BENEFIT MATTERS

2019

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LIVE WELL. CHOOSE WELL.

CITY OF SAN ANTONIO EMPLOYEE BENEFITS GUIDE

RETIREE

WELCOME TO YOUR 2019 BENEFIT MATTERS.

The information provided in this guide will serve as a resource tool for you as you prepare to select the best benefit choices for you and your family. From health care plan options to information about the City's vision and dental plans, you will find answers to many of your benefits questions within these pages.

WHAT'S INSIDE

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 group medical insurance coverage.

The continuous coverage can be a spouse's, employer's, or other qualified group health 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 or fail to maintain premium payments, 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 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.

Medicare Retirees

In 2019, Medicare-eligible retirees will continue to have the option of choosing between three plans; however, if you do not wish to change coverage, no action is required.

Medical Plan Options

For those retirees and their spouses who are eligible for Medicare, the City will continue to offer you the option of choosing between the Medicare Advantage PPO, Medicare Advantage PPO Plus, and Pharmacy-only plans.

Aetna will remain the provider for these three plans in 2019. If you have any questions about the Medicare plans, please contact Aetna at 800-842-1306. The monthly premiums for 2019 can be found on the following page.

Monthly Medicare Retiree Premiums

Retiree premiums comprise a portion of the actual cost of the retiree medical plan. The City pays approximately 67% of the cost for retiree medical coverage based on your years of service. 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.

The table found on the next page features the monthly premium amounts for Medicare retirees based upon your length of service at the time of your retirement. Included in this table is the amount the City contributes toward the cost of each option. For example, if you select the Medicare Advantage PPO plan, are in the Retiree-Only category, and had 30+ years of service, you pay $59 monthly and the City pays $135.06 monthly to cover the total cost of the monthly premium.

Medicare Retiree Premiums

2019 Monthly Medicare Premiums								
Hired Before 10/1/2007								
Years of Service	30+		25-29		20-24		19 & Under	
Medicare Advantage PPO								
	Retiree	City	Retiree	City	Retiree	City	Retiree	City
Retiree Only	$59	$135.06	$63	$131.06	$68	$126.06	$87	$107.06
Retiree + 1	$116	$272.12	$128	$260.12	$136	$252.12	$175	$213.12
Retiree + 2 or More	$175	$407.18	$193	$389.18	$204	$378.18	$262	$320.18
Medicare Advantage PPO Plus								
Retiree Only	$57	$129.59	$61	$125.59	$66	$120.59	$79	$107.59
Retiree + 1	$104	$269.18	$113	$260.18	$127	$246.18	$187	$186.18
Retiree + 2 or More	$155	$404.77	$168	$391.77	$191	$368.77	$264	$295.77
Medicare Pharmacy-Only								
Retiree Only	$46	$107.88	$50	$103.88	$54	$99.88	$70	$83.88
Retiree + 1	$93	$214.76	$101	$206.76	$108	$199.76	$138	$169.76
Retiree + 2 or More	$138	$323.64	$153	$308.64	$163	$298.64	$209	$252.64

Hired On or After 10/1/2007				
Years of Service	10+		5-9	
Medicare Advantage PPO				
	Retiree	City	Retiree	City
Retiree Only	$97	$97.06	$194.06	$0
Retiree + 1	$194	$194.12	$388.12	$0
Retiree + 2 or More	$291	$291.18	$582.18	$0
Retiree Only	$93	$93.59	$186.59	$0
Retiree + 1	$187	$186.18	$373.18	$0
Retiree + 2 or More	$280	$279.77	$559.77	$0
Medicare Pharmacy-Only				
Retiree Only	$77	$76.88	$153.88	$0
Retiree + 1	$154	$153.76	$307.76	$0
Retiree + 2 or More	$231	$230.64	$461.64	$0

For questions regarding coverage and benefits, contact Aetna at 800-842-1306 or vist aetnamedicare.com.

Non-Medicare Retirees

In 2019, non-Medicare retirees will have the option of selecting either the Consumer Choice or New Value PPO medical plan option; however, if you do not wish to change coverage, no action is required.

Medical Plans At-A-Glance

Here is a side-by-side comparison of the two medical plan options available to you in 2019. 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.

Also note that the City provides a contribution of $500 to individuals and $1,000 to families participating in the Consumer Choice high-deductible health plan.

