2024
BENEFITS

EXPLORE YOUR BENEFITS

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MEDICARE PART D NOTICE

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

GETTING STARTED

2024 BENEFITS

January 1, 2024 – December 31, 2024

The information in this booklet is a general outline of the benefits offered under the City of Roseville benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

The City of Roseville takes pride in offering a benefits program that provides flexibility for the diverse and changing needs of our employees and their families. We are pleased to provide you with the 2024 Employee Benefits Overview for eligible employees of the City of Roseville. Please review this guide carefully and retain this guide for the calendar year 2024 as an easy reference to your benefit plan offerings.

The City of Roseville offers you and your eligible dependents the following benefits:

- Medical, Dental and Vision Insurance
- Basic/Supplemental Life / Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Short-Term Disability (STD) Insurance
- Long-Term Disability (LTD) Insurance
- Flexible Spending Accounts (Medical and Dependent Care)
- Employee Assistance Program (EAP)
- Deferred Compensation

WHO'S ELIGIBLE FOR BENEFITS?

If you are a regular or limited term employee working 20 hours or more per week, you may enroll in the benefits program on your first day of employment for benefits eligible coverage starting the first of the month following your date of hire.

Your dependents are eligible for coverage under your health and welfare benefits package as long as they meet the requirements specified for each plan. Eligible dependents include:

- Your current spouse or state-registered domestic partner.

Definition of domestic partner pursuant to Family Code Section 297-297.5:

> A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State, and at the time of filing, all of the following requirements are met:
>
> 1. Both persons have a common residence.
> 2. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
> 3. Both persons are capable of consenting to the domestic partnership.
>   - "Have a common residence" means that both domestic partners share the same residence.

- Your natural children, stepchildren, domestic partner's children, adopted children of which the employee is the legal guardian. In addition, such children must be:
    1. Under age 26 (medical, dental and vision coverage)
    2. Under age 20, or age 25 if a full-time student (optional life insurance)
    3. Your disabled children age 26 (medical, dental and vision coverage) or 20/25 (supplemental life insurance) or older. Such disabled children must meet the same conditions as listed above and, in addition, are physically or mentally disabled on the date coverage would otherwise end because of age and continue to be disabled. For medical coverage only, the enrollment of a disabled dependent child over the age of 26 is subject to CalPERS approval.
    4. A child for whom you are required to provide benefits by a court order and who satisfies the same conditions as listed above

This is a brief description of the eligibility requirements and is not intended to modify or supersede the requirements of the plan documents. The plan documents will govern in the event of any conflict between this description and the plan documents.

DEPENDENT ELIGIBILITY VERIFICATION

All employees adding/removing dependents must submit documentation to verify their dependent's eligibility and/or Qualifying Life Event. The following chart is an easy guide to what documents must be submitted along with the Health Enrollment/Change form.

	Enrollment Form Required	Marriage Certificate Required	State of California Domestic Partner (DP) Registration	Birth Certificate /Certificate of Adoption Required	Social Security Number
Employee only	•				
Employee & Spouse	•	•			•
Employee & Domestic Partner (DP)	•		•		•
Employee & Children	•			•	•
Employee, Spouse/DP & Children	•	•	•	•	•

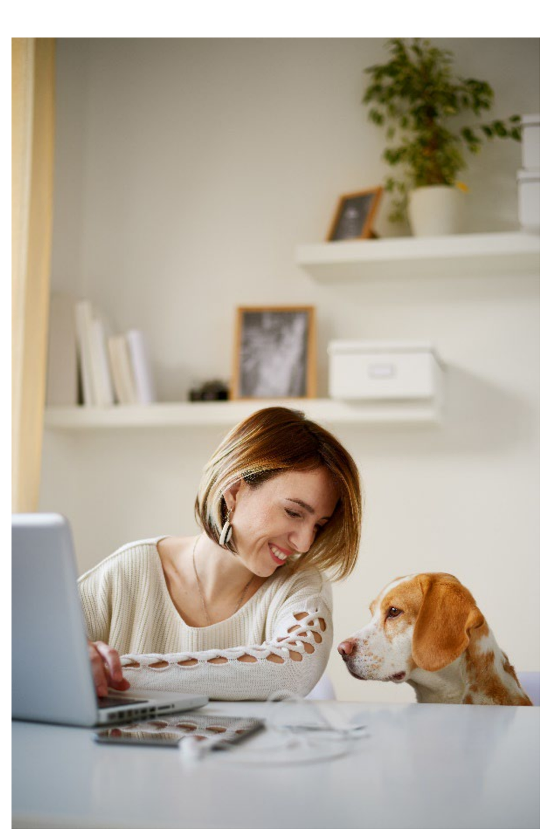
You are responsible for ensuring that the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or health care services incurred during the entire ineligibility period.

For example, if your divorce or dissolution occurred in 2018, yet you did not report it until 2021, your former spouse or domestic partner will be retroactively canceled from coverage effective the first of the month following the divorce or dissolution.

On page 7, you will find a detailed list of Qualifying Life Events, which must be reported to the HR Department so we can make the appropriate change to your health coverage. All Qualifying Life Event changes must be made within 60 days from the date of the event. Proper documentation is required, such as a copy of the marriage/domestic partnership certificate, birth/adoption certificate, or divorce/dissolution of domestic partnership decree.

For further clarification, please contact Human Resources at (916) 774-5475.

CHANGING YOUR BENEFITS



You may change your health plan at the following times:

IF YOU MOVE

You must change plans if you move out of your health plan's service area. Until you make the change, your previous health plan may limit coverage to emergency or urgent care only. When you move or change employment, you may submit your health plan change up to 60 days after the move. The effective date of the change will be the first of the month following the date your Health Benefits Officer receives your request.

WHEN YOU RETIRE

You may change health plans within 60 days of your retirement date. You may select any health plan available in your residential ZIP Code area. If you are a working retiree, you can use the ZIP Code of a current employer for eligibility purposes. The effective date of the change will be the first of the month following the date your Health Benefits Officer receives your request.

If you are a working retiree enrolled in a Medicare Advantage plan, you must use your residential address for eligibility. You cannot use your work address or a P.O. Box to enroll.

