2023 Benefits Guide

MEDICAL | DENTAL | VISION | FSA | LIFE | DISABILITY

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- If you require further assistance contact AssuredPartners. Mountain View Fire & Rescue has partnered with AssuredPartners as our benefits administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Group #	Web / Email	Phone
Medical and Prescription Cigna	617014	www.myCigna.com	1-800-997-1654
Health Savings Account Discovery Benefits	28748	www.benefitslogin.wexhealth.com	1-866-451-3399
Flexible Spending Accounts Discovery Benefits	28748	www.benefitslogin.wexhealth.com	1-866-451-3399
Health Reimbursement Arrangement Discovery Benefits	28748	www.benefitslogin.wexhealth.com	1-866-451-3399
Virtual Care, Employee Assistance Cigna	617014	www.myCigna.com	1-800-997-1654
Dental Cigna	617014	www.myCigna.com	1-800-997-1654
Vision Cigna	617014	www.myCigna.com	1-800-997-1654
Life/Disability/Accident/Critical Illness/Hospital Plans Hartford	892334	www.account.thehartford.com	1-800-523-2233
AssuredPartners Benefits Helpline		MVFRbenefits@AssuredPartners.com	1-877-221-1344

Welcome to your Employee Benefits!

Mountain View Fire & Rescue is pleased to offer a wide range of benefits to its employees and their families. These company sponsored benefits are an important part of a total compensation package. They represent both a valuable asset to our employees and to their families, and demonstrate an investment by Mountain View Fire & Rescue in our employees. We are proud of our compensation benefits program and are committed to continuously improving the plans that make up our benefits offerings.

This guide was created to answer some of the questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive.

If you have any benefits related questions or concerns, please do not hesitate to call the Employee Benefits Helpline.

Employee Benefits Helpline

1-877-221-1344

MVFRbenefits@AssuredPartners.com

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please refer to the Medicare Part D Notice at the back of this Guide for more details.

What's Inside

Important Contact Information . . 2

How to Enroll 2

Eligibility 3

Benefit Changes 4

Medical Coverage 5

Medical Plan Comparison 6

Prescription Coverage 7

Health Savings Accounts 8

Flexible Spending Accounts 9

Health Reimbursement Arrangement 10

Dental Coverage 11

Vision Coverage 12

Basic Life and AD&D Insurance 13

Voluntary Life and AD&D Insurance 13

Short-Term Disability 14

Long-Term Disability 14

Voluntary Benefits 15

Glossary of Terms 17

Annual Notices 18

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). Mountain View Fire & Rescue reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

How to Enroll

Open Enrollment Period

Mountain View Fire & Rescue's annual enrollment period will be held **November 1st through November 30th, 2022**.

Log on to the enrollment site to review your current benefits, make any plan changes, or update dependent and/or beneficiary information.

Newly Hired/Eligible Employees

New hires and newly eligible employees **MUST** complete online enrollment even if choosing to waive coverage in order to provide beneficiary information for your company-paid life insurance. Coverage, if elected, will begin on your date of hire, provided you enroll online within **30 days of your date of hire.**

Have social security numbers and birth dates for all dependents and beneficiaries available prior to logging on.

Enrolling In Your Benefits

Please review this guide to gain a full understanding of the plans being offered. Be sure to go online between November 1 and November 30, or within 30 days of becoming eligible, to review your current benefits and make any changes for the upcoming plan year.

https://workforcenow.adp.com

- Log in using your ADP login provided by HR.
- **Note**: If this is your first time logging in, click 'create account". If you are unsure of the registration code, please contact your HR team.

Once you start your enrollment, you will be taken to the Welcome Note. Please review all information on this page before clicking Next.

- **Manage Dependents** -
  The Manage Dependents page is where you can add/view/edit your dependent and beneficiaries.
- **Select Benefits** - This is split into three sections: Action Required, Selected Plans, and Eligible Benefits. You must review and complete the items in the Action Required section to move forward. Please ensure you review ALL sections before submitting enrollment..
- **Complete** - After you have made your benefit elections and verified them for accuracy, click "SUBMIT ENROLLMENT."

