City of Richmond

Benefits 2020 Guide

IMPORTANT BENEFIT INFORMATION

Active employees and retirees

CITY OF RICHMOND

DEPARTMENT OF HUMAN RESOURCES

The City of Richmond is pleased to provide this 2020 *Benefits Guide,* which offers the most up-to-date information about our comprehensive benefits program and provides important information you need as you make decisions during open enrollment or experience a life event that causes you to reconsider your current elections.

The City strives to deliver a high-quality, affordable benefits program to its employees and is proud to offer a wide array of benefits which allows you to tailor your benefits to meet your individual needs. The benefits available to you represent a significant portion of your total compensation package. These benefits provide important insurance protections for you and your family and some also offer tax advantages.

We hope you find our *Benefits Guide* to be a valuable resource and will share it with your family members. Please take the time to read it carefully and do not hesitate to contact the Human Resources Solutions Center at 804.646.5660 or your HR Generalist if you have questions.

Sincerely,

D. Karen Garland

D. Karen Garland
Interim Director of Human Resources

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Overview

The City of Richmond reviews programs annually, makes modifications that it deems appropriate, and offers its employees flexibility and choice. Throughout this Guide, you will find important information about the benefits offered to you. This page outlines benefits that you can elect during open enrollment and throughout the year. It also identifies changes that have been made to the benefits effective January 1, 2020.

Medical

We offer 3 medical plan options through Cigna Healthcare. They are the Premier Open Access Plus Plan A, the Classic Open Access Plus Plan B, and the Choice Fund Open Access Plus High Deductible Plan with HSA.

Refer to the section beginning on page 7 for a summary of the benefits. The plan rates for employees can be found on page 16. Plan rates for retirees begin on page 18.

Dental

We offer 2 dental plans, the Dental Preferred Provider Organization (DPPO) and the Dental Care Access. Cigna administers our dental coverage.

Refer to the section beginning on page 10 for a summary of the benefits. The plan rates can be found on page 17.

Flexible Spending Accounts (FSA)

Benefits are administered by WageWorks. The annual limit for the Healthcare FSA is $2,700 and $5,000 for the Dependent Care FSA. You must make a new election for January 1 to participate in either of the FSAs even if you are currently participating.

Refer to the section beginning on page 13 for a summary of the benefits.

Voluntary Benefits

Several programs are offered to employees to provide additional benefits. They include Accident Insurance, Cancer Insurance, Hospital Confinement Insurance, Critical Care Insurance, Term Life Insurance, Short-term Disability, and Legal Resources.

Refer to the sections beginning on page 26 for more information about these programs.

You may also purchase additional Group Term Life Insurance through the VRS (see page 22) and participate in the Deferred Compensation 457 plan (see page 24).

Please note: Although the City of Richmond expects to continue to provide a competitive and comprehensive benefits package to its eligible employees, the City of Richmond reserves the right to amend, modify, or eliminate benefits programs at any time.

Enrollment

Who Is Eligible

Permanent full-time active employees are eligible to participate in all benefit plans.

Permanent Part-time employees who work 20 or more hours per week are eligible to participate in our medical and dental benefits and Deferred Compensation 457 plan.

Provisional Employees who work 20 or more hours per week are eligible for the medical plans only.

Enrollment Process

During the Open Enrollment period, you make enrollment elections for the upcoming plan year, which runs from January 1 through December 31.

Employees hired after the Open Enrollment period must complete enrollment forms and return them to the Human Resources Department within 30 days of the hire date.

Why You Need to Enroll During Open Enrollment

If you wish to add or make changes to your insurance coverage(s), please update your choices in a timely manner. If you missed the deadline after your hire date, you will be able to take advantage of the coverages now available. If you do not enroll now, you will have to wait until the next Open Enrollment period to make new benefit elections.

When is Coverage Effective

For those electing coverage during Open Enrollment, coverage will become effective January 1, 2020.

For employees hired in 2020:

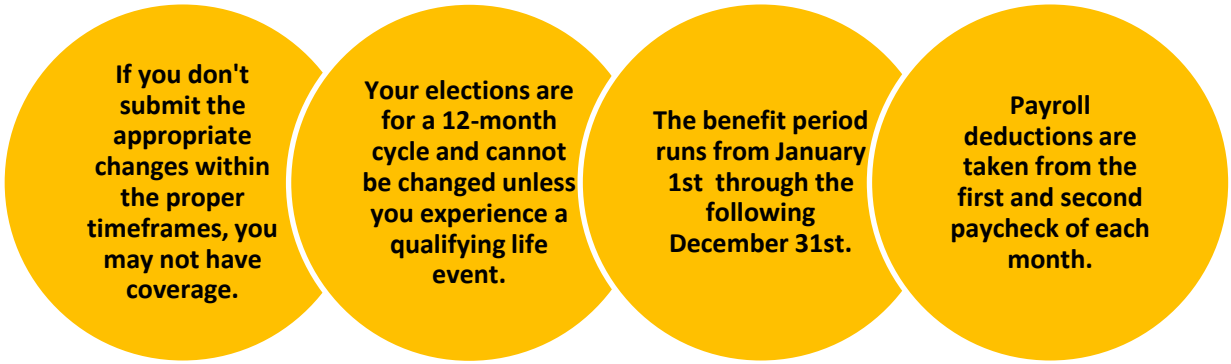
- Employees hired on the 1st of the month – coverage is effective that same day.
- Employees hired on the 2nd to the end of the month – coverage is effective the 1st day of the upcoming month.

For example: If you are hired May 1, 2020, your coverage begins May 1, 2020. If you are hired between May 2 – 31, your coverage begins June 1, 2020.

What to Do Before You Enroll

- Read this Benefits Guide thoroughly.
- Work up your benefit choices and costs on a separate sheet.
- Gather your beneficiary and dependent names, dates of birth, and Social Security numbers (SSNs), if needed.
- When enrolling dependents, include documentation such as marriage licenses and birth certificates.
- Complete the enrollment forms to make changes or to enroll in benefit plans.

Please note: You must provide each of your dependent's Social Security number in order to enroll them in medical benefits. This is required under the Affordable Care Act.



Benefit Elections – Things to Consider

Your Benefit Choices

Making benefit choices is like other choices you make in life. First, take a look at the benefits available to you. Next, think about what *you* need (whether that means you, or you and your family) and what will suit *you* . . . not everyone around you. Then fill in your selections during enrollment and enjoy the benefits you've chosen.

Your Past History

Review your medical and dental expenses over the last few years. How likely is it that you will need medical and dental treatment for the coming year? Remember, you always have to anticipate unexpected expenses. How much do you want to have covered by insurance and how much are you willing to pay for on your own?

Do Your Homework

One of the most important things you can do is to learn about your benefit choices. Without that knowledge, you might not choose programs that meet your needs.

This guide provides the information you need to understand the City of Richmond's benefits program and to create your own benefits package, including information about each benefit offered and steps required to enroll. Please review each section carefully.

What's Best for You

We all have different benefit needs. The City of Richmond's benefits program offers several options so that you can choose the benefits that address your needs. Pick the benefits most important to *you* that work within your budget.

If you have a family, you'll probably want to work through these decisions with them. Take it one step at a time. If your spouse is working, be sure to review the employee benefits available to your spouse so you can coordinate the type and level of coverages you choose through the City of Richmond with the coverage under your spouse's plan.

Anticipated Out-of-Pocket Expenses

Be realistic about how much you can afford to pay out of pocket, including deductibles, should you need medical or dental treatment. Keep in mind that you can enroll in the Healthcare FSA through AFLAC to pay your out-of-pocket health expenses on a pre-tax basis (for the period January 1st through December 31st) unless you enroll in the Choice Fund Open Access Plus HSA plan.

Remember that Your Decisions Cannot Be Changed for a Year

Unless there is a qualifying life event after you make your benefit selections (e.g., marriage, death of your spouse or dependent, or birth or adoption of a child), you will not be able to change your medical/dental/FSA/AFLAC elections until the next benefit open enrollment period.

Review Your Completed Elections

Review your completed election forms and RAPIDS Employee Self-Service carefully, consider the costs and the benefit coverages you have selected, and make any necessary adjustments. You will not be able to change your elections for a year.

Benefits You Can Choose

City of Richmond pays a significant portion of your Medical premiums. *Your cost for these benefits begins on page 16.*

Benefit Plan	What You Can Choose	Pre-Tax Deductions Permitted
Cigna HealthCare	The Premier Open Access Plus, the Classic Open Access Plus, or the Choice Fund Open Access Plus High Deductible Plan with HSA for you and your family	Yes
Cigna Dental Plan	The DPPO plan or the Dental Care Access plan for you and your family	Yes
Flexible Spending Accounts administered by WageWorks	Healthcare Spending Account Dependent Care Spending Account	Yes
AFLAC Voluntary Benefits	Personal Cancer Indemnity Accident Indemnity Advantage Hospital Advantage (Confinement) Critical Care and Recovery	Yes
AFLAC Voluntary Benefits	Short Term Disability Term Life Insurance	No
Legal Resources	Pre-paid Legal Services	No
VRS/Minnesota Life	Optional Employee Spouse and Child Group Term Life Insurance	No
ICMA – RC	Deferred Compensation 457 Plan	Yes
ICMA – RC	Roth IRA	No

More for Your Money—Pre-Tax Deductions

You pay for some of your benefits with pre-tax dollars. This means payroll deductions for certain benefits are taken out of your paycheck ***before*** taxes are calculated. This way, your taxable income is reduced, and you pay less in taxes. An **example** of your potential savings is shown below:

	Without Pre-Tax Deductions	With Pre-Tax Deductions
Gross Monthly Income	$2,500.00	$2,500.00
Pre-Tax Health Insurance Deduction	$0.00	$200.00
Taxable Income	**$2,500.00**	**$2,300.00**
Federal Tax (15%)	$375.00	$345.00
State Tax (5.75%)	$143.75	$132.25
FICA Tax (7.65%)	$191.25	$175.95
After-Tax Health Insurance Deduction	$200.00	$0.00
Monthly Spendable Income	**$1,590.00**	**$1,646.80**
By taking advantage of the pre-tax deduction, this employee was able to increase his/her spendable income by **$56.80 every month**!		

Refer to the "Pre-Tax Deductions Permitted" column in the previous chart for those benefits that can be paid for on a pre-tax basis.

Changing Elections Outside of Open Enrollment

Your benefit choices will be effective from January 1, 2020 through December 31, 2020 and cannot be changed until the next open enrollment period in October/November 2020 unless you experience a qualifying life event that allows a special enrollment.

Qualifying Life Event – You can change plan elections for yourself or eligible dependents **within 30 calendar days** of the specified qualifying event (some of which are listed below):

- Events that change your **legal marital status**, including marriage, divorce, death of a spouse.
- Events that change your **number of dependents**, including birth, adoption, placement for adoption, or death of a dependent.
- Changes in **employment status**, including termination or commencement of employment by you, your spouse, or dependent.
- Changes in **work schedule** that reduce or increase the number of hours of employment that affect benefit eligibility for the employee, spouse or dependent, including a switch between part-time and full-time, a strike or lockout, or the beginning of or return from an unpaid leave of absence.
- Changes in **residence or worksite** of the employee, spouse or dependent if the change affects your or their eligibility for the plan in which you are currently enrolled.
- A significant **change in the benefits or cost** of a dependent's coverage under their group plan.
- **A dependent satisfying or ceasing to satisfy a plan's requirements** to be an eligible dependent.
- Issuance of a judgment, decree or order (including QMCSO) resulting from divorce or change in legal custody requiring health coverage of a child who is your dependent.

