2022-2023 EMPLOYEE BENEFITS GUIDE

City of Charlottesville

MarshMcLennan Agency

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EXPLORE YOUR BENEFITS

The plan year is July 1, 2022 through June 30, 2023.

Learn

- Read through this Benefits Guide.
- View your Benefits Video here: 2022 - 2023 Charlottesville Benefits.

Evaluate

- Your current benefits enrollments.
- The amount of pre-tax contributions you want to make to your FSA.
- Your family's child or adult care costs if you want to contribute to the Dependent Care FSA.

Act

- There are 2 systems you can access during Open Enrollment and throughout the year to view your current benefits information, make changes to benefits and complete enrollment: *HR InTouch* and **BENEFITFOCUS® App.** See page 5 for details.
- Existing employees should submit benefit elections during the Open Enrollment period and by **June 3, 2022.**
- Newly hired employees should submit benefit elections during the New Hire Enrollment period and **within 30 days** following date of hire. Additionally there are 3 forms that must be signed and returned to HR within 30 days following date of hire. See additional information on page 5.

Have Questions?

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Making Changes after Open Enrollment

Several benefits may only be elected or changed during open enrollment or as the result of a qualified life event. You must notify HR within thirty (30) days of your qualifying event to make a change; otherwise, you must wait until the next open enrollment period which takes place each May for a July 1 effective date.

Examples of qualified life events:

- You get married, divorced, or legally separated (if legal separation is recognized in the state where you reside);
- You experience a loss of other group coverage;
- You have a baby, adopt a child, or are appointed as a legal guardian;
- You or your spouse has a change in employment status;
- You experience the death of a spouse or dependent;
- You become eligible for or lose Medicaid coverage; or
- Your dependent no longer qualifies as an eligible dependent

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 page 38 for more details.

ANNUAL OPEN ENROLLMENT FOR ALL EMPLOYEES

Open Enrollment is the time of year to review the valuable benefits offered by the City. It is your opportunity to review your current benefit elections, make adjustments to your coverage if you wish, and enroll or re-enroll in the flexible spending and parking programs. Open enrollment for the July 1, 2022- June 30, 2023 plan year begins May 16, 2022 and the last day to make changes to your elections is June 3, 2022. Elections made during open enrollment will be effective for the entire plan year.

If you do not wish to make any changes to your medical, dental, vision, life insurance or Aflac plans, no action is needed. Current elections will roll over to the new plan year. If you wish to participate in the Health Care Flexible Spending Account, Dependent Care Flexible Spending Account and/or the Pre-tax Parking Plan, you must take action to enroll or re-enroll in those benefits for the new plan year. Elections for those benefits do not roll over from one plan year to the next.

Your Benefit Open Enrollment window is May 16, 2022 – June 3, 2022.

Eligibility

If you are a regular full-time or part-time employee working 20 or more hours a week, you are eligible to enroll in the benefits found in this guide. Eligible dependents include your legal spouse, children up to age 26, and/or unmarried children over age 26 who are incapable of self-support.

Medical Opt-Out Program

The City provides a monetary Opt-Out Benefit each plan year to employees who decline medical insurance coverage and can show proof of other medical insurance coverage. Details are outlined on *HR InTouch*.

Key Information for 2022 - 2023

- Review benefits and make elections or changes:
  - ✓ Aetna Medical insurance benefits
  - ✓ Delta Dental insurance benefits
  - ✓ MetLife Vision insurance benefits
  - ✓ Minnesota Life/Securian Voluntary Supplemental Life insurance benefits
  - ✓ Aflac Plans [Accident, Cancer/Specified Disease, Hospital Indemnity, and/or Short-Term Disability]
- Required annual election*
  - ✓ Flexible Spending accounts NOW ADMINISTERED BY FLEXIBLE BENEFIT ADMINISTRATORS, Inc.
  - ✓ Pre-Tax parking program
  - ✓ Bicycle commuter program

*** Note:** Other important City-sponsored benefits that **do not** require review or action during open enrollment are Retirement Benefits, Long-Term Disability coverage, Optima Employee Assistance Program, Tuition Assistance and the CityFit Wellness Program. Existing and newly hired employees can enroll in and make changes to their 457 retirement program at any time.

ENROLLMENT DETAILS FOR NEW HIRES

When to Enroll

You have thirty days from your date of hire to submit your benefit elections or waive coverage.

How to Enroll

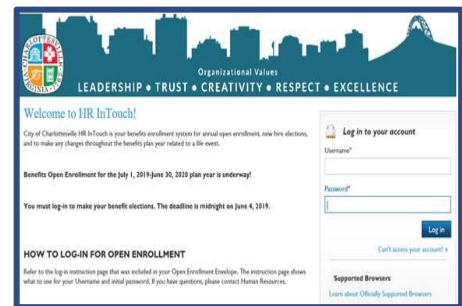
Enrollment in insurance plans is completed online at *HR InTouch*. The New Employee Orientation Form, Retirement Election Form and the Receipt Acknowledgement Form must be signed and returned to Human Resources **within 30 days** of hire.

Insurance Effective Date and Premiums

Insurance benefits are effective on the 1st of the month following date of hire. Benefits premiums will be deducted from an employee's paycheck starting with the 1st paycheck of the month following date of hire.

ONLINE ENROLLMENT FOR NEW HIRES AND THE ANNUAL OPEN ENROLLMENT PERIOD

You have two ways to enroll/make benefit election changes: online through *HR InTouch* at https://charlottesville.hrintouch.com or using the **BENEFITFOCUS® App**.



Online at https://charlottesville.hrintouch.com

1. Log-in to your online account via the URL above:
   - **User Name** is the uppercase letters COC followed by your 8-digit personnel number (no spaces or dashes)
     - **New Hires** will find your personnel number on the new employee orientation form in your onboarding email.
   - **Passwords**
     - **New Hires** Use Your Social Security Number (no dashes). You will be prompted to change your password.
     - **Annual open enrollment for all employees**: passwords are re-set every open enrollment to your Social Security Number (no dashes) You will be prompted to change your password

   EXAMPLE EMPLOYEE LOGIN: John Doe - employee ID number 00006783 and SSN 123-45-6789
   EXAMPLE USERNAME: COC00006783
   EXAMPLE INITIAL PASSWORD: 123456789
2. Click on *Open Enrollment* to enter the platform to review your current elections/make election changes **or** *New Employee* to make your new hire elections or waive coverage.
3. Submit open enrollment elections through the website or app by **June 3, 2022**
4. New hires have **30 days** to make elections and submit required forms.

Using the BENEFITFOCUS® App

Download the app today!

1. Install the **BENEFITFOCUS® App** from Google Play or the Apple App Store.
2. Enter the company ID: Charlottesville
3. Log in using the instructions outlined above

For Benefits Questions: Call the City of Charlottesville Benefits Team at +1434-970-3490 OR Visit https://Charlottesville.hrintouch.com

MEDICAL PLAN INFORMATION

Aetna | +1800-426-4363 | www.aetna.com

City of Charlottesville offers three medical plan options from which to choose. All plans offer comprehensive coverage and preventive care benefits.

Preventive Care

Preventive care is covered 100% by your plan. What is considered a preventive care service?

Preventive care includes those services that are linked to routine wellness exams. Examples include annual routine physicals, bone-density tests, cholesterol screenings, immunizations, mammograms, Pap smears, pelvic exams, colonoscopies, and other testing based on age and/or sex.

Take advantage of your network

While you have the flexibility to choose any provider you would like, taking advantage of in-network providers will offer the most cost-effective choice of care. The percentage you pay out-of-pocket will be based on a negotiated fee, which is often lower than the actual charges. If you choose a provider who is out-of-network, you may be responsible for the difference between the Usual, Customary, and Reasonable (UCR) charges and what the provider charges. You may also be responsible for submitting claim forms to your carrier.

