Medicare Eligible Retirees Open Enrollment Booklet 2018

OPEN ENROLLMENT

October 16, 2017 - November 13, 2017

Health • Dental • Vision

When it comes to choosing your Retiree Benefits, deciding on the right plans can sometimes seem difficult. The good news is that you can get help choosing a solution that's just right for you. Looking over the information in this Benefits Booklet and, if necessary, attending a Medicare Open Enrollment Informational Meeting, can provide good information to help you make that important decision.

Dental Insurance

For 2018, HumanaDental will continue as the City's dental provider for those retirees currently enrolled. There will be no plan design changes and the monthly premium will remain the same, with no increase. The HumanaDental plan is ***closed to new participant enrollment at this time.*** If you are currently enrolled and you wish to cancel your plan or change between plans, you will need to complete a change form. If you wish to make a change, contact the City of Tampa HR/Risk Management Division at (813) 274-5757 to request a change form be mailed to your home.

Vision Insurance

The City of Tampa is continuing their contract with Advantica for the vision plan in 2018. The vision plan offers comprehensive benefits on eye exams, lenses, frames and contacts. For 2018, there has been an enhancement made to the plan design but there will be no increase in the premium. The new plan is called ***Select Plus 150*** and you can review the plan design on Page 9. in this booklet for further details. The Advantica Vision plan is ***closed to new participant enrollment at this time***. If you are currently enrolled and wish to cancel your coverage, you will need to complete a change form. Contact the City of Tampa HR/Risk Management Division at (813) 274-5757 to request a change form be mailed to your home.

Health Insurance

Aetna will continue to provide City of Tampa Medicare eligible retirees a choice of two Medicare Advantage plans; the Aetna Group Medicare Advantage Local PPO and the Aetna Group Medicare National PPO.

Medicare Advantage (also known as Medicare Part C) health plans are administered through private insurance companies such as Aetna. They combine Medicare Part A (hospital visits), Part B (doctor visits and outpatient care) and Part D (prescription drugs) coverages into a single convenient plan. Then, they include some value added services that are not made available through the Original Medicare coverage such as the Silver Sneakers Fitness program.

Preferred Provider Organization (PPO) plans allow members to choose from in-network and out-of-network providers. PPOs give the member freedom to use out-of-network providers at a higher level of cost sharing. Please review the following pages regarding your medical, dental, and vision plan options. The side by side group health plan comparison charts are provided for you to make a well-educated choice of the plan design that fits your needs the best. If you wish to review the plan designs in more detail than the City of Tampa Benefits Booklet provides, enrollment information will be mailed to your homes directly from Aetna. Please watch your mailbox in the very near future if you have not received it already. For questions, you may contact Aetna directly by dialing 1-866-795-2091 (TTY 711), 8 a.m. to 6 p.m., 5 days a week; Monday through Friday.

Contact Aetna customer service at 1-866-795-2091 (TTY 711), 8 a.m. to 6 p.m., 5 days a week or go on-line for further information at www.aetnamedicare.com.

Highlights for 2018

- There are changes to the Local and National PPO plans for January 1, 2018. Please review the comparison charts in this booklet on pages 6 and 7.
- Dental and Vision Plans are closed for new participtant enrollment.

The City of Tampa will be presenting a Medicare Open Enrollment Informational Meeting to review the 2018 Aetna Medicare Advantage plans, Advantica Vision Plan and the HumanaDental Plans.

The meeting has been scheduled as follows:

Thursday, November 2, 2017 at 12 noon

CITY OF TAMPA
RAGAN PARK COMMUNITY CENTER
1200 E. LAKE AVE., TAMPA FL 33605

Who is Aetna

Aetna Inc. is an American managed health care company providing a range of services such as:

- Traditional and consumer directed health care insurance products;
- Related medical and pharmaceutical services;
- Behavioral health group services;
- Long-term care;
- Medical management capability services/programs;

Aetna offers disease management programs designed to help members manage certain health conditions such as hypertension and diabetes. Aetna also offers preventive benefits not covered under Medicare, a 24/7 Health Line, and many other additional benefits.

Aetna is a member of the Fortune 100. They provide insurance for over 200,000 Medicare retirees nationwide and are the leader in the public sector group Medicare Advantage market.

