Employee

Benefits

Guide 2022

REGULAR EMPLOYEES

Welcome to City of Fullerton!

This guide provides a summary of your benefit options and is designed to help you make choices and enroll for coverage. If you would like more information about any of the benefits described here, please contact the Human Resources Department.

City of Fullerton
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IMPORTANT INFORMATION

Annual Notices

City of Fullerton plans are partially arranged by the City of Fullerton and governed by it's plan rules and documents. ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. City of Fullerton distributes annual notices to new hires, and each year during open enrollment. You may also request a copy by contacting the Human Resources Department or visiting https://www.cityoffullerton.com/government/departments/human-resources/open-enrollment.

The following are a list of Annual Notices:

- **Medicare Part D Notice of Creditable Coverage:** Plans are required to provide each covered participant and dependent a Certificate of Creditable Coverage to qualify for enrollment in Medicare Part D prescription drug coverage when qualified without a penalty.
- **HIPAA Notice of Privacy Practices:** This notice is intended to inform employees of the privacy practices followed by City of Fullerton's group health plan. It also explains the federal privacy rights afforded to you and the members of your family as plan participants covered under a group plan.
- **Women's Health and Cancer Rights Act (WHCRA):** This act contains important protections for breast cancer patients who choose breast reconstruction with a mastectomy.
- **Newborns' and Mothers' Health Protection Act:** This act affects the amount of time a mother and her newborn child are covered for a hospital stay following childbirth.
- **Special Enrollment Rights:** Plan participants are entitled to certain special enrollment rights outside of City of Fullerton's open enrollment period. This notice provides information on special enrollment periods for loss of prior coverage or the addition of a new dependent.
- **Medicaid & Children's Health Insurance Program:** Some states offer premium assistance programs for those who are eligible for health coverage from their employers, but are unable to afford the premiums. This notice provides information on how to determine if your state offers a premium assistance program.
- **Summary of Benefits and Coverage (SBC):** Health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about your health plan's benefits and coverage.

ACA

Even though the Affordable Care Act (ACA)'s penalty for not having health coverage (known as the individual mandate) has been reduced to zero, if you are a taxpayer in California, you will still be required to have health coverage (unless you qualify for an exemption) or pay a penalty for the 2021 tax year. In addition, several other states, including Massachusetts, New Jersey, and Vermont, as well as the District of Columbia, have reinstated an individual mandate requirement, and others are considering doing so. You may consider these options below to satisfy this requirement:

- Enroll in a medical plan offered by the City of Fullerton or another group medical plan meeting the requirements for minimum essential coverage
- Purchase coverage through a health insurance marketplace
- Enroll in coverage through a government-sponsored program if eligible

However, if you choose to purchase coverage through the marketplace, because City of Fullerton's medical plans are considered affordable and meet minimum value under the Affordable Care Act, you may not be eligible for a subsidy, and you may not see lower premiums or out-of-pocket costs through the marketplace. In addition, employer contributions to your medical benefits will be lost and your portion of medical premiums will no longer be paid via payroll deductions on a pre-tax basis

For More Information
Go to **www.healthcare.gov.**

BENEFITS AT A GLANCE

City of Fullerton Benefit Plans

The City of Fullerton is proud to offer high quality, competitive benefit plans for you and your family. Below is a high level summary of the benefit plans offered by the City.

BENEFITS AT GLANCE	
Paid by the City of Fullerton	• Basic Life and Accidental Death & Dismemberment • Long Term Disability (All Units with the exception of POA-Safety) • Employee Assistance Program • Travel Assistance
Benefits that are paid by you and the City of Fullerton	• Medical • Dental • Vision • Flexible Spending Account* • Retirement Savings
Benefits paid by you at discounted group rates	• Supplemental Employee Life/AD&D • Supplemental Spouse and/or Child(ren) Life • Accident • Hospital • Critical Illness

*Please refer to your 2022 Benefits Guide for additional plan details. If you would like more information about any of the plans described here, please contact the Human Resources.

Opt-Out Program

City of Fullerton offers an opt-out credit of $50 per pay period to eligible employees who waive medical coverage. To be eligible, you must be a full-time employee with proof of alternate group coverage.

Contact the Human Resources Department for additional information.

ELIGIBILITY & ENROLLMENT INFORMATION

Who May Enroll

If you are a regular employee working at least 30 hours per week, you and your eligible dependents may participate in City of Fullerton's benefits program. Eligible dependents include:

- Legally married spouse
- Registered domestic partner
- Children under the age of 26, regardless of student or marital status

When You Can Enroll

As an eligible employee, you may enroll at the following times:

- As a new hire
- Each year, during open enrollment
- Within 30 days of a qualifying event as defined by the IRS (see Changes To Enrollment below)

Benefits Plan Year: January 1– December 31

Employment Class	Benefits Effective Date	Covered Benefits
Executive, Management, Police Management, Fire Management, Confidential/Non Represented	First day of the month following date of hire	All Benefits
Firefighters	First day of the month following date of hire	Medical and Vision
Federation, Police, Police Dispatchers	First day of the month after 30 days of employment	All Benefits
Firefighters	First day of the month after 30 days of employment	Dental

IRS Code Section 125

The City of Fullerton employee benefit plans are designed under Section 125 of the IRS Code. This allows you to take advantage of federal laws by purchasing some of your benefits with pre-tax dollars. Under Section 125, your Medical, Dental, and Vision contributions are deducted before taxes are withheld which saves you tax dollars. Paying for benefits before-tax means that your share of the costs are deducted before taxes are determined, resulting in more take-home pay for you. As a result, the IRS requires that your elections remain in effect for the entire year. You cannot drop or change coverage unless you experience a qualifying event.

Changes To Enrollment

The City's benefit plans are effective January 1st through December 31st. There is an annual open enrollment period each year, during which you can make new benefit elections for the following January 1st effective date. Once you make your benefit elections, you cannot change them throughout the year unless you experience a qualifying event as defined by the IRS. Examples include, but are not limited to the following:

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child
- A qualified medical child support order
- Death of a spouse or child
- A change in your dependent's eligibility status
- Loss of coverage from another health plan
- Change in your residence or workplace (if your benefit options change)
- Loss of coverage through Medicaid or Children's Health Insurance Program (CHIP)
- Becoming eligible for a state's premium assistance program under Medicaid or CHIP

Important

Coverage for a new dependent is not automatic. If you experience a qualifying event, you have 30 days to update your coverage. Please contact the Human Resources Department immediately following a qualifying event to complete the appropriate election forms as needed. If you do not update your coverage within 30 days of the qualifying event, you must wait until the next annual open enrollment period to update your coverage.