Search for a Provider

You can search online for doctors, hospitals and other healthcare providers by choosing the “Find a Doctor” option at www.aetna.com. Log in as a member or under “Guests” using the “Plan from an employer” option. Or call +1855-339-9404.

Aetna Choice POS 1 & Aetna Choice POS 2 Plans –

These "point of service" plans provide the option to select a primary care physician and specialist referrals are not required. A POS plan includes a network of doctors, hospitals and other health care providers who agree to provide medical services to plan enrollees at special, negotiated rates. Each health care provider in the network must meet and maintain strict quality requirements. You will still receive coverage when you see health care providers outside of the network coverage area but at a higher cost. See www.aetna.com/docfind or call +1855-339-9404 for a list of in-network providers.

Aetna Select - HMO – The Health Maintenance Organization (HMO) plan provides the option to select a primary care physician with no specialist referral requirement. In-network providers will charge a flat copay for each of your visits. You will have a lower payroll contribution compared to the POS plans, but will have more restrictions in selecting health care providers. An HMO plan delivers services through a network of doctors, hospitals and other health care providers who agree to provide medical services to plan enrollees at special, negotiated rates. Each network provider must meet and maintain strict quality requirements. For HMO participants, there is no out-of-network coverage (some exceptions for medical emergencies). HMO participants will be enrolled in an HRA (Health Reimbursement Account) provided by the City to help pay the plan deductible.

GLOSSARY

Commonly used insurance terminology

Term	Definition
Coinsurance	A percentage of a health care cost that the covered employee pays after meeting the deductible.
Copayment (Copay)	A fixed dollar amount for each doctor visit that the covered employee pays for a health care service, usually when the service is received. For example, a primary care doctor may charge a nominal copay per visit.
Deductible	A fixed dollar amount that the covered employee must pay out-of-pocket each plan year before the plan will begin reimbursing for non-preventive health expenses. Plans usually require separate limits for individual and other coverage tiers.
In-Network	Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.
Out-of-Network	A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than in-network providers.
Out-of-Pocket Limit	The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including copayments and coinsurance.

MEDICAL BENEFITS OVERVIEW

	Aetna Choice POS 1	Aetna Choice POS 2	Aetna Select - HMO
In-Network Overview			
Deductible (Plan Year)**	None	$300 Individual $600 Family	$1,250 Individual $2,500 Family
Embedded*/Non-Embedded**	N/A	Embedded	Embedded
Out-of-Pocket Maximum	$2,000 Individual $4,000 Family	$3,500 Individual $7,000 Family	$4,500 Individual $9,000 Family
Coinsurance	Covered at 100%	20%	30%
Preventive Care	Covered at 100%	Covered at 100%; deductible waived	Covered at 100%; deductible waived
PCP/Specialist Copay	$20 / $30 Copay	$25 / $40 Copay; deductible waived	$30 / $45; after deductible
Teladoc General Medicine	$20 Copay	$25 Copay; deductible waived	$49, after deductible
CVS Minute Clinic	No Charge	No Charge	No Charge
Urgent Care	$50 Copay	$50 Copay; deductible waived	$50 copay; after deductible
Emergency Room Visit	$200 Copay	$200 Copay; deductible waived	$200 copay; after deductible
Hospitalization	$400 Copay	20%; after deductible	30%; after deductible
Out-of-Network Overview			
Deductible	$100 Individual $200 Family	$300 Individual $600 Family	Emergency Only
Out-of-Pocket Maximum	$2,000 Individual $4,000 Family	$3,500 Individual $7,000 Family	
Coinsurance	20%	30%; after deductible	

- Deductible: a fixed amount that the covered employee must pay out-of-pocket each plan year before the plan will begin paying for non-preventive expenses. The POS1 does not have a deductible. The POS 2 and HMO plans do have a deductible as indicated above.
- *Embedded Deductible - In an embedded plan deductible, after each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan.

Blue text indicates change from previous year's plan.

HEALTH REIMBURSEMENT ARRANGEMENT

FOR EMPLOYEES ENROLLED IN THE AETNA SELECT HMO PLAN

Administered by Flexible Benefit Administrators | +1800-437-3539 | 24/7 Account access

https://fba.wealthcareportal.com/

What is an HRA?	An **HRA** is a reimbursement account set up and funded by the City that helps you pay for qualified medical expenses incurred throughout the plan year in your HMO plan
Who is eligible to request reimbursement through the HRA?	**You will be enrolled in the HRA if you choose the Aetna Select HMO Plan.** The HRA will not be available if you choose any other health insurance coverage
What expenses are eligible for reimbursement?	Medical expenses that apply toward the deductible, coinsurance and the out-of-pocket maximums of the Aetna Select HMO Group Health Plan
What expenses are NOT eligible for reimbursement?	Prescription expenses are not eligible for reimbursement through the HRA. Any expenses incurred out-of-network will not be eligible for reimbursement
Funds in your account	You have access to all of the money contributed into your HRA by the City each plan year. If you do not use all of your HRA dollars during the Plan Year, the funds will continue to rollover each year as long as you are an active employee and remain covered on the Company's health plan. The maximum amount you can keep in your HRA account is $4,500 (If you have Employee Only coverage) or $9,000 (if you have any other coverage amount).
How Does the Debit Card Work with Your HRA?	Your debit card will be loaded with the amount of your employer-funded account. Your benefits debit card gives you easy access to the funds in your tax-advantaged benefit accounts by swiping the card at the point of sale. The card can be used at any qualified service provider that accepts MasterCard. Funds are automatically transferred from the benefit account directly to qualified providers with no out-of-pocket cost and no need to file a claim for reimbursement. *Employees participating in both the HRA and health care Flexible Spending Account (FSA) will have funds for both plans loaded onto one debit card. If you are enrolled in both the Health Care FSA and the HRA, the FSA will pay first. Contact HR with questions about how the accounts work together.* Get Connected with Your Account Wherever, Whenever with the convenient participant portal accessible 24/7 at: https://fba.wealthcareportal.com/. To obtain a reimbursement from your HRA Account you must complete a Claim Form. This form is available from human resources. You must attach an Explanation of Benefits from your insurance carrier to show that the expense is going towards your deductible, even if you utilize the Benefits Card to spend down your HRA funding.

The City of Charlottesville allocates funds annually, based on your level of coverage.	
Employee only	$500
Employee plus spouse	$900
Employee plus child	$900
Employee plus children	$1,000
Family	$1,400

PHARMACY

Aetna | +1800-426-4363

	Aetna Choice POS 1		Aetna Choice POS 2		Aetna Select - HMO	
Rx Deductible	No Deductible		No Deductible		Not subject to deductible	
Rx Out-Of-Pocket Maximum	$4,350 Individual $8,700 Family		$2,850 Individual $5,700 Family		$1,850 Individual $3,700 Family	
	30 Day Retail	90 Day Mail Order	30 Day Retail	90 Day Mail Order	30 Day Retail	90 Day Mail Order
Preferred Generic Drugs	$10	$20	$10	$20	$10	$20
Preferred Brand -Name Drugs	$30	$60	$30	$60	$30	$60
Non-Preferred Generic and Brand-Name Drugs	$55	$110	$55	$110	$55	$110
Specialty	$55	N/A	$55	N/A	$55	N/A

Your Prescription Drug Benefits:

Prescription Drug Benefits are offered through Aetna. Aetna encourages the use of formulary medications. You can access your plan's Rx formulary here: http://www.aetna.com/formulary. Choose your plan name to find covered medicines and alternatives that cost less.

If your medication is not listed, ask your doctor about an equivalent medication that is listed on the formulary.

