CITY OF SAN ANTONIO EMPLOYEE BENEFITS GUIDE

TUNE IN TO YOUR BENEFITS

— 2024 —

RETIREE

CITY OF SAN ANTONIO TEXAS

INSIDE: HEALTH CARE PREMIUMS, HEALTH PLANS & HELPFUL TOOLS

WELCOME TO YOUR 2024 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.

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THANK YOU FOR YOUR SERVICE!

CONTACTS

Organization	Phone	Website/Email
Benefits Customer Service	210.207.0073	CosaBenefits@sanantonio.gov
Access2Care (Medicare transportation benefit)	855.814.1699	access2care.net
Aetna	800.338-4533 (TTY: 711)	aetnamedicare.com
Blue Cross Blue Shield of Texas	800.521.2227	bcbstx.com
CVS/caremark	866.808.7470	caremark.com
HSA Bank (Health Savings Account Customer Service)	855.731.5220	hsabank.com
Humana Dental Insurance	855.330.8060	humana.com (Dental PPO: Traditional Preferred Network | Dental HMO: HS205 Plan Network)
Medicare	800.633.4227	medicare.gov
MissionSquare Retirement	800.669.7400	icmarc.org/san-antonio-tx.html
Nationwide Retirement Solutions	877.677.3678	nrsforu.com
Retired Employees of the City of San Antonio (RECOSA)	210.504.9567	recosa.org
Social Security Administration	800.772.1213	ssa.gov
Texas Municipal Retirement System	800.924.8677	tmrs.com
Vision Service Plan (VSP)	800.400.4569	cosaretirees.vspforme.com

ELIGIBILITY FOR RETIREES & DEPENDENTS

City of San Antonio employees who leave the City with 20 or more years of service or have five years of service and are at least 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 of 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 other qualified 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, 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

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 three plans - **Medicare Advantage Standard PPO, Medicare Advantage Enhanced PPO**, and the **Pharmacy-only plan**.

Aetna will remain the provider for these three plans in 2024. If you have any questions about the Medicare plans, please contact Aetna at 800-338-4533 (TTY: 711). The monthly premiums for 2024 can be found on page 7.

Medicare Medical Plans At-A-Glance

Plan Benefit	Medicare Advantage Standard PPO	Medicare Advantage Enhanced PPO
Annual Deductible	$0	$0
Annual Maximum Member Could Potentially Pay	$2,500	$0
Office Visits - These co-pay amounts apply to in-network and out-of-network providers		
Physician Specialist	$15	$0
Primary Care Physician	$5	$0
Preventive Services	$0	$0
Outpatient Lab and X-ray	$0/$15	$0
Urgent Care	$15	$0
Emergency Care	$65	$0
Inpatient Hospital Care	$175 per stay	$0
Immunizations	$0	$0
Outpatient Surgery	$15	$0
Home Health Agency Care	$0	$0
Chiropractic Services	$15	$0
Durable Medical Equipment	20% co-insurance	$0
Podiatry Services	$15	$0
Diabetic Supplies	$0	$0

For questions regarding coverage and benefits, contact Aetna at 800-338-4533 (TTY: 711) or visit aetnamedicare.com.

Key Extra Benefits for Retirees with Medicare Medical Plans Description	
Plan Benefit	**Cost**
Hearing Aids	$500 reimbursement every 36 months
Fitness Benefit	In-person or virtual workouts through SilverSneakers
Transportation	40 trips with unlimited miles per trip
Meal Delivery	14 meals following an inpatient hospital stay
Aetna Healthy Rewards	Get rewards for completing healthy actions
Enhanced Podiatry	Reduction of nails, including mycotic nails, and the removal of corns and calluses, available for Enhanced plan only
Telehealth	Virtual visit with your primary care physician or an urgent care clinic for the cost of an in-person visit

Medical Plans At-A-Glance - Pharmacy Coverage

Plan Benefit	Cost
In-network Prescription Drug Coverage for Retirees with Standard PPO, Enhanced PPO and Pharmacy-only Plans	
Deductible	$0
Tier 1 - Generic (preferred)	$5 preferred retail/$15 standard retail co-pay
Tier 2 - Preferred Brand	$20 co-pay
Tier 3 – Non-preferred drug	$40 co-pay
Tier 4 – Specialty drugs	25% coinsurance
Coverage Gap	Full gap coverage*
Catastrophic Phase*	CMS standard
Mail-order Drugs	Two times retail cost share for a 90-day supply

***Minimum gap coverage (25%) for Pharmacy-Only Plan members.**

MEDICARE RETIREE PREMIUMS

Retiree premiums comprise a portion of the actual cost of the retiree medical plan. The City pays a portion 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 below features the monthly premium amounts for Medicare retirees based upon your length of service at the time of your retirement.

