CITY OF RICHMOND

Employee **Benefits** Guide

2025

CITY OF RICHMOND
Department of Human Resources

"Working for the City of Richmond is so much more than a job. It's a career opportunity to make a difference in your life as well as the lives of the residents of our great city."
— Mayor Levar Stoney

To Our Employees and Their Families:

Welcome to 2025 Benefits Enrollment! As an Employer of Choice, the City of Richmond strives to deliver a high-quality, affordable benefits program to its employees, inclusive of medical, vision, dental, life insurance, legal services, and many other voluntary benefits. This guide is designed to help you make informed benefits choices during our Open Enrollment period, as a new hire, or as you experience a life event that may require you to reconsider your current elections.

Through the offering of a wide array of benefits, each employee can tailor their benefits package to meet their individual needs and the needs of their families. The benefits offered by the City of Richmond represent an integral portion of your total compensation package and provide important insurance protections, some with tax advantages.

We hope you find our Benefits Guide to be a valuable resource. Take the time to read through all of the options and discuss with those who may also be receiving coverage. If any questions arise as you consider your benefits, do not hesitate to contact the Human Resources Benefits and Wellness Division at HRBenefits@rva.gov or 804-646-4700 with questions.

Sincerely,

Tyrome Alexander
Director of Human Resources

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BENEFITS YOU CAN CHOOSE

The City of Richmond reviews programs annually and offers its employees flexibility and choice. Throughout this Benefits Guide, you will find important information about the benefits you can elect during open enrollment, and throughout the year. It also identifies changes that have been made to the City's benefits plans effective January 1, 2025. Below please find an overview of the benefits offered by the City of Richmond.

Benefit Plan	What You Can Choose	Pre-Tax Deductions Permitted
Cigna Healthcare – Includes Medical, Vision, Prescription, and Wellness	There are three healthcare plans available through the City of Richmond, Plan 1 (High Deductible with Health Savings Account), Plan 2, and Plan 3. All plans come with access to the Richmond Network Marathon Health Clinics for free (or low cost for Plan 1). **Plan 1:** This is a High Deductible Plan that comes with an employer funded Health Savings Account (HSA) of $750 for an individual plan, or $1,250 for all others, which can be used towards medical expenses. > Features include having the lowest premium, coinsurance* at 10% after the deductible is met, no copays, and one of the two lowest out-of-pocket maximums. **Plan 2:** Features include the second lowest premium, the second lowest deductible, coinsurance at 20% after the deductible is met, copays for certain services, and one of the two lowest out-of-pocket maximums. **Plan 3:** Features include the highest premium, the lowest deductible, coinsurance at 10% after the deductible is met, copays for certain services, and the highest out-of-pocket maximums. **Vision Benefit:** Comprehensive vision coverage is included with all of the medical plans above, and is provided through Cigna in partnership with EyeMed. See page 14 for vision coverage details.	Yes
Cigna Dental Plans	The City of Richmond has two dental plans through Cigna in 2025: the Dental Preferred Provider Organization plan (DPPO) and the Dental Care Access plan (DHMO). > The **DPPO** is structured similarly to a medical plan with no limits on the provider network, but has coinsurances, deductibles, and a higher premium. > The **DHMO** has lower premiums and utilizes copayments based on services, but has a limited number of dentists that participate, and no out-of-network benefits.	Yes

* Coinsurance: The percentage of covered medical costs you pay.

BENEFITS YOU CAN CHOOSE continued

Benefit Plan	What You Can Choose	Pre-Tax Deductions Permitted
Flexible Spending Accounts administered by Aflac	The City of Richmond offers two flexible spending accounts (FSA): **Healthcare Spending Account –** for all employees, except those in Plan 1 > Elected pre-tax dollars that can be used for qualifying medical expenses such as glasses, contacts, deductibles, and copayments. The annual limit for the Healthcare FSA is $3,200 in 2024. The annual limit is subject to change for 2025. **Dependent Care Spending Account –** available to all employees with eligible dependent(s) > Elected pre-tax dollars that can be used for eligible childcare/ daycare expenses for a minor. Maximum election amount for 2025 is $5,000 for the Dependent Care Spending Account. *** FSA elections are administered by Aflac, and elections do not roll over, but you may rollover up to $640 of unused funds from 2024; 2025 amounts are still being confirmed. Elected amounts must be identified during Open Enrollment or the New Hire Period ***	Yes
Aflac Voluntary Benefits	The City of Richmond has partnered with Aflac to offer several pre-tax voluntary benefits, they include: • Personal Cancer Indemnity Insurance • Accident Advantage Insurance • Hospital Choice Insurance • Critical Care Protection Insurance	Yes
Aflac Voluntary Short-Term Disability and Life Insurance Benefits	The City of Richmond has partnered with Aflac to offer Short-Term Disability Insurance, up to six months, on a voluntary basis. Aflac also offers Term Life Insurance.	No
Legal Resources	Employees may enroll in pre-paid legal services to retain a lawyer through the City of Richmond's partner, Legal Resources.	No
Optional Life Insurance through VRS / Securian	In addition to the City's Basic Group Term Life Insurance, additional optional Group Term Life Insurance can be purchased for employee, spouse and child(ren).	No
Mission Square Retirement 457 Plan	Employees in both Virginia Retirement System and Richmond Retirement System are eligible to enroll in an optional 457 Deferred Compensation Plan through the City of Richmond, and make changes at any time.	Yes
Mission Square Retirement Roth IRA	Roth IRA accounts are available and can be elected at any time.	No

BENEFITS YOU CAN CHOOSE continued

MORE FOR YOUR MONEY—PRE-TAX DEDUCTIONS EXPLAINED

Some benefits offered are through pre-tax dollars, meaning payroll deductions are taken out of your paycheck before taxes are calculated. This way your taxable income is reduced - meaning you pay less in taxes and have a higher spendable income. An example of your potential savings is shown below.

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.

	Without Pre-Tax Deductions	With Pre-Tax Deductions
Gross Monthly Income	$2,500.00	$2,500.00
Pre-Tax Healthcare Flexible Spending Account	$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 Healthcare Expense	$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!**

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 the medical/vision and dental benefits, and City of Richmond 457 Deferred Compensation Plan, and Roth IRA.

PROVISIONAL EMPLOYEES who work 20 or more hours per week are eligible for the medical/vision plans only.

ENROLLMENT TIMELINE

2025 Benefits Open Enrollment is October 28 through November 17, 2024.

For Current Employees - THOSE ELECTING HEALTHCARE COVERAGE DURING OPEN ENROLLMENT, coverage becomes effective January 1, 2025.

For New Hires - The effective date of coverage is a choice of two options:

- Choice 1 - Day 1: The hire date will be the effective date of coverage.
- Choice 2 - First of the following month: Employees hired on the 1st day of the month will have coverage effective that same day. Employees hired on the 2nd to the end of the month will have coverage effective on the 1st day of the upcoming month.
  - > For example: If you are hired May 1, 2025, your coverage begins May 1, 2025. If hired May 2, 2025, your coverage starts June 1, 2025.

For Life Events - The benefits change must be requested within 30 days of the life event by contacting Human Resources Benefits & Wellness Division at HRBenefits@rva.gov. The effective date of coverage is dependent on the benefit and life event. See page 9 for more information.

ENROLLMENT PROCESS

DURING THE OPEN ENROLLMENT PERIOD, employees must make enrollment elections for the upcoming plan year on the City of Richmond self-service portal found through StarNet. If any issues with usernames or passwords, contact the Department of Information Technology at 804-646-6367.

EMPLOYEES HIRED AFTER THE OPEN ENROLLMENT PERIOD may complete their enrollment choices online, or through a paper form within 30 days of their hire date.

Scan Here For CORERP (enrollment)

WHY YOU NEED TO ENROLL DURING OPEN ENROLLMENT

Open Enrollment is the only time for current employees to make changes to their benefits. If you missed the deadline after your hire date, Open Enrollment allows you to take advantage of the coverage offered by the City of Richmond. If you do not enroll now, you will have to wait until the next Open Enrollment period to make new benefit elections, unless you have a qualifying life event.

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.)

If you don't submit the appropriate changes within the proper timeframes, you may not have coverage.

Your elections are for a 12-month cycle and cannot be changed unless you experience a qualifying life event.

The benefit period runs from January 1st through December 31st.

Payroll deductions are taken from the first and second paycheck of each month.

BENEFIT ELECTIONS – THINGS TO CONSIDER

GETTING STARTED

Making benefit choices is like other choices you make in life. Employees can take a number of steps to ensure they are making the right choices for themselves, their families, and life circumstances. Think about what best suits the needs of you (and your family). . . not what might best suit others around you. Consider the benefits offered to you by the City, if married, the benefits available through your spouse's plan, and how each aligns with your needs in the upcoming year.

UNDERSTAND THE BENEFITS OPTIONS

One of the most important things you can do is read through this Benefits Guide thoroughly. This guide provides the information you need to understand the City of Richmond's benefits program.

