City of Fairfield

2024 RETIREE BENEFITS GUIDE








Table of Contents

MEDICARE PART D NOTICE

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. Please see the Important Plan Information section for more details.

Ready, Set, Enroll!

The City of Fairfield values the contributions you have made to our success and wants to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

Open Enrollment provides you an opportunity to change plans and modify dependent coverage. Your election deductions begin in January and will remain in effect through the plan year (January 1. 2024 – December 31, 2024) for all of your benefits. **Open Enrollment will be held from October 7th – November 13th.**

Dropping coverage in any one or all of the City's retiree medical, dental, or vision plans at retirement is irrevocable. What this means is that if you drop any existing coverage at retirement, or at any time later, you will not be eligible for reinstatement onto that plan at a future date.

IMPORTANT NOTES:

1) Your benefit selections will be in effect for a 12-month period from January 1, 2024, through December 31, 2024.
2) If your eligibility changes during the year you must notify P&A Group within 30 days of the qualifying event such as divorce or death of spouse/dependent, or Medicare eligibility.
3) If you or a covered dependent will turn age 65 during this plan year, it is your responsibility to enroll in Medicare Parts A/B. If you are interested in enrolling in the Kaiser Senior Advantage Plan, please contact Human Resources at least two to three months before the 65th birthday for enrollment information. Adhering to Medicare's strict deadlines will avoid any potential delay in enrollment, which could impact your Senior Advantage premiums.

During open enrollment you can enroll in the following plans:

- Medical Insurance
- Dental Insurance
- Vision Insurance

The grid below shows the period of time the plan benefits accumulate and when premium rates are effective. "Calendar year" is January through December.

Carrier	Benefits	Benefits	Rates	Comments
Kaiser	Medical	Calendar year	12 months	
Sutter Health Plus	Medical	Calendar year	12 months	
Western Health Advantage	Medical	Calendar year	12 months	
The Hartford Medicare Supplement	Medical	Calendar year	Calendar year	Follows Medicare plan & rate rules
Delta Dental	Dental	Calendar year	12 months	
VSP	Vision	12 or 24 months from last date of service	12 months	

P&A Group

The City of Fairfield has chosen P&A Group to administer their billing services and assist retirees during open enrollment. Invoices will be mailed to you on the 15th of each month, with a due date of the first of the following month and a 30-day grace period. For example, an invoice due November 1st will be sent to you on October 15th and you have the entire month of November to make payment. As long as your payment is made electronically or postmarked by the last calendar day of that month, your coverage will remain in effect. Late payment letters are also sent as a courtesy to remind you that payment is due.

Payments – P&A offers multiple payment options:

- Secure Online Payment – To make a one-time payment or set-up recurring monthly payments; create an account on our website www.padmin.com
- IVR (Integrated Voice Response) – To make a one-time payment or set-up recurring monthly payments; call P&A at (800) 688-2611 to make a payment over the phone.
- ACH Payment – To setup an automatic debit from your checking or savings account, please complete the enclosed ACH authorization form and return to the P&A Group. With this option, you will need to make a payment by check for the first of the month while this process is setup. You can also authorize this processed online by logging into your account at www.padmin.com
- Check or Money Order – Pay by check or money order and mail your payments to: P&A Group, Dept. 652, PO Box 8000, Buffalo, NY 14267-8000.

P&A Website

- P&A offers several ways to manage your benefits online. Please visit www.padmin.com to setup your account. Within the "My Benefits" page, you can view your insurance coverage, cancel coverage online, and make payments. In addition, you can make demographic changes, and view your invoice and payment history.

Customer Service

- P&A Group customer service representatives are well trained in administration and are here to help answer your questions. Representatives are available Monday through Friday from 8am to 10pm EST at (800) 688-2611 or email cobra@padmin.com. Live chat is available during the same hours on our website, www.padmin.com by clicking the "Online Chat" tab on the top of the page or through the "Contact Us" tab.

Monthly Medical Contributions Early Retirees

Plans Medical	2024 Premium Rates
Kaiser Permanente $15 HMO	
• Single	$1172.61
• Two Party	$2345.23
• Family	$3318.50
Kaiser Permanente $35 HMO	
• Single	$1105.68
• Two Party	$2211.36
• Family	$3129.08
Kaiser Permanente Virtual Complete	
• Single	$845.91
• Two Party	$1691.82
• Family	$2393.92
SHP $10 HMO	
• Single	$913.40
• Two Party	$1827.40
• Family	$2586.40
SHP $20 HMO	
• Single	$877.50
• Two Party	$1755.50
• Family	$2484.70
SHP DHMO	
• Single	$725.60
• Two Party	$1451.60
• Family	$2054.70
WHA $15 HMO	
• Single	$1058.37
• Two Party	$2116.75
• Family	$2998.24
WHA $40 HMO	
• Single	$960.56
• Two Party	$1921.12
• Family	$2721.12
WHA DHMO	
• Single	$723.13
• Two Party	$1438.33
• Family	$2037.25

*Retiree pays 100% of premium

Monthly Medical Contributions – 65+ Retirees

Plans Medical	2024 Premium Rates
Kaiser Permanente Senior Advantage $15 HMO	
• Subscriber w/Medicare	$324.99
• Subscriber w/Medicare + Spouse w/Medicare	$649.98
• Subscriber w/Medicare + Spouse w/Medicare + Child(ren) Non-Medicare	$1623.25
• Medicare Part B Only	$634.99
Kaiser Permanente Senior Advantage $25 HMO	
• Subscriber w/Medicare	$248.56
• Subscriber w/Medicare + Spouse w/Medicare	$497.12
• Subscriber w/Medicare + Spouse w/Medicare + Child(ren) Non-Medicare	$1414.84
• Medicare Part B Only	$558.56
The Hartford - Medicare Supplement Plan**	
• Medical	$274.33
• Rx	$316.50