2024 Monthly Medicare Premiums						
	Hired before 10/1/2007				Hired on/after 10/1/2007	
Years of Service	30+	25-29	20-24	19 & Under	10+	5-9
Medicare Advantage Standard PPO						
Retiree Only	$25.86	$27.55	$29.66	$37.94	$40.75	$81.50
Retiree + 1	$51.04	$55.94	$59.66	$76.22	$81.50	$163.00
Retiree + 2 or More	$76.56	$84.41	$89.23	$115.47	$122.25	$244.50
Medicare Advantage Enhanced PPO						
Retiree Only	$132.76	$134.45	$136.56	$144.84	$147.65	$188.40
Retiree + 1	$264.84	$269.74	$273.46	$290.02	$295.30	$376.80
Retiree + 2 or More	$397.26	$405.11	$409.93	$436.17	$442.95	$565.20
Medicare Pharmacy-Only						
Retiree Only	$38.36	$40.05	$42.16	$50.44	$53.25	$94.00
Retiree + 1	$76.04	$80.94	$84.66	$101.22	$106.50	$188.00
Retiree + 2 or More	$114.06	$121.91	$126.73	$152.97	$159.75	$282.00

NON-MEDICARE RETIREES

In 2024, you have the opportunity to choose between three medical plans: **Consumer Choice PPO, Blue Essentials HMO, New Value PPO, or waive coverage.** All of the plans feature co-insurance, deductibles, and in-network preventive screenings covered at 100%. With the **Blue Essentials HMO,** you will be connected to a smaller group of qualified health care providers (Texas only), and your care will be directed by a primary care physician (PCP). The **Consumer Choice and New Value** PPO plan feature a nationwide open access provider network. As you see below, the coverage is the same for all three plans; however, the amount you pay out of pocket varies.

Plan Benefit	Consumer Choice (CDHP) PPO		Blue Essentials HMO		New Value PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Employee Only/ Family)	$2,000/ $4,000*	$4,000/ $8,000	$1,500/ $3,000	N/A	$1,500/ $3,000	$3,000/ $6,000
Co-insurance After Deductible	20% after deductible	40% after deductible	20% after deductible		20% after deductible	40% after deductible
Annual Out-of-Pocket Maximum (Employee Only/ Family)	$4,000/ $8,000**	$8,000/ $16,000	$3,500/ $7,000		$3,500/ $7,000	$7,000/ $14,000
Office Visits						
Primary Care	20% after deductible	40% after deductible	$25	N/A	$30	40% after deductible
Mental Health Visits			$25		$30	
Specialist			$45		$50	
Urgent Care			$75		$75	
Virtual Visit (MD Live)		N/A	$25		$30	N/A
Emergency Room		20% after deductible	$300		20% after $300 co-pay	
Preventive Screenings	Covered at 100%	40% after deductible	Covered at 100%		Covered at 100%	40% after deductible
Prescription Drugs						
Tier 1 (30-day retail)	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 list of these medications can be found at sanantonio.gov/ employeeinformation/ benefits/health.		$10 | Diabetes Meds $0	N/A	$10 | Diabetes Meds $0	
Tier 2 (30-day retail)			$35 | Diabetes Meds $10		$35 | Diabetes Meds $10	
Specialty (30-day retail)			$100		$100	
Tier 1 (90-day mail order)			$20 | Diabetes Meds $0		$20 | Diabetes Meds $0	
Tier 2 (90-day mail order)			$70 | Diabetes Meds $20		$70 | Diabetes Meds $20	

***The maximum deductible for one individual in a CDHP family plan will be $3,200 in 2024. **For family coverage, the maximum to be paid by any one individual on the plan will not exceed $7,350 in 2024.**

New in 2024, the City is expanding its focus on mental health support. For non-Medicare retirees, this includes removing financial barriers to mental care. Those enrolled in the City's New Value PPO or Blue Essentials HMO medical plans will have their office visits for mental health appointments reduced from that of a specialty provider to a primary care provider.