You can make changes to your selections prior to the enrollment deadline by logging back into the system and clicking on **Myself** -> **Benefits** -> **Enrollments** -> "**Manage Enrollment**"

Browser Sites / Requirements:

We encourage you to keep your browser updated with the latest version.

- Google Chrome
- Microsoft Edge
- Mozilla Firefox
- Safari

You must have Cookies, Java-script, and Style Sheets enabled.

The system will automatically log you out if left idle for more than 30 minutes.

Eligibility

Full-time employees with a schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Benefits for most benefit plans are effective on your date of hire. Part-time, seasonal, temporary, and contracted employees are not eligible to participate.

Eligible Dependents

Your dependents are eligible to participate in Mountain View Fire & Rescue's benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A domestic partner.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent’s 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

Newly Hired/Eligible Employees

New hires and newly eligible employees **MUST** complete enrollment even if choosing to waive coverage in order to provide beneficiary information for your company-paid life insurance.

Pre-Tax Benefits: Section 125

Mountain View Fire & Rescue's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

Pre-tax Note: When you pay for your dependent’s benefits on a pre-tax basis you are certifying that the dependent meets the IRS’ definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS’ definition will result in a tax liability to you, such as changing that dependent’s election to a post-tax election, or receiving imputed income on your W-2 for the dependent’s coverage that should not have been taken on a pre-tax basis.

Benefit Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, vision and flexible spending accounts, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this Plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

You must notify HR at within 30 days from the life event status change in order to make a change in your benefit selections.

Medical Coverage

Mountain View Fire & Rescue is proud to offer you a choice between three different medical plans. Coverage under the plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of each plan.

Option 1: Base Open Access HRA Included

Option 1 is a Preferred Provider Organization, or PPO for short. With this plan, you can use the doctors and hospitals within the Cigna network or go outside of the network for care. The plan does not require members to designate a "primary care physician" to coordinate care or require referrals to seek care for specialists.

- ✓ Copays for most services, lower deductible to fulfill
- ✓ Do not need to designate a Primary Care Physician (PCP)
- ✓ Specialist care does not require referral
- ✓ Out-of-Network coverage available but at a greater cost

This option includes HRA reimbursement up to $500.

Option 2: Buy Up Open Access PPO

Option 2 is a Preferred Provider Organization, or PPO for short. With this plan, you can use the doctors and hospitals within the Cigna network or go outside of the network for care. The plan does not require members to designate a "primary care physician" to coordinate care or require referrals to seek care for specialists.

- ✓ Copays for most services, lower deductible to fulfill
- ✓ Do not need to designate a Primary Care Physician (PCP)
- ✓ Specialist care does not require referral
- ✓ Out-of-Network coverage available but at a greater cost

Option 3: HSA Open Access PPO

Option 3 is a High Deductible Health Plan, or HDHP for short. This plan functions like a PPO, but features a lower monthly premium in exchange for a higher deductible.

- ✓ Higher deductible to fulfill before plan pays coinsurance
- ✓ Eligible to use Health Savings Account (more info on page 8)
- ✓ Do not need to designate a Primary Care Physician (PCP)
- ✓ Out-of-Network coverage available but at a greater cost

Build a Strong Relationship with Your Primary Care Physician

Most doctors went into the practice of medicine so that they could build strong emotional bonds with patients and guide them through health challenges.

Here are 3 tips to building a strong relationship with a new primary care physician, or improving the bond with your current one:

1. **Know what's important to you in a physician.**

   If you're looking for a new doctor, be sure this is someone with whom you will have good interpersonal chemistry, that they're committed to your well-being, and that their office is well organized.

2. **Get your doctor familiar with your health history.**

   Help your doctors to get to know you better by collecting your medical records, writing down your family's health history, and sharing this information with every new physician you meet.

3. **Ask the right questions to build rapport and get on the road to better health.**

   To maximize the time you have together, write down your health questions for your physician beforehand.