*Retiree pays 100% of premium

**All plans are now on a calendar year basis

Monthly Dental Contributions

Plans Dental	2024 Premium Rates*
PPO Buy-Up 1 - PPO+Premier 1500 Plan	
• Single	$50.41
• Two Party	$91.68
• Family	$134.94
PPO Buy-Up 2 - PPO+Premier 2500 Plan	
• Single	$57.29
• Two Party	$104.08
• Family	$153.31
HMO - Core	
• Single	$21.93
• Two Party	$39.88
• Family	$58.73

*Retiree pays 100% of premium

Monthly Vision Contributions

Plans Vision	2024 Premium Rates*
Base	
• Single	$5.52
• Two Party	$11.04
• Family	$13.13
Premier	
• Single	$9.33
• Two Party	$18.77
• Family	$21.96

*Retiree pays 100% of premium

Kaiser Medical Plans

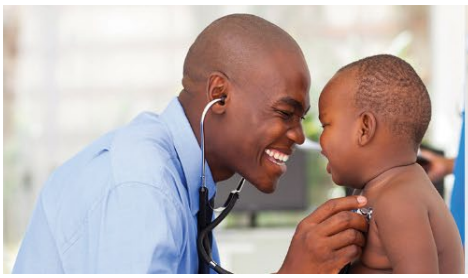
KAISER PERMANENTE

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

	Kaiser HMO $15 Early Retirees (Under 65)	Kaiser HMO $35 Early Retirees (Under 65)	Kaiser Virtual Complete Early Retirees (Under 65)
	In-Network	In-Network	In-Network
Annual Deductible	$0 per individual $0 family limit	$0 per individual $0 family limit	$2,000 per individual $2,000 per Individual within a family $4,000 family limit
Annual Out-of-Pocket Max	$1,500 per individual $3,000 family limit	$1,500 per individual $3,000 family limit	$5,000 per individual $5,000 per Individual within a family $10,000 family limit
Lifetime Max	Unlimited	Unlimited	Unlimited
Office Visit			
Primary Provider	$ 15 copay then plan pays 100%	$35 copay then plan pays 100%	$30 After Deductible
Specialist	$15 copay then plan pays 100%	$35 copay then plan pays 100%	$30 After Deductible
Preventive Services	Plan pays 100%	Plan pays 100% (see contract for limitations)	
Chiropractic Care	$15 copay then plan pays 100% (up to 20 visits per year)	$15 copay then plan pays 100% (up to 20 visits per year)	$15 copay per visit (up to 20 visits per year?
Lab and X-ray	Plan pays 100%	Plan pays 100%	20% Coinsurance after Deductible
Inpatient Hospitalization	Plan pays 100%	$100 admission copay then plan pays 100%	20% Coinsurance after Deductible
Outpatient Surgery	$15 copay then plan pays 100%	$35 copay then plan pays 100%	20% Coinsurance after Deductible
Urgent Care	$15 copay then plan pays 100%	$35 copay then plan pays 100%	$30 After Deductible
Emergency Room	$50 copay then plan pays 100% (copay waived if admitted)	$75 copay then plan pays 100% (copay waived if admitted)	20% Coinsurance after Deductible

Kaiser Medical Plans, cont.

KAISER PERMANENTE®



	Kaiser HMO $15 Senior Advantage	Kaiser HMO $25 Senior Advantage
	In-Network	In-Network
Annual Deductible	$0 per individual $0 family limit	$0 per individual $0 family limit
Annual Out-of-Pocket Max	$1,000 per individual $2,000 family limit	$1,000 per individual $2,000 family limit
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$15 copay then plan pays 100%	$25 copay then plan pays 100%
Specialist	$15 copay then plan pays 100%	$25 copay then plan pays 100%
Preventive Services	Plan pays 100%	Plan pays 100%
Chiropractic Care	$15 copay then plan pays 100% (up to 20 visits per year)	$20 copay then plan pays 100% (up to 20 visits per year)
Lab and X-ray	Plan pays 100%	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%	$250 admission copay then plan pays 100%
Outpatient Surgery	$15 copay then plan pays 100%	$25 copay then plan pays 100%
Urgent Care	$15 copay then plan pays 100%	$25 copay then plan pays 100%
Emergency Room	$50 copay then plan pays 100% (copay waived if admitted)	$50 copay then plan pays 100% (copay waived if admitted)

Kaiser Prescription Drugs

KAISER PERMANENTE®

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans.

	Kaiser HMO $15 Early Retirees (Under 65)	Kaiser HMO $35 Early Retirees (Under 65)	Kaiser Virtual Complete Early Retirees (Under 65)
	In-Network	In-Network	In-Network
Annual Out-of-Pocket Limit	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums
Pharmacy			
Generic	$5 copay then plan pays 100%	$10 copay then plan pays 100%	$15 copay
Preferred Brand	$15 copay then plan pays 100%	$30 copay then plan pays 100%	$30 copay
Non-preferred Brand	$15 copay then plan pays 100% (when approved through exception process)	$30 copay then plan pays 100% (when approved through exception process)	20% coinsurance (not to exceed $250) after deductible
Supply Limit	100 days	30 days	30 days
Mail Order			
Generic	$5 copay then plan pays 100%	$20 copay then plan pays 100%	$30 copay then plan pays 100%
Preferred Brand	$15 copay then plan pays 100%	$60 copay then plan pays 100%	$60 copay after deductible
Non-preferred Brand	$15 copay then plan pays 100% (when approved through exception process)	$60 copay then plan pays 100% (when approved through exception process)	Not applicable
Supply Limit	100 days	100 days	100 days

