City of Pittsburg
Forward Together.

2024

# EMPLOYEE BENEFITS GUIDE

# 2024 Open Enrollment

Welcome to our guide for City of Pittsburg 2024 benefit package! Whether you are a current employee reading this in late 2023 or a new employee reading this in 2024, this guide should provide much of the information you need to contemplate your benefit elections. Additionally, the HR team is available to support you in your decisions to elect or waive coverage. Please call upon us if you have any questions. You'll find our contact information at the back of the guide.

As a reminder, we have a self-funded health plan where employees and City of Pittsburg work together to cover the administrative fees and claim expenses. As a employee on our self-funded plan, we encourage everyone to be good stewards of the benefit. All of us need to do our part to live a healthy lifestyle and participate in recommended health screenings. If we seek care, we should do so in appropriate places; for instance, using Doctor on Demand instead of a minor care facility. Use the health cost estimator tool to seek services at lower prices. Ask for generic drugs instead of brand name medications. Lastly, if we are eligible to participate in services provided by Tria Health and/or IMA's international script sourcing program, we should comply with the requirements of these programs. Details related to Tria Health and IMA's international script sourcing programs are included in the guide. The benefit of both of these programs is the opportunity to save eligible employees and our plan money on eligible prescriptions.

We have been able to increase some of current benefits without effecting your premiums, please see the medical plan for the changes. All other benefits will remain the same in 2024. We take pride in minimizing changes to our benefits package. We hope employees enjoy the consistency of our package.

Open enrollment elections or waivers will be made using ADP again this year. All employees will need to access the open enrollment portal in ADP by **Friday, October 27, 2023**. If you do not wish to be covered, you must sign a paper waiver to indicate the reason you are declining coverage. Once the open enrollment period concludes, you will not be able to change your elections until the next enrollment period, unless you have a qualifying event. HR must be notified within 31 days of a qualifying event in order to change coverage.

We hope you have a successful and memorable 2024!

Sincerely,

*Human Resources*

# City of Pittsburg Benefits

## Your 2024 Employee Benefits Guide

At City of Pittsburg, we know our dedicated employees—YOU—are key to our overall success as an organization. As a way to reward you for your hard work, we provide a benefits package that is designed to help you reach your physical, financial, and mental health goals.

# What's New in 2024?

## 2024 Plan Summary

### Medical / $R_x$

- Medical rates will stay the same for the 2024 plan year.
- Copays for Office Visits and Mental Health Visits will decrease from $35 to $15 copay.
- Out of Pocket Maximum will also decrease for the single plan from $6,350 to $4,000 and for the family plan from $12,700 to $8,000.
- Employees will all recieved new ID Cards for the 2024 plan year.

### Flexible Spending Account (FSA)

- The FSA limit increased to $3,050.
- Employees can rollover up to $610 from 2023 to 2024.
- In order to access rollover funds, you must re-enroll in the FSA.

### Enrollment

- Enrollment will be completed through ADP Payroll System.

### Specialty Pharmacy

- We are moving from Script Sourcing to IMA Pharmacy Program.

# Eligibility


## Employees:

To elect your benefits, you must enroll online through the ADP self-service portal. The benefits coverage selected during the enrollment period will remain in effect until December 31, 2024, unless you experience a qualifying event.

## Eligibility:

Employees who work at least 30 hours per week are eligible for benefits on the first of the month following their hire date, or during the Annual Enrollment period.

## Dependents:

- Spouse/legally Registered Domestic Partner (same and opposite sex couples)*
- Child(ren) and children of Domestic Partner up to age 26*

## Qualifying Events for Changing Benefits

Because your premiums for medical, dental and vision are deducted from your salary on a pre-tax basis, the IRS has established strict rules regarding the operation of your plans. The choices made by you during your enrollment period must remain in effect for the entire plan year (until December 31). Exceptions are permitted under IRS rules when an employee has a qualifying event. If you have an event, you are required to notify the Human Resources Benefits team within 30 days, enter the appropriate changes in ADP. Documentation of the qualifying event may be required. Some examples of qualifying events include:

- Change in marital status
- Birth or adoption of a child
- Death of a covered dependent
- Loss of eligibility status by a covered dependent
- Change in employment status that affects eligibility for coverage
- Losing or gaining healthcare coverage eligibility under Medicare or Medicaid

## Consistency Rules

In order for a change in status to qualify for a midyear election change, the change in status must be “on account of,” and must correspond to, a change in status that affects the eligibility of an employee, Spouse/domestic partner, or dependent for coverage under an employer’s plan.

# Benefit Enrollment

## New Employees

As a new employee, you must enroll in benefits within 30 days of your date of hire. If you do not enroll within 30 days, you will need to wait until the next open enrollment period to enroll.

## Current Employees

Open enrollment is the only time during the year that you can change your benefits unless you experience a qualifying life event. During the open enrollment period, you have the opportunity to newly enroll in coverage or make changes to your current coverage.

If you wish to contribute pre-tax dollars to a flexible spending account in 2024, you must make a new election during open enrollment. FSA elections do not carry over from year to year.

At City of Pittsburg, open enrollment is typically held in October or November.

Any changes you make during open enrollment become effective January 1.

## Online Enrollment

Both new employee benefits enrollment and open enrollment is done online through the **ADP** website at **online.adp.com**.

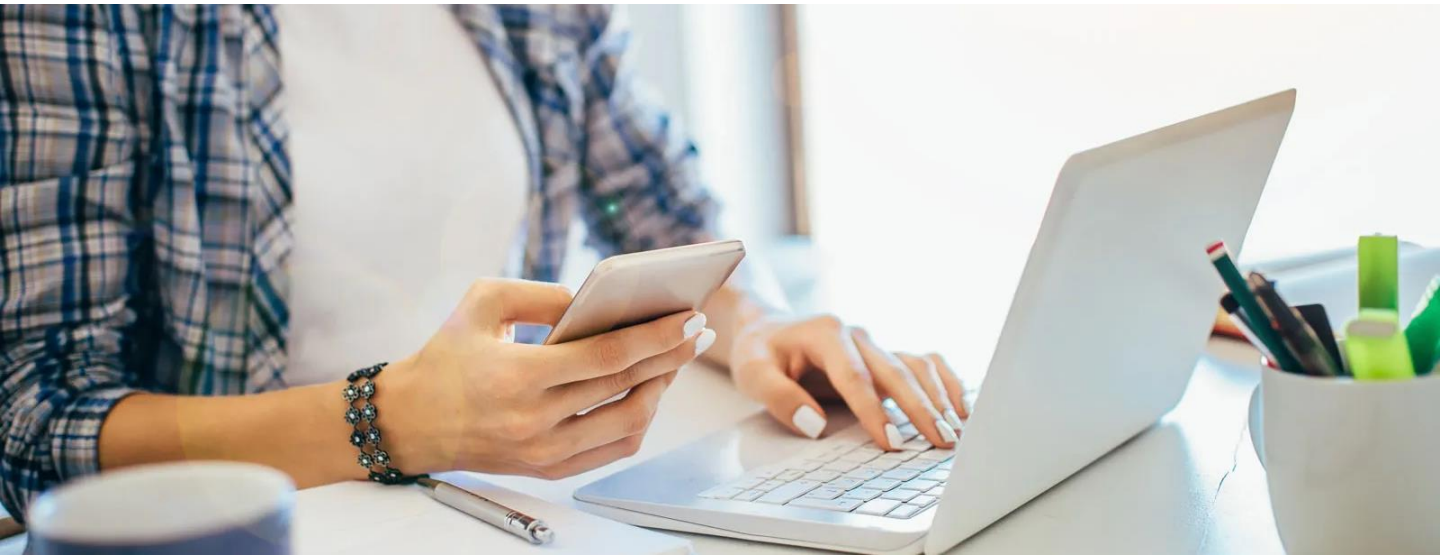
In order to complete your enrollment, you need:

- Dates of birth and social security numbers for yourself as well as any family members you are enrolling.
- Proof of eligibility for your spouse and dependent children (e.g., marriage license, birth certificate).

