employee benefits

2022 Plan Year

Your wellness is our focus...

Chesapeake VIRGINIA

Chesapeake VIRGINIA

Questions, Problems or Concerns

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

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

Important Contact Information

Carrier	Group #	Web / Email	Phone
Medical - Optima Plus HDHP Optima HMO Optima POS Optima PPO	 3164 60748 60772 72745	www.optimahealth.com	1-800-741-4825
Prescription Express Scripts		www.express-scripts.com	1-800-282-2881
Health Savings Account WageWorks		www.wageworks.com	1-877-924-3967
Flexible Spending Accounts WageWorks		www.wageworks.com	1-877-924-3967
Dental Anthem	DD7058	www.anthem.com	1-888-650-4047
Voluntary/Optional Vision Davis Vision	505715	www.davisvision.com	1-800-999-5431
Voluntary/Optional Life Insurance Virginia Retirement System		www.varetire.com	1-800-999-5431
Legal Resources Legal Resources		www.legalresources.com	1-800-728-5768
Voluntary Long Term Care Genworth		www.genworth.com	1-866-859-6060
The City of Chesapeake Human Resources		www.cityofchesapeake.net hrbenefits@cityofchesapeake.net	1-757-382-8956
The City of Chesapeake's Benefits Helpline For basic benefit questions		cityofchesapeake@assuredpartners.com	1-888-520-0255, Option 1

Welcome to your 2022 Employee Benefits!

The City of Chesapeake takes into consideration our employees' evolving needs, as well as ensuring a level of security and protection when making decisions regarding the benefits program being offered.

We recognize the important role employee benefits play as a critical component of an employee's overall compensation. We also strive to maintain a benefits program that is competitive within our industry.

This benefits guide, together with other enrollment materials, are provided to help you understand your benefit choices and navigate through the Open Enrollment / New Hire process.

Before you enroll, please read this guide to become familiar with the benefit options. Your decisions will impact your benefit selections and what you pay for these benefits.

The new rates for 2022 will be deducted in December with plan coverage effective January 1, 2022 for medical, dental, vision and legal benefits. Health and Dependent Care Flexible Spending and Health Savings Account deductions begin in January 2022.

City of Chesapeake Human Resources

1-757-382-8956

hrbenefits@cityofchesapeake.net

What's Inside

Eligibility 3

Benefit Changes 4

Benefit Costs 6

Medical Coverage 7

Medical Plan Comparison 8

Prescription Coverage 9

Health Savings Accounts 10

Virtual Appointments 11

Dental Coverage 12

Vision Coverage 13

Flexible Spending Accounts 14

Legal Resources 15

Optional Group Life Insurance 16

Long-Term Disability Coverage 17

Voluntary Group Long Term Care Insurance Program 18

Glossary of Terms 19

Important Notice from City of Chesapeake About Your Prescription Drug Coverage and Medicare 20

Annual Notices 21

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

2022 Employee Benefits

The City of Chesapeake offers a comprehensive suite of benefits to promote health and financial security for you and your family. This booklet provides you with a summary of your benefits. Please review it carefully so you can choose the coverage that's right for you. Plan eligibility and effective dates vary by plan.

What's New for 2022

- **City's contributions into Health Savings Accounts (HSA) for 2022:** For eligible employees enrolled in the CDHP, the contribution will be $250 for employee only or $500 for all other tiers. City Contributions will be made on a quarterly basis in 2022.
- **HSA Contribution limits:** The amount an employee can contribute to his/her HSA (employer + employee) has increased to $3,650 for employee only coverage tier and $7,300 for all other coverage tiers.

Important Reminders

- **FSA Enrollment:** If you are not currently enrolled in any of the City's medical plans, and you are participating in the Wellness Incentive program, your earned incentive will be deposited into your Flexible Spending Account.
- **Omada** will continue to be offered for employees at risk for Type II Diabetes and Heart Disease and will now include a $100 incentive. Omada is a digital, lifestyle-change program focused on reducing the risk of obesity-related chronic disease.
- **Diabetes Disease Management program** will continue to be offered to employees, spouses, and children covered by one of the City's health insurance policies and will now have an increased incentive of $300 for participation.
- **Diabetic Supplies** (pump infusion sets & supplies), as well as testing supplies (Includes test strips, lancets, lancet devices, blood glucose monitors and control solution) will be covered at 100% prior to the deductible under the HMO, POS and PPO medical plans.
- **FIT Kit is a screening test for colon cancer to use at home**. **As a benefit to you, it will be automatically sent to all members 50 years of age and older who have not had a colonoscopy in the last 10 years.**

Eligibility

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

When Benefits Become Effective

Hire date is on the 1st – 15th of the month: Benefits are effective the 1st of the following month.