Kaiser Prescription Drugs

KAISER PERMANENTE®

	Kaiser HMO $15 Senior Advantage	Kaiser HMO $25 Senior Advantage
	In-Network	In-Network
Annual Out-of-Pocket Limit	$1,000 / $1,000 / $2,000	$1,000 / $1,000 / $2,000
Pharmacy		
Generic	$5 copay then plan pays 100%	$10 copay then plan pays 100% / $20 copay then plan pays 100% / $30 copay then plan pays 100%
Preferred Brand	$15 copay then plan pays 100%	$25 copay then plan pays 100% / $50 copay then plan pays 100% / $75 copay then plan pays 100% / (when approved through exception process)
Supply Limit	100 days	30 days / 31-60 days / 61-100 days
Mail Order		
Generic	$5 copay then plan pays 100%	$10 copay then plan pays 100%/ $20 copay then plan pays 100%
Preferred Brand	$15 copay then plan pays 100%	$25 copay then plan pays 100% / $50 copay then plan pays 100%
Supply Limit	100 days	30 days / 31-100 days

Kaiser Resources

KAISER PERMANENTE®

Your care, your way

Connect to care anytime, anywhere

Get the care you need the way you want it. No matter which option you choose, your providers can see your health history, update your medical record, and give you personalized care that fits your life.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider.

In-person visit

Same-day appointments are often available. Sign on to **kp.org** anytime, or call us to schedule a visit.

Email

Message your doctor's office with nonurgent questions anytime. Sign in to **kp.org** or use our mobile app.[2]

Phone appointment

Save yourself a trip to the doctor's office for minor conditions or follow-up care.[2,3]

Video visit

Meet face-to-face online with a doctor on your computer, smartphone, or tablet for minor conditions or follow-up care.[2,3]

E-visit

Get quick online care for common health problems. Fill out a short questionnaire about your symptoms, and a physician will get back to you with a care plan and prescriptions (if appropriate) – usually within 2 hours.

Call us anytime at 1-866-454-8855 (TTY 711) to make an appointment or to get care advice.

Need care now? Know before you go.

Urgent care

An urgent care need is one that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition. This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms, and frequent urination or a burning sensation when urinating.

Emergency care

Emergency care[1] is for medical or mental health conditions that require immediate medical attention to prevent serious jeopardy to your health. Examples include chest pain or pressure, severe stomach pain that comes on suddenly, severe shortness of breath, and decrease in or loss of consciousness.

[1]If you believe you have an emergency medical condition, call **911** or go to the nearest hospital. For the complete definition of an emergency medical condition, please refer to your *Evidence of Coverage* or other coverage documents.

[2]These features are available when you receive care at Kaiser Permanente facilities.

[3]When appropriate and available.

Sutter Health Plus Medical Plans

	Sutter Health Plus HMO $10 Early Retirees (Under 65)	Sutter Health Plus HMO $20 HMO Early Retirees (Under 65)	Sutter Health Plus DHMO Early Retirees (Under 65)
	In-Network	In-Network	In-Network
Annual Deductible	$0 per individual $0 family limit	$0 per individual $0 family limit	$1,500 per individual $3,000 family limit
Annual Out-of-Pocket Max	$1,000 per individual $2,000 family limit	$1,500 per individual $3,000 family limit	$4,000 per individual $8,000 family limit
Lifetime Max	Unlimited	Unlimited	Unlimited
Office Visit			
Primary Provider	$10 copay then plan pays 100%	$20 copay then plan pays 100%	$20 copay then plan pays 100%
Specialist	$10 copay then plan pays 100%	$20 copay then plan pays 100%	$20 copay then plan pays 100%
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%
Chiropractic Care	$10 copay then plan pays 100% (up to 20 visits per year)	$20 copay then plan pays 100% (up to 20 visits per year)	$20 copay then plan pays 100% (up to 20 visits per year)
Lab and X-ray	Complex imaging: $50 copay then plan pays 100%; lab: $10 copay then plan pays 100%; x-ray: plan pays 100%	No Charge	Complex imaging: $50 copay then plan pays 100%; lab: $20 copay then plan pays 100%; x-ray: $10 copay then plan pays 100%
Inpatient Hospitalization	Plan pays 100%	$250 copay per admission (no limit) then plan pays 100%	Plan pays 80% after deductible
Outpatient Surgery	Plan pays 100%	$100 copay then plan pays 100%	Plan pays 80% after deductible
Urgent Care	$10 copay then plan pays 100%	$20 copay then plan pays 100%	$20 copay then plan pays 100%
Emergency Room	$50 copay then plan pays 100% (copay waived if admitted)	$100 copay then plan pays 100% (copay waived if admitted)	Plan pays 80% after deductible

Sutter Health Plus Prescription Drugs

	Sutter Health Plus HMO $10 HMO Early Retirees (Under 65)	Sutter Health Plus HMO $20 HMO Early Retirees (Under 65)	Sutter Health Plus DHMO Early Retirees (Under 65)
	In-Network	In-Network	In-Network
Annual Out-of-Pocket Limit	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums
Pharmacy			
Generic	$5 copay then plan pays 100%	$10 copay then plan pays 100%	$10 copay then plan pays 100%
Preferred Brand	$20 copay then plan pays 100%	$30 copay then plan pays 100%	$30 copay then plan pays 100%
Non-preferred Brand	$40 copay then plan pays 100%	$60 copay then plan pays 100%	$60 copay then plan pays 100%
Specialty	10% coinsurance up to $250 per prescription	20% coinsurance up to $250 per prescription	20% coinsurance up to $100 per prescription
Supply Limit	30 days	30 days	30 days
Mail Order			
Generic	$10 copay then plan pays 100%	$20 copay then plan pays 100%	$20 copay then plan pays 100%
Preferred Brand	$40 copay then plan pays 100%	$60 copay then plan pays 100%	$60 copay then plan pays 100%
Non-preferred Brand	$80 copay then plan pays 100%	$120 copay then plan pays 100%	$120 copay then plan pays 100%
Supply Limit	100 days	100 days	100 days

