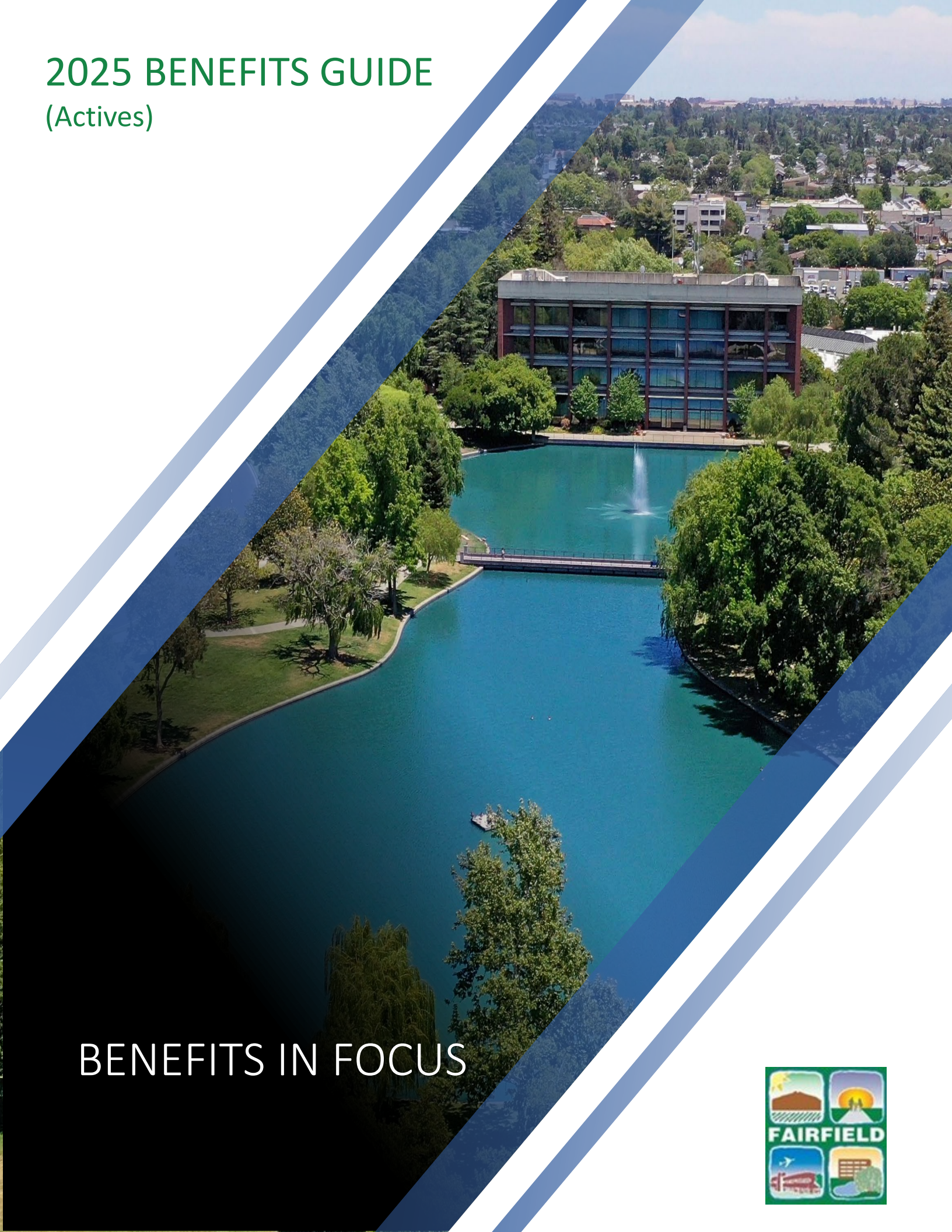
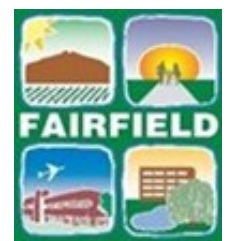


2025 BENEFITS GUIDE

(Actives)



BENEFITS IN FOCUS



CONTENTS



MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

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GETTING STARTED

2025 BENEFITS

January 1, 2025
through
December 31, 2025

IMPORTANT NOTE:

This guide is a summary overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents including your benefit summaries, summary of benefits and coverage (SBCs) and summary plan descriptions (SPDs). The plan documents determine how all benefits are paid.

The City of Fairfield values your contributions to our success and wants to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?



DECLINING COVERAGE

If you wish to decline City health benefits for cash back (\$518 monthly maximum), the Declination of Coverage form, including proof of alternate coverage, must be provided to Human Resources. You must also waive applicable coverage in [infinityhr.com](https://www.infinityhr.com).

Employees

Pro-Rata and Full-Time employees are eligible to receive benefits. Pro-Rata employees shall receive pro-rated full-time benefits.

Eligible dependents

- Legally married spouse (including same-sex spouse).
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26 are eligible to enroll in medical, dental and vision coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the plan documents for each benefit.

Who is not eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of the City of Fairfield, cannot also be covered as a dependent.
- Employees who work less than 20 hours per week, temporary employees not on City of Fairfield payroll, contract employees, or employees residing outside the United States.

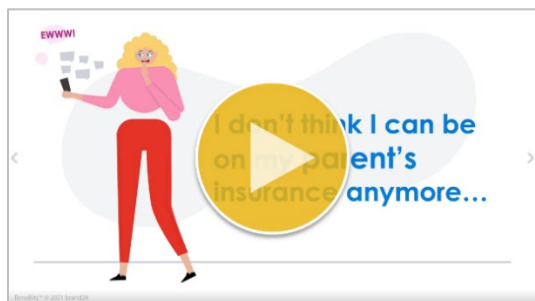
When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following date of hire. You must enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment, the one time each year that you can make changes to your benefits for any reason. Open enrollment is generally held in October every year for a January 1st, effective date.

CHANGING YOUR BENEFITS

Click to play video



LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in the number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth, or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 days after the event.

For additional information, please review the Qualifying Events on page 37.

Dependent Verification

Making changes to dependents is subject to eligibility verification to ensure that only eligible individuals participate in our plans. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Marriage Certification or License
- Birth/Death Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children, or children under legal guardianship
- Physician's written certification of the disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until the next open enrollment period.

ENROLLING FOR BENEFITS



Infinity (ARCORO)

Infinity is an online system that enables you to make all your benefit decisions in one place.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- LOG IN to infinityhr.com (Arcoro)

Username: Your last saved username.

If this is your first-time logging in or you forgot your password, you will need to click on the **“Forgot your username”** link.

Password: Your last saved password.

If this is your first-time logging in, or you forgot your password, you will need to click on the **“Forgot your password”** link.

To create or reset your password, you will need to provide your Date of Birth and SSN, then click on **“Find My Account”** and follow instructions to reset.

- Once you are logged in, under the Change Events section, click on **“Begin Event”** to begin your benefit elections.
- ADD your personal and dependent information.
- SELECT your benefit plans for the coming year.
- REVIEW your choices and costs before finalizing.