CONSUMER CHOICE, BLUE ESSENTIALS, AND NEW VALUE: HOW ARE PRESCRIPTIONS 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.

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 contain the same active ingredients as brand name medications. The majority of brand name drugs have an available generic equivalent. You still have the option of purchasing brand name medications; however, you will pay the cost of the brand name medication. 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 (Blue Essentials & New Value)

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, at the bottom of the prescription drugs tab, at sanantonio.gov/employeeinformation/retiredemployees/nonmedicarebenefits.

NON-MEDICARE RETIREES

Retiree premiums comprise a portion of the actual cost of the retiree medical plan. The City pays a portion 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.

The table below features the monthly premium amounts for non-Medicare retirees based upon your length of service at the time of your retirement.

2024 Monthly Non-Medicare Premiums						
	Hired before 10/1/2007				Hired on/after 10/1/2007	
Years of Service	30+	25-29	20-24	19 & Under	10+	5-9
Consumer Choice PPO						
Retiree Only	$139.00	$153.00	$166.00	$201.00	$557.00	$1,114.02
Retiree + 1	$261.00	$281.00	$309.00	$389.00	$1,114.00	$2,228.05
Retiree + 2 or More	$362.00	$390.00	$430.00	$544.00	$1,448.00	$2,896.46
Blue Essentials HMO						
Retiree Only	$180.00	$199.00	$215.00	$261.00	$614.00	$1,227.12
Retiree + 1	$339.00	$365.00	$401.00	$506.00	$1,227.00	$2,454.24
Retiree + 2 or More	$471.00	$507.00	$559.00	$707.00	$1,595.00	$3,190.51
New Value PPO						
Retiree Only	$277.00	$306.00	$331.00	$401.00	$682.00	$1,363.47
Retiree + 1	$522.00	$561.00	$617.00	$778.00	$1,363.00	$2,726.93
Retiree + 2 or More	$724.00	$780.00	$860.00	$1,088.00	$1,773.00	$3,545.01

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

CONSUMER CHOICE, BLUE ESSENTIALS, AND NEW VALUE: HOW ARE THEY DIFFERENT?

Plan Feature	Consumer Choice (CDHP) PPO	Blue Essentials HMO	New Value PPO
Monthly Premiums	Low	Medium	High
Annual Deductible	High	Low	Low
Co-pay	N/A	Yes	Yes
Co-insurance (In-network)	You pay 20%, the City pays 80% (after deductible)	You pay 20%, the City pays 80% (after deductible)	You pay 20%, the City pays 80% (after deductible)
Primary Care Physician or PCP	N/A	Required, must select a PCP at time of enrollment	N/A
Specialist Office Visits	No referral required	Required, referral from PCP No coverage outside of network	No referral required
Nationwide Network	Yes	No (Texas only)	Yes
Health Savings Account (HSA) with City Contribution	$500 - Employee Only $1,000 - Family	No	No
Annual Out-of-Pocket Maximum	High	Low	Low

FEATURES THAT WILL CONTINUE IN 2024

Next Generation Transform Diabetes Care - Manage Your Diabetes With No-Cost Tools

As part of the City's pharmacy benefit plan through CVS/caremark, you and your dependents have access to a program that offers no-cost tools, services, and extra support to help you manage your diabetes. This program includes:

- treatment supplies, including unlimited test strips and lancets to help keep track of your glucose levels, and
- two (2) diabetes metabolic health visits per year at MinuteClinic to help prevent diabetes-related conditions.
- a BioTel Care-connected glucose meter (with free testing supplies) to help keep track of your glucose levels for eligible employees, and
- more!

Applied Behavioral Analysis (ABA) Therapy

Applied Behavioral Analysis (ABA) Therapy is treatment for individuals who have autism spectrum disorders. It is intended to provide improvement in a variety of interpersonal skills, including looking, listening, imitating, language, behavioral, and social.

Please consult your health care professionals to determine if this treatment option is best for you. If you need assistance with finding an in-network doctor, contact the Blue Cross and Blue Shield of Texas Member Services Line at 1.800.521.2227.

My Medical Ally™

Formerly ConsumerMedical®, My Medical Ally™ benefit provides expert medical opinion and clinical advocacy to individuals diagnosed with a serious medical condition, such as cancer, or who are facing a procedure like a hip and knee replacement, hysterectomy, or lower back surgery. Through this benefit, you have access to customized, evidence-based support, educational materials, and assistance from a team of health care professionals throughout your health journey.