Medical Plans

The City of Fullerton offers health care benefits that give you both choice and affordability. With four medical plans, you choose how you want to manage your costs and healthcare provider relationships.

Kaiser Permanente | HMO Medical Plan

- All services must be obtained at Kaiser Permanente facility, except in the case of an emergency. All of your care must be directed through your selected doctor, but you can choose and change your doctor at any time, for any reason.
- Kaiser Permanente integrates all elements of healthcare such as physicians, medical centers, pharmacy, and administration in one convenient facility.

Kaiser Permanente Online, Mobile and Phone Access

Manage your care online by registering at www.kp.org. You can locate Kaiser Permanente facilities, make or cancel appointments online, refill prescriptions, email your doctor, view medical records, obtain health and wellness information and much more.

Once you've registered, download the Kaiser Permanente app, available on the App Store and Google Play for on-the-go convenience.

You can reach Kaiser customer service at 800-464-4000.

Cigna | HMO Select Network Plan

- You must choose a Primary Care Physician (PCP) or medical group within the Select network for all of your covered family members. All of your care must be directed through your PCP or medical group.
- Any specialty care you need will be coordinated through your PCP and will generally require a referral or authorization.
- You will receive benefits only if you use the doctors, clinics, and hospitals that belong to the medical group in which you are enrolled, except in the case of an emergency

Cigna | HMO Full Network Plan

This plan works just like the Select Network HMO plan, but uses a **larger network** of providers in the network. Since this plan offers more provider options, you will experience higher office visit copays and monthly premiums.

MEDICAL BENEFITS

Cigna | Open Access Plus (OAP) HSA Medical Plan

- You have the freedom to choose your doctor without the requirement of selecting a PCP and you may self-refer to specialists. You may use a network provider whose negotiated rates provide richer levels of benefits with claim forms filed by the providers. You may also obtain services using a non-network provider; however, you will be responsible for the difference between the covered amount and the actual charges and you may be responsible for filing claims.
- This plan is considered to be a High Deductible Health Plan (HDHP) linked to a special, tax-qualified Health Savings Account (HSA). You can contribute pre-tax money to your HSA up to IRS maximums to reduce your taxable income and save money on Federal income tax.
- You may use your HSA funds to pay for current eligible health care expenses or save for future expenses.

How the Health Savings Account (HSA) Works

The opportunity to establish and contribute to a Health Savings Account is available when you elect the HSA PPO medical plan option. It's like a personal, tax-free savings account for health care expenses that earns interest. Any unused money rolls over from year to year.

You may elect to make contributions into your account up to IRS maximums. IRS annual maximums for 2022 are:

- Employee: $3,650
- Family: $7,300
- Catch-up if you are 55 years of age or older: $1,000

The portion of your paycheck that you contribute to your HSA will be taken out before you pay federal income taxes, and most state taxes (excluding state taxes in AL, CA and NJ). Any contributions you make can be increased or decreased over the course of the year.

You can decide how to manage your money. The money in your HSA is yours to save and spend on eligible health care expenses whenever you need it, whether in this plan year or in future plan years. You can use the funds in your account to pay tax-free for qualifying out-of-pocket Medical, Dental and Vision expenses such as deductibles, coinsurance and copays.

Your account balance earns interest and the unused balance rolls-over from year to year. The money is yours to keep even if you leave the City of Fullerton, no longer participate in a high deductible health plan (like the HSA PPO) or retire. You may continue to make contributions to your HSA if you enroll in another qualified high deductible health plan, or elect COBRA continuation coverage of your HSA PPO coverage if your employment terminates.

Cigna Online, Mobile and Phone Access

Manage your care online by registering at www.mycigna.com. You can locate network providers, manage your claims, obtain health and wellness information and much more.

Once you've registered, download the Cigna app, available on the App Store and Google Play for on-the-go convenience.

You can reach customer service at 800-244-6224.

Cigna: Go to **www.mycigna.com** or call (800) 244-6224. Refer to the following medial plans when prompted:

- **Select HMO:** HMO, HMO POS, Network, Network POS - Southern California Select
- **Full HMO:** HMO, HMO POS, Network, Network POS - Southern California
- **HSA PPO:** PPO, PPO HDHP, EPO, EPO HDHP - PPO, PPO Tiered

Benefit Insurance Terms

Deductible
The set dollar amount a member must pay before insurance coverage for medical or dental expenses can begin. Usually, services that are subject to a copayment are not subject to the deductible.

Copayment (Copay)
The flat fee paid by the member when a medical or dental service is received. This is usually associated with doctor's office visits, prescription drugs or certain dental services under the OAP (PPO) plan.

Coinsurance
The percentage of the charges the member is required to pay for a medical or dental service in a plan. For example, on the Cigna OAP (PPO) Plan, Cigna will pay 80% of the covered claim and the member will pay 20% of the remaining amount after the deductible has been met.

Out-of-Pocket Maximum
The maximum amount the member will have to pay in a calendar year for eligible expenses in the medical plan. After reaching the Out-of-Pocket Maximum, the plan pays 100% of the allowable charges for covered services for the remainder of the calendar year.

Network Provider
A network provider is a hospital, doctor, medical group, dentist or other healthcare provider contracted to provide services to members at a contracted or discounted rate. Network providers are not allowed to "balance bill" members.

Reasonable Charges
Medical and Dental insurance companies determine if charges for a particular service are "reasonable" based on how much the average provider for a particular geographic area charges for a service.

Balance Bill
Out-of-Network (Non-Contracted) Providers can charge any amount they wish for a service. However, if that amount is higher than what the insurance company says is reasonable, the member may be responsible to pay the difference. Before seeking care with an Out-of-Network Provider, find out what their charges are and confirm the insurance company considers them "reasonable."