Hire date is on the 16th – the end of the month: Benefits are effective the 1st of the next following month.

Part-time, seasonal, temporary, internship, and contracted employees are not eligible to participate.

Eligible Dependents

Your dependents are eligible to participate in the Company's benefit plans. Your eligible dependents include*:

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

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

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

Newly Hired/Eligible Employees

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

For all benefits you must enroll within 30 days from your date of hire by going to www.cityofchesapeake.net.

Pre-Tax Benefits: Section 125

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

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

Benefit Changes

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

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

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

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

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

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

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

You must notify Human Resources at 1-757-382-8956 within 30 days from the life event status change in order to make a change in your benefit selections.

Benefit Changes *continued...*

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact The City of Chesapeake's HR Department to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any changes.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

If you Experience a Life Event Status Change

Log onto **www.cityofchesapeake.net** to add or drop dependents from your coverage if you experience a life event status change. Your user-name and password will be the same as you used during open enrollment.

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you are required to submit specific documents to Human Resources. The change will be inactive until proper documentation is received and approved. For assistance processing life event status changes, you can call Human Resources at **1-757-382-8956** or e-mail **hrbenefits@cityofchesapeake.net.**

Benefit Costs - premium tax status and eligibility

Benefit	Tax Treatment	Who Pays	Eligible Employees
Medical Coverage	Pre-Tax	The City & You	Full time* employees
Dental Coverage	Pre-Tax	The City & You	Full time* employees
Voluntary / Optional Vision Coverage	Pre-Tax	You	Full time* employees
Health Savings Account	Pre-Tax	The City & You	Full and regular part time employees
Flexible Spending Accounts	Pre-Tax	You	Medical Flexible Spending Account: Full time* employees Dependents Care Flexible Spending Account: Full and regular part time employees
Legal Plan	Pre-Tax	You	Full and regular part time employees
Voluntary / Optional Life Insurance	Pre-Tax	You	VRS eligible employees
Voluntary Long Term Care	Pre-Tax	You	VRS eligible employees
Long Term Disability enhanced "buy up"	Pre-Tax	You	VRS Plan 1 and Plan 2 eligible employees

**full time includes employees who meet the Affordable Care Act definition of 30 hours average weekly hours worked*

Culture of Wellbeing

- The $300 Wellness Incentive is available to all full-time employees, retirees on the City's health plan, and to spouses on the City's health plan.
- The $300 Diabetes Management Incentive Program is available to employees, spouses, and children on the City's health plan who have been diagnosed with Type 1 or Type 2 Diabetes.
- The $100 Omada Pre-Diabetic Incentive Program is available to employees/retirees on the City's health plan that are considered at risk for developing Diabetes or Heart Disease.
- There are a multitude of other events offered to employees such as free health screenings, free flu shots, mobile mammogram screenings, and many more! For more information, visit the **Wellness page on SharePoint** or **optimahealth.com/ches**.

Medical Coverage

The City of Chesapeake is proud to offer you a choice between four different medical plans. Coverage under these plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of each plan.

All 2022 Optima benefit guides (PPO, POS, HMO and CDHP with HSA) and other benefit plan materials can be found online at the following website: **www.optimahealth.com/ches**

Equity Plus HDHP

The Equity Plus HDHP Plan is a High Deductible Health Plan, or a HDHP for short. This plan functions like a Preferred Provider Organization (PPO), but features a low monthly premium in exchange for a higher deductible. The benefit of this plan is that you will be eligible to enroll in and contribute to a Health Savings Account (HSA). With an HSA your contributions are pre-tax so any amount you contribute is deducted from your taxable income at the end of the year. The money in your HSA can be spent on eligible healthcare expenses including copays, prescriptions, dental treatment, and more.

As with a PPO, both you and your family can see any health care provider in the Optima network, including specialists, without a referral. You are not required to choose a primary care physician.

Optima HMO

The Optima HMO Plan is a Health Maintenance Organization, or an HMO for short. With this plan, an entire network of health care providers agrees to offer you its services. You will have to select a primary care provider (PCP) who will coordinate all of your health services and care.

Under The Optima HMO Plan, you have 100% coverage for most types of preventative care and have coverage for a variety of specialist visits. Additionally, you will pay copayment fees for non-preventive medical visit.