MEDICAL

OUR PLANS

Kaiser Permanente

- HMO \$15
- HMO \$35
- Virtual Complete \$30 HMO

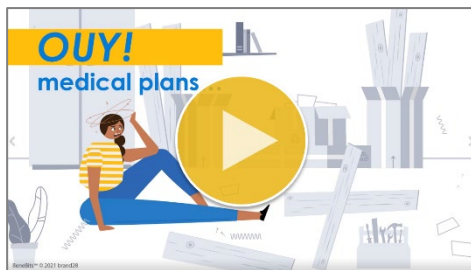
Sutter Health Plus

- HMO \$10
- HMO \$20
- DHMO

Western Health Advantage

- HMO \$15
- HMO \$40
- DHMO 1000

All About Medical Plans



We offer 3 medical plans through Kaiser Permanente, 3 medical plans through Sutter Health Plus and 3 medical plans through Western Health Advantage.

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan’s network.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All these factors together affect your total cost for healthcare.

Kaiser Medical Plans

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Kaiser HMO \$15	Kaiser HMO \$35	Kaiser Virtual Complete \$30
	In-Network	In-Network	In-Network
Plan Year Deductible¹ Individual/Family Embedded ²	\$0 / \$0 Embedded	\$0 / \$0 Embedded	\$2,000 / \$4,000 Embedded
Plan Year Out-of-Pocket Maximum^{1,4} Individual /Family Embedded ³	\$1,500 / \$3,000 Embedded	\$1,500 / \$3,000 Embedded	\$5,000 / \$10,000 Embedded
Office Visit Primary Care	\$15 copay	\$35 copay	\$30 copay ⁵ (deductible waived for first 3 visits) \$30 copay ⁵
Specialist	\$15 copay	\$35 copay	
Online Visit	No charge	No charge	No charge
Preventive Services	No charge	No charge	No charge
Chiropractic (20 visits/year)	\$15 copay	\$15 copay	\$15 copay
Lab X-Ray	No charge No charge	No charge No charge	\$15 copay 20% ⁵
Urgent Care	\$15 copay	\$35 copay	\$30 copay ⁵ (deductible waived for first 3 visits)
Emergency Room	\$50 copay (waived if admitted)	\$75 copay (waived if admitted)	20% ⁵
Inpatient Hospitalization	No charge	\$100 copay	20% ⁵
Outpatient Surgery	\$15 copay	\$35 copay	20% ⁵
PRESCRIPTION DRUGS - Kaiser Permanente Pharmacy			
Plan Year Deductible	N/A	N/A	N/A
Plan Year Out-of-Pocket Maximum	Combined with medical	Combined with medical	Combined with medical
Retail- 30 Day Supply Generic Preferred Brand Non-preferred Brand Specialty	\$5 copay (100-days) \$15 copay (100-days) \$15 copay (approval needed) 20% up to \$150	\$10 copay \$30 copay \$30 copay (approval needed) \$50 copay	\$15 copay \$30 copay \$30 copay (approval needed) 20% up to \$250
Mail Order- 100 Day Supply Generic Preferred Brand Non-preferred Brand Specialty	\$5 copay \$15 copay \$15 copay (approval needed) Not covered	\$20 copay \$60 copay \$60 copay (approval needed) Not covered	\$30 copay \$60 copay \$60 copay (approval needed) Not covered

¹Deductibles and out-of-pocket maximums accumulate on a plan year from January 1 through December 31.

²An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.

³An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

⁴All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

⁵After deductible.

Sutter Health Plus Medical Plans

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Sutter HMO \$10	Sutter HMO \$20	Sutter Deductible DHMO
	In-Network	In-Network	In-Network
Plan Year Deductible¹ Individual/Family Embedded/Aggregate ²	\$0 / \$0 Embedded	\$0 / \$0 Embedded	\$1,500 / \$3,000 Embedded
Plan Year Out-of-Pocket Maximum^{1,4} Individual/Family Embedded/Aggregate ³	\$1,000 / \$2,000 Embedded	\$1,500 / \$3,000 Embedded	\$4,000 / \$8,000 Embedded
Office Visit Primary Care Specialist	\$10 copay \$10 copay	\$20 copay \$20 copay	\$20 copay \$20 copay
Online Visit	\$5 copay	\$10 copay	\$10 copay
Preventive Services	No charge	No charge	No charge
Chiropractic (20 visits/year)	\$10 copay	\$20 copay	\$20 copay
Lab X-Ray Complex Imaging	\$10 copay No charge \$50 copay	\$20 copay No charge No charge	\$20 copay \$10 copay \$50 copay
Urgent Care	\$10 copay	\$20 copay	\$20 copay
Emergency Room	\$50 copay (waived if admitted)	\$100 copay (waived if admitted)	20% ⁵ (waived if admitted)
Inpatient Hospitalization	No charge	\$250 copay	20% ⁵
Outpatient Surgery	No charge	\$100 copay	20% ⁵
PRESCRIPTION DRUGS - Shutter Health Plus			
Plan Year Deductible	N/A	N/A	N/A
Plan Year Out-of-Pocket Maximum	Combined with medical	Combined with medical	Combined with medical
Retail- 30 Day Supply Generic Preferred Brand Non-preferred Brand Specialty	\$5 copay \$20 copay \$40 copay 10% up to \$250	\$10 copay \$30 copay \$60 copay 20% up to \$250	\$10 copay \$30 copay \$60 copay 20% up to \$100
Mail Order- 100 Day Supply Generic Preferred Brand Non-preferred Brand Specialty	\$10 copay \$40 copay \$80 copay Not covered	\$20 copay \$60 copay \$120 copay Not covered	\$20 copay \$60 copay \$120 copay Not covered

¹Deductibles and out-of-pocket maximums accumulate on a plan year from January 1 through December 31.

²An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.

³An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

⁴All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

⁵After deductible.

Western Health Advantage Medical Plans

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Western HMO \$15	Western HMO \$40	Western DHMO 1000
	In-Network	In-Network	In-Network
Plan Year Deductible¹ Individual/Family Embedded ²	\$0 / \$0 Embedded	\$0 / \$0 Embedded	\$1,000 / \$2,000 Embedded
Plan Year Out-of-Pocket Maximum^{1,4} Individual/Family Embedded ³	\$1,500 / \$2,500 Embedded	\$1,500 / \$2,500 Embedded	\$3,000 / \$6,000 Embedded
Office Visit Primary Care Specialist	\$15 copay \$15 copay	\$40 copay \$40 copay	\$20 copay \$20 copay
Online Visit	\$15 copay	\$40 copay	\$20 copay
Preventive Services	No charge	No charge	No charge
Chiropractic (20 visits/year)	\$15 copay	\$15 copay	\$15 copay
Lab X-ray Complex Imaging	No charge No charge No charge	No charge No charge No charge	No charge No charge No charge
Urgent Care	\$20 copay	\$50 copay	\$50 copay
Emergency Room	\$100 copay(waived if admitted)	\$100 copay(waived if admitted)	20% ⁵ (waived if admitted)
Inpatient Hospitalization	No charge	No charge	20% ⁵
Outpatient Surgery	\$100 copay	\$100 copay	\$250 copay ⁵
PRESCRIPTION DRUGS - Western Health Advantage			
Plan Year Deductible	N/A	N/A	Combined with medical
Plan Year Out-of-Pocket Maximum	Combined with medical	Combined with medical	Combined with medical
Retail- 30 Day Supply Generic Preferred Brand Non-preferred Brand Specialty	\$10 copay \$30 copay \$50 copay 20% up to \$100	\$10 copay \$30 copay \$50 copay 20% up to \$100	\$10 copay \$30 copay \$50 copay 20% up to \$100
Mail Order- 90 Day Supply Generic Preferred Brand Non-preferred Brand Specialty	\$25 copay \$75 copay \$125 copay 20% up to \$100 (30-day supply)	\$25 copay \$75 copay \$125 copay 20% up to \$100 (30-day supply)	\$25 copay \$75 copay \$125 copay 20% up to \$100 (30-day supply)

¹Deductibles and out-of-pocket maximums accumulate on a plan year from January 1 through December 31.