Calendar Year Maximum
Under the Dental PPO Plan, the Calendar Year Maximum is the total amount the insurance company will pay in a calendar year for services. Once a member has reached their Calendar Year Maximum, no further benefits will be paid until the next Calendar Year.

Medical Benefits

Virtual Visits

When you don't feel well, or your child is sick, the last thing you want to do is leave the comfort of home to sit in a waiting room. Now you don't have to.

Virtual Visits allow you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy. Use this service for minor issues such as colds, fever, flu, allergies, soar throats, headache, stomach ache and more. This service is part of your health benefits offered through Kaiser Permanente and Cigna.

Kaiser Permanente

Quickly and easily make your video visits online or via the Kaiser Permanente mobile app. You must be registered on Kaiser's website to take advantage of this service.
www.kaiserpermanente.org

Cigna

You may choose between two different health consultants – Amwell or MDLIVE. Both Amwell and MDLIVE operate national networks of board-certified doctors. Both have the capability to share consult notes with your primary care physician.
www.amwellforcigna.com
www.mdliveforcigna.com

Plan Name	Kaiser Permanente HMO	Cigna HMO Select
Network Name	Kaiser Facilities Only	Southern California Select
Health Benefits		
Lifetime Maximum	Unlimited	Unlimited
Deductible (Annual) - Individual - Family	 $0 $0	 $0 $0
Out-of-Pocket Maximum - Individual - Family	 $1,500 $3,000	 $1,000 $2,000
Co-Insurance (Plan Pays)	100%	100%
Office Visit Copay - Preventive Care - Primary Care Physician - Specialist Office Visit - Urgent Care - Virtual Visits	 No Charge $10 Copay $10 Copay $10 Copay $0 Copay	 No Charge $5 Copay $10 Copay $25 Copay $5 Copay
Hospitalization - Inpatient - Outpatient	 No Charge $10 Copay	 $100 Copay $50 Copay
Lab and X-Ray - Diagnostic - Complex	 No Charge No Charge	 No Charge $100 Copay
Emergency Services	$50 Copay	$50 Copay
Chiropractic	Not covered	$5 Copay PCP $10 Copay Specialist Unlimited visits
Pharmacy Benefits		
Pharmacy Deductible	$0	$0
Retail Pharmacy - Generic Formulary - Brand Name Formulary - Non-Formulary - Supply Limit	 $10 Copay $10 Copay N/A 100 Days	 $5 Copay $20 Copay $40 Copay 30 Days
Mail Order Pharmacy - Generic Formulary - Brand Name Formulary - Non-Formulary - Supply Limit	 $10 Copay $10 Copay N/A 100 Days	 $5 Copay $20 Copay $40 Copay 90 Days

Medical Benefits

Plan Name	Cigna HMO Full	Cigna OAP	
Network Name	Southern California	PPO, PPO Tiered	Non-Network
Health Benefits			
Lifetime Maximum Benefit	Unlimited	Unlimited	
Calendar Year Deductible - Individual - Family	 $0 $0	 $3,000 $6,000	 $6,000 $12,000
Out-of-Pocket Maximum - Individual - Family	 $1,500 $3,000	 $6,000 $12,000	 $12,000 $24,000
Co-Insurance (Plan Pays)	100%	80%	60%
Office Visit Copay - Preventive Care - Primary Care Physician - Specialist Office Visit - Urgent Care - Virtual Visits	 No Charge $20 Copay $20 Copay $25 Copay $20 Copay	 No Charge Deductible, 20% Deductible, 20% Deductible, 20% Deductible, 20%	 Deductible, 40% Deductible, 40% Deductible, 40% Deductible, 40% N/A
Hospitalization - Inpatient - Outpatient	 $100 Copay $50 Copay	 Deductible, 20% Deductible, 20%	 Deductible, $500 Copay, 40% Deductible, $350 Copay, 40%
Lab and X-Ray - Diagnostic - Complex	 No Charge $100 Copay	 Deductible, 20% Deductible, 20%	 Deductible, 40% Deductible, 40%
Emergency Services	$50 Copay	Deductible, 20%	
Chiropractic	$20 Copay Unlimited visits	Deductible, 20% Max 30 Visits/Year	Deductible, 40%
Pharmacy Benefits			
Pharmacy Deductible	$0	Medical Deductible Applies	N/A
Retail Pharmacy - Generic Formulary - Brand Name Formulary - Non-Formulary - Supply Limit	 $5 Copay $20 Copay $40 Copay 30 Days	 $10 Copay $40 Copay $60 Copay 30 Days	 Not Covered Not Covered Not Covered 30 Days
Mail Order Pharmacy - Generic Formulary - Brand Name Formulary - Non-Formulary - Supply Limit	 $5 Copay $20 Copay $40 Copay 90 Days	 $30 Copay $120 Copay $180 Copay 90 Days	 Not Covered Not Covered Not Covered N/A

MEDICAL BENEFITS

Tips for Using Your Medical Benefits

1 Utilize your free preventive care benefits to stay healthy.
Preventive care benefits are covered at no charge to you. Regular preventive care can reduce the risk of disease, detect health problems early, protect you from higher costs down the road, and most importantly… save your life! Take advantage of these no cost benefits now to hopefully avoid major illnesses and costs in the future.

2 Use urgent care centers versus hospital emergency rooms whenever possible.
Frequently, patients seek the services of the hospital emergency department for ailments or injuries that could be treated more economically, and just as effectively, at an urgent care center. It is not always easy to determine when you should choose urgent care over the hospital emergency department. The following lists offer some guidance, but are not necessarily all-inclusive.

Examples of URGENT CARE situations	Examples of EMERGENCY situations
Any illness or injury that would prompt you to see your primary care physician including but not limited to: • Accidents and falls • Sprains • Back problems • Breathing difficulties • Abdominal pain • Minor bleeding/cuts • High fever • Vomiting, diarrhea or dehydration • Severe sore throat or cough • Mild to moderate asthma	Any accident or illness that may lead to loss of life or limb, serious medical complication or permanent disability including but not limited to: • Chest pain* • Seizure or Shock • No pulse • Sudden dizziness, loss of coordination or balance • Severe abdominal pain • Severe or uncontrollable bleeding • Broken bones or compound fractures • Spinal cord or back injury • Severe burns • Major head injuries • Ingestion of poisons or obstructive objects • Animal, snake or human bites

*If you believe you may be experiencing a heart attack, call 911 immediately! Do not drive yourself to the emergency room!