Retail Pharmacy

For medicines like antibiotics that you take short term - you can visit any retail pharmacy - whether you are at home or on the go. For the best price, choose a network pharmacy on Aetna.com.

Mail Order Rx

CVS Caremark® Mail Service Pharmacy for long-term prescriptions. You can use this service for medicines you need to take for conditions like high blood pressure or diabetes. Your medicines are mailed to you quickly and safely at no extra charge. And you may get up to a 90-day supply.

Specialty Pharmacy

Some long-term health conditions, like multiple sclerosis or cancer, require special medicines that may need special storage and handling. This is when you would use a specialty pharmacy to ensure your medicines are packed securely and arrive safely. CVS Specialty© Pharmacy provides delivery to your home, doctor's office, a CVS Pharmacy, or any place you choose, at no added cost. Flexible payment options are available and package tracking is provided for prompt delivery. You can easily manage your prescriptions online at www.CVSpecialty.com or by calling +1-800-237-2767.

Price Comparison Tools

In your plan materials, you can see what medicines are covered and how much they will cost. You can also visit www.Aetna.com/formulary and choose your plan name to find covered medicines and alternatives that cost less. Don't see it, or need your plan name? Just ask human resources.

Retail Pharmacy Discount Programs

Did you know Wal-Mart, Target, Kroger, and other pharmacies offer generic medication programs for 30-day and 90-day supplies for less than $10? Several popular maintenance medications are offered through these generic programs. **NOTE: In order to take advantage of these programs, take your prescription to one of the participating pharmacies and present to the pharmacist. You will not need to show your Aetna ID card. It's that easy to start saving money!**

NEW - Aetna Back and Joint Care through Hinge Health

New digital musculoskeletal physical therapy program will be available to participating medical members and their dependents age 18+ effective July 1, 2022. $0 cost to members and not subject to deductible and coinsurance.

Aetna Back and Joint Care provides:

- Management of chronic back and joint pain with a 12-week digital exercise therapy program delivered via tablet and sensors and supported with one-on-one health coaching and a physical therapist
- Engagement with a physical therapist virtually with up to 6 visits
- Individually tailored prevention program delivered through the Hinge Health app to avoid common MSK conditions

Aetna Health℠ Mobile App

Manage your benefits on the go right from your phone with the Aetna Health mobile app. Download the app today from the App Store or Google Play.

- View, share or print your digital ID card whenever you need it.
- View your health plan summary and get information about what's covered.
- Track spending and progress toward meeting your deductibles for you and your family.
- View claims details and pay your claims.
- Search for facilities, procedures and medications.
- Find in-network providers accepting new patients.
- Estimate and compare costs for doctors' visits and procedures.
- Access Teladoc® to talk with a doctor anytime, from anywhere.

Medical and Pharmacy Employee Cost

Your pre-tax payroll deductions are shown below.

	Aetna Choice POS 1	Aetna Choice POS 2	Aetna Select - HMO
40 Hour Employee Bi-weekly Medical Employee Cost			
Employee Only	$36.28	$13.02	$0.00
Employee + Child	$154.07	$119.02	$40.30
Employee + Spouse	$237.36	$197.20	$94.94
Employee + Children	$206.01	$158.79	$53.36
Employee + Family	$302.15	$254.06	$138.74

	Aetna Choice POS 1	Aetna Choice POS 2	Aetna Select - HMO
30 Hour Employee Bi-weekly Medical Employee Cost			
Employee Only	$103.83	$80.59	$20.85
Employee + Child	$221.64	$186.60	$107.87
Employee + Spouse	$304.93	$264.77	$162.51
Employee + Children	$273.58	$226.34	$120.95
Employee + Family	$369.72	$321.62	$206.33

	Aetna Choice POS 1	Aetna Choice POS 2	Aetna Select - HMO
20 Hour Employee Bi-weekly Medical Employee Cost			
Employee Only	$171.42	$148.17	$88.42
Employee + Child	$289.20	$254.16	$175.45
Employee + Spouse	$372.51	$332.34	$230.07
Employee + Children	$341.15	$293.94	$188.49
Employee + Family	$437.29	$389.22	$273.87

CARE OPTIONS

Knowing Where to Go for Care

If you need immediate medical attention, your first thought may be to go to the Emergency Room. However, if your condition is not serious or life threatening, you may consider a less expensive choice. An urgent care center provides quality care like an ER, but can save you hundreds of dollars.

Primary Care	$	Routine, Primary, Preventive Care Regular Health Screenings Non-urgent treatment Chronic disease management	Primary Care is the doctor you already see during regular office hours. Your doctor knows you and has quick access to your health history and medical records.
Virtual Visits	$	Cold, flu, fever, sore throat, diarrhea rash, pink eye, sinus infections, cough, headache, stomach ache or ear ache	Virtual Visits give you 24/7/365 access to board-certified physicians on your schedule and from any location.
Convenience Care	$$	Common infections (ear, pink eye, strep, bronchitis), flu shots, vaccines, rashes, screenings	Convenience Care locations are typically onsite clinics, available at retail locations such as CVS, Walgreens, Walmart, or Target.
Urgent Care	$$$	Sprains, small cuts, strains, sore throats, minor infections, mild asthma, back pain or strain, vomiting, flu, fever, sports injuries *After hours care* *No appointments necessary*	Urgent Care is a walk-in clinic not found within an emergency room or a doctor's office; open outside of normal business hours, including weeknights and weekends.
Emergency Room	$$$$	Heavy bleeding, large open wounds, chest pain, spinal injuries, difficulty breathing, major burns, severe head injuries, seizures, unconsciousness, poisoning *Life Threatening emergency*	Head to the ER, either in a hospital or a freestanding emergency care facility, if you believe you are experiencing a serious injury or life-threatening condition.

If you believe you are experiencing a medical emergency, go to your nearest emergency room or call 911, even if your symptoms are not as described here.

Click here to watch a video about Knowing Where To Go

CVS MinuteClinic

The Minute Clinic benefit provides eligible Aetna members with access to a broad range of services to keep you and your family healthy. Minute Clinic is a walk-in clinic located inside select CVS Pharmacy® and Target stores that is open 7 days a week, including evenings and weekends. You can walk in or schedule appointments online beforehand, making it easy for you and your covered family members to access care in your local neighborhood or when traveling or away from home. Minute Clinic health care providers treat and diagnose a variety of illnesses, injuries and conditions. They can also write prescriptions, when medically appropriate. All available at no cost to you! Visit www.cvs.com/minuteclinic for more information and to locate a store near you.

TELEMEDICINE

Teladoc | 1+855-835-2362 | www.teladoc.com/Aetna

Why wait for care you need now?

Your medical plan includes a number of ways to see a doctor or healthcare provider outside of the office at any time. The cost of a visit may vary based on the plan in which you are enrolled and which service provider you use.

Teladoc®

Medical Visits

Telemedicine provided by Teladoc® provides you with 24/7/365 access to board-certified physicians through the convenience of your phone, tablet, or computer. So if you can't make an in-person visit or want to avoid the ER, you have convenient support options to talk to a doctor by phone or video. During your phone call or video visit, the doctor will diagnose, treat and even prescribe medicine for common conditions like the flu, sinus infections, sore throats and more. They can even schedule you for routine lab work!

Teladoc® providers can treat conditions such as:Cold and flu symptoms

- Allergies
- Bronchitis and other respiratory infections
- Migraines
- Sinus and ear infections
- Rashes and other skin irritations
- Pinkeye
- Urinary tract infections

Behavioral Health Visits

The Behavioral Health component of Teladoc® is also available. You can speak to a licensed counselor, therapist, psychologist, or psychiatrist virtually from your home or wherever you feel most comfortable, confidentially. Scheduling a video visit with a therapist is easy and convenient. You can make an appointment 7 days a week, from 7am to 9pm local time. Appointments are confirmed within 72 hours!