CONSIDER YOUR PAST HISTORY

Review your medical, vision, dental and other expenses over the last few years. How likely is it that you or someone in your family will need medical, vision and dental treatment in the coming year? Remember, you always have to anticipate unexpected expenses.

WORK-UP YOUR BENEFITS CHOICES AND COSTS

Review the premiums you will pay for each of the different coverages. Then, review the coverage offered by each plan. Estimate future costs to create your own benefits package. Be sure to include how much you would expect to pay out of your pocket, including deductibles. It may be helpful to estimate costs for what might be the lowest and highest usage.

COLLECT NEEDED DOCUMENTATION

Gather your beneficiary and dependent names, dates of birth, and Social Security Numbers (SSNs). When enrolling dependents, include documentation such as marriage licenses and birth certificates.

ENROLL!

Complete the enrollment process during the eligibility period to make changes or to enroll in benefit plans (see page 7 for instructions).

REVIEW YOUR COMPLETED ELECTIONS

Review your completed election forms and the CORERP Employee Self-Service Portal carefully to ensure you've selected the intended coverage.

REMEMBER THAT YOUR DECISIONS CANNOT BE CHANGED FOR A YEAR

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

CHANGING ELECTIONS OUTSIDE OF OPEN ENROLLMENT

Your benefit choices will be effective from January 1, 2025, through December 31, 2025, and cannot be changed until the next benefits year starting January 2026 (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, or 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 impacts benefit eligibility for you, a 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 qualified medical child support orders) resulting from divorce or change in legal custody requiring health coverage of a child who is your dependent.

SPECIAL ENROLLMENT RIGHTS ALLOWED UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – YOU MAY ALSO BE ELIGIBLE TO CHANGE AN ELECTION DUE TO:

- You 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 44, "Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)" 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 2025. The City has three choices, including one high deductible plan. All three provide coverage in full for eligible wellness visits and preventive care visits, are open access plans, and provide the same broad network of service providers. All three also provide vision and prescription drug benefits.

One of the primary differences in these three plan options is how much you pay in premiums and how much you will pay if/when you receive services (a cost that varies by your usage).

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 PRESCRIPTION DRUG BENEFITS

Cigna encourages 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 they prescribe 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. If filled at the Marathon Health clinic discussed below, medications on their formulary will not have a cost.

If you take a "maintenance" drug -- one that you are expected to take for a long period of time -- you may be able to save money by ordering a 90-day supply through the mail or utilizing the Cigna 90 Now℠ retail pharmacy program.

CIGNA VISION PLAN

You automatically receive vision coverage, in partnership with EyeMed, when you choose a medical plan with Cigna. Coverage includes an annual routine eye exam benefit, coverage for eyewear, discounts for eyeglass lens upgrades, and Lasik or PRK laser vision correction.

MARATHON HEALTH CLINICS

All plans come with access to the Richmond Network Marathon Health Clinics for free (or low cost for Plan 1). The clinics provide primary care services, sick care services, immunizations, laboratory services, a full on-site pharmacy, physical therapy, behavioral health services, and virtual care services, at three convenient locations. Please see page 11 for more details.

HEALTH CLINICS

Marathon Health™

Your healthcare benefit

We're excited to offer those on the medical plan Marathon Health as part of your benefits package as a City of Richmond employee, spouse, and/or dependent. Marathon Health is your complete health partner, covering up to 90% of your health and wellness needs.

Who can use Marathon Health?

Employees, spouses and dependents on any City of Richmond health plan have access to healthcare services.

How do I access healthcare services?

Marathon Health offers both in-person and virtual appointments for your convenience. To schedule an in-person or virtual appointment, call 888-830-6538 or visit the Marathon Health online patient portal or app.

How we're different:

- Care when you need it: With our same-day and next-day appointments for immediate concerns, you can talk to your provider quickly. Physical therapy, behavioral health, and health coaching is available with no referral required!
- Care how you want it: Say goodbye to crowded waiting rooms and rushed appointments. Say hello to seeing your provider for as long (or as short) as you want, in person or from home, thanks to our convenient patient portal/ app.
- Care at the cost you want: Services within the Marathon Health Centers are little to no cost to you!

Marathon Health
@ Downtown Richmond
626 E Broad St., Ste. 100
Richmond, VA 23219
888-830-6538

Hours

Mon.	7 am - 4 pm
Tues.	7 am - 4 pm
Wed.	7 am - 4 pm
Thur.	7 am - 4 pm
Fri.	7 am - 4 pm

Marathon Health
@ Hioaks
7012 Marlowe Rd., Ste. 100
Richmond, VA 23225
888-830-6538

Hours

Mon.	8 am - 5 pm
Tues.	8 am - 5 pm
Wed.	10 am - 7 pm
Thur.	8 am - 5 pm
Fri.	8 am - 5 pm
Sat.	8 am - 12 pm

Marathon Health
@ Hanover
10412 Washington Hwy. Ste. C
Glenn Allen, VA 23059
888-830-6538

Hours

Mon.	8 am - 5 pm
Tues.	10 am - 7 pm
Wed.	8 am - 5 pm
Thur.	10 am - 7 pm
Fri.	8 am - 5 pm
Sat.	8 am - 12 pm

Schedule an appointment
Call 888-830-6538
or visit **my.marathon.health**

HEALTH CLINICS continued

Marathon Health

Our services

In-person and virtual care

Marathon Health is your health partner, covering up to 90% of your health and wellness needs.

Primary and preventive care

- Annual exams and preventive screenings
- Blood pressure screenings
- Biometric screenings (height, weight, blood glucose, and cholesterol)
- Condition management (diabetes, heart disease, COPD, and more)
- Mental health services
- Vaccines (Flu, HPV, TDAP, COVID and more)

Immediate & sick care

- Bronchitis
- Common cold and cough
- Constipation
- Diarrhea
- Eye infections
- Headache
- Joint pain
- Nausea and vomiting
- Nosebleed
- Sinus infections
- Skin infections
- Strep throat

Additional services

- Physical therapy at Marathon Health @ Hioaks (No Referral Needed)
- Onsite pharmacy at Marathon Health @ Hioaks (Prescriptions covered in full)
- Virtual and in-person health coaching

Lab services - all no cost

- Basic metabolic panel
- Blood draws and sample collection
- Cholesterol
- Hemoglobin A1c
- Pregnancy test
- Screening for diabetes
- Urinalysis
- *Additional lab tests can also be drawn and sent to an outside lab for processing at no cost*

Schedule an appointment
Call 888-830-6538
or visit **my.marathon.health**

The care you receive by Marathon Health is confidential and protected by state and federal law.

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	Plan 1 (High Deductible with HSA)	Plan 2	Plan 3
Annual Deductible* - Individual / Family	$2,000 / $4,000	$750 / $1,500	$500 / $1,000
Employer HSA Contribution**	$750 Ind. / $1,250 Family	N/A	N/A
Deductible if HSA Funds Applied	$1,250 Ind. / $2,750 Family	N/A	N/A
Out-of-Pocket Limit* - Individual / Family	$4,000 / $8,000	$4,000 / $8,000	$5,000 / $10,000
Individual in a Family	$4,000	—	—
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
Coinsurance	10%	20%	10%
Other Services			
Inpatient Hospital (per admission)	Deductible, then 10%	Deductible, then 20% + $500	Deductible, then 10% + $500
Outpatient Surgery	Deductible, then 10%	Deductible, then 20% + $300	Deductible, then 10% + $250
PCP / Specialist Office Visit	Deductible, then 10%	$25 copay / $50 copay	$20 copay / $40 copay
Lab and X-ray			
Doctor's Office - PCP / Specialist	Deductible, then 10%	$25 copay / $50 copay	$20 copay / $40 copay
Independent Lab / Outpatient Facility	Deductible, then 10%	Deductible, then 20%	Deductible, then 10%
Advanced Imaging			
Doctor's Office - PCP / Specialist	Deductible, then 10%	$25 copay / $50 copay	$20 copay / $40 copay
Independent Lab / Outpatient Facility	Deductible, then 10%	Deductible, then 20%	Deductible, then 10%
Chiropractic Services (Medical Necessity Review)	Deductible, then 10% (Combined with Rehabilitation)	$25 / $50 copay (30 days)	$20 / $40 copay (30 days)
Short-term Rehabilitation (Physical, Speech, and Occupational Therapy)	Deductible, then 10% (Combined 90 days)	$25 / $50 copay (Combined 60 days)	$20 / $40 copay (Combined 60 days)
Marathon Health Physical Therapy Appt.	$25 until ded. is met, then 10%	Covered in full by plan	Covered in full by plan
Maternity Care (Excluding IP Hospital)	Deductible, then 10%	Global Maternity Fee: Deductible, then 20% Office visits in addition to Global Fee: $25 copay / $50 copay	Global Maternity Fee: Deductible, then 10% Office visits in addition to Global Fee: $20 copay / $40 copay
Fertility Services	Authorized benefits are covered based on the place of treatment and the type of service provided.		
Marathon Health Office Visit	$25 until ded. is met, then 10%	Covered in full by plan	Covered in full by plan
Urgent Care	Deductible, then 10%	$50 copay	$40 copay
Emergency Room (Copay waived if admitted)	Deductible, then 10%	$250 copay, then 20%	$200 copay, then 10%
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, including gender-affirming surgical procedures, hormone therapy, mental health care, and all related medical visits and laboratory services. Note that all applicable benefit limitations, precertification, and medical necessity criteria will still apply.		
Mental Health / Substance Use Disorder			
Inpatient Hospitalization	Deductible, then 10%	Deductible, then 20% + $500	Deductible, then 10% + $500
Outpatient Services			
Doctor's Office:	Deductible, then 10%	$25 copay	$20 copay
Marathon Health Behavioral Health Visit	$25 until ded. is met, then 10%	Covered in full by plan	Covered in full by plan
All Other Services:	Deductible, then 10%	Deductible, then 20%	Deductible, then 10%
OUT-OF-NETWORK BENEFITS			
Annual Deductible* - Individual / Family	$4,000 / $8,000	$1,500 / $3,000	$1,500 / $3,000
Out-of-Pocket Limit* - Individual / Family	$13,100 / $26,200	$10,000 / $20,000	$10,000 / $20,000
Coinsurance	50%	50%	50%