²An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.

³An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

⁴All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

⁵After deductible.

KAISER RESOURCES

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (866) 454-8855 (TTY 711).

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Kaiser's travel [website](#) will explain what to do if you need emergency or urgent care during your trip.

myStrength

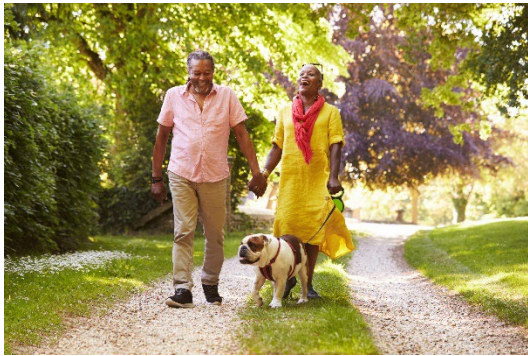
The myStrength app is designed to help navigate life's challenges, make positive changes, and support your overall well-being. The app can help you set goals and work towards them in the ways that work best for you. You can access myStrength at kp.org/selfcareapps and choose the mental health and wellness areas you want to focus on.

Ginger App

Use the Ginger app to text one-on-one with an emotional support coach anytime, anywhere. Through the app you have access to 24/7 text-based emotional support coaching and self-care resources recommended for your needs. Download Ginger from the App StoreSM or Google Play[®].

Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps.



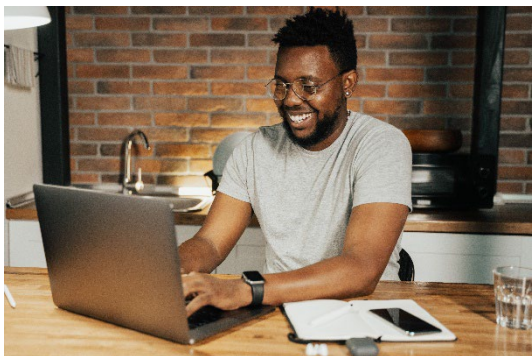
FINDING A KAISER PROVIDER

To find a Kaiser Permanente provider near you, please visit www.kp.org or call (800) 464-4000.

MY HEALTH MANAGER

Stay engaged with your health and simplify your busy life by using the [Kaiser Website](#) or download the Kaiser Permanente app from the App StoreSM or Google Play[®].

SUTTER HEALTH PLUS RESOURCES



NEED HELP FINDING A DOCTOR?

Please visit sutterhealthplus.org to find doctors, specialists, hospitals, Sutter Walk-In Care, urgent care centers, and more.

DID YOU KNOW?

Sutter Health Plus Member Services is available to help you find a provider, answer questions about benefits, or assist in scheduling appointments with many Sutter doctors and clinicians.

Call: 855-315-5800

Monday through Friday, 8am – 7pm

Member Portal

Sutter Health Plus offers a member portal for your convenience.

Register at shplus.org/memberportal to get convenient 24/7 access from your smartphone, tablet, or computer. Use your member portal to change your PCP, request or print ID cards, check eligibility, benefits, and claims information, etc.

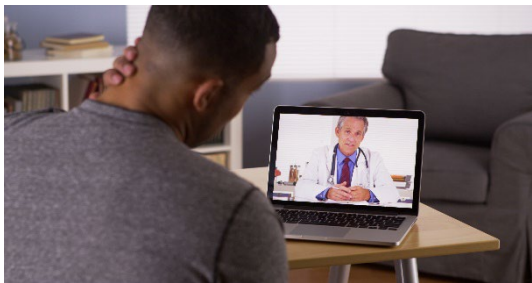
Pharmacy Benefits

Sutter Health Plus partners with CVS Caremark® for pharmacy benefits, including retail, mail order and specialty prescription drugs. Use the CVS Caremark Guest Website to find a pharmacy, check drug costs, view sample plan options, or find the Sutter Health Plus Formulary. Visit sutterhealthplus.org/pharmacy.

My Health Online (MHO)

As a Sutter Health Plus member, you can enroll in My Health Online (MHO), a convenient way to manage your health when and where you want. With MHO, it's easy to stay connected with your care team and have 24/7 access to your health information. You can book a video visit, view test results, pay bills and copays online, etc. For more information, visit sutterhealth.org/myhealthonline.

WESTERN HEALTH ADVANTAGE TELEHEALTH SERVICES



LEARN MORE ABOUT TELEVISITS

Contact your PCP or WHA Member Services at (888) 563-2250

CONNECT TO HEALTH CARE SERVICES — VIRTUALLY

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

St. Joseph Health Medical Network

Providence Health Connect

See a healthcare provider from your tablet, smartphone, or computer. Sit down with one of Providence's board-certified providers through secure video chat on your smartphone, tablet, or computer. Talk with them about your symptoms, and they can diagnose and treat minor medical concerns you're dealing with. They can also prescribe medication or lab work as needed. Learn more about Providence Express Care Virtual here: virtual.providence.org.

Magellan Healthcare

Convenient Counseling Services

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

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

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

NorthBay Healthcare

Instant Visit

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

Note: Sometimes conditions are more complex than the symptoms suggest, and your instant visit provider may ask to see you at NorthBay Urgent Care. Learn more about instant visits with NorthBay Healthcare here northbay.org/urgent-care/instant-visit.cfm.

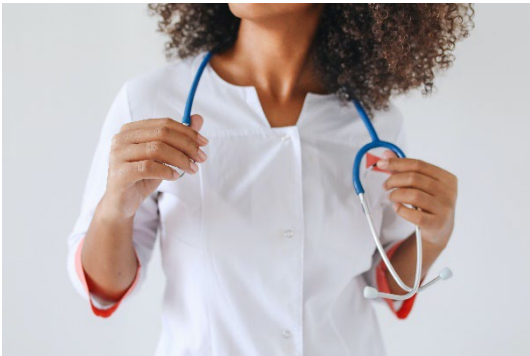
Mercy Medical Group & Woodland Clinic

Dignity Health's mycare. app

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

Learn more about video visits through Dignity Health at www.dignityhealth.org/videovisitresources.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit [healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/) for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive






Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	<ul style="list-style-type: none"> Identifying symptoms Decide if immediate care is needed Home treatment options and advice 	24/7	\$0
Online visit 	Many non-emergency health conditions	<ul style="list-style-type: none"> Cold, flu, allergies Headache, migraine Skin conditions, rashes Minor injuries Mental health concerns 	24/7	\$
Office visit 	Routine medical care and overall health management	<ul style="list-style-type: none"> Preventive care Illnesses, injuries Managing existing conditions 	Office Hours	\$\$
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	<ul style="list-style-type: none"> Stitches Sprains Animal bites Ear-nose-throat infections 	Office Hours, or up to 24/7	\$\$\$
Emergency room 	Life-threatening conditions requiring immediate medical expertise	<ul style="list-style-type: none"> Suspected heart attack or stroke Major bone breaks Excessive bleeding Severe pain Difficulty breathing 	24/7	\$\$\$\$\$



DENTAL

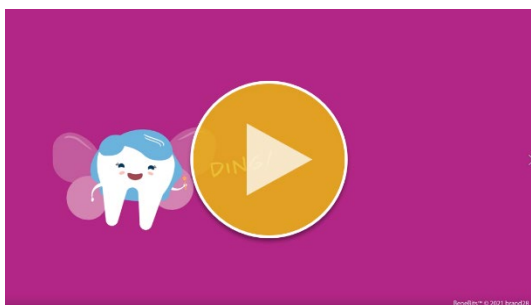
OUR PLANS

Delta Dental Core PPO Plan

Delta Dental Buy-Up PPO Plan

Delta Dental DeltaCare HMO Plan

Click to play video



We offer 3 dental plans through Delta Dental. The City of Fairfield provides you with comprehensive coverage through Delta Dental (CSAC EIA).

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

Delta Dental Core Plan

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Delta Dental Core DPPO Plan		
	In-Network	Premier Network	Out-of-Network
Annual Deductible Individual/Family	\$0 / \$0	\$25 / \$75	\$25 / \$75
Annual Plan Maximum Per Individual	\$1,500	\$1,500	\$1,000
Waiting Period	None	None	None
Diagnostic & Preventive	No charge (deductible waived)	10% (deductible waived)	10% (deductible waived)
Basic Services			
Fluoride Treatment ²	Included	Included	Included
Fillings	10%	20% ¹	20% ¹
Root Canals	10%	20% ¹	20% ¹
Periodontics	10%	20% ¹	20% ¹
Major Services	10%	20% ¹	20% ¹
Prosthodontics			
Dental Implants	40%	50% ¹	50% ¹
Bridges and Dentures			
Orthodontia Children only	50% (deductible waived)	50% (deductible waived)	50% (deductible waived)
Ortho Lifetime Max	\$1,500	\$1,500	\$1,500

¹After deductible.

²Fluoride treatment for adults and children, limited to 2 treatments per year.

What you need to know about this plan



Features:

See any provider, but you'll pay more out of network

Am I restricted to in-network providers?

No

Do I have to select a primary dentist?

No

Can I use my FSA?

If you participate in a healthcare FSA, you can use your account to pay for dental expenses.

Where can I get more details?

For more information visit deltadentalins.com or call 888-335-8227.

Delta Dental Buy-up Plan

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Delta Dental Buy-Up DPPO Plan		
	In-Network	Premier Network	Out-of-Network
Annual Deductible Individual/Family	\$0 / \$0	\$25 / \$75	\$25 / \$75
Annual Plan Maximum Per Individual	\$2,500	\$2,500	\$2,500
Waiting Period	None	None	None
Diagnostic & Preventive	No charge (deductible waived)	10% (deductible waived)	10% (deductible waived)
Basic Services			
Fluoride Treatment ²	Included	Included	Included
Fillings	10%	20% ¹	20% ¹
Root Canals	10%	20% ¹	20% ¹
Periodontics	10%	20% ¹	20% ¹
Major Services	10%	20% ¹	20% ¹
Prosthetics			
Dental Implants Bridges and Dentures	40%	50% ¹	50% ¹
Orthodontia Children only	50% (deductible waived)	50% ¹ (deductible waived)	50% ¹ (deductible waived)
Ortho Lifetime Max	\$1,500	\$1,500	\$1,500

¹After deductible.

²Fluoride treatment for adults and children, limited to 2 treatments per year.

What you need to know about this plan



Features:

See any provider, but you'll pay more out of network

Am I restricted to in-network providers?

No

Do I have to select a primary dentist?

No

Can I use my FSA?

If you participate in a healthcare FSA, you can use your account to pay for dental expenses.

Where can I get more details?

For more information visit deltadentalins.com or call 888-335-8227.

Delta Dental DHMO Plan

You always pay the deductible and copayment (\$).

	Delta Dental DHMO Plan
	In-Network
Annual Deductible Individual/Family	\$0 / \$0
Annual Plan Maximum	None
Waiting Period	None
Diagnostic & Preventive¹	\$0 - \$45 copay
Basic Services¹ Fillings Root Canals Periodontics	\$0 - \$75 copay \$0 - \$205 copay \$0 - \$195 copay
Major Services¹	\$0 - \$195 copay
Orthodontia¹ Adults (over age 19) Children (up to age 19)	\$1,900 copay \$1,700 copay
Ortho Lifetime Max	Unlimited

¹Varies by services, see contract for fee schedule.

What you need to know about this plan



Features:

See any provider, but you'll pay more out of network

Am I restricted to in-network providers?

Yes

Do I have to select a primary dentist?

Yes

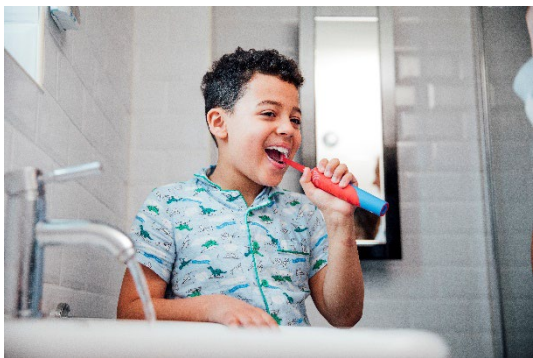
Can I use my FSA?

If you participate in a healthcare FSA, you can use your account to pay for dental expenses.

Where can I get more details?

For more information visit deltadentalins.com or call 800-422-4234.

DELTA DENTAL RESOURCES



DELTA DENTAL MOBILE APP

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

SmileWay® Wellness Benefits

If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer, or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings. You can opt in by visiting www.deltadentalins.com/smileway or by calling Customer Service Monday through Friday.

Toothpic

Toothpic is a photo-based tele-dentistry app for PPO & premier plan members. Although Toothpic is not available for dental emergencies, members can set up a virtual dental screening or even send in photos for dental issues. A Delta Dental dentist, who is part of the PPO & Premier Network, can highlight issues from the photos, such as cavities, gum disease, oral hygiene, or other dental concerns. The dentist can then assist with the next steps, possible treatments, or a home care regimen.

Cost Estimator

Members can plan visits and compare costs before they receive their treatments. Estimates for each member are personalized based on benefits. Should members need to plan in terms of costs, they can compare procedure costs at nearby dentists. Members can also receive a detailed explanation of their costs based on upcoming treatment.

Amplifon & Qualsight Discounts

With the Amplifon discount, Delta Dental members get an average savings of 62% off the latest retail hearing aid price. For more information call 1-888-779-1429 or email amplifonusa.com/deltadentalins. PPO members may even be able to use their plan benefits in coordination with Amplifon discounts. There is also a QualSight discount for Delta Dental members. Members receive 40-50% off the national average price of traditional LASIK eye surgery when they use an experienced QualSight LASIK surgeon. For more information, email qualsight.com/-delta-dental or call 1-855-248-2020.