Optima POS $750

The Optima POS $750 plan is a Point of Service plan that utilizes the HMO network but has in and out of network benefits. The POS plan does not require referrals to a specialist.

Optima PPO Plus $750

Closed Plan, No New Enrollment Allowed.

The Optima PPO Plus $750 Plan is a Preferred Provider Organization, or PPO's for short. Under this plan, both you and your family can see any health care provider in the Optima network, including specialists, without a referral. You are not required to choose a primary care physician.

Build a Strong Relationship with Your Primary Care Physician

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

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

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

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

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

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

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

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

Medical Plan Comparison

The City of Chesapeake offers a choice of medical plan options so you can choose the plan that best meets your needs and those of your family. Each plan includes comprehensive health care benefits, including free preventive care and coverage for prescription drugs.

	Equity Plus HDHP 2,800		Optima HMO Vantage $750	Optima POS $750		Optima PPO Plus $750 (Closed Plan)	
	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible							
Individual	$2,800	$3,100	$750	$750	$1,000	$750	$1,000
Family	$5,600	$6,200	$1,500	$1,500	$2,000	$1,500	$2,000
Out-of-Pocket Maximum							
Individual	$3,500	$6,000	$4,000	$4,000	$6,500	$4,000	$5,000
Family	$7,000	$12,000	$8,000	$8,000	$13,000	$8,000	$10,000
HSA Contributions Employee / All other	$250 / $500		None	None	None	None	None
Preventive Care	$0	30% AD*	$0	$0	40% AD*	$0	40% AD*
Office Visit							
PCP	0% AD*	30% AD*	$25	$25	40% AD*	$25	40% AD*
Specialist			$70	$50		$70	
MD Live	$39/$0 AD	$39/$0 AD	$0	$0	$0	$0	$0
Inpatient Hospital Visit	0% AD*	30% AD*	20% AD*	15% AD*	40% AD*	25% AD*	40% AD*
Outpatient Surgery	0% AD*	30% AD*	20% AD*	15% AD*	40% AD*	25% AD*	40% AD*
Urgent Care	0% AD*	30% AD*	$70	$50	40% AD*	$70	40% AD*
Emergency Room Care	0% AD*		20% AD*	15% AD*		25% AD*	

** This is a brief summary of coverage. The benefits summary plan description contains exclusions and limitations that are not shown here. Please refer to the benefits summary for the full scope of coverage at www.optimahealth.com/ches.*

*** In-network services are based on negotiated charges; out-of-network services are based on Reasonable & Customary (R&C) charges.*

Monthly Rates	Equity Plus HDHP 2,800	Optima HMO Vantage $750	Optima POS $750	Optima PPO Plus $750 (Closed Plan)
Employee Only	$27.00	$66.00	$98.00	$192.00
Employee + Spouse	$98.00	$244.00	$473.00	$834.00
Employee + Child	$61.00	$152.00	$283.00	$505.00
Employee + Children	$93.00	$234.00	$435.00	$777.00
Family	$230.00	$576.00	$936.00	$1,477.00

Please refer to the Coverage Summary at www.optimahealth.com/ches for more information about rates, pre-existing condition period and exclusions/limitations.

Prescription Coverage

Your prescription drug benefit is part of your medical plan. The prescription drug formulary generally lists many drugs and ranks them in groups described as tiers. Copayments and/or coinsurance is determined by the tier in which the health plan will pay for, and prefer you use.

To find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.express-scripts.com** or by calling **1-800-282-2881**.

Prescrtiption Search

Go to **https://www.express-scripts.com/** where you can find a pharmacy, submit for a refill, price your medications and see your claims and balances.

Rx Mail Order Program

Save time and money by filling maintenance drugs through the Mail Order Program. The Mail Order Program benefits members who are on long-term medications for chronic conditions such as diabetes, high cholesterol, high blood pressure, depression or asthma. By utilizing the Mail Order Program, you can receive a 90-day supply of medication at a discounted price. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.