*** Deductible and Out-of-Pocket Limits will RESET each January 1.**

**** City of Richmond pre-tax contributions to a Health Care Flexible Savings Account or Plan 1 Health Savings Account can be used for deductibles or copays. To learn more see pages 17 - 19.**

CIGNA PRESCRIPTION DRUG PLAN BENEFITS

You automatically receive prescription drug coverage when you choose a medical plan with Cigna. Please refer to your full description of benefits provided by Cigna for complete details.

IN-NETWORK BENEFITS	Plan 1 (High Deductible with HSA)	Plan 2	Plan 3
Prescription Drugs (The formulary that applies to this program is Cigna's Standard formulary, which is a closed formulary)			
30-Day Retail			
Generic	Deductible, then $10 copay	$10 copay	$10 copay
Preferred Brand	Deductible, then $30 copay	$30 copay	$30 copay
Non-Preferred Brand	Deductible, then $55 copay	$55 copay	$55 copay
Specialty	20% to a maximum of $250	20% to a maximum of $250	20% to a maximum of $250
90-Day Home Delivery / Retail			
Generic	Deductible, then $10 copay	$10 copay	$10 copay
Preferred Brand	Deductible, then $60 copay	$60 copay	$60 copay
Non-Preferred Brand	Deductible, then $165 copay	$165 copay	$165 copay
Specialty (30-day only)	20% to a maximum of $250	20% to a maximum of $250	20% to a maximum of $250
Diabetes Test Strips through OneTouch	Covered in full	Covered in full	Covered in full

Prescriptions filled through Marathon Health are free with no deductible or copay, if on the formulary. See page 12 for more information. Refer to page 13 for the deductible amounts.

CIGNA VISION PLAN BENEFITS

You automatically receive vision coverage when you choose a medical plan with Cigna. Please refer to your full description of benefits provided by Cigna for complete details.

	In-Network	Out-of-Network	Frequency Period*
Exam Copay	$15	NA	12 months
Exam Allowance (once per frequency period)	Covered 100% after copay	Up to $45	12 months
Material Copay	$0	NA	12 months
Eyeglass Lenses Allowances (one pair per frequency period)			
Single Vison	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 $87	12 months
Therapeutic	Covered in full	Up to $210	12 months
Frame Retail Allowance (one per frequency period)	Covered in full	Up to $55	24 months

*** Your frequency period begins on January 1 (calendar year basis).**

MEDICAL, PRESCRIPTION AND VISION RATES

Pre-tax deductions are taken 24 pay periods a year. Your contributions, or bi-weekly premium, will vary depending upon whether you and your covered spouse have taken and submitted your biometric screening results to Marathon Health, which was a new process communicated widely in 2024. The Healthcare Incentive for 2024 has been closed. The 2025 Healthcare Incentive will be open in mid-2025 for 2026 rates. In summer 2025, check StarNet and your email for updates to ensure you receive the 15%+ discount towards 2026 rates.

CIGNA MEDICAL, PRESCRIPTION AND VISION

ALL ELIGIBLE EMPLOYEES	Total monthly	What COR contributes monthly	What you pay monthly	What you pay bi-weekly
Plan 1 (High Deductible with City Contribution to Health Savings Account)				
	Healthcare Incentive Taken (with Marathon Health)			
Employee Only	$899.81	$867.75	$32.06	$16.03
Employee + One Child	$1,544.78	$1,335.58	$209.20	$104.60
Employee + Children	$2,069.56	$1,789.70	$279.86	$139.93
Employee + Spouse	$2,109.52	$1,824.38	$285.14	$142.57
Employee + Family	$2,460.06	$1,977.22	$482.84	$241.42
	Healthcare Incentive NOT Taken (with Marathon Health)			
Employee Only	$899.81	$858.79	$41.02	$20.51
Employee + One Child	$1,544.78	$1,297.32	$247.46	$123.73
Employee + Children	$2,069.56	$1,737.46	$332.10	$166.05
Employee + Spouse	$2,109.52	$1,771.12	$338.40	$169.20
Employee + Family	$2,460.06	$1,887.22	$572.84	$286.42
Plan 2				
	Healthcare Incentive Taken (with Marathon Health)			
Employee Only	$1,070.57	$996.35	$74.22	$37.11
Employee + One Child	$1,822.01	$1,498.11	$323.90	$161.95
Employee + Children	$2,462.31	$2,006.39	$455.92	$227.96
Employee + Spouse	$2,488.99	$2,028.67	$460.32	$230.16
Employee + Family	$2,900.69	$2,231.11	$669.58	$334.79
	Healthcare Incentive NOT Taken (with Marathon Health)			
Employee Only	$1,070.57	$976.49	$94.08	$47.04
Employee + One Child	$1,822.01	$1,439.11	$382.90	$191.45
Employee + Children	$2,462.31	$1,922.33	$539.98	$269.99
Employee + Spouse	$2,488.99	$1,943.67	$545.32	$272.66
Employee + Family	$2,900.69	$2,111.11	$789.58	$394.79
Plan 3				
	Healthcare Incentive Taken (with Marathon Health)			
Employee Only	$1,172.57	$1,009.47	$163.10	$81.55
Employee + One Child	$1,994.31	$1,534.19	$460.12	$230.06
Employee + Children	$2,696.89	$2,071.73	$625.16	$312.58
Employee + Spouse	$2,724.32	$2,094.64	$629.68	$314.84
Employee + Family	$3,175.08	$2,381.32	$793.76	$396.88
	Healthcare Incentive NOT Taken (with Marathon Health)			
Employee Only	$1,172.57	$972.47	$200.10	$100.05
Employee + One Child	$1,994.31	$1,449.37	$544.94	$272.47
Employee + Children	$2,696.89	$1,957.99	$738.90	$369.45
Employee + Spouse	$2,724.32	$1,979.64	$744.68	$372.34
Employee + Family	$3,175.08	$2,237.32	$937.76	$468.88

CIGNA DENTAL PLANS

Cigna will continue to provide your dental benefits in January 2025. There are two dental plan options available to you -- Dental PPO plan (Cigna Total DPPO) and DHMO plan (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 for services.
- The Cigna Dental Care Access plan (DHMO) is similar to a Medical HMO because you must select a dentist who is in the Cigna Dental Care Access network and receive services from that dentist. You will pay fixed copays for any covered dental services provided by a Dental Care Access dentist.

DENTAL PLAN FEATURES	Total DPPO In-network	Total DPPO Out-of-Network	Dental Care Access (Charge may vary based on actual procedure codes)
Annual Deductible - Individual / Family	$50 / $150	$50 / $150	$0
Annual Benefit Maximum	Year 1: $1,500	Year 1: $1,500	—
(Members progress to the next level by	Year 2: $1,600	Year 2: $1,600	—
using Class I services in the prior year)	Year 3: $1,700	Year 3: $1,700	—
	Year 4+: $1,800	Year 4+: $1,800	—
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	No charge	No charge	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	Deductible, then 20%	Deductible, then 20%	Refer to Cigna Dental Care Patient Charge Schedule
Class III - Major Restorative Care Crowns, Bridges, and Implants, Dentures (Full & Partial Upper/Lower)	Deductible, then 50%	Deductible, then 50%	Refer to Cigna Dental Care Patient Charge Schedule
Class IV – Orthodontia			
Employee and All Dependents	50%	50%	Refer to Cigna Dental Care
Lifetime Maximum Benefit	$1,500	$1,500	Patient Charge Schedule

Please refer to your full description of benefits provided by Cigna for complete details.

