





Retiree Benefits Enrollment Guidebook





Benefit Phone Number and Website Information

Service/Plan	Company	Phone Number	Website
To access benefit information and to locate forms	City of Garland	Visit website	http://www.hrconnection.com user name — cogretiree password - Garland1
CityCare Clinic	City of Garland	972-205-3727	N/A
Blue Cross Blue Shield Plans (for pre-65 retirees and/or dependents)	Blue Cross Blue Shield	1-800-521-2227	www.bcbstx.com
Prime Therapeutics (Prescription Drug Plan)	Prime Therapeutics	1-877-357-7463, option 3	N/A
CIGNA Medicare Surround Health Plan (Medicare eligible retirees and/or dependents)	CIGNA	1-800-244-6224	www.cignamedicare.com
CIGNA Medicare Surround Pharmacy Only	CIGNA	1-800-558-9562	www.cignamedicare.com
Dental Plans Customer Service	Guardian Dental	1-800-541-7846, option 1	www.guardiananytime.com
Dental Plans Claims Services	Guardian Dental	1-800-541-7846, option 1	www.guardiananytime.com
Vision Plan	VSP	1-800-877-7195	www.vsp.com
Medicare Hotline	Medicare	1-800-633-4227	www.medicare.gov
Texas Municipal Retirement System	TMRS	1-800-924-8677	www.tmrs.org
Retiree Billing	CAPROCK/Verity National	1-800-840-3977 x138	N/A
	N	EW	
Compass HealthPro	Compass Health	1-800-513-1667	answers@compassphs.com

For benefit questions, please contact:

Esmeralda Arellano

HR Benefits Coordinator PO Box 469002 Garland, TX 75046-9002 972-205-3840 tel 972-205-3625 fax earellan@garlandtx.gov

Retiree Billing

CAPROCK/Verity National will continue to administer retiree billing and drafting. For questions or concerns, please contact them by: Phone: 1-800-840-3977 x138

Mail: PO Box 1885, San Antonio, TX 78297

Email: CityofGarland@VerityNational.com

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The City of Garland is pleased to provide you with this booklet that contains important information about your 2014 Benefits Program. Your participation in the program can help safeguard your financial interests and take care of your health care needs.

Please read this information carefully and take time to fill out the enclosed 2014 Retiree Benefits Enrollment form. The deadline for returning your form to the City of Garland HR Department is **Friday, November 22, 2013**.

This guide provides a brief description of the City of Garland's benefit plans. The official plan documents govern the terms and conditions of each plan and will control in the event of any discrepancy between the information in this guide and the official plan documents. The City of Garland retains the right to change, modify, interpret or cancel any plan—in whole or in part—without advance notice and at its sole discretion. The Plan Document is available at www.hrconnection.com (username: cogretiree password: Garland1).

The Affordable Care Act ("ACA")

Updates to the Affordable Act (also known as national health care reform) will impact the City of Garland Group Medical Plan, effective January 1, 2014. Here are some of the effects the law will have on you and the City in the future.

For Members

- There is no annual or lifetime cap on the benefits that the plan will pay. In the past there was an annual maximum of \$1 million and lifetime maximum of \$2 million
- There are no exclusions for pre-existing conditions.
- Eligible dependents who have not reached their 26th birthday can be covered on the plan regardless of their student status.
- Preventive benefits have been expanded and the plan is required to provide these benefits with no deductible, coinsurance, or copay.
- Currently, doctor office copays and deductibles do not accrue to your out-ofpocket maximum. Starting January 1, 2014, these payments will count and cap your outof-pocket maximum much more quickly than in the past.
- Beginning January 1, 2015, prescription drug copays will also apply to your out-of-pocket maximum amount.

For The City

- Patient-Centered Outcomes Research Institute (PCORI) – the City is required to pay the federal government for each employee, retiree, spouse, dependent child or grandchild \$1 per person per year to fund this research
- Transitional Research Fee (to help exchanges offset the cost of covering pre-existing conditions) – the City is required to pay the federal government for each employee, retiree, spouse, dependent child or grandchild \$63 per person per year to fund this research
- The City will be required to pay out over \$310,000 in new fees annually to continue offering group health insurance to employees, retirees, and dependents.

Eligibility and Enrollment

Eligible Retirees

You are eligible to participate in the City of Garland's retiree benefits program if you:

- Are a retired employee of the City,
- Meet the Texas Municipal Retirement System (TMRS) criteria for receiving a monthly retirement check (see www.tmrs.org for details), and
- Elect coverage at the time of retirement and maintain continuous, uninterrupted coverage.

Important Reminder

If you drop medical coverage at any time after you retire, you will not be able to reenroll in the future, except within 30 days of your 65th birthday, when you become eligible for Medicare.

Open Enrollment—Make Your Elections for 2014

Open Enrollment begins November 1, 2013 and ends on November 22, 2013. Please take time to review this guide and determine which benefit plans and options best meet your needs. Then, complete the 2014 Retiree Benefits Enrollment form and return it to the City of Garland HR Department at the address shown on the inside front cover of this guide. All retirees must complete and return an Enrollment form annually. If you fail to return a 2014 enrollment form, your current elections will automatically renew at the 2014 rates and benefits.