3 Use generic and over the counter drugs when available.
The best way to save on prescriptions is to use generic or over the counter medications as opposed to brand name drugs. Generic drugs must use the same active ingredients as the brand name version of the drug. A generic drug must also meet the same quality and safety standards.

4 Use the mail-order prescription drug benefit for maintenance medications.
The mail order pharmacy is a fast, easy and convenient way to save time and money on your maintenance medications. You can order additional supplies of medication at a discount. See carrier provisions for details.

Educational Video

Deductibles, Copays, Coinsurance, and Out-of-Pocket Maximums
http://video.burnhambenefits.com/terms/

High Deductible Health Plans and Health Savings Accounts
http://video.burnhambenefits.com/hdhp/

Weight Management and Diabetes Prevention

Coming Soon...Omada for Cigna available January 1, 2022

Omada is a digital lifestyle change program focused on building healthy, long-lasting habits.

- Designed to help you lose weight, gain energy and reduce the risks of type 2 diabetes and heart disease
- Surrounds you with the tools and support you need to make lasting, meaningful changes to the way you eat, move, sleep and manage stress — one small step at a time
- Teaches healthy habits - guided by interactive online lessons and support groups, professional health coaching and a digitally connected scale
- There is no additional cost if you or your covered adult dependents are enrolled in the City's medical plan offered through Cigna, are at risk for type 2 diabetes or heart disease, and are accepted into the program.
- In 2022, you may be eligible to earn an incentive for participating in the Omada program. Visit myCigna.com for more information.

Kaiser | Healthy Balance

If you are enrolled in the Kaiser medical plan, you may be eligible to enroll in Kaiser's Healthy Balance program, a weight management and diabetes prevention program that promotes healthy eating, daily habits and getting active. Speak with your doctor to see if you are at risk for Type II diabetes and eligible to enroll in Kaiser's Healthy Balance program.

WELLNESS

Cigna | Wellness Reward

Earn up to $300 in debit or gift cards

Cigna members can participate in their voluntary wellness program, Motivate*Me*, to complete various wellness activities to earn up to $300 in rewards. Rewards may be available in debit or gift cards. Complete any of the wellness activities listed below and earn rewards along the way. The maximum amount of rewards you can earn in 2022 is $300.

Activity Goal	Value
• Complete a confidential online health assessment on mycigna.com	$50
• Complete an annual physical exam with your primary care provider or ob/gyn	$150
• Make progress towards a personal health goal by completing a Telephonic Health Coaching session	$50
• Complete a preventive cancer screening (i.e., mammogram, colonoscopy or cervical cancer screening)	$50
• Enroll and complete Cigna Healthy Pregnancies, Healthy Babies program	$150 in the 1st trimester and $75 in the 2nd trimester
• Flu/COVID-19 vaccine	$50/$25
• Participate in Cigna's upcoming Fitness Challenge - watch for more information	$50
• Diabetes prevention program with Omada	$100
• EAP Goal - take the pledge to learn more about the City's EAP benefit by attending an EAP seminar or completing a self-assessment	$50
• Online health coaching - choose from a number of online health improvement coaching sessions. Examples include: nutrition, weight management, stress, quit tobacco, asthma, heart disease, and much more.	$25

Accessing Cigna's Wellness Program

Go to www.mycigna.com to see a complete list of rewardable wellness activities and get started today!

Kaiser Permanente | Wellness Program

Take advantage of Kaiser's Wellness Programs and Classes

Kaiser offers wellness programs and classes for their members at virtually no cost or at a discount. Examples of available classes include:

- Diet and nutrition
- Chronic conditions
- Quitting smoking

Accessing Kaiser's Wellness Program

Check out https://healthy.kaiserpermanente.org/southern-california/health-wellness for additional programs and discounts.

Dental Benefits

The City provides you with a choice of two dental plans through Delta Dental of California, DeltaCare USA (DHMO) and Delta Dental PPO. Both offer comprehensive dental coverage, quality care and excellent customer service.

DeltaCare USA DHMO

- You are required to select a general dentist who is a member of the DeltaCare USA network to provide your dental care. If specialty care is needed, your general dentist will provide the necessary referral.
- For covered procedures, you'll pay the pre-set copay or coinsurance fee described in your DHMO copay schedule. Please keep a copy of the schedule to refer to when utilizing your dental care. This will show the applicable copays that apply to all of the dental services that are covered under this plan.

Delta Dental PPO

- You can choose any dentist you wish for your dental care.
- When you utilize an in-network dentist for covered services, costs may be up to 30% less than if you visited an out-of-network dentist.
- You may also obtain services using a non-network dentist; however, you will be responsible for the difference between the covered amount and the actual charges and you may be responsible for filing claims.

Plan Name	Delta Dental DHMO	Delta Dental PPO	
Network Name	DeltaCare USA	Delta Dental PPO	Non-Network
Dental Benefits			
Calendar Year Maximum	Unlimited	$1,500	$1,500
Calendar Year Deductible - Individual - Family	 $0 $0	 $50 $150	 $50 $150
Preventive - Exams, X-Rays, Cleanings	No Charge for Most Services	No Charge	No Charge*
Basic Services - Fillings, Oral Surgery, Endodontics, Oral Surgery	See Copay Schedule	Deductible, 20%	Deductible, 20%*
Major Services - Periodontics, Crowns, Prosthetics	See Copay Schedule	Deductible, 50%	Deductible, 50%*
Orthodontia - Covered Members - Orthodontia Limit	 Children & Adults $1,700 Child / $1,900 Adult	 N/A Not Covered	

*Dentists who are out-of-network have not agreed to pricing, and may bill you for the difference between what Delta Dental pays them and what the dentist usually charges.

Finding a Dental Provider

Go to **www.deltadentalins.com** or call (800) 422-4234 for DHMO or (800) 335-8227 for PPO. DHMO participants should refer to the "DeltaCare USA" network, and PPO participants should refer to the "Delta Dental PPO" network when prompted.