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	$31.83	$0.00	$31.83	$15.92
Employee + One Child	$52.53	$0.00	$52.53	$26.27
Employee + Spouse	$65.58	$0.00	$65.58	$32.79
Employee + Family	$103.65	$0.00	$103.65	$51.83
Dental Care Access (DHMO)				
Employee Only	$17.94	$0.00	$17.94	$8.97
Employee + One Child	$29.35	$0.00	$29.35	$14.68
Employee + Spouse	$36.56	$0.00	$36.56	$18.28
Employee + Family	$50.05	$0.00	$50.05	$25.03

HEALTH SAVINGS ACCOUNT (HSA) DETAILS

You will be automatically enrolled in a Health Savings Account if you enroll in Plan 1 (the High Deductible Health Plan). The HSA consists of a Federal Deposit Insurance Corporation (FDIC)-insured deposit account, and the option to invest the funds through an investment account once the account balance exceeds $1,000.

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 during the year.

You can use your HSA to pay for current and future qualified medical expenses — tax-free, for not only yourself, but also for your spouse and any dependents claimed on your taxes, regardless of their coverage.

If you choose to also contribute to your HSA, it is a tax-free deduction. You can maximize your tax savings by contributing up to the maximum annual amount allowed by the Internal Revenue Service (IRS).

The 2025 maximum contribution amount allowed (including what the City of Richmond and you contribute) is $4,300 for single coverage and $8,550 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.

Note: Active employees and retirees over age 65 cannot contribute to an HSA during the year, nor will the City make contributions to an HSA account for these individuals.

QUALIFIED MEDICAL EXPENSES

The 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 prostheses
- Dental treatment
- Contact lenses
- Doctor’s fees
- Hearing aids and hearing aid batteries
- Hospital services
- Laboratory fees
- Prescription medicines or drugs
- Nursing home services
- X-rays
- Certain over-the-counter (OTC) drugs

As the HSA owner, you are ultimately responsible for determining whether a healthcare expense is eligible for reimbursement from your HSA. You can refer to IRS Publications 502 and 969 for more information.

Insulin and prescribed drugs will continue to be eligible for payment or reimbursement from an HSA. 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 contracts
- Any health plan maintained while an individual is receiving unemployment compensation under federal or state law
- For account holders 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

REMINDER: You should save all of your medical expense receipts and doctor’s prescriptions, including over-the-counter 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.

FLEXIBLE SPENDING ACCOUNTS (FSA) DETAILS

The City of Richmond offers two flexible spending accounts to employees — a health care account and a dependent care account (to be utilized for childcare services). These accounts allow you to use a portion of your pay, before it is taxed, to pay for or be reimbursed for, certain qualified expenses.

HEALTH CARE EXPENSES

Any employee who does not participate in Healthcare Plan 1 may elect to participate in the Health Care Flexible Spending Account (FSA).

The Health Care Flexible Spending Account may be used for eligible medical 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 Plan 1 (High Deductible with HSA). The Health Care Flexible Spending Account is advantageous when you have predictable healthcare expenses, such as routine prescriptions, copays, or glasses/contacts.

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. You can also visit: https://www.healthequity.com/hsa-qme

Health Care Flexible Spending Account: You may contribute up to $3,200 in the 2024 plan year by electing through Aflac. The amount for 2025 is still being finalized.

DEPENDENT CARE AND THE FEDERAL TAX CREDIT

If you have eligible dependents, you may choose to use the Dependent Care Flexible Spending Account and the Federal Child and Dependent Care Tax Credit when you file your annual tax return. Whatever you contribute to the Dependent Care Flexible Spending Account will reduce the amount of available federal tax credit.

You may be eligible to claim a federal income tax credit of eligible dependent care expenses for one or more qualified dependents. The amount of your tax credit depends on the 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 deductions on a pre-tax basis. This means that contributions to this plan will be deducted from your pay before taxes, and are 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 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 married, your spouse must work, be a full-time student, or be mentally or physically unable to care for him or herself 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

FLEXIBLE SPENDING ACCOUNTS continued

for him or herself. **These children and relatives must be dependents as defined by the Internal Revenue Code.**

Eligible services include:

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

Note: You cannot claim payments for services provided by a dependent or one of your own children under the age of 19.

Dependent Care Spending Account: You can contribute $5,000 for single individuals and married individuals filing jointly, and $2,500 for married individuals filing separately.

GUIDELINES

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

- 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.
- Expenses reimbursed from your Dependent Care Spending Account cannot be claimed under the Federal Tax Credit.
- In order to receive reimbursement from your account, you must incur expenses (i.e., service performed and received) during the plan year.
- 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.

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.

IMPORTANT NOTES REGARDING FLEXIBLE SPENDING ACCOUNTS

- Once you make an election to contribute to an FSA, **you cannot change that election** until the beginning of the following plan year (January 1) unless you have a qualified change in status. Qualifying life events are discussed on page 9 of this booklet. The change must be consistent with the type of life event that has occurred.
- You may use your Health Equity Flexible Spending Debit Card at the point of service, or you can submit a reimbursement form.

"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 $640 for 2024. Any unused amount above the rollover maximum will be forfeited.**

Scan here to watch a short flimp video about HSA vs FSA

FLEXIBLE SPENDING ACCOUNTS continued

HOW DO FLEXIBLE SPENDING ACCOUNTS WORK?

An employee earns $2,500 per month and contributes the following amounts to their Flexible Spending Accounts for anticipated expenses in 2025:

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

Total contributions to the Flexible Spending Accounts: $360.00 per month

	Without FSA	With FSA
Gross Monthly Income	$2,500.00	$2,500.00
Eligible Pre-Tax Health Care FSA Deduction	$0.00	$60.00
Eligible Pre-Tax Dependent Child Care FSA Deduction	$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!

Improve Your Quality of Life.

EXPLORE

Assistance Managing Your Health and Healthcare

Cigna, in partnership with the City of Richmond, has many programs and resources available to help you and your dependents manage their healthcare. See below for details.

Cigna One Guide – Concierge service to help with everything Cigna

Your One Guide representative will help guide you through the complexities and unclear jargon of the health care system, and help you avoid costly missteps. Cigna's One Guide service provides personalized assistance to help you:

Resolve health care issues, find the right hospitals and other health care providers in your plan's network, get cost estimates, understand your bills and more!

To reach a One Guide representative call:
1-800-Cigna24 Or 1-800-244-6224.

Access the Cigna One Guide support tool by downloading the myCigna App.

Personal Health Team – Health Coaching, Treatment Decision Support

LIVE personalized support for you and your family to help you manage your health and remove barriers to care. Your health advocate will help you understand your condition, discuss treatment options, remind you to refill your prescription, visit your doctor, or follow-up on other forms of care. They're there to help you learn how to develop healthier habits for a healthier you.

Call 1-800-Cigna24 or 1-800-244-6224 or download the myCigna App.

Cigna Pharmacy - Home Delivery - Quickswitch® - Cigna 90 Now

Cigna Home Delivery Pharmacy is designed for individuals who take prescription medications on a regular basis, such as those used for diabetes or high blood pressure to name a few.

- Fast, convenient delivery of your prescription medications to a location of your choice
- Free refill reminder service will call, text, or email you when it's time to refill prescriptions
- Cigna pharmacists are available 24/7 to answer your medication questions

Quickswitch® makes filling a prescription simple. We will request a prescription from your doctor and once we receive it, we will fill your medication and mail it to your home or other location of your choice.

Cigna 90 Now is a pharmacy program designed to allow customers to fill 90-day supplies of medication at any in-network pharmacies contracted to fill for 90-day supplies.

With Quickswitch you may have a Cigna representative change your 30-day scripts to a 90-day prescription by contacting your doctor for you.

Call 1-800-285-4812 to Quickswitch your prescriptions to home delivery.

Virtual Care – MDLIVE

Cigna offers virtual doctor's visits through MDLIVE - to help you get the care you need –including most prescriptions - for a wide range of minor conditions. You can connect with a board-certified doctor via video chat or phone, without leaving your home or office. Telehealth visits are covered under the medical plan and billed at the same rate or less than a regular office visit.

- Visits are available in the areas of Dermatology, Primary Care, Wellness, and Behavioral Care.

Create an account on MDLIVEforCigna.com. You can also download the Apps on your mobile device.

Call MDLIVE at 1-888-726-3171.

Estimate your Costs Tool - Medical or Pharmacy costs

Did you know that the costs of medical procedures or prescriptions can vary among facilities? Using the Estimate your Cost tool, you can see what your projected cost would be for an upcoming medical procedure as well as compare pricing among in network facilities nearby. Cost estimates are based on your coverage and deductible status and clearly indicate which doctors are in-network to help you make the most of your plan. Medication cost estimates are also available on this tab.

Available on myCigna.com & the mobile App.

Your Health First – Cigna Chronic Condition Support

Your Health First coaches are specially trained to help and provide support for individuals who have a chronic health condition such as asthma, low back pain, depression, diabetes, coronary artery disease and more. If you have a chronic condition, they can help you:

- Make more educated decisions about your health and treatment options
- Create a plan to help improve your health & identify the triggers that affect your condition
- Understand medications and doctor's orders
- Know what to expect if you need to stay in the hospital

Call 1-855-246-1873 to speak with a coach.