WHEN YOU QUALIFY FOR MEDICARE

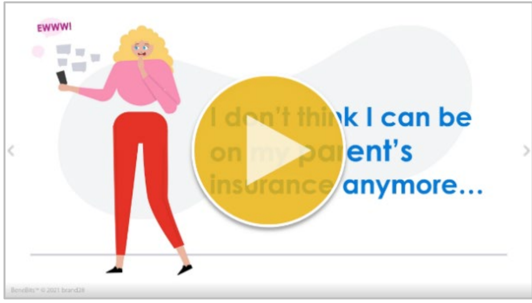
As a retiree, when you first become eligible for Medicare, you must request a change from a CalPERS Basic health plan to a CalPERS Medicare health plan. You may also change health plans within 60 days from the effective date of your Medicare enrollment. The effective date of the change will be the first of the month following the date your Health Benefits Officer receives your request.

DURING THE CALPERS OPEN ENROLLMENT PERIOD

Open Enrollment is held each fall, and changes become effective the following January 1. Additionally, if you did not include eligible family members in your initial health plan enrollment or add them within the applicable 60-day eligibility period, you may enroll them during the Open Enrollment period. To make changes during Open Enrollment, active members should contact their Health Benefits Officer. Retirees should contact CalPERS.

ELIGIBLE QUALIFYING LIFE EVENTS

Click to play video



LIFE HAPPENS

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

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

1. Any change you make must be consistent with the change in status.
2. You must make the change within **60 days** of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Below are examples of eligible qualifying life events that allow you to make certain changes to your benefit:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, dissolution of domestic partnership, and death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status, including the start or termination of employment by you or your spouse.
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child.
- An event that is a qualifying life event under the Health Insurance Portability and Accountability Act (HIPAA), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
  - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation;
  - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage.

Please contact Human Resources should any of the above apply to you to determine what changes can be made to your current enrollment.

MEDICAL

MAKE TIME FOR HEALTH

OUR PLANS

CalPERS Medical

Click here to view your CalPERS Evidence of Coverage/SBC's!

or visit www.calpers.ca.gov and click Active Members > Health Benefits > Plans and Rates > "View all Health plan Summary of Coverage and Evidence of Coverage Documents".

Explore Your Benefits with my|CalPERS
Access your health information year-round, including available health plans and Open Enrollment updates, by logging in to myCalPERS at https://my.calpers.ca.gov.

Health Maintenance Organization (HMO)

Under HMO plans, most services and medicines are covered with a small copay. Most HMOs require you to select a Primary Care Physician (PCP) to coordinate your care and require advance approval for some services, such as treatment by a specialist. Care must generally be obtained from in-network providers, or you may be required to pay out of pocket for the cost of services (except in the event of emergency or urgent care services). Not all HMO plans are available in all California counties.

Preferred Provider Organization (PPO)

PPO plans are designed to provide choice, flexibility and value. A PPO plan is a managed care organization of medical doctors, hospitals, and health care providers who have contracted with your insurer to provide health care at reduced rates to you. Members have a choice of using network providers or going directly to any physician (non-network provider) without a referral. For most services, there is an annual deductible to meet before benefits apply. You are also responsible for a certain percentage of the charges (coinsurance), and the plan pays the balance up to the agreed upon amount. Non-network providers are typically covered at a lower benefit level requiring you to pay a higher percentage of the bill.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Set aside healthcare dollars for the coming year

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

Click to play video

ARE YOU ELIGIBLE?

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

Find out more

- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

How the Flexible Spending Account works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,050, the 2024 annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 01/01/2024 and 03/15/2025 and claims must be submitted for reimbursement no later than 03/31/2025. If you don't spend all the money in your account, you forfeit the leftover balance.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

FSA TAX SAVINGS EXAMPLE

$60,000 Annual Pay, with $1,500 FSA Contribution		
$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings
$120,000 Annual Pay, with $2,750 FSA Contribution		
$660 24% Federal income tax	**$210** 7.65% FICA tax	**$870** Annual FSA tax savings

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

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)

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

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

Here's how the Dependent Care Flexible Spending Account works

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

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

Please note: You must re-enroll in this program each year.

EVERY OPPORTUNITY TO SAVE

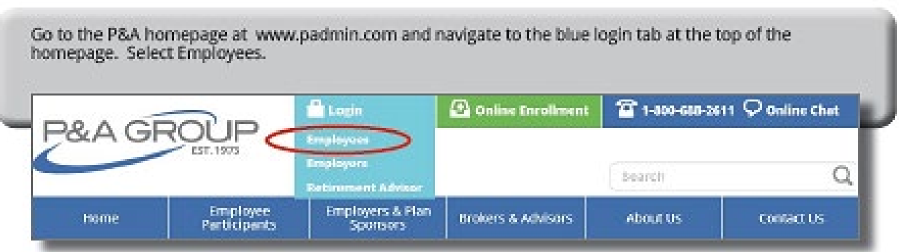
The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

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

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

How to access my benefits

Follow the steps below to login and access your P&A benefit account(s). It's fast, easy, and allows you to have 24-hour access to your accounts!



Log into your account underneath the My Benefits Account Login box. Enter your username and password credentials and click the "Submit" button. NOTE: If you press the Enter key on your keyboard instead of "Submit," it will not work. If you are a first time user, please click on the "First Time Logging In" link located near the submit button. You will then be prompted to create a username and password for your account.

Home | Employee Participants | Employers & Plan Sponsors

Home > Employee Participants > Account Login

ACCOUNT LOGIN

My Benefits Account Login

Username

Password

Forgot your username or password?

First time logging in? Sign up here.

SUBMIT

Once you log in you will reach your "My Benefits Summary," which lists the summary of each plan made available to you through your employer.

