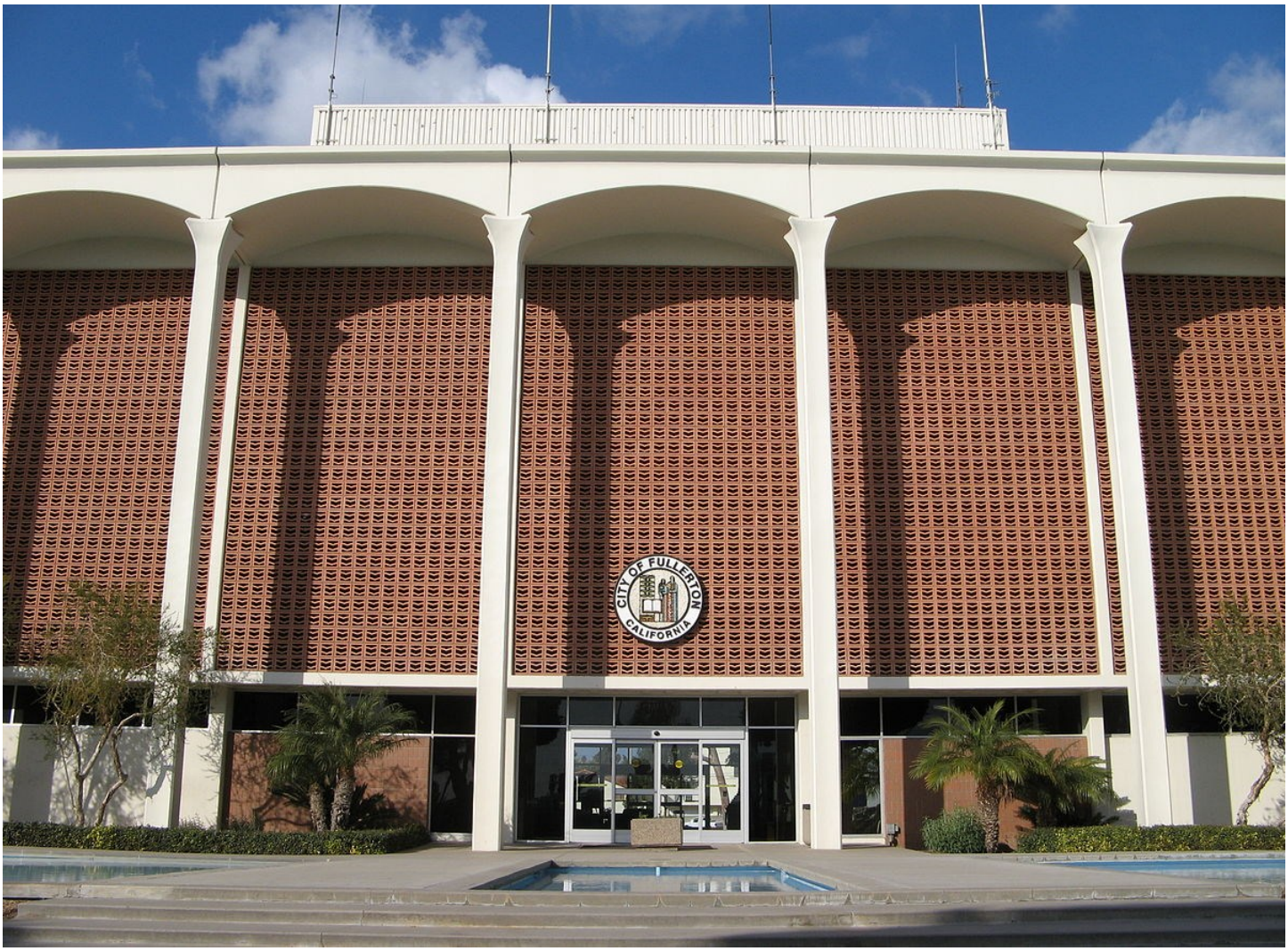
Employee

Benefits

Guide 2022

RETIREES UNDER 65



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
Christine Pilapil, Human Resources
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CONTENTS

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.**

ELIGIBILITY & ENROLLMENT INFORMATION

Retiree Eligibility

If you retired from the City, you and your eligible dependents may be eligible to participate in the City sponsored Medical and Dental plans. 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 retiree, you may enroll at the following times:

- 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

When Coverage Begins

Coverage will begin for all benefits effective January 1, 2021 and will continue through December 31, 2022 (or until you cease to be eligible for coverage).

Adding or Deleting Dependents

You may add eligible dependents to the City's sponsored medical and dental plans during Open Enrollment.

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.

Retiree Medical Plan Options

Retirees and Dependents Who Are Not Eligible for Medicare

Your medical plan options are the same as those available to active employees. 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 per paycheck 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 maximums for 2022 are:

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

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 no longer participate in a high deductible health plan (like the HSA PPO). 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.

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 POS program.

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 United HealthCare PPO Plan, United HealthCare 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 POS 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.

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.

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**
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, Kaiser, Anthem, Blue Shield, Health Net & UnitedHealthcare (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 14** 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 14**.

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 14**.

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 14**.

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**
Phone	1-866-444-EBSA (3272)
U.S. Department of Health and Human Services—Center for Medicare & Medicaid Services	
Website	**www.cms.hhs.gov**
Phone	1-877-267-2323, Menu Option 4, Ext. 61565

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

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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.