Medical Plan Comparison

Plan Name	Base Open Access	Buy-Up Open Access	HSA Open Access
Deductible			
Individual	$1,500	$250	$4,000
Family	$3,000	$500	$8,000
Out-Of-Pocket Max			
Individual	$4,750	$2,500	$4,000
Family	$9,500	$5,000	$8,000
Coinsurance			
Coinsurance	20%	10%	0%
Physician Services			
Office Visits (PCP / Specialist)	$20/$50	$10/$20	0% after deductible
Preventive Care	$0	$0	$0
Virtual Visits	$20	$10	0% after deductible
Diagnostic Lab / X-Ray	100% covered	100% covered	0% after deductible
Advanced Imaging	20% after deductible	10% after deductible	0% after deductible
Prescription Drugs			
Rx Deductible	N/A	N/A	Medical Deductible applies
Rx (30 Day Supply)	$15/$35/$70/20% to $250 per Rx	$10/$35/$60/20% to $250 per Rx	0% after deductible
Rx (90 Day Mail Order Supply)	$37.50/$87.50/$175	$25/$87.50/$150	0% after deductible
Hospital Services			
Inpatient Hospital	20% after deductible	10% after deductible	0% after deductible
Outpatient Surgery	20% after deductible	10% after deductible	0% after deductible
Emergency Services			
Emergency Room	$300	$250	0% after deductible
Urgent Care	$75	$75	0% after deductible
Out-of-Network			
Indv/Family Deductible	$5,000/$10,000	$5,000/$10,000	$10,000/$20,000
Indv/Family Out of Pocket Max	$10,000/$20,000	$10,000/$20,000	$20,000/$40,000
Coinsurance	50%	50%	50%

Employee Premium Per Payroll Deduction (24)	Base Open Access	Buy-Up Open Access	HSA Open Access
Employee	$0.00	$59.08	$0.00
Employee + Spouse	$104.26	$229.10	$0.00
Employee + Child(ren)	$93.49	$235.57	$0.00
Employee + Family	$148.89	$307.20	$0.00

Disclaimer*: The actual/final rates for the group are determined by the carrier, only after submission of all completed applications. The information provided is intended only as a summary; benefits may contain limitations and exclusions. Actual rates and benefits are based on actual enrollment, insurer-specific underwriting guidelines, utilization, and must be approved by the insurer. Rates and benefits cannot be guaranteed in advance and are subject to change by the insurer without notice. This is not a contract and does not replace the master contract or any other insurer documentation. Always refer to insurer publications to verify benefits and plan availability. Coverage will not be issued until final underwriting approval. Underwriting requires all applications are complete prior to final underwriting approval. If you do not have final rates and approval do not cancel your current carrier coverage. This may result in two carrier's coverage for the first month as retroactive termination is not allowed.*

Prescription Coverage

Your prescription drug benefit is part of your Medical plan and is based on a four-tier drug system. Copayment and/or coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned as one of the four tiers. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.myCigna.com.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

Rx Mail Order Program

Save time and money by filling maintenance drugs through the mail order program. The Mail Order Program benefits members who are on long-term medications for chronic conditions such as diabetes, high cholesterol, high blood pressure, depression or asthma. By utilizing the Mail Order Program, you can receive a 90-day supply of medication for the equivalent of 2.5 retail copayments. Find out more info through the Cigna website or calling member services.

Save money with Generic Drugs

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. That's because they're held to the same federal standards for safety and performance as the brand names. Because they're not branded, generics can sell for 30 percent to 80 percent less than their brand-name equivalents.

Plan Name	Base Open Access	Buy-Up Open Access	HSA Open Access
Prescription Drugs			
Rx Deductible	N/A	N/A	Medical Deductible applies
Rx (30 Day Supply)	$15/$35/$70/20% to $250 per Rx	$10/$35/$60/20% to $250 per Rx	0% after deductible
Rx (90 Day Mail Order Supply)	$37.50/$87.50/$175	$25/$87.50/$150	0% after deductible

Health Savings Accounts

You must be enrolled in the district's HDHP Medical Plan to be eligible for an HSA.