FSA -- Choose an action --

Plan Summary

Plan ID: DEMO1415
Plan type: UNREIMBURSED MEDICAL ACCOUNT
Plan year start date: 05/01/2014
Plan year end date: 04/30/2015
Final date to submit claims: 09/30/2014
Status: Active

Election amount: $1,800.00
Available funds: $1,645.00
Amount contributed: $69.23
Total of claims submitted: $155.00
Total of claims paid: $155.00

Show/Hide Plan Details

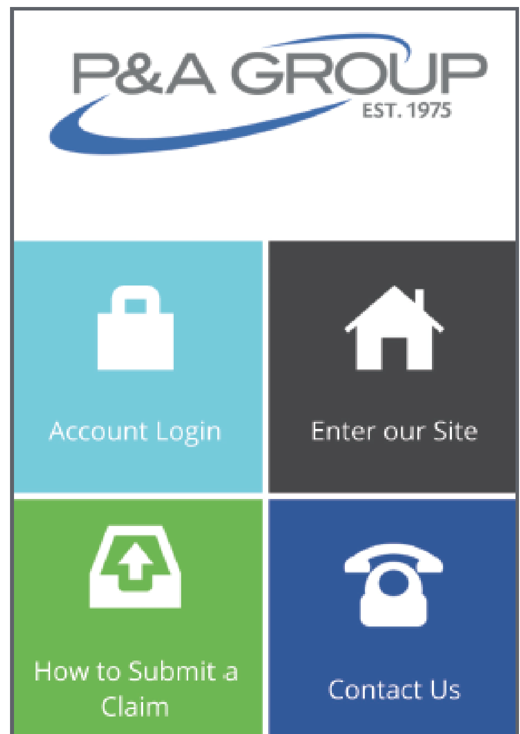
Click "Show/Hide Plan Details" on your plan summary to see your claims submitted, pending claims, claims paid and contributions.

Plan Details

Claims Submitted | Pending Payment | **Claims Paid** | Contributions

Check Number	Claim Number	Payment Type	Date	Amount	Memo
1019052	1897025	Check	07/03/2014	$125.00	UPV269847
1019052	1904626	Check	07/03/2014	$5.00	UPV275625
3163475	3163475	N/A	05/13/2014	$25.00	N/A

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)



P&A'S MOBILE SITE -

www.padmin.com on your smartphone

Customer Service Options

Phone: (800) 688-2611
Monday through Friday 8:30am to 10pm ET

Web: www.padmin.com
Live online chat available during customer service hours

Mailing Address: 17 Court Street, Suite 500, Buffalo, NY 14202

P&A Group Mobile Technology

Getting quick and easy access to your accounts on the go has never been easier! P&A Group offers you a variety of mobile tools to make managing your account easy, convenient and effective- the way it should be.

Mobile Site

P&A Group's mobile site allows you to manage your account directly from your smartphone or mobile device. You can check your account balance, submit a claim, contact us with a question or check out account tools to help oversee your plan. Visit www.padmin.com on your mobile device.

Quikclaim

Submit your claims electronically. Log into your account and upload a claim along with any supporting documentation.

Text Messaging Options

Receive on-the-go account information via text message once you update your online profile with your mobile number. To update your profile, log into your P&A Account online at www.padmin.com (select "Login", then "Employee".) Once your account is updated with your mobile number, you can text specific codes to the number 70626 and instantly receive updated account details.

FEATURE	TEXT CODE	INSTRUCTIONS
Account balance	BAL	Text BAL to receive a text message with your account balance
Claim Status	CLM	Check the status of your most recent claim
History of Last Five Reimbursements	HIS	Instantly get an update on your last five reimbursements
Deposit Update	DEP	View your last five deposits into your account(s)

DENTAL

OUR PLANS

DELTA DENTAL PPO LOW PLAN

DELTA DENTAL PPO HIGH PLAN

Under the Delta Dental Preferred Provider Organization (PPO) plan, dental services are provided through the Delta Dental PPO network. However, you can choose to visit any dentist in any location inside or outside of the Delta Dental network. How much you pay for dental services depends on whether you choose a participating Delta Dental dentist. If you choose a non-participating dentist, you pay the difference between the amount the dentist receives from Delta Dental (the “allowable amount”) and the dentist’s charges.

We offer two Dental plans through Delta Dental.

Why Sign Up For Dental Coverage?

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

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

Dental insurance covers four types of treatments:

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

DELTA DENTAL – LOW PLAN & HIGH PLAN

DENTAL*	Low Plan		High Plan	
	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Calendar Year Maximum	$1,500	$1,000	$1,500	
Calendar Year Deductible Individual / Family	$25 / $75	$50 / $150	$0 / $0	$25 / $75
Diagnostic and Preventive[1] Oral Examinations X-Rays Teeth Cleaning Fluoride Treatment Space Maintainers Bitewings Sealants	100%	80%	100%	100%
Basic Services Amalgam/Composite Filings Periodontics (Gum disease) Endodontics (Root Canal) Extractions & Other Simple Oral Surgery	80%	60%	90%	80%
Major Services Crown Repair Restorative - Inlays and Crowns Prosthodontics	50%	50%	80%	70%
Implant Benefits	70% to $1,500 Lifetime		70% to $1,500 Lifetime	
Temporomandibular Joint (TMJ) Benefits	70% up to $500 Lifetime		70% up to $500 Lifetime	
Orthodontia Adults and Children up to age 26	50% up to $1,500 Lifetime		50% up to $1,500 Lifetime	

*Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.
** Non-Delta Dentists are reimbursed at the lesser of the submitted charge or the fee that satisfies the majority of dentists in the same geographical area with the same training (51st percentile of Usual, Customary and Reasonable)
[1]Diagnostic and Preventive—2X per year

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description.

DELTACARE USA – DENTAL DHMO

Under the DeltaCare USA plan, dental services are provided through the DeltaCare USA network. When you enroll, you select a contract dentist to provide services. The DeltaCare USA network consists of private practice dental facilities that have been carefully screened for quality.

There are no deductibles, and no annual or lifetime dollar maximums. Out-of-pocket costs are clearly defined and out-of-area dental emergency coverage is up to $100 per emergency.

DENTAL*	Enrollee Pays
Diagnostic and Preventive Oral Evaluation	No Cost
Prophylaxis Cleaning—Adult	No Cost
Additional Prophylaxis Cleaning—Adult	$45
Restorative Amalgam Filing (1-4 Surfaces)	No Cost
Resin Based Composite Filling—Anterior (1-4 Surfaces)	No Cost
Resin Based Composite Filling—Posterior (1-4 Surfaces)	Up to $85
Periodontics Gingivectomy—four or more contiguous teeth per quadrant	$130
Osseous Surgery—four or more contiguous teeth per quadrant	$280
Endodontics Pulp Cap—Direct (excluding final restoration)	No Cost
Root Canal Therapy Anterior (excluding final restoration)	$55
Root Canal Therapy Bicuspid (excluding final restoration)	$120
Prosthodontics Immediate Denture Maxillary/ Mandibular	$165
Complete Denture Maxillary/ Mandibular	$145
Crown and Bridge Crown—Porcelain/Ceramic Substrate	$240
Crown—Porcelain Fused to High Noble Metal	$240
Oral Surgery Extractions—Impacted tooth: Soft tissue	$50
Extractions—Impacted tooth: Partial bony	$70

*Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions. See the "Description of Benefits and Copayments" for a full list of your benefits.