- Anxiety/depression
- Bereavement/grief counseling
- Stress management
- Marital or relationship issues
- Family/adolescent counseling

Dermatology

Our Dermatology service provides care from licensed dermatologists for persistent or serious skin issues such as eczema, acne, rosacea, psoriasis, rashes and more. The dermatologist will diagnose your condition and provide a personalized treatment plan within two days or less of your visit request.

Remote Care with Your Local PCP or Specialist

You may be able to consult with your local PCP or Specialist for routine checkups, ongoing wellness needs, referrals and more using a video or phone visit. The cost of these visits is the same as going to your doctor's office in person. Check with your healthcare provider to find out if this option is available to you.

DENTAL BENEFITS OVERVIEW

Delta Dental | +1800-237-6060 | www.DeltaDentalVA.com

You have the opportunity to enroll in the dental plan from Delta Dental. Refer to plan documents for full details.

		Employee Costs
In-Network Overview		
Deductible (Plan Year)		$50 per person; $100 per family
Annual Benefit Maximum		$1,500
Diagnostic & Preventive Services	Exams, cleanings, x-rays	Covered at 100%
Basic Services	Fillings, Periodontics, Endodontics	20%
Major Services	Crowns, Prosthodontics/dentures and bridges, Implants - one per site for members age 16 or older	50%
Orthodontia	Children to Age 19	50%
Orthodontia Lifetime Maximum		$1,000
Out-of-Network Overview*		
Reimbursement		100% Preventive/ 80% Basic/ 50% Major

*Out-of-Network providers can balance bill you the difference between what they charge and the carrier's reasonable and customary amount.

Blue text indicates change from previous year's plan

About Your Dental Plan

- Each year, employees must satisfy a deductible for most services (other than preventive). After the deducible is satisfied, when covered dental charges are incurred, the plan pays a percentage of the customary and reasonable charges, up to the annual benefit maximum.
- Employees are responsible for the coinsurance payment (and any amount over the customary and reasonable charge).
- Deductible waived for preventive care

Dental Employee Cost

Your pre-tax payroll deductions are shown below.

	40 - Hour	30 - 39 Hour	20 - 29 Hour
Employee Bi-weekly Dental Employee Cost			
Employee Only	$ 0.00	$ 3.89	$ 7.79
Employee + Child	$ 8.42	$12.30	$16.21
Employee + Children	$10.70	$14.61	$18.50
Employee + Spouse	$10.70	$14.61	$18.50
Employee + Family	$21.24	$25.12	$29.03

VISION BENEFITS OVERVIEW

MetLife | +1855-638-3931 | www.metlife.com/mybenefits

City of Charlottesville offers a comprehensive vision care benefit from MetLife. Enrolling in this coverage can help you manage the cost of eyeglasses and contact lenses, as well as eye examinations. Refer to your plan documents for full details.

	In-Network	Out-Of-Network Reimbursement
Benefits		
Exam - Every 12 Months	$10 Copay	$45 Allowance
Materials	$25 Copay	N/A
Frames - Every 24Months	$130 Allowance, 20% discount for amounts over $130	$70 Allowance
Lenses - Every 12 Months		
Single	Covered after materials copay	$30 Allowance
Bifocal		$60 Allowance
Trifocal		$65 Allowance
Lenticular		$100 Allowance
Contact Lenses - Instead of Glasses or Both		
Conventional	$130 Allowance	$105 Allowance

Vision Employee Cost

Your pre-tax payroll deductions are shown below.

2022 Bi-weekly Vision Employee Cost	
Employee Only	$2.50
Employee & Spouse	$4.99
Employee & Child(ren)	$4.22
Family	$6.97

FLEXIBLE SPENDING ACCOUNTS

NOW ADMINISTERED BY: Flexible Benefit Administrators (FBA) | +1800-437-3539 |

www.flex-admin.com or https://fba.wealthcareportal.com

You may contribute to Flexible Spending Accounts (FSAs) to help with the cost of your eligible healthcare expenses. Contributions to your FSA are deducted from your pay prior to being taxed, which reduces your taxable income. You should contribute the amount of money you expect to spend on eligible expenses for the plan year. **You must actively enroll each year per IRS regulations if you want to participate in this plan. Enrollment does not automatically roll over.**

	Health Care FSA
Funding Account Used With	All medical plans
Eligible Expenses	Medical, Dental, Vision, Prescriptions, and over-the-counter medicines
Funds Available	Full amount available at the beginning of the plan year *Minimum election of $100 required
Deadlines	Services must be incurred between July 1, 2022-June 30, 2023
Claims	All claims for the July 1, 2022-June 30, 2023 plan year must be submitted by September 30, 2023
Roll-over	There is a roll-over provision for unused funds. Unused funds between $50 and $570 in the account on June 30 will roll-over to the following plan year
Receipts	Keep your receipts in case the IRS asks to confirm use of funds

	Dependent Care FSA
What?	Helps with Child or Elder care while you and your spouse work
Examples Include:	Daycare, adult day centers, after-school care, day camps, elder care, private childcare, and more
Funds Available	Funds are only available after they are deducted from your paycheck. *Minimum election of $100 required
Carryover	Funds are not eligible for carryover

FBA provides:

- ✓ FBA mobile app
- ✓ FBA member portal
- ✓ FBA Benefits Card - one card issued for HCFSA, DCFSA and HRA plans

2022 Maximum FSA Contributions

$2,850

Health Care FSA

$5,000

Dependent Care FSA

($2,500 if married and filing separately)

$100

Minimum Amount you can contribute to both Health Care and Dependent Care FSA

Additional Information about your FSA plans

Flexible Spending Account (FSA) administration will move from LD&B to Flexible Benefit Administrators (FBA), effective July 1, 2022.

Participants will be issued one new debit card with the FBA logo that will work for the Health Care and Dependent Care flexible spending plans. This card will be activated automatically for your use on July 1, 2022. (Prior to July 1, you should continue to use your LD&B benefits card.) Additional cards can be issued for spouses or dependents over the age of 18. Replacement cards and dependent cards can be requested through the portal, mobile app or paper form. Debit cards are valid for three years from date of issue.

For employees enrolled in the July 1, 2021-June 30, 2022 plan year: 2021-2022 Elections Run-Out Period

If you have any unused FSA funds remaining in your account as of June 30, 2022, you will have a "run-out period" of 90 days to submit paper claims to LD&B (the expense must be incurred between July 1, 2021 - June 30, 2022).

- The deadline for claims submission during this run-out period is September 30, 2022.
- Your LD&B benefits card will be de-activated on June 30, 2022. After this date, you will not be able to use the card for healthcare or HRA expenses. Dependent care FSA has a grace period where the card will continue to work for dependent care expenses through July 31, 2022.
- If you have a benefits card, the card will not work for the rollover account during the 90 day runout period. Any claims to be applied to the rollover account must be submitted manually.

Claims Incurred 7/1/21 - 6/30/22
90-Day Run-Out Period until 9/30/22

LD&B Benefits Administrators

205C South Liberty Street
Harrisonburg, VA 22801

www.LDBbenefitsadmin.com

Fax: 540-438-4133
Toll Free: 877-532-5478
Email: KGochenour@LDBbenefitsadmin.com

Existing 2021 LD&B Unused Rollover Funds

Any amount you have left in your HealthCare FSA balance that is between $50 and $500 as of July 1, 2022, will be deposited into the 2022 - 2023 FSA with FBA, the new FSA administrator.

- During this transition period, these "carryover funds" will not be immediately available.
- Your carryover funds for the 2021 - 2022 plan year will be available with FBA approximately 14 days after the 90 day healthcare FSA runout period has been completed, around October 14, 2022.