Questions? Contact My Medical Ally™ at 1.888.361.3944 from Monday through Friday, 8 a.m. to 8 p.m. CT.

Travel & Lodging

This benefit provides reimbursement for those traveling to receive treatment for a transplant or inpatient/outpatient cancer treatments. The travel distance requirement for reimbursement is 100 miles at the IRS rate for the most direct route between the patient's home and the designated provider. Eligible expenses should be compliant with IRS guidelines, subject to a $10,000 lifetime maximum. Benefits are paid at a per diem (per day) rate of $50 per person per night. Individuals can include a person traveling with them.

To be reimbursed, you will need to submit a qualifying receipt. Examples of travel expenses include:

- airfare at coach rate,
- taxi,
- ground transportation, and
- mileage reimbursement.

Prior authorization is not required for the travel, but would be required for any covered treatments.

For more information about this benefit, call the Blue Cross and Blue Shield of Texas Member Services Line at 1.800.521.2227.

BLUE CROSS & BLUE SHIELD OF TEXAS BENEFIT VALUE ADVISOR & MEMBER REWARDS PROGRAMS

Benefit Value Advisor Program

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!

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 Sapphire, you 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 15), 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 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***

Note: 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.

*Cost examples are for illustration purposes only.

How Does It Work?

1. When a doctor recommends treatment, log into Blue Access for Members at bcbstx.com (or simply contact a BVA 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 within four (4) to six (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.

TOOLS TO HELP YOU CHOOSE THE RIGHT PLAN

We all know that making health care decisions can be difficult, and selecting the best health care plan for you and your family is no exception. When considering your health care options, there are several factors to keep in mind.

- Your family's and your health care needs for the upcoming year. Do you expect any major medical expenses?
- The amount you pay out of pocket for health care. Do you normally meet your deductible?
- Your use of maintenance prescription drugs. How much do you pay for prescription medications annually?
- The cost of having a health care plan, whether you use it or not. How much will I pay just to have coverage, even if I do not use or need it?

Need Help?

Refer to the example below and plug in your own family's amounts to see which plan might be the best choice for you in 2024.

A Real-life Example (In-Network Benefits)

- John Retiree Hired Before October 1, 2007
- 30+ years of service
- Retiree + 1
- Gross Medical Expenses of 10 Primary Care Physician Visits Per Year With a Generic Antibiotic Prescribed at Each Visit*

Plans	Consumer Choice PPO	Blue Essentials HMO	New Value PPO
Annual Premium	$3,132	$4,068	$6,264
Deductible	$1,100*	-	-
Co-insurance	-	-	-
Office Visit Co-pay	-	$250 ($25 x 10 visits)	$300 ($30 x 10 visits)
Pharmacy Co-pay	-	$100 ($10 x 10 Rx)	$100 ($10 x 10 Rx)
City-Funded Health Savings Account	($1,000)	-	-
Total Retiree Cost	$3,232	$4,418	$6,664
Most Cost Effective Plan: Consumer Choice			

***Assumes 10 office visits at $80 per visit ($80 x 10 = $800) and generic antibiotics at retail are estimated at $30 per prescription ($30 x 10 = $300).**

If you need help locating an in-network doctor or provider, ask a Benefit Value Advisor by calling the Blue Cross & Blue Shield of Texas Member Services line at 1.800.521.2227.

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 www.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

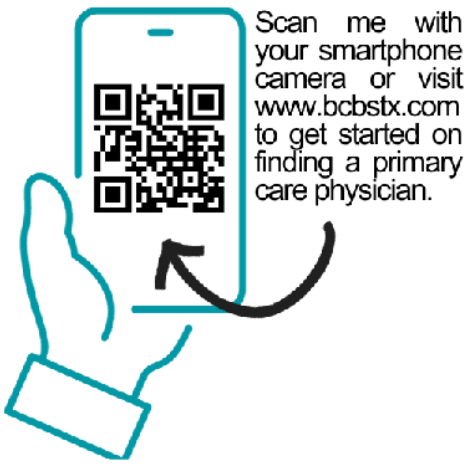
Finding Your In-Network PCP for the Blue Essentials HMO

Those who select this health plan are required to designate an in-network primary care physician (PCP) at the time of enrollment. To find a list of participating PCPs and make a selection, access the Blue Cross and Blue Shield of Texas website by either 1) hovering a smartphone camera over the QR code below and clicking the link or 2) visiting www.bcbstx.com. Once you access the website, please follow the steps below.