LifePerks

As a Delta Dental member, you have access to a wide variety of local and national offers and discounts to help you care for your whole body and maintain a healthy life. Register and learn more about LifePerks at discountmember.lifecare.com.



VISION

OUR PLANS

VSP Basic Plan

VSP Premier Plan

We offer 2 vision plans through VSP Vision.

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

Click to play video



VSP Vision Plans

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	Basic Plan		Premier Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Exams				
Benefit	\$20 copay	Reimbursed up to \$45	\$10 copay	Reimbursed up to \$45
Materials	\$25 copay	See schedule below	\$25 copay	See schedule below
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Eyeglass Lenses				
Single Vision Lens	\$25 copay	Reimbursed up to \$30	\$25 copay	Reimbursed up to \$30
Bifocal Lens	\$25 copay	Reimbursed up to \$50	\$25 copay	Reimbursed up to \$50
Trifocal Lens	\$25 copay	Reimbursed up to \$65	\$25 copay	Reimbursed up to \$65
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames				
Benefit	\$150 + 20% discount over allowance	Reimbursed up to \$70	\$200 + 20% discount over allowance	Reimbursed up to \$70
Frequency	Once every 24 months	Once every 24 months	Once every 12 months	Once every 12 months
Contacts (Elective)¹				
Conventional	\$130 allowance	Reimbursed up to \$105	\$200 allowance	Reimbursed up to \$105
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months

¹Copay waived; instead of eyeglasses.

What you need to know about this plan



Features:

See any provider, but you'll pay more out of network

What other services are covered?

The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?

Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

Where can I get more details?

For more information visit vsp.com/offers or call 800-877-7195.

VSP SAVINGS AND RESOURCES



ACCESS TO OVER \$3,000 IN EXCLUSIVE MEMBER SAVINGS

Visit vsp.com/offers to learn more about these resources and other VSP exclusive member extras.

Extra Savings on Glasses and Sunglasses

Get an extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. You can also save 30% on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.

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

Retinal Screening

You won't pay more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam.

LASIK - Laser Vision Correction

Save up to an average of 15% off the regular price of LASIK or 5% off the promotional price. Discounts are only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

TruHearing[®] Hearing Aid Discount

VSP[®] Vision Care members can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too. TruHearing also provides members with:

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

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call (877) 396-7194.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video



ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. **Find out more**

- [Eligible Expenses](#) – now include more over-the-counter items!
- [Ineligible Expenses](#)
- americanfidelity.com or call 800-437-1011 to learn more.

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through American Fidelity.

How the American Fidelity works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and even eligible drugstore items.
- You can contribute a minimum of \$150 up to \$3,200, the 2024 annual limit set by the IRS (subject to change). Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 01/01/2025 and 3/15/2026 (2 ½ month "grace period" after the end of the plan year to incur claims), and claims must be submitted for reimbursement no later than 03/31/2026. If you don't spend all the money in your account, any additional remaining balance will be forfeited.
- Elections cannot be changed during the plan year unless you experience a qualifying event.
- You must re-enroll in this program each year.

FSA TAX SAVINGS EXAMPLE (SINGLE FILERS)

\$60,000 Annual Pay, with \$1,500 FSA Contribution

\$330	\$115	\$445
22% Federal income tax	7.65% FICA tax	Annual FSA tax savings

\$120,000 Annual Pay, with \$2,850 FSA Contribution

\$684	\$219	\$903
24% Federal income tax	7.65% FICA tax	Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

PAYING FOR DAYCARE? MAKE IT TAX-FREE!



EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to \$5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by American Fidelity.

Here's how the American Fidelity works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to \$5,000 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to \$2,500 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.



Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.



BASIC LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Basic life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase. See the Voluntary Benefits section for details.

BASIC LIFE AND AD&D INSURANCE



A NOTE ABOUT TAXES

Company-provided life insurance coverage over \$50,000 is considered a taxable benefit. The value of the benefit over \$50,000 will be reported as taxable income on your annual W-2 form.

TRAVEL ASSISTANCE SERVICES

Travel Assistance Services provides a benefit in the event of an emergency medical transport (when traveling outside your home country and the USA and can only be used in conjunction with an eligible medical evacuation), medical assistance, travel and security assistance. City of Fairfield provides this coverage through Prudential/IMG at no cost to you.

Benefits include IMG’s extensive global network of medical care providers, and onsite 24/7/365 USA based call center assistance.

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing or to your beneficiary if you have a fatal accident. Prudential Insurance Company of America provides coverage for eligible employees, and premiums are paid in full by the City of Fairfield.

Basic Life and AD&D Benefits	Basic Life & AD&D Amount
Class 1 Executive Management, FGMA, Confidential Management, FPMA, FFMA, FPFA, and FPOA	1.5 times of covered annual earnings up to \$150,000
Class 2 General Employees (FEA & Confidential Non-Management)	\$50,000
Class 3 Elected Officials	\$30,000
Class 4 City Manager	1x salary to \$150,000
Class 5 Pro-Rata Employees	\$50,000

SHORT-TERM DISABILITY INSURANCE (STD)

Short-Term Disability (STD) insurance replaces part of your income for limited-duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. All eligible employees contribute \$6 per month toward this benefit. Coverage is provided by Prudential Insurance Company of America.



EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

SUBMITTING A CLAIM

If you are disabled due to an illness or accidental injury, unable to work, and under the care of a licensed physician, you are eligible to submit a claim for benefits under this plan. As long as you remain disabled and meet the plan's disability requirements, you will continue to receive a percentage of your earnings until benefits are no longer payable.

Weekly Benefit Amount	Plan pays 69% of weekly earnings
Maximum Weekly Benefit	\$1,619.15
Benefits Begin After	
Accident	8 days of disability
Sickness	8 days of disability
Maximum Payment Period*	180 days

*Maximum payment period is based on the first day you are disabled, not when benefits begin.

LONG-TERM DISABILITY INSURANCE (LTD)



3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer-term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. The City of Fairfield pays the cost of this coverage for employees who are eligible for City benefits. Coverage is provided by Prudential Insurance Company of America.

Prudential Insurance LTD Plan

Monthly benefit amount	Class 1: City Manager: 60% up to a maximum of \$15,000
	Class 2: Executive Management (not including city manager): 60% up to a maximum of \$10,000
	Class 3: All Employees other than those classified by the Employer as City Manager, Executive Management, Elected Officials, Temporary Part-Time or Career Part-Time: 60% up to a maximum of \$8,250
	Class 4: Pro-Rata Employees: 60% up to a maximum of \$8,250
Benefits begin	After 180 of disability
Maximum payment period	Up to your normal retirement age under the Social Security Act



VOLUNTARY PLANS

OUR VOLUNTARY PLANS

- Voluntary Life/AD&D (employee, spouse, and child(ren))
- Accident Insurance
- Cancer Insurance
- Group Critical Illness
- Short-Term Disability
- Individual Term Life

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

City of Fairfield offers plans to help:

- replace income if you're injured or ill
- bridge the gap for special healthcare needs

You pay the entire cost for these plans, but rates may be more affordable than individual coverage.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

VOLUNTARY LIFE INSURANCE

Protecting those you leave behind

Voluntary Term Life Insurance is available for purchase by eligible employees in addition to the Basic Life/AD&D insurance provided by the City of Fairfield, ensuring additional protection for your family's financial security. The total cost for this benefit is the employee's responsibility and varies based on age and the chosen coverage amount. Coverage is offered through the Prudential Insurance Company of America.