Note

We recommend you ask your dentist for a pre-treatment estimates if total charges are expected to exceed $300. Pre-treatment estimates enable you and your dentist to know in advance what the payment will be for any service that may be in question.

Vision Benefits

The City provides the option to enroll in vision benefits through Vision Service Plan (VSP).

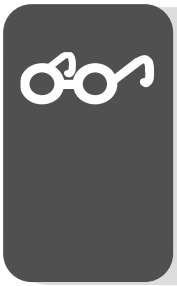
Vision Service Plan (VSP)

- VSP provides professional vision care and high quality lenses and frames through a large network.
- You will receive greater benefits if you utilize a network provider.
- If you utilize an out-of-network provider, you will be responsible for paying all charges at the time of your appointment and will be required to file an itemized claim.

Kaiser Permanente | Vision Allowance

- If you enroll in the Kaiser Permanente medical HMO option, you will be automatically enrolled in the Kaiser Vision plan at no extra charge. Routine eye exams are covered as part of the basic medical benefits.
- You must utilize these vision benefits from a Kaiser Permanente facility. Eyewear prescriptions from non-Kaiser Permanente providers cannot be filled at a Kaiser Permanente facility under this benefit.

Plan Name	VSP PPO		Kaiser Permanente Vision Allowance
Network Name	**VSP Signature**	**Non-Network**	**Kaiser Facilities Only**
Vision Benefits			
Exam & Materials Copay	$10 Copay	N/A	N/A
Examination	No Charge after Copay	$50 Reimbursement	Subject to Medical Plan Copay
Lenses - Single Vision - Bifocal - Trifocal	 No Charge after Copay No Charge after Copay No Charge after Copay	 $50 Reimbursement $75 Reimbursement $100 Reimbursement	Lenses, Frames, and Contact Lenses Are Covered in Full Up to the $100 Plan Allowance
Frames	$130 Allowance, then 20% Savings	$70 Reimbursement	
Contact Lenses	In Lieu of Frames and Lenses		
- Cosmetic / Elective	$130 Allowance	$105 Reimbursement	
Laser Vision Correction	Discounts Apply	Not Covered	Not Covered
Benefit Frequency			
Examination	Every 12 Months		Every 12 Months
Lenses	Every 12 Months		Every 24 Months
Frames	Every 24 Months		Every 24 Months
Contact Lenses	Every 12 Months		Every 24 Months



Finding a Vision Provider

VSP: VSP has the largest network of private-practice eye care doctors in the industry. VSP's network includes 50,000 access points nationwide. VSP also contracts with Costco Optical, Visionworks, and other affiliate retail providers. Please note, benefits may vary at affiliate locations. Go to **www.vsp.com** or call (800) 877-7195. Refer to the "VSP Signature" network when prompted.

Kaiser: Go to **www.kaiserpermanente.org** or call (800) 464-4000.

Flexible Spending Accounts

FSA Plan Year: January 1 - December 31

Igoe Administrative Services (Igoe) administers the City's Flexible Spending Accounts (FSAs). FSAs are special tax-advantaged accounts used to pay for eligible out-of-pocket health care and dependent care expenses. If elected, your account(s) will be funded with tax-free dollars using convenient payroll deductions. Only expenses for services incurred during the plan year are eligible for reimbursement from your account(s). As you incur health care and/or dependent care expenses throughout the year, submit a claim to Igoe for reimbursement. All receipts should be itemized to reflect what product or service was purchased. Credit card receipts are not sufficient per IRS guidelines. Visit goigoe.com for additional information.

City of Fullerton | Health Care FSA

This plan is used to pay for expenses not covered under your health plans, such as deductibles, coinsurance, copays and expenses that exceed plan limits. You may defer up to $2,750 pre-tax per year.*

Eligible health care expenses include:

Coinsurance, Copays and Deductibles

Medical and Prescriptions

Dental and Orthodontia

Eye Exams, Eyeglasses and Lasik Eye Surgery

*2022 FSA IRS limits not announced at time of production of this guide.

City of Fullerton | Dependent Care FSA

This plan is used to pay for eligible expenses you incur for child care, or for the care of a disabled dependent, while you work. Employees may defer up to $5,000 pre-tax per year.

Eligible dependent care expenses include:

Licensed nursery schools, qualified childcare centers, after school programs, summer camps (under age 13), preschool

Adult daycare facilities

Important FSA Rules

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

Your FSA elections will expire each year on December 31st. If you plan to participate in the FSA for the upcoming plan year, you are required to re-enroll. **Your 2022 elections are due to Human Resources by December 3, 2021.**

Health Care FSA

The Healthcare FSA includes a 2.5 month grace period that allows you to incur claims through March 15, 2022. All 2021 claims must be filed by March 31, 2022.

Important Note for HSA Medical Participants:
If you enroll in the HSA PPO Medical Plan and contribute to your HSA account, you may only participate in the Limited Purpose Health Care FSA Plan to cover out-of-pocket Dental and Vision expenses.

Dependent Care FSA

Unused funds will NOT be returned to you or carried over to the following year. The Dependent Care FSA includes a 2.5 month grace period that allows you to incur claims through March 15, 2022. All 2021 claims must be filed by March 31, 2022.

Educational Video

Click here to learn more about how Health Care and Dependent Care FSAs work.
Flexible Spending Accounts
http://video.burnhambenefits.com/fsa/

INCOME PROTECTION BENEFITS

Disability Insurance

Disability insurance provides benefits that replace part of your lost income when you become unable to work due to a covered injury or illness.

The Standard | Long Term Disability

City of Fullerton offers you Long Term Disability (LTD) benefits through The Standard to provide income replacement if you become disabled for an extended period of time.

Unit	Long Term Disability Benefit
Executive	66-2/3% of the first $18,000 of pre-disability earnings, reduced by deductible income; 55 day waiting period
Confidential/NR, Management, Fire Management	66-2/3% of the first $15,000 of pre-disability earnings, reduced by deductible income; 55 day waiting period
Federation, Police Officers Association, Police Dispatcher	66-2/3% of the first $10,500 of pre-disability earnings, reduced by deductible income; 55 day waiting period
Firefighters	The City shall reimburse the Association up to $23.50 per month per employee, but no more than the actual premium for a single long-term disability policy.