Sutter Health Plus Resources

Sutter Health Plus
Your Health Plan

MANAGING HEALTH BENEFITS AND CARE

Convenient 24/7 Access

Sutter Health Plus Member Portal

Register or log in at *shplus.org/memberportal*

- Request or print member ID cards
- Change your primary care physician
- Access your health plan documents
- View a summary of individual and family deductibles and out-of-pocket balances
- View and download Sutter Health Plus forms, resources and member newsletters
- Navigate to the Health and Wellness site

My Health Online*

Register or log in at *myhealthonline.sutterhealth.org*

- Email your care team
- Make an appointment
- Renew prescriptions
- View test results
- Update your health history
- Pay bills

*Not offered by all providers

Member Services 1-855-315-5800 | sutterhealthplus.org

Sutter Health Plus
Your Health Plan

PM-17-017

Western Health Advantage Medical Plans

	Western Health Advantage HMO $15 Early Retirees (Under 65)	Western Health Advantage HMO $40 Early Retirees (Under 65)	Western Health Advantage DHMO Early Retirees (Under 65)
	In-Network	In-Network	In-Network
Annual Deductible	$0 per individual $0 family limit	$0 per individual $0 family limit	$1,000 per individual $2,000 family limit
Annual Out-of-Pocket Max	$1,500 per individual $2,500 family limit	$1,500 per individual $2,500 family limit	$3,000 per individual $6,000 family limit
Lifetime Max	Unlimited	Unlimited	Unlimited
Office Visit			
Primary Provider	$15 copay then plan pays 100%	$40 copay then plan pays 100%	$20 copay then plan pays 100%
Specialist	$15 copay then plan pays 100%	$40 copay then plan pays 100%	$20 copay then plan pays 100%
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%
Chiropractic Care	$15 copay then plan pays 100% (up to 20 visits per year)	$15 copay then plan pays 100% (up to 20 visits per year)	$15 copay then plan pays 100% (up to 20 visits per year)
Lab and X-ray	Plan pays 100%	Plan pays 100%	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%	Plan pays 80% after deductible
Outpatient Surgery	$100 copay then plan pays 100%	$100 copay then plan pays 100%	$250/visit after deductible
Urgent Care	$20 copay then plan pays 100%	$50 copay then plan pays 100%	$50 copay then plan pays 100%
Emergency Room	$100 copay then plan pays 100% (copay waived if admitted)	$100 copay then plan pays 100% (copay waived if admitted)	Plan pays 80% after deductible

Western Health Advantage Prescription Drug

	Western Health Advantage HMO $15 Early Retirees (Under 65)	Western Health Advantage HMO $40 HMO Early Retirees (Under 65)	Western Health Advantage DHMO Early Retirees (Under 65)
	In-Network	In-Network	In-Network
Annual Out-of-Pocket Limit	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums
Pharmacy			
Generic	$10 copay then plan pays 100%	$10 copay then plan pays 100%	$10 copay then plan pays 100%
Preferred Brand	$30 copay then plan pays 100%	$30 copay then plan pays 100%	$30 copay then plan pays 100%
Non-preferred Brand	$50 copay then plan pays 100%	$50 copay then plan pays 100%	$50 copay then plan pays 100%
Specialty	20% coinsurance up to $100 per prescription	20% coinsurance up to $100 per prescription	20% coinsurance up to $100 per prescription
Supply Limit	30 days	30 days	30 days
Mail Order			
Generic	$25 copay then plan pays 100%	$25 copay then plan pays 100%	$25 copay then plan pays 100%
Preferred Brand	$75 copay then plan pays 100%	$75 copay then plan pays 100%	$75 copay then plan pays 100%
Non-preferred Brand	$125 copay then plan pays 100%	$125 copay then plan pays 100%	$125 copay then plan pays 100%
Supply Limit	90 days	90 days	90 days

Western Health Advantage Resources

Telehealth Services

CONNECT TO HEALTH CARE SERVICES — VIRTUALLY

Western Health Advantage covers services provided through telehealth at the same cost sharing that would apply to those services if they had been provided in person. This means that when a WHA network provider offers telehealth services, such as virtual visits, WHA members will have the same cost-sharing that they would have for an office visit. Please refer to your copayment summary for cost-sharing amounts.

Mercy Medical Group & Woodland Clinic

Dignity Health's my care. app

- See a doctor instantly. Video chat with a doctor any time. Most visits happen within 20 minutes.
- Chat from anywhere. On vacation or work travel? As long as you are a resident of CA and 18 years or older, you can use this service.
- Get prescriptions. If needed, your doctor can set up your prescription at a local drug store

Learn more about video visits through Dignity Health.
> dignityhealth.org/mobile-apps/video-visits

St. Joseph Health Medical Network

Providence Health Connect

It's convenient, face-to face care, wherever you are. See a health care provider from your tablet, smartphone or computer. Sit down with one of Providence's board-certified providers through secure video chat on your smartphone, tablet or computer. Talk with them about your symptoms, and they can diagnose and treat minor medical concerns you're dealing with. They can also prescribe medication or lab work as needed.