DELTA DENTAL RESOURCES

FINDING A DELTA PROVIDER

To find a Delta Dental provider near you, please visit deltadentalins.com and click "Find a Dentist." For PPO plans choose "Delta Dental PPO" and for HMO plans choose "DeltaCare USA."

SmileWay® Wellness Benefits

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

Delta Dental Mobile App

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

Toothpic

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

Cost Estimator

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

Amplifon & Qualsight Discounts

With the Amplifon discount, Delta Dental members get an average savings of 62% off the latest retail hearing aid price. PPO members may even be able to use their plan benefits in coordination with Amplifon discounts. There is also a QualSight discount for Delta Dental members. Members receive 40-50% off the national average price of traditional LASIK eye surgery when you use an experienced QualSight LASIK surgeon.

VISION

OUR PLANS

VSP Choice Plan

Click to play video

We offer one vision plan through Vision Service Plan (VSP).

Why Sign Up For Vision Coverage?

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

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

VISION

You are eligible for vision coverage through VSP Vision. VSP provides coverage for eye exams and materials, such as lenses and frames. VSP now covers standard progressive lenses in full.

VISION	VSP Choice Network	Non-Network
Exam	$10 copay	Plan pays up to $45
Single Lenses	Covered in Full	Plan pays up to $30
Bifocal Lenses	Covered in Full	Plan pays up to $50
Trifocal Lenses	Covered in Full	Plan pays up to $65
Contact Lenses Fitting and Evaluation	Covered in Full*	N/A
Contact Lenses**		
Elective	Plan pays up to $150	Plan pays up to $105
Medically Necessary	Covered in Full***	Plan pays up to $210
Frames	$150 Allowance	Plan pays up to $70
Benefit Frequency		
Exam	Every 12 Months	
Lenses and Contacts**	Every 12 Months	
Frames	Every 24 Months	

*Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $60.00 copayment
**Contact lenses are available once every 12 months in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.
***Subject to Copayment

You may receive benefits when using non-VSP providers by submitting your claims directly to VSP. Reimbursements will be made as indicated in the out-of-network schedule above. Find a VSP network doctor at www.vsp.com or call (800) 877-7195.

VSP SAVINGS AND RESOURCES

ACCESS TO OVER $3,000 IN EXCLUSIVE MEMBER SAVINGS

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

Extra Savings on Glasses and Sunglasses

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

Retinal Screening

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

LASIK - Laser Vision Correction

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

TruHearing® Hearing Aid Discount

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

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

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

VSP Diabetic Eyecare Plus Program

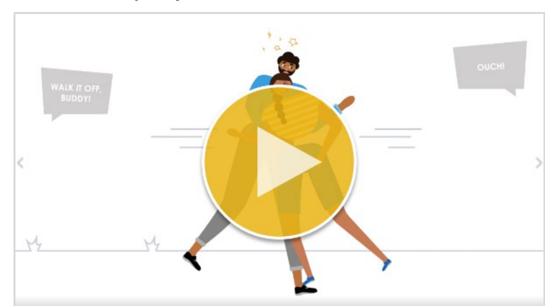
This program provides coverage of additional eyecare services specifically for members with diabetic eye disease, glaucoma or age-related macular degeneration (AMD). Eligible members can receive both routine and follow-up medical eyecare from their VSP doctor—the doctor who already knows their eyes best.

The program also provides supplemental coverage for non-surgical medical eye conditions such as diabetic retinopathy, abnormal blood vessel growth on the eye (rubeosis), and diabetic macular edema. Members can self-refer, visit their VSP Provider as often as needed, and pay only a copay for services.

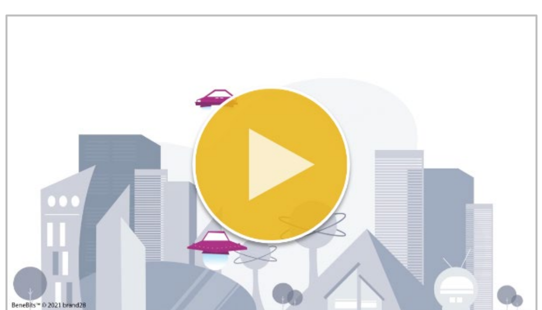
ENGAGE

Maximize Your Healthcare

Click to play video



Urgent Care vs ER



Virtual Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

KNOW WHERE TO GO

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

Type	Appropriate for	Examples	Access	Cost
Nurseline	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or ▪ stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
Surgery	Ambulatory Surgery Center (ASC)	▪ Specializes in same-day surgeries ▪ Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more ▪ Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy	Free-standing physical therapy center	▪ Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study	Home testing	▪ Diagnoses sleep apnea and other conditions ▪ Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy	Home or outpatient infusion therapy	▪ For drugs that must be delivered by intravenous injections, or epidurals ▪ Delivered by licensed infusion therapy provider ▪ Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay*

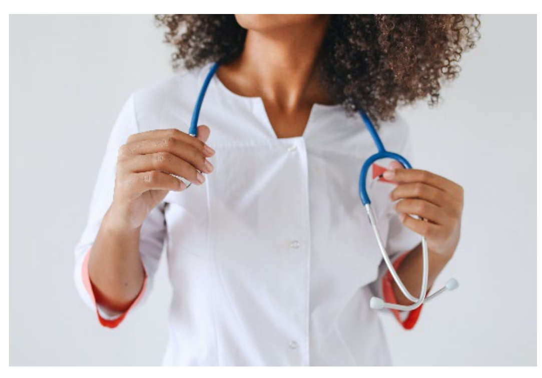
**in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

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

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

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

What is Preventive Care?

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

Visit cdc.gov/prevention for recommended guidelines.

