smokeless tobacco (chewing tobacco, snuff, dip, or any other product that contains tobacco), clove cigarettes, or any other smoking devices that use tobacco such as hookahs. Electronic and smoke-free cigarettes are also included in the definition of a tobacco product.

Tobacco Cessation Resources

The City's prescription drug plan covers several popular tobacco cessation prescription medications. These medications include, Buproban, which is a Tier 1 prescription medication, and Chantix, Nicotrol, and Zyban, which are Tier 3 prescription medications. Additionally, a resource for those seeking to quit tobacco is the American Cancer Society's Texas Tobacco Quitline, 877-YESQUIT (937-7848), and their website, quitnow.net/texas.

I Quit, So What is Next?

You can stop the $40 monthly surcharge by completing a tobacco cessation program and remaining tobacco-free for 60 consecutive days. Once you have done both of these things, you should contact the Employee Benefits Office at 210-207-0073 to submit a new Tobacco Declaration Form certifying that you no longer use tobacco and a certificate of completion from your tobacco cessation program. The system will be updated to reflect your new status and your monthly premium payment will be adjusted within four to six weeks from the time that you submit your documentation.

Note: You will not be refunded for any amount you have paid in monthly fees prior to the new Tobacco Declaration Form being processed.

Retiree Dental Plan

Because regular dental visists are a key part of maintaining your overall health, the City offers you access to dental insurance through Delta Dental.

Through the dental benefits plan administered by Delta Dental, you have access to a network of dental providers who can help you meet your oral health goals.

DeltaCare Dental HMO

The DeltaCare Dental HMO is a dental plan that provides comprehensive dental care when services are obtained from an in-network primary dentist. If this is your first time enrolling in the retiree dental care plan, you will need to select a participating dentist from the DeltaCare network of providers to serve as your primary dentist. The dentist should be within a 35-mile radius of your zip code.

With this plan, you are only responsible for the co-pays for any covered services you receive from your selected dentist. There are no deductibles, yearly maximums, or paperwork to file. Examples of common services and co-pays are featured in the chart below.

Monthly Premiums

Dental Plan	DeltaCare DHMO
Retiree Only	$13.66
Retiree + Spouse / Domestic Partner	$25.45
Retiree + Child(ren)	$25.45
Retiree + Family	$38.19

Description	Procedure Code	Co-pay
Office Visit	D0999	$5
Oral Exam, X-rays, and Fluoride Treatment	--	No Cost
Prophylaxis (Teeth Cleaning Twice a Year)	D1110	No Cost
Periodontal Scaling and Root Planning, Per Quadrant	D4341	$40
Amalgam Fillings for One Surface, Anterior	D2140	$5
Surgical Extraction and Erupted Tooth	D7210	$45
Root Canal-Molar (Excluding Final Restoration)	--	$280
Crown	D2750	$295
Orthodontics (Children and Adults)	D8070 (children) / D8090 (adults)	$1,700 / $1,900

Retiree Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Through Davis Vision, you have access to a national network of doctors and retail providers. Eye exams, eyeglasses, and contacts are available to you at only the cost of applicable co-pays.

Davis Vision Collection

To maximize your vision plan benefit, consider purchasing frames or contact lenses from The Davis Vision Collection. The Collection is available at a number of independent provider locations. Independent providers do not include retail stores such as Visionworks or Walmart. To locate a participating independent provider near you, visit *DavisVision.com.*

Frame Benefits

With the Davis Vision Frame Collection, you have access to select designer and brand name frames for only the cost of applicable co-pays. You are allowed a $130 retail allowance toward frames outside of the Davis Vision Frame Collection.

Contacts Benefits

Contact lenses selected from Davis Vision's Contact Lens Collection are covered in full. You are allowed a $150 retail allowance toward contacts outside of the Davis Vision Contact Lens Collection.

Additional Vision Benefits

You also have access to additional discounts on popular lens options and coatings such as scratch-resistant coating, polycarbonate lenses, and standard progressives (no-line bifocal).

Through Davis Vision's Eye Health Connection Program, individuals with cataracts, diabetes, macular degeneration, and glaucoma are eligible to receive an additional eye exam during the calendar year.