Special Enrollment Rights Allowed under HIPAA – You may also be eligible to change an election due to:

- Your or your dependent's loss of other coverage due to exhaustion of COBRA coverage, loss of eligibility for a healthcare plan, or employer termination of plan contributions.

Special Enrollment Rights Allowed under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

There are two other Special Enrollment Rights under HIPAA.

- You or your dependent loses eligibility to participate in Medicaid or a state Children's Health Insurance Program (CHIP);
- You or your dependent qualifies for state premium assistance under Medicaid or CHIP.

You must notify Human Resources within **60 days** of either (1) losing eligibility to participate in Medicaid or CHIP; or (2) being notified of eligibility for premium assistance from your state of residence. Coverage will become effective on the first day of the following month. See the notice beginning on *page 38* "Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Low-Cost Health Coverage to Children & Families" for more information about the program.

If any of these events occur during the year, contact Human Resources. You may be able to make a change to your benefit elections. To make a change in your benefit elections, you will be asked to provide proof of the event. In all instances, the change must be consistent with the type of event that has occurred and must be made within 30 calendar days (60 for CHIPRA) of the event.

Health Care Programs - Overview

Cigna Medical Plan

Medical benefits are very important for almost everyone. Our goal is to continue offering the highest quality and most cost-effective health care coverage for our employees.

Cigna Healthcare will continue to be the City of Richmond's medical plan administrator in 2020. You will continue to have the Premier Open Access, the Classic Open Access, and the Choice Fund Open Access Plus High Deductible Plan with HSA.

Out-of-Network Benefits

In all of the plan options, you may receive care from providers outside of the provider network. However, the benefits you receive in the network will be paid at a higher level than those received out of the network.

You can visit Cigna's website for a complete listing of participating providers at **www.Cigna.com**. Enter your zip code to find a provider in your area.

Cigna Vision Plan

You automatically receive the vision coverage when you choose a medical plan with Cigna. Cigna Healthcare provides vision coverage which includes an annual routine eye exam benefit. The plan also offers coverage for eyewear, discounts for eyeglass lens upgrades and Lasik or PRK laser vision correction.

Cigna Telehealth Connection

Cigna provides access to two telehealth services as part of your medical plan – **AmWell** and **MDLIVE**. Cigna Telehealth Connection lets you get the care you need – including most prescriptions – for a wide range of minor conditions. Now you can connect with a board-certified doctor via secure video chat or phone, without leaving your home or office. Pre-registration on both **AmWell** and **MDLIVE** will give you access to a doctor to help with:

■ Sore throat ■ Fever ■ Rash ■ Headache ■ Cold and flu ■ Acne ■ Stomach ache ■ Allergies ■ UTIs ■ and more

Televisits with **AmWell** and **MDLIVE** can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. And the cost of a phone or online visit is the same or less than with your primary care provider. Remember, your telehealth services are not available for life-threatening conditions. In an emergency, dial 911 or go to the nearest hospital. To pre-register, visit: www.AmWellforCigna.com and/or www.MDLIVEforCigna.com

Additional Medical Benefits

24/7 NurseLine

You have access to a nurse 24 hours a day. These Cigna nurses can help you by answering questions about health concerns. They can also help you to decide if emergency or urgent care is more appropriate if your doctor is not available. You can reach the NurseLine at the number on the back of your Cigna ID card (1-800-CIGNA24).

myCigna Mobile App

Cigna has a mobile app which can be downloaded to your phone to help make your life easier and healthier. You may use the mobile app to access the network provider directory, to view your ID card, to review claims, search formulary costs and pharmacy locations, and to view your HSA balance if you are enrolled in the Choice Fund Open Access Plus HSA plan.

Healthy Rewards

Cigna offers discounts on health products and programs you can use every day: weight management, fitness, vision and hearing care, and healthy lifestyle. Just use your ID card when you pay to receive the discounts. A complete list can be found at mycigna.com.

Convenience Care Clinic

Cigna offers the convenience of care by covering services for minor illnesses at various retail locations. These clinics can help with conditions such as: allergies, bronchitis, ear infections, pinkeye, and sinus infections.

Cigna Medical Plans - *This is only a summary of benefits. Please refer to your full description of benefits provided by Cigna for complete details. In the event of a discrepancy, the information provided by Cigna will determine how your benefits will be applied.*

In-Network Benefits	Premier Open Access	Classic Open Access	Choice Fund Open Access HSA
Annual Deductible *	Individual: $250 Family: $500	Individual: $500 Family: $1,000	Individual: $1,500 Family: $3,000
Employer HSA Contribution	N/A	N/A	Individual: $750 Family: $1,250
Coinsurance	10%	20%	20%
Out-of-Pocket Limit *	Individual: $5,000 Family: $10,000	Individual: $6,350 Family: $12,700	Individual: $6,000 Individual in a Family: $6,000 Family: $12,000
***Deductible and Out-of-Pocket Limits will RESET each January 1**			
Preventive Care			
Adult Preventive Exams and Tests	Covered in full by plan	Covered in full by plan	Covered in full by plan
Mammogram, PAP, PSA Tests	Covered in full by plan	Covered in full by plan	Covered in full by plan
Well Child Care	Covered in full by plan	Covered in full by plan	Covered in full by plan
Other Services			
Inpatient Hospital	$500 copay per admission, Deductible, then 10%	$500 copay per admission, Deductible, then 20%	Deductible, then 20%
PCP / Specialist Office Visit	$20 copay / $40 copay	$25 copay / $50 copay	Deductible, then 20%
Lab and X-ray	Doctor's Office: $20/$40 Independent Lab/Outpatient Facility: Deductible, then 10%	Doctor's Office: $25/$50 Independent Lab/Outpatient Facility: Deductible, then 20%	Deductible, then 20%
Advanced Imaging	Doctor's Office: Plan pays 100% after $20/$40 copay Outpatient Facility: Deductible, then 10%	Doctor's Office: Plan pays 100% after $25/$50 copay Outpatient Facility: Deductible, then 20%	Deductible, then 20%
Chiropractic Services (Medical Necessity Review)	$20/$40 copay (30 days)	$25/$50 copay (30 days)	Deductible, then 20% (Combined with Rehabilitation)
Short-term Rehabilitation (Physical, Speech, and Occupational Therapy)	$20/$40 copay (Combined 60 days)	$25/$50 copay (Combined 60 days)	Deductible, then 20% (Combined 90 days)
Maternity Care (Excluding IP Hospital)	Global Maternity Fee: Deductible, then 10% Office visits in addition to Global Fee: $20/$40 copay	Global Maternity Fee: Deductible, then 20% Office visits in addition to Global Fee: $25/$50 copay	Deductible, then 20%
Outpatient Surgery	$250 facility copay, Deductible, then 10%	$300 facility copay, Deductible, then 20%	Deductible, then 20%
Urgent Care	$40 copay (Copay waived if admitted)	$50 copay (Copay waived if admitted)	Deductible, then 20%
Emergency Room	$200 copay, then 10% (Copay waived if admitted)	$250 copay, then 20% (Copay waived if admitted)	Deductible, then 20%
Transgender-Related Services	Medically necessary care, behavioral health services, hormone replacement therapy, and gender reassignment surgery are covered services under the plans based on the type and place of service. Note that all applicable benefit limitations, precertification, and medical necessity criteria will still apply.		
Mental Health / Substance Use Disorder			
Inpatient Hospitalization	$500 copay per admission, Deductible, then 10%	$500 copay per admission, Deductible, then 20%	Deductible, then 20%
Outpatient Services	Doctor's Office: $20 copay All Other Services: Deductible, then 10%	Doctor's Office: $25 copay All Other Services: Deductible, then 20%	Deductible, then 20%
Prescription Drugs (The formulary that applies to this program is Cigna's Standard formulary, which is a closed formulary)			
30-Day Retail			After Deductible is met:
Generic	$10 copay	$10 copay	$10 copay
Preferred Brand	$30 copay	$30 copay	$30 copay
Non-Preferred Brand	$55 copay	$55 copay	$55 copay
90-Day Home Delivery/Retail			After Deductible is met:
Generic	$10 copay	$10 copay	$10 copay
Preferred Brand	$60 copay	$60 copay	$60 copay
Non-Preferred Brand	$165 copay	$165 copay	$165 copay
Out-of-Network Benefits			
Annual Deductible *	$1,000 / $2,000	$1,000 / $2,000	$3,000 / $6,000
Annual Out-of-Pocket Limit *	$10,000 / $20,000	$10,000 / $20,000	$13,100 / $26,200
Coinsurance	50%	50%	50%

Coordination of Benefits

If you or a dependent is enrolled in another medical plan as well as the City of Richmond's medical plan, your total benefit payments from the plans will never be more than the highest payment allowed by one of the benefit plans. You will not be paid in full by both plans. (Your Medical and Dental Benefit Booklets from Cigna will explain Coordination of Benefits in more detail.)

Cigna Diabetes Prevention Program

Cigna, in collaboration with Omada, is offering a digital lifestyle and behavior change program focusing on reducing the risk of diabetes through healthy weight loss. It offers a personalized experience for you featuring easy, online enrollment and tech support; Omada professional health coaches; social support groups; and interactive online training sessions on healthy eating, physical activity, sleep, and stress.

Cigna One Guide

The Cigna One Guide Service gives you the one-on-one support you need to take control of your health and your health spending – whether it's choosing a plan, finding a provider, or exploring ways to improve your health, One Guide is able to help. You can access One Guide via app, chat, online, or phone along with Cigna's personalized customer service.

Cigna Prescription Drug Benefits

The prescription drug benefits for our medical plans encourage physicians to prescribe from a published list of prescription drugs (the formulary) which is available by logging on to myCigna.com. Your formulary may not cover all FDA-approved medications; however, it contains a full range of drugs including all of those required under applicable health care laws. You will pay more if you or your doctor chooses a "Non-Preferred" Brand drug. Your physician may work with Cigna to ensure that the medications he/she prescribes for you are covered by Cigna. Keep in mind, regardless of the type of drug prescribed, all of your prescriptions must be filled at participating pharmacies.

You may be able to save money by using the Home Delivery prescription drug program available through Cigna. If you take a "maintenance" drug -- one that you are expected to take for a long period of time -- you can order a 90-day supply through the mail. You may be able to get a 90-day supply for less than you would pay at the retail pharmacy. Also familiarize yourself with the Cigna 90 Now℠ retail pharmacy program.

If you are diabetic, you may also save money by using Generic and Preferred Brand test strips because they will be covered in full. The only preferred manufacturer is One Touch.