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

Not all exams and tests are considered preventive

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

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

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

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

LINCOLN LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

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

Is your family protected?

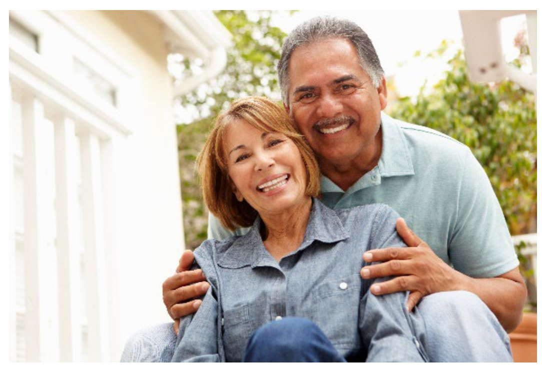
Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large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

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

If you need additional coverage

We offer voluntary life coverage that you can purchase for yourself, your spouse, and your children and also offer voluntary short-term disability.

LINCOLN CITY-PROVIDED LIFE AND AD&D INSURANCE



A NOTE ABOUT TAXES

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

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Lincoln and premiums are paid in full by City of Roseville.

Lincoln Basic Life and AD&D

2x base annual earnings up to a maximum of **$500,000**

Spouse Benefit

Amount equal to **$5,000**

Child(ren) Benefit

Birth to 26 years of age : **$2,000**

The benefit amounts above will be reduced if you are age 70 or older. Refer to the plan document for details.

LINCOLN VOLUNTARY LIFE INSURANCE

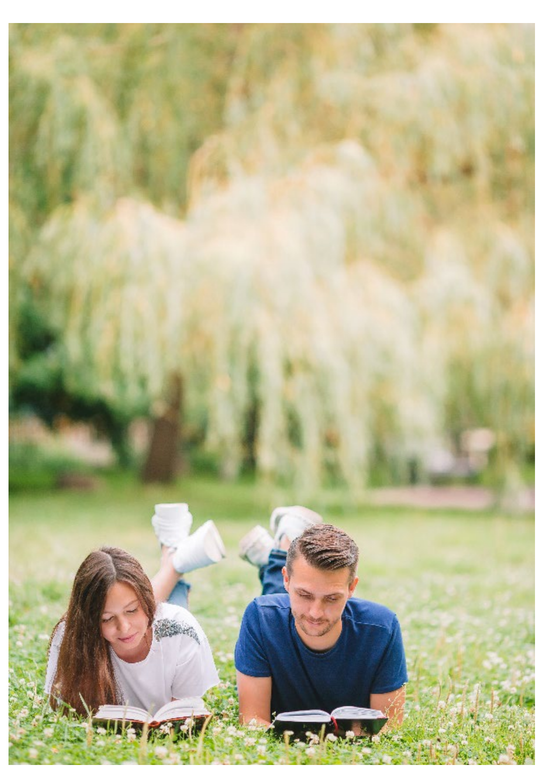
Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Lincoln and available for your spouse and/or child(ren).

Lincoln Voluntary Life

Employee	Increments of $10,000 up to $500,000 Guaranteed Issue: $250,000
Spouse	Increments of $5,000 up to $250,000 *(not to exceed 100% of the employee's elected life benefit)* Guaranteed Issue: $50,000
Child(ren)	Flat $10,000 (birth to age 26)

Note: *The benefit amounts above will be reduced if you are age 70 or older. Refer to the plan document for details.*



GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

In the event of a serious or fatal accident

Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Coverage is provided by Lincoln and available for your spouse and/or child(ren).

Lincoln Voluntary AD&D

Employee	Increments of $10,000 up to $500,000
Spouse	Increments of $5,000 up to $250,000 *(not to exceed 100% of the employee's elected life benefit)*
Child(ren)	Flat $10,000 (birth to age 26)

Evidence of Insurability (EOI)

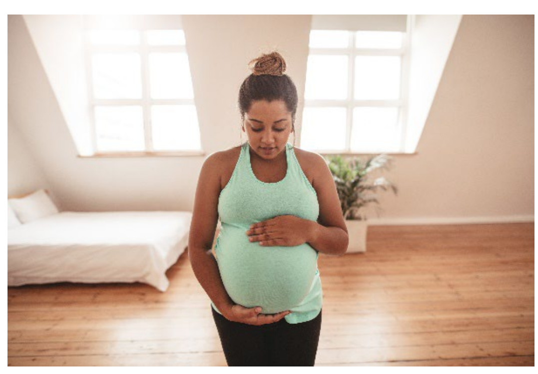
If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (enrolling more than 60 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Lincoln. You can find the form at Lincoln4Benefits.com, click on the Evidence of Insurability link, and follow the easy instructions on your screen.

LINCOLN VOLUNTARY SHORT-TERM DISABILITY INSURANCE (STD)

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

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

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. You pay the cost of this coverage. Coverage is provided by Lincoln.



Eligibility	All Employee's except Local 39 employees
Weekly Benefit Amount	Plan pays 66.7% of weekly earnings
Maximum Weekly Benefit	$1,620
Benefits Begin After Accident Sickness	 7 days of disability 7 days of disability
Maximum Payment Period[1]	8 weeks

[1]Maximum payment period is based on the first day benefits begin, not the first day you are disabled.

EXPECT THE UNEXPECTED

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

SUBMITTING A CLAIM

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

Evidence of Insurability (EOI)

When you are first offered this coverage (and during approved open enrollment periods), you may be able to take advantage of this important coverage with no evidence of insurability (proof of health).

However, if you are a late entrant (enrolling more than 60 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Lincoln. You can find the form at Lincoln4Benefits.com, click on the Evidence of Insurability link, and follow the easy instructions on your screen.