Eligible Dependents

The following dependents are also eligible to participate, if you enroll them for coverage at the time you retire:

- Your spouse, as defined and recognized by Texas state laws
- Dependent child, children, or grandchildren under age 26, who are:
 - · Your biological children,
 - Legally adopted or placed with you pending formal adoption,
 - Your stepchildren, or
 - Grandchildren for whom you are the legal guardian.

After you make your initial benefits election at the time of retirement, <u>you can add dependents (with proof of dependency) only if:</u>

- You get married and contact the City of Garland HR Department within 30 days of the marriage to add your new spouse, or
- A court decree orders the City of Garland to insure your eligible children or grandchildren.

Action Required When You or Your Spouse Becomes Eligible for Medicare

Thirty days before your 65th birthday, your spouse's 65th birthday, or when the person becomes Medicare eligible through disability, you need to:

- 1. Enroll in Medicare Part A and Part B only (visit www.medicare.gov for details). Do NOT sign up for Medicare Part D. CIGNA will automatically enroll you in Part D of Medicare for prescription drug benefits. (See page 11.)
- 2. Contact CAPROCK/Verity National at 1-800-840-3977, extension 138. Tell the service representative that you or your spouse will be turning 65. Your rates on your medical coverage may be reduced. IMPORTANT: You must make the call before the first of the month in which the individual will turn 65. For example, if you or your spouse will turn 65 on September 25, you must contact CAPROCK/Verity National before September 1.
- 3. Provide the City of Garland HR Department with a copy of your Medicare ID card.

Important Note: If you are the primary insured (retiree of City of Garland) and you become eligible for Medicare, but your spouse is not yet 65, you will receive a new CIGNA medical ID card and Blue Cross Blue Shield (BCBS) will terminate your policy. However, your spouse will continue to be covered under the Blue Cross Blue Shield plan and will receive a NEW medical ID card in the mail. The ID card for the old policy will no longer work in a provider's office or pharmacy. You must use the new ID card.

Plans Available to Pre- and Post-65 Retirees and Eligible Dependents

The table below shows the plan options in which you and your eligible dependents can enroll. Descriptions of each option are found on pages 6-19, with information on monthly premiums on page 5.

	Pre-65 Retiree and/or Eligible Dependent(s)	Medicare Eligible Retiree and/or Eligible Dependent(s)	
Medical	BCBS Blue Choice Plus or BCBS Blue Choice Core	CIGNA Medicare Surround Plan	
Dental	Guardian Scheduled Dental Plan Guardian Basic Plan Guardian Premium Plan		
Vision	VSP Vision Plan (retiree and spouse only)		

Required Monthly Rates for 2014

2014 Medical

Pre-65 Retiree/Dependents

	BCBS Blue Choice Plus	BCBS Blue Choice Core
Retiree only	\$394.90	\$529.45
Retiree + Child(ren)	\$621.63	\$870.00
Retiree + Spouse	\$687.61	\$935.00
Retiree + Family	\$997.35	\$1,463.00

Post-65 Retiree/Spouse with Dependent Children

	CIGNA Medicare Surround	Medicare Surround and BCBS Blue Choice Plus	Medicare Surround and BCBS Blue Choice Core
Retiree only	\$182.00	n/a	n/a
Retiree + Child(ren)	n/a	\$625.44	\$585.00
Retiree + Spouse	\$398.00	n/a	n/a
Retiree + Family	n/a	\$763.00	\$881.00

One Pre-65 and One Post-65 Retiree/Spouse (With or Without Dependents Under Age 26)

	Medicare Surround and BCBS Blue Choice Plus	Medicare Surround and BCBS Blue Choice Core
Retiree + Spouse	\$525.16	\$660.41
Retiree + Family	\$804.00	\$993.00

2014 Dental

	Scheduled Dental	Basic Dental	Premium Dental
Retiree Only	\$20.00	\$31.00	\$42.00
Retiree + Family	\$46.00	\$71.00	\$95.00

2014 Vision

Retiree Only	\$11
Retiree + Spouse	\$18

2014 Medical Plan Options Pre-65 Retirees and Dependents

Medical Plan

The retiree medical plan for pre-65 retirees and/or their dependents is administered by Blue Cross Blue Shield (BCBS) and utilizes the nationwide BCBS Blue Choice and/or the Blue Options network. You can use any doctor, lab or hospital you choose. However, when you use in-network providers, the plan pays a larger percentage of the cost of your care, so you save money. If you choose out-of-network providers, the plan pays a smaller percentage of the cost.

Eligible retirees and dependents under age 65 can choose either the BCBS Blue Choice Plus option or the BCBS Blue Choice Core option.

It is the responsibility of each participant (not your doctor) to verify a provider's network affiliation with the BCBS Blue Choice and/or Blue Options plan prior to the utilization of any medical treatment or services.

Helpful Hint: Out-of-Pocket Maximum With both the Blue Choice Plus and Core options, the medical plan will begin to pay 100% of eligible charges for the rest of the calendar year once you reach the annual out-of-pocket maximum(s). These amounts are different for each option, as shown in the chart on page 8.

Note: Individuals who have been approved for pre-65 retiree disability Medicare must enroll in the Medicare Surround Plan; see page 15.

To view the summary of benefits, log on to www.HRconnection.com.

Then, follow these steps to find the summaries:

 Click on "Benefits", then "Plan Information", then "Medical" and "View Plan Details" of your BCBS medical option. Then click on the "Plan Document" tab.