Note: The PCP must fall under: Family Practice, Internal Medicine,

Pediatric, or General Medicine.

- Click on “Find Care.”
- Click on the link for “Find a Doctor or Hospital.”
- Click “Search as Guest.”
- Fill in “Where would like to search for care (city, state, or zip)?”
- Under “Select Plan/Network,” select Blue Essentials (HMO).
- Under Common Searches, select “Primary Care”
- Select a type of doctor (ex: Family Practice, General Practice, Internal Medicine, OB-GYN, or Pediatrics)
- Click on the doctor’s name to locate the doctor’s 10-digit NPI number (you will need to provide this number at the time of enrollment).



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 deposits are 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 retiree-only level, or $1,000 for those enrolled at the family level. These funds will be available in January 2024. Even if you are currently enrolled in Consumer Choice and plan to continue coverage in this plan for 2024, you will still receive the City's contribution. In 2024, the IRS maximum for HSA contributions is $4,150 for an individual and $8,300 for a family. Those 55 and older can contribute an additional $1,000 as a catch-up contribution. The City's contributions and any funds you contribute apply to these maximum amounts.

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 medical plan, including Medicare Advantage or Tricare.
- Are not claimed as a dependent on someone else's federal tax return, including a spouse's Health Care Flexible Spending Account..

Contact Human Resources Customer Service at 210.207.8705 or AskHR@sanantonio.gov with any questions regarding HSA eligibility.

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.

Eligible HSA expenses include:

- deductibles and co-insurance for medical, dental, and vision care, and
- prescription medications.

Ineligible HSA expenses include:

- vision warranties and service contracts,
- over-the-counter medications without a prescription,
- teeth whitening, and
- cosmetic/aesthetic medical procedures.

TOOLS & RESOURCES FOR NON-MEDICARE RETIREES

Tools & Resources	What it provides	Where to find it
Blue Access for Members (BAM)	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
My Medical Ally™	This benefit provides access to expert medical opinions and clinical advocacy.	888.361.3944
CVS/caremark Member Services	Member Services allow 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.	866.808.7470 caremark.com
CVS/caremark Pharmacy List	A list of in-network pharmacies.	caremark.com

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 2024.

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 effective tobacco cessation prescription medications at no cost to you.

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.

DENTAL PLANS FOR ALL RETIREES

Because regular dental visits are a key part of maintaining your overall health, the City offers you access to dental insurance. Humana Dental serves as the dental provider offering two plans - Humana PPO and Humana Dental HMO. Through these two dental benefits plans, you have access to a network of dental providers who can help you meet your oral health goals. Humana will mail enrollment packets to eligible retirees for annual enrollment. The Employee Benefits Office will provide enrollment materials to active employees upon their retirement.

Monthly Premiums		
Dental Plan	**Humana Dental HMO (HS205 Plan Network)**	**Humana PPO**
Retiree Only	$12.61	$37.79
Retiree + Spouse / Domestic Partner	$23.51	$62.62
Retiree + Child(ren)	$23.51	$62.62
Retiree + Family	$35.27	$97.13

Humana PPO

The Humana 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% usual and customary*
Type B - Basic Care (Fillings, Simple Extractions, and Periodontics)	Covered at 80%	Covered at 80% usual and customary
Type C - Major Care (Bridges and Dentures)	Covered at 50%	Covered at 50% usual and customary
Deductible (Individual / Family)	$50 / $150	$50 / $150
Annual Maximum Benefit (Per Person)	$1,200	$1,200

***The term "usual" refers to a fee that an individual dentist most frequently charges for a given dental service. The term "customary" refers to a fee determined by the insurance company based on the range of usual fees charged by dentists in the same geographical area.**

Humana Dental HMO (HS205 Plan Network)

The Humana Dental HMO (HS205 Plan Network) is a dental plan that provides comprehensive dental care when services are obtained from an in-network primary dentist. With the City's chage to Humana, retirees who elect the HMO option will need to select a participating dentist. Please note, you will not need to elect a provider during the actual enrollment process. Post-enrollment, those retirees who elect the HMO will receive a letter from Humana asking you to please call the help-line number provided so they can assist you in the selection of an in-network provider that is convenient for you.