If you enroll in the **HDHP Medical Plan**, a Health Savings Account (HSA) can be opened for you through Discovery Benefits. HSA's are financial accounts that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the Internal Revenue Service. **HSA contributions are as follows per Pay Period: Employee: $49.72, Employee + Spouse: $13.71, Employee + Child(ren): $0.00, Employee + Family: $10.10**.

The account acts like a regular savings account with a debit card and accrues interest. The money in the account is owned by you and is fully portable. Funds can accumulate over time and roll over each year. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

How you save with an HSA

As an HSA user, you will save in several ways:

- HSA contributions are not taxed
- You earn tax-free interest on HSA balances
- HSA funds used for qualified medical expenses are not taxed

HSA funds remain yours to grow

With an HSA, you own the account and all contributions. Unlike flexible spending accounts (FSAs), the entire HSA balance rolls over each year and remains yours even if you change health plans, retire or leave Mountain View Fire & Rescue.

Supplement your retirement

Once your HSA balance reaches $2,000, you may invest your funds for increased earning potential that is also tax-free. After age 65, you can use your HSA much like a 401(k) and withdraw funds for any purpose. Qualified medical expenditures remain tax-free even into retirement.

You can win with an HSA

Regardless of your personal medical situation, an HSA can empower you to maximize savings while building a reserve for the future.

Using your HSA for qualified medical expenses

HSA funds can be used for a variety of qualified medical, dental and vision expenses; for yourself, your spouse, and your qualified dependents. Eligible expenses include:

- Birth control
- Chiropractor
- Contact lenses
- Dental treatment
- Prescription eyeglasses
- Hearing aids
- Physical exams
- Prescriptions
- Stop-smoking programs
- Surgery (non-cosmetic)
- Therapy
- and more...

2023 HSA Annual Contribution Limit:

$3,850 for individual coverage

$7,750 for all other coverage tiers

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. If you are or will be age 55 or over during the calendar year, you may also make a "catch-up" HSA contribution of an additional $1,000 each year. Contact HealthEquity to schedule and adjust your contribution amount.

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax adviser about your specific tax situation before deferring monies to your Health Savings Account. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. https://www.irs.gov/pub/irs-pdf/p969.pdf

Flexible Spending Accounts

Eligibility Based on Medical Plan Election

Flexible Spending Accounts (FSA's) offer another way to save money on health care and dependent care expenses. You may submit expenses incurred by any of your dependents, whether or not they are covered by the insurance plans you have through your employer. Employees need not be enrolled in either medical plan to participate in FSAs.

If you enroll, you fund the accounts via a payroll deduction each pay period. Money that you contribute to your FSAs is not subject to social security taxes, federal, and in most cases, state income taxes.

Account	HSA Participants	Non-HSA Participants	How it works
Healthcare FSA	✗	✓	**Employee-funded.** Can use funds for all healthcare related expenses. Federal regulations do not allow participation in an HSA and this type of account.
Dependent Care FSA	✓	✓	**Employee-funded.** Can use funds for all dependent care related expenses such as day care, nursery school, or elder care.
Limited Purpose FSA	✓	✗	**Employee-funded.** LPFSAs are tax-advantaged accounts that let you use pre-tax dollars to pay for eligible dental and vision expenses. Pairing an LPFSA with a health savings account (HSA) allows you to maximize your pre-tax HSA contributions and contribute additional pre-tax dollars to your LPFSA.

**No Double dipping! Expenses reimbursed by a LPFSA cannot also be reimbursed by a HSA and vice versa. Each taxpayer is responsible for monitoring their eligibility for HSA/FSA/DEP FSA/LPFSA.*

HCFSA Annual Contribution Limit: **$3,050**

Health Care Flexible Spending Account (HCFSA)

Federal regulations do not allow participation in an HSA and this type of account. Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. These include deductibles and coinsurance expenses not covered by your medical plan, expenses for glasses or contact lenses, and more.

DCFSA Annual Contribution Limit: **$5,000**

Or $2,500 if you are married and file a separate tax return.

Dependent Care Flexible Spending Account (DCFSA)

You may use pre-tax dollars from your DCFSA to pay expenses for care when the services enable you and your spouse to work outside of the home. These include expenses for the care of a dependent child, spouse or elderly parent inside your home. Also included are baby-sitters, nursery schools, and day care centers.