Benefits That Will Save You Money (\$\$\$) Applicable for Pre-65 Retirees Only

1. Compass Professional Health Services

To assist employees in finding the most affordable health care options, the City has partnered with Compass Professional Health Services (Compass). When you have a health care question, you may contact the City's designated Compass Health Pro. The Health Pro will serve as your personal health care advisor.

Your Health Pro can help:

- Recommend doctors
- Find low-cost service provider alternatives within the BCBSTX network
- Get actual price estimates for procedures, medications, and other health services
- Answer questions about the City medical plans and how they work
- Schedule appointments for you
- Answer questions about medical bills and Explanation of Benefits (EOB) forms
- Work with you to resolve billing and payment issues with insurance carriers and/or medical providers

Next time you have a question about your health care, contact a Compass Health Pro at 1-800-513-1667 or answers@compassphs.com.

2. BAYLOR HEALTH CARE NETWORK

The City in-network coinsurance benefit is 80% of applicable medical charges after the annual



deductible has been satisfied. Beginning January 1, 2014, you will receive a **90**% coinsurance benefit when you *voluntarily* choose to utilize a Baylor Health Care facility for any eligible services.

3. BLUE OPTIONS PROVIDERS

Did you know you could save \$5 on your Primary



Care and/or Specialist office visit copay when you voluntarily elect to go to a Blue Options provider?

To find a participating *Blue Options* provider, please visit www.bcbstx.com:

- 1. Click on "Provider Finder."
- 2. Select Blue Options as your Network Type.
 - a. Search by Provider Type, Provider Name, and/or location
- 3. Select a Provider with **TWO*** blue flags in the Blue Compare column beside their name.

Cannot find the necessary provider in the Blue Options Network? The City of Garland utilizes BCBS's largest PPO network called the Blue Choice Network and you only pay a copay for most services you receive from providers in this network.

To find a participating Blue Choice provider, please visit www.bcbstx.com:

- 1. Click on "Provider Finder."
- Select the Blue Choice PPO Plan as your Network Type.
 - a. Search by Provider Type, Provider Name, and/or location

4. Preventive Care Covered at 100%

The Affordable Care Act requires health plans to provide coverage for "preventive care services" without cost-sharing (such as coinsurance or copays), when a member uses a network provider. Services may include screenings, immunizations, and other types of care, as recommended by the federal government.

^{*} Only providers with TWO blue flags qualify for the \$5 discount. If they have one or no flag, they are not eligible for the discount. A Blue Options provider has provided additional necessary documentation showing they meet or exceed expected quality related and cost efficiency performance compared to other doctors.

2014 Benefit Comparisons (Pre-65 Retirees and/or Dependents)

Plan Provisions

The table below shows highlights of how the two options work. For complete plan provisions, visit **www.HRconnection.com**.

	BCBS Blue	Choice Plus	BCBS Blue (hoice Core	
Annual Deductible*					
In-Network			_		
Individual		250		\$1,250	
Family	\$4,	500	\$2,5	500	
Out-of-Network			ć2 F00		
Individual		500	\$2,5		
Family Annual Out-of-Pocket Maximum*	\$9, 1	000	\$5,0	000	
In-Network					
Individual	\$6	350	\$6,3	350	
Family		,700	\$12,		
Out-of-Network		¥ : <u>2</u> // 33		1 :-/:	
Individual	\$12,700		\$12,700		
Family	\$25	\$25,400		\$25,400	
Co-Pays*	Blue Options Provider:	Blue Choice Providers:	Blue Options Provider:	Blue Choice Providers:	
Preventive Care Primary Care Physician Specialist	\$0 \$40 \$60	\$0 \$45 \$65	\$0 \$35 \$55	\$0 \$40 \$60	
Urgent Care Emergency Room	\$500 c	00 opay + charges	\$10 \$500 co 20% of	opay +	
Coinsurance* (What you pay after you meet deductible)	Baylor Facility	Non-Baylor Facility	Baylor Facility	Non-Baylor Facility	
In-Network	10%	20%	10%	20%	
	40%		40%		
Out-of-Network	40)%	40	%	

^{*}The amounts shown here are the amounts you will pay when you receive care.

Helpful Hint: Network Providers

To see if your doctor, specialist, or hospital is affiliated with the BCBS Blue Choice network, visit **www.bcbstx.com**, or call this toll-free number: 1-800-521-2227. Provider affiliation may change; we recommend checking before each medical visit to be sure your provider still participates in the network. And remember, you'll receive the highest level of coverage and save money if you use in-network providers.

Special note: Chiropractic visits are limited to 24 visits per year, subject to the specialist visit co-pay.

2014 Prescription Drug Plan

(Pre-65 Retirees and/or Dependents)

Both Blue Choice options offer coverage for approved prescription drugs. Your cost depends on the drug category:

- Generic: A lower cost, chemically equivalent version of a brand-name drug
- Preferred Brand Name: A brand-name medication found on the BCBS formulary (for a list of BCBS formulary medications, go to www.bcbstx.com)
- Non-Preferred Brand Name: A brand-name not found on the BCBS formulary.