	Equity Plus HDHP 2,800	Optima HMO Vantage $750	Optima POS $750	Optima PPO Plus $750 (Closed Plan)
Retail Prescription Drug (31 day supply)	Deductible Applies Co-payments apply AD*			
Generic	$10	$10	$10	$10
Brand Preferred	$30	$30	$30	$30
Brand Non-Preferred	$50	$50	$50	$50
Specialty Drugs	20% to $250 max	20% to $250 max	20% to $250 max	20% to $250 max
Mail Order Prescription Drug (90 day supply)				
Generic	$25	$25	$25	$25
Brand Preferred	$75	$75	$75	$75
Brand Non-Preferred	$125	$125	$125	$125
Specialty Drugs	None	None	None	None

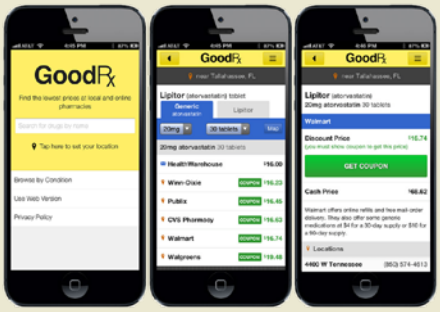
Save money with Generic Drugs

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

GoodRx Mobile App

Regardless of which plan you decide to enroll in, we encourage you to download and use the GoodRx Mobile App to help you save on your prescription drug costs. Prices for prescription drugs vary widely between pharmacies. The cost of a prescription may differ by more than $100 between two pharmacies across the street from each other.

GoodRx doesn't sell the medications, they will tell you where you can get the best deal on them. GoodRx will show you prices, coupons, discounts and savings tips for your prescription at pharmacies near you.



Health Savings Accounts

Only Equity Plus HDHP Participants are Eligible

If you enroll in the Equity Plus HDHP, you are eligible to open and use a Health Savings Account (HSA). An HSA is a financial account that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the IRS. The account is similar to a traditional savings account with a debit card. The money in the account is owned by you and is fully portable. Funds can accumulate over time and roll over each year. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

How You Save With an HSA

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

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

HSA Funds Remain Yours to Grow

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

You Can Win With an HSA

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

Using your HSA for qualified medical expenses

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

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

City of Chesapeake's Contribution to your HSA:

To help you get started on saving on eligible medical expenses, City of Chesapeake will contribute the following amounts to your Health Savings Account:

$250 for employee only coverage

$500 for all other coverage tiers

City of Chesapeake Employees will receive contributions quarterly. You may choose to contribute additional funds up to the IRS annual maximums of $3,650 for employee only coverage or $7,300 for all other coverage tiers. If you are or will be age 55 or over during the calendar year, you may also make a "catch-up" HSA contribution of an additional $1,000 each year. The IRS maximums include The City of Chesapeakes' contribution. Contact The City of Chesapeake Employee Benefit Center to adjust your contribution amount.

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

Virtual Appointments

Optima MDLIVE

Get 24/7/365 access to Board Certified-doctors anytime, anywhere for only $0 co-pay ($39 on the CDHP and $ 0 AD). To get started, call **1-866-648-8638** or go to **www.mdlive.com/optima**.

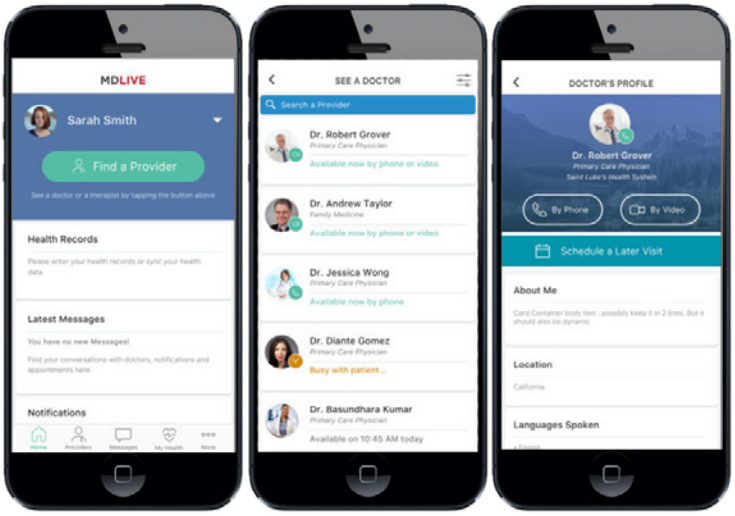
Online Video: See your doctor using a computer, smart phone or over the Internet

Phone Call: No webcam? No problem! Talk to a doctor over the phone!