**Need to Know Updates and Info**

- What is new for 2024
- What is new with you? Did you have a baby, get married?
- Online Enrollment dates:
  - **October 16 – October 27**
- **This will be an mandatory enrollment year, you must complete ADP in order to have benefits for the 2024 plan year.**
- What you need to do to make changes/newly enroll

# Carrier Contacts



| Benefit | Contact Information | Network/Formulary |
|---|---|---|
| Medical<br>HPI | 1.888.275.3775<br>www.hpitpa.com | |
| Telemedicine<br>Doctor on Demand | 1.800.997.6196<br>www.doctorondemand.com | |
| Prescription Benefit Manager<br>Southern Scripts | 1.800.710.9341<br>www.southernscripts.net | |
| Ask Charlie – IMA's Employee Benefits Advocacy Center | 1.866.599.4965<br>CityOfPittsburg@imacorp.com | |
| Flexible Spending Account<br>HPI | 1.800.532.7575<br>www.HPITPA.com | |
| Dental<br>Delta Dental | 1.800.733.5823<br>www.deltadentalks.com | Delta Dental PPO or Premier |
| Vision<br>VSP | 1.800.877.7195<br>www.vsp.com | EyeMed Access |
| Basic Life<br>The Standard | 1.800.628.8600<br>www.standard.com | |
| Voluntary Life and Disability<br>KPERS | 1.888.275.5737<br>www.kpers.org | |
| Medical Transport Solutions<br>AIRMEDCARE | 1.620.717.5957<br>www.airmedcarenetwork.com | |
| EAP<br>ComPsych | 1.800.272.7255<br>www.guidanceresources.com | |
| Specialty Medication Management<br>ScriptSourcing | 410.902.8811<br>www.scriptsourcing.com | |
| Pharmacy Advocate Program<br>Tria Health | 1.888.799.8742<br>www.triahealth.com | |

# Benefit Rates

**Pre-tax Payroll Deductions – Per 24 Pay Periods**

| 2024 Rates | Total Premium | City of Pittsburg Contribution | Employee Portion Per Month | Employee Portion Per Pay Period |
|---|---|---|---|---|
| Medical/Rx - HPI | | | | |
| Employee Only | | | | $33.98 |
| Employee + Spouse | | | | $118.65 |
| Employee + Child(ren) | | | | $113.93 |
| Family | | | | $142.39 |
| Dental – Delta Dental | | | | |
| Employee Only | | | | $7.57 |
| Employee + Spouse | | | | $34.22 |
| Employee + Child(ren) | | | | $32.86 |
| Family | | | | $42.54 |
| Vision - VSP | | | | |
| Employee Only | | | | $4.43 |
| Employee + Spouse | | | | $7.09 |
| Employee + Child(ren) | | | | $7.24 |
| Family | | | | $11.67 |
| Life - Standard | | | | |
| Employee Only | | | | $2.29 |
| Family | | | | $3.74 |
| KPERS Optional Life | | | | |
| Child - $10,000 | | | | $1.10 |
| Child - $20,000 | | | | $2.20 |
| **AIRMEDCARE** | | | | |
| 1- Year Membership | | | | $65.00 |

# Medical / Rx

## HPI

| | Medical PPO Plan | |
|---|---|---|
| | ProviDRs Care Network | None |
| | In-Network | Out-of-Network |
| **Plan Year** | 2024 | |
| **Benefit Period** | 1/1/2024 – 12/31/2024 | |
| **Deductible** Individual \| Family | $500 \| $1,000 | $500 \| $1,000 |
| **Co-Insurance** Plan \| Member | 80% \| 20% | 60% \| 40% |
| **Co-Insurance Max** Individual \| Family | | |
| **Out-of-Pocket Max** Individual \| Family (Includes Deductible, Coinsurance, and Med & Rx Copays) | $4,000 \| $8,000 | $8,000 \| $12,000 |
| **Benefits** | | |
| **Preventive Care** | Plan pays 100% | Plan pays 100% |
| **Office Visit** Primary \| Specialist | $15 Copay | $15 Copay |
| **Telemedicine** (Doctor on Demand) | $5 Copay | $5 Copay |
| **Urgent Care Visit** | $35 Copay | $35 Copay |
| **Emergency Room Visits** | $300 copay, then Ded & Coin | $300 copay, then Ded & Coins |
| **Inpatient Hospital& Outpatient Facility** | Ded & Coin | Ded & Coin |
| **Outpatient Mental Health** | $15 Copay | $15 Copay |
| **Accidental Injury Coverage** | Covered up to $1,000 per person per calendar year | Covered up to $1,000 per person per calendar year |
| **Prescription Drugs – Retail \| Mail Order** | No Deductible | No Deductible |
| **Tier 1 – Generic** | $15 \| $37.50 | Not Covered |
| **Tier 2 - Name Brand Formulary** | $50 \| $125 | Not Covered |
| **Tier 3 - Name Brand Non-Formulary** | $75 \| $187.50 | Not Covered |
| **Specialty Formulary** | $150 | Not Covered |

Out-of-network benefits are paid differently than in-network benefits. Please see the SBC for out-of-network benefits.

## HOW TO FIND A PROVIDER?

Check out the ProviDRs Care link below:

**ProviDRs Care Provider Search**

1. Enter your Group Number (this will be on your Medical I.D. Card)
2. Search for the provider or type of service

# HST

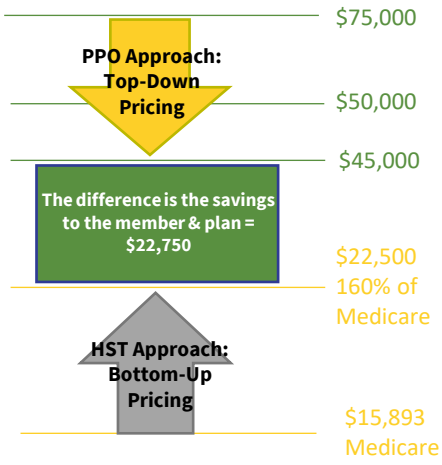
The City of Pittsburg uses a Value Based Payment (VBP) arrangement for any services provided in a hospital setting, which means a hospital PPO network is not being utilized under your health insurance plan. The VBP arrangement is also in place for all services that are provided by a physician, specialist or other health care provider who is not a contracting provider inside the ProviDRs Care Network. If you receive a bill from a hospital and the amount exceeds the patient's responsibility as identified on your Explanation of Benefits (EOB) from HPI, don't pay the bill. Contact the HST Patient Advocacy Center at:
Phone - 1.888.837.2237 or Email - **patientadvocacy@hstechnology.com**

***NOTE: If you select a facility that will not negotiate with HST (like KU, Mayo or MD Anderson), you will be responsible for most of your bill. Those facilities do not negotiate or contract with most insurance companies.***

**However, the City of Pittsburg has negotiated with Via Christi & Freeman Hospital, so if you utilize those hospital facilities, you will not be responsible for any amount over your patient responsibility.**

## How is the price determined?

VBP's pricing methodology uses Medicare plus a percentage & cost information to determine a fair & reasonable price for your medical services.




**Contact PAC via:**

Phone: (888) 837-2237

Fax: (949) 891-0420

Email: pac@hstechnology.com

Monday-Friday 7:00am–5:00pm PST

HSTConnect (mobile app)

# HST

## Patient Advocacy Center (PAC)
### Balance Bill Workflow — Member Edition

**P: 888.837.2237**
**E: pac@hstechnology.com**
**F: 949.891.0420**

Should you receive a balance bill for an amount above your responsibility a copy of your bill and Explanation of Benefits (EOB) is to be submitted to the Patient Advocacy Center. Our responsibility is to ensure the hospital's excessive charges are not passed on to you and that you receive a fair price.

PAC will send you an introductory letter about HST an the advocacy services provided to you once your case is open.

Your Patient Advocate will call the hospital to educate them on your Health Plan and/or negotiate if needed. If negotiations are successful, the Plan will issue a new EOB which may require an additional out-of-pocket expense related to deductibles and coinsurance

PAC will call you to confirm you received the introductory letter and guide you through the PAC process. PAC will provide you with your Patient Advocate's contact information. You are only responsible for paying the patient responsibility amount referenced on your Explanation of Benefits. Please make sure you pay your patient responsibility, or we will be unable to provide our PAC services.


Negotiating balance bills take an average of 15 business days for the hospital to review and respond to us.


The average time to resolve a balance bill is 45 days and is dependent on the hospital's responsiveness.

Billing collection statements from the hospital do not affect your credit report. Although we request your account to be placed on hold, you may continue to receive billing statements and phone calls from the hospital. If this happens, provide them your Patient Advocate's contact information. If you receive any additional notices, please send us a copy.

During this time, your Patient Advocate will follow up with you every 10 business days by phone or email to keep you apprised of their efforts through resolution.