MyCigna.com & MyCigna Mobile App

MyCigna.com and the myCigna Mobile App provide a variety of tools to make managing your health and your health finances easier!

You can access ID cards for your entire family; locate a nearby medical facility, find doctors, and compare quality-of-care ratings; get medical procedure cost estimates for nearby in-network facilities; compare drug costs among local pharmacies; view health claims and manage account and deductible balances.

Go to: myCigna.com, to register and create a User ID & Password.

Download the myCigna App from the Apple or Google App stores

24/7 Nurse Line & Health Information

Not sure if you need to go to the doctor? Have a health concern and need some advice? The 24/7 Nurse Line provides toll-free access to specially trained staff any time of day or night to answer health questions and give guidance with health concerns.

Call: 1-800-564-9286 or 1-800-244-6224.

Behavioral Health

Coaching and support services with access to behavioral experts with extensive experience. Find a health care professional in the network geared to your needs. Behavioral health challenges can be diverse and complex. Cigna has a broad menu of virtual provider options.

To learn more, visit myCigna.com, Wellness Tab, Mental Health Support. Or call the toll-free number on you ID card.

To access more information scan QR code.

Improve Your Quality of Life.

EXPLORE

Wellness Resources & Support Programs

Whether you need help reducing stress, are feeling motivated to make a change in your life, or need to talk to someone, Cigna and the City of Richmond offers a variety of tools to help support you and your dependents in your total wellness.

Self-paced Lifestyle Management Programs -Weight, Stress & Tobacco

Cigna has partnered with WebMD to provide resources related to improving your overall wellbeing! Whether you want to utilize a tracker to manage your stress level, or learn how to reduce or quit tobacco, these programs could help! Each program is easy to use and available where and when you need it. Want some additional support? Pair a Lifestyle Management Program with the support of health coaching (described below).

Visit myCigna.com, and under Wellness, click on Health Assistant.

Digital Health Coaching from My Health Assistant

My Health Assistant, in partnership with WebMD, offers online coaching programs for better health and wellness. Some options include Lose Weight; Eat Better; Enjoy Exercise: Feel Happier; Conquer Stress; Quit Tobacco; Manage Diabetes; Manage Heart Disease; Manage Asthma; Manage COPD; and more.

Visit myCigna.com, and under Wellness, click on Health Assistant.

Healthy Rewards Incentive Program–Cigna Member Discounts

Cigna offers discount programs through its Healthy Rewards Program for wellness products, fitness clubs such as Planet Fitness, Crunch and Gold's Gym, Lasik Vision Correction, hearing exams and aids, massage, acupuncture and more.

To learn more visit my.cigna.com/wellness/healthyrewards, or call 1-800-870-3470. Don't forget to print and present your Healthy Rewards Discount Card to participating providers.

MotivateMe – Incentives & Rewards Program

MotivateMe allows members to earn rewards for participating in health improvement activities – such as an annual physical, completing a health assessment and/or participating in health coaching. Employees who participate earn rewards!

Go to my Cigna.com and view the 'Incentive Spotlight'under Wellness.

Healthy Pregnancies/Health Babies

The Cigna maternity management program called Healthy Pregnancies/Healthy Babies is designed to support members throughout pregnancy. Nurses are available over the phone 24/7 to help with everything from morning sickness to maternity benefits. You are also eligible for rewards for participating in the program.

Call to enroll: 1-800-615-2906. MotivateMe Rewards: $150 gift card if you enroll first trimester; $75 gift card if you enroll second trimester. Must complete your postpartum check in to redeem.

Employee Assistance Program (EAP)

EAP personal advocates will work with you and your household members on issues you may be facing, connect you with the right mental health professionals, direct you to a variety of helpful resources in your community and more. A wide range of services are offered, including face-to-face counseling sessions, legal assistance, referrals, and financial consultation. The EAP provides resources for parenting, eldercare, pet care, and more.

Call: 1-877-622-4327
Visit myCigna.com.
ID: COR

Personal Health Assessment Tool

The Cigna Health Assessment is an online health risk assessment tool that helps you analyze your health status. It takes 15-20 minutes to complete and provides you with a personalized action plan with resources for improving your health.

Find it on myCigna.com, under Wellness.

Diabetes Prevention Program with Omada

Omada is a personalized program that helps members with pre-diabetes lose weight and create healthier habits through one-on-one personal coaching and the tools needed to make long-lasting health changes.

Check to see if you are eligible and join today for $0.
omadahealth.com/richmondgov

Findhelp.org Social Needs Support

Cigna has provided access to a website that can locate community programs, services, and resources available in the Richmond area, like free or low-cost housing, access to food, education, transportation and more. Visit the link on the right to learn more.

Visit cignacommunity.findhelp.com and enter a zip code.

Autism Specialty Care Program

Members with a child diagnosed with an Autism Spectrum Disorder can gain access to a dedicated team of licensed mental health professionals with extensive expertise. The Cigna Autism Specialty Care Program can help members understand an ASD diagnosis, explain treatment choices under the benefits plan, help coordinate care, and much more.

You can sign up for the series at Cigna.com/autism.
Or call 800.274.7603 and at the prompt, choose "Behavioral Health," and ask for a Autism Case Manager.

Emotional Wellbeing Apps

iPrevail is an on-demand coaching and personalized learning program offered through Cigna. Learn how to boost your mood and improve mental health with on-demand coaching, 24/7.

Happify is a free science-based resilience app offered through Cigna. Happify's activities and games are designed to help you overcome life's challenges, and can be accessed at any time.

To learn more, visit myCigna.com then click on the Wellness Tab and Mental Health Support. Or call the toll-free number on your ID card, or visit: iPrevail.com/cigna and happify.com/cigna.

The Changing Lives By Integrated Mind and Body (CLIMB) program

The CLIMB program has free podcasts to incorporate mindfulness into your daily life, including:

- Basic Guided Mindfulness Meditation
- Meditation and Body Scan
- Working with Difficulties and Cultivating the Positive
- Managing Stress
- Compassion and Self-Care

To learn more, visit myCigna.com or cigna.com/CLIMB.

To access more information scan QR code.

RICHMOND RETIREMENT SYSTEM DEFINED BENEFIT EARLY RETIREE HEALTHCARE PROGRAM

City of Richmond employees who apply to retire as active members in the Richmond Retirement System Defined Benefit Plan, or the Enhanced Defined Benefit Plan, are eligible for health insurance benefits at retirement.

The following conditions apply for calendar year 2025:

- The employee must be at least age 55 (but not over age 65) and must have worked for the City of Richmond for at least 10 years with the last 5 years consecutive.
- Coverage must be elected with the City within 30 days of the departure of employment. The decision to reject coverage or to drop coverage at a later date is a final, permanent decision.
- Enrolling dependents in coverage with the City is permitted if the dependents have no access to healthcare through their own employer. Dependents must be enrolled at the time of the employee's departure of employment. The decision to reject dependent coverage or to drop coverage at a later date is a final, permanent decision.
- Choices include Plan 1 High Deductible Plan or Plan 2 (no Plan 3 option).

Contribution from the City toward the premium is based on years of service. In 2025, the City's contribution toward coverage in the City's health insurance benefits is as follows:

- For 10-14 years of service - $100 per month
- For 15-19 years of service - $200 per month
- For 20-24 years of service - $300 per month
- For 25 years of service or more - $400 per month

Note: Those who participate in the biometric screening healthcare incentive will receive an additional credit of $25 per month in City contributions.

For additional terms and conditions, contact Human Resources or the Richmond Retirement Department.

If you (or your family members and friends) do not have health insurance through a job, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or another source that provides qualifying health coverage, the federal government's Marketplace can help. What you pay for this coverage depends on income and other factors.

For more information see page 47 in the Benefits Guide, or go to the Marketplace at HealthCare.gov.

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.
- Employee deductions of 0.71% of salary are taken from your pay on an after- tax basis on 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 Securian.

OPTIONAL GROUP TERM LIFE INSURANCE

The optional Group Life Insurance Plan is administered by VRS and underwritten by Securian. If you have Basic Life Insurance coverage with the City of Richmond, you may purchase additional coverage for yourself, spouse, and your eligible children. Eligible children are under the age of 21 or age 21-25 (verified full-time student).

You may apply for Optional Group Term Life Insurance through the Virginia Retirement System Portal, regardless of retirement plan, at any time, not just during open enrollment or a qualified life event. The VRS system can be visited at https://myvrs.varetire.org/login/. All applications must go through Securian or the myVRS portal. Once approved, Human Resources will be alerted by our partners.

You may select from eight options that provide one to eight times your salary up to $975,000. In addition, please find the coverage rate options for spouse and children.