Aetna offers the SilverSneakers program to our members which allows you to get fit the way you want, at your convenience. Go to www.silversneakers.com for more information. With this innovative program you can:

- Use all basic amenities plus take SilverSneakers classes at certain fitness facilities and YMCA's in the area
- Have guidance and assistance from a Program Advisor™
- Enjoy fun social activities with people like you
- Go outside with FLEX™, which includes classes and activities at parks, recreation centers and other local venues.

City of Tampa Medicare Plan Comparison

aetna	2018 Aetna Group Medicare Advantage (PPO) (Florida Residency Required)	
Plan Options	**In Network**	**Out of Network**
Deductible	$400	$700
Coinsurance	May Apply	May Apply
Annual Out of Pocket Maximum	$3,400	$5,000
Primary Care Office visits	$25	35%
Specialist Office visits	$50	35%
Preventive Care visits	No Charge	35%
Inpatient Hospital	$200 per day; days 1-5	35%
Emergency Room - worldwide	$65	$65
Ambulance	$150	35%
Annual Physical	$0	35%
Outpatient Lab and X-ray	10%	35%
MRI, MRA, CT & PET scans	10%	35%
Outpatient Surgery	20%	35%
Outpatient Non Surgery	20%	35%
Skilled Nursing Facility	$0 (days 1-20); 20% (days 21-100); 100 day limit	35%
Home Health Agency Care	$0	35%
Vision (routine eye exam every 12 months)	$0	35%
Podiatry (limited to Medicare covered benefits)	$50	35%
Hearing Hearing Aid Reimbursement	$0; Office Visit may apply; $500 Hearing Aid allowance every 36 mo.	35%; Office Visit may apply; $500 Hearing Aid allowance every 36 mo.
Durable Medical Equipment/Prosthetic Devices	20%	35%
Urgent Care - worldwide	$50	$50
Prescription Drugs (30 day supply)		
Tier 1 - Preferred Generics	$10	NO COVERAGE if filled at a non-participating pharmacy.
Tier 2 - Non-Preferred Generics	$20	
Tier 3 - Preferred Brand	$45	
Tier 4 - Non-Preferred Brand	$95	
Tier 5 - Specialty	$95	
Retail/Mail Order (90 day supply)	2 copayments for 90 day supply	N/A
Part B Drugs including Chemotherapy Rx	20%	35%
Note: Pharmacy Drug Deductible is $0 Coverage Gap and Catastrophic Coverage Phase.	Once you and the plan have paid $3,750 in total drug cost, **you** will then pay 44% coinsurance for generic drugs and 35% for brand drugs. Once **your** out-of-pocket drug costs reach $5,000 you will pay the greater of $3.35 or 5% for generics and $8.35 or 5% for all other drugs.	
MONTHLY PREMIUM RATE	**$67.33**	

Aetna Group Medicare Advantage PPO (Local) Service Areas

Limited to the following State of Florida Counties for In-Network benefits:

Bradford, Brevard, Broward, Charlotte, Citrus, Collier, Desoto, Duval, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Volusia.

City of Tampa Medicare Plan Comparison

aetna	2018 Aetna Group Medicare Advantage (National PPO) Plan	
Plan Options	**In Network**	**Out of Network**
Deductible	$400	$400
Coinsurance	May Apply	May Apply
Annual Out of Pocket Maximum	$3,500	$3,500
Primary Care Office visits	$10	$10
Specialist Office visits	$30	$30
Preventive Care visits	No Charge	No Charge
Inpatient Hospital	$250 per day; days 1-5	$250 per day; days 1-5
Emergency Room - worldwide	$50	$50
Ambulance	$100	$100
Annual Physical	$0	$0
Outpatient Lab and X-ray	$20	$20
MRI, MRA, CT & PET scans	10%	10%
Outpatient Surgery	10%	10%
Outpatient Non Surgery	10%	10%
Skilled Nursing Facility	$0 (days 1-20) $75 (days 21-100) 100 day limit	$0 (days 1-20) $75 (days 21-100) 100 day limit
Home Health Agency Care	$0	$0
Vision (routine eye exam every 12 months)	$30	$30
Podiatry	$20	$20
Hearing	$0; Office Visit copays may apply $500 hearing aid allowance every 36 mo	$0; Office Visit copays may apply $500 hearing aid allowance every 36 mo
Durable Medical Equipment	20%	20%
Urgent Care - worldwide	$35	$35
Prescription Drugs (30 day supply)		
Tier 1 - Generic	$15	$15
Tier 2 - Preferred Brand	$25	$25
Tier 3 - Non-Preferred Brand	$45	$45
Tier 4 - Specialty	25%	25%
Retail/Mail Order (90 day supply)	2 copayments for 90 day supply	N/A
Part B Drugs including Chemotherapy Rx	20%	20%
Note: Pharmacy Drug Deductible is $0	After the member's copays/ coinsurance total $5,000, the catastrophic coverage kicks in.	
MONTHLY PREMIUM RATE	**$210.05**	

Aetna Group Medicare Advantage (National PPO) Service Areas

The National PPO network provides coverage throughout Florida and all other continental US states.