Prudential Voluntary Life

- Employee** Increments of \$10,000 up to \$500,000 (not to exceed 6x your covered annual earnings)
Minimum: \$20,000
Guaranteed Issue: \$200,000
- Spouse** Increments of \$5,000 up to \$250,000 (not to exceed 50% of your optional term life coverage amount)
Guaranteed Issue: \$30,000
- Child(ren)** Up to \$10,000 (not to exceed 50% of your optional term life coverage amount)

Note: Benefit amount reduces to 35% at age 65.



VOLUNTARY LIFE & AD&D INSURANCE COSTS

If you elect voluntary coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck.

VOLUNTARY LIFE INSURANCE – MONTHLY RATE PER \$1,000 OF COVERAGE

AGE	EMPLOYEE/SPOUSE RATES
Under age 20	\$0.080
Age 20-24	\$0.080
Age 25-29	\$0.080
Age 30-34	\$0.080
Age 35-39	\$0.120
Age 40-44	\$0.180
Age 45-49	\$0.250
Age 50-54	\$0.500
Age 55-59	\$0.850
Age 60-64	\$0.950
Age 65-69	\$1.350
Age 70-74	\$2.250
Age 75+	\$2.250

VOLUNTARY AD&D – MONTHLY RATE PER \$1,000 OF COVERAGE

Employee & Spouse	\$0.03
Child(ren)	\$0.03

To calculate your per paycheck AD&D cost, follow the same steps as the table above.

CALCULATE YOUR LIFE INSURANCE COST

1. Desired Coverage (\$1,000 Increments)

You:	Spouse:
------	---------

2. Divide Step 1 by 1,000 =

You:	Spouse:
------	---------

3. Multiply Step 2 by Rate from Table =

You:	Spouse:
------	---------

4. Multiply Step 3 by 12 and divide by 24 =

You:	Spouse:
------	---------

5. Add You + Spouse from Step 4:

TOTAL COST PER PAYCHECK:

CHILD LIFE INSURANCE

COVERAGE AMOUNT	Rate per \$1,000 of coverage	Total Cost Per Paycheck
\$10,000	\$0.05	\$0.25

Premium includes all eligible children.

Eligible children include dependent children under age 26 as long as you apply for and are approved for coverage for yourself.

VOLUNTARY AMERICAN FIDELITY PLANS



THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Accident Insurance

Accident Insurance from American Fidelity helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

Cancer Insurance

Many people are concerned about the financial impact of a cancer diagnosis. Cancer insurance provides tax-free benefits for many of the costs associated with cancer treatment, such as radiation, chemo, surgery, diagnostic tests, and physician charges. You can cover yourself and your family members if needed. American Fidelity provides coverage for this program.

Group Critical Illness

Group Critical Illness Insurance from American Fidelity can help fill a financial gap if you experience a serious illness such as cancer, heart attack, or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

Short-Term Disability

American Fidelity's Short-Term Disability Income Insurance is designed to help protect you if you become disabled and cannot work due to a covered Accidental Injury or Sickness. Please review the Prudential STD plan provided by the City of Fairfield in your evaluation of this product. If you become disabled due to a covered accident or sickness, short-term disability income insurance will pay up to 25% of your monthly income once you have satisfied the elimination period.

Individual Term Life

American Fidelity offers an Individual Term Life Insurance policy to help with your financial needs for your short-term and long-term goals. Individual Term Life insurance is a death benefit protection with no cash accumulation feature. The policy is initially written for a 10, 20, or 30-year term period but may be renewed at the insured's option for the same level renewal period depending on the term chosen.



WELLBEING & BALANCE

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

EMPLOYEE ASSISTANCE PROGRAM (EAP)



CONTACT THE EAP

Phone

(800) 344-4222

Website

[Employees.concernhealth.com](https://employees.concernhealth.com)

Company Code

Fairfield

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Concern can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7, 365 days a year
- In-person or video counseling for short-term issues; up to 8 sessions per individual, per year and 10 sessions for substance or alcohol use by Supervisor Referrals
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care
- 3 free phone sessions per year

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues
- Free one to two 30-minute phone consultations

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy
- Free 30-minute consultation and 25% discount on hourly rates

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics



IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Qualifying Events
- Your benefit contributions
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

Qualifying Events

Once Open Enrollment ends and the Group Health Plan Year begins, changes in coverage elections are generally not allowed. Under Federal law, there are limited changes that **MUST** be allowed and some changes that **MAY** be allowed if previously defined in the Plan Document. Any new election must be **CONSISTENT** with allowed cause. This chart covers the rules for what **MUST** and what **MAY** be allowed and lists what **CAN'T** be allowed.

EVENT	APPLIES TO	CHANGE ALLOWED	WHEN
Change in employee's legal marital status that affects eligibility for coverage.	Marriage, divorce, death of spouse, legal separation, annulment.	Spouse may be enrolled or dropped from the employee's group health plan coverage that is consistent with the change. New enrollees must be otherwise eligible for coverage under the plan and may elect any health plan offered. Employees may change plans consistent with the need to cover or drop the spouse or may revoke/decrease the employee's coverage only when such coverage becomes effective or is increased under the spouse's plan.	Employee must request change within 30 days from the event. Coverage must be effective no later than the first day of the month following the date of the enrollment request.
Change in number of legally-defined dependents that affects eligibility for coverage.	Birth or death of dependent, commencement or termination of adoption proceedings, acquisition of dependents by marriage or court decree.	Dependents may be enrolled or dropped from employee's group health plan coverage consistent with the change. New enrollees must be otherwise eligible for coverage under the plan and may elect any health plan offered. Employee may change plans consistent with need to cover or drop dependents but may not drop employee coverage.	Employee must request change within 30 days from the event. Coverage must be effective no later than the first day of the month following the date of the enrollment request. For newborns or placement for adoption, coverage must be retroactive to the first of the month following the date of the event.
Gain or loss of dependent eligibility.	Limiting age, gain or loss of student status or change in marital status, loss of eligibility for Medicaid/MediCal or a State Child Health Insurance Plan (SCHIP,) Qualified Medical Support Orders (QMSO).	(Under "tag-along" rule, any dependents not previously enrolled may be added at this time if family coverage added is for all dependents, but no dependent may be dropped who is not affected by the change.) May add coverage if Medicaid/MediCAL or SCHIP is lost, or state premium assistance becomes available, but may not drop coverage when eligibility for either is gained.	
Change in residence that affects eligibility for coverage.	Change in employee, spouse or dependent residence affecting eligibility for group health plan coverage.	If change in residence creates loss of eligibility or gain of eligibility for group health coverage (typically involves moving into or out of health plan service area,) employee may enroll, change election or revoke election consistent with the change. Employee may change plans consistent with need to cover or drop dependents but may not drop employee coverage unless no alternate group health plan is available. (Under "tag-along" rule, any dependents not previously enrolled may be added at this time if family coverage added is for all dependents, but no dependent may be dropped who is not affected by the change.)	Employee must request change within 30 days from the event. Changed coverage must be effective no later than the first day of the month following the date of the enrollment request.
Change in employment status that creates loss of group health plan coverage.	Includes termination of employment of spouse; strike or lockout; unpaid leave of absence starting or ending; reduction in hours or change in classification; death or divorce of primary enrollee; other employer ceases contributions to group health plan.	Loss of non-COBRA group health coverage due to change in employment status for employee or spouse covered by other group health plan when coverage was previously declined. New enrollees must be otherwise eligible for coverage under the plan and may elect any health plan offered. (Under "tag-along" rule, any dependents not previously enrolled may be added at this time if family coverage added is for all dependents.)	Employee must request change within 30 days from the event. Changed coverage must be effective no later than the first day of the month following the date of the enrollment request.
Exhaustion of COBRA Coverage.	Regardless of who is paying for coverage.	Exhaustion of COBRA coverage which was in effect when group health coverage was previously declined. New enrollees must be otherwise eligible for coverage under the plan and may elect any health plan offered. (Under "tag-along" rule, any dependents not previously enrolled may be added at this time if family coverage added is for all dependents.)	Employee must request change within 30 days from the event. Changed coverage must be effective no later than the first day of the month following the termination of COBRA coverage but need not be effective before COBRA coverage is ended.