Plan Benefit	Consumer Choice (CDHP) PPO		New Value PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Retiree Only / Family)	$2,000 / $4,000*	$4,000 / $8,000	$1,500 / $3,000	$3,000 / $6,000
Annual Out-of-Pocket Maximum (Retiree Only / Family)	$4,000 / $8,000**	$8,000 / $16,000	$3,500 / $7,000	$7,000 / $14,000
Co-insurance After Deductible	80% / 20%	60% / 40%	80% / 20%	60% / 40%
Preventive Screenings	Covered at 100%	60% after deductible	Covered at 100%	60% after deductible
Office Visits: Primary Care Specialist Urgent Care	20% after deductible	40% after deductible	$30 $55	40% after deductible
Emergency Care and Ambulance Services	20% after deductible		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, and Speech Therapy	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Prescription Drugs: Tier 1 Tier 2 Tier 3 Tier 4	100% of the cost of prescription medications until deductible is met. For IRS-approved maintenance medications, 20% of cost since they are not subject to the deductible.		Co-pays: $10 | Diabetes Meds: $0 $35 | Diabetes Meds: $10 $65 | Diabetes Meds: $20 $100	
Contributions to Health Savings Account (HSA) (Retiree Only / Family)	$500 / $1,000 Health Savings Accounts are funded by City and retiree contributions. They are medical savings accounts.		Not Available	

*The maximum deductible for one individual in a family plan will be $2,700 in 2019.

**For family coverage, the maximum to be paid by any one individual on the plan will not exceed $7,350 in 2019.

Non-Medicare Retiree Premiums

Retiree premiums comprise a portion of the actual cost of the retiree medical plan. The City pays approximately 67% of the cost for retiree medical coverage based on your years of service. 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 Monthly Premium Rates

The table below features the monthly premium amounts for non-Medicare retirees based upon your length of service at the time of your retirement. 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 $204 monthly and the City pays $910.02 monthly to cover the total cost of the monthly premium.

2019 Monthly Non-Medicare Premiums								
Hired Before 10/1/2007								
Years of Service	30+		25-29		20-24		19 & Under	
Consumer Choice PPO								
	Retiree	City	Retiree	City	Retiree	City	Retiree	City
Retiree Only	$204	$910.02	$222	$892.02	$241	$873.02	$303	$811.02
Retiree + 1	$409	$1,819.05	$429	$1,799.05	$474	$1,754.05	$631	$1,597.05
Retiree + 2 or More	$583	$2,313.46	$617	$2,279.46	$682	$2,214.46	$911	$1,985.46
New Value PPO								
Retiree Only	$277	$962.52	$306	$933.52	$331	$908.52	$401	$838.52
Retiree + 1	$522	$1,957.03	$561	$1,918.03	$617	$1,862.03	$778	$1,701.03
Retiree + 2 or More	$724	$2,498.74	$780	$2,442.74	$860	$2,362.74	$1,088	$2,134.74

Hired On or After 10/1/2007				
Years of Service	10+		5-9	
Consumer Choice PPO				
	Retiree	City	Retiree	City
Retiree Only	$557	$557.02	$1,114.02	$0
Retiree + 1	$1,114	$1,114.05	$2,228.05	$0
Retiree + 2 or More	$1,448	$1,448.46	$2,896.46	$0
New Value PPO				
Retiree Only	$619	$620.52	$1,239.52	$0
Retiree + 1	$1,239	$1,240.03	$2,479.03	$0
Retiree + 2 or More	$1,611	$1,611.74	$3,222.74	$0

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

Non-Medicare Retiree Plans

Consumer Choice and New Value - How Are They Different?

Of the two non-Medicare medical plan options, Consumer Choice is a Consumer-Driven Health Plan (CDHP) with a high deductible and employer-funded Health Savings Account (HSA). 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.