Dental Insurance

Humana.

For those retirees currently enrolled, HumanaDental will continue to be the City's dental plan provider. The network of Providers can be found online at www.humanadental.com. To change your dentist, contact Humana before the end of the month. ***This benefit is closed to new participant enrollment.***

Things to think about when deciding on your dental coverage:

- Do you have a regular dentist you want to continue visiting? Is he or she a member of the HumanaDental DHMO network?
- If you choose the HumanaDental DHMO plan you must select a dentist from the directory.
- Review the benefits summaries and make a note of the differences between the PPO and DHMO plans with regard to deductibles, calendar year maximums, reimbursement percentages, and copayments.

HumanaDental DHMO (HS 195)

The pre-paid DHMO plan provides benefits when using In-Network providers only. All benefits are subject to a fee schedule and limitations and copayments apply.

DHMO Monthly Cost			
	Single Coverage	**Individual +1**	**Family Coverage**
Humana DHMO HS 195	$13.22	$26.18	$46.54

For more information regarding the dental plan options, contact HumanaDental at (800) 233-4013.

Humana PPO

The plan provides you with total freedom of choice by allowing you to use any licensed dentist for treatment. The plan reimburses a percentage of eligible expenses based on in-network and out-of-network charges.

	In-Network	**Out-Of-Network**
Type I - Diagnostic *Oral Exam* *Cleaning* *Flouride* *X-Rays* *Sealants*	100%	80%
Type II - Basic Services *Fillings* *Tooth Extraction* *Endodontics*	80%	60%
Type III - Major Services *Some restrictions*	50%	50%
Type IV - Orthodontic Services *Dependent children 18 years of age or younger*	50%	50%

When you choose a dentist outside of the Humana PPO network, your out-of-pocket costs will be higher and members will be subject to "balance billing" for provider fees that exceed the contracted ***maximum allowable charge.*** You can locate participating (In-Network) dental providers by visiting Humana's website at **www.humana.com**.

PPO Monthly Cost			
	Single Coverage	**Individual +1**	**Family Coverage**
Humana	$33.78	$64.17	$105.82

Vision Insurance

The City of Tampa offers a vision plan called the Select Plus 150 provided by Advantica. The company provides a national network of eye care providers and a team of dedicated member service representatives to assist with all aspects of the program. Please find a brief overview of the benefits below. If you wish to cancel your coverage, please contact the City of Tampa HR/Risk Management Office at (813) 274-5757 for a cancellation form. ***This benefit is closed to new participant enrollment.***

Routine Exam: In-Network

- One routine eye exam per year is covered at 100%. No co-payment applies.
- 12 months

Frames and $150.00 Materials Benefit/Allowance

- Retail discounts after $15 co-payment with participating providers.
- 12 months

Eyeglass Lenses: $15 co-payment includes:

- Single vision lenses
- Bifocal lenses
- Trifocal lenses
- No co-payment if included with frames
- 12 months

Polycarbonate Lenses - $0 member cost for members age 19 and younger; $30 over age 19
Standard Progressive Lenses - $50 co-payment
Transitions (Photochromic) Lenses - $60 co-payment

Contact Lenses

- No limit on resupply purchases from network providers
- Contact lens examination (fitting) - $30 allowance
- Contact lenses in lieu of eyeglasses - $15 Co-payment and $150 material allowance.

Laser Vision Correction

While laser vision correction is not a covered benefit, Advantica has partnered with QualSight to provide our members with access to discounted laser vision correction providers. QualSight has over 800 locations nationwide and features a network of ophthalmologists specializing in laser vision correction. With QualSight, laser vision correction surgery is now affordable at prices that are 40-50% of the national average price for traditional LASIK. For more information, call (877) 718-7661.

Quarterly Premium*

	Single Coverage	Individual +1	Family Coverage
Select Plus 150	$22.72	$43.00	$70.18

*Includes $2.50 invoice processing fee.