Life/AD&D Insurance

The City provides you with financial protection for your family/beneficiaries with Life and Accident Insurance.

The Standard |Basic and Voluntary Life/AD&D

Life insurance protects your family or other beneficiaries in the event of your death while you are still actively employed with the City.

Accidental Death and Dismemberment (AD&D) coverage provides an additional benefit to your beneficiary if your death is due to a covered accident or injury.

Basic Life/AD&D	Coverage Level
City Council Members and Police Dispatch	Flat $10,000
Police and Firefighters	Flat $20,000
Federation	Flat $25,000
Executive, Management, Confidential/NR, Police Management and Fire Management	1x base annual salary to a maximum of $200,000

INCOME PROTECTION BENEFITS

Life/AD&D Insurance

The City provides you with financial protection for your family/beneficiaries with Life and Accident Insurance.

The Standard | Voluntary Life/AD&D

This is a voluntary benefit - if elected, enrollment is required

In addition to the City-provided Basic Life/AD&D benefits, you may elect to purchase additional Term Life/AD&D insurance at discounted group rates provided by The Standard. You pay for this coverage with after-tax dollars through convenient payroll deductions.

Covered Individual	Voluntary Life/AD&D Coverage Level	Guarantee Issue*
Employee	You may purchase coverage for yourself in increments of $10,000 up to the lesser amount of 1) 5x annual earnings or 2) $500,000.	$200,000
Spouse or Domestic Partner	If you buy coverage for yourself, you may also purchase coverage for your eligible spouse or domestic partner. Benefits for your spouse or domestic partner are available in increments of $10,000 up to lesser of 1) 100% of your voluntary life election or 2) $150,000. Benefits shall not to exceed 100% of your employee election.	$30,000
Child(ren)	If you buy coverage for yourself, you may also purchase coverage for your eligible dependent child(ren). Benefits for your child(ren) are available in increments of $1,000 up to a maximum benefit of $10,000, not to exceed 100% of your employee election.	$10,000

***Guarantee Issue:** Guarantee issue is a pre-approved amount of coverage that does not require you to provide proof of good health, and is available to you during your initial eligibility period (upon hire).

If you are no longer in your initial eligibility period, you may enroll in Voluntary Life/AD&D insurance anytime during the year as long as you provide proof of good health. To provide proof of good health, you will be asked to complete a health questionnaire (Evidence of Insurability) and are subject to insurance carrier approval. The Standard may approve or decline coverage based on a review of your health history.

Choosing a Beneficiary

A beneficiary is a person or entity who you designate to receive your death benefits. Choosing a beneficiary and keeping your beneficiary up-to-date is an essential part of owning life insurance. Please remember to review your beneficiary designation as new situations arise, such as the birth or adoption of a child, marriage, or divorce. You may call the Human Resources Department for a copy of the Beneficiary Designation Form as needed or visit the City's intranet under Benefits and Services / Life Insurance.

SUPPLEMENTAL BENEFITS

You may purchase additional insurance from The Standard that will help to cover additional out-of-pocket expenses. These policies offer direct-to-the-policyholder cash payouts to help cover what other insurance may not. Your premiums are paid through payroll deductions on an after-tax basis. These policies are portable, which means that you can keep them should you change employers or retire.

The Standard | Accident Insurance

This is a voluntary benefit available to FMEF, Management and Confidential Units only- if elected, enrollment is required

The Standard's Accident insurance will pay you a lump sum benefit to help cover your out-of-pocket expenses and extra bills that can occur for covered injuries due to an accident.

- Coverage is available for you, your spouse and/or dependent children. You must elect coverage for yourself to elect coverage for your spouse or children.
- For covered accidental injuries, fixed benefits are paid directly to you, regardless of any other coverage. Benefits are paid according to a fixed schedule that includes benefits for hospitalization, fractures and dislocations, emergency room visits, major diagnostic exams, physical therapy, and more.

Examples of covered injuries include burns, bone fractures and dislocations, accidental death and dismemberment

Examples of covered services include emergency room treatment, hospitalization, pain management and more

Semimonthly Rates			
Employee	Employee & Spouse	Employee & Child(ren)	Employee, Spouse & Child(ren)
$3.34	$5.31	$6.64	$10.35

The Standard | Hospital Indemnity

This is a voluntary benefit available to FMEF, Management and Confidential Units only- if elected, enrollment is required

The Standard's Hospital Indemnity insurance can help provide financial protection for covered individuals by paying a lump sum benefit if you are admitted to the hospital, as well as a daily benefit for days spent confined. It pays a benefit directly to you for hospital related events, regardless of your treatment costs or other insurance coverage you might have. It can help cover out-of-pocket expenses such as copays, deductibles and out-of-network charges, as well as everyday living expenses. Benefits are paid directly to the insured and do not coordinate with any other benefit payments.

Benefits	
Hospital Admission (maximum 1 per calendar year)	$1,000 per day
Daily Hospital Confinement (maximum 15 days per stay)	$100 per day
Critical Care Unit Admission* (maximum 1 per calendar year)	$1,000
Daily Critical Care Unit Confinement* (maximum 15 days per stay)	$100 per day

*Payable in addition to the Hospital Admission and/or Daily Hospital Confinement benefit you may be eligible to receive.

Semimonthly Rates			
Employee	Employee & Spouse	Employee & Child(ren)	Employee, Spouse & Child(ren)
$6.88	$14.73	$13.45	$22.80

The Standard | Critical Illness

This is a voluntary benefit available to FMEF, Management and Confidential Units only- if elected, enrollment is required

Critical Illness insurance is designed to help you and your family offset the financial effects of a catastrophic illness with a lump sum benefit payable to you if you are diagnosed with a covered illness. The benefit is based on the amount of coverage in effect on the date of diagnosis of a critical illness, or the date treatment is received.

Covered conditions include:

- Heart attack
- Severe stroke
- Invasive cancer
- End stage renal (kidney) failure
- Major organ failure
- Coma
- Paralysis of two or more limbs
- Loss of sight
- Occupational hepatitis
- ALS (Lou Gehrig's disease)
- Advanced Alzheimer's disease
- Advanced Multiple Sclerosis
- Advanced Parkinson's disease
- Benign brain tumor
- Bone marrow transplant
- Loss of hearing
- Loss of speech

All election amounts are guarantee issue during the initial enrollment period with no medical underwriting required. Future increases in benefits or new enrollments will be subject to health questions.