Secure Email Advice: Ask questions and get advice privately using secure e-mail

When to use Optima MDLIVE

- If you are considering the emergency department or urgent center for a non-emergency medical issue
- Your primary care doctor is not available
- Request prescriptions or get refills - Prescriptions are issued only when clinically appropriate. No controlled substances may be prescribed, the availability may be restricted by law
- Traveling and in need of medical care
- During or after normal business hours, nights, weekends, and holidays



Call MDLIVE for treatment of:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold & Flu
- Ear Infection
- Fever
- Gout
- Headache
- Infections
- Insect Bites
- Joint Aches
- Nausea
- Pink Eye
- Poison Ivy
- Rashes
- Respiratory Infections
- Sinus Infections
- Skin Inflammation
- Nausea & Vomiting
- Sports Injuries
- And More...

Seek treatment immediately for:

Allergic reactions that cause breathing or swallowing difficulties, severe asthma attacks, broken bones with skin puncture and chest pain.

Dental Coverage

Anthem

The dental plan offers flexibility to see the provider of your choice each time you seek dental care. You can find a network dentist online at **www.anthem.com**, or by calling **1-888-650-4047**.

Plan Provisions	Comprehensive Dental In-Network, Premium, Out-of-Network
Annual Deductible Individual Family	 $50 $150
Annual Maximum (Per Person)	$1,500
Diagnostic and Preventive Care Includes cleanings, fluoride treatments, sealants and x-rays	100%
Basic Restorative Includes fillings, periodontics, scaling and root planing and oral surgery	80%
Major Restorative Includes crowns, bridges, implants and full and partial dentures	50%
Orthodontia (Children only up to age 18)	50% $1,500 maximum

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Monthy Rates	Delta Dental DPPO
Employee Only	$14.92
Employee + Spouse	$25.00
Employee + Child	$27.16
Employee + Children	$31.20
Family	$43.12

In-Network PPO -$	In-Network Premier - $$	Out-of-Network - $$$
Network dentists have agreed to Anthem's lower PPO fee schedule. Therefore you will pay less if you select an In-network PPO dentist.	In-Network Premier dentists agree to Anthem's higher fee schedule; therefore, employees pay more for services using a Premier dentist.	Out-of-Network dentists have not agreed to Anthem's fee schedule. Accordingly, you will be responsible for any required coinsurance and deductibles (if applicable) as well as the difference between the non-participating dentist's charge and Anthem's payment for covered benefits.

Vision Coverage

Davis Vision

Davis Vision gives you access to one of the country's largest networks of vision providers with more than 61,000 providers and provider locations nationwide, including the 4 of 5 top retailers. To find an in network provider, visit **www.davisvision.com** or call **1-800-999-5431** to find an in-network provider near you.

Help protect your vision and Health.

Routine eye checkups are more than just making sure you can see clearly. They're important to health, safety and learning. Even if you think you have 20/20 vision it's key that you're checked regularly – at every age.

- Eye exams can give you a glimpse into major health problems like diabetes, high blood pressure and heart disease.
- Eye diseases often have no warning signs. Because of that, many people don't realize that they might have a condition that could lead to their vision getting worse or potentially suffer blindness.
- One in four children has an undetected vision problem that can affect their ability to read and learn.

Network providers keep it simple.

When you use network providers, you may pay less out of your pocket and you can usually avoid paperwork hassles. In-network providers check your benefits with us and then file your claims for you. All you have to do is:

- Schedule a visit with an in-network provider
- Show the staff your member ID card at your visit
- Pay your copay or any balance

Uniview Vision		
Benefit	**In-Network**	**Out-of-Network**
Exam	$15 copayment	$35 allowance
Frames	Up to $140 allowance, then 20% off remaining balance	$45 allowance
Lenses		
Single Vision - standard	$15 copay, then covered in full	$25 allowance
Bifocal - standard	$15 copay, then covered in full	$40 allowance
Trifocal - standard	$15 copay, then covered in full	$55 allowance
Progressive Lenses (Standard / Premium / Ultra)	$50 / $90 / $140	
Anti-Reflective (AR) Coating (Standard / Premium / Ultra)	$35 / $48 / $60	
Contact Lenses	$0 (with prior approval)	$210 allowance
Medically Necessary	Up to $140 allowance then	$105 allowance
Elective	15% off remaining balance	
Frequency		
Exam	Once every calendar year	
Lenses	Once every calendar year	
Frames	Once every 2 calendar years	

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Monthy Rates	**Vision Plan**
Employee Only	$4.36
Employee + Spouse	$7.68
Employee + Child	$7.68
Employee + Children	$8.72
Family	$12.68

Flexible Spending Accounts

Eligibility Based on Medical Plan Election

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

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

	HSA Participants	Non-HSA Participants	
Health Care FSA	✘	✔	**Employee-funded.** Can use funds for all healthcare related expenses. Federal regulations do not allow participation in an HSA and this type of account.
Dependent Care FSA	✔	✔	**Employee-funded.** Can use funds for all dependent care related expenses such as day care, nursery school, or elder care.

