



WE BENEFIT TOGETHER

BENEFIT MATTERS 2021



UNIFORM FIRE

INSIDE THIS EDITION

- HEALTH CARE PREMIUMS
- HEALTH PLANS BENEFITS
- HELPFUL TOOLS

WELCOME TO YOUR 2021 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. Complete details about your health care plans can be found in your Collective Bargaining Agreement.

We understand that you might have circumstances unique to you and your family, so at any time, feel free to contact the Human Resources Department at 210-207-8705 or AskHR@sanantonio.gov for assistance.



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YOUR BENEFITS

As a uniformed fire employee, you have a choice between two (2) medical health care plan options. This guide provides you with an overview of these benefits. **Please refer to your Collective Bargaining Agreement for complete details about your health plan options.**

If you have any questions about the information in this guide, contact Human Resources Customer Service at 210-207-8705 or AskHR@sanantonio.gov.

IN 2021

- You will have the ability to choose between the **Fire - CDHP or Fire - Value** health plans. More information about both of these options can be found on [pages 6-8](#).
- Additionally, you have the opportunity to participate in a Health Savings Account or Flexible Spending Account. Specific details about these benefits can be found on [pages 10-11](#).
- During the annual Open Enrollment period, you must re-enroll your dependents to ensure they have health care coverage.

Quick Reference Guide

Benefit	Your Options
Medical	<ul style="list-style-type: none"> • Fire - CDHP PPO • Fire - Value PPO • The City and employees share in the cost of this coverage. • Blue Cross and Blue Shield of Texas is the claims administrator for these plans.
Pharmacy	CVS/caremark serves as the pharmacy claims administrator.
Basic Life, Accidental Death & Dismemberment Insurance	The City provides Basic Life Insurance and Accidental Death & Dismemberment Insurance equal to one (1) time your annual base salary.
Flexible Spending Account (Health Care FSA)	<ul style="list-style-type: none"> • You can contribute to the Health Care FSA with pre-tax dollars to pay for eligible out-of-pocket health care expenses for you and your family. • The funds are available to use the first payday in January 2021. For newly-sworn employees, the funds will be deposited into your account following verification that the account is open. • Whatever is not spent by March 15, 2022 and submitted for reimbursement by March 31, 2022 will be forfeited. • The annual contribution limit is \$2,750.
Daycare / Elder Care Flexible Spending Account	<ul style="list-style-type: none"> • You can contribute to the Daycare/Elder Care FSA with pre-tax dollars to pay for eligible out-of-pocket daycare/elder care expenses. • The funds will be available to you as they are deposited into your account. Your Daycare/Elder Care FSA plan year ends on December 31, 2021. You have until March 31, 2022 to submit claims for eligible services incurred from January 1 to December 31, 2021. • The annual contribution limit is \$5,000.
Health Savings Account (HSA)	<ul style="list-style-type: none"> • With enrollment in the Fire - CDHP health plan option, you may be eligible to receive a contribution from the City of \$1,500 to your HSA and you can also contribute to your HSA with pre-tax dollars to pay for eligible health expenses. This account earns interest, you own it, and what is not used rolls over to the next year. • The City's annual contribution will be available on the first payday in January 2021. For newly-sworn employees, the City's annual contribution will be made to your account following verification that the account is open. • The annual contribution limit is \$3,600 for an individual and \$7,200 for a family. Under the catch-up provision, employees age 55 or older can contribute an additional \$1,000.

ELIGIBILITY/DEPENDENT ELIGIBILITY

The City of San Antonio's Uniform Fire Benefit Program is open to all full-time uniform fire employees and their eligible dependents. Employees with alternate health care coverage have the option of waiving the City's health care coverage during Open Enrollment. If this is the case, employees will be asked to provide information about their alternate medical health care coverage.

Dependent Verification

Current full-time employees may elect health care coverage for themselves and their eligible dependents during this Special Open Enrollment period. New full-time employees may do so within 31 days of being sworn. See the chart below for the types of documentation required to add a dependent. Validation information is subject to change. Contact Human Resources Customer Service at 210-207-8705 or AskHR@sanantonio.gov for more information.