Cigna Vision Plan Benefits

Coverage	In-Network Benefit	Out-of-Network Benefit	Frequency Period**
Exam Copay	$15	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to $45	12 months
Materials Copay	$0	N/A	12 months
Eyeglass Lenses Allowances (one pair per frequency period)			
Single Vision	Covered in full	Up to 32	12 months
Bifocal	Covered in full	Up to $55	12 months
Trifocal	Covered in full	Up to $65	12 months
Lenticular	Covered in full	Up to $80	12 months
Contact Lenses Allowances (one pair or single purchase per frequency period)			
Elective	Covered in full up to $100	Up to $87	12 months
Therapeutic	Covered in full	Up to $210	12 months
Frame Retail Allowance (one per frequency period)	Covered in full up to $100	Up to $55	24 months
** Your Frequency Period begins on January 1 (Calendar year basis)			

Choice Fund HSA Details

Health Savings Account (HSA)

The HSA consists of a Federal Deposit Insurance Corporation (FDIC)-insured, deposit account and an investment account. **An HSA works in conjunction with an HSA-compatible health plan.** You can use your HSA to pay for current and future qualified medical expenses—tax-free. You will be automatically enrolled in the HSA plan if you enroll in the Cigna Choice Plus High Deductible Health Plan. The City will contribute $750 for employee only coverage and $1,250 for employee plus dependents. This amount is pro-rated if you enroll in the High Deductible Health Plan with HSA during the year. **Retirees over age 65 cannot contribute to a HSA during the year, nor will the City make contributions to a HSA account for these retirees.**

The money you contribute to your HSA is tax-deductible and can be used to pay for qualified medical expenses for not only yourself, but also for your spouse and tax dependents. You can maximize your tax savings by contributing up to the maximum annual amount allowed by the Internal Revenue Service (IRS). The 2020 maximum contribution amount allowed (including what the City of Richmond and you contribute) is $3,550 for single coverage and $7,100 for family coverage. If you are 55 or older, you can make an additional catch-up contribution. The maximum annual catch-up contribution is $1,000. Your HSA balance plus investment earnings carry over from year to year — tax-free. State taxes may still apply, so please consult your tax advisor. Employees age 65 and over are not eligible to contribute to the HSA account.

Qualified Medical Expenses

To help you determine whether an expense qualifies for tax-free reimbursement under your HSA, Internal Revenue Code Section 213(d) states that eligible expenses must be for "medical care." This is defined as amounts paid for the "diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. Examples of common qualified medical expenses include:

- Acupuncture
- Ambulance services
- Artificial limbs or prosthesis
- Dental treatment
- Contact lenses
- Doctor's fees
- Hearing aids and hearing aid batteries
- Hospital services
- Laboratory fees
- Prescription medicines or drugs
- Nursing home services
- Nursing services
- X-rays

As of January 1, 2011, expenses for over-the-counter (OTC) drugs became ineligible for payment or reimbursement from a HSA without a doctor's prescription. This change is a result of the 2010 healthcare reform legislation. A few examples of OTC medicines that will require a doctor's prescription for payment or reimbursement from the HSA are:

- Cold, cough and flu medications
- Allergy and sinus medications
- Pain relief medications
- Acid controllers
- Sleep aids and sedatives

Insulin and prescribed drugs will continue to be eligible for payment or reimbursement from a HSA. You should save your receipts and doctor's prescriptions for OTC medicines for tax purposes. Qualified medical expenses are eligible for reimbursement through your HSA as long as they are not reimbursed through insurance or other sources. Insurance premiums are generally not considered qualified medical expenses. However, the following types of insurance premiums typically do qualify:

- Continuation coverage under federal law (i.e., COBRA).
- Qualified long-term care insurance contract.
- Any health plan maintained while an individual is receiving unemployment compensation under federal or state law.
- For accountholders age 65 and over (i.e., those eligible for Medicare), premiums for any health insurance (including Medicare Part B and Medicare Part D premiums) other than a Medicare supplemental policy.

As the HSA owner, you are ultimately responsible for determining whether a healthcare expense is eligible for reimbursement from your HSA.

Cigna Dental Plans

Cigna will continue to provide your dental benefits in January 2020. There are two dental plan options available to you -- a Dental PPO plan (Cigna Total DPPO) and a Dental Care Access plan.

The Cigna Total DPPO plan allows you to use a dentist from Cigna's DPPO network or to use a provider not in the network. If you use a dentist not in Cigna's DPPO network, you will generally pay more. The Cigna Dental Care Access plan is similar to a Medical HMO because you must select a dentist who is in the Cigna Dental Care Access network, you must receive services from that dentist, and you will pay fixed copays for any covered dental services provided by a Dental Care Access dentist.

Dental Plan Features	Total DPPO		Dental Care Access (Charge may vary based on actual procedure codes)
	In-network	Out-of-Network	
Annual Deductible - Individual	$50	$50	$0
Annual Deductible - Family	$150	$150	$0
Annual Benefit Maximum (Members progress to the next level by using Class I services in the prior year)	Year 1: $1,500 Year 2: $1,600 Year 3: $1,700 Year 4: $1,800	Year 1: $1,000 Year 2: $1,100 Year 3: $1,200 Year 4: $1,300	None
Separate Office Visit Fee (Regular Hours)	None	None	$5
Class I - Preventive & Diagnostic Care			
Oral Exams Cleanings Routine X-Rays Fluoride Application Sealants Space Maintainers (non-orthodontic) Non-Routine X-rays Emergency Care to Relieve Pain	Covered in full **No** deductible	Covered in full **No** deductible	Refer to CIGNA Dental Care Patient Charge Schedule
Class II - Basic Restorative Care			
Fillings Oral Surgery/Extractions Surgical Extraction of Wisdom Teeth Anesthesia Periodontics Endodontics (Root Canal Therapy) Relines, Rebases Adjustments to Dentures Repairs – Bridges, Crowns, Inlays Repairs – Dentures Brush Biopsy Stainless Steel/Resin Crowns	20%, after deductible	20%, after deductible	Refer to CIGNA Dental Care Patient Charge Schedule
Class III - Major Restorative Care			
Crowns and Bridges Dentures (Full & Partial Upper and Lower)	50%, after deductible	50%, after deductible	Refer to CIGNA Dental Care Patient Charge Schedule
Class IV – Orthodontia			
Children (to age 19) Lifetime Maximum Benefit	50%, **No** deductible $1,000	50%, **No** deductible $1,000	Refer to CIGNA Dental Care Patient Charge Schedule
Adults Lifetime Maximum Benefit	Not Covered	Not Covered	Refer to CIGNA Dental Care Patient Charge Schedule

Note: This is only a summary of benefits. Please refer to your full description of benefits provided by Cigna for complete details. In the event of a discrepancy in benefits, the information provided by Cigna will determine how your benefits will be applied.

CARING FOR A CHILD WITH AUTISM?

The Cigna Autism Specialty Care Program can help.

If your child has been diagnosed with an Autism Spectrum Disorder (ASD), it can be hard to know where to turn for help and support.

With the **CIGNA Autism Specialty Care Program**, you have access to a dedicated team of licensed mental health professionals. Each has extensive expertise in autism spectrum disorders and provides confidential, one-on-one support to parents and caregivers.

When you call, you'll be linked to an Autism Care Manager who will:

- Help you understand the ASD diagnosis
- Explain the treatment choices available under your benefits plan
- Help coordinate care between your behavioral and health care benefits
- Provide referrals to Cigna's network of qualified health care professionals
- Help you find local and state support, including early intervention programs in your area
- Assist with researching educational and tutoring programs designed to meet your child's unique behavioral and learning needs
- Lead clinical oversight to make sure treatment plans are appropriate
- Provide referrals to before and after school care, recreation and respite programs
- Guide you to a variety of resources and tools on Cigna.com/autism, cignabehavioral.com and other sites
- Offer referrals to other Cigna programs available through your plan such as the Lifestyle Management program and Stress Management
- Provide ongoing case management and help with all of your questions and concerns

CIGNA'S AUTISM AWARENESS SERIES

Your Autism Care Manager will also give you the latest information on Cigna's free monthly phone seminars. The seminars are designed to give parents and caregivers information on the physical, mental, and emotional issues common in children with an autism spectrum disorder. The seminars highlight techniques and methods that can be used to deal with the day to day challenges of caring for a child with autism.

CARING FOR A CHILD WITH AUTISM?

The Cigna Autism Specialty Care Program can help.

Link with an Autism Care Manager today.

- Call the number on the back of your Cigna card. At the prompt, choose "Behavioral Health."
- If there is not a number on the card, you can also call Cigna Behavioral at 800.274.7603.
- You'll be linked to a Personal Advocate.
- Ask to speak to an Autism Care Manager.
- An Autism Care Manager will call you within 24 hours. Calls are made Monday – Friday, 8 am – 5pm (EST).

SEE WHAT CUSTOMERS ARE SAYING.

Cigna's Autism Specialty Team gives customers the support they need. In fact, 99% of customers were very pleased with the information and help they received.[1]

[1] Cigna Satisfaction Survey, 2014.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow employees to allocate pre-tax dollars to a healthcare and/or dependent care spending account to pay for eligible after-tax expenses.

Two spending accounts are available to employees—a health care account and a dependent care account. These accounts allow you to use a portion of your pay, before it is taxed, that can reimburse you for certain qualified expenses. You can participate in one, both or neither of the accounts—it is your choice.

Federal tax law requires separate accounts for the two types of expenses, and you must elect a separate amount to be deposited in each account in which you elect to participate.

Since you are receiving tax advantages, federal tax law imposes certain requirements on Flexible Spending Accounts.

- Once you elect to participate in the spending account plan, you cannot change your election during the plan year unless you have a qualifying event. *Qualifying life events are discussed on page 5 of this booklet.* If one of these events occurs, and you want to change your election, the change must be consistent with the type of event that has occurred.
- In order to receive reimbursement from your account, you must incur expenses (i.e., service performed and received) during the plan year. You may use your *Wage Works Flexible Spending Debit Card* at the point of service or you can submit a reimbursement form.
- Keep receipts for your tax records.
- You cannot claim a tax deduction or credit on your personal tax return for expenses reimbursed from your flexible spending account.
- The expenses cannot be eligible for reimbursement from any other source.
- When taxable income is lowered, Social Security taxes are also lowered. This may result in a slight reduction in Social Security retirement benefits.

Maximum Flexible Spending Account Contributions

Health Care Flexible Spending Account: You may contribute up to $2,700 in the 2020 plan year.

Dependent Care Flexible Spending Account: In 2020, you may contribute up to $5,000 for single individuals or for married individuals filing a joint tax return, and $2,500 for married individuals filing separately.

Healthcare Expenses

The Health Care Flexible Spending Account may be used to reimburse eligible expenses incurred by you or your dependents, as long as the expenses are not covered by insurance or any other source. **You may not enroll in the Health Care Flexible Spending Account if you enroll in the Choice Fund Open Access Plus HSA plan.** The maximum amount that you may contribute to your Health Care Account for the 2020 plan year is $2,700. The Health Care Flexible Spending Account is advantageous when you have predictable healthcare expenses.

You can refer to IRS Publication 502, Medical and Dental Expenses to identify eligible expenses. This publication can be found at www.irs.gov/pub/irs-pdf/p502.pdf or by calling 1-800-TAX-FORM.

Dependent Care Expenses

- Care in your home or someone else's home;
- Child care or dependent care facilities, including day care centers and nurseries; or
- Housekeeping services in your home that include day care.