HCFSA Annual Contribution Limit:
$2,850

Health Care Flexible Spending Account (HCFSA)

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

DCFSA Annual Contribution Limit:
$5,000
Or $2,500 if you are married and file a separate tax return.

Dependent Care Flexible Spending Account (DCFSA)

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

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

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

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

Chesapeake has elected to participate in the FSA rollover provision, allowing employees to rollover up to $570 from one plan year to the next. **You must be enrolled in an HCFSA both plan years and you must still be employeed for rollover funds. Once an individual seperates employment from The City they have 90 days to submit claims that incurred by their seperation date**. You are still encouraged to consider your expenses carefully before you decide how much to contribute to each Flexible Spending Account. As a reminder, your election will cover the period from January 1 through December 31. You should not contribute more than you are reasonably certain to use.

Legal Resources

Legal Resources protects City of Chesapeake employees from the high cost of attorney fees by providing legal services and courtroom representation. As a member, you are covered for expected and unexpected legal needs including real estate closings, will preparation, traffic matters, divorce and much more. Most attorneys charge between $200-400 per hour, but as a Legal Resources member, you and your family are covered for $17.00 per month

The Legal Resources Plan Truly Delivers in all the Right Ways:		
100% Coverage	**It's Comprehensive**	**It's Valuable**
• Pay no attorney fees • Covers a broad range of legal services and includes coverage for qualifying dependents	• No waiting period • No annual usage limits • No deductible • No co-payments	• Annual cost = less than what an attorney typically charges for just one hour

How the Plan Works

1. Become a member by authorizing a low monthly payroll deduction during Open Enrollment.
2. Choose a law firm that best suits your needs from our highly rated law firm network. Use our Law Firm Finder at LegalResources.com to find a firm near you.
3. Receive your welcome kit with member identification cards and information about your law firm.
4. Call when you need legal services. Simply say, "I am a Legal Resources member."
5. Certified paralegals in our Member Services Department provide you with dedicated, ongoing support and assist you with any coverage or attorney-related concerns.
6. If you ever need to transfer to another Plan Law Firm, simply call Member Services.

* *Participating employees agree to a 12 month commitment and cancellation may only occur during open enrollment. The plan provides coverage for you, your spouse and qualifying dependents*

** *If you become non-benefits eligible or leave employment with City of Chesapeake, you may continue coverage by setting up direct billing with Legal Resources. Coverage remains exactly the same.*

For more information visit www.LegalResources.com or call Member Services at 1-800-728-5768

Optional Group Life Insurance

If you are covered under the Virginia Retirement System (VRS) Group Life Insurance Program, you may purchase additional coverage for yourself through the Optional Group Life Insurance Program. If you elect optional group life insurance coverage, you may also cover your spouse and dependent children. Optional group life insurance provides benefits for natural and accidental death or dismemberment. The premiums are paid through payroll deduction.

Optional Group Life Insurance Coverage Options

Option	Your Insurance Amount	Spouse Insurance Amount	Insurance Amount per Dependent
1	1 x your compensation	½ x your compensation	$10,000
2	2 x your compensation	1 x your compensation*	$10,000
3	3 x your compensation	1 ½ x your compensation*	$20,000
4	4 x your compensation	2 x your compensation*	$30,000