Learn more about Providence Express Care Virtual.
> virtual.providence.org

LEARN MORE ABOUT TELEVISITS | Contact your PCP or WHA Member Services at **888.563.2250**

Magellan Healthcare

Convenient Counseling Services

Could you use some help getting through an issue, but don't have time or just aren't comfortable going to a counselor's office? Now you can meet with a counselor by video conference. Benefits include:

- Faster access to mental health services
- Flexible appointment times
- Completely confidential
- Savings on time and money by not commuting to a counselor's office

Use Magellan's provider search tool to find a provider who offers telehealth services.
> magellanfindaprovider.com/wha

NorthBay Healthcare

Instant Visit

- Get care without leaving the comfort of home—or your office. Get treatment for straight forward conditions from our providers within 2 hours.
- Typical response time is 30 minutes between 9:30 a.m. to 5:30 p.m.; for Instant Visits started after 5:30 p.m. we will respond by the following morning.

Note: Sometimes conditions are more complex than the symptoms suggest, and your instant visit provider may ask to see you at NorthBay Urgent Care.

Learn more about instant visits with NorthBay Healthcare.
> northbay.org/urgent-care/instant-visit.cfm

The Hartford Medicare Supplement Plan

Medicare Supplement Plan		
Benefits	In-Network	Out-Of-Network
	Medicare 2024 Benefits	Medicare Supplement
Hospital Confinement (Part A)	Medicare pays all approved amounts, but Medicare Part A Deductible (First 60 days)	Plan pays Medicare Part A Deductible (First 60 days)
Skilled Nursing Facilities (Part A)	Medicare pays all approved amounts (First 20 days)	N/A (First 20 days)
Hospice Care (Part A)	Medicare pays all costs, but limited to costs for out-patient drug and in-patient respite care	Plan pays co-insurance charges for in-patient respite care, drugs and biologicals approved by Medicare
Blood Deductible – (Hospital Confinement and Out-Patient Medical Expenses) (Part A)	None (First 3 pints) Medicare pays all additional amounts (Additional amounts)	Plan pays all costs (First 3 pints) N/A (Additional amounts)
Out-Patient Medical Expenses (Part B)		
Medicare Part B Deductible	None	Plan pays Medicare Part B Deductible
Remainder of Medicare-approved amounts	Medicare pays generally 80%	Plan pays 20%
Clinical Laboratory services, blood tests, urinalysis and more	Medicare pays all costs	N/A
Additional Services **(**Preventive Medical Care & Cancer Screenings)		
Physical Exam (within first 12 months)	Medicare pays all costs	N/A
Annual Wellness Visit	Medicare pays all costs	N/A
Vaccinations	Medicare pays all costs	N/A
Breast Cancer Screening (mammogram once per year)	Medicare pays all costs	N/A
Foreign Travel Emergency	None	80% after $250 Deductible (to a lifetime maximum of $50,000)

Getting Care When You Need It Now

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life-threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to earache, sore throat, rashes, sprains, flu, and fever.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

Delta Dental Plans

Regular visits to your dentist can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease. The City of Fairfield provides you with comprehensive coverage through Delta Dental (CSAC EIA).

	Delta Dental $1,500 Annual Maximum (Dual Option w/Fluoride*) Core PPO Plan		
	PPO In-Network	**Premier Network**	**Out-of-Network**
Calendar Year Deductible	$0 per individual $0 per family	$25 per individual $75 per family	$25 per individual $75 per family
Annual Plan Maximum	$1,500 per individual	$1,500 per individual	$1,000 per individual
Waiting Period	None	None	None
Fluoride Treatment*	Included Adults and Children (Limited to 2 treatments per year)	Included Adults and Children (Limited to 2 treatments per year)	Included Adults and Children (Limited to 2 treatments per year)
Diagnostic and Preventive	Plan pays 100%	Plan pays 90% after deductible	Plan pays 90% after deductible
Basic Services			
Fillings	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Root Canals	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Periodontics	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Services	Plan pays 60% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontic Services			
Orthodontia	Plan pays 50% (deductible waived)	Plan pays 50% (deductible waived)	Plan pays 50% (deductible waived)
Lifetime Maximum	$1,500	$1,500	$1,500

Delta Dental Plans, cont.

	Delta Dental $2,500 Annual Maximum (Dual Option w/Fluoride*) Buy-Up PPO Plan		
	PPO In-Network	**Premier Network**	**Out-of-Network**
Calendar Year Deductible	$0 per individual $0 per family	$25 per individual $75 per family	$25 per individual $75 per family
Annual Plan Maximum	$2,500 per individual	$2,500 per individual	$2,500 per individual
Waiting Period	None	None	None
Fluoride Treatment*	Included Adults and Children (Limited to 2 treatments per year)	Included Adults and Children (Limited to 2 treatments per year)	Included Adults and Children (Limited to 2 treatments per year)
Diagnostic and Preventive	Plan pays 100% (deductible waived)	Plan pays 90% after deductible	Plan pays 90% after deductible
Basic Services			
Fillings	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Root Canals	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Periodontics	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Services	Plan pays 60% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontic Services			
Orthodontia	Plan pays 50% (deductible waived)	Plan pays 50% (deductible waived)	Plan pays 50% (deductible waived)
Lifetime Maximum	$1,500	$1,500	$1,500

Delta Dental Plans, cont.