HST
REVOLUTIONIZING HEALTHCARE

# HST

## UNWILLING TO NEGOTIATE

**9**

If the hospital is unwilling to accept the Plan's payment or negotiate a settlement during the initial discussions, we may need to forward you a letter for your review and signature.

This letter is designed to protect your credit under the Fair Credit Reporting Act. The letter requests the hospital communicate directly with the Patient Advocacy Center and gets you out of the middle. We are actively seeking resolution and want to make sure the hospital's excessive charges aren't passed on to you.

**10**

The provider has 30 days to review and respond to the letter. Once reviewed, we'll continue our negotiations to reach a reasonable settlement. If the hospital is unresponsive, a follow up call is made every 5 business days to ensure the letter has been received and reviewed. Should we continue to not receive a response, we will escalate discussions to the Director or VP level to discuss a possible settlement.

**12**

If the dispute has not been closed within the 180 days, all remedies are exhausted, and we will call your Health Plan to present options to determine how they'd like to move forward. The balance owed depends on how the Plan wants to proceed with the hospital. Your Patient Advocate will follow up with you to inform you of the Plan's decision.

**11**

Although Federal law permits this process up to 180 days, your Patient Advocate will keep you apprised every 10 business days through resolution. We understand this can be an intimidating process and we are here to support you. As a reminder, do not pay the balance bill as this will only disrupt the progress the PAC has made and will hinder any negotiations with the hospital for future cases. If you are unsure of the process or if the hospital continues to call, rest assured that we are still negotiating on your behalf and corresponding with the hospital

HST
REVOLUTIONIZING HEALTHCARE

# Where Should I Go For CARE?

Seeking care at an appropriate place of treatment can help you save money and time. Use the chart to help guide you to the most time and cost-effective place of treatment.


## Virtual Care – Minor Medical Conditions

Access virtual care to treat minor medical conditions. Connect with a board-certified doctor via video or phone when, where and how it works best for you. Visit bcbsks.com/telemed or call to talk with a doctor 24/7.*

- Colds and flu
- Rashes
- Sore throats
- Headaches
- Stomachaches
- Fever
- Allergies
- Acne
- Urinary tract infections and more

› Costs the same or less than a visit with your primary care provider (PCP)
› Appointments typically in an hour or less
› No need to leave home or work

## Convenience Care Clinic

Treats minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends.

- Colds and flu
- Rashes or skin conditions
- Sore throats, earaches, sinus pain
- Minor cuts or burns
- Pregnancy testing
- Vaccines

› Same or lower than provider's office
› No appointment needed

## Health Care Provider's Office

The best place to go for routine or preventive care, or to keep track of medications. Many primary care physicians offer virtual care. Contact your PCP to schedule an in-person or virtual care visit.

- General health issues
- Preventive care
- Routine check-ups
- Immunizations and Screenings

› May charge copay / coinsurance and / or deductible
› Usually need appointment
› Short wait times

## Urgent Care

For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.

- Fever and flu symptoms
- Minor cuts, sprains, burns rashes
- Headaches
- Lower back pain
- joint pain
- Minor respiratory symptoms
- UTIs

› Cost lower than emergency room (ER)
› No appointment needed
› Wait times vary

## Emergency Room

For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life threatening, call 911 or go to the nearest ER. "Freestanding" ER locations are becoming more common in many areas. Because these ERs are not inside hospitals, they may look like urgent care centers. When you receive care at an ER, you're billed at a much higher cost than at other health care facilities.

- Sudden numbness, weakness
- Uncontrolled bleeding
- Seizures or loss of consciousness
- Shortness of breath
- Chest pain
- Head injury/major trauma
- Blurry or loss of vision
- Severe cuts or burns
- Overdose

› Highest cost
› No appointment needed
› Wait times may be long

# Telemedicine

## DOCTOR ON DEMAND

### GET THE CARE YOU NEED.

Doctor on Demand doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more!

Doctor on Demand is just a click or call away! Download the App!

www.doctorondemand.com

1-800-997–6196

Available on the iPhone App Store

ANDROID APP ON Google play

## THERAPY SERVICES HELP

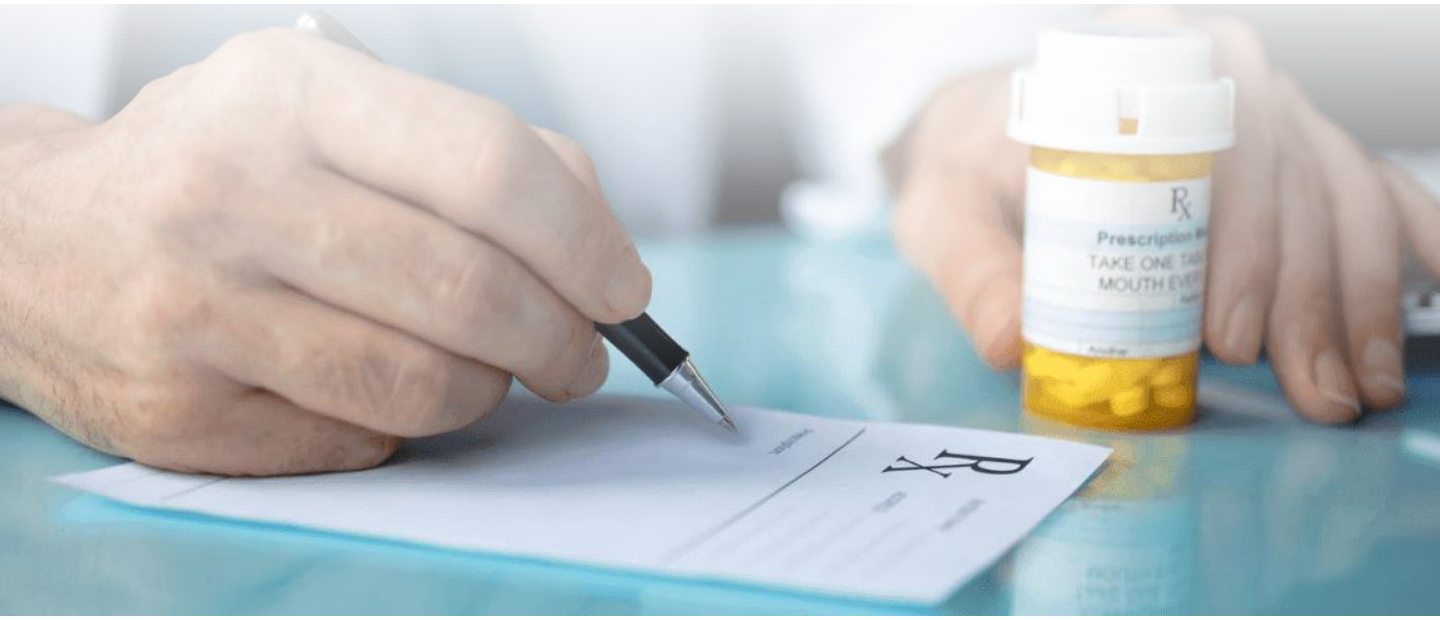
- Addiction
- Anxiety
- Big Life Changes
- Depression
- Family Difficulties
- Grief Counseling
- Work Pressures & More
- Marital Issues
- PTSD
- Stress

dr. on demand

# Prescriptions

Taking cost-effective prescription drugs helps save you money. The chart below provides examples of types of medications your provider may prescribe. Knowing what tier your prescription falls into may help save you money.

| DRUG TIERS | WHAT DOES THAT MEAN? |
|---|---|
| **$**<br>**Generic** | Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Generic drugs generally cost less than brand-name drugs. |
| **$$**<br>**Preferred Brand** | Preferred brand drugs are brand-name drugs that may not be available in generic form but are chosen for their cost effectiveness compared to alternatives. Your cost-share will be more than generics but less than non-preferred brand drugs. |
| **$$$**<br>**Non-Preferred Brand** | Non-preferred brand drugs often have a generic or preferred brand drug option where your cost-share will be lower. |
| **$$$$**<br>**Specialty** | Specialty medications are one prescribed for a patient with a complex or chronic medical condition, typically requiring additional patient education and support, and often associated with high monthly cost. Specialty medications are not usually readily stocked in retail or local pharmacies. |
| **$$$$**<br>**Non-Preferred Specialty** | A non-formulary specialty drug is categorized as a specialty medication that is not preferred medication, generally due to cost. |



# SouthernScripts

Choosing generics over brand name prescriptions, when available, is one of the best strategies for saving money. Always talk with your doctor or pharmacist about interactions with other medications you take and possible side effects. Members of Southern Scripts have access to reduced prescription costs at participating FirstChoice pharmacies.*

## PRESCRIPTION COPAY

| RETAIL OR MAIL ORDER | 30, 34, 60 DAYS/61-90 DAYS |
|---|---|
| Tier 1 (Generic) | $15/$37.50 |
| Tier 2 (Formulary Brand) | $50/$125 |
| Tier 3 (Non-Formulary Brand) | $75/$187.50 |
| Specialty (30 day supply only) | $150/Not available |

**To find a list of FirstChoice pharmacies, use the pharmacy locator instructions below.**
**Look for the FirstChoice logo next to member pharmacies before filling your prescriptions.**

The **Variable Copay Program** uses coupons provided by the manufacturer to greatly reduce costs on eligible medications. Please contact a CRx Customer Care Associate at 1-800-710-9341 to find out if your prescriptions qualify.