LINCOLN LONG-TERM DISABILITY INSURANCE (LTD)

LTD benefits cushion the financial impact of a disability

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

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

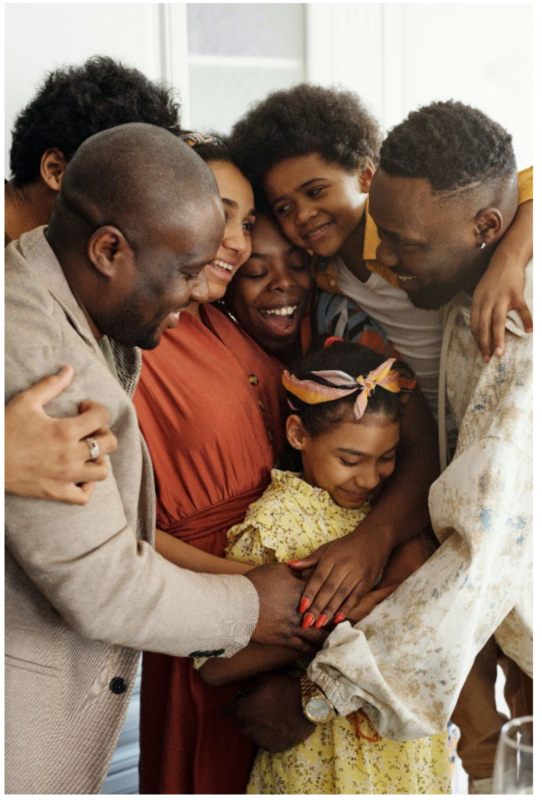
If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. The City pays the entire cost of LTD coverage after the first 5 years of service for Classes 1, 2 & 3. Coverage is provided by Lincoln.

	Class 1	Class 2	Class 3	Class 4	Class 5
Eligibility	Management & Confidential Employees	Local 39 Employees	IBEW Employees	Sworn & Non-Sworn Police	Firefighters
Contributions	Employee pays for first 5 years of service, and thereafter the City pays	Employee pays for first 5 years of service, and thereafter the City pays	Employee pays for first 5 years of service, and thereafter the City pays	Employee pays	Employee pays
Elimination Period	60 Days				
Monthly Benefit					
Core Plan	60% of Monthly Earnings up to $6,000				
Buy-Up Option	70% of Monthly Earnings up to $11,000				
Minimum Monthly Benefit	$100				

Evidence of Insurability (EOI)

If you elect Buy-Up Long-Term Disability coverage, or if you are a late entrant (enrolling more than 60 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Lincoln. You can find the form at Lincoln4Benefits.com, click on the Evidence of Insurability link, and follow the easy instructions on your screen.

LINCOLN VALUE ADDED SERVICES



WellnessPATH®

Lincoln WellnessPATH® provides tools and personalized steps to manage your financial life. From creating a budget to building an emergency fund to paying down debt, this easy-to-use online tool helps you turn information into action so you can focus on both short- and long-term goals, like saving for retirement. Contact your Human Resources contact to start using Lincoln WellnessPATH® today.

TravelConnect® Services

TravelConnect® services provide a wealth of medical, safety and travel-related services you can access while on a business or leisure trip more than 100 miles from home. It includes evacuation services, Travel Assistance services, and medical, dental and pharmacy referrals.

To access call collect from anywhere in the world:

+1(603) 328-1955 or

Toll Free from US or Canada: (866) 525-1955.

LifeKeys® Services

This program provides access to a wide array of services to help you and your loved ones through life's ups and downs — and prepare you for whatever lies ahead. Services include online will preparation, access to GuidanceResources® Online, protection against identity theft, and guidance and support for your beneficiaries. It's easy to access LifeKeys® services. Just call (855)891-3684 or visit GuidanceResources.com.

(First-time user: Enter Web ID LifeKeys).

WELLBEING & BALANCE

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

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

A Happier, Healthier You

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

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Take time to spend with family and friends, take care of personal business, or just have a little extra “me time”
- Assist with and offer resources for financial and legal matters

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

LINCOLN *EMPLOYEECONNECT* (EAP)

CONTACT EMPLOYEECONNECT

Phone
Toll-free (888) 628-4824,
available 24 hours a day

Website
www.guidanceresources.com
Username: LFGSupport
Password: LFGSupport1

Help for you and your household members

EmployeeConnect offers professional, confidential services to help you and your loved ones improve your quality of life. Lincoln's *EmployeeConnect* is here 24/7 to connect or refer you to a professional who can help with marriage, family and relationship issues; problems in the workplace; stress, anxiety and sadness; grief, loss, or responses to traumatic events; concerns about your use of alcohol or drugs; and financial and legal issues.

You and your household members are entitled to 5 face-to-face sessions or unlimited telephonic or online consultations for problem-solving support per individual, per incident, per policy year. You also receive one free 30-minute in-personal legal consultation per legal issue (**25% off** subsequent meetings).

All services are confidential and in accordance with professional ethics and federal and state laws. Use of the EAP is strictly voluntary.

The EAP is offered to you in addition to the Anthem EAP Program.

Unlimited 24/7 Assistance

You and your family can access the following services anytime – online, on the mobile app, or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more
- Legal information and referrals for family law, estate planning, consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online Resources

EmployeeConnect offers a wide range of information and resources you can research and access on your own. Expert Advice and support tools are just a click away when you visit guidanceresources.com or download the *GuidanceNow* mobile app. You'll find:

- Article and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets, and more

ANTHEM EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone

Toll-free (833) 954-1067,
available 24 hours a day

Website

www.anthemEAP.com
(**Access Code**: PRISM)

With Anthem EAP, you have access to virtual visits through LiveHealth Online. You can access LiveHealth Online by visiting the website at www.livehealthonline.com or by downloading the app from the Apple or Google app store.

Help for you and your household members

The Employee Assistance Program (EAP) is designed to help with life's many challenges. Anthem is here 24/7 to connect or refer you to a professional who can help with marriage, family and relationship issues; problems in the workplace; stress, anxiety and sadness; grief, loss or responses to traumatic events; concerns about your use of alcohol or drugs.

You and your household members are entitled to 6 face-to-face sessions or telephonic or online consultations for problem-solving support per individual, per incident, per policy year.

All services are confidential and in accordance with professional ethics and federal and state laws. Use of the EAP is strictly voluntary.

Work & Life Services

- **Child and Eldercare Assistance** – Help accessing available community and financial resources and referrals to pre-screened providers for childcare, eldercare and more. You may also be entitled to help with adoption, parenting skills, child development, special needs, emergency care, relocation services and educational issues.
- **Financial Issues** – Budgeting, credit and financial guidance (tax or investment advice, loans and bill payments not included), retirement planning.
- **Legal Services** – Employees can talk to an attorney for 30 minutes about legal matters like wills and estate planning. If more time is needed, they can get discounts on future meetings.
- **Identity Theft Recovery Services** – Employees and their household members have access to identity monitoring and telephone consultation to help them recover from, and minimize the impact of, a breach of identity.