Covered Individual	Available Coverage Amounts
Employee	Flat amount of $10,000 or $20,000
Spouse	Flat amount of $5,000 or $10,000 (not to exceed 50% of employee coverage amount)
Child(ren) up to age 26	Automatically covered at 25% of your covered amount
Wellness benefit (annual)	$50

Semimonthly Attained Age Premiums					
Coverage Amount	Age Band				
	< 30	30-39	40-49	50-59	60-64
$5,000	$1.28	$1.90	$3.85	$7.95	$15.23
$10,000	$2.55	$3.80	$7.70	$15.90	$30.45
$20,000	$5.10	$7.60	$15.40	$31.80	$60.90

Employee Assistance Program

Cigna | Employee Assistance Program

When you're facing challenges - big or small - the Employee Assistance Program (EAP) is here to connect you with real people who can help you find real solutions. The EAP program provides you and your household members with free, confidential assistance to help with personal or professional problems that may interfere with work or family responsibilities and obligations.

Cigna's EAP can connect you with a range of services, including emotional support, financial assistance, home/life support, and legal assistance.

You and your household members can:

- Connect over the phone or through live chat, and receive a referral to licensed clinicians and consultants
- Receive up to 5 face-to-face counseling sessions with a counselor in your area
- Have 24/7 access to meet with licensed mental health professionals and referrals to supportive resources virtually on your phone, tablet or home computer
- Access to live, on-demand EAP webcasts and online programs to offer something different than traditional counseling
- Access to quick and confidential help from legal and financial experts
- 100% confidential
- Available to anyone in your household
- No additional cost to you

Accessing the EAP

Go to **www.cignabehavioral.com** (Employer ID: cityoffullerton) or you may call (877) 622-4327 to be immediately connected to an EAP counselor.

Travel Assistance Program

The Standard | Travel Assistance Program

City of Fullerton provides a Travel Assistance Plan to you at no cost. This program, provided by The Standard, offers emergency assistance when you and/or your family are traveling 100+ miles away from home or internationally for up to 180 days for business or pleasure.

With the Travel Assistance Program, trained professionals will assist you with passport/visa/weather/currency information, emergency ticket/credit card/passport replacement, funds transfer, assistance with missing baggage, 24/7 phone access to registered nurses for health related issues, emergency evacuation and medically necessary repatriation, connection to medical care providers/interpreter services/local attorney/consular office/bail bond services, return of travel companion, logistical arrangements for ground transportation, housing and/or evacuation in the event of political unrest and social instability. See contract for limitations.

Accessing the Travel Assistance Program

If you are in the US, call (800) 527-0218. If you are outside of the US, call (410) 453-6330. You may also send an email to **assistance @uhcglobal.com**.

RETIREMENT BENEFITS

ICMA-RC | Plan 457

You are encouraged to participate in the City's 457 Deferred Compensation plan. This plan allows you to fund your retirement with pre-tax dollars. If elected, the contributions you make will reduce your taxable income for the year. These contributions and all associated earnings are not subject to tax until you withdraw the funds. You can make withdrawals from your account when you leave employment with the City. You have the ability to take payments as needed, or request scheduled automatic payments. You maintain control over your investments and continue to benefit from tax deferral even if you leave.

CalPERS | Retirement Plan

The contribution amounts you and the City make under this plan are based on your bargaining unit and hire date into CalPERS.

Miscellaneous Employee Groups	Retirement Formula	Member Rate (EPMC)		Employee Cost Share and Employer Rate		Total		
		City Paid[1]	Employee Paid	Employee Cost Share	Employer Normal Cost Rate	Total PERS Rate	Paid by City	Paid by Employee
FMA, FMEF, FPOA-D	2% @ 55	7.000%	0.000%	7.000%	9.440%	16.440%	9.440%	7.000%
FFA (non-Safety)	2% @ 55	7.000%	0.000%	10.000%	9.440%	16.440%	6.440%	10.000%
Confidential	2% @ 55	6.000%	1.000%	1.958%	9.440%	16.440%	13.482%	2.958%
Executive	2% @ 55	0.000%	7.000%	1.958%	9.440%	16.440%	7.482%	8.958%
Council Appointed City Manager	2% @ 55	0.000%	7.000%	1.958%	9.440%	16.440%	7.482%	8.958%
PEPRA - All Miscellaneous includes FFA/FPOA-S Trainees (hired on or after1/1/2013)	2% @ 62	0.000%	0.000%	7.000%	9.440%	16.440%	9.440%	7.000%
Miscellaneous Unfunded Liability Contribution FY 21/22—$5,944,362								
Safety Employee Groups								
FPMA, FPOA-S (hired on or before 12/22/12)	3% @ 50	9.000%	0.000%	9.252%	19.550%	28.550%	19.298%	9.252%
FPMA, FPOA-S (hired after 12/22/12)	3% @ 55	9.000%	0.000%	9.000%	19.550%	28.550%	19.550%	9.000%
PEPRA—FPMA, FPOA-S (hired on or after 1/1/2013)	2.7% @ 57	0.000%	0.000%	12.500%	19.550%	32.050%	19.550%	12.500%
Council Appointed Police Chief	3% @ 55	7.000%	2.000%	6.357%	19.550%	28.550%	20.193%	8.357%
FFA (hired on or before 12/22/12)	3% @ 50	9.000%	0.000%	12.557%	19.550%	28.550%	15.993%	12.557%
FFA (hired after 12/22/12)	3% @ 55	9.000%	0.000%	12.000%	19.550%	28.550%	16.550%	12.000%
PEPRA—FFA (hired on or after 1/1/2013)	2.7% @ 57	0.000%	0.000%	12.500%	19.550%	32.050%	19.550%	12.500%
FFMA (hired on or before 12/22/12)	3% @ 50	7.000%	2.000%	9.557%	19.550%	28.550%	16.993%	11.557%
FFMA (hired after 12/22/12)	3% @ 55	7.000%	2.000%	9.000%	19.550%	28.550%	17.550%	11.000%
Executive Fire Chief	3% @ 50	0.000%	9.000%	8.164%	19.550%	28.550%	11.386%	17.164%
Safety Unfunded Liability Contribution FY 21/22—$13,534,121								

[1] Per Resolution 2020-59, the City of Fullerton pays the member rate (or a percentage thereof) on behalf of the employee and reports the payment as compensation to CalPERS.