Visit *DavisVision.com* for more information about the additional vision benefits available to you.

Out-of-Network Benefits

You have the option of receiving services from an out-of-network provider. When receiving these services, you must pay the provider directly for all charges and then submit a claim form for reimbursement to: *Vision Care Processing Unit, P.O. Box 1525 Latham, NY 12110.* The reimbursement form can be found online at *sanantonio.gov/employeeinformation/benefits/resources.*

Vision Plan	Monthly Premium
Retiree Only	$10.05
Retiree + Spouse / Domestic Partner	$17.95
Retiree + Child(ren)	$17.95
Retiree + Family	$26.60

In-Network Benefit Summary

Comprehensive Eye Exam - $10 co-pay, one exam per year	
Frames (in lieu of contacts)	Contacts (in lieu of eyeglasses)
Once per calendar year beginning January 1.	Once per calendar year beginning January 1.
$130 retail allowance toward any frame from provider, plus 20% off balance[3].	$150 retail allowance toward Non Collection Contact lenses, plus 15% off balance[2].
OR	OR
Any Fashion or Designer frame from Davis Vision's Collection[1] *(value up to $175).	Any contact lenses from Davis Vision's Contact Lens Collection[1].
One year eyeglass breakage warranty included at no additional cost.	Contact Lens Evaluation, Fitting & Follow-Up Care: Once per calendar year beginning January 1. Davis Collection contact lens covered in full, including fitting fee. Fitting fee is an additional charge minus 15% discount if Non Collection contact lens[2].
Spectacle Lenses - Once per calendar year beginning January 1. For standard single-vision, lined bifocal, or trifocal lenses.	

1. Davis Vision Collection is not available at retail providers. It is only available at participating independent provider locations.

2. For dependent children, monocular patients, and patients with prescriptions of 6.00 diopters or greater.

3. Additional discounts not applicable at Walmart or Sam's Club locations.

Eligibility for Retirees / Dependents

City of San Antonio employees who leave the City with at least 20 years of service or have five years of service and are 60 years of age are eligible for City of San Antonio retiree medical benefits.

Retirees who meet eligibility requirements for retiree medical benefits must enroll in a City retiree medical plan or waive coverage within 31 days from the date of separation from service.

Waiving Medical Coverage

Retirees also have the option of waiving the City's medical coverage; however, you must do so at the time that you separate from the City. Retirees who choose to waive coverage are allowed one opportunity to re-enter the City's medical plan at a later date, as long as they provide proof of continuous medical insurance coverage.

The continuous coverage can be a spouse's, employer's, or individual plan and enrollment must be requested within 31 days of the loss of that coverage. Those who do not enroll in the City's medical plan at the time of separation and do not elect to waive coverage will not be allowed to enroll in the City's medical plan at any time. If you enroll in the City's medical coverage and then request to cancel that coverage, you will not be allowed to re-enroll in the City's medical plan.

Eligible Dependents

Dependents may be enrolled in City retiree medical benefits if they were covered at the time of your retirement and you enroll them at the time of your initial retiree medical election. Dependents who continue to meet eligibility requirements will remain on the plan until you remove them, cease to make the required contribution, or the dependent no longer meets the eligibility criteria. Once a dependent is removed, the dependent cannot be added back onto the medical plan.

Retirees who waived coverage at the time of separation but are eligible to re-enter the City's medical plan, may only enroll those dependents who were covered at the time coverage was waived. Dependents must return to the plan along with the retiree; they will not be added to the plan at a later date.

Making Changes During the Year

There are certain life events that can happen during the year that will allow you to change the level of coverage (retiree only, retiree plus one, or retiree plus 2 or more) for your medical plan.

Those life events are:

Divorce, Annulment, Dissolution of a Domestic Partnership and Death of a dependent.

You must notify the Employee Benefits Office within 31 calendar days of your life event and provide all required documentation in order for the changes in your coverage to take effect during the calendar year. If you fail to notify the Employee Benefits Office within 31 calendar days, you forfeit any past premium refund.

Retiree Annual Enrollment

Annual enrollment begins October 12 and ends November 6, 2015. Selections will become effective January 1, 2016.