However, you cannot claim payments for services provided by a dependent or one of your own children under the age of 19.

For more information regarding eligible expenses under either the Health Care or Dependent Care Flexible Spending Accounts, please refer to your Flexible Spending Accounts information packet.

Dependent Care and the Federal Tax Credit

If you have eligible dependents, you may choose to use *either* or *both* the Dependent Care Flexible Spending Account and the Federal dependent care tax credit when you file your annual tax return. Whatever you contribute to the Dependent Care Spending Account will reduce the amount of the available Federal tax credit.

The annual maximum the IRS currently allows you to contribute to a Dependent Care Account is $5,000 for single individuals and married individuals filing jointly, and $2,500 for married individuals filing separately.

You may be eligible to claim a federal income tax credit of up to $3,000 of eligible dependent care expenses for one qualified dependent and up to $6,000 for two or more qualified dependents. The amount of your tax credit depends on your adjusted gross income reported on your federal income tax return.

IRS Publication 503 explains the child and dependent care tax credit in more detail. You can obtain a copy of this publication from the Internet at www.irs.gov/pub/irs-pdf/p503.pdf or by calling 1-800-TAX-FORM.

If you choose to participate in the Dependent Care Spending Account, your contributions will be made through payroll deduction and will be made on a "pre-tax" basis. This means that contributions to this plan will be deducted from your pay before taxes and are, therefore, tax-free. This will increase your net take-home pay since your federal, state, and FICA taxes will be reduced.

You must decide whether using the Dependent Care Flexible Spending Account or taking the federal dependent care tax credit for your dependent care expenses will provide you with more tax savings. If you are uncertain as to which is best for you, we recommend that you check with a tax advisor before making your final decision.

Who May Participate in the Dependent Care Spending Account Plan?

If you are married, your spouse must work, be a full-time student or be mentally or physically unable to care for him or herself in order to be eligible to participate in this plan. You may also participate in this plan if you are not married and incur eligible dependent care expenses.

Expenses that Can Be Submitted under this Plan

You can claim dependent care expenses for "qualifying individuals" who include (1) your children under age 13, (2) other relatives, such as a parent, who can be claimed as a dependent on your tax return; or (3) a spouse or other dependent who is physically or mentally incapable of caring for him or herself. **These children and relatives must be dependents as defined by the Internal Revenue Code.**

Important Note: You may not have both Health Flexible Spending Account and Health Savings Account.

Important Notes Regarding Flexible Spending Accounts

Once you make an election to contribute to a FSA, **you cannot change that election** until the beginning of the following plan year (January 1) unless you have a qualified change in status.

"USE IT OR LOSE IT"
If you do not use all of the money in your Health Care FSA by the end of the plan year (December 31), **you may rollover up to $500 to the next plan year. Otherwise, you will forfeit it.**

Expenses reimbursed from your Health Care Spending Account **cannot be claimed as medical deductions** on your income tax.

Expenses submitted for reimbursement must be **incurred during the plan year.**

Expenses reimbursed from your Dependent Care Spending Account **cannot be claimed under the Federal Tax Credit.**

How Do Flexible Spending Accounts Work?

An employee earns $2,500 per month and incurs the following monthly out-of-pocket expenses:

- Family medical expenses (deductibles, copays, dental expenses): $ 60.00 per month
- Dependent child care expenses (daycare): $300.00 per month

Contributions to the Health Care Flexible Spending Account: $360.00 per month

	Without Flexible Spending Account	With Flexible Spending Account
Gross Monthly Income	$2,500.00	$2,500.00
Eligible Pre-Tax Medical Expenses	$0.00	$60.00
Eligible Pre-Tax Dependent Child Care Expenses	$0.00	$300.00
Taxable Income	**$2,500.00**	**$2,140.00**
Federal Tax (15%)	$375.00	$321.00
State Tax (5.75%)	$143.75	$123.05
FICA Tax (7.65%)	$191.25	$163.71
After-Tax Medical Expenses	$60.00	$0.00
After-Tax Dependent Child Care Expenses	$300.00	$0.00
Monthly Spendable Income	**$1,430.00**	**$1,532.24**

By taking advantage of the Health Care Flexible Spending Account, this employee was able to increase his/her spendable income by **$102.24** every month! This means an annual tax savings of **$1,226.88.** Remember, with the Flexible Spending Accounts, the better you plan, the more you save!

Active Employee Contributions for HealthCare Program

Deductions are taken each pay period. Your medical contributions will vary depending upon whether you and your spouse have taken the Health Risk Assessment.

Cigna Medical	ALL ELIGIBLE EMPLOYEES Total monthly	What COR contributes monthly	What you pay monthly	What you pay Bi-Weekly
Plan A - Premier Plan				
Health Assessment Completed				
Employee Only	$828.82	$744.46	$84.36	$42.18
Employee + One Child	$1,409.69	$1,044.57	$365.12	$182.56
Employee + Spouse	$1,925.71	$1,426.93	$498.78	$249.39
Employee + Family	$2,244.29	$1,543.07	$701.22	$350.61
Health Assessment Not Completed				
Employee Only	$828.82	$718.82	$110.00	$55.00
Employee + One Child	$1,409.69	$934.69	$475.00	$237.50
Employee + Spouse	$1,925.71	$1,277.71	$648.00	$324.00
Employee + Family	$2,244.29	$1,332.29	$912.00	$456.00
Plan B – Classic Plan				
Health Assessment Completed				
Employee Only	$757.58	$695.08	$62.50	$31.25
Employee + One Child	$1,287.89	$959.57	$328.32	$164.16
Employee + Spouse	$1,759.34	$1,310.84	$448.50	$224.25
Employee + Family	$2,050.38	$1,425.34	$625.04	$312.52
Health Assessment Not Completed				
Employee Only	$757.58	$676.58	$81.00	$40.50
Employee + One Child	$1,287.89	$860.89	$427.00	$213.50
Employee + Spouse	$1,759.34	$1,176.34	$583.00	$291.50
Employee + Family	$2,050.38	$1,237.38	$813.00	$406.50
Choice Fund HDHP with HSA				
Health Assessment Completed				
Employee Only	$636.03	$608.37	$27.66	$13.83
Employee + One Child	$1,092.77	$864.61	$228.16	$114.08
Employee + Spouse	$1,492.79	$1,181.11	$311.68	$155.84
Employee + Family	$1,739.74	$1,285.68	$454.06	$227.03
Health Assessment Not Completed				
Employee Only	$636.03	$600.03	$36.00	$18.00
Employee + One Child	$1,092.77	$795.77	$297.00	$148.50
Employee + Spouse	$1,492.79	$1,087.79	$405.00	$202.50
Employee + Family	$1,739.74	$1,149.74	$590.00	$295.00

Active Employee Dental Contributions

Cigna Dental	ALL ELIGIBLE EMPLOYEES Total monthly	What COR contributes monthly	What you pay monthly	What you pay Bi-Weekly
Total DPPO				
Employee Only	$30.06	$0.00	$30.06	$15.03
Employee + One Child	$49.62	$0.00	$49.62	$24.81
Employee + Spouse	$61.94	$0.00	$61.94	$30.97
Employee + Family	$97.90	$0.00	$97.90	$48.95
Dental HMO				
Employee Only	$19.94	$0.00	$19.94	$9.97
Employee + One Child	$32.62	$0.00	$32.62	$16.31
Employee + Spouse	$40.62	$0.00	$40.62	$20.31
Employee + Family	$55.62	$0.00	$55.62	$27.81

Retiree Contributions for HealthCare Program

City of Richmond employees who apply to retire as active members in the Defined Benefit Plan and Enhanced Defined Benefit Plan are eligible for health insurance benefits at retirement if the employee is under age 65 and has worked for the City of Richmond for more than 15 years, or has worked for the City of Richmond for more than 10 years with 5 years of continuous health insurance coverage to their effective retirement date. Medical contributions will vary depending upon whether the employee and spouse have taken the Health Risk Assessment and upon years of service with the City (the 50% category requires 10-15 years of service, the 75% category requires 15-25 years of service, and the 100% category requires 25 or more years of service).

ALL ELIGIBLE RETIREES			
Cigna Medical	Total monthly	What COR contributes monthly	What you pay monthly
Plan A – Premier Plan			
0% City Contribution – Health Assessment Completed			
Retiree Only	$1,141.01	$0.00	$1,141.01
Retiree + Child	$1,939.72	$0.00	$1,939.72
Retiree + Spouse	$2,282.03	$0.00	$2,282.03
Retiree + Family	$3,088.13	$0.00	$3,088.13
0% City Contribution – Health Assessment Not Completed			
Retiree Only	$1,141.01	$0.00	$1,141.01
Retiree + Child	$1,939.72	$0.00	$1,939.72
Retiree + Spouse	$2,282.03	$0.00	$2,282.03
Retiree + Family	$3,088.13	$0.00	$3,088.13
Dependent Only	$826.41	$0.00	$826.41
Dependent + Family	$2,237.71	$0.00	$2,237.71
50% City Contribution – Health Assessment Completed			
Retiree Only	$1,141.01	$762.16	$378.85
Retiree + Child	$1,939.72	$1,186.36	$753.36
Retiree + Spouse	$2,282.03	$1,252.85	$1,029.18
Retiree + Family	$3,088.13	$1,538.70	$1,549.43
50% City Contribution – Health Assessment Not Completed			
Retiree Only	$1,141.01	$663.66	$477.35
Retiree + Child	$1,939.72	$990.49	$949.23
Retiree + Spouse	$2,282.03	$985.26	$1,296.77
Retiree + Family	$3,088.13	$1,135.85	$1,952.28
75% City Contribution – Health Assessment Completed			
Retiree Only	$1,141.01	$832.87	$308.14
Retiree + Child	$1,939.72	$1,238.14	$701.58
Retiree + Spouse	$2,282.03	$1,323.58	$958.45
Retiree + Family	$3,088.13	$1,609.41	$1,478.72
75% City Contribution – Health Assessment Not Completed			
Retiree Only	$1,141.01	$752.75	$388.26
Retiree + Child	$1,939.72	$1,055.73	$883.99
Retiree + Spouse	$2,282.03	$1,074.39	$1,207.64
Retiree + Family	$3,088.13	$1,224.95	$1,863.18
100% City Contribution – Health Assessment Completed			
Retiree Only	$1,141.01	$903.60	$237.41
Retiree + Child	$1,939.72	$1,289.90	$649.82
Retiree + Spouse	$2,282.03	$1,394.29	$887.74
Retiree + Family	$3,088.13	$1,680.12	$1,408.01
100% City Contribution – Health Assessment Not Completed			
Retiree Only	$1,141.01	$841.88	$299.13
Retiree + Child	$1,939.72	$1,120.94	$818.78
Retiree + Spouse	$2,282.03	$1,163.48	$1,118.55
Retiree + Family	$3,088.13	$1,314.04	$1,774.09

Retiree Contributions for HealthCare Program

City of Richmond employees who apply to retire as active members in the Defined Benefit Plan and Enhanced Defined Benefit Plan are eligible for health insurance benefits at retirement if the employee is under age 65 and has worked for the City of Richmond for more than 15 years, or has worked for the City of Richmond for more than 10 years with 5 years of continuous health insurance coverage to their effective retirement date. Medical contributions will vary depending upon whether the employee and spouse have taken the Health Risk Assessment and upon years of service with the City (the 50% category requires 10-15 years of service, the 75% category requires 15-25 years of service, and the 100% category requires 25 or more years of service).