Monthly Medical Contributions

Plans	2025 Premium Rates	FPOA / FPMA / FPFA / FFMA	
Medical		City Contribution	Employee Contribution
Kaiser Permanente \$15 HMO			
• Single	\$929.67	\$697.24	\$232.43
• Two Party	\$1,859.33	\$1,394.48	\$464.85
• Family	\$2,630.95	\$1,973.20	\$657.75
Kaiser Permanente \$35 HMO			
• Single	\$878.71	\$696.30	\$182.41
• Two Party	\$1,757.43	\$1,392.59	\$364.84
• Family	\$2,486.75	\$1,970.53	\$516.22
Kaiser Permanente Virtual Complete			
• Single	\$665.07	\$653.55	\$11.52
• Two Party	\$1330.15	\$1,307.11	\$23.04
• Family	\$1882.16	\$1,849.57	\$32.59
SHP \$10 HMO			
• Single	\$880.90	\$701.42	\$179.48
• Two Party	\$1,762.00	\$1,402.83	\$359.17
• Family	\$2,493.60	\$1,985.01	\$508.59
SHP \$20 HMO			
• Single	\$847.50	\$711.64	\$135.86
• Two Party	\$1,695.20	\$1,423.27	\$271.93
• Family	\$2,398.90	\$2,013.93	\$384.97
SHP DHMO			
• Single	\$702.60	\$666.64	\$35.96
• Two Party	\$1,405.40	\$1,333.28	\$72.12
• Family	\$1,988.90	\$1,886.60	\$102.30
WHA \$15 HMO			
• Single	\$879.82	\$691.34	\$188.48
• Two Party	\$1,749.98	\$1,382.19	\$367.79
• Family	\$2,478.68	\$1,955.66	\$523.02
WHA \$40 HMO			
• Single	\$798.78	\$689.24	\$109.54
• Two Party	\$1,597.56	\$1,375.99	\$221.57
• Family	\$2,262.80	\$1,949.72	\$313.08
WHA DHMO			
• Single	\$602.22	\$580.33	\$21.89
• Two Party	\$1,197.82	\$1,154.43	\$43.38
• Family	\$1,696.60	\$1,635.10	\$61.50

Monthly Medical Contributions, cont.

Plans Medical	2025 Premium Rates	Executives / Confidential Managers / FGMA	
		City Contribution	Employee Contribution
Kaiser Permanente \$15 HMO			
• Single	\$929.67	\$682.84	\$246.83
• Two Party	\$1,859.33	\$1,365.68	\$493.65
• Family	\$2,630.95	\$1,932.46	\$698.49
Kaiser Permanente \$35 HMO			
• Single	\$878.71	\$681.90	\$196.81
• Two Party	\$1,757.43	\$1,363.79	\$393.64
• Family	\$2,486.75	\$1,929.79	\$556.96
Kaiser Permanente Virtual Complete			
• Single	\$665.07	\$653.55	\$11.52
• Two Party	\$1,330.15	\$1,307.11	\$23.04
• Family	\$1,882.16	\$1,849.57	\$32.59
SHP \$10 HMO			
• Single	\$880.90	\$687.02	\$193.88
• Two Party	\$1,762.00	\$1,374.03	\$387.97
• Family	\$2,493.60	\$1,944.27	\$549.33
SHP \$20 HMO			
• Single	\$847.50	\$697.24	\$150.26
• Two Party	\$1,695.20	\$1,394.47	\$300.73
• Family	\$2,398.90	\$1,973.19	\$425.71
SHP DHMO			
• Single	\$702.60	\$666.64	\$35.96
• Two Party	\$1,405.40	\$1,333.28	\$72.12
• Family	\$1,988.90	\$1,886.60	\$102.30
WHA \$15 HMO			
• Single	\$879.82	\$676.94	\$202.88
• Two Party	\$1,749.98	\$1,353.39	\$396.59
• Family	\$2,478.68	\$1,914.92	\$563.76
WHA \$40 HMO			
• Single	\$798.78	\$674.84	\$123.94
• Two Party	\$1,597.56	\$1,349.19	\$248.37
• Family	\$2,262.80	\$1,908.98	\$353.82
WHA DHMO			
• Single	\$602.22	\$580.33	\$21.89
• Two Party	\$1,197.82	\$1,154.43	\$43.40
• Family	\$1,696.60	\$1,635.10	\$61.51

Monthly Medical Contributions, cont.

Plans Medical	2025 Premium Rates	FEA / Confidential Non-Managers	
		City Contribution	Employee Contribution
Kaiser Permanente \$15 HMO			
• Single	\$929.67	\$832.02	\$97.65
• Two Party	\$1,859.33	\$1,664.11	\$195.22
• Family	\$2,630.95	\$2,354.70	\$276.25
Kaiser Permanente \$35 HMO			
• Single	\$878.71	\$831.10	\$47.61
• Two Party	\$1,757.43	\$1,662.24	\$95.19
• Family	\$2,486.75	\$2,352.05	\$134.70
Kaiser Permanente Virtual Complete			
• Single	\$665.07	\$665.07	\$0.00
• Two Party	\$1,330.15	\$1,330.15	\$0.00
• Family	\$1,882.16	\$1,882.16	\$0.00
SHP \$10 HMO			
• Single	\$880.90	\$841.78	\$39.12
• Two Party	\$1,762.00	\$1,684.18	\$77.82
• Family	\$2,493.60	\$2,383.73	\$109.87
SHP \$20 HMO			
• Single	\$847.50	\$810.78	\$36.72
• Two Party	\$1,695.20	\$1,622.08	\$73.13
• Family	\$2,398.90	\$2,295.83	\$103.07
SHP DHMO			
• Single	\$702.60	\$676.48	\$26.12
• Two Party	\$1,405.40	\$1,353.48	\$51.93
• Family	\$1,988.90	\$1,915.83	\$73.08
WHA \$15 HMO			
• Single	\$879.82	\$826.13	\$53.69
• Two Party	\$1,749.98	\$1,651.82	\$98.16
• Family	\$2,478.68	\$2,337.16	\$141.52
WHA \$40 HMO			
• Single	\$798.78	\$776.02	\$22.76
• Two Party	\$1,597.56	\$1,552.07	\$45.49
• Family	\$2,262.80	\$2,198.29	\$64.52
WHA DHMO			
• Single	\$602.22	\$590.17	\$12.06
• Two Party	\$1,197.82	\$1,174.12	\$23.70
• Family	\$1,696.60	\$1,662.96	\$33.64