### Specialty Pharmacy

If you are prescribed specialty medications by your doctor, use our Network Pharmacy Locator tool to find specialty pharmacies in your area or call 1-800-710-9341.

### Mail Order

Sign up to get your prescriptions mailed directly to your home. Call 1-800.710.9347 today.

### Lower your Costs Today

Get instant access to your benefits, price-check tools, and more. Visit southernscripts.net/members

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firstchoice southernscripts

1. Visit southernscripts.net/members
2. Enter your Zip Code
3. Use the Bin Number Listed (015433)
4. Enter your Group Code (PI0000)
5. Select your search radius


southernscripts

# Specialty Rx Savings Program

## IMA Pharmacy Advocates

The City of Pittsburg is partnering with IMA Pharmacy Advocates to find alternative sourcing options for specialty medications.

### How Does the Program Work?

IMA Pharmacy Advocates provides a unique opportunity to help employees save money on specialty medications. This is a free and confidential benefit that will support you in managing your specialty medications and healthcare budget.

### Are the prescriptions safe?

Yes! The tier 1 countries (Canada, Australia, New Zealand and UK) where medications are being sourced from meet or exceed U.S. Food and Drug Administration (FDA) requirements.

### Who Should Participate?

IMA's Pharmacy Advocate Program is available for employees and/or dependents on The City of Pittsburg's health insurance taking specialty medications.

### Why Participate?

IMA Pharmacy Advocates save you and the health plan money, which translates into more stable premiums over time. Active employees will receive specialty medications **at no cost** directly to you with no shipping or handling costs.

### If I Participate Does City of Pittsburg Have Access to My Health Information?

No, IMA Pharmacy Advocates are separate from The City of Pittsburg. The City of Pittsburg will see who is eligible to participate but will not receive any Protected Health Information.

### How Will I Receive My Medication?

Medications will be mailed to you, but a signature is required for delivery. You can sign in advance via the USPS website.

### How Do I Get Started?

Employees and/or dependents on The City of Pittsburg health insurance will be identified by IMA Pharmacy Advocates. If a medication you and/or dependents are taking is eligible to participate in this program, IMA Pharmacy Advocates will contact you directly to get enrolled in the program and help you through the process. Due to HIPAA, IMA Pharmacy Advocates must speak directly to your eligible dependents if over age 18.

# Tria Health – Pharmacy Advocate Program

Healthcare and insurance is confusing and difficult, especially if you take a lot of medications and have chronic conditions. Tria Health is a free and confidential benefit that will support you in managing your health, medications and healthcare budget. Talk to a pharmacist over the phone and receive the personalized care you deserve.

## Who Should Participate?

Tria Health's Pharmacy Advocate Program is available for employees and/or dependents on the City of Pittsburg health insurance. Tria Health is recommended for member who have any of the following conditions:

- Diabetes
- Heart Disease
- High Cholesterol
- High Blood Pressure
- Mental Health
- Asthma/COPD
- Osteoporosis
- Migraines

## Why Participate?

Pharmacists are the experts in how medications work and can provide valuable feedback to you and your doctor(s). Your Tria Health pharmacist can help:

- Make sure your medications are working as intended.
- Help you save money.
- Answer any questions you have about your health.
- Coordinate care with your doctor(s).

## Active employees Can Save Money on Their Medications & Earn Wellness Points

Active employees will receive discounted copays on select medications used to treat targeted chronic conditions. You are not required to change your medications, pharmacy or doctor to receive this benefit.

- Free generics
- 50% off select brand medications*

## Free Diabetes Test Strips & Meter

Active employees with diabetes will have access to a FREE blood glucose meter, testing strips, and mobile app designed to help you better manage your diabetes!

## FAQs

### Does my doctor know about Tria Health?

Tria Health's pharmacist will inform your doctor about Tria Health and our services. All necessary information and recommendations are provided to the member's doctor as part of our coordination ofcare.

### Am I required to change my medications or pharmacy?

After speaking with your pharmacist, Tria Health may provide recommendations to you AND your doctor(s) to improve the outcomes you receive from your medications and/or lower your out-of-pocket cost. Any changes are left up to you and your doctor for approval.

## How to Sign up?

Call 1.888.799.8742 or visit **www.triahealth.com/enroll**

After you enroll, TRIA Health will call you to schedule an appointment to speak with a TRIA Pharmacist.

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Is there a way to save money on the medications I take?

I'm taking everything my doctor prescribed, butI still don't feel great. Who should Icall?

Can I reduce the numberof medications I take without impacting myhealth?

**Tria Health is only a phone call away. 1.888.799.8742**

tria HEALTH

# Flexible Spending Account (FSA)

## HPI

### What is a Flexible Spending Account (FSA)?

A Flexible Spending Account offers you a significant tax savings opportunity. They allow you to pay for eligible health care expenses using pre-tax dollars (money taken out of your paycheck before income or Social Security taxes have been calculated). There are three different types of FSA accounts

The easiest way to manage your account is online at **www.hpitpa.com** or through the HPI smart mobile app.

You can't change your election amount during the plan year, unless you experience a change in status or qualifying event. Outside of the rollover, any unused funds that remain in your account at the end of the year will be forfeited. Plan carefully and use all the money in your dependent care FSA by the end of the plan year.

### The Two Types of FSAs:

#### Health Care FSA

You can use money set aside in your HealthCare FSA for eligible medical, dental, and vision expenses incurred by you, your spouse, or your taxable dependents. This includes diagnosis, treatment, and prevention of disease or treatment for any part or function of the body. Great examples of this include copays, and deductibles.

Cosmetic medical expenses, such as facelifts or hair removal, are not eligible. Expenses that benefit general health, such as vacation or health club memberships, are also not eligible.

Remember to keep your receipts and/or other documentation in case it is needed to verify the medical expense. Some items may require additional documentation, such as a letter from your medical provider.

**The maximum amount you can contribute is $3,050 per year. Funds are available on the first day of the plan effective date.**

#### Dependent Care FSA

In order for dependent care services to be eligible, they must be for the care of a taxable dependent under the age of 13 who lives with you or for a taxable dependent who is incapable of caring for himself or herself.

The care must be needed so that you and your spouse (if applicable) can go to work. Because of this, care must be given during normal working hours and cannot be provided by another of your dependents.

As always, it is important to consult with your tax advisor to determine if participation in this benefit is to your advantage or if filing for your childcare credit on your annual tax return may be more beneficial.

**The maximum amount you can contribute is $5,000 per year, dependent on your marital and tax-filing status.**

**NOTE: These accounts are separate. You cannot use money from one account to pay for expenses that are eligible under the other.**

# Flexible Spending Account (FSA)

## QUALIFYING HEALTH CARE EXPENSES

- Alcoholism / Drug / Substance Abuse Treatment
- Allergy and Sinus Medications
- Allergy Medications and Testing
- Chiropractor
- Contact Lenses
- Copays
- Dental Treatment
- Diabetic Monitors, Test Kits, Strips, and Supplies
- Flu Shots
- Hearing Aids
- Hospital Services
- Laboratory Fees
- Over-the-counter meds
- Oxygen
- Physical Examination
- Prescription Eyeglasses & Sunglasses
- Prescription Medications
- Psychiatric Care / Psychologist
- Surgery
- Vision Correction Surgery
- X-Ray