Humana Dental HMO (HS205 Plan Network)

Description	Procedure Code	Co-pay
Office Visit (normal hours)	D9430	No Co-pay
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	$55
Amalgam Fillings for One Surface, Anterior	D2140	$5
Surgical Extraction and Erupted Tooth	D7210	$40
Root Canal-Endodontic Therapy, molar tooth (excluding final restoration)	D3330	$250
Crown	D2750	$270
Orthodontic Treatment	D8070 (children) / D8090 (adults)	$1,900 / $1,900

***Note: Fluoride Treatment with varnish is for child<16; excluding varnish 16>**

VISION PLANS FOR ALL RETIREES

Healthy eyes and clear vision are an important part of your overall health and quality of life. Through Vision Service Plan, you will have access to thousands of private practice doctors and over 700 Visionworks retail locations nationwide. See the vision benefits summary below.

Your Coverage With a VSP Provider			
Benefit	**Description**	**Co-pay**	**Frequency**
WellVision Exam	Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses		$0	See frame and lenses
Frame	• $200 featured frame brands allowance • $200 Visionworks frame allowance • $150 frame allowance including Walmart®/Sam's Club® • 20% savings on the amount over your allowance • $80 Costco® frame allowance	$0 - Included in prescription glasses	Every calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	$0 - Included in prescription glasses	Every calendar year
Lense Enhancements	• Scratch-resistant coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $0 $95 - $105 $150 - $175	Every calendar year
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	$0	Every calendar year
Essential Medical Eye Care	• Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. • Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 per exam	As needed

Your Coverage With a VSP Provider Continued...	
Benefit	**Description**
Extra Savings	**Glasses and Sunglasses** • Extra $50 to spend on featured frame brands. Go to vsp.com/framebrands for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities
Additional Benefit	**Hearing Aids** A hearing health care plan is accessible to you and your family members through Vision Service Plan that includes a discount of up to 40% for hearing aids. Note: This is a stand-alone benefit and cannot be applied to any other promotion or discount offer.
Out-of-network Providers	Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services at 800.877.7195 for out-of-network plan details.

Vision Plan	Monthly Premium
Retiree Only	$7.24
Retiree + 1	$12.93
Retiree + 2 or more	$19.16

Using your benefit is easy! Create an account on vsp.com to view your in-network coverage, find the VSP network doctor who's right for you, anddiscover savings with exclusive member extras. At yourappointment, just tell them you have VSP.

Shop online and connect your benefits. Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits.See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

RETIREE BROWN BAG SESSIONS

The City will continue hosting in-person Retiree Brown Bag Sessions in 2024. Through these sessions, retirees have the opportunity to learn about topics including health care, fitness, and stress management. 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.

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, 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 and do not have other medical coverage.

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.

Health Plan Types

Consumer-Driven Health Plan (CDHP) - A type of medical insurance plan in which you are responsible for 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 other traditional health plans, but slightly higher deductibles and out-of-pocket maximums.

Health Maintenance Organization (HMO) - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally will not cover out-of-network care except in an emergency. The City's Blue Essentials HMO does not provide coverage outside of Texas.

Preferred Provider Organization (PPO) - A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

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.

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.

GLOSSARY OF COMMON HEALTH CARE TERMS CONTINUED...

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.

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 his 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 2023-09-14-0623).

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.

HEALTH BENEFITS NOTICES CONTINUED...

PrudentRx Solution for Specialty Medications Privacy Practices

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, Blue Essentials HMO and New Value PPO have contracted to offer the PrudentRx Solution for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer co-pay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance, after satisfaction of any applicable deductible. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Co-pay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at 800.578.4403 to register for any manufacturer co-pay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the co-pay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will reach out to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call 800.578.4403. Eligible members who fail to enroll in an available manufacturer co-pay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 800.578.4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act, will not count toward your deductible or out-of-pocket maximum (if any), unless otherwise required by law. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is medically necessary for a particular individual.

PrudentRx can be reached at 800.578.4403 to address any questions regarding the PrudentRx Solution.

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210.207.8705

SanAntonio.gov/EmployeeInformation/RetiredEmployees

AskHR@sanantonio.gov

Text **COSARetiree** to **877.872.4241** to
receive retiree-related messages

CITY OF SAN ANTONIO TEXAS

HUMAN RESOURCES