ALL ELIGIBLE RETIREES			
Cigna Medical	Total monthly	What COR contributes monthly	What you pay monthly
Plan B – Classic Plan			
0% City Contribution – Health Assessment Completed			
Retiree Only	$1,045.46	$0.00	$1,045.46
Retiree + Child	$1,777.28	$0.00	$1,777.28
Retiree + Spouse	$2,090.93	$0.00	$2,090.93
Retiree + Family	$2,829.51	$0.00	$2,829.51
0% City Contribution – Health Assessment Not Completed			
Retiree Only	$1,045.46	$0.00	$1,045.46
Retiree + Child	$1,777.28	$0.00	$1,777.28
Retiree + Spouse	$2,090.93	$0.00	$2,090.93
Retiree + Family	$2,829.51	$0.00	$2,829.51
Dependent Only	$757.58	$0.00	$757.58
Dependent + Family	$2,050.38	$0.00	$2,050.38
50% City Contribution – Health Assessment Completed			
Retiree Only	$1,045.46	$681.71	$363.75
Retiree + Child	$1,777.28	$1,048.75	$728.53
Retiree + Spouse	$2,090.93	$1,095.67	$995.26
Retiree + Family	$2,829.51	$1,329.04	$1,500.47
50% City Contribution – Health Assessment Not Completed			
Retiree Only	$1,045.46	$587.14	$458.32
Retiree + Child	$1,777.28	$859.33	$917.95
Retiree + Spouse	$2,090.93	$836.90	$1,254.03
Retiree + Family	$2,829.51	$938.92	$1,890.59
75% City Contribution – Health Assessment Completed			
Retiree Only	$1,045.46	$752.42	$293.04
Retiree + Child	$1,777.28	$1,100.51	$676.77
Retiree + Spouse	$2,090.93	$1,166.38	$924.55
Retiree + Family	$2,829.51	$1,399.77	$1,429.74
75% City Contribution – Health Assessment Not Completed			
Retiree Only	$1,045.46	$676.23	$369.23
Retiree + Child	$1,777.28	$924.55	$852.73
Retiree + Spouse	$2,090.93	$926.00	$1,164.93
Retiree + Family	$2,829.51	$1,028.04	$1,801.47
100% City Contribution – Health Assessment Completed			
Retiree Only	$1,045.46	$823.13	$222.33
Retiree + Child	$1,777.28	$1,152.27	$625.01
Retiree + Spouse	$2,090.93	$1,237.09	$853.84
Retiree + Family	$2,829.51	$1,470.46	$1,359.05
100% City Contribution – Health Assessment Not Completed			
Retiree Only	$1,045.46	$765.32	$280.14
Retiree + Child	$1,777.28	$989.77	$787.51
Retiree + Spouse	$2,090.93	$1,015.09	$1,075.84
Retiree + Family	$2,829.51	$1,117.10	$1,712.41

Retiree Contributions for HealthCare Program

City of Richmond employees who apply to retire as active members in the Defined Benefit Plan and Enhanced Defined Benefit Plan are eligible for health insurance benefits at retirement if the employee is under age 65 and has worked for the City of Richmond for more than 15 years, or has worked for the City of Richmond for more than 10 years with 5 years of continuous health insurance coverage to their effective retirement date. Medical contributions will vary depending upon whether the employee and spouse have taken the Health Risk Assessment and upon years of service with the City (the 50% category requires 10-15 years of service, the 75% category requires 15-25 years of service, and the 100% category requires 25 or more years of service).

ALL ELIGIBLE RETIREES			
Cigna Medical	Total monthly	What COR contributes monthly	What you pay monthly
Choice Fund HDHP with HSA			
0% City Contribution – Health Assessment Completed			
Retiree Only	$860.95	$0.00	$860.95
Retiree + Child	$1,463.61	$0.00	$1,463.61
Retiree + Spouse	$1,721.89	$0.00	$1,721.89
Retiree + Family	$2,296.29	$0.00	$2,296.29
0% City Contribution – Health Assessment Not Completed			
Retiree Only	$860.95	$0.00	$860.95
Retiree + Child	$1,463.61	$0.00	$1,463.61
Retiree + Spouse	$1,721.89	$0.00	$1,721.89
Retiree + Family	$2,296.29	$0.00	$2,296.29
Dependent	$636.03	$0.00	$636.03
Dependent + Family	$1,739.74	$0.00	$1,739.74
50% City Contribution – Health Assessment Completed			
Retiree Only	$860.95	$561.41	$299.54
Retiree + Child	$1,463.61	$863.66	$599.95
Retiree + Spouse	$1,721.89	$902.29	$819.60
Retiree + Family	$2,296.29	$1,078.60	$1,217.69
50% City Contribution – Health Assessment Not Completed			
Retiree Only	$860.95	$483.52	$377.43
Retiree + Child	$1,463.61	$707.67	$755.94
Retiree + Spouse	$1,721.89	$689.18	$1,032.71
Retiree + Family	$2,296.29	$761.99	$1,534.30
75% City Contribution – Health Assessment Completed			
Retiree Only	$860.95	$619.63	$241.32
Retiree + Child	$1,463.61	$906.29	$557.32
Retiree + Spouse	$1,721.89	$960.52	$761.37
Retiree + Family	$2,296.29	$1,135.98	$1,160.31
75% City Contribution – Health Assessment Not Completed			
Retiree Only	$860.95	$556.89	$304.06
Retiree + Child	$1,463.61	$761.38	$702.23
Retiree + Spouse	$1,721.89	$762.57	$959.32
Retiree + Family	$2,296.29	$834.30	$1,461.99
100% City Contribution – Health Assessment Completed			
Retiree Only	$860.95	$677.86	$183.09
Retiree + Child	$1,463.61	$948.91	$514.70
Retiree + Spouse	$1,721.89	$1,018.75	$703.14
Retiree + Family	$2,296.29	$1,193.36	$1,102.93
100% City Contribution – Health Assessment Not Completed			
Retiree Only	$860.95	$630.27	$230.68
Retiree + Child	$1,463.61	$815.09	$648.52
Retiree + Spouse	$1,721.89	$835.93	$885.96
Retiree + Family	$2,296.29	$906.60	$1,389.69

Employee Health and Wellness Program

Our employee wellness program is well-rounded and aimed at helping employees and their families in all facets of life. It is open to all City of Richmond employees.

Vision: The vision is for each employee to achieve their highest level of wellness.

Mission: The mission is to foster a work environment that promotes healthy lifestyles, decreases the risk of disease and enhances the quality of life through educational opportunities, wellness activities and self-improvement.

Program Highlights

Programs are designed with the goal of helping employees decrease risk of disease and improve quality of life. Employee input and healthcare costs help guide what types of programs are offered. Programs are delivered in a variety of ways so that, regardless of your work schedule, there are programs available and relevant. Types of programs offered include:

- 4, 6, and 8 week Classes to focus on Stress, Nutrition, Weight Loss, Ergonomics, and more
- Behavior Change Challenges
- Financial Wellness Sessions and Webinars
- One-Time Lunch and Learn Sessions
- On-Site Exercise Classes
- Telephonic and Online Health Coaching Programs
- Sports Events and Activities

Programs are taught by healthcare professionals or highly qualified health educators from the Richmond area.

What our employees say:

"I really enjoyed this challenge. Life changing….Drinking water, eating healthier, walking and exercising….and I feel GREAT!!! The challenge has been exciting and life changing. And yes, I lost 7.5 pounds. And feel GREAT!!!"

"I can truly say being on a team for the Walking Challenge has helped me. Now I feel a lot better moving and walking without being so out of breath and it's quite enjoyable."

"My knees don't feel as achy when I stand up to help a patron. Since I do this multiple times a day, I'm feeling better all around! I'm also sleeping better. Just wanted you to know—thanks!"

"I thoroughly enjoyed your class today. You shared a lot of valuable helpful information. I learned a lot! I did 5 counter top push-ups while waiting for the water to heat for my tea."

"I became healthier/happier because I felt better. I had more energy, looked better, was able to buy new clothes because I dropped a couple of dress sizes, and my emotional health improved. In addition, my A1C blood sugar is at a normal level and no longer in a type 2 pre-diabetes range."

Watch for newletters and StarNet for more information on Health and Wellness activites, and ask to join HR's Facebook group. Search for "RVAHR Facebook Group" or go to:
https://www.facebook.com/groups/1527477864142662

Group Term Life Insurance

Basic Group Term Life Insurance

If you are a full-time, permanent employee, you are automatically covered for an amount of group term life insurance equal to twice your annual salary rounded to the next higher thousand dollars. Your coverage begins on the first day of employment. In the event of accidental death, your coverage is four times your annual salary rounded to the next higher thousand dollars. In the event of dismemberment, as defined in the policy, your coverage amount will be equal to your annual salary. This plan is mandatory, and the City pays a portion of the cost. Deductions are taken from your pay on an after- tax basis the second pay period of each month to cover your portion of the cost.

The plan is administered by the Virginia Retirement System (VRS) and underwritten by Minnesota Life Insurance Company.

Optional Group Term Life Insurance

If you have Basic Group Term Life Insurance coverage with the City of Richmond, you may purchase additional life insurance coverage for yourself, your spouse, and your eligible children through the Optional Group Term Life Insurance plan administered by VRS and underwritten by Minnesota Life Insurance Company. You may purchase coverage in the amount of one, two, three, or four times your salary up to a maximum benefit of $375,000, without providing Evidence of Insurability. If you select more than $375,000 of coverage, you will be required to submit an Evidence of Insurability form. Until your request for coverage is approved, your benefit will be limited to the amount of the next-lowest option, not exceeding $375,000. If you elect one times your salary, your spouse will be eligible to receive up to one-half of your salary (all other options require Evidence of Insurability). All coverage purchased for children is guaranteed (the amount of their coverage is based upon your optional life election as outlined below).

If you are currently enrolled in the Minnesota Life Optional Life Insurance plan, and do not want to make changes, you will not need to do anything to continue that coverage. If you did not enroll for this coverage within 31 days after either your employment date or initial eligibility date, you may apply at any time, but you will have to submit Evidence of Insurability for yourself and each family member to be covered with your enrollment application. Based upon that information, Minnesota Life will determine whether to provide the requested optional life insurance for you and your family.

Optional Life Insurance Coverage Options:

	Option 1	Option 2	Option 3	Option 4
Employee	1 x salary	2 x salary	3 x salary	4 x salary
Spouse	0.5 x salary	1 x salary	1.5 x salary	2 x salary
Child(ren)	$10,000	$10,000	$20,000	$30,000

If you die while covered by this plan, the benefit is paid to the beneficiary (or beneficiaries) you have designated for the Basic Life Insurance plan. You are the beneficiary for the Optional Group Life Insurance on your spouse and children. When you experience a life event, be sure to update your beneficiary designation.