## HEALTH CARE EXPENSES NOT ALLOWED

- Baby Sitting
- Baby Wipes
- Cosmetics
- Cosmetic Surgery
- Dancing Lessons
- Deodorants
- Diaper Service
- Electrolysis or Hair Removal
- Field Trips
- Finance Charges
- Food
- Funeral Expenses
- Future Medical Care
- Hair Transplant
- Health Club Dues
- Household Help
- Insurance Premiums
- Illegal Operations and Treatments
- Maternity Clothes
- Medicine and Drugs from Other Countries
- Pedicures
- Perfume
- Physical Exams for Caregivers
- Shampoo and Conditioner
- Skin Care
- Sun-tanning Products
- Swimming Lessons
- Teeth Whitening
- Toothbrushes
- Veterinary Fees
- Weight-Loss Program

**If you have extra FSA dollars to spend at the end of the year visit FSASTORE.COM**

# Your Dental Benefits

## DELTA DENTAL OF KANSAS

| | Dental Plan<br>Delta Dental PPO & Premier Network<br>In-Network |
|---|---|
| **Plan Year** | 2024 |
| **Benefit Period** | 1/1/2024 – 12/31/2024 |
| **Maximum Benefit(s) Per Person** | $1,500 |
| **Deductible** Individual \| Family<br>(Applies to Basic & Major Services) | $25 \| $75 |
| **Diagnostic & Preventive**<br>(Cleanings – Unlimited, Oral Exams, X-Rays, Topical Fluoride, Space Maintainers, Sealants) | 100% covered, no deductible |
| ***Basic Services (see link below)**<br>(Ancillary, Oral Surgery, Fillings (except gold), Endodontics, Non-surgical periodontics)<br>**Covered 100% for dependents age 12 and under!** | 80% after deductible |
| ***Major Services (see link below)**<br>(Periodontal surgery, Bridges, crowns, Dentures)<br>**Covered 100% for dependents age 12 and under!** | 50% after deductible |
| **CHILD Orthodontia**<br>For Dependent children to age 26 | Covered after deductible up to max of $3,000 |
| **ADULT Orthodontia** | Covered after deductible up to max of $3,000 |

Out-of-network benefits are paid differently than in-network benefits. Please see the SBC for out-of-network benefits.

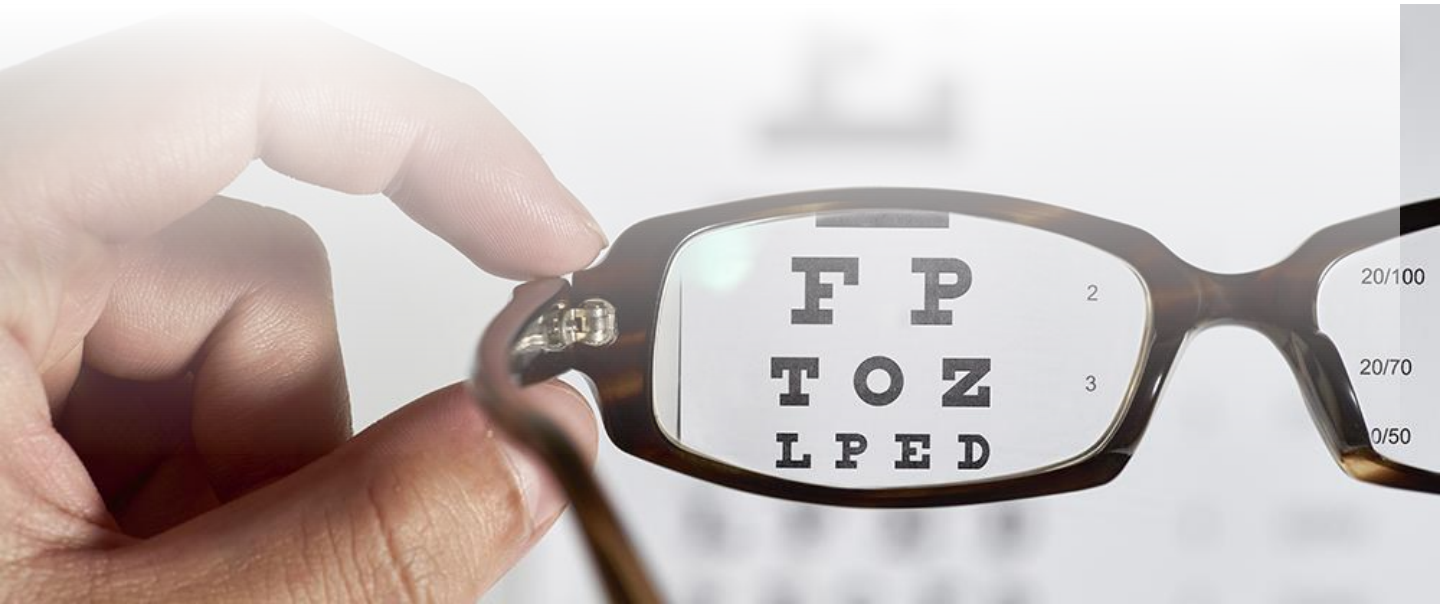
*What Dental Insurance Covers | Delta Dental (deltadentalks.com)

## FIND A DENTIST

### How to find a network dentist:

1. Go to **www.deltadentalks.com**
2. Select "I'm a member"
3. Select "Find a Dentist"
4. Select Specialty in drop down menu
5. Select Network in drop down menu
6. Fill in Dentist's last name (Optional)
7. Select "Yes" to search current location or "No" to add a different location
8. Click on "Find Dentist"

# Your Vision Benefits




## VSP

| | Vision Plan<br>Network<br>In-Network |
|---|---|
| **Plan Year** | 2024 |
| **Benefit Period** | 1/1/2024 – 12/31/2024 |
| **Exam** | $10 Copay |
| **Exam Frequency** | Once every calendar year |
| **Lens/Contact Lens Frequency** | Once every calendar year |
| **Frames Frequency** | Once every other calendar year |
| **Standard Frames** | $130 Allowance with 20% off over $130 |
| **Lenses*** (Single, Bifocal, Trifocal) | $25 Copay |
| **Elective Contact Lenses**** | $130 Allowance, copay does not apply |

* *Lens Copay only covers Single, Bifocal, and lined Trifocal. Progressive Lenses and other lens options are available at an additional cost.*

** *Contact lens allowance is in lieu of standard glass lenses.*

Out-of-network benefits are paid differently than in-network benefits. Please see the SBC for out-of-network benefits.

Visit www.xxxx.xxx to create your secure account, find a provider, print ID cards, check your eligibility or claims status and more!

Annual eye exams are covered at 100% for those enrolled in the medical benefits through HPI using a ProviDr's Care provider. Remember to present your insurance card at the time of visit.

# Essential Medical Eye Care

VSP® Vision Care is committed to providing eye care that supports our members' overall health and wellness. That's why we offer Essential Medical Eye Care. With your vision benefits from VSP, you have access to supplemental coverage for urgent and medical eye care.

vsp vision care

## What's Included With Essential Medical Eye Care?

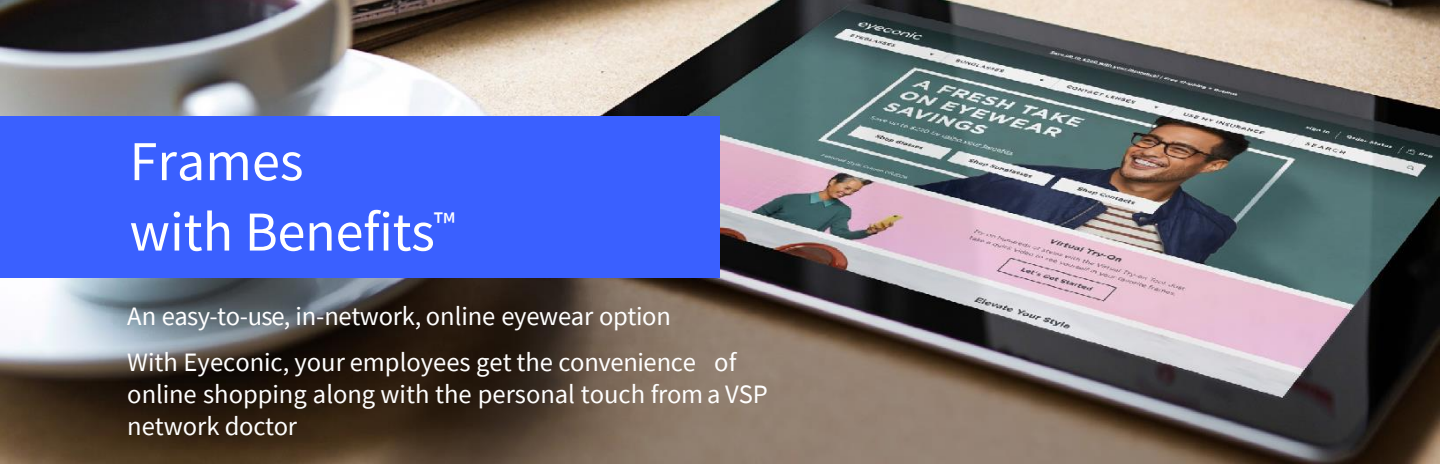
- Fully covered retinal screening for members with diabetes. These high-resolution images of the inside of the eye are a non-invasive way to monitor diabetes.
- Exams and services to treat immediate issues like pink eye and sudden changes in vision.
- Treatment options to monitor ongoing health conditions such as dry eye, diabetic eye disease, glaucoma, and more.