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 pre-tax dollars. You are eligible for an HSA if all the following are true. You: • Are enrolled in the Consumer Choice plan. • Are not covered by any other qualified medical plan. • Are not claimed as a dependent on someone else's federal tax return.	Not available with this plan.
Office Visits	20% after deductible ($2,000 for individual / $4,000 for family)	Co-pays apply in the amounts of $30, $50, and $55 based on the type of provider you select.
Family Deductible	The family deductible can be met by one family member or a combination of family members. For example, for a family of five, one family member alone or any combination of the five family members could meet the family's $4,000 deductible.	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 $1,500 each in health care expenses in order to meet the $3,000 family deductible.
Out-of-Pocket Maximum	Your out-of-pocket maximum includes your deductible and co-insurance. For 2019, an individual on a family plan will not exceed $7,350 in out-of-pocket costs.	Your out-of-pocket maximum includes your co-pays, deductible and co-insurance. The maximum out-of-pocket to be paid by one individual on the plan will not exceed $3,500.
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 $0 co-pays for Tier 1 medications, $10 for Tier 2, and $20 for Tier 3.

Blue Cross and Blue Shield of Texas' Benefit Value Advisor & Member Rewards Programs

Benefit Value Advisor Program - Interested in Possible Savings?

The Benefit Value Advisor (BVA) Program provides non-Medicare retirees with the opportunity to speak to a specially-trained advisor from Blue Cross and Blue Shield of Texas about your options when it comes to receiving care. A BVA can:

- help compare costs at different providers near you,
- tell you about online educational tools,
- help you identify a qualifying provider for the Member Rewards Program (see more information below)
- help you schedule your medical appointments, and much more!

To get started with your own BVA, call Blue Cross and Blue Shield of Texas Customer Service at 800-521-2227.

Member Rewards Program - Same Procedure, Different Cost, & Potential Cash in Your Pocket!

Prices for the same quality medical services can differ by thousands of dollars within the same region and health plan network. And through Blue Cross and Blue Shield of Texas' Member Rewards Program, administered by Vitals, you now have the opportunity to earn cash rewards when you select a lower-cost, quality provider from several possibilities. The Member Rewards Program, combined with Provider Finder® (see page 12), can help you:

- compare costs and quality for numerous procedures.
- estimate out-of-pocket costs.
- earn cash while shopping for care.
- save money and make the most efficient use of your health care benefits.
- consider treatment decisions with your doctors.

Estimated cost comparison for maternity delivery	
Provider A: $10,696*	Provider B: $13,677*
Estimated cost comparison for a knee MRI	
Provider A: $374*	Provider B: $2,779*
Estimated cost comparison for a hip replacement	
Provider A: $32,293*	Provider B: $52,307*

1. Benefit Value Advisors offer cost estimates for various providers, facilities, and procedures. Lower pricing and cost savings are dependent on the provider or facility of your choosing. *Allowable in-network cost data from Tarrant County. Costs are examples.

How Does It Work?

1. When a doctor recommends treatment, log into Blue Access for Members at bcbstx.com (or simply contact a Benefit Value Advisor for assistance).

2. Click the Doctors and Hospitals Tab – then on Find a Doctor or Hospital – and Shop for Procedures.

3. Choose a Member Rewards eligible location, and you may earn a cash reward of up to several hundred dollars!

4. Complete your procedure and, once verified, you will receive a check for the shared savings amount indicated within 4 to 6 weeks. It is easy to understand how much you could save with a reward option, based on location. After verification, Vitals will send you any earned reward check. Rewards are taxable.

You can quickly and easily find the information you need to help you choose a facility or service via your computer or mobile device.

Questions? Contact Blue Cross and Blue Shield of Texas Customer Service at 800-521-2227.

Health Savings Accounts

The ABCs of Your Health Savings Account

A Health Savings Account (HSA) is a bank account that is owned and managed by the account holder - YOU. The funds in the account are to be used for the sole purpose of paying for qualified health care expenses and saving for future eligible health care (medical, dental, vision, and pharmacy) expenses.

Like your personal checking or savings account, your HSA is held at a bank, HSA Bank. Yes, the bank where your HSA funds are held is called HSA Bank. HSA Bank will open a Health Savings Account for you and will issue you a debit card that will allow you to access your funds.

To help you get started, the City will contribute $500 to your HSA account with HSA Bank for those enrolled in the Consumer Choice health plan option at the employee-only level, or $1,000 for those enrolled at the family level. These funds will be available in January 2019. Even if you are currently enrolled in Consumer Choice and plan to continue coverage in this plan for 2019, you will still receive the City's contribution. In 2019, the IRS maximum for HSA contributions is $3,500 for an individual and $7,000 for a family. The City's contributions and any funds you contribute apply to this maximum.