TALKSPACE

CONTACT TALKSPACE
Website:
www.talkspace.com/prismeap
Organization: City of Roseville

Sign up for Talkspace today

- Use a web browser to register at talkspace.com/prismeap
- When registering, enter your employer's name in the "Organization name" field.
- Complete the QuickMatch provider finder questions.
- Await your provider match, then send a message or schedule a virtual session

Virtual Behavioral Health Service

If you or a loved one is struggling with life's challenges, finding a mental health professional to talk to quickly can make a big difference. That's why your Anthem Employee Assistance Program (EAP) is offering Talkspace, a service that provides confidential counseling by text, audio, or video — whatever way feels right for you. Talkspace is now available to all employees and their dependents age 13 and older.

How it works

Talkspace matches you with a dedicated, licensed clinician when, where and how it's most comfortable for you. 70% of Talkspace members see clinically significant symptom improvement in less than 12 weeks.

- Create a private, personalized support plan with your provider of choice
- Unlimited messaging by text, voice, video, or photo
- Every Talkspace member has a secure, private "room" to communicate with their therapist and can send messages in the room 24/7
- Book two 30-minute live video sessions per month via web or mobile app using the Live Scheduler tool
- Access to self-guided exercises such as meditation and journaling, whether or not you engage with a therapist

Lasting relationship counseling app

When people have strong relationships, they can show up in all areas of life with more focus and less stress.

- Can be used alone or combined with Talkspace therapy
- Improve relationship satisfaction featuring topical sessions, discussion guides, live workshops and more!
- Pairs sign up individually and connect accounts within the app
- Sessions are completed independently, allowing each person to reflect and express feelings on a number of topics, including conflict and communication
- Sessions are compared, allowing each person to safely learn and comment about the other's thoughts, feelings, and needs
- Popular topics of discussion include Relationship Foundations, Emotional Connection, Parenting Together, and Family Culture

MISSIONSQUARE DEFERRED COMPENSATION

The Deferred Compensation Plan is an easy and convenient way to supplement your PERS retirement. It allows you to defer a portion of your salary through payroll deductions into the plan and invest it, on a tax-deferred basis. It is a tax-deferred, defined contribution, supplemental retirement program. Funds in the Deferred Compensation Plan are not subject to taxes until they are withdrawn from the Plan. At the time of withdrawal normal income taxes are due, but there is no IRS penalty, regardless of your age. Because of the tax-deferred status of the funds in the Deferred Compensation Plan, Federal law strictly limits access to these funds and under normal circumstances prohibits participants from withdrawing these funds while employed with the City.

457 Plan

The 457 Plan is authorized under Section 457 of the Internal Revenue Code. This plan is available to all benefited City of Roseville employees. Payroll deductions may be changed or stopped at any time. You can change your 457 deferred compensation contribution by computing a 457 change form.

Limitation	2023
Annual Deferral Limit	$22,500
"Pre-Retirement" Catch-Up Limit	$22,500 ($45,000 total)
"Age 50" Catch-Up Limit	$7,500 ($30,000 total)

401(A)

The 401(a) Plan is administered by ICMA-RC, now known as MissionSquare and is authorized under Section 401(a) of the Internal Revenue Code. This plan is only available to employees in the Management/Confidential group within 60 days of initial hire. Once enrolled in the plan employees may not elect to opt out of contributions.

Limitation	2023
Annual Deferral Limit	$66,000

IMPORTANT PLAN INFORMATION

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

- City Contributions
- Health Premium Rates
- Contact information for our benefit carriers and vendors
- Benefits Glossary to help you understand important insurance terms.
- Summary of the health plan notices you are entitled to receive annually, and where to find them

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify HR if your domestic partner is your tax dependent.

CITY CONTRIBUTIONS

Following are the 2024 City Contribution amounts for bargaining units Local 39, RPOA (Sworn), Management Confidential, IBEW*, RFF and RPA (Non-Sworn), effective January 1, 2024.

Tier	Cafeteria Contribution
Employee Only (EE Only)	$1,347.00
Employee Plus One Dependent (EE+1)	$1,347.00
EE Plus Family (Family)	$1,347.00

Tier	Flex Credit
	IBEW, RFF, RPOA, LOCAL 39, MGMT/CONF, RPA
Employee Only (EE Only)	$200.00
Employee Plus One Dependent (EE+1)	$513.00
EE Plus Family (Family)	$918.00

Seasonal Appointments	Cafeteria Contribution	Flex Credit
1500 Hour Temporary Employees	$157.00	N/A

*IBEW (represented employees) – The City contributes one hundred dollars ($100) monthly into employees deferred compensation plan. **Employees may choose to contribute this amount toward their medical plan**. This is an annual election made during open enrollment.

If you decide to decline to enroll in medical coverage and provide proof of other medical coverage, you will receive a $150.00 per month cash-out option. Please note that by selecting this option of cash payment, it will be reported as taxable income. Please contact Human Resources at (916) 774-5475 for more information.

HEALTH PREMIUM RATES

Monthly Health and Welfare Program Insurance Premium Rates
01/01/2024 through 12/31/2024

MEDICAL	Employee Only	Employee & 1 Dependent	Employee with 2 or more dependents
HMO's			
Anthem HMO Select	$1,138.86	$2,277.72	$2,961.04
Anthem HMO Traditional	$1,339.70	$2,679.40	$3,483.22
Blue Shield Access+	$1,076.84	$2,153.68	$2,799.78
Blue Shield Trio[1]	$946.84	$1,893.68	$2,461.78
Kaiser Permanente	$1,021.41	$2,042.82	$2,655.67
UnitedHealthcare Alliance	$1,091.13	$2,182.26	$2,836.94
UnitedHealthcare Harmony	$937.39	$1,874.78	$2,437.21
Western Health Advantage	$807.23	$1,614.46	$2,098.80
PPO's			
PERS Platinum	$1,314.27	$2,628.54	$3,417.10
PERS Gold	$914.82	$1,829.64	$2,378.53
PORAC[2]	$931.00	$2,117.00	$2,651.00