This is the time you can choose a new medical plan or enroll in the retiree vision or dental plans, so be sure to review your choices and enroll by the deadline.

Selections may be changed ONLY during the Annual Enrollment period. See page 10 to learn about changing your level of coverage during the year.

How to Make Changes for 2016

Health care selections should be made carefully, and the Human Resources Department is happy to assist you. Retirees are encouraged to utilize the various online tools referenced throughout Benefit Matters to help you make the most informed decisions. You can also visit the 2016 Retiree Annual Enrollment Meeting to learn more about your options - see the next page for a schedule of the meetings.

Non-Medicare Consumer Choice and New Value Plans

If you wish to remain in your existing medical plan, then you do not need to take any action during annual enrollment.

If you would like to change your medical plan for 2016, there are two ways to do so. Choose the option that works best for you:

- Enrollment Form - Complete the paper enrollment form included with this benefit guide. Once complete, you can return your medical enrollment form to the appropriate address.
- In-person Enrollment - If you would like to discuss changes to your health plan for 2016 or would like assistance with making changes, you can attend the annual enrollment meeting.

Vision and Dental Plans for All Retirees

Retirees who were enrolled in the retiree vision or dental plan in 2015 will automatically have their coverage carry over to 2016.

If you are not currently enrolled in the retiree vision or dental plan, but would like to be in 2016, contact Davis vision at 800-448-9372 or Delta Dental at 800-422-4234.

2016 Retiree Annual Enrollment Meetings

Non-Medicare retirees will have the opportunity to visit one-on-one with UnitedHealthcare, Davis Vision, Delta Dental, and representatives from the Employee Benefits Office at the 2016 Annual Enrollment Meeting. You will also be able to receive enrollment assistance.

Non-Medicare Retirees: 2016 Retiree Annual Enrollment Meeting			
Date	Time	Location	Room
Friday, October 30	8 a.m. - noon	Central Library, 600 Soledad St., 78205	Auditorium

Glossary of Common Health Care Terms

The following is a list of health care terms that are used throughout this benefit guide. We have provided explanations for each of them so that you may better understand your benefits, how they work, and what choices will be best for you and your dependents.

Consumer-Driven Health Plan (Consumer Choice)

Consumer-Driven Health Plan (CDHP) - A type of insurance plan in which you are responsible for most of the cost of your health care expenses until the plan's deductible and out-of-pocket maximum are reached. This type of plan has lower premiums than the other two health plans, but higher deductibles and out-of-pocket maximums.

Health Plan Features

Annual deductible - The amount you need to pay, not including co-pays, for covered health care services before the health plan pays. The annual deductible counts toward your out-of-pocket maximum.

Co-insurance - The percentage you have to pay for health care services after you have met your annual deductible. Co-insurance amounts count toward your out-of-pocket maximum.

Co-pay - The flat fee you pay for certain services like doctor's, specialist's, or urgent care office visits or prescription drugs. Prescription drug and office visit co-pays count toward your out-of-pocket maximum.

Health Savings Account (HSA) - A tax-exempt savings account that can be used to help pay for current and future qualified medical expenses. You can only have an HSA if you are enrolled in a Consumer-Driven Health Plan like Consumer Choice.

Out-of-pocket maximum - The most you will pay for covered health care services in a calendar year. Once you reach it, the health care plan pays 100% of the cost of covered health care services for the remainder of the year. All covered health care expenses count toward the out-of-pocket maximum, except for premiums.

Prescription Drugs

Tier 1 (Generic) drugs - Medications that generally cost the least. They usually include the generic equivalents of brand name drugs.

Tier 2 (Preferred brand formulary) drugs - Medications that are typically your mid-range-cost option. Consider a Tier 2 drug if no Tier 1 medication is appropriate to treat your condition.

Tier 3 (Non-preferred brand) drugs - Medications that often include brand name drugs without generic versions or brand name drugs that are new to the market.

Tier 4 (Specialty) drugs - Medications that require special handling, administration, or monitoring. These drugs are often used to treat chronic illnesses such as cancer, hemophilia, multiple sclerosis, and Crohn's disease.