Only the portion of expenses which enable you to remain employed are eligible. Educational expenses are not eligible.

The FSA Plan Year is January 1 until December 31.
FSA Open Enrollment is held annually in November.

"Use it or lose it" FSA Rollover Provision - HCFSAs only

Mountain View Fire & Rescue has elected to participate in the FSA rollover provision, allowing employees to rollover up to $570 from one plan year to the next. You must be enrolled in an HCFSA both plan years. You are still encouraged to consider your expenses carefully before you decide how much to contribute to each Flexible Spending Account. As a reminder, your election will cover the period from January 1 through December 31. You should not contribute more than you are reasonably certain to use.

Flexible Spending Accounts *cont.*

Eligible Dependents

In regards to your Dependent Care FSA, the IRS defines an eligible dependent as:

- A child under the age of 13 and may be claimed as a deduction for personal exemption under Code Section 151(c).
- A spouse who is physically or mentally incapable of selfcare.
- A disabled person who is physically or mentally incapable of self-care who you provide more than 50% support, and who qualifies as your dependent under Code Section 152.

FSA Debit Card

An FSA debit card is provided to all HCFSA participants and is available for Dependent Care participants upon request. The debit card is similar to a bank account debit card that allows you to remove funds from your FSA at a merchant payment terminal. By using the debit card to purchase eligible expenses, you avoid paying for a purchase with money out of your pocket. Remember, you still must keep your receipts even when you use the debit card. Periodically, the IRS requires proof of purchase.

Changing Your Contribution Amount

Federal regulations prohibit you from changing your enrollment or the amount of your election during the plan year. You are only eligible to change your elections during the year if you have a life event status change. Only benefit changes consistent with the change in status are permitted. Life event status changes that may warrant a change in benefit elections are described on page 3 and 4 of this guide.

Health Reimbursement Arrangement (w/ Cigna Base Plan Only)

MVFR's HRA Plan pays the second $500 of health plan deductible expenses after participant pays the first $500. The maximum benefits per 12-month plan year is $500.00 per Participant or Family.

You can claim these dollars via the Wex website at www.wex.com. The HRA does not apply to the BuyUp health plan due to the lower deductibles, or the HSA plan due to IRS rules.

Dental Coverage

The Cigna Dental Plans offers you flexibility to see the provider of your choice each time you seek dental care. You can find a Cigna Dental network dentist online at www.cignadentalplans.com/dentist-search.

Carrier Name/Network	Cigna LF / PPO		Cigna LF / PPO	
Plan Name	**Base Plan**		**Buy Up Plan**	
Network	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Individual Annual Deductible	$50	$50	$50	$50
Family Annual Deductible	$150	$150	$150	$150
Annual Plan Maximum (Per Person)	$1,000		$3,000	
Waiting Period	Late Entrants, 12 Months Class 3		Late Entrants, 12 Months Class 3/4	
UCR Percentile - Out of Network Only		90th		90th
Type I: Preventive Services				
Oral Exams, Routine Cleanings, X-Rays	100%	100%	100%	100%
Type II: Basic Services				
Routine Fillings, Simple Extractions, Oral Surgery	80%	80%	80%	80%
Type III: Major Services				
Inlays, Onlays, Crowns, Dentures, Prosthodontics	50%	50%	50%	50%
Implants Included	no	no	no	no
Surgical Endodontics & Periodontics				
Included in Basic or Major Services	80% basic	80% basic	80% basic	80% basic
Type IV: Orthodontia				
Lifetime Maximum	Not Covered	Not Covered	$1,500	$1,500
Orthodontia Benefit	N/A	N/A	50%	50%
Network				
Dental Network	Cigna PPO		Cigna PPO	
Employee Premium Per Payroll Deduction (24)	**Base Plan**		**Buy Up Plan**	
Employee	$0.00		$0.00	
Employee + Spouse	$4.80		$6.99	
Employee + Child(ren)	$5.76		$8.79	
Employee + Family	$8.28		$12.47	