July 1, 2022-June 30, 2023 FBA FSA Contributions

Any amount you have elected to contribute to your FSA for the July 1, 2022 - June 30, 2023 plan year will be reflected in the health care and dependent care account with FBA. The funds will accrue each pay period.

- *Keep an eye on your mail.* FBA will mail your new smart debit card for the July 1, 2022 - June 30, 2023 plan year. The card will be mailed in a non-descript envelope that may look like junk mail. Please do not throw these cards away.

Claims Incurred 7/1/22 - 6/30/23
90-Day Run-Out Period until 9/30/23

Flexible Benefit Administrators
www.flex-admin.com

Toll Free 1.800.437.3539
Fax 757.431.1155
Phone Hours Mon- Fri 8:30am- 5:00pm EST
Office Hours Mon - Fri 8:30am - 5:00pmEST
2875 Sabre Street, Suite 300
Virginia Beach, VA 23452

LIFE AND AD&D INSURANCE

Securian Financial | +1800-392-7295 | www.ochsinc.com / ochs@ochsinc.com

Basic Life and AD&D Insurance

City of Charlottesville provides all full-time employees with Basic Group Term Life and Accidental Death & Dismemberment (AD&D) insurance at no cost. Employees are automatically covered with a Life benefit that is equal to **2x annual earnings up to $500,000** benefit maximum.

The Basic Life and AD&D insurance benefit also includes coverage for accidental death and dismemberment, which matches your life amount. However, there are some limitations regarding when benefits are payable for accidental death and dismemberment. Full details regarding the Basic Life and AD&D insurance plan, including eligibility and benefit limits and exclusions, are included in the City's group life certificate of insurance.

Employee Paid Supplemental Life Insurance

If you would like additional protection, you are also eligible to elect Supplemental Life and AD&D Insurance for yourself and your dependents. Employees pay the full cost for this plan, and premiums will be deducted from your paycheck on a post-tax basis. Employees are able to purchase Dependent Life coverage, even if you do not purchase Supplemental Life coverage for yourself. Employee premiums are based on employee age and spouse coverage is based on the age of your spouse, which is adjusted each January 1st. If you do not enroll when you are first eligible, you must provide proof of good health by submitting an "Evidence of Insurability" form and wait for approval from our life insurance carrier. Please refer to the plan documents for additional details.

Note: If you elect to purchase Supplemental Life insurance, you will need to complete an EOI form as part of the application process. The insurance carrier will review the health information on the EOI and notify you of approval for coverage.

Spouse coverage: Only new hires and those who are newly-eligible for benefits will be able to purchase Spouse Life without proof of good health (evidence of insurability).

Life coverage for Dependent Children: You may cover dependent children from live birth up to age 26. However, coverage may be extended for children over age 26 who are physically or mentally incapable of self-support. See the City's plan certificate for details.

The cost of Dependent Life is $.083/$1,000 of coverage or $.83 per month for $10,000, $1.25 per month for $15,000 or $1.66 per month for $20,000. These costs apply to family units – regardless of the number of eligible children in your family. You will not be charged separately for each covered, dependent child.

Supplemental AD&D

Supplemental AD&D Insurance allows you to purchase additional protection to supplement your Basic AD&D coverage. This plan also allows you to purchase coverage for your family, and proof of good health is not required.

You may elect employee only or family coverage. You must purchase Employee coverage in order to cover your family members. The amount of coverage varies based on the number of dependents covered.

	Supplemental Life Coverage	Supplemental AD&D Coverage
Employee	• Increments of $10,000 • Up to a max of $500,000 • Guaranteed Issue $300,000 (at the time of hire) • No reduction in coverage due to your age • Coverage includes an “accelerated life benefit” that allows you to receive up to 100% of your coverage amount, in advance, if you are diagnosed with a terminal illness • EOI required: late entrants, amounts over $300,000, increasing coverage	• Increments of $10,000 units, up to the lesser of ten times (10) your annual salary or $500,000
Spouse	• Increments of $10,000 up to $250,000 • Limited to 100% of Employee basic and supplemental life coverage • Guaranteed Issue $50,000 • EOI required: new enrollee, amounts over $50,000, increasing coverage	• If no dependent children are covered: 50% of employee’s AD&D election • If dependent children are covered: 40% of employee’s AD&D election
Child	• Amounts of $10,000, $15,000, or $20,000 • Guaranteed Issue all amounts • Live birth to 26 years	• Children to age 26 • If no spouse is covered: 15% of employee's election to $15,000 • If spouse covered: 10% of employee’s election

Beneficiaries

You must designate at least one beneficiary for both Life and Supplemental Life coverage. When you enroll a dependent in Supplemental Life Insurance, you automatically become the beneficiary.

Terms to Know

Guaranteed Issue is the maximum amount of coverage you can obtain, regardless of health status.

Evidence of Insurability (EOI) is an application and approval process detailing your health status. The EOI process is required to purchase certain types or levels of insurance coverage.

Securian Financial, offers employees their ‘LifeSuites’ program which includes:

- Travel Assistance services at www.LifeBenefits.com/travel or +1855-516-5433.
- Legal, financial, and grief resources at +1877-849-6034
- Legacy Planning Resources at www.LegacyPlanningResources.com

Monthly Costs

Supplemental Life Coverage Rate per $1,000		
Age	Employee	Spouse
<25	$0.068	$0.041
25-29	$0.068	$0.041
30-34	$0.091	$0.062
35-39	$0.103	$0.073
40-44	$0.158	$0.095
45-49	$0.216	$0.136
50-54	$0.374	$0.229
55-59	$0.647	$0.365
60-64	$0.907	$0.624
65-69	$1.599	$1.081
70-74	$2.597	$2.060
75*	$2.597	$2.380
*Rates beyond age 75 are available upon request		
Child Term Life		$0.083 per $1,000
Rates increase with age and all rates are subject to change.		
Supplemental AD&D Rate per $1,000		
Employee		$0.026
Family		$0.042

DISABILITY

Long-Term Disability

OCHS | +1651-665-3789 | ochs@ochsinc.com / www.ochsinc.com

The City of Charlottesville provides all benefits eligible employees with Long-Term Disability (LTD) benefits at no cost. Long-Term Disability pays a monthly benefit in the event you cannot work because of a long-term illness or injury.

	Long-Term Disability
Benefits Begin	After 90 days
Benefits Payable/Duration	If you are Disabled on or before age 62, benefits may continue to age 65 but not less than 42 months. If Disabled after age 62, refer to Maximum Benefit Period in the Schedule of Benefits of certificate of insurance.
Percentage of Income Replaced	60%
Maximum Monthly Benefit	$6,000

VOLUNTARY AFLAC PROGRAMS

Aflac | +1434-296-9500 | www.aflac.com/charlottesville

Accident Insurance

Are you prepared for life's unexpected moments? One mishap can send you on an unexpected trip to your local emergency room - and leave you with a flood of unexpected bills. Accident Insurance coverage from Aflac can give you peace of mind in the event of a covered accident by providing a safety net for you and your family. Aflac pays cash benefits directly to you when you are sick or injured. You can use the cash to help cover expenses that major medical does not - like mortgage, groceries, or whatever you need. Employees are responsible for the full cost of this coverage; premiums will be deducted from your paycheck.

What does Accident Insurance Cover?

Ambulance
Wheelchair
Crutches
Cuts
Stitches
Broken bones
ER visits

Click here to watch a video about Accident Insurance

Accident Insurance Coverage

You can cover yourself, your spouse, and your dependent children. Cash Benefits are paid directly to you and you decide the best way to spend them. The coverage also includes a Wellness Benefit. Aflac will pay $60 if you or any one covered person undergoes routine examinations or other preventive testing during the Calendar year.