Enrollment Procedures

Medical – You must sign your health plan enrollment form and return it to your pension office *EVERY* year.

1. Read, compare and make your selection wisely.
2. All Medicare eligible retirees MUST complete a City of Tampa Enrollment Form.
3. Medical Enrollment forms must be received by your pension office ***NO LATER THAN MONDAY, NOVEMBER 13, 2017.*** A return envelope is included for your convenience.

Dental

1. This benefit is closed to new participant enrollment.
2. Call (813) 274-5757 for enrollment questions.

Vision

1. This benefit is closed to new participant enrollment.
2. Call (813) 274-5757 for enrollment questions.

REMEMBER

REQUIRED ACTION ON YOUR PART

2018 GROUP HEALTH PLAN ENROLLMENT FORMS MUST BE RECEIVED BY YOUR PENSION OFFICE NO LATER THAN 4:30 P.M. MONDAY, NOVEMBER 13, 2017

Important Notice from the City of Tampa About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Tampa and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of Tampa has determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a "Stand Alone Medicare Prescription Drug Plan," your current Aetna Medicare Advantage Plan coverage will be affected. The health insurance plans that are offered through Aetna to the City of Tampa retirees are Medicare Advantage Plans (MAP). The prescription coverage is built into the plans and both prescription drug options offered by Aetna are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are therefore considered Creditable Coverage.

If you should join a "Stand Alone Medicare Prescription Drug Plan," CMS (Center for Medicare and Medicaid Services) will automatically cancel your coverage under the City of Tampa group health care plan.

If you decide to join a Medicare drug plan and drop your current City of Tampa coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of Tampa and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the City of Tampa HR/Risk Management for further information at (813) 274-5757.

NOTE: You'll get this notice each year. You will get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Tampa changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about his extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Annual Notices

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other plan. However, you must request enrollment within 30 days after your or your dependents' other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Pension office.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

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're eligible for health coverage from your employer, your state 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 aren't eligible for Medicaid or CHIP, you won't 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 www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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 your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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 aren't 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 www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado
(Colorado's Medicaid Program) &
Child Health Plan Plus (CHP+)
Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943/State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+: Customer Service: 800-359-1991/State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidplrecovery.com/hipp/
Phone: 877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/ime/
members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/
subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/
index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/
masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/
health-care/health-care-programs/programs-and-services/
medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/
hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/
MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.AccessNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.
pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/
dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH– Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Glossary of Terms

Brand Name Drug: A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Drug Coverage: In Medicare Part D, a name for the step of a drug plan in which you pay only a small coinsurance or small copay for a covered drug, and your plan pays the rest of the cost for the remainder of the year. You will move into the Catastrophic Drug Coverage level after you have expensed $5,000 in covered prescription drug copays.

Centers for Medicare & Medicaid Services (CMS): The federal government agency that runs the Medicare program and works with the states to manage their Medicaid programs.

Coinsurance: A cost-sharing feature in which the member pays a fixed percentage of medical expenses.

Co-Payment (or Co-Pay): A cost-sharing feature in which the member pays a flat dollar amount of medical expenses.

Creditable Drug Coverage: Prescription drug coverage, from a plan other than a Medicare Part D stand-alone plan or a Medicare Advantage plan with drug coverage, which meets certain Medicare standards. The Aetna Medicare Advantage plans meet the requirements for creditable drug coverage. *The Aetna Medicare Advantage plans meet the requirements for creditable drug coverage.*

Custodial Care: Care that provides help with the activities of daily living, like eating, bathing, or getting dressed.

Deductible: A fixed amount which the member pays before the plan starts paying benefits. In 2018, if enrolling in the Local PPO plan, you will need to meet a $400 Deductible when using In-Network Providers and $700 Deductible (combined) when using Out-of-Network Providers. The National PPO has a $400 Deductible when using In-Network or Out-of-Network providers.

Disenroll: Ending your health care with a health plan. To disenroll from the City of Tampa Retiree Group Health Plan, please contact your pension office and the insurance company.

Drug Formulary: A list of drugs that are considered to be safe and effective for patients. The drugs are approved based upon how well they work, how safe they are, and the cost of each.

Emergency: A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Exclusions: Specific conditions or circumstances that are not covered under the benefit plan. It is important to consult the carrier to understand what services are not covered.

Generic Drug: A drug which is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, dosage form and effectiveness as the brand name drug.