HSA Eligibility

You are eligible for an HSA if all the following are true. You:

- Are enrolled in the Consumer Choice plan.
- Are not covered by any other qualified medical plan.
- Are not claimed as a dependent on someone else's federal tax return.

Contact Human Resources Customer Service at 210-207-8705 with any questions regarding HSA eligibility.

Note: As mentioned above, you are not eligible for an HSA if you have any other medical plan.

Health Savings Accounts—A Triple Tax Advantage

In addition to providing you with a way of paying for your current qualified health care expenses and saving for your future health care needs, an HSA provides you with a triple tax advantage. The funds in an HSA: 1) are not taxable when they are deposited, 2) accrue interest tax-free, and 3) are not taxable when being withdrawn to cover eligible medical expenses.

YOU, not the City, are responsible for maintaining records (receipts, explanation of benefits, etc.) of how you spent the funds in your HSA to provide to the IRS in the event of an IRS audit.

Eligible HSA expenses for you and your family include:

- Deductibles and co-insurance for medical, dental, and vision care and services
- Prescription medications

Ineligible HSA expenses for you and your family include:

- Vision warranties and service contracts
- Over-the-counter medications without a prescription
- Teeth whitening

Consumer Choice and New Value How Prescriptions Are Covered

When considering your retiree health plan options, it is important to consider your prescription needs. The City's prescription drug benefit, which is administered by CVS/caremark, provides you with access to a wide variety of medications, while helping to make the ones you need more affordable. You also have access to a large group of in-network pharmacies to fill your next prescription, including CVS, Walgreens, and H-E-B. Please visit sanantonio.gov/employeeinformation/benefits/resources for a list of local in-network pharmacies.

To locate an in-network pharmacy near you, call CVS/caremark Customer Service at 866-808-7470.

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 that 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.

90-Day Mail Order Prescriptions

Purchasing a 90-day mail order supply of your prescription drugs saves you money on the maintenance medications you take every day. In addition to saving money, it is convenient to have your medications delivered to you at home through the Mail Order Pharmacy Program. This is the best way to ensure your medication is available when you need it. To begin receiving a 90-day mail order supply of your maintenance medications, visit caremark.com and login to your account (or create one), or call CVS/caremark at 866-808-7470.

Value-Based Co-pays (New Value Only)

It is important for retirees and their dependents with diabetes to follow their prescription drug regimen to effectively manage their health. 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, including $0 co-pays on Tier 1 medications.

Prescriptions and Consumer Choice

You are responsible for 100% of the discounted cost of your prescription medications until you reach your deductible. For IRS-approved maintenance drugs, like those used to control high blood pressure, cholesterol, and diabetes, you only pay 20% of their 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.

2019 Prescription Drug Coverage	New Value		Consumer Choice
	Co-pays	Value-Based Co-pays	
	30-day Retail		
Tier 1 (generics)	$10	$0	20% after deductible
Tier 2 (preferred brand formulary)	$35	$10	20% after deductible
Tier 3 (non-preferred brand)	$65	$20	20% after deductible
Tier 4 (specialty)	$100	Not Available	20% after deductible
	90-day Mail Order		
Tier 1 (generics)	$20	$0	20% after deductible
Tier 2 (preferred brand formulary)	$70	$20	20% after deductible
Tier 3 (non-preferred brand)*	$130	$40	20% after deductible

*For IRS-approved maintenance medications, you only pay 20% of the discounted cost since these medications are not subject to the deductible. A complete list of these medications can be found at sanantonio.gov/employeeinformation/benefits/resources.

Tool to Help You Choose the Right Health Plan

Trying to Decide Which Plan to Select?

Use the example below and plug in your own family's amounts to see which plan might be the best choice for you in 2019.

A Real-life Example (In-Network Benefits)

- Joe Retiree Hired Before October 1, 2007
- Retiree + 2 or more
- Gross Medical Expenses of 10 Primary Care Physician Visits * Per Year with a Generic Antibiotic Prescribed at Each Visit

Plans	Consumer Choice	New Value
Annual Premium	$6,996	$8,688
Deductible	$1,200*	-
Co-insurance	-	-
Office Visit Co-pay	-	$300 ($30 x 10 visits)
Pharmacy Co-pay	-	$100 ($10 x 10 Rx)
City-Funded Health Savings Account	($1,000)	-
Total Employee	$7,196	$9,088

*Assumes 10 office visits at $90 per visit ($90 x 10 = $900) and generic refills at retail are estimated at $30 per prescription ($30 x 10 = $300).