Monthly Cost for Optional Term Life Employee and Spouse	
Rates increase with age of employee/spouse	
Age	Rates / $1,000
34 and under	$0.05
35-39	$0.06
40-44	$0.08
45-49	$0.14
50-54	$0.20
55-59	$0.33
60-64	$0.59
65-69	$1.06
70 and over	$2.06
Monthly Cost for Child(ren)	
One rate covers all eligible children	
Option 1	$0.80
Option 2	$0.80
Option 3	$1.60
Option 4	$2.40

IMPORTANT NOTE: Make sure your beneficiary designation information is up-to-date.

Leave Benefits

The City of Richmond currently provides vacation, sick, military, and family medical leave to our employees.

Vacation

Full-time and part-time employees in permanent positions are eligible for vacation time which is accrued on a bi-weekly rate based on years of service. Part-time employees receive pro-rated vacation based on the number of hours worked. Employees in provisional/temporary positions do not earn vacation.

Vacation (Permanent Classified Full-time Employees)

Years of Service	Bi-Weekly Rate	Maximum Accumulation
Less than 5	3.7	192
5 – 10	4.6	240
10 – 15	5.5	288
15 – 20	6.6	336
20 & over	7.4	384

Sick Leave

Full time and part-time employees in permanent positions and provisional/ temporary positions receive sick leave. Full-time employees accrue sick leave at the rate of 3.7 hours bi-weekly. Part-time employees receive pro-rated sick leave based on the number of hours worked. There is no maximum accrual amount. Sick leave may be used for doctor appointments, care for family members who are ill or hospitalized, and Family Medical Leave (allowed under FMLA).

Holidays

The City of Richmond designates the following paid holidays for employees.

Holidays *
New Year's Day
Martin Luther King, Jr. Day
President's Day
Good Friday/Spring Holiday
Memorial Day
Independence Day
Labor Day
Veteran's Day
Thanksgiving Day
Day after Thanksgiving
Christmas Eve
Christmas Day

* Additionally, employees may take one personal floating holiday in 2020 provided they are employed prior to May 1, 2020.

Family and Medical Leave Act (FMLA)

The Family Medical Leave Act provides up to 12 weeks or 480 work hours of job protected leave for:

- the care and treatment of a serious health condition incurred by an employee or employee's immediate family member,
- the birth of a child and to bond with the newborn within 1 year of birth,
- the placement of a child with the employee for adoption or foster care and to bond with the newly placed child within 1 year of adoption/placement,
- the military family leave categories of qualifying exigency leave or military caregiver leave.

FML may be paid or unpaid if vacation and sick leave accruals are available. An employee must be employed with the City for at least twelve months and must have worked a minimum of 1,250 hours during the twelve-month period preceding the leave. The twelve months is based on a rolling 12-month period. The City also offers paid parental leave to eligible employees.

Funeral Leave

An employee who has a death in his/her immediate family may be granted upon request, leave with pay for a maximum of three consecutive working days. This leave applies to immediate family members. Immediate family is defined as mother, father, wife, husband, child, brother, sister, legal ward, grandparents and grandchildren of the employee or the employee's spouse; or any other relative of the employee or spouse who lives in the employee's household.

Military Leave

Upon presentation of a copy of official orders, a military leave of absence shall be granted to any employee who either volunteers or is called to active duty with the Armed Forces of the United States, Virginia Defense Force, the National Guard, or the Naval Militia. After paid military leave is exhausted, leave is without pay.

Your Retirement

The City of Richmond, through the Richmond Retirement System (RRS), has set up a defined contribution plan retirement account on your behalf. The RRS, in partnership with ICMA-RC, is available to assist you with your retirement goals.

- Your defined contribution plan offers a comprehensive selection of investment options.
- Account transactions, including fund-to-fund transfers, may be made over the telephone or via the Internet at www.icmarc.org.
- If you change jobs, you can consolidate the vested portion of your retirement plan in another IRS qualified 401 plan, 457 deferred compensation plan, tax sheltered 403(b) annuity plan, or an IRA.
- Comprehensive participant services, including quarterly plan statements, are available to you.
- You can access your account balance daily by calling ICMA-RC's 24-hour, toll-free voice response system at 800-669-7400 or through the Internet at www.icmarc.org after logging in.

Participation in the 401a Plan

You are eligible to participate in the 401a Defined Contribution Plan if you are a permanent full-time employee who was hired or rehired on or after July 1, 2006.

Employer Contribution

Each eligible participant has an account to which the City of Richmond makes bi-weekly contributions on your behalf based on your years of service and salary, according to the following schedule:

Years of Creditable Service	Contribution Percentage
Less than 5	5%
5 through 9	6%
10 through 14	8%
15 or greater	10%

The contributions to your account are not taxed until you receive them, usually during retirement. Earnings in your account also grow on a tax-deferred basis.

Vesting ("Ownership")

Vesting is your ownership of the assets in your plan and is based on your years of employment service.

Your account becomes 100% vested (you gain 100% ownership of the City's contributions and associated earnings) after five years of continuous employment service. Assets that you roll over to your account, plus earnings, are always 100% percent vested. Your account also becomes 100% vested if you are approved for disability retirement, reach normal retirement age or die while actively employed.

Employee Contributions in the 457 Plan

All permanent employees who work 20 or more hours per week may elect to make contributions into a 457 Deferred Compensation Plan. (Employee contributions are not required in order to receive the employer contributions mentioned above.)

For more information about any of these plans, please contact RRS at 804-646-5958.

Employee Assistance Program (EAP)

Cigna will continue to be the provider of the Employee Assistance Program (EAP) for the City of Richmond. This benefit is available to all City employees and their household members. (You do not need to participate in the Cigna Medical program to use the EAP benefit.) It can be accessed 24 hours a day, 7 days a week, 365 days a year, and all services provided through the EAP are completely confidential. The program is available to help with any number of issues that you or your household members may face. A few common examples of the types of issues that the EAP can help you with are those related to:

- Parenting
- Death/Grief
- Divorce
- Work/Life Support for Elder Care, Child Care, and Pet Care
- Depression
- Violence and Abuse
- Stress
- Financial and Legal Matters

The EAP will provide 1 to 5 face-to-face sessions for each issue that you or your household members may face during the year as well as unlimited telephonic consultation. If you want more information about the services offered or you want to access the EAP for assistance with an issue, you may do so by calling 1-877-622-4327 or by going to www.mycigna.com and entering your Employer ID: COR.

Voluntary Benefits

Benefits Provided through AFLAC

Several voluntary insurance plans are offered to employees through AFLAC. These benefits are available to all full-time and part-time employees in permanent positions, working 20 or more hours per week. By supplementing your medical and dental benefits with voluntary plans, you may be able to increase your level of financial protection and lower your financial stress. You may pay for these plans through payroll deduction.

Some features of AFLAC voluntary benefits:

- Offset your out-of-pocket expenses under your medical plan with the benefits paid directly to you (unless you specify otherwise).
- Provide financial security for you and your family if something happens to you.
- Continue your coverage at the same rates if you change jobs or retire.
- Simplified underwriting options make it easier to qualify for coverage.
- Your premiums will not increase if your health changes.
- If you have an older plan, you may keep that plan or upgrade to current coverage offered at the new rate.

Plans that are available to you and your family include:

- Accident Advantage Insurance (24 hr. Accident Only)
- Hospital Advantage (Confinement)
- Personal Cancer Indemnity
- Critical Care Protection
- Term Life Insurance*
- Short Term Disability Insurance

***Available to full-time employees only.**

Accident Advantage

This plan pays cash benefits for accidental injuries that occur on or off the job. The benefits are paid directly to you, unless you choose otherwise. The plan is designed to provide you with cash benefits throughout the different stages of care, regardless of the severity of the injury.

Accident Advantage	
Bi-Weekly Rates – Option 4	
Individual	$15.47
Individual and Spouse	$20.61
1-Parent Family	$23.99
Family	$30.23

Hospital Advantage Confinement

This plan is designed to supplement your Medical benefit program by paying fixed per/day benefits to you if you are in the hospital. It does not constitute comprehensive health insurance coverage. This plan provides hospital confinement indemnity benefits.

Hospital Advantage				
Age	Individual	Individual and Spouse	1-Parent Family	Family
Bi-Weekly Rates – Option 2 Guaranteed Issue				
18-75	$24.51	$39.20	$34.13	$43.10
Bi-Weekly Rates – Option 4 Underwriting Required				
18-75	$32.44	$53.89	$42.71	$55.90

Personal Cancer Indemnity

This plan provides cash benefits directly to you (unless assigned) for the treatment of specific types of cancer, giving you the ability to help pay bills related to treatment such as health plan deductibles, copayments, and travel expenses.

Personal Cancer Indemnity	
Bi-Weekly Rates – Level 2	
Individual	$13.45
1-Parent Family	$16.45
Family	$22.75

Critical Care Protection

This is a limited health insurance plan, which will pay you a lump-sum benefit upon diagnosis of certain primary, specified health events. The primary, specified health events covered by the plan include: coma, paralysis, end-stage renal disease, persistent vegetative state, stroke, heart attack, major third-degree burn, coronary artery bypass surgery, major human organ transplant, sudden cardiac arrest.

Critical Care Protection				
Bi-Weekly Rates – Level 2				
Age	Individual	Individual and Spouse	1-Parent Family	Family
18-35	$8.45	$16.25	$14.36	$18.46
36-45	$12.03	$21.13	$17.03	$23.47
46-55	$16.38	$28.47	$21.91	$31.33
56-70	$21.13	$39.65	$28.80	$43.03

Term Life Insurance*

This plan allows you to purchase term life insurance coverage to assist your family in paying the bills if something happens to you. If you are age 50 or under, you may apply for up to $500,000 of life insurance coverage. If you are between the ages of 51 and 68, you may be eligible for up to $200,000 in life insurance protection. The plan also offers the option of guaranteed-issue 10-year, 20-year, or 30-year term life coverage with a face amount of $20,000 or $25,000 – meaning you can obtain the coverage without having to complete a medical questionnaire.

Examples of Cost for 20-Year Term Life Insurance Policies			
Face Amount	Age	Gender	Bi-Weekly Rate
$50,000	35	Female	Non-Tobacco = $5.65
$100,000	35	Female	Non-Tobacco = $9.30

*Available to full-time employees only.