Adding a Dependent - Required Information	
Type of Eligible Dependent	The following is a list of information required by the City to add a dependent. Additional information may be requested to complete your enrollment.
Spouse / Common Law Spouse	The City requires: <ul style="list-style-type: none"> • Copy of marriage certificate OR Declaration of Informal Marriage, AND • Properly completed enrollment form
Domestic Partner	The City requires: <ul style="list-style-type: none"> • An Affidavit of Domestic Partnership, AND • Properly completed enrollment form In addition, two (2) of the following supporting documents with both your names are also required: <ul style="list-style-type: none"> • Joint lease or mortgage, OR • Joint bank account, OR • Joint credit card billing statement, OR • Jointly paid household expense (ex: utility bill) OR • Beneficiary of life insurance or will, OR • Power of attorney
Dependent Child up to age 26 (Biological child, stepchild, adopted child, Domestic Partner child, or foster child)	The City requires: <ul style="list-style-type: none"> • Properly completed enrollment form In addition, one (1) of the following supporting documents is also required: <ul style="list-style-type: none"> • Copy of birth certificate OR Verification of Birth Facts, OR • Copy of adoption agreement, OR • Copy of Qualified Medical Child Support Order, OR • Copy of court custody or guardianship documents

Making Changes During the Year

Elections made during Open Enrollment will be effective for the current plan year, January 1 through December 31, 2021. The Internal Revenue Service (IRS) requires that your benefit elections remain in effect for the entire calendar year, unless you experience a Qualifying Life Event.

Qualifying Life Events may include:

- Marriage
- Establishment of a Domestic Partnership
- Divorce, Dissolution of a Domestic Partnership
- Birth or Adoption of a child
- Change in you or your spouse's / domestic partner's work status (full-time or part-time) that affects benefits eligibility
- Death

You must notify the Employee Benefits Office (210-207-0073) within 31 calendar days of your Qualifying 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 days, you must wait until the next Open Enrollment period to change your benefit elections.

DOMESTIC PARTNER TAX IMPLICATIONS

When you enroll your domestic partner or your domestic partner's child in one of the City's health plans, the IRS considers the City's contribution toward their coverage as income for federal tax purposes. This income is the amount the City contributes towards the cost of coverage for your domestic partner and / or your partner's child.

The amount of this income depends upon the plan in which you are enrolled and the level of your coverage. This income increases your taxable gross income for federal income taxes and FICA (Social Security and Medicare). Taxes are withheld from your paycheck and will be reported on your annual W-2 form. More details are available in the Domestic Partner Enrollment Packet, which can be obtained by contacting the Employee Benefits Office at 210-207-0073.

To the right is a simplified example of how this income tax is calculated for a uniform fire employee who selected the Fire - Value health plan option with employee plus spouse / domestic partner coverage. The City understands this is a complex issue. Please consult your personal tax advisor for assistance.

The City contributes \$664.67 towards your total bi-weekly medical premium for Employee + Spouse / Domestic Partner, and	the City contributes \$389.04 towards a total bi-weekly medical premium for Employee Only, then	\$275.63 is the difference of bi-weekly income you would be taxed on.
\$664.67 (Employee + Spouse / Domestic Partner)	\$389.04 (Employee Only)	\$275.63 = (\$664.67 - \$389.04)

MEDICAL PLANS AT-A-GLANCE

For 2021, you can choose between two (2) health care plan options: Fire - CDHP and Fire - Value. Both plans feature co-insurance, deductibles, and in-network preventive screenings covered at 100%. They are PPO plans, meaning they offer you the freedom to select your health care providers from a nationwide network.

Here is a side-by-side comparison of both plan options. As you can see, the coverage is the same for both plans; however, the amount you pay out of pocket varies between the two plans. Refer to your Collective Bargaining Agreement for full details.