Looking for an In-Network Doctor or Facility?

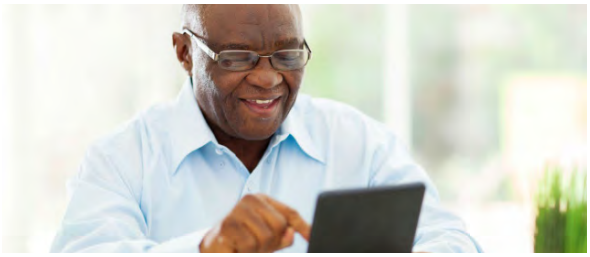
Do you need help locating an in-network doctor or facility? If you already have a primary care physician or medical health care provider that you love, do you want to make sure that he or she is still in the network? No problem! With the help of the online Provider Finder® tool, you can do just that by following a few easy steps:

- Visit bcbstx.com
- Click on the button for the Provider Finder® tool
- Select "Texas" in the drop-down menu for the first question, then hit "Start Search"
- Choose the "Plan Networks" button and "Blue Choice PPO" from the drop-down menu
- Enter your search criteria, then hit "Search"
- Review and filter the results until you find the information that you want

If you need help locating an in-network doctor or provider, ask a Benefit Value Advisor by calling Blue Cross and Blue Shield of Texas Customer Service at 800-521-2227.

Tools & Resources for Non-Medicare Retirees

Tool & Resource	What it provides	Where to find it
Blue Access for Members (BAM) website	A secure member website that allows you to find information about your health benefits anytime, anywhere using your computer, phone, or tablet. You can check the status or history of a claim, view or print Explanation of Benefits statements, and locate an in-network doctor or hospital.	bcbstx.com/member (click the login tab and register)
Benefit Value Advisor	A specially-trained advisor from Blue Cross and Blue Shield of Texas who can speak with you about your options when it comes to receiving care and help schedule medical appointments.	800-521-2227
Blue Cross and Blue Shield of Texas Onsite Service Representative	Our onsite Service Representative is available to assist you with questions regarding the City's medical plans, your medical claims, health care providers, and Blue Cross and Blue Shield of Texas health and wellness programs.	210-207-0103 sanantonio.gov/employeeinformation/benefits/resources --> BCBSTX Representative Tab
Blue Cross and Blue Shield of Texas Provider Finder®	An online tool that helps you locate an in-network doctor or provider.	bcbstx.com Click on "Find a Doctor or Hospital" Click on the Provider Finder® tool Select "Texas" from the drop-down menu, then hit "Start Search" Select the "Plan Networks" button and "Blue Choice PPO" from the drop-down menu Enter search criteria, then hit "Search" Review and filter results to find the doctor or provider you want
CVS/caremark Member Services website	This member services website allows you to order refills, check drug cost and coverage, enroll in mail order and more. You will also find out about ways to save money on your prescriptions.	caremark.com
CVS/caremark Member Services website	A list of in-network pharmacies.	caremark.com 866-808-7470



Retiree Dental Plans

Because regular dental visits are a key part of maintaining your overall health, the City offers you access to dental insurance through Delta Dental. Through these two dental benefits plans, you have access to a network of dental providers who can help you meet your oral health goals. DeltaCare enrollment packets, with participating providers, are mailed to eligible retirees annually during open enrollment.

CitiDent PPO

The CitiDent PPO is a dental PPO plan that allows you to obtain care per the chart below from the dentist of your choice. Obtaining services from an in-network provider will lower your out-of-pocket costs.

Coverage Type	In-Network	Out-of-Network
Type A - Preventive Care (Cleanings and Oral Exams)	Covered at 100%	Covered at 100% maximum allowed
Type B - Basic Care (Fillings, Simple Extractions, and Periodontics)	Covered at 80%	Covered at 80% maximum allowed
Type C - Major Care (Bridges and Dentures)	Covered at 50%	Covered at 50% maximum allowed
Deductible (Individual / Family)	$50 / $150	$50 / $150
Annual Maximum Benefit (Per Person)	$1,200	$1,200

Monthly Premiums

Dental Plan	DeltaCare DHMO	DeltaCare PPO
Retiree Only	$13.66	$37.90
Retiree + Spouse / Domestic Partner	$25.45	$62.80
Retiree + Child(ren)	$25.45	$62.80
Retiree + Family	$38.19	$97.40

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.