Short Term Disability

This plan will provide you with coverage for disabilities resulting from a covered sickness or off-the-job injury. Because this is an individual policy, you may choose the plan that best meets your financial needs and income. Coverage options are as follows:

- Monthly Benefit: $500-$6,000 (subject to income requirements)
- Total Disability Benefit Period: 6 months
- Partial Disability Benefit Period: 3 months
- Elimination Periods (Injury/Sickness) – 7/14

Examples of Cost for Disability Income Protection Advantage					
6-Month Benefit Period Waiting Period: 7 Days (Off-the-Job Accident) 14 Days (Sickness)					
Ages 18-49			Ages 50-64		
Annual Salary	Monthly Benefit	Bi-Weekly Premium	Annual Salary	Monthly Benefit	Bi-Weekly Premium
$12,000	$700	$8.19	$12,000	$700	$11.38
$16,000	$800	$9.36	$16,000	$800	$13.00
$18,000	$900	$10.53	$18,000	$900	$14.63
$20,000	$1,000	$11.70	$20,000	$1,000	$16.25
$22,000	$1,100	$12.87	$22,000	$1,100	$17.88
$24,000	$1,200	$14.04	$24,000	$1,200	$19.50
$26,000	$1,300	$15.21	$26,000	$1,300	$21.13
$28,000	$1,400	$16.38	$28,000	$1,400	$22.75
$30,000	$1,500	$17.55	$30,000	$1,500	$24.38
$32,000	$1,600	$18.72	$32,000	$1,600	$26.00
$34,000	$1,700	$19.89	$34,000	$1,700	$27.63
$36,000	$1,800	$21.06	$36,000	$1,800	$29.25
$38,000	$1,900	$22.23	$38,000	$1,900	$30.88
$40,000	$2,000	$23.40	$40,000	$2,000	$32.50
$42,000	$2,100	$24.57	$42,000	$2,100	$34.13
$44,000	$2,200	$25.74	$44,000	$2,200	$35.75
$46,000	$2,300	$26.91	$46,000	$2,300	$37.38
$48,000	$2,400	$28.08	$48,000	$2,400	$39.00
$50,000	$2,500	$29.25	$50,000	$2,500	$40.63

LEGAL RESOURCES

QUALITY.
VALUE.
SERVICE.
PEACE OF MIND.

CITY OF RICHMOND

PEACE OF MIND FOR $8 PER PAY PERIOD

The Legal Resources plan provides 100% coverage for you, your spouse and dependent children for the most often needed legal services, protecting you and your family from the high costs of legal fees.

As a member, you are covered for expected and unexpected legal needs, including real estate closings, will preparation, traffic matters, divorce and much more. Most attorneys charge between $200-$400 per hour, but as a Legal Resources member, you and your family are covered for **$8 per pay period**.

THE LEGAL RESOURCES PLAN TRULY DELIVERS IN ALL THE RIGHT WAYS

100% COVERAGE

Pay no attorney fees: *Covers a broad range of legal services and includes coverage for qualifying dependents*

It's comprehensive: *no waiting periods, annual usage limits, deductibles, or co-payments*

It's Valuable
Annual cost = less than what an attorney typically charges for just one hour

Parent Coverage included
Parents of Legal Resources Members receive legal services at a 25% discount on attorney fees and/or legal assistant/paralegal fees when using a Legal Resources Network Law Firm.

Exceptional law firm network
Over 13,000 attorneys nationwide

Superior Customer Service
Certified paralegals answer your calls and questions

COMMONLY USED LEGAL SERVICES	WHAT NON-MEMBERS PAY	WHAT MEMBES PAY
Legal advice and consultation	$200-$400 per hour	$0
Will preparation	$500-$750 per person	
Purchase, sale or refinance of primary residence	$400-$700	
Traffic court representation (including 1st offense DUI)	$750-$1,500	
Uncontested divorce representation	$1,250-$2,000	
Tenant dispute with landlord	$200-$400 per hour	
Uncontested domestic adoption (including name change)	$1,000-$1,500	
Review of a financial contract or lease	$200-$400 per hour	
District court representation in a civil action	$200-$400 per hour	
Defense of child in juvenile court (misdemeanor)	$875-$1,500	

Please visit LegalResources.com for more information or call Members Services at 800.728.5768. We look forward to serving you and your family.

General Notice of COBRA Continuation Coverage Rights

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child),

you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources Solutions Center at 804-646-5660.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Human Resources Solutions Center
900 East Broad Street, Room 902
Richmond, Virginia 23216
804-646-5660

OMB Control Number 1210-0123 (expires 12/31/2019)

Important Notice from City of Richmond about Your Prescription Drug Coverage and Medicare

Note: This is a notice that is required to be distributed annually to any Medicare-eligible employee or dependent who is covered under our group medical/prescription drug plan.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Richmond 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. City of Richmond has determined that the prescription drug coverage offered by the Cigna plans 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 through December 7th.

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

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

If you decide to join a Medicare drug plan, your current City of Richmond coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current City of Richmond coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Richmond 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 Human Resources Solutions Center at 804-646-5660 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 City of Richmond 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. When you are eligible for Medicare, 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 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

CMS Form 10182-CC, updated 4/1/2011

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).

Breast Reconstruction Surgery Benefits and Women's Health and Cancer Rights Act of 1998

Note: This is a notice that is required to be distributed annually to any employee or dependent who is covered under our group medical plan.

If you or a dependent receives covered benefits for a mastectomy, you should know that the Women's Health and Cancer Rights Act of 1998 provides for:

- Reconstruction of the breast(s) on which a covered mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications related to all stages of a covered mastectomy, including lymphedema (swelling). Prior Authorization is not applicable to such prostheses.

The manner in which services are provided is between you and your physician. Coverage is subject to all of the terms and conditions of your health plan, including any applicable deductible, copayment, and coinsurance. You may be entitled to additional benefits as mandated by state law.

Newborns' and Mothers' Health Protection Act of 1996

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Privacy Notice

This notice describes how medical information about you can be used and disclosed and how you can get access to this information. Please review it carefully.

The federal Health Insurance Portability and Accountability Act's privacy regulations provide you with important rights regarding use and disclosure of your personal health information. This notice describes practices and procedures used by City of Richmond medical plan (the Plan) to protect the privacy of certain personal health information concerning individuals who are participants under the Plan, such as you, your spouse, and your dependents. The Plan must maintain the privacy of protected health information and provide plan participants with a notice about the Plan's legal duties and privacy practices regarding protected health information. The Plan is required to use and disclose protected health information as described in this notice. This notice is effective October 1, 2015.

Protected health information (PHI) means health information collected or received by City of Richmond, the Plan, another health plan, a life insurer, a school or university, a health care clearinghouse, or a health care provider that personally identifies plan participants and relates to their health care, past, present, or future physical or mental health conditions, or past, present, or future payments for health care. It does not include certain employment records, such as medical certifications used for compliance with the federal Family and Medical Leave Act, federal Americans with Disabilities Act, or workers' compensation laws.

Use and Disclosure of Protected Health Information. Unless otherwise permitted by law, the Plan generally cannot use or disclose your PHI unless you authorize the use or disclosure in writing. However, in some cases, obtaining your written authorization for certain types of use or disclosure of PHI is impractical or unduly cumbersome. For example, written authorizations are not required to use or disclose your PHI for medical treatments, payments of medical bills, and health care operations. In addition, a number of limited exceptions allow or require the Plan to use and disclose PHI without your written authorization for certain legal, public health, and medical purposes.

Treatment, payment, and health care operations. The Plan does not need your written authorization or permission to use or disclose your PHI for the following reasons:

- ***Payment***. The Plan can use and disclose PHI for payment of your health care claims. For example, the Plan can obtain information about your medical diagnosis, treatment, supplies, or procedures from a health care provider and share this PHI with health plan administrators or insurers for billing, cost sharing, claims processing, review of benefit or coverage denials, and other purposes related to administering your benefits and coverage under the Plan.
- ***Health care operations***. The Plan can use and disclose PHI to City of Richmond for purposes of health care plan administration. For example, the Plan can use PHI in underwriting, negotiating premiums, assessing rating risks, conducting quality assessments and improvement activities, evaluating health care providers, performing audits and legal functions, conducting business management and planning, and carrying out general administrative activities.
- In addition, the Plan can disclose your PHI to certain employees of City of Richmond who are authorized and designated to handle certain health care plan administrative tasks. These employees must protect the privacy of your PHI and take steps to ensure that it is used or disclosed only as described in this notice. PHI used solely by City of Richmond for health care operations is not used or disclosed in connection with employment decisions affecting you, such as hiring, promotions, layoffs, or terminations. Whenever possible, City of Richmond remove information that identifies specific plan participants from medical records and uses only summary health data for operational purposes, such as negotiating coverage changes, evaluating insurance alternatives, or obtaining cost estimates.
- ***Business associates***. The Plan can disclose PHI to our business associates for authorized plan administration needs related to payment and health care operations. For example, third-party administrators, auditors, attorneys, consultants, and payroll processors are considered our business associates. Our business associates must enter contracts agreeing to safeguard the confidentiality of PHI received from the Plan.
- ***Health care providers***. The Plan can disclose your PHI to health care providers and other covered entities as required for treatment or payment activities.
- ***Health care education***. The Plan can use and disclose PHI to inform you about alternative

treatment options and health-related benefits and services that might be of interest to you.

- **Legal, public health, and related purposes**. Besides using and disclosing PHI for treatment, payment, and health care operations, the Plan is permitted or required to use or disclose PHI without your written authorization for particular purposes or under specific conditions including:
  - **Legal compliance.** The Plan can use and disclose PHI as required by federal, state, or local laws or regulations, or to comply with valid legal requests, such as subpoenas, discovery requests, and other court or administrative orders. The Plan also must disclose PHI to the Secretary of the U.S. Department of Health and Human Services for HIPAA compliance purposes.
  - **Abuse, neglect, or domestic violence.** The Plan can use and disclose your PHI to appropriate authorities as required for reporting abuse, neglect, or domestic violence. The Plan informs you when making such uses or disclosures.
  - **Law enforcement.** The Plan can use and disclose your PHI to law enforcement officials when reporting a suspected workplace crime or a death due to a suspected crime. Law enforcement officials can request and receive your PHI for purposes of locating or identifying suspects, fugitives, witnesses, or missing persons. Law enforcement officials also can receive limited PHI when needed to identify crime victims, but only when you are unable to give consent to disclosure and certain other conditions are met. In addition, the Plan can use and disclose your PHI to correctional facilities when needed for medical or safety reasons.
  - **Public health and safety.** Various federal public health agencies and certain individuals can receive your PHI to address serious and imminent safety and health threats to you or the public. The Plan also can disclose your PHI to appropriate authorities when required to comply with federal Food and Drug Administration regulations or to prevent or control diseases, injuries, or disabilities.
  - **Health oversight committees.** In general, government health agencies can receive your PHI for necessary and authorized oversight activities, including audits, investigations, licensing activities, criminal or administrative proceedings, and inspections.
  - **Coroners, medical examiners, and funeral directors.** Coroners and medical examiners can receive your PHI for identification purposes, determinations of the cause of death, or other authorized reasons. Funeral directors also can receive your PHI for carrying out specific duties.
  - **Organ and tissue donation.** If you are an organ or tissue donor, the Plan can give your PHI to organ procurement organizations or other entities for facilitating organ or tissue donations or transplants.
  - **Research purposes.** The Plan can provide your PHI for authorized research purposes.
  - **Workers' compensation.** The Plan can use and disclose your PHI for workers' compensation or related purposes.
  - **Military or national security functions.** If you serve, have been discharged, or are a veteran of a U.S or foreign military service, the Plan can provide your PHI as required by appropriate military authorities. The Plan also can disclose your PHI for authorized national security and intelligence activities.
  - Although your written authorization is not required for the above-listed uses and disclosures of your PHI, the Plan releases only the minimum details necessary to carry out these authorized functions. In addition, your express written authorization almost always is required in these situations:
  - **Disclosure of psychotherapy notes.** The Plan must receive your authorization in most cases before releasing your PHI that relates to psychotherapist notes taken during mental health sessions.
  - **Use of PHI for marketing purposes.** The Plan generally must receive your authorization for using or disclosing your PHI for certain marketing purposes.