	Delta Dental DeltaCare DHMO
Calendar Year Deductible	$0 per individual $0 per family
Annual Plan Maximum	$1,500 per individual
Waiting Period	None
Diagnostic and Preventive	$0-$45 copay (varies by services, see contract for fee schedule)
Basic Services	
Fillings	$0-$75 copay (varies by services, see contract for fee schedule)
Root Canals	$0-$205 copay (varies by services, see contract for fee schedule)
Periodontics	$0-$195 copay (varies by services, see contract for fee schedule)
Major Services	$0-$195 copay (varies by services, see contract for fee schedule)
Orthodontic Services	
Orthodontia	$1,700 or $1,900 copay (see contract for fee schedule)
Lifetime Maximum	Unlimited

Delta Dental Resources

DELTA DENTAL MEMBER DISCOUNTS

While your oral health remains the top priority, Delta Dental also cares about the bigger picture — your overall well-being[1]. That's why dental member now have access to preferred pricing on hearing aid and LASIK services through Amplifon Hearing Health Care and QualSight[2].

Access to sizeable savings	62% average savings off retail hearing aid pricing,[3] backed by a best price guarantee[4]	40-50% off the national average price of Traditional LASIK[5]
Convenient locations	Broad nationwide network of providers	1,000+ LASIK locations[6]
Quality care and products	Access to the nation's leading brands featuring the latest hearing aid technology	Experienced LASIK surgeons who have collectively performed 6.5+ million procedures[6]
Customized support	Amplifon acts as your personal concierge at every step, from appointment scheduling and hearing aid selection to coordinating follow-up care.	A QualSight care manager will walk you through the program, coordinate care and help select the right physician and procedure.
For more information	Amplifon's hearing aid discounts, visit www.amplifonusa.com/deltadentalins or call 1-888-779-1429. Patient Care Advocate will help you find a hearing care provider near you.	QualSight's LASIK discounts, visit www.qualsight.com/-delta-dental or call 1-855-248-2020. A care manager will explain the program and answer any questions.

[1]Delta Dental of California, Delta Dental Insurance Company, Delta Dental of Pennsylvania, Delta Dental of New York, Inc. and our affiliated enterprise companies.

[2] The Vision Corrective Services and hearing health care services are not insured benefits. Delta Dental makes the Vision Corrective Services program available to enrollees to provide access to the preferred pricing for LASIK surgery. Delta Dental makes the hearing health care services program available to enrollees to provide access to the preferred pricing for hearing aids and other hearing health services.

[3] Amplifon Hearing Health Care utilization database, January-December 2018. Discounts or savings may vary by manufacturer and technology level of the hearing aid device.

[4] Amplifon offers a price match on most hearing devices; some exclusions apply. Not available where prohibited by law. Visit www.amplifonusa.com/deltadentalins or call 1-888-779-1429 for more details.

[5] Refractive Quarterly Update, Market Scope LLC, November 2018. Discounts or savings may vary by provider.

Delta Dental Resources, cont.

DELTA DENTAL MOBILE APP

Anyone can use Delta Dental Mobile without logging in to access our Find a Dentist and Toothbrush Timer tools, conveniently located on the home screen. You also have the option to save your ID card to the home screen for easy access without logging in.

Delta Dental subscribers can log in using the username and password they use to log in to our website. If you haven't registered, there is a link on the home screen to register for an account. If you've forgotten your username or password, you can also retrieve these via Delta Dental Mobile.

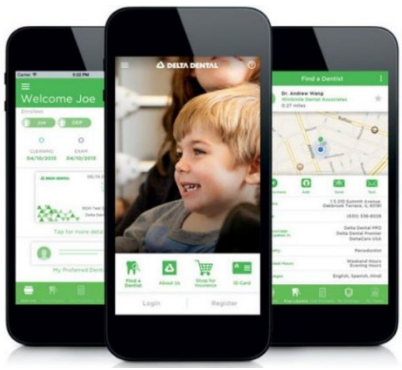
You must enter your username and password each time you access the secure portion of the app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed via a link on the Login page of the app.

ONLINE SERVICES - DELTADENTALINS.COM

- Printable ID cards
- Secure login for benefits and eligibility lookup
- Claims status available to enrollees & dentists
- Dentist directory with maps & driving directions
- Extensive dental health section
- Enrollee section in Spanish
- SmileKids – an interactive site for children
- Fee Finder
- Explanation of Benefits – use it!
- Articles and Quizzes on Oral Health Dental Wire Newsletter

IMPORTANT TIPS

- Pre-Treatment estimate - Make sure you always get one so you know how much you will be paying BEFORE you get to your appointment!
- If you are having extensive dental work done
- Ensuring that a procedure is covered
- To see if you will exceed your maximum
- If you need to plan your payment in advance
- If you would like an advance breakdown of the charges and coverage



VSP Vision Plans

Routine vision exams can not only correct vision, but also detect more serious health conditions. We give you a choice between two vision plans through Vision Service Plan (VSP).

	VSP - Basic Plan		VSP - Premier Plan	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Examination				
Benefit	$20 copay then plan pays 100%	Plan pays 100% (reimbursed up to $45)	$10 copay then plan pays 100%	Plan pays 100% (reimbursed up to $45)
Frequency	1 x every 12 months from last date of service	In-network limitations apply	1 x every 12 months from last date of service	In-network limitations apply
Materials	$25 copay then plan pays 100%	Plan pays 100% (see schedule below)	$25 copay then plan pays 100%	Plan pays 100% (see schedule below)
Eyeglass Lenses				
Single Vision Lens	plan pays 100% of basic lens (materials copay apply)	Reimbursed up to $30	plan pays 100% of basic lens (materials copay apply)	Reimbursed up to $30
Bifocal Lens	plan pays 100% of basic lens (materials copay apply)	Reimbursed up to $50	plan pays 100% of basic lens (materials copay apply)	Reimbursed up to $50
Frequency	1 x every 12 months from last date of service	In-network limitations apply	1 x every 12 months from last date of service	In-network limitations apply
Frames				
Benefit	Reimbursed up to $150 plan pays (20% discount over allowance)	Reimbursed up to $70	Reimbursed up to $200 plan pays (20% discount over allowance)	Reimbursed up to $70
Frequency	1 x every 24 months from last date of service	In-network limitations apply	1 x every 12 months from last date of service	In-network limitations apply
Contacts (Elective)				
Benefit	Reimbursed up to $130 (copay waived; instead of eyeglasses)	Reimbursed up to $105 (in-network limitations apply)	Reimbursed up to $200 (copay waived; instead of eyeglasses)	Reimbursed up to $105 (in-network limitations apply)
Frequency	1 x every 12 months from last date of service	In-network limitations apply	1 x every 12 months from last date of service	In-network limitations apply