Home Health Care: In Part A and Part B, skilled nursing care and therapy, such as speech therapy or physical therapy, provided to the homebound on a part-time or intermittent basis.

In network: Refers to the use of providers that participate/contract with the carrier. Many plans require members to use in network providers to receive benefits or the highest level of benefits.

IRMAA (Income Related Medicare Adjustment Amount): The amount of your modified adjusted gross income (MAGI) determines the amount of your Part B premium. In general, the higher your MAGI, the higher your Part B premium. People who pay the income-related Part B premiums will also pay an additional income-related Part D premium, known as a monthly adjustment amount. The monthly adjustment amount is not related to the premium of the plan in which such beneficiaries are enrolled, but is based on a percentage of the Base Beneficiary Premium for the year as determined by CMS (Medicare.) Contact Social Security if you should need further explanation of this important information.
1-800-772-1213 (TTY 1-800-325-0778).

Maximum Out-of-Pocket Amount: The most that you pay out-of-pocket during the plan year for in-network covered Part A and Part B services. Amounts you pay for your Plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount.

Medically Necessary: Health care services or supplies that are appropriate for a particular sickness or injury. To be considered medically necessary, a health care service or item must be consistent with the symptoms and treatment of the injury or sickness. It also needs to be within the standards of good medical practice in the area, and the most appropriate level of care that can be provided to a member safely. Also, medically necessary services cannot be solely for the member's convenience or the convenience of a doctor or hospital.

Medicare Advantage Plans: A type of Medicare health plan offered by a private company that contracts with Medicare to provide members with all their Medicare Part A, Part B and optionally Part D benefits. Medicare Advantage Plans include plans such as Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO). When enrolled in a Medicare Advantage Plan, a member must be enrolled in both Medicare Part A and Part B but services are covered through the private insurance company plan and aren't paid for under Original Medicare.

Out of network: Refers to the use of non-network providers.

Part A: The part of Original Medicare that provides help with the cost of hospital stays, skilled nursing services following a hospital stay, and some other kinds of skilled care.

Part B: The part of Original Medicare that provides help with the cost of doctor visits, outpatient hospital care, durable medical equipment, and other medical services that don't involve overnight hospital stays.

Part C: The part of Medicare that allows private insurance companies to offer plans that combine help with hospital costs with help for doctor's visits and other medical services. Part C plans are usually referred to as "Medicare Advantage" plans.

Preferred Provider Organization (PPO): In Part C, a type of Medicare Advantage plan in which you can use either doctors and hospitals in the plan's network, or go to doctors and hospitals outside the network. If you go outside the network, you'll usually pay a larger share of the cost of your care.

Prescription Coverage Gap: The Group Medicare Advantage PPO plan offered through Aetna includes a prescription coverage gap. As a result of the recent Health Reform, the federal government is requiring pharmaceutical manufacturers to provide some assistance on the cost of covered generic and brand-name prescription drugs for beneficiaries in a coverage gap, or "donut hole."

Skilled Nursing Facility: A nursing facility with the staff and equipment to give skilled nursing care and, in most cases skilled rehabilitation services and other related health services.

Important Phone Numbers and Websites

General Employee Pension Office	(813) 274-7850
Fire & Police Pension Office	(813) 274-8550
City of Tampa HR – Employee Relations	(813) 274-8041
City of Tampa Benefits Questions Line	(813) 274-5757
Aetna Medicare Advantage Pre-Enrollment Aetna Medicare Advantage Post-Enrollment	(800) 307-4830; TTY 711 (888) 267-2637; TTY 711
HumanaDental	(800) 233-4013
Advantica (Vision)	(866) 425-2323
WEBSITES	
City of Tampa	www.tampagov.net
Medicare Aetna	www.aetnamedicare.com
HumanaDental	www.humana.com/dental
Advantica (Vision)	www.advanticabenefits.com

Notes

The information in this guide is a summary of the benefits available to you and should not be intended to take the place of the official carriers' Member Certificates. This guide contains a general description of the benefits to which you may be entitled as a Medicare eligible retiree. This guide does not change or otherwise interpret the terms of the official plan documents. To the extent that any of the information contained in this guide is inconsistent with the official plan documents, the provisions of the official documents will govern in all cases and the plan documents and carrier certificates will prevail. For more detailed information on the plans and your legal rights under the plans, be sure to read the Annual Notice of Change for your plan.