Your Rights. You have certain rights regarding your PHI. These rights include the following:

- **The right to designate a relative or representative to access your PHI**. You can provide written notice to the Plan to designate a relative, friend, lawyer, or other individual as someone closely involved in your health care to whom the Plan can disclose your PHI for any purpose you specifically permit. This authorization allows the Plan to release all appropriate records to your designated representative without obtaining a separate authorization from you for each record request. You can revoke this authorization at any time.
- **The right to request restrictions on certain uses and disclosures of PHI**. You can request the Plan to restrict any use or disclosure of your PHI for carrying out treatment, payment, or health care operations or to your personal representative, including family members. The Plan does not have to agree to your request and can disclose

your PHI as allowed or required by law or if an emergency arises.

- **The right to receive confidential communications of PHI.** You can receive PHI communications through alternative means or at alternative locations if the communication channels normally used would jeopardize your physical safety. To exercise this right, you must give the Plan a written statement to the effect that disclosing all or part of your PHI through normal channels could endanger you. For example, you can request that communications be mailed to you at an address that is different from your home address.
- **The right to inspect and copy your PHI**. You can make a written request to inspect and copy your PHI that the Plan retains, excluding psychotherapy notes, information compiled for use in any legal proceeding, or records otherwise restricted or exempt from disclosure under federal laws or regulations. The Plan will either mail the requested records to you or send you a letter explaining why your request is denied. The Plan will respond to your request within certain deadlines, usually 30 or 60 days, depending on how recently the requested records were created and whether records are maintained on site. If your request is denied, a review of the denial is available in most cases.
- **The right to amend protected health information.** You can amend your PHI by sending the Plan a written request explaining the need for changing your PHI. Your request can be denied if the PHI is not available for inspection by law or if the Plan did not create the PHI record, does not maintain the record, or determines that the record is complete and accurate. The Plan also will amend your PHI if it receives amended PHI from an appropriate entity covered by the law.
- **The right to receive an accounting of disclosures of protected health information.** You can make a written request to the Plan to provide you with a statement of the disclosures of your PHI that were made by the Plan for up to six years before the date of your request. However, the Plan does not have to supply an accounting of certain routine or permitted PHI disclosures, such as disclosures made to your designated representative or to carry out treatment, payment, or health care operations. No charge applies to your first request for an accounting of disclosures in a given year. A nominal administrative fee applies if you submit additional requests within the same 12-month period; however, you can reduce or avoid extra charges by modifying or withdrawing additional requests. The Plan will supply this accounting of disclosures of your PHI within 60 days after the Plan receives you request unless it notifies you in writing of the need for a 30-day extension.
- **Your rights under state law.** In addition to your rights described in this notice, you might have additional rights regarding your PHI under the laws of the state where you live, such as rights relating to mental health, pregnancy, HIV/AIDS, and health treatment of minors.
- **The right to receive a privacy notice.** Plan participants receive this notice when they enroll in the Plan and you can request additional copies of this notice at any time. You also can request a paper copy of this notice if you first received it electronically. The Plan issues notice reminders at least every three years informing plan participants of their right to receive this notice and where to obtain it.

Changes to This Notice. The Plan can change provisions of this notice at any time for compliance or other reasons. In general, changes to the notice are effective on the date the notice is revised. Plan participants receive information regarding changes to this notice within 60 days after revisions are made and can request a revised copy of the notice.

Complaints. If you believe that the Plan has not complied with its obligations or your rights as described in this notice have been violated, you can submit a written complaint to City of Richmond's privacy officer, the Plan, or the Secretary of the U.S. Department of Health and Human Services.

You will not be retaliated against or penalized in any manner for filing a complaint, participating in any legal proceeding, or opposing any unlawful act or practice.

Employer Contact Information. For more information about this notice or your privacy rights, you can contact City of Richmond's privacy officer.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children & Families

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, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com MedicaidEligibility:http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	MedicaidWebsite:http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website:http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website:http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website:http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we- serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website:http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com\ Toll-free Phone: 1-855-MYWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid/CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any more States have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, you can contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

Notice Regarding Wellness Program

The City of Richmond's Employee Health and Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health assessment or "HA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol and blood sugar. You are not required to complete the HA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of lower health insurance premiums. Although you are not required to complete the HA or participate in the biometric screening, only employees who do so will receive the lower health insurance premiums.

Additional incentives of gift cards and other prizes may be available for employees who participate in certain health-related activities such as lunch-n-learns and walk or bike to work activities. If you are unable to participate in any of the health-related required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Human Resources Solutions Center at 804-646-5660.

The information from your HA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as a personal health coach at CIGNA HealthCare. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the City of Richmond may use aggregate information it collects to design a program based on identified health risks in the workplace, we will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are clinically trained health professionals at CIGNA HealthCare in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the City's Human Resources Solutions at 804-646-5660.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employers does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact The Department of Human Resources @ 804-646-5660.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name City of Richmond		4. Employer Identification Number (EIN) 54-6004556
5. Employer address 900 East Broad Street		6. Employer phone number 804-646-5660
7. City Richmond	8. State VA	9. ZIP code 23219
10. Who can we contact about employee health coverage at this job? Department of Human Resources		
11. Phone number (if different from above)	12. Email address AskHR@Richmondgov.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All Employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:
    Full-Time and Part-Time Permanent Employees
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Spouses and dependent children under the age of 26.
  - ☐ We do not offer coverage.
- ☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis). if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs coverage by the plan is no less than 60 percent of such costs (Section 36B©(2)(ii) of the Internal Revenue Code of 1986.)

Glossary

After-tax	Paying for benefits after federal, state and FICA taxes are deducted.
Beneficiary	The person(s) you designate to receive payment from your insurance policies when you die.
Capitation	A set dollar limit that you or your employer pay to a health maintenance organization (HMO), regardless of how much you use (or don't use) the services offered by the health maintenance provider
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985, federal legislation that allows you and/or your dependents to continue to purchase health insurance for up to 18 months if you lose your job or your employer-sponsored coverage is otherwise terminated. Dependents may be eligible for COBRA coverage for up to 36 months in the event of your divorce or death, or when your child reaches the limiting age under the plan. COBRA is available to employees who work for an employer with 20 or more employees.
Coinsurance	The percentage of covered medical costs you pay.
Coordination of Benefits	An arrangement in health insurance to discourage multiple payments for the same claim under two or more policies. When a person is covered by two or more group health insurance plans, one plan becomes the *primary* plan and the other plan(s) the *secondary* plan(s).
Copayment	The flat fee that you pay per unit for certain medical services.
Covered Expenses	Charges eligible for plan payment
Deductible	A fixed dollar amount of covered medical charges you must pay before the plan pays for additional covered services. Your deductible depends on the medical plan you select.
Dependent	In the Medical and Dental plans, a dependent is defined as: (1) your lawful spouse; and (2) any child of yours who is: • less than 26 years old. • 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage. Child means a child born to you or a child legally adopted by you. It also includes a stepchild or a child for whom you are the legal guardian. Benefits for a Dependent child will continue until the last day of the month in which the limiting age is reached. Anyone who is eligible as an employee will not be considered as a Dependent spouse. A child under age 26 may be covered as either an employee or as a Dependent child. You cannot be covered as an employee while also covered as a Dependent of an employee. No one may be considered as a Dependent of more than one employee.
Disability	Inability to work because of a medically certified illness or injury.
Explanation of Benefits (EOB)	The insurance company's written explanation regarding a claim, showing what they paid and what you must pay.
Generic Drug	Once a company's patent on a brand-name prescription drug has expired, other drug companies are allowed to sell the same drug under a generic label. Generic drugs are less expensive than brand-name drugs.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	A legislative act that allows people to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also mandates the use of 1) standards for the electronic exchange of health care data; 2) national identification systems for health care patients, providers, payers, and employers; and 3) measures to protect the security and privacy of personally identifiable health care.

Health Maintenance Organization (HMO)	Health maintenance organizations represent "pre-paid" or "capitated" insurance plans in which doctors are paid a fixed monthly fee for services instead of separate fees for each visit or service. The monthly fees remain the same, regardless of types or levels of services provided. Services are provided by physicians who are employed by, or under contract with, the HMO. HMOs vary in design.
Inpatient Care	Medical care you receive after you're formally admitted into a hospital.
Life Insurance	Term life insurance that pays a death benefit to your beneficiary if you die. There is no cash surrender value.
LTD (Long-term Disability)	A disability due to a medically-certified illness or injury that lasts for more than 180 days.
Medicaid	A health insurance program for low-income individuals who cannot otherwise afford Medicare or other commercial health insurance plans. Medicaid is funded in part by the government and by the state where the enrollee lives.
Medicare	The federal health insurance program created to provide health coverage for Americans aged 65 and older and later expanded to cover younger people who have permanent disabilities or who have been diagnosed with end-stage renal disease or amyotrophic lateral sclerosis (ALS).
Network	A group of health care providers, including doctors, hospitals and specialists who join together to provide care at specially negotiated rates.
Non-duplication of Benefits	A coordinated payment method used when more than one health insurance plan is paying benefits.
Orthodontia	Dental services which straighten teeth and correct bite.
Out-of-Pocket Maximum	The maximum dollar amount you pay out of your pocket in a calendar year for covered expenses, including deductibles and coinsurance. The plan pays 100% of covered expenses after the limit is reached (up to the plan's maximum benefit) for the remainder of the year.
Patient Protection and Affordable Care Act (PPACA), also known as Affordable Care Act (ACA)	The health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will continue to be rolled out over the next four years.
Point of Service (POS)	A point of service (POS) plan is a combination of an HMO and a PPO. It has a network that functions like an HMO. A member may also choose to use out-of-network providers; however, the member will pay more when using out-of-network providers.
Pre-tax	A contribution for benefits that is taken from your pay before federal, state, and FICA taxes are withheld. Note that Tax Sheltered Annuities are pre-tax on federal and state only.
Preferred Provider Organization (PPO)	A preferred provider organization (PPO) is a managed care organization of health providers who contract with an insurer to provide health insurance coverage. Services by these providers are discounted substantially. If a member uses a physician outside the PPO plan, they typically pay more for the medical care.
Preventive Care	Services that maintain good health and prevent disease - such as check-ups and early detection screenings.
Primary Care Physician (PCP)	The doctor responsible for directing all your medical care and referrals.
Spouse	A person who is legally married to an employee under the laws of the state in which the employee resides.

Contacts

Cigna www.mycigna.com 1-800-244-6224
WageWorks www.FSAWorks4Me.com/takecare www.takecarewageworks.com 1-800-950-0105
AFLAC www.aflac.com 1-800-992-3522
Legal Resources www.LegalResources.com 1-800-728-5768
Minnesota Life 1-800-441-2258
Cigna - Employee Assistance Program www.mycigna.com, Employer ID: COR 1-877-622-4327
Richmond Retirement System http://www.richmondgov.com/Retirement/GeneralContactUs (804) 646-5958
City of Richmond - Human Resources www.richmondgov.com\HumanResources askhr@richmondgov.com (804) 646-5660

This Benefits Enrollment Guide is intended as a summary of your employee benefits.
Please refer to the booklets and/or contracts that apply to each of the plans for complete details.
In the event of a discrepancy in benefits, the full plan booklets and contracts will determine how your Benefits will be applied.