Short-Term Prescriptions (30-Day Supply)

For short-term prescriptions, you can purchase up to a 30-day supply through your local pharmacy that is part of the BCBS Prime Rx network. Visit www.bcbstx.com or call 1-800-521-2227 to see if your pharmacy is in the network. Below are some network pharmacies in Garland, Rowlett, and Sachse. Check the BCBS website for additional providers.

National Chains

- CVS Pharmacy
- Kroger Pharmacy
- Sack N Save Pharmacy
- Sam's Pharmacy
- Sav-On Pharmacy at Albertsons
- Target Pharmacy
- Tom Thumb Pharmacy
- Walgreens Pharmacy
- Wal-Mart Pharmacy

Important Note About Brand-Name Prescriptions

If you fill a prescription with a brand-name drug when a generic is available, you will pay the difference in cost between the brand-name and generic, PLUS the applicable preferred generic copay amount.

\$4 Generic Rx

The \$4.00 prescription program is available at participating pharmacies at Kroger, Target, Tom Thumb, and Wal-Mart. The program is available to any and all persons with eligible listed prescriptions.

There is no need to provide proof of insurance to receive the benefits of the \$4.00 Prescription co-pay.

Here are the instructions on how this program works:

- 1. When you get your prescription from your doctor, check the pharmacy listings to see if it is listed as an approved drug.
- 2. If your prescription is listed, go to the pharmacy to get your prescriptions dispensed.
- 3. You will not need to mention you have group health insurance as this is not needed.
- 4. Pay \$4 for the prescriptions on the list of approved generic products.

For a complete listing of the \$4.00 covered prescription programs, please visit the following websites at:

- Kroger Pharmacy: www.kroger.com/pharmacy
- Target Pharmacy: www.target.com/pharmacy
- Tom Thumb Pharmacy: www.tomthumb.com/pharmacy
- Wal-Mart Pharmacy: www.walmart.com/pharmacy

Note: In participating in the program, not only are you saving money on your co-pays but you are saving the City of Garland money.

2014 Prescription Drug Plan

(Pre-65 Retirees and/or Dependents)

Long-Term Prescriptions (90-Day Supply)

For ongoing "maintenance" drugs (those used for treating chronic conditions like high cholesterol, epilepsy or diabetes), you can save money by getting a 90-day supply through the PrimeMail Home Delivery Pharmacy Program or from your local network retail pharmacy.

To order prescriptions through the PrimeMail Pharmacy service, call 1-877-357-7463, select Option 3, and talk with a service representative.

Once your prescription is authorized, PrimeMail's licensed pharmacists process the order and send it to you.

Mail order delivery typically takes between 10 and 14 days to arrive.

Your Cost for Prescription Drugs

The table below shows what you pay for each prescription. There is a \$100 per member annual deductible for non-generic prescriptions for the Retail 30-Day or Retail 90-Day supplies. There is no deductible for any Mail Order prescriptions. To make the most of your benefits and pay the lowest amount out of your pocket, ask your doctor to prescribe generics.

Important Note About Brand-Name Prescriptions

If you fill a prescription with a brandname drug when a generic is available, you will pay the difference in cost between the brand-name and generic, PLUS the applicable preferred generic copay amount.

	30-Day Supply (Retail)	90-Day Supply (Retail)	90-day Supply (Mail Order)
Annual Deductible	\$100 per member per year on non- generic drugs only		Annual deductible on mail order applies to non-preferred medications only
Generic	\$10	\$25	\$20
Preferred Brand Name	\$45	\$112.50	\$90
Non-Preferred Brand Name	\$90 \$225		\$180
Brand Name with Generic Equivalent	\$10, plus difference in cost between brand and generic \$25, plus difference in cost between brand and generic		\$20, plus difference in cost between brand and generic
Specialty Prescription Drug Benefits	\$200 copay		
Rx Out-of-pocket Maximum - includes all pharmacy deductibles, copays, and member cost sharing on covered medications	Individual: \$6350 Family: \$12,700		

The Affordable Care Act: Preventive Services at 100%

Preventive Care Services Covered Without Cost-sharing — Without Copay, Coinsurance or Deductible

The Affordable Care Act requires nongrandfathered health plans and policies to provide coverage for "preventive care services"¹ without cost-sharing (such as coinsurance, deductible or copayment), when the member uses a network provider. Services may include screenings, immunizations, and other types of care, as recommended by the federal government.

Blue Cross and Blue Shield of Texas (BCBSTX) is committed to implementing coverage changes to meet ACA requirements as well as the needs and expectations of our members.

General Highlights of New Regulations

- Applies to group health plans including insured and selfinsured plans, as well as individual and family policies.
- Preventive services are to be covered without any costsharing when using a network provider. Cost-sharing can still be required when using a provider that is not in the BCBSTX provider network.
- New requirements can be issued at any time. As new or updated preventive care recommendations or guidelines are issued, employers and insurers have one year to implement the new guidelines unless otherwise specified by the government.²
- Plans that cover preventive services in addition to those required may apply cost-sharing requirements for the additional services.
- The regulation references preventive care services with an A or B rating as outlined by the United States Preventive Services Task Force (USPSTF).¹ They are listed in this fact sheet and can be found at:

www.healthcare.gov/news/ factsheets/2010/07/preventive-services-list. html

BCBSTX will use reasonable medical management techniques to determine any coverage limitations on the service, including the frequency, method, treatment or setting for the service, and the use of an out-of-network provider.