## If You Need Treatment

1. Contact your VSP network doctor to schedule an appointment.
2. If you don't have an eye doctor, visit **vsp.com** to find one and receive the eye care you need from an eye care expert.
3. When your VSP network doctor participates in your medical insurance plan's network, your medical insurance will be billed. You may be able to coordinate with your VSP benefits to help reduce out-of-pocket costs. If your VSP doctor doesn't participate with your medical insurance plan, VSP has you covered with only the cost of your copay.*

**Find a VSP network doctor at vsp.com or call 800.877.7195.**

*A standard copay of up to $20 is required for medical eye exams. Other covered services are covered-in-full, including retinal screening for members with diabetes. Log in to **vsp.com** to view your benefits.




# Frames with Benefits™

An easy-to-use, in-network, online eyewear option

With Eyeconic, your employees get the convenience of online shopping along with the personal touch from a VSP network doctor

## Online shopping with benefits

Employees can easily connect their VSP® benefits to see their savings in real time. Online shoppers will also love:

- Free shipping and returns
- Virtual Try-On tool
- Free frame adjustment or contact lens consultation
- All-inclusive pricing on glasses and lenses

## More bang for their buck

If your employees shop online for glasses and contacts, they'll get more value on Eyeconic®.

- Average savings of $220
- Up to $120 savings on an annual contact lens supply
- 20% off additional pairs of glasses or sunglasses
- HSA and FSA accepted

## Share the love

Spreading the word that employees can use their vision benefits to shop on Eyeconic is easy. Ask your VSP representative about these turnkey tools:

- Flier
- Intranet article
- Benefit fair support

vsp vision care

## More

In-network eyewear choices

eyeconic
a vsp vision company

**It's even easier to increase employee satisfaction through your VSP benefit. Why wait? Check out eyeconic.com® today!**

# Put your eyes at ease with VSP LightCare

## Why UV and Blue Light Coverage?

Even if you don't wear prescription glasses, an annual eye exam is an easy and cost-effective way to take care of your eyes and overall health.

With VSP LightCare™, you can use your frame and lens benefit to get non-prescription eyewear from your VSP® network doctor. Sunglasses or blue light filtering glasses may be just what you're looking for.

### KEEP YOUR EYES PROTECTED OUTDOORS AND IN:

**Always wear sunglasses outdoors.** Protect your eyes from the sun's ultraviolet rays that can damage your corneas and cause eye-related diseases like cataracts. 100% UVA and UVB protection is the best choice for your sunglasses.[2]
Wear blue light filtering glasses indoors to combat digital eye strain. Digital screens and fluorescent lighting emit blue light that can contribute headaches, blurred vision, and sore eyes—all possible symptoms of digital eye strain.

### PROVIDER CHOICES YOU WANT

The VSP Premier Program includes thousands of **private practice doctors** and more than 700 **Visionworks® retail locations** nationwide.

### Prefer to shop online?

At **eyeconic.com®**, you'll be shopping at the preferred online retailer for VSP members where you can connect and use your benefits.[3]

vsp vision care

## Your VSP LightCare Coverage with a VSP Network Doctor*

### Eye Exam

A fully covered comprehensive WellVision Exam®.[1]

### Eyewear

Visit a VSP network doctor and choose either prescription eyewear coverage, or use your frame and lens allowance toward ready-to-wear:

- non-prescription sunglasses *or*
- non-prescription blue light filtering glasses

*Register and log in to **vsp.com** to review your benefit information. Based on applicable laws; benefits may vary by location.

**Questions? vsp.com | 800.877.7195**

**1**. Less any applicable copay **2**. Tips for Choosing the Best Sunglasses, American Academy of Ophthalmology, June 2021 **3.** To find out whether your employer participates in Eyeconic®, log in to **vsp.com** to check your vision benefits.

# SETTING A NEW STANDARD

**VSP Vision Care has raised the bar as the only vision care company to offer covered-in-full standard progressive lenses—at no extra cost.[1]**

With fully-covered standard progressive lenses, your employees have one more option to enjoy clear, precise vision at an exceptional value. There's no extra cost and nothing more for you and your employees to do.

## WHAT ARE PROGRESSIVE LENSES?

- Progressive lenses offer smooth, continuous vision at near, middle, and distant focal ranges—with no lines or unsettling image jumps.
- Bifocals, on the other hand, correct near and distant vision only—with a visible line between the two fields of vision.

## WHO NEEDS PROGRESSIVE LENSES?

- More than 34% of the U.S. population experiences presbyopia—a normal loss of ability to focus on nearby objects that happens with age.[2]
- For many employees, progressive lenses are an attractive solution and a popular alternative to bifocal and trifocal lenses.

## VSP® MEMBERS ARE THE PRIORITY

- There are a wide variety of progressive lenses—including standard, premium, and customized lenses.
- Now with covered-in-full standard progressive lenses, employees have another option to enjoy clear, precise vision at an exceptional value.

**PROGRESSIVE LENS WEARERS IN THE WORKFORCE:**

**74M**

**EMPLOYEES IN THE U.S. ARE AGED 40–64[3]**

**73%**

**OF PROGRESSIVE LENS WEARERS ARE AGED 40–64[4]**

**Employees can visit a VSP network doctor to discuss which lenses are best for them.**

**1.** Some exceptions apply. Contact your VSP Account Executive or Client Manager for details. A doctor will prescribe the best Rx and lenses to meet the patient's needs. **2.** Global Presbyopia Report by Market Scope, LLC, 2012. **3.** Bureau of Labor Statistics 2017 CPS. **4.** The Vision Council VisionWatch Eyewear U.S. Study, June 2017.

# Voluntary Life and AD&D

## THE STANDARD

### Voluntary Life and AD&D Plan

As an employee of City of Pittsburg, you have the option of purchasing additional life insurance for yourself, a spouse and/or children. This benefit provides valuable income protection if you suffer a sever accident or loss of life. Any amounts over the Guarantee Issue amount will require an Evidence of Insurability form to be completed and sent to The Standard for underwriting approval. **This benefit is only available to you at your first opportunity to enroll as a new hire.**

| | Employee* | Spouse/Domestic Partner | Child(ren) |
|---|---|---|---|
| **Coverage Options** | $25,000 increments | $5,000 Increments | $1,000 Increments: Includes all children in family |
| **Guarantee Issue Amount (New Hires Only)** | $200,000 | $50,000 | $10,000 |
| **Maximum Amount** | 7x Base Annual Salary up to $500,000 | 50% of employee coverage up to $250,000 | Up to $10,000 |

In order to elect dependent coverage, you must first elect life insurance for yourself. Spouse's rate is based on employee's age.
**You must name a beneficiary for your Life and AD&D benefits. Beneficiary changes may be made at any time during the plan year.**
**NOTE:** Your life insurance benefits and guarantee issue amounts are subject to age reductions. At age 65, amounts reduce to 65%. At age 70+, amounts reduce to 50%. Spouse coverage terminates at age 70. Employee coverage terminates at retirement. Reductions will occur on January 1 following attainment of that age. If you are to leave City of Pittsburg, conversion and portability options are available to you.

# Voluntary Emergency Medical Transport

## AIRMEDCARE NETWORK

AirMedCare Network (AMCM) provides emergency medical transport services. When you or your dependents need transport from a far-away medical facility for recovery closer to home, Fly-U-Home* coverage guarantees that everything is taken care of. Members never pay a dime out-of-pocket when transported by an AMCN provider. Enjoy peace of mind for as little as $85 a year, or $65 a year for seniors. Additional membership cost for Fly-U-Home return flights. This is not payroll deducted. To join, sign up at **https://www.airmedcarenetwork.com/apply**.

How it works

### Here's what happens in case of an emergency:

When a medical professional determines emergency transport is necessary, they may decide that air ambulance is the fastest and safest way to get you to the care you need.