Plan Benefit	Fire - CDHP PPO		Fire - Value PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Employee Only / Family)	\$3,000 / \$6,000	\$4,500 / \$9,000	\$500 / \$1,000	\$1,500 / \$3,000
Annual Out-of-Pocket Maximum (Employee Only / Family)	\$3,000 / \$6,000	\$4,500 / \$9,000	\$1,500 / \$3,000	\$3,000 / \$6,000
Co-insurance (Member share)	0% once deductible is met	0% once deductible is met	20% after deductible	40% after deductible
Office Visits: Primary Care Specialist Urgent Care	0% once deductible is met	0% once deductible is met	\$25 co-pay \$50 co-pay \$50 co-pay	40% after deductible
Emergency Room Facility Charges	0% once deductible is met	0% once deductible is met	\$250 co-pay, then 20% co-insurance, co-pay waived if admitted	\$250 co-pay, then 20% co-insurance, co-pay waived if admitted
Emergency Room Physician Charges	0% once deductible is met	0% once deductible is met	20% after deductible	20% after deductible
Immunizations	0%	0% after deductible	0%	40% after deductible
Dependent Children Well Visits	0% birth to age 2 with no annual \$ limit	0% after deductible up to \$300 per year	0% birth to age 2 with no annual \$ limit	40% after deductible up to \$300 per year
Routine Physical Exams (Annual for age 2 years and up)	0%	0% after deductible up to \$300 per year	0%	40% after deductible up to \$300 per year
Pap Smear / Mammogram / PSA Exams	Covered at 100%, annually, age and gender appropriate	0% after deductible	Covered at 100% annually, age and gender appropriate	40% after deductible
Chiropractic	0% once deductible is met	Not covered	20% after deductible	Not covered
Serious Mental Health Physician Services - Office Visits	Full Mental Health Parity - Covered same as any illness			
Occupational, Speech, and Therapy	No annual limit Speech includes child born under the plan with developmental disorder or birth defects			
Prescription Drug	*In-Network Only* <ul style="list-style-type: none"> Affordable Care Act Preventive Drugs - Covered at 100% Non-Affordable Care Act Preventive Drugs - Subject to same co-pay structure as Fire - Value All Other Medications - Subject to the calendar year deductible 		*In-Network Only* <ul style="list-style-type: none"> Affordable Care Act Preventive Drugs - Covered at 100% \$100 separate brand drug deductible per person 30-Day Retail Tier 1: \$10 co-pay (or prescription cost, whichever is less) Tier 2: \$25 co-pay Tier 3: \$40 co-pay 	

YOUR PHARMACY BENEFITS

When considering your health plan options, it is important to think about your prescription needs. Your prescription drug benefit, which is administered by CVS/caremark, provides you with access to a large group of in-network pharmacies to fill your next prescription, including CVS, H-E-B, and Walgreen's. Visit sanantonio.gov/employeeinformation/benefits/resources for a list of local in-network pharmacies. See your [Collective Bargaining Agreement](#) for full details.

Automatic Generics Program

This program automatically provides you with a generic equivalent to your prescription medication, when one is 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 and formulary drugs.

You still have the option of purchasing brand name medications; however, you will pay the difference in cost between the generic and brand name drug plus the co-pay. If your doctor requires that you only take brand name medications, make sure your prescriptions indicate "dispense as written." With this instruction 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 log into your account (or create one) or call CVS/caremark at 866-808-7470.



Prescription Drug Coverage - Fire - CDHP & Fire - Value	
Fire - CDHP	Co-pays (In-Network)
Affordable Care Act Preventive Drugs	Covered at 100%
Non-Affordable Care Act Preventive Drugs	Subject to the same co-pay structure as the Fire - Value plan shown below
Fire - Value	Co-pays (In-Network)
Affordable Care Act Preventive Drugs	Covered at 100%
30-day Retail	
Tier 1	\$10 (or prescription cost, whichever is less)
Tier 2	\$25
Tier 3	\$40
90-day Retail / Mail Order	
Tier 1	\$20
Tier 2	\$50
Tier 3	\$80

Note: For the Fire - Value plan, there is a \$100 separate in-network brand drug deductible per person. For employees enrolled in Fire - CDHP, all other medications are subject to the calendar year deductible.

FIRE – CDHP AND FIRE – VALUE PLANS: HOW ARE THEY DIFFERENT?

Plan Feature	Fire - CDHP	Fire -Value
Bi-Weekly Premiums	Low	High
Annual Deductible	High	Low
Co-pay	N/A	Yes
Co-insurance (In-network)	N/A	You pay 20%
Nationwide Network	Yes	Yes
City Contribution	\$1,500 - Employee Only/Family	N/A
Annual Out-of-Pocket Maximum	High	Low
Health Savings Account (HSA) vs. Health Care Flexible Spending Account (FSA)	HSA	FSA

Note: Refer to your Collective Bargaining Agreement for full plan details.