Plans that are "grandfathered," meaning plans that had at least one individual enrolled on March 23, 2010 and have not made certain changes since that date to cause a loss of grandfathered status, are not required to implement some of the new requirements of the Affordable Care Act, including the requirement to cover preventive services with no cost-sharing.

For more information visit this BCBSTX web site: http://bcbstx.com

Preventive Care Services to Be Offered Without Copay, Coinsurance or Deductible

Evidence-based preventive services: The list of ACA required preventive services includes those that are recommended and rated "A" or "B" by the USPSTF.

Routine vaccinations: A list of immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are included in the rule. They are considered routine for use with children, adolescents and adults, and range from childhood immunizations to periodic tetanus shots for adults.

Prevention for children: The rule includes preventive care guidelines for children from birth to age 21 developed by the Health Resources and Services Administration with the American Academy of Pediatrics. Services include regular pediatrician visits, developmental assessments, immunizations, and screening and counseling to address obesity.

Prevention for women: The regulation mandates certain preventive care measures for women. These recommendations will be in place until new requirements for prevention for women are issued by the USPSTF or appear in comprehensive guidelines supported by the Health Resources and Services Administration. ²

BCBSTX's Focus on Prevention

Laying the groundwork for a healthy tomorrow means disease prevention and early detection.

Many chronic diseases and conditions can be prevented and/or managed through early detection. Preventive screenings are an important way to track your health and avoid chronic conditions before they become more serious.

BCBSTX encourages you to take full advantage of your preventive care benefits and other available wellness resources. After completing a health screening, take appropriate steps to improve your health. Talk with your physician about ways to improve your health. There is no better time than now to get started – and head off potential health problems before they begin.

Billing and Office Visits

 If a recommended preventive service or item is billed separately from an office visit, then costsharing may be applied to the office visit.

- If a recommended preventive item or service is not billed separately from an office visit and the primary purpose is preventive care, then cost-sharing requirements may not be imposed with respect to the office visit.
- If a recommended preventive item or service is not billed separately from an office visit and the primary purpose of the office visit is not preventive care, then cost-sharing may be applied to the office visit.

Covered Preventive Care Services¹

Depending on the particular health plan, coverage may be provided for the following preventive services without costsharing. This list may not include all of a particular plan's covered services. BCBSTX members can call Customer Service at the number on their member ID card for details on how these benefits apply to their coverage and the most up-todate list of covered preventive services, including those paid without any cost-sharing.

Children and Adolescents

Well-child exam

Examples of services included as part of a well-child exam include history and physical exam, measurements of height, weight and body mass index (BMI), hearing screening⁴, vision acuity test⁵, developmental and behavioral assessments, prescription of fluoride if water source is deficient in fluoride, evaluation of need for a dentist visit, counseling about health risks such as sexually transmitted infections, and obesity counseling.

Immunizations

- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type B
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza (Flu)
- Measles, Mumps, Rubella

- Meningococcal
- Pneumococcal
- Inactivated Poliovirus
- Rotavirus
- Varicella (Chickenpox)

Screening tests

- Screening for hearing loss, hypothyroidism, sickle cell disease and phenylketonuria (PKU) in newborns
- Hematocrit or hemoglobin screening
- Obesity screening
- Lead screening Dyslipidemia screening for children at higher risk of lipid disorder
- Tuberculin testing
- Depression screening
- Screening for sexually transmitted infections (STIs)
- HIV screening
- Cervical dysplasia screening

Preventive treatments

 Gonorrhea preventive medication for eyes of all newborns

Adults

Preventive exam

Examples of services included as part of a preventive exam include history and physical exam, measurements of height, weight and body mass index (BMI).

Immunizations

- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza (Flu)
- Measles, Mumps, Ruebella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella (chickenpox)
- Zoster

Screening tests

- Blood pressure screening
- Cholesterol screening
- Colorectal cancer screenings using fecal occult blood testing, sigmoidoscopy or colonoscopy³
- Depression screening
- Diabetes screening for adults with high blood pressure
- HIV screening
- Obesity screening
- Sexually transmitted infection (STI) screenings (chlamydia, gonorrhea, syphilis)

Health Counseling

- Alcohol misuse
- Healthy diet
- Obesity
- Prevention of sexually transmitted infections (STIs)
- Tobacco use and cessation
- Use of aspirin to prevent cardiovascular disease
- Use of folic acid

Men Only

Abdominal Aortic Aneurysm screening

Women Only

- Annual well woman visit
- Breast cancer screening/ Screening mammography
- Cervical cancer screening including Pap smear
- Osteoporosis screening
- Genetic counseling and evaluation for BRCA testing where family history is associated with an increased risk
- Human Papillomavirus (HPV) DNA test
- Counseling related to chemoprevention of breast cancer
- Breastfeeding⁹
- Domestic violence counseling
- Contraception⁶

Contraception⁶

- Depending on your particular health plan, coverage without cost-sharing may expand to include the following contraceptive services when provided by a health care provider in the BCBSTX network.
- Prescription⁷ One or more products within the categories approved by the FDA for use as a method of contraception
- Over-the-counter Contraceptives available approved by the FDA for women (foam, sponge, female condoms) when prescribed by a physician
- The morning after pill
- Medical devices such as IUD, diaphragm, cervical cap and contraceptive implants
- Female sterilization⁸ including tubal ligation