1

2

If requested by a hospital or first responder, AirMedCare Network providers respond with caring, experienced, highly-trained crews and aircraft equipped with the latest life-saving and life-support equipment.

You're transported to the closest appropriate hospital for continuing care.

3

4

When an AMCN member is transported by one of our Network providers, you can recover without financial worry, knowing all out-of-pocket flight expenses are covered.

# Employee Assistance Program

## ComPsych

City of Pittsburg has partnered with ComPsych to provide all employees and their family members free confidential short-term counseling. These licensed counselors are effective and experienced in real life concerns you or your family may face.

### Common Concerns ComPsych Can Help With Are:

**Confidential Counseling**

- Family and Parenting Concerns
- Life Event Changes
- Marital and Relationship Issues
- Addictions
- Substance Abuse Services
- Self Esteem Concerns
- Grief and Loss
- Stress, Depression and Anxiety
- Work Related Pressures
- Divorce Recovery
- Relationship Challenges

**Financial and Legal Assistance**

- Financial and Legal Counseling

**24-hour Crisis Intervention and Assessment**

- 24-hour emergency services available by calling 800.272.7555

### How Do I Contact ComPsych?

Call 1-800-272-7255 to schedule an appointment or to talk with a counselor. When you call, ask for the specialty area. If a therapist is not immediately available, you may leave a confidential voice mail. Some initial information will be taken over the telephone and an appointment for an evaluation can be scheduled at that time, if requested. For EMERGENCY SERVICES 24-Hours, 7-days a week call 800.272.7555. To access this benefit, log on to **www.guidanceresources.com**.

**Your access code is: COM589**

COMPSYCH® GuidanceResources® Worldwide

# KPERS Life and AD&D

KPERS provides all full-time employees with a life insurance benefit of 150% of your annual salary.

## KPERS OPTIONAL LIFE (OPEN ENROLLMENT IS THE MONTH OF SEPTEMBER)

In addition to your employer sponsored KPERS life and AD&D benefit, you may also voluntarily elect to enroll in optional life insurance coverage through KPERS. Benefits reduce to 65% at age 65, and another 50% at age 70. Certain coverage levels and enrollments may require medical history information for yourself and dependents. Contact HR.

| | GUARANTEE ISSUE | INCREMENTS | MAXIMUM |
|---|---|---|---|
| **Employee Coverage** | $250,000 or less | $5,000 | $400,000 |
| **Spouse Coverage** | $25,000 or less | $10,000/$25,000/$50,000/$100,000 | $100,000 |
| **Child Coverage** | $10,000 or $20,000 | | $20,000 |

**You must enroll upon new hire, status change to full time employee, or during KPERS special enrollment period in September annually.**

## KPERS LONG-TERM DISABILITY (LTD)

In the event that you are not able to work due to a qualified injury or illness, you have LTD Coverage available through KPERS. Contact HR for assistance. Both KPERS and KP&F members are qualified to apply for benefits.

| ELIMINATION PERIOD | BENEFIT | OWN/ANY OCCUPATION | DURATION |
|---|---|---|---|
| **180 Days — KPERS**<br>**None — KP&F** | 60% of monthly earnings to a max of $5,000/mo | 24 Months/<br>24 Months | If the disability begins before age 60, the period remaining to the member's 65th birthday or retirement, whichever occurs first. |

# KPERS 457

## KPERS 457

## Traditional Pre-Tax & Roth After-Tax (NEW)

KPERS 457 is a governmental 457(b) deferred compensation plan. It's a retirement savings plan that allows eligible employees to supplement any existing retirement and pension benefits by saving pre-tax dollars or Roth after-tax deductions through a voluntary salary contribution.

- The minimum amount you can contribute to each plan is $12 or 1% per pay period.
- The maximum amount you can contribution is set by the IRS an is up to 99% of your salary or $20,500 whichever is less.
- You can have an additional $6,500 as a catch-up contribution if you are age 50 or older.
- KPERS 457 also offers a special catch-up provision, If you are within 3 calendar years of your normal retirement age, you can contribute up to twice the regular limit - $41,000.
- You are not able to use both of the catch-up contribution's types in the same calendar year.
- You can enroll online at **www.kpers457.org** or by phone at 800-232-0024, you will need your Group Number and Plan Enrollment Code
- The 10% early withdrawal penalty that applies to 401(k) plans and IRA's generally does not apply to distributions from your KPERS 457 account.
- Counselors are available to assist you at no additional costs.

kpers457
a deferred compensation savings plan

# Mental Health Resources

## 988 Suicide & Crisis Lifeline

We can all help prevent suicide. The Lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals in the United States.

The 988 Suicide & Crisis Lifeline is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week in the United States. We're committed to improving crisis services and advancing suicide prevention by empowering individuals, advancing professional best practices, and building awareness.

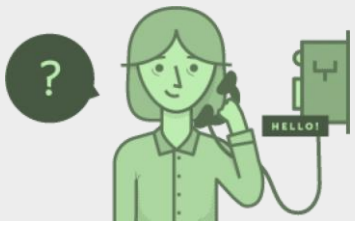
**First, you'll hear an automated message featuring additional options while your call is routed to your local Lifeline network crisis center.**

**We'll play you a little music while we connect you with a skilled, trained crisis worker.**

**Then, a trained crisis worker at your local center will answer the phone.**

**This person will listen to you, understand how your problem is affecting you, provide support and get you the help you need.**

**Lifeline Center calls are FREE and CONFIDENTIAL, and we're available 24 / 7.**




**For more information on resources or to chat online with Lifeline visit**
**www.988lifeline.org**

988 Suicide & Crisis Lifeline

988

**CHAT WITH LIFELINE**

# Terms & Definitions

**COPAY** – A predetermined rate the insured employee (member) pays for healthcare services (medical, dental, vision) at the time of the appointment.

**DEDUCTIBLE** – A specified amount of money that the member must pay before the insurance company will pay the claim.

**COINSURANCE** – The percentage of costs of a covered healthcare service that the member pays after you've paid your deductible. For example, let's say your health insurance plan's allowed amount for an office visit is $100 and your coinsurance is 20%. If you've paid your deductible, you pay 20% of $100, or $20 and the insurance company pays 80% of $100, or $80.

**OUT-OF-POCKET MAXIMUM** – The most the member pays for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. The out-of-pocket limit does NOT include your monthly insurance premiums.

**IN-NETWORK** – Refers to providers or health care facilities and hospitals that are part of the health plan's network of providers with which it has negotiated a contract and set rates. Coverage for service is usually greater than an out-of-network provider. An in-network provider cannot balance bill a patient.

**OUT-OF-NETWORK** – Typically refers to physicians, hospitals or other health care providers who do not contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out of network providers might not be covered, or coverage may be less than for in-network providers.

**PRE-ADMISSION CERTIFICATION** – Also called "precertification" or "pre-admission review." Approval granted by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or inpatient facility before admittance. The goal is to ensure that individuals are not exposed to inappropriate health care services, or services that are not medically necessary.

# Notices

The following pages provide employee benefit plan notices. Please read them carefully as we generally provide these once a year during annual open enrollment. You may see some of these notices in other documents as well, but we consolidate the following notices here for your convenience:

- MEDICARE PART D PRESCRIPTION DRUG CREDITABILITY/NON-CREDITABILITY
- OUR PLAN PAYS SECONDARY TO DISABILITY-BASED MEDICARE AFTER BEING SOCIAL SECURITY DISABLED FOR 24 MONTHS
- NON-GRANDFATHERED MEDICAL PLAN APPEALS PROCESSES
- WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)
- PUBLIC HEALTH INSURANCE MARKETPLACE
- SPECIAL MEDICAL ENROLLMENT RIGHTS AND RESPONSIBILITIES UNDER HIPAA
- PREMIUM ASSISTANCE UNDER MEDICAID OR THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Throughout these pages you are invited to "contact HR" for assistance. For any questions or requests you may have about the pages below, including a request for a paper copy of this notice packet, contact Kadie Hawpe in human resources (HR) at 620-530-5589.