***Disclaimer**: The actual/final rates for the group are determined by the carrier, only after submission of all completed applications. The information provided is intended only as a summary; benefits may contain limitations and exclusions. Actual rates and benefits are based on actual enrollment, insurer-specific underwriting guidelines, utilization, and must be approved by the insurer. Rates and benefits cannot be guaranteed in advance and are subject to change by the insurer without notice. This is not a contract and does not replace the master contract or any other insurer documentation. Always refer to insurer publications to verify benefits and plan availability. Coverage will not be issued until final underwriting approval. Underwriting requires all applications are complete prior to final underwriting approval. If you do not have final rates and approval do not cancel your current carrier coverage. This may result in two carrier's coverage for the first month as retroactive termination is not allowed.*

Vision Coverage

Choose a Cigna doctor or any other provider from the Cigna Network. To find a provider, visit www.cigna.vsp.com or call 1-800-997-1654. At your appointment, tell them you have Cigna. There's no ID card necessary. Cigna will handle the rest—there are no claim forms to complete when you see a Cigna doctor!

Carrier Name/Network	**Cigna PPO**	
Plan Name	**C1**	
Coverage	**In-Network**	**Out-of-Network Reimbursement**
Exam Copay	$10	Up to $45
Materials Copay (Lenses and Frames)	$25	N/A
Eyeglass Lenses Allowances		
Single Vision	100% after materials copay	Up to $32
Lined Bifocal		Up to $55
Lined Trifocal		Up to $65
Lenticular		Up to $80
Contact Lenses Allowances		
Medically Necessary	Covered 100%	Up to $210
Elective	$130 allowance	Up to $105
Frame Retail Allowance	$130 allowance	
Benefit Frequency		
Examination	12 months	
Lenses	12 months	
Contact Lenses	12 months	
Frames	12 months	
Network		
Contracted Vision Network	Cigna PPO	
Employee Premium Per Payroll Deduction (24)	**Cigna PPO**	
Employee	$5.06	
Employee + Spouse	$7.75	
Employee + Child(ren)	$7.81	
Employee + Family	$11.06	

Disclaimer*: The actual/final rates for the group are determined by the carrier, only after submission of all completed applications. The information provided is intended only as a summary; benefits may contain limitations and exclusions. Actual rates and benefits are based on* ***actual enrollment****, insurer-specific underwriting guidelines, utilization, and must be approved by the insurer. Rates and benefits cannot be guaranteed in advance and are subject to change by the insurer without notice. This is not a contract and does not replace the master contract or any other insurer documentation. Always refer to insurer publications to verify benefits and plan availability. Coverage will not be issued until final underwriting approval. Underwriting requires all applications are complete prior to final underwriting approval. If you do not have final rates and approval do not cancel your current carrier coverage. This may result in two carrier's coverage for the first month as retroactive termination is not allowed.*

Basic Life and AD&D Insurance

You can't put a price tag on your life, but you can protect your loved ones with life insurance in the event of a premature loss.

Basic Life and AD&D - You are automatically enrolled in this employer-paid coverage.

- 1 x your Earnings to a Maximum of $140,000

Hartford	
Life Benefit	1 x Annual Earnings to $140,000
Guarantee Issue Amount	$140,000
Accelerated Death Benefit	Included
Waiver of Premium	Included
Conversion	Included
Age Reduction Schedule	
Age 64 or Younger	No Reduction
65 - 69	35%
70 - 74	50%
75 - 79	65%

Voluntary Life and AD&D Insurance

Voluntary Life and AD&D - You must submit an application and be approved to be enrolled in this employee-paid coverage.

Portability Options for Basic & Voluntary Life

Portability is available when an Insured Person's employment terminates for a reason other than sickness or injury or retirement at the Social Security Normal Retirement Age (SSNRA). The Insured Person's coverage must be enforce for at least 12 months in a row just prior to the date employment ends.

This person has the option to continue all or part of his or her insurance enforce when employment ends without Evidence of Insurability. To continue insurance, application and the first premium payment must be made within the time period specified in the policy. Coverage can continue until the earlier of the date the master policy terminates or up to 36 Months.

For information on Portability, please contact Mountain View Fire & Rescue's Benefits Helpline.