Cancer/ Specified Disease Insurance

While you can never prepare for being diagnosed with a critical illness, you can prepare for the financial consequences by enrolling in Aflac's Cancer / Specified Disease Insurance policy. A cancer/specified-disease insurance policy can help protect your income and savings from expenses that are not covered by your major medical insurance, including deductibles, copays and travel expenses. Cancer/Specified Disease insurance can help with the treatment costs of a covered illness, such as a heart attack or stroke, while you focus on recuperating instead of out-of-pocket costs. You receive cash benefits directly - giving you the flexibility to pay bills related to treatment or to help with everyday living expenses such as car payments, mortgage, childcare and utility bills.

Employees are responsible for the full cost of this coverage; premiums will be deducted from your paycheck.

What does Cancer/ Specified Illness Insurance Cover?

Heart attack
Stroke
Cancer
Kidney Failure
Coma
Blindness

Click here to watch a video about Critical Illness

Cancer/ Specified Illness Insurance Coverage

You can cover yourself, your spouse, and your dependent children. Benefits are paid directly to you. The coverage also includes a Wellness Benefit of $75 per calendar year when a covered person receives a preventive screening or prevention vaccine.

Hospital Confinement

Planned or unplanned, a trip to the hospital can be scary. When you are hospitalized for an injury or illness, there will probably be medical expenses and out-of-pocket costs incurred that are not covered by medical insurance. Hospital confinement coverage provides cash benefits directly to you to use as you see fit for hospital-related events, regardless of your treatment costs or any other insurance you have. Whether you want a policy that provides hospitalization benefits only, or one that also addresses diagnostic procedures, outpatient surgery and ambulance transportation, Aflac can help.

Short-Term Disability Coverage

Should you become unable to work due to a non-work related illness or injury, disability coverage acts as income replacement to protect you and your family from serious financial hardship. Aflac's short-term disability policy provides a source of monthly income directly to you for a period of time you select at a time you may need help taking care of your bills while you take care of yourself. This means that you will have added financial resources to help with expenses incurred due to medical treatment, ongoing living expenses or any purpose you choose. Refer to plan documents for additional details.

Employees are responsible for the full cost of this coverage; premiums will be deducted from your paycheck.

Voluntary Aflac Benefits Employee Cost

Your payroll deductions are shown below.

2021 Bi-weekly Premiums	Accident Insurance	Cancer / Specified-Disease Insurance	Hospital Confinement
Employee	$12.42	$13.80	$17.00 - $25.00
Employee & Spouse	$16.56		$25.00 - $33.00
Employee & Child(ren)	$19.26	$17.26	$28.00 - $41.00
Family	$24.24	$24.00	$32.00 - $44.00
	Short-Term Disability Insurance		
Employee	$6.00 - $31.00		

How to Enroll in Aflac Plan(s) – Contact Aflac directly for enrollment

See the Aflac Portal for complete details about these benefits. Contact the following for help with your Aflac benefits:

AFLAC Agent Contact Information for Enrollment, Cancellation or Questions:

Michelle Lawson
MLawson@bostbenefits.com
Phone: +1434-760-2257

CLAIMS:

www.aflac.com
You can access One Day Pay through online claims
PHONE: +11800-992-3522
Phone App: Download AFLAC app

TRANSPORTATION PROGRAMS

Pre-Tax Transportation Program

The Pre-Tax Transportation Program gives you the ability to pay for qualified transportation expenses, such as parking and mass transportation, with pre-tax dollars. The Internal Revenue Code defines qualified expenses and dollar limits. Our Program also has maximums and minimums for the amounts you may elect for your transportation expenses.

Expenses qualified for reimbursement include:

- Parking Expenses – cost of parking your car at a facility located near your work location or cost of parking at a facility that is located at or near a location from which you commute to work.
- Commuter Highway Vehicle – a commuter highway vehicle is a highway vehicle with a seating capacity of six or more adults (not including the driver).

****Amounts remaining in your account after 45 days following the Program year will be returned to you as after-tax pay.*****

The Employee Parking Subsidy Program

The program will provide discounted rates at three parking facilities located near City Hall. Employees who have contracted paid parking in other locations will also be eligible for a subsidy to help pay for their parking.

Program Guidelines:

1. Participants must be enrolled in the Pre-Tax Parking Program to be eligible.
2. Enrollment for the Pre-Tax Parking Program is allowed within 30 days of initial employment date or annually during Open Enrollment for a July 1, 2022 effective date.
3. Participants must have a monthly contracted parking spot with a parking provider to be eligible for the Employee Parking Subsidy Program. Documentation may be required.
4. If you currently do not have a contracted parking spot but wish to enroll in the Employee Parking Subsidy Program, contact the parking facility to secure a spot in one of the facilities listed below (subject to availability), and return a completed enrollment form to Human Resources. Contracting with a provider other than one of the facilities listed below is the participant's responsibility.
5. The subsidy for plan year July 1, 2022 - June 30, 2023 will be $50.00 per month.
6. Reimbursement for parking facilities or providers other than the three listed below will be one-half of the monthly facility cost, not to exceed $50.00.
7. If two City employees carpool, the subsidy per month will be $70.00. If receiving the carpool subsidy, both employees will have a payroll deduction.
8. For new employees who enroll at the time of hire and for all employees who enroll during Open Enrollment, their payroll deduction will be pre-taxed. For mid-year enrollments, the deduction will be post-taxed.
9. If you park in the Water Street Garage, Market Street Garage, or the 7th Street Lot, your deduction will automatically be taken from your paycheck and sent to the facility. This eliminates the need to file a claim for reimbursement.
10. If you park in another parking facility, you will need to file a claim for reimbursement with Human Resources for your portion of the payment and the City subsidy. The employee is responsible for paying the parking facility.
11. Funding for the program is provided on an annual basis and subject to Council approval.

Parking Facility Discounted Rates	
Location	Monthly Employee Rate After City Subsidy
Water Street Garage	$60.00
Market Street Garage	$60.00
7th Street Lot	$65.00

Bicycle Reimbursement Allowance Benefit

Bicycle Reimbursement Allowance Benefit for those employees who regularly ride their bicycle to work.

On January 1, 2009, the qualified bicycle commuting reimbursement was added to the list of qualified transportation fringe benefits covered in section 132 (f) of the Internal Revenue Service Code.

The intent of this provision is to help defray some of those fixed costs such as: the purchase of a decent commuter vehicle; bike lock; helmet; bike parking facilities; shower facilities; and general maintenance.

A qualified bicycle commuting month is any month during the plan year in which an employee:

- regularly uses a bicycle for a substantial portion of the travel between his residence and his place of employment, and
- does not receive any other qualified transportation benefit for:
    - vanpool (commuter highway vehicle transportation),
    - transit, and
    - parking

For reimbursement, complete a claim form (found at http://citynet/HumanResources) and attach receipts (if applicable) to the form. The maximum reimbursement is $20.00 per month or $240.00 per plan year.

Reimbursements will be issued quarterly. In order to be reimbursed each quarter, submit claim forms by the 15th of the month following the end of the quarter. All claims for the current plan year must be submitted by July 12, 2022.

Note: Per IRS regulations, bicycle reimbursements are taxable.

CITYFIT WELLNESS PROGRAM

The City offers wellness initiatives throughout the year. Check out our physical fitness gym reimbursement program which reimburses up to $34.00 per month toward the cost of an individual gym membership. See the Wellness Tab on *HR InTouch* or click here for details!

EMPLOYEE ASSISTANCE PROGRAM

Optima EAP (Employee Assistance Program) is a resource to help you overcome life challenges, solve personal problems and address work-related issues. Services provided are fully confidential and free of charge to you and your household members. Visit OptimaEAP.com to access videos, posts, webinars, and other helpful resources. Or call +1800-899-8174 to schedule an appointment to talk to a counselor.