OPTIONAL GROUP TERM LIFE INSURANCE LEVELS

Option	Employee	Spouse	Child(ren)
1	1 x salary	0.5 x salary	$10,000
2	2 x salary	1.0 x salary	$10,000
3	3 x salary	1.5 x salary	$20,000
4	4 x salary	2.0 x salary	$30,000
5	5 x salary	2.0 x salary	$30,000
6	6 x salary	2.0 x salary	$30,000
7	7 x salary	2.0 x salary	$30,000
8	8 x salary	2.0 x salary	$30,000

If you die while covered by this plan, the benefit is paid to the beneficiary you have designated. You are the beneficiary for the Optional Group Life Insurance on your spouse and children.

Beneficiary designations must be updated through the myVRS portal.

LIFE INSURANCE continued

OPTIONAL GROUP TERM LIFE INSURANCE RATES

Monthly Cost for 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	$0.12
50-54	$0.20
55-59	$0.31
60-64	$0.54
65-69	$1.02
70 and over	$2.06

Monthly Cost for Child(ren)	
One rate covers all eligible children	
Option 1 & 2	$0.80
Option 3	$1.60
Option 4 - 8	$2.40

Here's how to calculate your monthly premium based on your annual salary.

Example: Salary of $54,500 is rounded up to $55,000. In this example, $55,000 is used for calculation purposes.

Coverage amount $ _____

Divided by 1,000 $ _____

Times your rate $ _____

= Monthly Premium $ _____

** Please note, this calculation is an estimate. Final rates are determined by Securian.

GUIDELINES

- If the option you elected, whether a new hire or current employee, will provide insurance of $400,000 or higher, you must complete an Evidence of Insurability form (EOI).
- Your spouse must also complete an EOI form if you elected options 2 through 8.
- Optional amounts of insurance in excess of $975,000 for an employee and $487,500 for a spouse are not provided.
- If you and your spouse are insured as employees under the Basic VRS Group Life Insurance Plan neither of you is eligible for coverage as a spouse.
- If you do not apply when you are first eligible to do so, or within 31 days immediately thereafter, you must complete an EOI for yourself and eligible dependents you subsequently elect to insure. Evidence of insurability will also be required if you wish to increase your level of insurance.
- Securian will determine whether to provide the requested optional life insurance for you and your family. All changes and coverage decisions for Optional Life Insurance are determined by Securian.

DISABILITY INSURANCE

The City is excited to announce that an employer sponsored short-term disability plan and a long-term disability plan will be added in 2025 for eligible full-time permanent employees. Options to purchase additional long-term disability coverage will also become available. At the time of printing this booklet the City is finalizing the details. Look for more information on these plans to be provided separately from this guide. Once added, employees enrolled in AFLAC's short-term disability insurance will receive information on how to work directly with AFLAC, as payroll withholdings will no longer be available.

LEAVE BENEFITS

The City of Richmond offers a comprehensive leave policy, including vacation leave, sick leave, mental health days, military leave, civil leave, bereavement leave, education leave, and others. To see the full leave policy - Administrative Regulation 4.8 - click here or scan the QR code below.

VACATION LEAVE

Active full-time and part-time benefits-eligible employees in permanent positions are eligible for vacation time which is accrued in accordance with the City's bi-weekly pay schedule 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. Additional vacation leave details can be found in the Leave Policy.

VACATION (PERMANENT CLASSIFIED FULL-TIME EMPLOYEES)*

Years of Service	Bi-Weekly Rate	Max. 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

* Shift Fire personnel earn vacation leave at different rates.

SICK LEAVE

Full-time and part-time benefits-eligible 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, with carryover maximums if hired after July 1, 2024.

Part-time employees receive pro-rated sick leave based on the number of hours worked. Sick leave may be used for personal illness, bodily injury or disease, medical appointments, care for immediate family illness, and Family Medical Leave (allowed under FMLA). Additional sick leave details, including for shift employees, can be found in the Leave Policy.

HOLIDAYS

At minimum, the City of Richmond designates and observes the eleven (11) federal holidays. Additional holidays are at the discretion of the Mayor and Chief Administrative Officer, and are updated annually. All holidays, inclusive of the additional City holidays, can be found on StarNet. Additional details can be found in the holiday policy - Administrative Regulation 5.2.

Holidays	
New Year's Day	Independence Day
Martin Luther King, Jr. Day	Labor Day
President's Day	Indigenous Peoples' Day
International Women's Day	Election Day
Spring Holiday	Veteran's Day
Memorial Day	Thanksgiving Holiday (Wed. - Fri.)
Juneteenth Holiday	Winter Holiday (Dec. 24 - 25)

MENTAL HEALTH/WELLNESS DAYS

Employees are allotted 16 hours of mental health/wellness time per calendar year. Mental health/wellness days may be observed on any regularly scheduled workday mutually agreed upon by the employee and appointing authority/department head during that calendar year. Except for shift Fire Personnel (see policy for details), mental health/wellness days must be taken in eight (8) hour increments, subject to supervisor approval. Mental health/wellness days do not carry forward, shall not be paid out upon separation, and do not count toward calculation of creditable service for retirement. Any unused mental health days will expire at the end of each calendar year.

PAID PARENTAL LEAVE

City of Richmond provides up to eight (8) workweeks of paid leave for the care of and bonding with a new child, and up to four (4) workweeks of paid leave for the care of a parent with a serious health condition. Paid Parental Leave (PPL) is provided to City employees who meet the eligibility for leave under the Family and Medical Leave Act (FMLA) and works in conjunction with the City of Richmond's Family and Medical Leave Act Policy. Additional Paid Parental Leave details can be found in the policy.

LEAVE BENEFITS continued

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family Medical Leave Act provides up to 12 weeks 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 one 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 one year of adoption/placement
- the military family leave categories of qualifying exigency leave or military caregiver leave.

Family Medical Leave may be paid or unpaid depending on 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. Additional details can be found in the Family Medical Leave Act policy.

BEREAVEMENT 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. Immediate family is defined as parent, a person standing in loco parentis to the employee, spouse, child, sibling, 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. Any employee who has had a death in their non-immediate family or of a friend shall be granted, upon request, bereavement leave for a maximum of eight (8) consecutive hours, to attend a burial service (or equivalent).

MILITARY LEAVE

The city administers its military leave policy in accordance with applicable law, including the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) and the Code of Virginia. See the Military Leave policy for more details.

YOUR RETIREMENT

Preparing for retirement is one of the most important activities you can undertake. All full-time permanent employees with the City of Richmond are eligible for a retirement plan.

In January 2024, the City of Richmond transitioned to the Virginia Retirement System. As part of this transition, those employed as of December 31, 2023, have one year to decide if they want to stay in the Richmond Retirement System (RRS) or transition to the Virginia Retirement System (VRS).

At the time of printing, the window for employees hired prior to January 1, 2024, to transition to VRS is still open and employees have until December 31, 2024, to complete the transition form and join the VRS plan. Please visit https://rva.gov/retirement-transition to learn more and download the transition form.

The City's partnership with VRS allows you to take advantage of the statewide benefits, including a pension component (Defined Benefit) and cost of living adjustments in all plans.

Some Key Retirement Items to Note:

- Full-time permanent employees hired after January 1st, 2024, are automatically enrolled in VRS.
- Employees hired prior to January 1, 2024, were enrolled in either the RRS Defined Benefit (DB) plan or Defined Contribution (DC) plan. During the transition period, these employees have one year to transition to VRS or may stay in their RRS DB or DC plan. (Most employees hired prior to July 1, 2006, were enrolled in the RRS DB plan, while those hired or rehired from July 1, 2006, through December 31, 2023, were enrolled in the RRS DC plan. If you are unsure which is your retirement plan, please contact the Richmond Retirement System.)
- All employees – whether in RRS or VRS automatically contribute 5% of their pre-tax base pay to their retirement account; the City of Richmond also contributes to both retirement plans for employees.
- Employees can view their anticipated Defined Benefit retirement amounts (which includes the City's contribution) with VRS by visiting https://www.varetire.org/calculators/. For RRS, please call 804-646-5958.
- Employees in the VRS Hybrid Plan can voluntarily contribute up to an additional 4% of their pre-tax base bi-weekly pay to a VRS 457 plan (with Voya Financial as of January 2025) and receive an additional tiered matching contribution from the City (up to 2.5%).
- VRS and RRS both require five years of service to be fully vested, meaning an employee can keep all of the funds contributed by the City of Richmond. However, VRS has tiered vesting for some plan components which allows some funds contributed by the City to be kept before five years.
  To learn more visit: https://www.varetirement.org/hybrid/plan-info/plan-provisions.html
- Regardless of retirement plan, all employees may opt to save even more toward their retirement by opening a City of Richmond ROTH IRA and/or 457 plan through Mission Square.
  - The 2024 IRS limit to 457 contributions is $23,000 (up to an additional $7,500 if you are 50+). It is your responsibility to ensure your contributions, inclusive of both 457 accounts, does not exceed this annual maximum.