Monthly Dental Contributions

Plans	2025 Premium Rates	FPOA / FPMA / FPFA / FFMA	
Dental		City Contribution	Employee Contribution
PPO Buy-Up 1 - PPO+Premier 1500			
• Single	\$50.41	\$31.88	\$18.53
• Two Party	\$91.68	\$78.62	\$13.06
• Family	\$134.94	\$110.53	\$24.41
PPO Buy-Up 2 - PPO+Premier 2500			
• Single	\$57.29	\$31.88	\$25.41
• Two Party	\$104.08	\$78.62	\$25.46
• Family	\$153.31	\$110.53	\$42.78
HMO – DeltaCare			
• Single	\$20.10	\$18.62	\$1.48
• Two Party	\$35.80	\$33.09	\$2.71
• Family	\$52.80	\$48.82	\$3.98
Plans	2025 Premium Rates	Executives / Confidential Managers / FGMA	
Dental		City Contribution	Employee Contribution
PPO Buy-Up 1 - PPO+Premier 1500			
• Single	\$50.41	\$32.31	\$18.10
• Two Party	\$91.68	\$57.16	\$34.52
• Family	\$134.94	\$111.69	\$23.25
PPO Buy-Up 2 - PPO+Premier 2500			
• Single	\$57.29	\$32.31	\$24.98
• Two Party	\$104.08	\$57.16	\$46.92
• Family	\$153.31	\$111.69	\$41.62
HMO – DeltaCare			
• Single	\$20.10	\$19.96	\$0.14
• Two Party	\$35.80	\$35.80	\$0.00
• Family	\$52.80	\$52.80	\$0.00
Plans	2025 Premium Rates	FEA / Confidential Non-Managers	
Dental		City Contribution	Employee Contribution
PPO Buy-Up 1 - PPO+Premier 1500			
• Single	\$50.41	\$32.18	\$18.23
• Two Party	\$91.68	\$56.95	\$34.73
• Family	\$134.94	\$111.38	\$23.56
PPO Buy-Up 2 - PPO+Premier 2500			
• Single	\$57.29	\$32.18	\$25.11
• Two Party	\$104.08	\$56.95	\$47.13
• Family	\$153.31	\$111.38	\$41.93
HMO – DeltaCare			
• Single	\$20.10	\$18.92	\$1.18
• Two Party	\$35.80	\$33.66	\$2.14
• Family	\$52.80	\$49.67	\$3.13

Monthly Vision Contributions

Plans	2025 Premium Rates	All Employees Except FPOA	
		City Contribution	Employee Contribution
Vision			
Base			
• Single	\$4.43	\$4.43	\$0.00
• Two Party	\$8.98	\$8.98	\$0.00
• Family	\$14.48	\$14.48	\$0.00
Premier			
• Single	\$8.17	\$4.34	\$3.83
• Two Party	\$16.49	\$8.82	\$7.67
• Family	\$26.55	\$14.22	\$12.33

Plans	2025 Premium Rates	FPOA	
		City Contribution	Employee Contribution
Vision			
Base			
• Single	\$5.17	\$4.43	\$0.74
• Two Party	\$9.73	\$8.98	\$0.75
• Family	\$15.22	\$14.48	\$0.74
Premier			
• Single	\$9.05	\$4.34	\$4.70
• Two Party	\$17.36	\$8.82	\$8.54
• Family	\$27.43	\$14.22	\$13.21

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website
Kaiser Permanente	Kaiser Medical	(800) 464-4000	kp.org
Sutter Health Plus	Sutter Health Plus Medical	(855) 315-5800	sutterhealthplus.org
Western Health Advantage	Western Health Advantage Medical	(888) 227-5942	westernhealth.com
The Hartford	The Hartford Medicare Supplement	(877) 480-2432	thehartford.com
Delta Dental	Delta Dental DPPO and DHMO	DPPO: (888) 335-8227 DHMO: (800) 422-4234	deltadentalins.com
VSP	VSP Vision	(800) 877-7195	vsp.com
Concern	Concern Employee Assistance Program	(800) 344-4222	www.concernhealth.com
Prudential	Prudential Life and Disability	(800) 778-2255	prudential.com
American Fidelity	American Fidelity Voluntary Benefits	(800) 662-1113	americanfidelity.com
BCN	Benefits Communication Network (BCN)	(510) 769-1088	bcnfin.com

GLOSSARY

-A-

AD&D Insurance

An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount

The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)

A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit

A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing

In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is \$100 but the plan's allowable charge is only \$70, an out-of-network provider may bill YOU for the \$30 difference (the balance).

Beneficiary

The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug

A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA

A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim

A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance

Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment

A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible

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

Family coverage may have an **aggregate** or **embedded** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services

Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services

Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)

An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age

13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense

A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service

A service that your health plan doesn't pay for or cover.

-F-

Formulary

A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug

A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered

A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA)

An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)

A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP)

A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network

In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance

An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance

Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order

A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment

The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network

Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of-network services at all.

Out-of-Pocket Cost

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

Out-of-Pocket Maximum

Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care

Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy

A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year

A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug

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

Preventive Care Services

Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)

The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance

Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine

A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

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 care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations

Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit

An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this guide.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Notice of Availability of Alternative Standard for Wellness Plans:** Describes right to alternatives ways of participating in employer's wellness program

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

Medicare Part D Notice

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Fairfield has determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your City of Fairfield coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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

If you do decide to join a Medicare drug plan and drop your City of Fairfield prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Fairfield changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	The City of Fairfield
Contact-Position/Office:	Human Resources – benefits@fairfield.ca.gov
Address:	1000 Webster Street, Fairfield, CA
Phone Number:	(707) 428-7394

Women's Health and Cancer Rights Act

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

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

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

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

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

Availability of Privacy Practices Notice

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

Notice of Choice of Providers

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

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

Notice of Availability of Alternative Standard for Wellness Plan

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

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, 2024. 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
Health Insurance Premium Payment (HIPP) Program website: 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.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.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
Health Insurance Premium Payment Program and All Other Medicaid Websites: https://www.in.gov/medicaid/ or http://www.in.gov/fssa/dfp/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicicaid.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.mymaineconnection.gov/benefits/s/?language=en_US 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: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ 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: HSHIPPProgram@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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
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: https://www.hhs.nd.gov/healthcare 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 Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: https://www.pa.gov/en/agencies/dhs/resources/chip.html CHIP Phone: 1-800-986-KIDS (5437)
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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhpp.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, 2024, 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

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