[1]Only available in El Dorado, Nevada, Placer, Sacramento, and Yolo Counties
[2]Available only to members of Police Officer's Research Association of California (only RPOA and RFF members are eligible)

DELTA DENTAL	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
High Opt PPO	$63.75	$112.22	$110.28	$169.43
Low Opt PPO	$43.43	$78.03	$73.97	$115.15
DeltaCare	$17.40	$34.20	$32.10	$57.00

VISION	Employee Only	Employee & 1 Dependent	Employee with 2 or more dependents
Vision Service Plan (VSP)	$7.49	$10.86	$19.48

PLAN CONTACTS

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

Provider	Phone Number	Website	Policy No.
Anthem Blue Cross Select & Traditional HMO	(855) 839-4524	www.anthem.com/ca/calpers/	
Anthem Blue Cross PPO	(855) 839-4524	www.anthem.com/ca/calpers/	
Blue Shield	(800) 334-5847	www.blueshieldca.com/calpers	
Kaiser Permanente HMO	(800) 464-4000	mybenefits.kp.org/calpers/	
PORAC	(800) 937-6722	www.porac.org	
UnitedHealthcare Alliance HMO	(877) 359-3714	www.uhc.com/calpers	
Western Health Advantage	(888) 942-7377	www.westernhealth.com/calpers	
Delta Dental PPO	(800) 499-3001	www.deltadentalins.com	#00713
DeltaCare USA (HMO)	(800) 422-4234	www.deltadentalins.com	#70302
VSP	(800) 877-7195	www.vsp.com/	#12137687
Lincoln (Basic Life/AD&D & LTD)	(877) 275-5462	www.mylincolnportal.com **Company Code:** LF1232CIT	**Life/AD&D:** #SA3-890-LF1232-01 **STD:** #GD3-890-LF1232-01 **LTD:** #GF3-890-LF1232-01
Lincoln Employee Connect (EAP)	(888) 628-4824	www.guidanceresources.com **User Name:** LFGSupport **Password:** LFGSupport1	
Anthem (EAP)	(833) 954-1067	www.anthemeap.com **Company Web ID:** PRISM	City of Roseville
P&A Group (Flexible Spending Account)	(800) 688-2611	www.padmin.com	
ICMA-RC/MissionSquare (Deferred Compensation)	(800) 362-7272	www.icmarc.org	

GLOSSARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

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

Excluded Service
A service that your health plan doesn’t pay for or cover.

-F-

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

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

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

-H-

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

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

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

GLOSSARY

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

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

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

-S-

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

-T-

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

-U-

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

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

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

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

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

MEDICARE PART D (PRESCRIPTION DRUG) THROUGH CALPERS

Medicare Part D is a voluntary federal outpatient prescription drug benefit available to everyone with Medicare. The Medicare Part D premium varies based on the prescription drug plan and is paid to your health carrier as part of the CalPERS health premium. As with Medicare Part B, if your income exceeds established thresholds, the SSA will assess an additional income-related monthly adjustment amount. Payment of this amount is mandatory to protect your Medicare enrollment and eligibility to remain enrolled in a CalPERS Medicare health plan.

To be enrolled in a CalPERS Medicare health plan, you cannot be enrolled in a non-CalPERS Medicare Part D plan.

CalPERS Health Plans and Medicare Part D

CalPERS participates in the Employer Group Waiver Plan (EGWP). EGWPs are Prescription Drug Plans governed by the CMS.

If you are a Medicare-eligible subscriber or dependent, you are automatically enrolled into EGWP. If for some reason, you chose to opt out of EGWP, you will be financially responsible for all of your prescription drug costs. In addition, if you enroll in a non-CalPERS Medicare Part D plan, you are no longer eligible to remain enrolled in a CalPERS Medicare health plan. Consequently, you and all of your covered dependents will be terminated. Contact the City of Roseville Human Resources Department for more details.

Medicare Part D Notice

Important Notice from City of Roseville 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 Roseville 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 Roseville has determined that the prescription drug coverage offered by CalPERS is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.
However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2024
Name of Entity/Sender:	City of Roseville
Contact-Position/Office:	Human Resources
Address:	311 Vernon Street, Roseville, CA 95678
Phone Number:	(916) 774-5475

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.

Women's Health and Cancer Rights Act

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

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

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

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

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

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

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

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

Availability of Privacy Practices Notice

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

Notice of Choice of Providers

HMO plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, your carrier will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier directly.

For children, you may designate a pediatrician as the primary care provider.

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

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, 2023. 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 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp | Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | 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 or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or 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 January 31, 2023, 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
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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.

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COBRA CONTINUATION COVERAGE

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% in 2023 of your modified adjusted household income.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find private individual 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 2023 for coverage starting as early as January 1, 2024.

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 the Employment-Based Health Coverage We Offer to You Affect Your Eligibility for Premium Savings through the Marketplace?

Yes. If we have offered you health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and you may wish to enroll in our health plan if you are eligible. (Just because you received this Marketplace notice does not mean you are eligible.) However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if we do not offer coverage to you at all or do not offer coverage that meets certain standards. If the cost of self-only coverage under our health plan is more than 9.5% of your household income for the year, or if our health plan does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution—as well as your employee contribution—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 About the Health Insurance Marketplace?

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.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS

Part B: Information About Employer-Provided Health Plan Coverage

If you decide to complete an application for coverage in the Marketplace, you will be asked for information about our health plan coverage. The information below can help you complete your application for coverage in the Marketplace.

1. General Employer Information

Employer Name:	City of Roseville
Employer Identification Number (EIN):	94-6000409
Employer Street Address:	311 Vernon Street
Employer Phone Number:	(916) 774-5475
Employer City:	Roseville
Employer State:	CA
Employer ZIP Code:	95678
Who Can We Contact About Employee Health Coverage At This Job?	Human Resources
Email Address:	humanresources@roseville.ca.us

2. Eligibility. You may be asked whether you are currently eligible for our health plan coverage or whether you will become eligible for coverage within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting Human Resources at (916) 774-5475.

3. Minimum Value. If you are eligible for coverage under our health plan, you may be required to check a box indicating whether our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard

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