Hartford	
Voluntary Life Benefit	**Employee:**
	Increments: $10,000
	Minimum: $10,000
	Maximum: 5 x Earnings or $500k
	Spouse:
	Increments: $5,000
	Minimum: $5,000
	Maximum: 100% of EE or $100,000
	Child:
	Increments: $10,000
	Minimum: $10,000
	Maximum: $10,000
Guarantee Issue Amount	**Employee:** $100,000
	Spouse: $25,000
	Child: $10,000
Accelerated Death Benefit	Included
Waiver of Premium	Included
Conversion	Included
Portability	Included
Age Reduction Schedule	
Age 64 or Younger	No Reduction
65 - 69	35%
70 - 74	50%
75 - 79	65%

Short-Term Disability

Accidents and illnesses happen and often when we least expect them. Ensure you are financially prepared to stay afloat in the midst of medical condition with short-term disability insurance.

Hartford	
Benefit Percentage	60%
Maximum Weekly Benefit	$2,000
Definition of Disability	Material duties & 20% income loss
Accident Elimination Period	0 days
Sickness Elimination Period	7 days
Maximum Benefit Duration	26 weeks

Long-Term Disability

Long-Term Disability (LTD) insurance helps replace a portion of your income for an extended period of time. Eligibility for long-term benefits is generally defined as if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and are complying with the requirements of the treatment and you are unable to earn more than 80% of your predisability earnings at your own occupation for any employer in your local economy.

Hartford	
Benefit Percentage	60%
Maximum Monthly Benefit	$7,000
Elimination Period	180 days
Definition of Disability	Material Duties & 20% income loss
Own Occupation Period	24 months
Maximum Period of Payment	SSNRA
Pre-Existing Condition	3/12
Survivor Benefit	Included
Self Reported Illness Limitation	Case by Case
EAP	Included
Mental Illness / Substance Abuse Limitation	24 Months Combined

Pre-Existing Condition Limitations

The carrier will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

Disclaimer*: The actual/final rates for the group are determined by the carrier, only after submission of all completed applications. The information provided is intended only as a summary; benefits may contain limitations and exclusions. Actual rates and benefits are based on* ***actual enrollment****, insurer-specific underwriting guidelines, utilization, and must be approved by the insurer. Rates and benefits cannot be guaranteed in advance and are subject to change by the insurer without notice. This is not a contract and does not replace the master contract or any other insurer documentation. Always refer to insurer publications to verify benefits and plan availability. Coverage will not be issued until final underwriting approval. Underwriting requires all applications are complete prior to final underwriting approval. If you do not have final rates and approval do not cancel your current carrier coverage. This may result in two carrier's coverage for the first month as retroactive termination is not allowed.*

Voluntary Benefits

Even with medical insurance, you could still be subject to unexpected out-of-pocket expenses in the form of copays, deductible, and coinsurance. Voluntary Benefits provide lump sum payments to be used towards your health care expenses, or however you see fit.

Accident - Hartford	
Injury	**Benefit Amount**
Burn	$1,500 - $15,000
Coma	$15,000
Concussion	$200
Dental Injury	$150 - $450
Dislocation	$400 - $8,000
Eye Injury with Surgical Repair	$600
Fracture	$200 - $9,000
Knee Cartilage Injury with Surgical Repair	$1,000
Ruptured Disc with Surgical Repair	$1,000
Tendon / Ligament / Rotator Cuff Injury with Surgical Repair	$1,000 - $1,500
Accidental Death and Dismemberment AD&D	Covered Amount
Employee	$50,000
Spouse	$25,000
Children	$12,500
Covered Loss	% of Benefit
Loss of life; loss of both hands or both feet or one hand or one foot; quadriplegia; loss of speech and hearing in both ears; or loss of sight in both eyes	100%
Loss of one hand or foot; paraplegia; hemiplegia; loss of use of one hand and food or both hands or feet; or loss of speech, hearing in both ears, or sight in one eye	50%
Loss of thumb and index finger on the same hand; loss of use of one arm, leg, hand, or foot; or loss of hearing in one ear	30%
Common Carrier	Included
Employee Premium Per Payroll Deduction (24)	
Employee	$3.67
Employee + Spouse	$5.79
Employee + Child(ren)	$6.26
Employee + Family	$9.80