Specifically for Pregnant Women

- Alcohol misuse screening and counseling
- Anemia screening
- Bacteriuria screening
- Rh Incompatibility screening
- Gestational diabetes screening
- Hepatitis B screening
- Screenings for Sexually Transmitted Infections (STIs) including chlamydia, gonorrhea, and syphilis
- Tobacco use and cessation counseling

Footnotes

- 1 ACA requires non-grandfathered health plans and policies to provide coverage for preventive care services without costsharing only when the member uses a network provider. This includes preventive care services with an A or B rating as outlined by the United States Preventive Services Task Force as follows:
- Evidence-based items/services rated A or B in the current recommendations of the U.S. Preventive Services Task Force
- Routine immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease control and prevention
- Evidence-informed preventive care and screenings for infants, children, and adolescents in the comprehensive guidelines of the Health Resources and Services Administrations
- Evidence-based preventive care and screenings for women described in the comprehensive guidelines of the Health Resources and Services Administration

For a listing of these services visit www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html

- ² New requirements can be issued at any time. Plans/policies have one year from issuance to add the new benefit. New requirements on women's preventive services were released by the U.S. Department of Health and Human Services on Aug. 1, 2011. Non-grandfathered plans/policies are required to cover these services beginning with plan/policy years starting on or after Aug. 1, 2012.
- ³ Anesthesia also covered as preventive
- Further evaluation recommended as a result of a hearing screening test is not considered preventive and may not be covered at 100%.
- ⁵ Vision acuity test to detect amblyopia (lazy eye), strabismus (cross eye), and defects in visual acuity in children younger than age 5 years. Normal vision screening and further evaluation recommended as a result of an acuity test are not considered preventive and may not be covered as preventive.
- ⁶ Under federal guidelines, certain religious employers may not be required to cover contraceptive services. Also, religiousaffiliated employers meeting certain criteria may qualify for a temporary enforcement safe harbor period which doesn't require them to cover the recommended contraceptive services for one year.
- ⁷ Prescription coverage for contraception may vary according to the terms and conditions of your health plan's pharmacy benefit. Please call the customer service number on the member ID card for coverage details.
- 8 Certain restrictions may apply; there might be copay, coinsurance or deductible in some cases – call the number on your member ID card for more information. Hysterectomies are not considered part of the women's preventive care benefit.
- 9 Breastfeeding
- Breastfeeding specialist/nurse practitioner with staterecognized certification who is in your provider network
- Breastfeeding support and counseling by a trained in-network provider while you are pregnant and/or after you've given birth
- Breast pumps (manual, electric and hospital grade)*
- * The Blue Cross and Blue Shield (BCBS) implementation of preventive services without cost-sharing under the Affordable Care Act (ACA) previously covered manual breast pumps only. Effective April 15, 2013, BCBS expanded its coverage to include electric and hospital grade breast pumps. This coverage applies to non-grandfathered plans and policies and expands the breastfeeding support options available to members without cost-sharing (some limitations or restrictions may apply). Contact a BCBS representative or call the number located on the back of the member ID card for more information

This information is a high-level summary and for general informational purposes only.

The information is not comprehensive and does not constitute legal, tax, compliance or other advice or guidance.

2014 Medical Plan for Medicare-Eligible Participants

Medical Plan

The medical plan offers coverage that helps you and your eligible dependents maintain your good health, or pay for care when you are ill or injured.

Eligible retiree and dependents have one enrollment option: the CIGNA Medicare Surround Plan. (This plan is also the only option for retirees who have been approved for pre-65 retiree disability Medicare.) Once you reach age 65, Medicare will become your primary coverage and CIGNA will be secondary.

This plan does not use a network, but pays benefits to any doctor, lab or hospital that accepts Medicare. You don't have to pay any deductibles; CIGNA will cover both Medicare Part A and Part B deductibles for you. The plan also pays 100% of the Medicareapproved medical expenses not paid by Medicare. Expenses that are not considered medically necessary and are considered elective procedures will not be covered.

Look for Your ID Card

If you are a new enrollee, CIGNA will mail you a medical ID card to your home in late December.

Reminder: Call Before You Go

Because the CIGNA Medicare Surround Plan only pays benefits to providers who accept Medicare, it's important to call and ask a doctor's office or facility before you receive services. This ensures that any covered services you receive will be reimbursed by Medicare.

2014 Prescription Plan for Medicare-Eligible Participants

Prescription Drug Plan

Retirees and dependents age 65 or older who enroll in the CIGNA Medicare Surround Plan are automatically enrolled by CIGNA in Medicare Part D and will receive prescription drug coverage through the CIGNA Medicare Rx Plan. Please do not enroll yourself in any other Part D programs. If you previously enrolled in Medicare Part D, CIGNA will automatically have your current prescription plan dropped and re-enroll you into the CIGNA Medicare Rx plan.

Short-Term Prescriptions (30-Day Supply)

For short-term prescriptions, you can purchase up to a 30-day supply through your local pharmacy that is part of the CIGNA network. See page 8 for a list of local network pharmacies in Garland, Rowlett, and Sachse. To see if your pharmacy is part of CIGNA's network, visit www.CIGNAmedicare.com or call 1-800-558-9562.