YOUR RETIREMENT continued

UNDERSTANDING VIRGINIA RETIREMENT SYSTEM

VRS enrolls employees in one of three accounts - Plan 1, Plan 2, and Hybrid. Most employees will be eligible for and automatically enrolled in the Hybrid plan, although that will vary. If you are a sworn police officer or firefighter you are eligible for a hazardous duty plan. VRS determines which plan you will be enrolled in based on factors such as:

- Did you work for a VRS participating employer previously, and were you vested (contributing to a VRS plan for 5 or more years)?
  - If you worked for a participating VRS employer for 5 years or more and are deemed vested, you should return to the same VRS plan. Some exceptions may include non-sworn vs. sworn employment.
- Did you take a refund upon separation from a previous VRS employer?
  - If you requested a refund, you may be eligible to buy back the years of service and receive credit for time previously worked, however you will not necessarily return to that plan. Check with VRS once you have received your welcome letter.

JOINING VIRGINIA RETIREMENT SYSTEM

Once employed by the City of Richmond, or after submitting your retirement transition form, employees will be registered with VRS and Mission Square (Voya Financial as of January 2025). You will receive in the regular mail a welcome letter with information on how to log on to your account once your enrollment has been processed by Human Resources. Please note that you must log into your account within 45 days, or you will be locked out. In addition, please ensure Human Resources has your correct address on file to ensure you receive this important information from VRS.

VRS contributions are deducted from each paycheck. Employees who transition from the City of Richmond prior to retirement should contact the Human Resources Benefits and Wellness Division at 804-646-4700 and the Virginia Retirement System to discuss options related to closing their City of Richmond VRS account.

For more information on the Virginia Retirement System visit https://www.varetire.org/ or call 888-827-3847.

For more information on Mission Square, or to contact them visit https://www.missionsq.org/ or call 800-669-7400.

To learn more about the Virginia Retirement System's transition to Voya Financial, visit https://www.varetire.org/retirement-plans/defined-contribution-plans/dcp-transition/.

UNDERSTANDING RICHMOND RETIREMENT SYSTEM - ONLY ELIGIBLE EMPLOYEES HIRED BEFORE JANUARY 1, 2024

Some employees hired before January 1, 2024, may be in the Richmond Retirement System. The Richmond Retirement System provides a Defined Benefit (DB) Plan for employees in qualifying positions, and a Defined Contribution (DC) Plan for some employees who elected to remain in RRS.

Defined Benefit Plan

Employees hired before July 1, 2006, and sworn or executive employees hired from July 1, 2006 – December 31, 2023, had the option to be in the Defined Benefit Plan. Employees contribute a minimum of 5% of their salary to this plan as of January 1, 2024, and the City also contributes. Contributions are slightly different for those in the sworn / enhanced plans.

YOUR RETIREMENT continued

RICHMOND RETIREMENT SYSTEM 2024 CONTRIBUTION RATE FOR DB PLAN MEMBERS

	Employee Rate (Base + Additional)
General Employee DB Basic	5%
General Employee DB Enhanced	5% + 3.57%
Sworn Employee DB Basic	5%
Sworn Employee DB Enhanced	5% + 3.95%

Defined Contribution Plan

Each eligible participant in the Defined Contribution Plan has an account to which the City of Richmond makes bi-weekly contributions on your behalf based on your years of service and salary. Below is the 2024 schedule:

	Employee Rate	Employer Rate
> 10 Years (6% total)	5%	1%
> 10-15 Years (8% total)	5%	3%
15+ Years (10% total)	5%	5%

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. Any contribution percentage changes for 2025 will be disseminated and posted on StarNet.

Vesting

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

Your DC 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% vested. Your account also becomes 100% vested if you are approved for disability retirement, reach normal retirement age, or die while actively employed.

OTHER RETIREMENT PLAN OPTIONS FOR ALL EMPLOYEES

RRS 457 PLAN

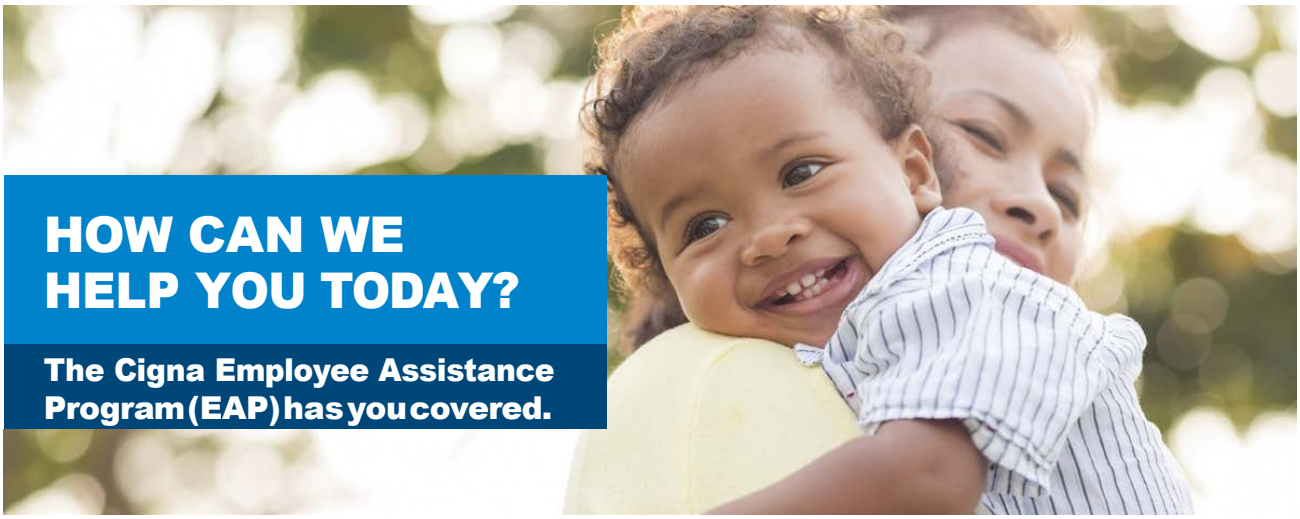
All permanent employees who work 20 or more hours per week may elect to make contributions to their retirement through a 457 Deferred Compensation Plan. VRS participants may contribute to the City's 457 plan in addition to the Hybrid 457 plan.

ROTH IRA

Employees also have the option to elect into a Roth IRA through Mission Square. For additional information contact Mission Square at 800-669-7400.

More information? For more information about any of the RRS plans, please call 804-646-5958. For more information on VRS, visit www.varetire.org or call 888-827-3847.

EMPLOYEE ASSISTANCE PROGRAM



As an employee you have access to the valuable Cigna Employee Assistance Program (EAP) at no cost to you.

EAP personal advocates will work with you and your household family members to help you resolve issues you may be facing, connect you with the right mental health professionals, direct you to a variety of helpful resources in your community and more.

Take advantage of a wide range of services offered at no cost to you

- ***6*** face-to-face counseling sessions with a counselor in your area, as well as video-based sessions.
- **Legal assistance:** 30-minute consultation with an attorney, face-to-face or by phone.*
- **Financial:** 30-minute telephone consultation with a qualified specialist on topics such as debt counseling or planning for retirement.
- **Parenting:** Resources and referrals for childcare providers, before and after school programs, camps, adoption organizations, child development, prenatal care and more.
- **Eldercare:** Resources and referrals for home health agencies, assisted living facilities, social and recreational programs and long-distance caregiving.
- **Pet care:** Resources and referrals for pet sitting, obedience training, veterinarians and pet stores.
- **Identity theft:** 60-minute consultation with a fraud resolution specialist.

We're here to listen. Contact us any day, anytime.

Call 1.877.622.4327
myCigna.com.
Employer ID: COR

Initially Register or log in to myCigna.com to access EAP under "Review My Coverage".

Together, all the way.®

Cigna®

*Employment-related legal issues are not covered.

Some work/life services offered under the Cigna Employee Assistance Program may be provided by a Cigna contracted third-party vendor.

VOLUNTARY BENEFITS

BENEFITS PROVIDED THROUGH AFLAC

The City of Richmond partners with Aflac to administer several voluntary insurance plans. These benefits are available to all full-time and part-time employees in permanent positions, working 20 or more hours per week (except Term Life Insurance).

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 deductions.

Plans that are available to you and your family include:

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

**Available to full-time employees only.*

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 through Aflac, or upgrade to current coverage offered at the new rate.

Below please find summaries of the offerings. Visit https://www.aflacenrollment.com/CityofRichmond/T32414316858 to learn more.

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
2-Parent Family	$30.23

HOSPITAL CHOICE

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 Choice Bi-Weekly Rates (1500)– Guaranteed Issue			
Age	**18-49**	**50-59**	**60-75**
Individual	$18.01	$18.20	$19.11
Individual and Spouse	$26.26	$27.76	$30.16
1-Parent Family	$22.36	$22.62	$22.88
2-Parent Family	$26.52	$28.02	$30.42

PERSONAL CANCER INDEMNITY

This plan provides cash benefits directly to you 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

VOLUNTARY BENEFITS continued

BENEFITS PROVIDED THROUGH AFLAC

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 includes: coma, paralysis, end-stage renal disease, persistent vegetative state, stroke, heart attack, major third-degree burn, coronary artery bypass surgery, major human organ transplant, and sudden cardiac arrest.