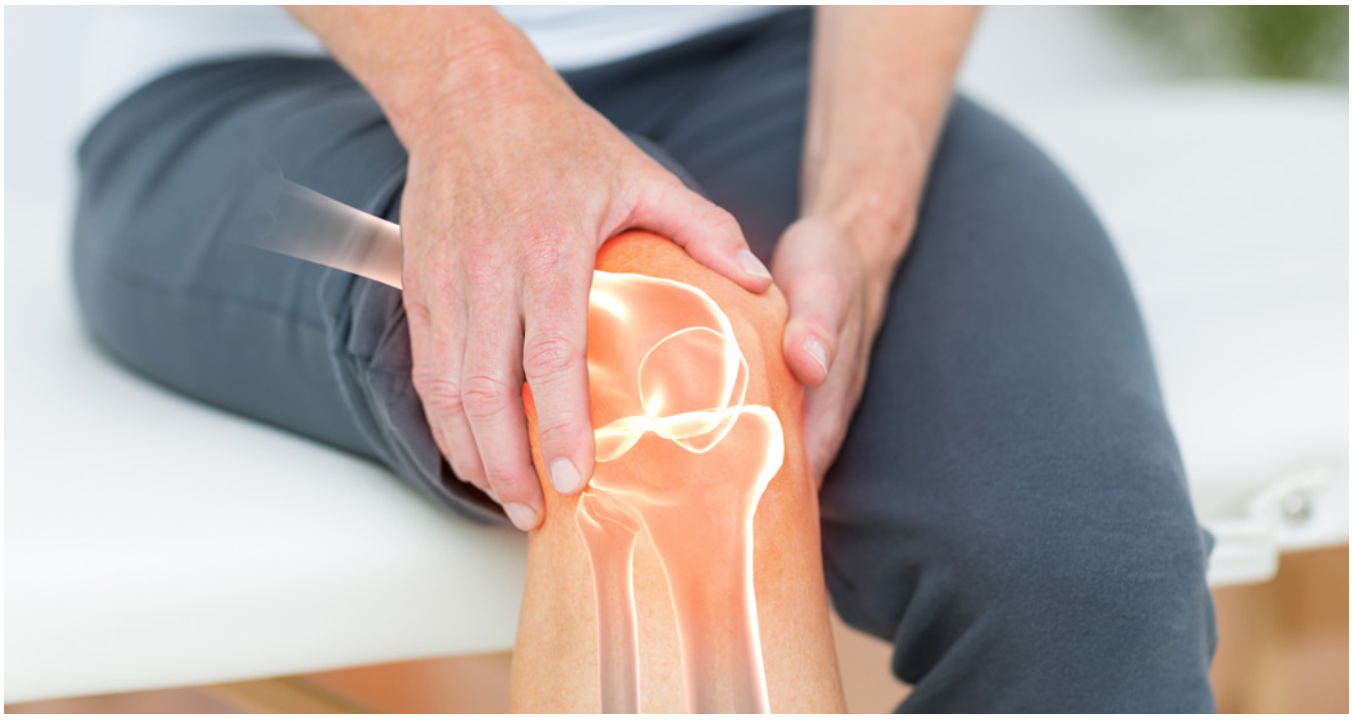
** Evidence of Insurability required on spouse even for new hires if Option 2 or more is selected*

Coverage for Yourself	Coverage for Your Spouse	Coverage for Dependent Children	Evidence of Insurability Proof Required if:
• You can select one of the coverage options to cover yourself, up to a maximum of $750,000.	• You can cover your spouse up to $375,000. Coverage for your spouse ends when your coverage ends or if you and your spouse divorce. If both you and your spouse are eligible for Optional Group Life insurance through the City, neither can buy additional coverage for the other.	• At the age of 15 days or older, you can cover each child for $10,000, $20,000 or $30,000. Coverage ends when your child marries, becomes self-supporting, or reaches age 21 (25 as a college student). Coverage continues for unmarried, disabled children.	• You elect Option 2 or more plus spouse coverage • You apply 31 days after employment date or a qualifying event • You wish to add spouse/ child 31 days after your date of hire as a full- time employee • You wish to purchase more than $375,00 for yourself • You wish to increase your optional group life insurance coverage for yourself or your spouse

Long-Term Disability Coverage and Enhanced "Buy-up" Option

- Long Term Disability provides a monthly monetary benefit if you are unable to work because of a qualifying disability.
- Employees in the VRS Hybrid Plan are automatically covered by LTD benefit administered by the Reed Group and paid for by the City.
- Employees in VRS Plans 1 or 2 are covered in a Basic Benefit paid for by the City
- Employees in VRS Plans 1 or 2 were offered the opportunity to purchase an enhanced LTD benefit with guaranteed issue in 2016.
- Employees in VRS Plans 1 or 2 can request coverage in the enhanced LTD benefit during open enrollment. Medical underwriting is required and thus approval is not guaranteed.
- Newly hired employees in VRS Plan 1 or 2 are offered the "Buy-up" option with Guaranteed issue if enrolled within 30 days of hire

	Basic Benefit	Enhanced "Buy Up" Benefit
Waiting Period	180 days	90 days
Income Replacement Percentage	40%	60%
Maximum Benefit Period	2 years	Normal Social Security Retirement Age



Commonwealth of Virginia (COV) Voluntary Group Long Term Care Insurance Program

Most medical plans don't cover long-term care services such as nursing home care or at-home care to assist with bathing, eating or other activities of daily living. Anyone at any age may need these services, the cost of which can quickly deplete savings or retirement income. The Commonwealth of Virginia (COV) Voluntary Group Long Term Care Insurance Program can help with these costs.