BI-WEEKLY HEALTH PLAN PREMIUMS

Medical Plan	Fire - CDHP	Fire - Value
Employee Only	\$0	\$0
Employee + Child(ren)	\$0	\$36.90
Employee + Spouse / Domestic Partner	\$0	\$55.05
Employee + Family	\$0	\$91.35

Note: While you receive 26 paychecks, your medical health care plan premiums are only deducted from 24 of them.



ADDITIONAL PLAN FEATURES

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 skill areas, 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.

ConsumerMedical®

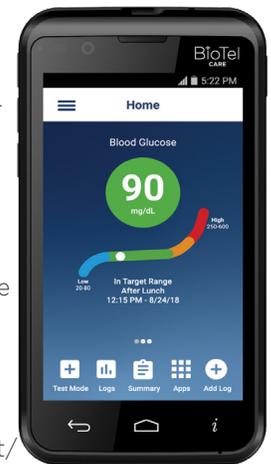
The ConsumerMedical® benefit provides expert medical opinion and clinical advocacy to individuals diagnosed with a serious medical condition, such as cancer, or who are facing a procedure like a hip and knee replacement, hysterectomy, or lower back surgery. Through this benefit, you have access to customized,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

Questions? Contact ConsumerMedical® at 1.888.361.3944.

Next Generation Transform Diabetes Care

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

- individualized care management plan specific to each participant,
- two (2) diabetes monitoring 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!



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. Eligible expenses should be compliant with IRS guidelines and are 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 at the IRS rate for the most direct route between the patient's home and the designated provider.

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

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

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 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.

The City will contribute \$1,500 to your HSA account with HSA Bank for those enrolled in the Fire - CDHP health plan. Covered dependent spouses who are uniformed fire employees are also eligible for the \$1,500 contribution, and those funds will be placed in your account. These funds will be available in January 2021.

In 2021, the IRS maximum for HSA contributions is \$3,600 for an individual and \$7,200 for a family. Under the catch-up provision, employees age 55 or older can contribute an additional \$1,000. The City's contributions and any funds you contribute through bi-weekly payroll deductions apply to this maximum.

Your account balance in the HSA is yours to keep and is not forfeited even if you leave employment. Any funds unused at the end of the year will roll over to the next year. You can also change the amount you contribute through bi-weekly payroll deductions. IRS rules prohibit a family from having both an HSA and a Health Care Flexible Spending Account (FSA) at the same time. HSA funds will be available for use as they are deposited into your account.

Note: If you have unspent dollars in a Health Care Flexible Spending Account (FSA) from 2020, you will not have access to the 2021 HSA funds until April 1, 2021.

HSA Eligibility

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

- Are enrolled in the Fire - CDHP plan.
- Are not covered under any other medical plan.
- Are not claimed as a dependent on someone else's federal tax return.

Contact Human Resources Customer Service at 210-207-8705 or AskHR@sanantonio.gov with any questions regarding HSA eligibility.

Health Care 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
- Cosmetic / aesthetic medical procedures

FLEXIBLE SPENDING ACCOUNTS

An Overview of Your Health Care Flexible Spending Account (FSA)

If you enrolled in the Fire - Value PPO health plan options or cannot open an HSA, you can open a Health Care Flexible Spending Account (FSA) to help cover the cost of eligible health care expenses. With each paycheck, you set aside some of your pay, before taxes, to use for eligible expenses. You will be provided with a debit card for your convenience.

Through your FSA, you can get reimbursed for out-of-pocket health care expenses incurred by you or your IRS tax dependents, whether or not you or your dependent is covered by the City's health plans.

- The annual contribution limit is \$2,750 for an FSA.
- Only eligible expenses incurred between January 1, 2021 and March 15, 2022 may be reimbursed from your FSA. All claims for reimbursement must be filed by March 31, 2022. Any remaining money will be forfeited.

The administrator for our FSA benefit is Flexible Benefit Service Corporation (Flex). Everyone who enrolls in this benefit will receive a debit card to access their funds.