RETIREMENT: PLAN FOR YOUR FUTURE

CURRENT EMPLOYEES: Upon hire you made a choice between a defined benefit pension plan or a defined contribution 401a plan. Current employees should visit HR INTOUCH to view the summaries of the plan chosen at their time of hire or call human resources with questions. Please remember employees can enroll in the voluntary 457 retirement plan at any time during your employment.

INFORMATION FOR NEW HIRES

You have thirty (30) days from date of hire to enroll in either the City of Charlottesville Defined Contribution or the City of Charlottesville Defined Benefit Retirement Plan. The election is irrevocable.

**Library employees are not eligible for the Defined Benefit Retirement Plan*

A Defined Benefit Plan is a traditional pension plan that pays a monthly benefit in retirement using a formula based on your earnings history, length of service, and age. If you choose this plan, you will make a 5% contribution from your pay each pay period towards your pension. This plan has a 5-year vesting schedule. If you leave employment before you reach 5 years of service, then you are not vested, meaning you are not entitled to the pension. But you will receive a refund of the contributions you made from your pay.

A Defined Contribution Plan is a 401(a) plan, and if you choose this plan, the City will make a contribution to your account each pay period based on years of creditable service.

- Less than 5 years of service = 8%
- 5 to 10 years of service = 9%
- 10 or more years of service = 10%

You will choose the investments for your account. This plan has a 3-year vesting schedule. In other words, you earn ownership of the employer contributions over 3 years. If you leave employment after 1 full year, you are 33% vested. If you leave after 2 full years, you are 67% vested and once you have reached 3 full years, you are 100% vested. The value of your account fluctuates based on the performance of the investments. At retirement, you can use the balance in your account to help fund your retirement, but you do not receive a guaranteed amount.

Please refer to the plan comparison on the following page for more details on the plans. You must complete the Retirement Election Form to make your choice. **If you do not return the form to Human Resources within 30 days of employment, you will default into the 401(a) Plan.**

HIGHLIGHTS OF THE TWO RETIREMENT PLAN OPTIONS:

Benefit	**Defined Benefit Plan (3)** For Employees Hired on or after 7/1/2017 City of Charlottesville Code, Chapter 19 Article IV	**Defined Contribution 401a** MissionSquare acts as record keeper [contribution schedule updated July 1, 2022]
Eligibility:	Regular employees working at least half time for at least 36 weeks per year	Regular employees working at least half time for at least 36 weeks per year.
Contributions	Employer contribution is determined annually based on actuarial valuation data; Employees contribute 5% of base salary, pre-tax. *(pre-tax for Federal and State tax purposes).*	The City contributes a percentage of base salary to the account of each plan participant in accordance with the following schedule, based on years of creditable service: Less than 5 years 8% 5 or more years up to 10 9% 10 or more years 10% Contributions are made each bi-weekly pay period.
Vesting ***To be "vested" means that you have earned the right to receive a retirement benefit, even if you leave the Plan before you retire.***	At 5 years of creditable service credit. If you leave the plan before retirement as a vested employee, you will be eligible to receive a vested pension at age 65 (general employees) or age 60 (public safety employees)	Vesting in accordance with the following schedule of creditable service: • 1 year- 33% vested • 2 years- 67% vested • 3 years- 100% vested
Benefit Formula	1.6% of average final compensation (AFC) multiplied by the number of years of creditable service. AFC is the average of employee's 60 highest consecutive months of creditable compensation	Distribution is the value of the individual account.
Normal Retirement Age:	General Employees-age 65 with at least 5 years of creditable service Public Safety Officers-age 60 with at least 5 years of creditable service *Public Safety Officers have a mandatory retirement age of 60.*	• Distribution equals vested account balance at any age upon termination of employment
Earliest Unreduced Retirement Eligibility **(Unreduced means no benefit reduction for retiring before the "normal retirement age")**	• General Employees-age 60 with 30 years of creditable service • Public Safety Officers-age 50 with 25 years of creditable service	• Distribution equals vested account balance at any age upon termination of employment

Earliest Reduced Retirement Eligibility **(Reduced means the amount determined by the Defined Benefit formula will be reduced by ½ of one percent for each complete month by which retirement precedes the earlier of age 65 or the date on which you would have completed 30 years)**	• General Employees-age 60 with 5 or more years of creditable service • Public Safety Officers-55 with 5 or more years of service	• Distribution equals vested account balance at any age upon termination of employment
Public Safety Supplement for Police Officers, Firefighters, and Sheriff Deputies	1.0% of average final compensation multiplied by the number of years of creditable service. Must have 20 years of hazardous duty service to be eligible for supplement. Supplement Amount is limited to estimated unreduced primary social security benefit. Payable until full retirement age, as in effect on 7/1/2005, for purposes of qualifying for unreduced social security benefit with payment not to exceed 17 years prior to social security eligibility.	Not applicable.
Refunds *An Employee is eligible for a refund of any funds they contributed as set forth in Section 19-104.1 of Article IV of Chapter 19 of the City of Charlottesville Code.* *Refunds of accumulated contributions can be rolled over to an IRA, TDA, or qualified plan. If you receive the refund directly, it will be subject to taxation.*	• If you terminate employment before you are fully vested, you will receive a refund of your accumulated contributions plus credited interest. Creditable service is forfeited. • If you are vested when you leave the plan but elect to receive your accumulated contributions as a lump sum at time of termination rather than defer your vested benefit until normal retirement age, you may do so however you will cease to be a member in the plan and will not be entitled to any future benefits.	Not Applicable
Purchase of Prior Service:	A vested employee can purchase prior service to increase number of years of creditable service as set forth in Section 19-95.2 of Article IV of Chapter 19 of the City of Charlottesville Code. *(service types to include other state/city retirement system, CETA, prior City service, and active military service)*	Not applicable.
Portability:	The City has a Portability Asset Transfer Agreement with the Virginia Retirement System. <u>If transferring assets from VRS to the City's plan, the employee has 18 months from the date of becoming 100% vested to make a portability election. The employee must contact HR upon vesting if electing this option.</u>	The Portability Asset Transfer Agreement with the Virginia Retirement System is not applicable to the Defined Contribution 401a. Rollovers from/to other qualified plans however are permitted into and out of the plan upon employment or termination.

Disability	Group long-term disability insurance is available. Employees receiving long term disability insurance will continue to accrue creditable service for purposes of defining eligibility for retirement and, if applicable, the amount of any retirement benefit. Accrual of creditable service terminates on the employee's normal retirement date or date of termination of LTD benefits.	Group long-term disability insurance is available. Employees receiving long term disability insurance will continue to accrue creditable service for purposes of defining eligibility for retirement and, if applicable, the amount of any retirement benefit. Accrual of creditable service terminates on the employee's normal retirement date or date of termination of LTD benefits.
Retiree Life Insurance:	Employee must retire with at least 10 years of creditable service to be eligible for life insurance provided by the City. The amount of the insurance is the active employee benefit reducing monthly until it reaches (1/4) of the amount at the time of retirement.	No retiree life insurance benefit provided by the City. Supplemental group term life insurance may be continued by the retiree, if available, at full retiree expense.
Sick Leave	Creditable service includes 50% of unused sick leave, up to 2000 hours. This service is not counted for benefit eligibility.	Not applicable.
Health Insurance Benefits: ➢ *Health and Dental Insurance Benefits end at Medicare eligibility* ➢ *Benefits are subject to change at any time*	Eligible for medical and dental benefits with a City contribution toward cost if the employee retires with at least ten years of creditable service. The City's Contribution Amount is determined on an annual basis and is subject to change for current and future retirees. The City contribution will be pro-rated according to years of creditable service. For employees who retiree with ten years of service and elect to continue in the City's health care plan after retirement, the City will pay 40% of the annual contribution amount. For employees who retire with more than ten years of service, the City will pay an additional 4% of the annual contribution amount for each additional full year of service completed as of the effective date of retirement. In order for family members to be eligible for medical and/or dental insurance upon employee's retirement, it is required they be covered under the plan for thirty six (36) consecutive months prior to employee's retirement.	Eligible for access to continue medical and dental benefits if, at time of termination, the employee satisfies the "retirement ages" applicable to the Defined Benefit Pension Plan 3 and terminates employment with at least 10 years of service. The City does not pay any of the cost for retiree only or retiree and dependent coverage. The cost is the retiree's sole expense. If eligible for access to benefits, in order for family members to be eligible for medical and/or dental insurance, it is required they be covered under the plan for thirty six (36) consecutive months prior to employee's retirement date.