Provider Networks

In-network - A group of approved doctors, hospitals, and other health care professionals that provide quality care at contracted rates. These providers must pass a rigorous review of their personal history, disciplinary actions, licenses and certifications, and relevant training and experience.

Out-of-network - Doctors, hospitals, or other health care professionals that are not in the health plans' network. Service from these providers will, in many cases, cost you more than the same service from an in-network health care provider.

Types of Office Visits (Co-Pays)

Premium Designation Specialist - A visit to an in-network specialist or speciality center who is in a designated group of providers. A visit to a specialist or specialty center with the Premium Designation will result in a lower office visit co-pay than a visit to a specialist or specialty center without the designation.

These providers meet or exceed quality of care and cost efficiency standards as recognized by the United Health Premium Designation.

Primary Care - A visit to a physician, nurse practitioner, clinical nurse specialist, or physician assistant who provides, coordinates, or helps you access a range of health care services.

Specialist - A visit to a physician specialist who focuses on a specific area of medicine to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Notes

Contacts

Organization	Phone	Website
San Antonio Human Resources Department	210-207-8705	sanantonio.gov/employeeinformation/retiredemployees hrcustomerservice@sanantonio.gov cosaretiree@sanantonio.gov
Retiree Ombudsman - Ann Solis	210-207-0073	ann.solis@sanantonio.gov
Davis Vision	800-448-9372	davisvision.com
Delta Dental (Delta Care DHMO)	800-422-4234	deltadentalins.com/cityofsanantonio/retirees.html
ICMA Retirement Corporation	800-735-7202	icmarc.org
Nationwide Retirement Solutions	877-677-3678	nrsforu.com
San Antonio Fire & Police Pension	210-534-3262	safppf.org
Social Security Administration	800-772-1213	socialsecurity.gov
Texas Municipal Retirement System	800-924-8677	tmrs.com
UnitedHealthcare	800-996-2078	myuhc.com
UnitedHealthcare (Health Savings Account Customer Service)	800-791-9361	myuhc.com

Health Benefits Notices

The City of San Antonio makes every effort to communicate regularly with retirees. Our primary method of communication is through Retiree Matters, the City's newsletter for retirees. It is produced quarterly and at other times when we need to share information. Retiree Matters is mailed to your home address. Please make sure the City has your correct address at all times. If you change your address, email Human Resources Customer Service at ***CosaRetiree@sanantonio.gov*** to update your information.

We also encourage you to visit the retiree website at ***SanAntonio.gov/employeeinformation/retiredemployees.*** Refer to it to learn more about your retiree medical benefits and for complete information on each of the notices referenced below.

City Retiree Medical Benefit Program Design and Funding

Any benefits and contributions under the City of San Antonio's insurance or self-funded programs are subject to change as determined by the City Council in any budget year, or by ordinance or amendment.

The City Manager, or her Designee, may be authorized to amend the City retiree medical benefits plan and set premiums for retiree and dependent coverage, so long as sufficient funds are appropriated by City Council (see ordinance **#2015-09-10-0754**).

Creditable Coverage

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please visit ***sanantonio.gov/employeeinformation/retiredemployees.aspx.***

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) details the rules the City of San Antonio will follow to safeguard the confidentiality of medical information obtained through the course of enrollment and administration of our health plans. For detailed information, visit hhs.gov/ocr/privacy.

Summary Plan Documents/Plan Documents

This guide is intended to provide summary information about the benefit plans offered to retirees of the City of San Antonio. Complete plan details are available in the Summary Plan Documents for the Consumer Choice and New Value PPO plans and can be obtained from the Human Resources Department. In the event of a discrepancy between this document and the official Summary Plan Document/Plan Document, the Plan Documents shall govern.

Women's Health Act

The Women's Health and Cancer Rights Act of 1998 requires that all health insurance plans that cover mastectomy also cover the following medical care:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedemas and mastectomy bras and external prostheses limited to the lowest cost alternative that meets the patient's physical needs.

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HUMAN RESOURCES DEPARTMENT

210.207.8705 | sanantonio.gov/employeeinformation/retiredemployees