VSP Vision Resources

A vision exam helps detect the signs of health conditions like high blood pressure, diabetes, and high cholesterol—along with other eye and health issues.

BETTER PROVIDER CHOICE WITH VSP

You can choose your provider from 71,000 access points, including the largest national network of independent doctors and nearly 4,500 participating retail chain locations. For convenience, most VSP participating doctors also offer early morning, evening and weekend appointments, and 24-hour access to emergency care.

If you prefer to use a non-network provider, this option is also available under our plan however, the benefit allowances are lower.

EXCLUSIVE MEMBER DISCOUNTS

EXTRA SAVINGS ON GLASSES & SUNGLASSES

- Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details.
- 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.

Eyeconic®, an easy-to-use, in-network, online eyewear platform is also available to all members. Eyeconic® offers free shipping and returns, virtual try-on tool, free frame adjustment or contact lens consultation and all-inclusive pricing on glasses and lenses. For more information on Eyeconic®, visit eyeconic.com.

LASER VISION CORRECTION

- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

HEARING AID DISCOUNT

VSP® Vision Care members can save up to 60% on a pair of digital hearing aids. Dependents and even extended family members are eligible for exclusive savings, too.

TruHearing also provides members with:

- 3 provider visits for fitting, adjustments, and cleanings
- A 45-day money back guarantee
- 3-year manufacturer's warranty for repairs and one-time loss and damage
- 48 free batteries per hearing aid.

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or, call 877.396.7194 with questions.

Plan Contacts

If you need to reach our plan providers, here is their contact information:

Vendor Contacts			
	Provider	**Phone Number**	**Website**
KAISER PERMANENTE	Kaiser Medical	(800) 464-4000	kp.org
Sutter Health Plus Your Health Plan	Sutter Health Plus Medical	(855) 315-5800	sutterhealthplus.org
Western Health Advantage	Western Health Advantage Medical	(888) 227-5942	westernhealth.com
The Hartford	The Hartford Medicare Supplement	(303) 379-3352	thehartford.com
DELTA DENTAL	Delta Dental Dental PPO and DHMO	(800) 765-6003	deltadentalins.com
vsp	VSP Vision	(800) 877-7195	vsp.com
P&A GROUP EST. 1975	P&A Group	(800) 688-2611	padmin.com

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE - The amount of healthcare expenses you must pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plans out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, crowns, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as bridges, dentures, inlays and onlays.

Annual and Medicare Part D Notices

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

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

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to 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 City of Fairfield coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under health plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your City of Fairfield prescription drug coverage, be aware that you and your dependents will not be able to get your coverage back through the City of Fairfield.

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below 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 the City of Fairfield changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (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 information about this extra help, visit Social Security on the web at socialsecurity.gov, or 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).

Date:	January 1, 2024
Name of Entity/Sender:	The City of Fairfield
Contact-Position/Office:	Human Resources - benefits@fairfield.ca.gov
Address:	1000 Webster Street, Fairfield, CA
Phone Number:	(707) 428-7394

Women's Health and Cancer Rights Act

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; 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 this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' & 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). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in the City of Fairfield health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the City of Fairfield health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the City of Fairfield's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for the City of Fairfield describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the Human Resources Department.

Notice of Choice of Providers

Your health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your health plan directly. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan.

Notice of Availability of Alternative Standard for Wellness Plan

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 us at Human Resources 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.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp | Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

RETIREE FREQUENTLY ASKED QUESTIONS

Q1. When should I sign up for Medicare?

A1. If like most people, you become eligible for Medicare at age 65, this seven-month window will surround your 65th birthday. This one-time enrollment period is your first opportunity to sign up for Medicare Part A and/or Part B. This is also your first chance to enroll in a Medicare Advantage plan (Part C) or Part D Prescription Drug plan.

If you miss your eligibility window, you will need to wait until Medicare's GEP (general enrollment period) to enroll in your benefits and will be subject to Medicare's LEP (late enrollment period), which is a lifetime penalty. If you are still actively working and covered through the employer for health insurance benefits, you have the option to postpone enrollment into your Medicare benefits without penalty until you retire.

Q2. How do I sign up for Medicare?

A2. About three months before your 65th birthday, you will want to sign up for Medicare. If you have not received your automatic enrollment information in the mail, and if you are not already getting retirement or disability benefits, you can sign up in one of the following ways:

- Call Social Security at (800) 772-1213.

- Visit your local Social Security office. You can use the Social Security Office locator at https://secure.ssa.gov/ICON/main.jsp or call (800) 772-1213

- Fill out a form online (if applying for Medicare only and not Social Security benefits) at https://secure.ssa.gov/iClaim/rib. Before you start, gather information on this checklist: http://www.ssa.gov/hlp/isba/10/isba-checklist.pdf.

Q3. Do I have to pay Social Security for Medicare Parts A and B?

