



CITY OF
FULLERTON

**EMPLOYEE
BENEFITS
GUIDE**

2023



Retiree with Medicare



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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Annual Notices

City of Fullerton plans are governed by a combination of federal, state, and City of Fullerton rules and regulations. This includes a requirement for the City of Fullerton to provide certain notices annually to plan participants. Our policy is to distribute these notices to new hires and each year during open enrollment. You may also request a copy of the notices by contacting the Human Resources Department or visiting the City of Fullerton's website (<https://www.cityoffullerton.com/government/departments/human-resources/benefits-2023>).

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 2023 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

Who May Enroll

If you retired from the City, you and your eligible dependents are 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 employee, 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, 2023 and will continue through December 31, 2023 (or until you cease to be eligible for coverage).

Adding or Deleting Dependents

You may add eligible dependents to the City's 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 Plans

Eligibility: Age 65 and over

Medicare Coverage

You are automatically signed up for Medicare Part A when you turn 65 if you are receiving Social Security payments. If you are not already receiving Social Security retirement benefits, you should contact the Social Security Administration three to six months before your 65th birthday to sign up for Medicare. You can sign up for Medicare Part A, even if you do not plan to retire at age 65.

There are three parts to what is known as the Original Medicare Plan:

- **Part A:** Hospital insurance that helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay), some home health care, and hospice care.
- **Part B:** Medical insurance that helps pay for doctors' services, outpatient hospital care, and many other medical services and supplies that are not covered by hospital insurance.
- **Part D:** Prescription insurance that covers prescription drugs.

Medicare Plans

Medicare provides essential health care coverage for retirees, but it doesn't pay all of your health care costs. That's why most people supplement their Medicare coverage, either with an employer plan like the ones described on the following page, or one of the many Medicare Supplemental Insurance plans on the market. This is something you have to think about carefully as your 65th birthday approaches.

The City offers the Kaiser Permanente Senior Advantage HMO Medical Plan that works with your Medicare benefits to provide a higher level of coverage. To learn more about your Medicare coverage, contact Medicare or the Social Security Administration.

Kaiser Permanente | Senior Advantage 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.

MEDICAL BENEFITS

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

Kaiser Senior Advantage Medical Benefits	Your Cost
Network Name	Kaiser Facilities Only
Lifetime Maximum	Unlimited
Deductible (Annual)	\$0
Out-of-Pocket Maximum	
- Individual	\$1,000
- Family	\$2,000
Office Visit Copay	
- Preventive Care	No Charge
- Primary Care Physician	\$20 Copay
- Specialist Office Visit	\$20 Copay
- Urgent Care	\$20 Copay
- Virtual Visits	\$0 Copay
Hospitalization	
- Inpatient	\$500 Per Admission
- Outpatient	\$50 Per Procedure
Lab and X-Ray	
- Diagnostic	No Charge
- Complex	No Charge
Emergency Services	\$50 Per Visit

Pharmacy Benefits

The Kaiser Senior Advantage plan covers Medicare Part D prescription drugs in accordance with Kaiser Part D formulary.

Initial coverage level—until you have received Medicare Part D drugs totaling \$3,750 in the calendar year under any Medicare Part D Plan	
- Generic	- \$10 Copay for up to 100-day supply
- Brand Name	- \$25 Copay for up to a 100-day supply
After the initial coverage limit—after you receive Medicare Part D drugs totaling \$3,750 unless you pay \$5,000 in 2022	
- Generic	- 44% of the price for generic drugs
- Brand Name	- 35% of the price (plus a portion of the dispensing fee) for brand name drugs

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
<p>Any illness or injury that would prompt you to see your primary care physician including but not limited to:</p> <ul style="list-style-type: none"> • 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 	<p>Any accident or illness that may lead to loss of life or limb, serious medical complication or permanent disability including but not limited to:</p> <ul style="list-style-type: none"> • 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/>

DENTAL BENEFITS

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	
	DeltaCare USA	Delta Dental PPO	Non-Network
Dental Benefits			
Calendar Year Maximum	Unlimited	\$1,500	\$1,500
Calendar Year Deductible			
- Individual	\$0	\$50	\$50
- Family	\$0	\$150	\$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		N/A	
- Covered Members	Children & Adults	Not Covered	
- Orthodontia Limit	\$1,700 Child / \$1,900 Adult		

*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		
Mission Square	Ryan Carpenter Phone: (866) 838-9365 Email: rcarpenter@missionsq.org	www.missionsq.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: 01/01/2023

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Medicare Part D Notices of Creditable Coverage

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. To help you decide whether or not to enroll in a Medicare Part D prescription drug plan, this Notice will inform you whether or not the value of the prescription drug benefit under your group health plan equals or exceeds the value of standard prescription drug coverage available under Medicare Part D.

Women's Health & Cancer Rights Act (WHCRA)

This act contains important protections for breast cancer patients who choose breast reconstruction with a mastectomy. The U.S. Departments of Labor and Health and Human Services are in charge of this act of law which applies to group health plans if the plans or coverage provide medical and surgical benefits for a mastectomy.

Newborn & Mother's Health Protection Act

This Notice informs employees of the amount of time a mother and her newborn child are covered for a hospital stay following childbirth.

HIPAA Special Enrollment Rights

Plan participants are entitled to certain special enrollment rights outside of the company 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

If you are eligible for health coverage, but are unable to afford premiums, some states have premium assistance programs that can help pay for coverage. This Notice provides information on how to contact your state's Medicaid office to receive information.

ANNUAL NOTICES

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Important Notice from City of Fullerton About Your Prescription Drug Coverage and Medicare As a Retiree Participating in Coverage Provided by Cigna, Kaiser, Anthem, Blue Shield, Health Net and UnitedHealthcare

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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this Notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The prescription drug coverage offered by City of Fullerton under the Cigna, Kaiser, Anthem, Blue Shield, Health Net & UnitedHealthcare (HMO & PPO), 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 Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage with Cigna, Kaiser, Anthem, Blue Shield, Health Net & UnitedHealthcare will be affected. If you decide to join a standard Medicare drug plan and drop your current medical plan coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Cigna, Kaiser, Anthem, Blue Shield, Health Net & UnitedHealthcare 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 Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll 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 10** 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 Cigna, Kaiser, Anthem, Blue Shield, Health Net & UnitedHealthcare changes. You also may request a copy of this notice at any time.

ANNUAL NOTICES

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 10**.

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 10**.

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 10**.

ANNUAL NOTICES

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, 2022, 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
..... 1-877-267-2323, Menu Option 4, Ext. 61565
Phone

In addition, if you live in one of the States listed below, you may also be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2022. Contact your State for more information on eligibility.

KANSAS – Medicaid

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



2211 Michelson Drive, Suite 1200 | Irvine, California 92612
Telephone: (949) 833-2983 | Fax: (949) 833-9549

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.