Long-Term Prescriptions (90-Day Supply)

For ongoing "maintenance" drugs (those used for treating chronic conditions like high cholesterol, epilepsy or diabetes), you can save money by getting a 90-day supply from a local CIGNA network retail pharmacy. Because the 90-day co-pay is only twice the amount of the 30-day co-pay, you save a third of the cost!

Your Cost for Prescription Drugs

The table below shows what you pay for each prescription. The CIGNA Medicare Rx Plan covers the cost of all Medicare Part D deductibles. All medications you fill through this plan are subject to CIGNA's Medicare formulary. CIGNA covers all Part D deductibles, so you only pay the amounts shown below for each prescription.

	30-Day Supply (Retail)	90-day Supply (Retail)
Annual Deductible	Part D deductibles	
Generic (Medicare Part D Tier 1)	\$10	\$20
Preferred Brand Name (Tier 2)	\$30	\$60
Non-Preferred Brand Name and High Cost (Tiers 3 and 4)	\$60	\$120

Helpful Hint: Approved Medications

You can find a list of preferred brand name drugs at www.CIGNAmedicare.com.

2014 Dental Plan Benefits

The Guardian Life Insurance Company of America is our provider of Dental benefits. Guardian is an industry leader that has been helping people protect their financial well-being for over 150 years. They offer quality coverage at affordable group rates, superior claims and customer service, as well as resources to understand and get the most out of your benefits. Below are highlights of the Guardian benefits provided by The City of Garland.

Guardian Dental Customer Service: 1-800-541-7846, option 1
Guardian Claims Service: 1-800-541-7846, option 1
Guardian Dental Website: www.guardiananytime.com

	Scheduled	Basic	Premium
Calendar Year Deductible			
Individual	\$50	\$75	\$50
Family limit	\$150	\$225	\$150
Calendar Year Maximum Benefit (Per Covered Member)	\$1,500	\$1,000	\$1,500
Maximum Rollover	No	Yes	No
Type 1			
Preventive / Diagnostic Benefits	Refer to Schedule on www.hrconnection.com	100% - deductible waived	100% - deductible waived
Type 2			
Basic Benefits	Refer to Schedule on www.hrconnection.com	50% after deductible	80% after deductible
Type 3			
Major Benefits	Refer to Schedule on www.hrconnection.com	50% after deductible	60% after deductible
Orthodontia (Adult and Child)	50% after deductible \$1,250 lifetime max	50% after deductible \$1,250 lifetime max	50% after deductible \$1,250 lifetime max

Sample Procedure Listing (Current Dental Terminology © American Dental Association)

Type 1	Type 2	Type 3
Routine Exam (2 per benefit period)	Restorative Amalgams	• Onlays
Bitewing X-rays (2 per benefit period)	Restorative Composites	• Crowns* (1 in 5 years per tooth)
Full Mount / Panoramic X-rays	• Endodontics (nonsurgical)	Crown Repair*
(1 in 36 months)	Endodontics (surgical)	 Implants
Periapical X-rays	Periodontics (nonsurgical)	• Prosthodontics (fixed bridge; removable
 Cleaning (2 per benefit period) 	Periodontics (surgical)	complete/partial dentures) (1 in 5 years)
Fluoride for Children 18 and under	Denture Relines	Denture repairs and adjustments
(1 per benefit period)	Simple Extractions	
• Sealants	Complex Extractions	
Space Maintainers	• Anesthesia	

^{*} If posterior crowns are needed, porcelain materials are not covered as they are considered cosmetic. Amalgam crowns are covered on posterior teeth.

2014 Dental Plan Benefits

Guardian Dental	1-800-541-7846, option 1	
Customer Service:	1-800-341-7846, option 1	
Guardian	1 000 541 7046 antion 1	
Claims Service:	1-800-541-7846, option 1	
Guardian Dental		
Website:	www.guardiananytime.com	

Find a Dental Provider

City of Garland belongs to the Guardian PPO network – **Dental Guard Preferred.** You may call 1-800-541-7846 or go online to find the contracted network providers who are most convenient for you.

- Under Resources, Select "Find a Provider" (far right)
- 2. Select "Find a Dentist"
- 3. Select your dental plan "PPO"
- 4. Choose to search by location or search for a specific dentist or practice and enter your search criteria
 - If searching by location: enter your ZIP code or address and if desired, enter your preference on radius, provider specialty and/or language spoken.
 - Select your dental network "Dental Guard Preferred", hit "continue"
- 5. You will receive a list of providers to select from and will be able to download at your convenience.

Within the website, there is a form where you can nominate a dentist to become part of the network. Simply click on the "Nominate your Provider" tab and complete the information. Once completed, click on the "submit" button and it will be transferred to the appropriate dental recruiter for that area.

Online Access – Guardian Anytime – Member portal

Once you receive your id card, you will have access through our online member portal Guardian Anytime. With online access, you are able to find a provider, review benefit information, and have availability to discounts on certain products and services.

Go to www.guardiananytime.com

- 1. Select the "Register Now" button (far right)
- 2. Under "User Role" select the "member" button, read Member Disclosure Statement at the bottom and click on "I agree"
- 3. Create your profile. You will need your id card when completing this portion.
- 4. You will receive online confirmation of registration with a link that directs you to Guardian Anytime.