A3. Most people get premium-free Part A if they are age 65 or older and they or their spouse worked and paid Medicare taxes for at least 10 years. However, if you do not qualify for premium-free Part A, you can purchase it at an additional cost per month. If you choose NOT to buy Part A, you can still buy Part B when eligible. Part B premiums change each year.

RETIREE FREQUENTLY ASKED QUESTIONS

Q4. How do I know whether or not I qualify for Medicare?

A4. In general, those who are eligible for premium-free Part A (hospital insurance) and Part B (medical insurance) include individuals who are 65 and have worked 10 years in this country or who have a spouse who has, or individuals who are under 65 and have received Social Security disability benefits for 24 months. If you are receiving Social Security, you are likely already enrolled in Part A and Part B when you turn 65. You can determine whether you're eligible by one of the following:

- Call Social Security at (800) 772-1213. If you are deaf or hard of hearing, call (800) 325-0778. (Medicare is managed by the Centers for Medicare and Medicaid Services. Social Security works with CMS by enrolling people in Medicare.)
- Visit your local Social Security office. Use the Social Security Office locator at https://secure.ssa.gov/ICON/main.jsp or call (800) 772-1213.
- Go online to the Medicare.gov website's Eligibility & Premium Calculator: https://www.medicare.gov/eligibilitypremiumcalc/#eligibility.

Q5. I don't qualify for premium-free Part A under Medicare. What does this mean?

A5. Most people get premium-free Part A. However if you don't qualify for premium-free Part A in your own right, if you are married and your spouse is at least 62 years of age when you attain Medicare eligibility and they are entitled to premium-free Part A, you can draw from their benefit. Your drawing from your spouse's benefit does not affect their entitlement.

If you do not qualify in your own right or through a spouse, you can purchase it at an additional cost per month. If you choose NOT to buy Part A, you can still buy Part B when eligible. If you do not have Part A, you can enroll in the City's Kaiser Permanente Senior Advantage Part B only option, however, your costs under the plan will be higher.

Q6. How do I pay for my retiree medical coverage?

A6. P&A Administrative Service, Inc. (P&A) is our Retiree Administrator. Once you retire, you will receive a packet from P&A outlining your payment options, which include payment by check, via their online portal or through ACH/automatic payments to P&A.

RETIREE FREQUENTLY ASKED QUESTIONS

Q7. How do I set up payment from my RHS account to my medical premiums?

A7. To pay for your medical premiums, you will need to set up direct premium payments from Meritain to your bank account. From there, you will need to go to the P&A website and set up automatic payments from that same bank account.

Q8. I know that I may be eligible to receive a portion of sick leave pay upon retirement, but how does this work?

A8. Please reference your specific MOU for more details on sick pay conversion.

Q9. As a Retiree, can I sign up for just dental and vision coverage (no medical)?

A9. Yes, you are not required to elect medical coverage to continue dental and/or vision coverage. Should you elect to drop coverage in any one or all of the City's Retiree Medical, Dental or Vision plans at the time of retirement (or at a later date), you will not be eligible for reinstatement into those plans at a future date.

Q10. Will I lose my Dental and Vision when I turn 65 and/or become Medicare-eligible?

A10. No, as long as you continue to make premium payments you will not lose your Dental or Vision coverage.

Q11. What benefit options do I have if I am moving out of state after retirement?

A11. The City's medical plans available to Retirees under age 65 and/or not Medicare-eligible consist of Kaiser, Sutter Health, and Western Health Advantage. All plans are HMOs that require members to live or work in their specific service areas in California. They do not have any service areas outside of California.

Retirees over age 65 and/or who are Medicare-eligible have the choice between Kaiser Permanente Senior Advantage (KPSA) and The Hartford Supplement plans. KPSA is a Medicare Advantage plan and available to members residing in the KPSA service area within California. The Hartford Supplement plan is available for members nationwide, as long as your doctor accepts Medicare.

RETIREE FREQUENTLY ASKED QUESTIONS

Q12. I and/or my Spouse is turning 65 soon. How do I add him/her to my Kaiser Senior Advantage Plan?

A12. 90 days before their 65th birthday, the member needs to be enrolled in Medicare Parts A & B. Once enrolled, you need to complete the group Senior Advantage form and send it to the City for processing. You can obtain the form from the City.

Q13. What is the Harford Supplement plan?

A13. The Hartford Supplement plan helps pay some of the health care costs that Original Medicare (Parts A and B) doesn't cover. These gaps include items like co-payments, co-insurance, and deductibles. The Hartford Supplement plan also includes a Prescription, or Part D, benefit through Express Scripts. Please review the Hartford Supplement benefit summary for more plan details.

Q14. Can I use the Hartford Supplement plan outside of CA?

A14. Yes, as long as your provider accepts Medicare.

Q15. Will my benefits change under the Hartford Supplement plan?

A15. Depending on the plan you were previously enrolled in, possibly. Medicare benefits can be different than non-Medicare group plan benefits.

Q16. How do I enroll in the Hartford Supplement plan?

A16. Complete The Hartford enrollment form and return it to the City for processing.

Q17. If I have more questions regarding the Hartford Supplement plan, who do I contact?

A17. You can review additional FAQs from The Hartford in the Retiree Information section of the City's website. Should you have further questions, you can call Bay Bridge Administrators (BBA) at (800) 275-2147 or retireehealth@bbadmin.com.

RETIREE FREQUENTLY ASKED QUESTIONS

Q18. How do I get a 1095-C form for tax purposes?

A18. If you were a full-time employee and retired during the tax year, you will receive a 1095-C form. Thereafter, per the Affordable Care Act (ACA) rules, 1095-Cs are not issued to Retirees as the forms are only required for employees.

Notes