VRS has contracted with Genworth Life Insurance Co. as the insurer for the program. Participant-paid coverage provides a monthly benefit allowance for covered long-term care expenses. Genworth will begin accepting new enrollees September 16*, and coverage will begin December 1.

***Note:** Employees who enrolled in the long-term care insurance program before December 31, 2016, will continue their coverage under that program.

Eligibility

Open Enrollment begins **October 12th** and ends **October 29th**.

General Eligibility

You are eligible to apply for coverage in the COV Voluntary Long Term Care Insurance Program if you are over age 18 and a:

- State employee or faculty member who works at least 20 hours a week. You do not have to be a VRS member.
- School division employee or political subdivision employee who works at least 20 hours a week, provided your employer has elected to participate in the program. You do not have to be a VRS member.
- Deferred VRS member under age 75 who is vested (you have at least five years of service credit).
- Retiree under age 75 receiving a VRS-administered benefit.
- Retiree of a Virginia public college or university age 75 and under.

***Note:** If you are a deferred VRS member or retiree, your employer is not required to have elected the program. You are subject to full medical underwriting regardless of your age when you apply.

Family members may also apply for coverage if they are between the ages of 18 and 75 and undergo full medical underwriting. Eligible family members include:

- A spouse.
- Adult children.
- Parents, parents-in-law and step parents.
- Siblings.
- Grandparents, grandparents-in-law, step grandparents and step grandparents-in-law.

Program Features

- Reduced medical underwriting (proof of good health) if you are age 65 and under and apply within 60 days of employment. Full medical underwriting will be required after 60 days or if you are over age 65.
- Full medical underwriting is required for any family members who apply, or if you are a VRS deferred member or retiree.
- At group rates, your premiums may be more affordable. You pay premiums directly to Genworth.
- If you leave or retire from your position, you may continue your coverage under Genworth. If you are not enrolled, you can apply as a deferred VRS member or retiree.
- You can choose one of three benefit increase options that will allow you to increase your coverage over time to help protect against the rising cost of care.
- If you are eligible for the VSDP Long-Term Care Plan or have other long-term care insurance, you may be able to coordinate with the voluntary program to obtain even more coverage.

For more information, call Genworth Life toll-free at **1-866-859-6060** or visit **www.genworth.com**

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current City of Chesapeake coverage will not be affected. Details of the Plan's prescription drug benefits are included in the separate benefits booklet previously provided to you as part of (or along with) the Plan's Summary Plan Description. In addition, keep in mind that your current coverage pays for other health expenses for you and, if applicable, your eligible dependents, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits even if you choose to enroll in a Medicare prescription drug plan. If you are enrolled in both the Plan and a Medicare prescription drug plan, your prescription coverage under the Plan will be coordinated with the Medicare prescription drug benefit.

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

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

You should also know that if you drop or lose your current coverage with City of Chesapeake 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 November to join.

For More Information about this Notice or Your Current Prescription Drug Coverage

Contact the person or office listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Chesapeake 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).

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 whether or not you are required to pay a higher premium (a penalty).

Date: 1/1/2022

Name of Entity/Sender: City of Chesapeake

Contact Position/Office: Human Resources Dept.

Address: 306 Cedar Road Chesapeake, VA 23322

Phone Number: 1-757-382-8956

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

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

Newborns' and Mothers' Health Protection Act

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

Notice Regarding Special Enrollment

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

States with Individual Mandate

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

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

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

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

Genetic Nondiscrimination

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

Qualified Medical Child Support Order

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

Annual Notices *continued...*

Notice of Required Coverage Following Mastectomies

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

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

Women's Preventive Health Benefits

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Mental Health Parity and Addiction Equity Act of 2008

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

COBRA

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

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

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. 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: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

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

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

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

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

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

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

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

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

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

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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

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

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/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

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

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

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

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

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

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

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

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

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

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

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

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

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

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

WEST VIRGINIA – Medicaid
Website: http://mywwhipp.com/
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 January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.**

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in the Company's medical plan, then PPACA may have little effect on you. The Company's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by the Company, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. **(See https://www.healthcare.gov/have-job-based-coverage/)**.

If you are not eligible to enroll in the Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit **healthcare.gov** or call **800-318-2596.**

Chesapeake
VIRGINIA

Human Resources: 1-757-382-8956 www.cityofchesapeake.net