Eligible FSA expenses for you and your family include:

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

Ineligible FSA expenses for you and your family include:

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

Substantiation

The IRS has established specific guidelines that require all FSA transactions to be substantiated. This means that Flex is required to verify that purchases using the debit card are for an IRS-qualified medical expense.

If you receive a substantiation notice from Flex and do not respond with the proper documentation in a timely manner, your debit card may be suspended/locked until you do. Acceptable documentation to avoid suspension of your debit card must include:

- patient and provider names,
- date and description of service, and
- the amount paid.

Daycare/Elder Care FSA

You can use the Daycare/Elder Care FSA to pay for eligible daycare expenses related to the care of or services provided to children under the age of 13, or tax dependents who are mentally or physically incapable of caring for themselves. Like with the Health Care FSA, you set aside some of your pay from each paycheck, before taxes, to use for eligible expenses. Daycare/Elder Care claims are submitted using a paper reimbursement form available at sanantonio.gov/employeeinformation/benefits/resources. The annual contribution limit is \$5,000 for Daycare/Elder Care FSA. Funds will be available to you as they are deposited into your account each payday. The IRS requires funds to be forfeited if not used for eligible services by December 31, 2021.

Eligible Daycare/Elder Care FSA expenses include:

- babysitter,
- day camp,
- child care center, and
- adult care center.

Ineligible Daycare/Elder Care FSA expenses include:

- expenses you claim under the Federal Dependent Care Tax Credit,
- health care expenses you pay for your dependents,
- clothing for your dependents, and
- transportation to and from a care provider.



TOOLS AND RESOURCES

Making health care decisions can be difficult, and selecting the best health care plan is no exception. When considering your health care options, there are several factors to keep in mind, including:

- Your and your family’s 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 With Selecting Your Health Plan?

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 2021.

- Jane Cosa, Firefighter
- Employee Only
- Gross Medical Expenses of 10 Primary Care Physician Visits Per Year With a Generic Antibiotic Prescribed at Each Visit*

*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).

Plans	Fire - CDHP PPO	Fire - Value PPO
Annual Premium	\$0	\$0
Deductible	\$1,100*	-
Co-insurance	-	-
Office Visit Co-pay	-	\$250 (\$25 x 10 visits)
Pharmacy Co-pay	-	\$100 (\$10 x 10 Rx)
City-Funded Health Savings Account	-\$1,500	-
Net Employee Cost	+\$400	\$350
Most Cost Effective Plan: Consumer Choice		

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)
ConsumerMedical®	This benefit provides access to expert medical opinions and clinical advocacy.	1.888.361.3944
CVS/caremark Member Services website/ Pharmacy List	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 and find a list of network pharmacies.	caremark.com
Health Care Forms	Health-care-related forms, including: <ul style="list-style-type: none"> • Life Insurance Beneficiary Form • FSA Reimbursement Request Form • Recurring Day Care/Dependent Care Request Form 	sanantonio.gov/EmployeeInformation/Benefits/Resources --> Forms Tab
SAPOA Claims Advocates	Assistance with reviewing your health care claims history	210-822-4428/rosie@sapoa.org
Video Library	Short videos about health-care-related topics, including: <ul style="list-style-type: none"> • Consumer Choice Plan with Health Savings Account • Dental/vision Benefits • Flexible Spending Accounts • Life and AD & D Insurance • Medical Plans Comparison 	sanantonio.gov/EmployeeInformation/Benefits/Resources -->Video Library Tab

LIFE INSURANCE

One of the most important things about life insurance is the financial peace of mind it gives your loved ones. The City provides all full-time employees with Basic Life and Accidental Death & Dismemberment Insurance in the amount of one (1) time your annual salary, for each. This insurance is provided at no cost to you and is administered by Dearborn National Life Insurance Company.

Note: Life insurance benefits expire upon separation from the City.

SUPPLEMENTAL RETIREMENT

The City of San Antonio provides part-time and full-time employees an additional way to save for retirement through a 457 Deferred Compensation Plan, administered through two providers. The plan is designed to supplement an employee's TMRS and Social Security benefits. Nationwide Retirement Solutions and ICMA Retirement Corporation are the City's deferred compensation vendors. Representatives from these companies are on-site in the Human Resources Department weekly.