[2] Per the Shared Command Staff agreement with the City of Brea, the Fire Chief is currently an employee of the City of Brea.

RESOURCES AND CONTACTS

Coverage and Carrier	Member Services	Carrier Website/email address
Medical		
Cigna HMO and PPO Medical	(800) 244-6224	**www.cigna.com**
Kaiser Permanente HMO Medical	(800) 464-4000	**www.kaiserpermanente.org**
Dental		
Delta Dental	(800) 422-4234 DHMO (800) 765-6003 PPO	**www.deltadentalins.com**
Vision		
VSP Vision	(800) 877-7195	**www.vsp.com**
Reimbursement Account Plans		
Igoe Administrative Services	Phone: (800) 633-8818 Opt #1 Email: flex@goigoe.com	**www.goigoe.com**
Life/AD&D, Long Term Disability, Accident, Hospital Indemnity, Critical Illness		
The Standard	(818) 386-6200	**www.thestandardins.com**
Employee Assistance Program		
Cigna EAP	(877) 622-4327	**www.cignabehavioral.com**
Retirement Savings		
ICMA- RC	(866) 838-9365 Ryan Carpenter	**www.icmarc.org**
CalPERS	(888) 225-7377	**www.calpers.ca.gov**
Retirement Medical Billing		
Benefit Coordinators Corporation (BCC) PO Box 3595 Attn: Retiree Administration Two Robinson Plaza, Suite 200 Pittsburgh, PA 15205-1324	(800) 685-6100 Mon-Thur: 5 AM – 5 PM PST Friday: 5 AM – 3 PM PST	

Burnham Advocate (800) 391-6812

The Burnham Advocate toll-free customer service help-line can provide assistance with insurance related issues when you are unable to resolve them directly with the insurance carriers. With the Burnham Advocate help-line, you will receive fast, skilled assistance with Medical, Dental and Vision provider issues, referral assistance, and claims management.

ANNUAL NOTICES

To obtain more information regarding any of the information listed in this packet, or if you have any questions, please contact:

City of Fullerton
Human Resources
714.738.6834
Christine.pilapil@cityoffullerton.com
303 W. Commonwealth Avenue | Fullerton, CA 92832
Plan Effective Date: 01/01/2022

Contents

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Important Notice from City of Fullerton
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 City of Fullerton under the Cigna and Kaiser (HMO & PPO) 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. City of Fullerton has determined that the prescription drug coverage offered under the above plan option(s), 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 15th through December 7th. 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 Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage with City of Fullerton will not be affected. If you decide to join a Medicare drug plan and drop your current medical plan coverage, be aware that you and your dependents will be able to get this coverage back (for example, at the next annual open enrollment period or upon incurrence of a special enrollment event).

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 City of Fullerton 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 Your Medicare Prescription Drug Coverage Options

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll receive 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; or
- Call (800) MEDICARE or (800) 633-4227. TTY users should call (877) 486-2048.

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

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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

Contact the person listed on **page 24** for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Fullerton changes. You also may request a copy of this notice at any time.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

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 states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- 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 the medical plan.

To obtain more information on WHCR benefits, please call or email the person listed on **page 24**.

NEWBORN AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

To obtain more information, please call or email the person listed on **page 24**.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependent (s) (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or if the employer stops contributing toward your or your dependents' other coverage).

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 birth, adoption, or placement for adoption.

To obtain more information, please call or email the person listed on **page 24**.

MEDICAID & CHILDREN'S HEALTH INSURANCE PROGRAM

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 are a California resident, please contact the California Department of Health Care Services to see if you may be eligible for premium assistance:

Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

In addition, if you live in one of the States listed on the following pages, you may also be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2021. Contact your State for more information on eligibility.

KANSAS – Medicaid

Website: **https://www.kancare.ks.gov/**
Phone: 1-800-792-4884

ANNUAL NOTICES

HIPAA NOTICE OF PRIVACY PRACTICES

Your Information | Your Rights | Our Responsibilities

Health Care Flexible Spending Account Benefits (RAP)

This Notice describes how medical information about you that we receive from your health care flexible spending account may be used and disclosed and how you can get access to this information. Please review it carefully.

Contact the person listed on **page 24** for further information.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell your family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Bill for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

ANNUAL NOTICES

HIPAA NOTICE OF PRIVACY PRACTICES

Your Rights	**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.
Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with you health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on Page 22 of this booklet. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. • We will not retaliate against you for filing a complaint.

ANNUAL NOTICES

HIPAA NOTICE OF PRIVACY PRACTICES

Your Choices

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described on below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care. • Share information in a disaster relief situation. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	**Example:** A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	**Example:** We use health information about you to develop better services for you.
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	**Example:** We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	**Example:** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HIPAA NOTICE OF PRIVACY PRACTICES

Our Uses and Disclosures (continued)	How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.
Help with public health and safety issues	• We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: • For workers' compensation claims. • For law enforcement purposes or with a law enforcement official. • With health oversight agencies for activities authorized by law. • For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, visit: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of Notice

This Notice is current as of 01/01/2022.

WELLNESS PROGRAM DISCLOSURE

Notice must be given by any group health plan offering a wellness program that requires individuals to meet a standard related to a health factor in order to obtain a reward.

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means.

Contact the person listed on **page 24** and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NOTES

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A BALDWIN RISK PARTNER

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Learn more at **www.burnhambenefits.com**

This Employee Benefits Guide provides an overview of some of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment. Neither is it a legal plan document. If there is a disagreement between this guide and the plan documents, the plan documents will govern.

In addition, the plans described in this guide are subject to change without notice. Continuation of any benefit plan or coverage is at the City's discretion and in accordance with federal and state laws. If you need additional information or have any questions about the benefit program, please contact the Human Resources Department.