Before we get into the notices, some basic rules governing our plan are summarized below:

- You may only enroll when first eligible or during our annual open enrollment each October or November.
- **Your election is locked** for the entire plan year, January 1 to December 31.
- You can generally submit an election change form **within [30 days] of a qualifying life event** to request a benefit change during the plan year. We may require substantiating documentation of the event, and we may determine the event does not qualify to make the requested change.
- At any time, we may audit dependent status and require current substantiating documentation.
- Declining to enroll in coverage will require your signature each year.
- **Please keep us informed of address or beneficiary changes.**
- When first enrolling in health coverage, a **general notice of rights and responsibilities to continue health coverage under COBRA** is mailed to the home. It explains that when certain life events make an enrolled individual no longer eligible to stay on the plan, coverage might be able to continue for a limited time under COBRA so long as you or your spouse follow our procedures to notify us within [30 days] of the qualifying life event.
- Your rights and responsibilities under the FMLA and our company-specific FMLA policies are discussed in our employee handbook.

# Notices

## MEDICARE PART D PRESCRIPTION DRUG CREDITABILITY/NON-CREDITABILITY

When you or a family member becomes eligible for Part D (Medicare's prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain "creditable" coverage (i.e., coverage which on average pays at least as well as Part D pays on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity.

Below are highlights to note:

- A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.
- The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1% of Part D base premium for each month you are late.
- When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).
- The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

| Creditable Coverage | Non-Creditable Coverage |
|---|---|
| **PPO Option** | **None (all plans are creditable)** |

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at ***https://www.medicare.gov/Contacts/#resources/ships***.

## OUR PLAN PAYS SECONDARY TO DISABILITY-BASED MEDICARE AFTER BEING SOCIAL SECURITY DISABLED FOR 24 MONTHS

When you or a dependent are determined disabled by the Social Security Administration, it is imperative such individual have Medicare begin immediately after 24 months of Social Security disability. Regardless whether the individual is enrolled in Medicare or not, our plan will calculate how much Medicare would have paid and then pay secondary (meaning it will pay very little or nothing).

If we employ 100 or more full- and part-time employees during 50% or more of business days during the previous calendar year, then we will give everyone an update that our plan will begin paying primary (not secondary) to disability-based Medicare.

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at ***https://www.medicare.gov/Contacts/#resources/ships***.

## NON-GRANDFATHERED MEDICAL PLAN APPEALS PROCESSES

Your medical plan booklet will explain how to appeal a claim denial through the plan, through a government-authorized third party, and with the help of a consumer assistance office.

# Notices

## WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Enrolled individuals may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For 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 co-insurance applicable to other medical and surgical benefits provided under the medical plan. If you would like more information on WHCRA benefits, please contact HR.

## PUBLIC HEALTH INSURANCE MARKETPLACE

For individuals needing to purchase health insurance on their own, the Affordable Care Act (ACA) created a new public health insurance Marketplace. This website and call center helps individuals shop for private health insurance, helps individuals enroll in Medicaid or the Children's Health Insurance Program (CHIP), and evaluates eligibility for new tax credits. Open enrollment for public Marketplace coverage occurs each fall for coverage starting January 1, but special enrollment periods may be available for certain life events. Learn more or request assistance at ***www.healthcare.gov***.

Please note that insurance companies are not required to participate in the public Marketplace, so you are unlikely to see all plans available in the community when shopping the public Marketplace.

The public Marketplace can help you determine whether you may be eligible for tax credits under section 36B of the Internal Revenue Code for Marketplace coverage. One tax credit can lower your monthly premium, and the other can lower your cost sharing (such as your deductible). Since tax credits are based on your projected household income and typically paid in advance to the insurance company, there is a chance you may have to repay some or all tax credits on your tax return if your income for the year ends up higher than anticipated.

Tax credits are not available to those eligible for "affordable, minimum value" medical coverage. "Minimum value" means our plan is intended to pay, on average, at least 60% of the costs of medical care received. "Affordable" means our lowest-cost minimum value plan costs you no more than 9.5% (indexed annually) of your household income to be enrolled in single (not family) coverage.

Our plan is intended to be affordable and minimum value. As a result, if you or someone in your family wanted to compare your health insurance options in the public Marketplace to the insurance offered through us, you'll need to remember that:

- You might pay full retail price for public Marketplace insurance (without the new tax credits)
  a) You would no longer be paying for insurance on a pre-tax basis
  b) You would no longer have an employer contribution toward your insurance (note that employer contributions are typically excludable from income for federal income tax)
- You would navigate any questions you have directly with the insurance company you choose…HR will not be able to assist you with your public Marketplace plan
- Should you desire to come back to our plan in the future, you will either need to:
  a) experience a "qualifying event" recognized by our plan as a mid-year election change, or
  b) wait until our next annual open enrollment

# Notices

## SPECIAL MEDICAL ENROLLMENT RIGHTS AND RESPONSIBILITIES UNDER HIPAA

When you are eligible to participate in our group medical plan, you may have to enroll and agree to pay part of the premium through payroll deduction in order to actually participate.

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you of your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

### SPECIAL ENROLLMENT PROVISION

- **Loss of Eligibility under Medicaid or a State Children's Health Insurance Program (CHIP).** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while coverage under Medicaid or CHIP is in effect, you may be able to enroll yourself and your dependents in this plan **if eligibility is lost for the other coverage**. However, **you must request enrollment within 60 days** after the other coverage ends.
- **Loss of Eligibility for Other Coverage.** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other medical coverage is in effect, you may be able to enroll yourself and your dependents in this plan if eligibility is lost for the other coverage (or if the employer stops contributing toward it). However, **you must request enrollment within 30 days** after the other coverage ends (or after the employer stops contributing toward it).
- **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you have a new dependent as a result of marriage, birth, adoption, or placement with you for adoption, you may be able to enroll yourself and your new dependents. However, **you must request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.
- **Eligibility for Medicaid or CHIP State Premium Assistance Subsidy.** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through CHIP with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, **you must request enrollment within 60 days** after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact HR.

### IF YOU DECLINE COVERAGE, YOU MUST COMPLETE A "FORM FOR EMPLOYEE TO DECLINE COVERAGE."

- If you decline enrollment for yourself or for an eligible dependent, you must complete a "Form for Employee to Decline Coverage."
- On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or CHIP) is the reason for declining enrollment, and you are asked to identify that coverage.
- If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or CHIP with respect to coverage under this plan, as described above.
- If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or CHIP with respect to coverage under this plan.

# Notices

## PREMIUM ASSISTANCE UNDER MEDICAID OR 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)**.

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**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 July 31, 2023. Contact your State for more information on eligibility -**

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

# Notices

| GEORGIA – MEDICAID | INDIANA – MEDICAID |
|---|---|
| GA HIPP Website: https://medicaid.georgia.gov/health insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: (678) 564-1162, Press 2 | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>Phone 1-800-457-4584 |
| **IOWA – MEDICAID AND CHIP (HAWKI)** | **KANSAS – MEDICAID** |
| Medicaid Website: https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website: http://dhs.iowa.gov/Hawki<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: https://dhs.iowa.gov/ime/members/medicaid a-to-z/hipp<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **KENTUCKY – MEDICAID** | **LOUISIANA – MEDICAID** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)<br>Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) |
| **MAINE – MEDICAID** | **MASSACHUSETTS – MEDICAID AND CHIP** |
| Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: (617) 886-8102<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – MEDICAID** | **MISSOURI – MEDICAID** |
| Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and services/other-insurance.jsp<br>Phone: 1-800-657-3739 | Website: http://www.dss.mo.gov/mhd/employees/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – MEDICAID** | **NEBRASKA – MEDICAID** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – MEDICAID** | **NEW HAMPSHIRE – MEDICAID** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 |
| **NEW JERSEY – MEDICAID AND CHIP** | **NEW YORK – MEDICAID** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – MEDICAID** | **NORTH DAKOTA – MEDICAID** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: http://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |

# Notices

| OKLAHOMA – MEDICAID AND CHIP | OREGON – MEDICAID |
|---|---|
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.Oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – MEDICAID** | **RHODE ISLAND – MEDICAID AND CHIP** |
| Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line) |
| **SOUTH CAROLINA – MEDICAID** | **SOUTH DAKOTA – MEDICAID** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – MEDICAID** | **UTAH – MEDICAID AND CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **VERMONT – MEDICAID** | **VIRGINIA – MEDICAID AND CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – MEDICAID** | **WEST VIRGINIA – MEDICAID** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – MEDICAID AND CHIP** | **WYOMING – MEDICAID** |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>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 (1-866-444-3272)

**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.

City of Pittsburg

Forward Together.

IMA

# Benefits Enrollment Guide

*This Enrollment Guide is for general educational purposes and is based on information provided by the employer, summary plan descriptions, and other sources. In case of discrepancy, plan documents will prevail over information presented in this Guide. Please treat this information as confidential and only share it with your dependents. Contact Human Resources with questions.*