Contribution limits are set yearly by the IRS. For 2021, the maximum contribution is \$19,500, and employees over age 50 can contribute an additional \$6,500. City employees who wish to participate must contribute a minimum contribution of \$10 per paycheck.

As long as an employee elects to participate in a 457, a deduction will be taken from each of the 26 paychecks per year. You may stop deductions at any time by contacting Nationwide Retirement Solutions or ICMA Retirement Corporation.

VENDOR CONTACTS

Organization	Phone	Website / Email
Human Resources Customer Service	210-207-8705	sanantonio.gov/employee information AskHR@sanantonio.gov
Blue Cross and Blue Shield of Texas (Medical Plan Claims Administrator)	800-521-2227	bcbstx.com (Blue Choice PPO Network)
CVS/Caremark (Pharmacy Plan Claims Administrator)	866-808-7470	caremark.com
Dearborn National Life Insurance	800-778-2281	dearbornnational.com
Flexible Benefit Service Corporation/Flex (Flexible Spending Account/FSA Customer Service)	1-888-345-7990	myflexaccount.com service@myflexaccount.com
HSA Bank (Health Savings Account (HSA) Customer Service)	855-731-5220	hsabank.com
ICMA Retirement Corporation (Deferred Compensation Provider)	800-669-7400	icmarc.org
Nationwide Retirement Solutions (Deferred Compensation Provider)	877-677-3678	nrsforu.com
San Antonio Fire & Fire Pension Fund	210-534-3262	safppf.org

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.

Flexible Spending Account - A tax-exempt account to which you contribute a portion of earnings to pay for certain expenses such as medical and dependent care. If you enrolled in the Value PPO health plan option or cannot open an HSA, you can open a Health Care Flexible Spending Account.

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.

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.

Tier 3 (Specialty) drugs - Specialty drugs are more complex and are used to treat patients with serious and often life-threatening conditions. These medications may be taken orally, but often must be injected or infused.

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.

Substantiation

The process of verifying that a purchase using one's Flexible Spending Account (FSA) was for an IRS-qualified medical expense. Most FSA transactions will be auto-substantiated when the employer-sponsored plans have co-pays associated with their medical, dental, and/or vision plans. Amounts equal to a co-pay at the provider will auto-substantiate. All purchases that do not qualify for auto-substantiation must be manually substantiated with receipts or other documentation submitted for review to the FSA vendor, in the City's case, Flexible Benefit Service Corporation.

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

Below are summaries of important health benefits notices. Visit the Human Resources Department's website at sanantonio.gov/employeeinformation/benefits/resources for complete information on each of the notices.

Children's Health Insurance Plan (CHIP)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) - If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, Texas may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid and you live in Texas, you may be eligible for assistance paying your employer health plan premiums. To find out if premium assistance is available, visit gethipptexas.com or call 1.800.440.0493.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, contact the Texas Medicaid or CHIP office, dial 1.877.KIDS.NOW (543.7669), or visit insurekidsnow.gov to find out how to apply.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call 1.866.444.EBSA (3272).

For more information on special enrollment rights, contact either the:

- U.S. Department of Labor, Employee Benefits Security Administration - dol.gov/ebsa or 1.866.444.EBSA (3272) or
- U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services - cms.hhs.gov or 1.877.267.2323.

Newborns' and Mothers' Health Protection Act

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of hospital stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain preauthorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for a cesarean delivery.

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/O/files/employeeinformation/benefits/privacy.pdf.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Summary Plan Documents / Summary of Benefits & Coverage (SBC)

This guide is intended to provide summary information about the benefit plans offered to the civilian employees of the City of San Antonio. Complete plan details are included in the Summary Plan Documents and Summary of Benefits & Coverage available from the Human Resources Department. In the event of any discrepancy between this document and the Summary Plan Documents, the Summary Plan Documents shall govern. Visit sanantonio.gov/employeeinformation/benefits/health to view the Summary Plan Documents.

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 EMPLOYEE HEALTH BENEFITS PLAN AND SET PREMIUMS FOR EMPLOYEE AND DEPENDENT COVERAGE, SO LONG AS SUFFICIENT FUNDS ARE APPROPRIATED BY CITY COUNCIL (SEE ORDINANCE #2020-09-17-0641).

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



AskHR@SanAntonio.gov



HUMAN RESOURCES DEPARTMENT