Description	Procedure Code	Co-pay
Office Visit	D0999	$5
Oral Exam, X-rays, and Fluoride Treatment*	N / A	No Co-pay
Prophylaxis (Teeth Cleaning Twice a Year)	D1110	No Co-pay
Periodontal Scaling and Root Planing, Per Quadrant	D4341	$40
Amalgam Fillings for One Surface, Anterior	D2140	$5
Surgical Extraction and Erupted Tooth	D7210	$45
Root Canal-Endodontic Therapy, molar (excluding final restoration)	D3330	$280
Crown	D2750	$295
Orthodontics (Children and Adults)	D8070 (children) / D8090	$1,700 / $1,900

*Note: Fluoride Treatment is specific for children up to age 19.

Retiree Vision Plans

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.

Comprehensive Eye Exam

Through Davis Vision, you are allowed one comprensive eye exam per year with a co-pay of $10.

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

Several designer and brand name frames are available to you at only the cost of the applicable co-pays through Davis Vision's Frame Collection. For frames outside of the Davis Vision Frame Collection, you are allowed a $130 retail allowance. In 2019, when you shop at a Visionworks store, you will receive a $155 retail allowance toward any frame.

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.

Access to LASIK discounts is also available. Members get low prices on LASIK procedures through Qualsight, making permanent vision correction more affordable.

Discounts on hearing aids is another additional benefit offered through Davis Vision. Members can save up to 60% on brand name hearing aids and have access to the largest network of audiologists and Ear, Nose and Throat specialists in the nation through EPIC Hearing Healthcare.

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	$9.75
Retiree + 1	$17.41
Retiree + 2 or more	$25.80

Tobacco Use for Non-Medicare Retirees

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 2019.

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 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.

Brown Bag Sessions for Retirees

The City will continue to offer the Retiree Brown Bag Sessions in 2019. Through these sessions, you will have the opportunity to learn more about topics including health care, fitness, 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 AskHR@sanantonio.gov.

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)

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.

Urgent Care - A visit to an urgent care facility to receive treatment for an illness, injury, or condition serious enough to seek care right away, but not so severe as to require a trip to the emergency room.

Contacts

Organization	Phone	Website
San Antonio Human Resources Department	210-207-8705	sanantonio.gov/employeeinformation/retiredemployees AskHR@sanantonio.gov cosaretiree@sanantonio.gov
Retiree Liaison - Ann Solis	210-207-0073	ann.solis@sanantonio.gov
Aetna	800-842-1306	aetnamedicare.com
Blue Cross and Blue Shield of Texas	800-521-2227	bcbstx.com
CVS/caremark (Pharmacy Claims Administrator)	866-808-7470	caremark.com
Davis Vision (Vision Provider)	800-448-9372	davisvision.com
DeltaCare DHMO (Dental Plan)	800-422-4234	deltadentalins.com/cityofsanantonio/retirees.html
DeltaDental PPO (Dental Plan)	800-521-2651	deltadentalins.com/cityofsanantonio/retirees.html
HSA Bank (Health Savings Account Customer Service)	855-731-5220	hsabank.com
ICMA Retirement Corporation	800-669-7400	icmarc.org
Medicare	800-633-4227	medicare.gov
Nationwide Retirement Solutions	877-677-3678	nrsforu.com
Retired Employees of the City of San Antonio	210-504-9567	recosa.org
Social Security Administration	800-772-1213	socialsecurity.gov
Texas Municipal Retirement System	800-924-8677	tmrs.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 #2018-09-13-0709).

Notice of Privacy Practices

The City of San Antonio takes the privacy and security of your confidential health information seriously. Health information about you is protected and will be shared only with other covered entities for treatment, payment, and health care operation activities. Additionally, you have the right to obtain copies of your health record (medical claims and enrollment records), request a correction, restrict communications, request a copy of our Privacy Practices Policy, authorize someone to represent you or file a complaint if you believe your privacy rights have been violated. For detailed information regarding the City of San Antonio Privacy Policy, please visit sanantonio.gov/Portals/0/Files/EmployeeInformation/Benefits/privacy.pdf.

Summary 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.

P: 210.207.8705

sanantonio.gov/employeeinformation/retiredemployees

AskHR@SanAntonio.gov