***Disclaimer**: The actual/final rates for the group are determined by the carrier, only after submission of all completed applications. The information provided is intended only as a summary; benefits may contain limitations and exclusions. Actual rates and benefits are based on **actual enrollment**, insurer-specific underwriting guidelines, utilization, and must be approved by the insurer. Rates and benefits cannot be guaranteed in advance and are subject to change by the insurer without notice. This is not a contract and does not replace the master contract or any other insurer documentation. Always refer to insurer publications to verify benefits and plan availability. Coverage will not be issued until final underwriting approval. Underwriting requires all applications are complete prior to final underwriting approval. If you do not have final rates and approval do not cancel your current carrier coverage. This may result in two carrier's coverage for the first month as retroactive termination is not allowed.*

Voluntary Benefits *continued...*

Covered Illnesses/Benefits	Critical Illness - Hartford % of Benefit for First Occurrence		% of Benefit for Additional Occurrences	
Cancer (Invasive)	100%		100%	
Cancer (Non Invasive)	25%		25%	
Coronary Artery Bypass Graft	25%		25%	
Heart Attack	100%		100%	
Major Organ Transplant	100%		100%	
Stroke	100%		100%	
Scheduled Benefit	**Employee**		**Spouse**	
Guarantee Issue Amount	$20,000		$10,000	
Maximum Amount	$20,000		$10,000	
Rate Per 5 Year Age Band Per Payroll Deduction (24)	**EE Only**	**EE + SP**	**EE + CH**	**Family**
Age 24 or Younger	$3.35	$5.27	$4.57	$6.69
25 - 29	$4.14	$6.44	$5.36	$7.86
30 - 34	$4.66	$7.23	$5.88	$8.65
35 - 39	$5.99	$9.22	$7.21	$10.64
40 - 44	$8.44	$12.97	$9.66	$14.39
45 - 49	$13.18	$20.30	$14.40	$21.72
50 - 54	$18.41	$28.41	$19.63	$29.84
55 - 59	$25.20	$38.98	$26.42	$40.40
60 - 64	$35.57	$55.04	$36.78	$56.46
65 - 69	$48.66	$74.99	$49.88	$76.41
70 - 74	$64.55	$99.37	$65.77	$100.79
Rates based on Original or Attained Age	Attained Age			

Hospital Indemnity - Hartford	
Hospital Admission (First Day)	$1,500
Hospital Confinement (Day 2 Forward)	$200
Hospital Intensive Care (Day 2 Forward)	$400
Health Screening Benefit	$50
Employee Premium Per Payroll Deduction (24)	
Employee	$7.60
Employee + Spouse	$21.17
Employee + Child(ren)	$18.02
Employee + Family	$33.32

Disclaimer: *The actual/final rates for the group are determined by the carrier, only after submission of all completed applications. The information provided is intended only as a summary; benefits may contain limitations and exclusions. Actual rates and benefits are based on* ***actual enrollment****, insurer-specific underwriting guidelines, utilization, and must be approved by the insurer. Rates and benefits cannot be guaranteed in advance and are subject to change by the insurer without notice. This is not a contract and does not replace the master contract or any other insurer documentation. Always refer to insurer publications to verify benefits and plan availability. Coverage will not be issued until final underwriting approval. Underwriting requires all applications are complete prior to final underwriting approval. If you do not have final rates and approval do not cancel your current carrier coverage. This may result in two carrier's coverage for the first month as retroactive termination is not allowed.*

Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Annual Notices

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in Mountain View Fire & Rescue-sponsored health and welfare benefit plan are reminded that Mountain View Fire & Rescue's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, Mountain View Fire & Rescue asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices *continued...*

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

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 July 31, 2022. 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:
https://health.alaska.gov/dpa/Pages/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/
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
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
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/
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, 2022, 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

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP) *continued...*

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)

Your Benefits Helpline: 877-221-1344 MVFR@AssuredPartners.com