Effective for City of Charlottesville employees hired on or after July 1, 2017

Library employees are not eligible for Defined Benefit Plan 3

457 Deferred Compensation Plan – ALL EMPLOYEES

Enroll in a Voluntary 457 Deferred Compensation Retirement Plan at any time during your employment

In addition to the City plans described above, you can enroll in and make changes to a 457 retirement plan at any time during your employment. A 457 is a Deferred Compensation Plan. You can set this up as a traditional pre-tax 457 plan or a post-tax Roth 457 plan. You decide the amount of money you wish to contribute each pay period. You can change your contribution at any time. The maximum contribution for 2022 is $20,500 per calendar year (or $27,000 if you are age 50 or older). You contributions will be invested in the funds that you select, and the value of your account will fluctuate based on the performance of the funds

LODA

Public Safety Employees: Police officers, Firefighters and Sheriff Deputies

The Virginia Line of Duty Act (LODA), established in Title 9.1 of the Code of Virginia and enacted in 1972, provides benefits to eligible family members of eligible employees and volunteers killed in the line of duty and to those eligible employees and volunteers disabled in the line of duty and their eligible family members. Please visit www.valoda.org for information on eligibility, benefits, claims and other resources.

CONTACT LIST

The insurance companies that collaborate with the City to provide employee benefits offer online information, tools and resources to support their programs. Carrier services and contact information are detailed below. We hope you find this information helpful.

WE ARE HERE TO HELP

If you have any questions about the employee benefits described herein or would like more information, please refer to your plan documents and insurance booklets or contact:

Human Resources Benefits Staff:

Sara Butler, Benefits Administrator +1434-970-3462 or butlers@charlottesville.gov

Deanna Guedj, HR Specialist-Benefits +1434-970-3526 or guedjd@charlottesville.gov

Lisa Burch, Benefits Coordinator-Retirement +1434-970-3097 or burche@charlottesville.gov

	Carrier	Phone	Web
Medical and Pharmacy	Aetna	+1800-426-4363	www.Aetna.com
Telemedicine	Teladoc	+1855-835-2362	www.teladoc.com/Aetna
Dental	Delta Dental	+1800-237-6060.	www.deltadentalva.com
Vision	MetLife	+1855-638-3931	www.metlife.com/mybenefits
Health Reimbursement Arrangement Flexible Spending Account	Flexible Benefit Administrators	+1800-437-3539	https://fba.wealthcareportal.com
Basic & Supplemental Life and AD&D	Securian Financial	+1800-392-7295	www.ochsinc.com
Short-Term Disability Accident Cancer/Specified Illness Hospital Confinement	Aflac	+1434-296-9500	www.aflac.com/charlottesville
Employee Assistance Program	Optima	+1800-899-8174	www.OptimaEAP.com

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer.

REQUIRED NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the Deductible and the Coinsurance applies.

If you would like more information on WHCRA benefits, call your Plan Administrator.

NEWBORNS' AND MOTHERS HEALTH PROTECTION ACT ENROLLMENT NOTICE

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

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 **+1877-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 +1866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	**FLORIDA – Medicaid**
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	Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA - Medicaid	INDIANA - Medicaid
A 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	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 (Hawki)	KANSAS - Medicaid
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
KENTUCKY - Medicaid	LOUISIANA - 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	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	MASSACHUSETTS - Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
MINNESOTA - Medicaid	MISSOURI - 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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	NEBRASKA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA - Medicaid	NEW HAMPSHIRE - Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY - Medicaid and CHIP	NEW YORK - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	NORTH DAKOTA - Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP	OREGON - Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA - Medicaid	RHODE ISLAND - Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA - Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS - Medicaid	UTAH - Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT- Medicaid	**VIRGINIA - Medicaid and CHIP**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: +1800-432-5924 CHIP Phone: +1800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA - Medicaid**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP	**WYOMING - Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2022, or for more information on special enrollment rights, contact either:

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

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

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer for retirees, or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Sara Butler, butlers@charlottesville.gov, (434) 970-3462. FLEXIBLE BENEFIT ADMINISTRATORS is the COBRA Administrator for City of Charlottesville: 1-877-532-5478 or www.ldbbenefitsadmin.com.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Contact: Sara Butler, butlers@charlottesville.gov, (434) 970-3462. COBRA Administrator: FLEXIBLE BENEFIT ADMINISTRATORS 1-877-532-5478 or www.ldbbenefitsadmin.com.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan Administrator informed of address changes

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

Please contact the Plan Administrator for additional information.

HIPAA NOTICE OF PRIVACY PRACTICES

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

City of Charlottesville sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of City of Charlottesville Name, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) Your past, present or future physical or mental health or condition;

(2) The provision of health care to you; or

(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by City of Charlottesville, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the City of Charlottesville HIPAA Privacy Officer:

City of Charlottesville Name
Attention: HIPAA Privacy Officer
Sara Butler
P.O. Box 911
Charlottesville, VA 22902

Effective Date

This Notice as revised is effective May 16, 2022.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or

(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;

(2) treating such person as your personal representative could endanger you; or

(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or

- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years and may not include dates prior to your request. Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

HIPAA SPECIAL ENROLLMENT MODEL NOTICE

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

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

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact your Plan Administrator.

CREDITIBLE COVERAGE NOTICE

IMPORTANT NOTICE FROM CITY OF CHARLOTTESVILLE 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 Charlottesville 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 Charlottesville has determined that the prescription drug coverage offered by the Medical Plan(s) are, 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 while enrolled in City of Charlottesville coverage as an active employee, please note that your City of Charlottesville coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in City of Charlottesville coverage as a former employee.

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

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

You should also know that if you drop or lose your current coverage with Company Name 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 your Plan Administrator 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 Charlottesville changes. You also may request a copy of this notice at any time.

More detailed information about Medicare plans that offer prescription drug coverage can be found 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:

1. Visit www.medicare.gov
2. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
3. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov , or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	5/16/2022
Name of Entity/Sender:	City of Charlottesville
Contact--Position/Office:	Sara Butler
Address:	P.O. Box 911 Charlottesville, VA 22902
Phone Number:	+1434-970-3462

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE – NEW HIRE ONLY

Part A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

How Can I get More Information?

For more information about the coverage offered by your employer, please check your summary plan description or contact Human Resources.

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

Part B: Information About Health Coverage Offered by Your Employer

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

Employer Name:	**City of Charlottesville**
Employer EIN:	54-6001202
Employer Address:	P.O. Box 911
City:	Charlottesville
State:	VA
Zip:	22902
Employer Phone Number:	+1434-970-3462

Who can we contact about employee health coverage at this job? Sara Butler

Email Address: butlers@charlottesville.gov.

Your employer offers a health plan to eligible employees and dependents. See the Plan Information section of the SPD for details. This coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable based on employee wages.

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

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