Pre-Treatment Authorization

While we don't require a pre-treatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pre-treatment estimate to Guardian. We'll inform both you and your dentist of the amount your insurance will cover and the amount that you will be responsible for. That way, you can help minimize surprises once the work has been completed.

Basic Plan Carryover from 2013

If you submitted at least one dental claim in 2013 and your total paid claims for the year were under \$500, you may be eligible to roll over \$250, which will be added to your calendar year maximum for 2014.

2014 Vision Plan Benefits

If you elect vision benefits, coverage includes eye exams, contacts and eyeglass lenses and frames. You'll also get discounts on special features such as scratch-resistant lenses and laser eye surgery.

When you need eye care services, you may choose whether or not to use a network provider that has contracted with VSP. You receive a higher benefit when you use a network provider. If you use an out-of-network provider, you will pay in full at the time you receive care and submit your receipts to VSP to receive the appropriate reimbursement.

For participating providers in other areas, log on to **www.vsp.com** or call **1-800-877-7195**.

Please be advised that this program is a paperless plan, therefore, no ID cards are required or provided. To use this benefit, you will provide your vision provider with the name of the insurance carrier and the online systems will verify your coverage for you.

Covered Services: VSP Signature Provider Network:

Covered Services.	V3F 3ignature Flovider Network.	
Exams	\$10 copay	
(Once Every 12 Months)		
Materials	\$25 copay	
(Once Every 12 Months)		
Frames	Frame of your choice covered up to \$120	
(Once Every 12 months)	Plus, 20% of any out-of-pocket costs	
Pair of Lenses	Single vision, lined bifocal, lined trifocal lenses and tints covered in full	
(Once Every 12 months)	• \$25 copay	
Contact Lens Care	When you choose contacts instead of glasses, your \$120 allowance for frames applies to	
(Once Every 12 months)	the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in	
	addition to your vision exam to ensure proper fit of contacts.	
	Current soft contact lens wearers may qualify for a special contact lens program that	
	includes a contact lens evaluation and initial supply of replacement lenses. Learn more	
	from your doctor or by going online to www.vsp.com.	
Out-of-Network	Exam—up to \$45	
Reimbursement Amounts	Lenses:	
nembarsement Amounts	Single Vision—up to \$45	
	Lined Bifocal—up to \$45	
	Lined Britcal—up to \$85 Lined Trifocal—up to \$85	
	• Tints—up to \$5	
	Frame—up to \$47	
	• Contacts—up to \$105	
Extra Discounts and Savings	Laser Vision Correction Discounts	
	Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings	
	and progressives	
	Up to 20% savings on additional prescription glasses and sunglasses	
	15% off cost of contact lens exam (fitting and evaluation)	
	, , ,	

2014 Vision Plan Benefits

Locate VSP Providers

It's simple to locate and make an appointment with a VSP provider. Just follow these steps:

- 1. Find a VSP network doctor at **vsp.com** or call 1-800-877-7195.
- 2. Make an appointment and tell the doctor you are a VSP member.
- 3. Your doctor and VSP will handle the rest.

A list of some of the VSP providers in the Garland area is shown below.

VSP Providers in Garland: Name and Address	Phone (area code 972) , unless otherwise indicated
Soby Abraham, OD, 3121 N. George Bush Hwy., Suite 101	495-7772
Justin K. Barnett, OD, 5120 Hwy 78, Suite 700	530-2020
Michael J. Bollish, OD, 6850 N. Shiloh Rd, Suite T	414-0444
Lance M. Chong, OD, 2930 S. 1st St.	278-0154
Robert E. Day, Jr., OD, 3034 Broadway Blvd.	278-2121
Glenn G. DeShaw, OD, 2636 W. Walnut St., Suite 200	485-0700
Clifton E. Dewey, OD, 424 N. Jupiter Rd.	487-2020
Reyna A. Hernandez, OD, 3385 Naaman School Rd.	495-3997
Stephen T. Khong, OD, 3575C W. Walnut St.	272-9455
Steven T. Le, OD, 5001 Ben Davis Rd.	675-9626
D. L. Morgan, OD, 1456 Belt Line Road, Suite 129	214-227-4342
Samantha N. Naidoo, OD, 3121 N. George Bush Hwy., Suite 101	495-7772
Kimberly Nguyen, OD, 3575C W. Walnut St.	272-9455
Mark A. Ruiz, OD, 1821 Old Mill Run	494-2020
Craig E. Schacherer, OD, 303 S. Highway 78, Suite 203	442-2020
Elliot Stendig, OD, 1821 Old Mill Run	494-2020
Michael J. Stewart, OD, 401 W. Centerville Rd., Suite 6	840-8998
Lorraine C. Suder, OD, 6850 N. Shiloh Rd., Suite T	414-0444
Bradley J. Wemhoener, OD, 3046 Lavon Dr., Suite 130	495-8998



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Don't Overpay for Healthcare.

Compass Professional Health Services is a benefit that gives you unlimited access to healthcare experts. Our mission is simple. Get you the best possible medical care while making sure you don't overpay. Your Compass Health Pros can help every step of the way:



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Save up to 75% on common procedures

BILLING

Never deal with a problem bill again

MEDICATIONS

Pay \$4 for many \$125 prescriptions

DOCTORS

Go to the best physicians in your area