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

TERM LIFE INSURANCE

Available to full-time employees, this plan allows you to purchase term life insurance coverage to assist your family in paying the bills if something happens to you. This plan is separate from the life insurance provided through the City of Richmond. Please note with this plan you will be required to complete a medical questionnaire.

Face Amounts:

- If you're age 50 or under, you may apply for up to 500,000 in coverage.
- If you're between the ages of 51 – 68, you may be eligible for up to $200,000 in life insurance protection.

Issue Ages	Employee	Spouse
18 - 68	10-year term life plan	10-year term life rider
18 - 60	20-year term life plan	20-year term life rider
18 - 50	30-year term life plan	30-year term life rider

TERM LIFE INSURANCE COST EXAMPLES

Coverage	Age	Gender	Bi-Weekly Rate
$50,000	35	Female	Non-Tobacco = $5.65
$50,000	40	Male	Non-Tobacco = $7.90
$75,000	45	Male	Non-Tobacco = $15.73
$100,000	35	Female	Non-Tobacco = $9.30

SHORT-TERM DISABILITY

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

You may choose an option below, but not above, your current salary.

Coverage options are as follows:

- Monthly Benefit: $700-$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

Annual Salary	Monthly Benefit	Ages 18-49	Ages 50-64	Ages 65-74
$12,000 (min.)	$700	$8.19	$11.38	$14.11
$22,000	$1,100	$12.87	$17.88	$22.17
$32,000	$1,600	$18.72	$26.00	$32.24
$42,000	$2,100	$24.57	$34.13	$42.32
$52,000	$2,600	$30.42	$42.25	$52.39
$61,000	$3,100	$36.27	$50.38	$62.47
$73,000	$3,400	$39.78	$55.25	$68.51
$82,000	$3,600	$42.12	$58.50	$72.54
$102,000	$4,000	$46.80	$65.00	$80.60
$153,000	$5,100	$59.67	$82.88	$102.77
$180,000 (max.)	$6,000	$70.20	$97.50	$120.90

LEGAL RESOURCES

LEGAL RESOURCES®
Relax... you're covered.®

PROTECT YOURSELF AND YOUR FAMILY FOR ONLY $8.00 A PAY PERIOD!

Don't let this opportunity get away!

FULLY COVERED SERVICES

LEGAL RESOURCES COVERS 100% OF THE ATTORNEY FEES FOR FULLY COVERED LEGAL SERVICES [1]

General Advice and Consultation
- Unlimited in-person or telephone advice and consultation for fully covered services

Family Law
- Uncontested domestic adoption
- Uncontested divorce
- Uncontested name change

Elder Law
- Estate advice
- Powers of attorney for members' parents

Criminal Matters[2]
- Defense of misdemeanor
- Misdemeanor defense of juveniles

Fully covered for fir t offense involving alcohol or illegal drugs

Wills and Estate Planning
- Will preparation and periodic updates
- Advance medical directive
- Financial powers of attorney
- Contingent trust for minor children

Traffic Violations
- Traffic inf actions and misdemeanors
- Speeding
- Reckless driving
- Driving under the influence

1st Offense

Civil Actions
- Representation as defendant
- Representation as plaintiff
- Insurance matters
- Initial administrative hearing
- Small Claims Court advice

Preparation and Review of Routine Legal Documents
- Unlimited pages and occurrences

Real Estate
- Purchase, sale, or refinan e of primary residence
- Deed preparation
- Tenant-Landlord matters
- Landlord-Tenant consultation

Consumer Relations and Credit Protection
- Warranty disputes
- Billing disputes
- Collection agency harassment

Identity Theft
- Prevention assistance
- Education services
- Identity recovery assistance

SCAN QR CODE TO ACCESS THE ENROLLMENT PORTAL

Or visit *Legalresources/enroll-now.com*

Company code: 345 **OE Enrollment code: corlegal**

YOUR LEGAL NEEDS WILL BE COVERED!

Don't see your legal need listed?

The Legal Resources Plan covers pre-existing legal matters as well as ANY less commonly needed legal service at a **25% discount.**[3]

This **SUMMARY OF COVERAGE** is intended to provide a broad general overview of plan coverage and is not a contract. Coverage may vary by organization. For specific overage questions, please call Member Services at 800.728.5768. Member is responsible for all non-attorney costs such as filing fees, court costs, fines, etc.

1 Member is responsible for all non-attorney costs such as filing fees, fines, court costs, etc. The Plan covers the individual, spouse, and qualifying dependents. 12 month commitment required. Courtroom representation, when necessary, is fully covered through General District Court. The definition of General District Court may vary by state.

2 Offenses involving illegal drugs, alcohol (except 1st offense DUI), and firearms are covered at a 25% discount.

3 Since your employer is the participating sponsor, you may not use the Plan in a dispute with your employer.

4 Parent Benefit Available. Parents of the Primary member and their spouse may be eligible for 25% discount. Please contact Member Services for details.

Please visit LegalResources.com for more information or call Member Services at 800.728.5768.

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: Benefits and Wellness Division at 804-646-4700.

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.

GENERAL NOTICE OF COBRA continued

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

Benefits and Wellness Division
900 East Broad Street, Room 902
Richmond, Virginia 23219
HRBenefits@rva.gov
804-646-4700

IMPORTANT LEGAL NOTICES

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. You may be entitled to additional benefits as mandated by state law.

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact HR Benefits and Wellness Division.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

HR Benefits and Wellness
HRBenefits@rva.gov
804-646-4700

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

IMPORTANT LEGAL NOTICES continued

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission: Marketing purposes, Sale of your information.

IMPORTANT LEGAL NOTICES continued

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor or contracted care manager, Marathon Health, for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

OTHER INSTRUCTIONS FOR NOTICE

- January 1, 2025
- HR Benefits and Wellness Division, HRBenefits@rva.gov, 804-646-4700

IMPORTANT LEGAL NOTICES continued

NOTICE REGARDING WELLNESS PROGRAMS

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 activities 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 Benefits and Wellness Division at 804-646-4700.

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 Benefits and Wellness Division at 804-646-4700.

IMPORTANT LEGAL NOTICES continued

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

IMPORTANT NOTICE FROM CITY OF RICHMOND ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with 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 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your 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 will 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 Benefits and Wellness Division at 804-646-4700 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. 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).

IMPORTANT LEGAL NOTICES continued

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

Date:	January 1, 2025
Name of Entity/Sender:	City of Richmond Human Resources
Contact--Position/Office:	HR Benefits and Wellness Division
Address:	900 East Broad Street, Room 902, Richmond, Virginia 23219
Phone Number:	804-646-4700 (office)

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

IMPORTANT LEGAL NOTICES continued

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

IMPORTANT LEGAL NOTICES continued

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa

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

Paperwork Reduction Act Statement- According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137. OMB Control Number 1210-0137 (expires 1/31/2026)

IMPORTANT LEGAL NOTICES continued

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

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 employer 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.

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.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

IMPORTANT LEGAL NOTICES continued

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 804-646-7000	
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) 804-646-4700	12. Email address HRBenefits@rva.gov	

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.

* 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.

GLOSSARY continued

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.

Specialty Drugs
Specialty drugs or specialty pharmaceuticals are a type of pharmaceuticals that are classified as high- cost, high-complexity and/or high-touch. Specialty drugs may also include biologics that are injected or infused. This class of drug is not typically available from a retail pharmacy.

Spouse
A person who is legally married to an employee under the laws of the state in which the employee resides.

CONTACT INFORMATION

CIGNA
www.mycigna.com
1-800-244-6224

CIGNA - EMPLOYEE ASSISTANCE PROGRAM
www.mycigna.com, Employer ID: COR
1-877-622-4327

AFLAC
https://www.aflacenrollment.com/CityofRichmond/T32414316858
1-800-992-3522

HEALTH EQUITY / WAGEWORKS
www.FSAWorks4Me.com/takecare
www.healthequity.com/wageworks

LEGAL RESOURCES
www.LegalResources.com
1-800-728-5768

SECURIAN
1-800-441-2258

MARATHON HEALTH
my.marathon-health.com
1-888-830-6538

MISSION SQUARE RETIREMENT
www.icmarc.org
1-800-669-7400

RICHMOND RETIREMENT SYSTEM
https://www.rva.gov/retirement-system/home
1-804-646-5958

VIRGINIA RETIREMENT SYSTEM
www.varetire.org
1-888-827-3847

RICHMOND BENEFITS HOTLINE
Email: HRBenefits@rva.gov
RVA.gov Website:
https://www.rva.gov/human-resources/employee-benefits-0
StarNet Website:
http://starnet/index.php?q=humanresources/1780
1-804-646-4700

CITY OF RICHMOND - HUMAN RESOURCES
https://www.rva.gov/human-resources
1-800-646-5660

900 East Broad Street

Room 902

Richmond, Virginia 23219

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.