City of Irvine

2022 Full-Time Employee Benefits Overview

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices on page 34 for more details.

We've Got You Covered.

The City of Irvine takes pride in offering you and your family a comprehensive benefits program. Please review this brochure to determine which plans are best suited for you. Please consider your options carefully because you may only make changes to your benefit elections during open enrollment, or if you experience a mid-year "qualified status change" (see page 6).

Open enrollment is your annual opportunity to elect, change or cancel your benefits coverage, or add/drop dependent coverage. Please consider your options carefully because you may only make changes to your benefit elections during open enrollment, or if you experience a mid-year "qualified status change" (see page 6). All open enrollment benefit changes will be effective January 1, 2022.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan summary of benefits and coverage.

A list of plan contacts is included at the back of this guide.

YOUR OPEN ENROLLMENT PERIOD IS FROM OCTOBER 13, 2021 TO NOVEMBER 3, 2021.

The benefits in this summary are effective:

January 1, 2022 - December 31, 2022

2022 Benefits Information

Attend in person or virtually one of the following informational meetings to learn more about the City of Irvine's 2022 Benefits Program:

- In Person, Wednesday October 13, 7-8 a.m. – OSF Lunch Room
- Virtually, Wednesday, October 13, 2-3 p.m. Click Here to Join Meeting
- Virtually, Thursday, October 21, 2-3 p.m. Click Here to Join Meeting

A recorded session will be available to view at a later time for employees who are not able to participate in one of the live webinars.

OPEN ENROLLMENT ASSISTANCE

Employees who would like assistance with the online enrollment process may schedule an individual virtual appointment with a human resources benefits team member. Please send an email to benefits@cityofirvine.org and provide your availability. The first available team member will assist you.

PASSIVE ENROLLMENT

Employees who are not making any changes to their 2022 health benefits DO NOT need to log in to WORKTERRA. The 2021 benefit elections will rollover to 2022 at the updated rates.

You MUST log in to WORKTERRA to make any changes to your existing coverage, including changing plans or dropping dependents. You MUST log in to WORKTERRA to renew your Flexible Spending or Health Savings Account elections. You will be required to enroll/re-enroll in all benefits page by page.

ACCESSING THE ONLINE SYSTEM

- Go to *workterra.net*
- *Please turn off any pop-up blockers before proceeding through your enrollment.*
- *For optimal performance, please use Microsoft Edge or Google Chrome.*
- The Mandatory Insurer Reporting Law requires group health plans to report spouse and dependent social security numbers for purposes of possible coordination of benefits with the Medicare and Medicaid Services (CMS). Please gather the social security numbers of your dependents so that you are prepared to enter them into WORKTERRA.
- User ID – The first six letters of your last name, first letter of your first name, and first four digits of your social security number. For example, the USER ID for employee John Smith with SSN 123-45-6789 would be **smithj1234**
- Password – Your social security number (You will be prompted to change your personal password when you first log into the system)
- Company Name – City of Irvine

Who Can You Cover?

EMPLOYEE ELIGIBILITY

If you are a full-time employee working at least 40 hours per week you are eligible for City of Irvine sponsored group benefits.

DEPENDENT ELIGIBILITY

You can enroll the following family members in our medical, dental and vision plans.

- Your legal spouse.
- Your registered domestic partner. The cost of coverage section explains the tax treatment of domestic partner coverage.
- Your, or your domestic partner's, natural children, stepchildren, adopted children and/or children for which the employee or domestic partner is the legal guardian. In addition, dependent children must meet the following age requirements:
  - For Medical & Vision Insurance: Dependents are eligible up to age 26.
  - For Dental Insurance: Unmarried dependents are eligible up to age 26
- Children over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
- Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHEN COVERAGE BEGINS

Your coverage for health benefits will be effective on the first of the month following date of hire. If the date of hire is the first day of the month, an employee is eligible to enroll on that day.

ENROLLMENT PERIODS

New Hire Enrollment: It is the responsibility of the employee to enroll in the plan within 30 days of hire. Any employee who declines coverage as a new hire will not have the option to enroll again until open enrollment held annually in October.

Open Enrollment: It is the one time each year that employees can make changes to their benefit elections without a qualified status change.

Qualified Status Change: Notify Human Resources within 31 days if you have a qualified status change and need to add or drop dependents outside of Open Enrollment. Status changes include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

Qualified Status Changes

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualified status change or qualify for a "special enrollment". If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.

QUALIFIED STATUS CHANGES INCLUDE:

- **Change in legal marital status,** including marriage, divorce, legal separation, annulment, and death of a spouse
- **Change in number of dependents,** including birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status that affects benefit eligibility,** including the start or termination of employment by you, your spouse, or your dependent child
- **Change in work schedule,** including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- **Change in a child's dependent status,** either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in place of residence or worksite,** including a change that affects the accessibility of network providers
- **Change in your health coverage or your spouse's coverage** attributable to your spouse's employment
- **Change in an individual's eligibility for Medicare or Medicaid**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child

- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, employees have **60 days** after the following events to request enrollment:
    - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP
    - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP

Two rules apply to making changes to your benefits during the year:

1. Any changes you make must be consistent with the change in status, AND
2. You must make the changes within **31 days** of the date of the *event* (marriage, birth, etc.) unless noted above.

Getting Care When You Need It

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency?

Kaiser Permanente Plan Participants

- Call Kaiser's 24/7 NurseLine at 800-464-4000
- Find an urgent care center by visiting *kp.org*

Blue Shield Medical Plan Participants

- Call Blue Shield's NurseHelp at 877-304-0504.
- Call Blue Shield's 24/7 Teladoc service at 800-835-2362
- *blueshieldca.com* or *teledoc.com/bsd*.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

OUT-OF-STATE COVERAGE

If you or your dependent will be residing out of state temporarily, you can access your medical plan as follows:

- Blue Shield HMO – Contact member services to take advantage of the "Away From Home Care" program. Depending on your location, you may be able to access a Blue Shield provider while out of state.
- Blue Shield PPO – You can access the Blue Shield national Blue Card network and receive in-network benefits. You may call member services or visit *bluecares.com* to find an out-of-state provider.

Medical HMO

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

The City of Irvine gives you a choice between HMO medical plans through Kaiser Permanente and Blue Shield of California.

Plan Benefits	Blue Shield of California HMO	Kaiser Permanente Traditional HMO
	In-Network	**In-Network**
Annual Deductible	None	None
Annual Out-of-Pocket Max	$500 Individual $1,500 Family	$1,500 Individual $3,000 Family
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$10 copay	$10 copay
Specialist	$10 copay (self-referred: $30 copay)	$10 copay
Preventive Services	No charge	No charge
Chiropractic Care	$10 copay (up to 30 visits per year)	$10 copay (up to 20 visits per year)
Lab and X-ray	No charge	No charge
Inpatient Hospitalization	$100 admission copay	$100 admission copay
Outpatient Surgery	$50 copay	$10 copay
Urgent Care	$10 copay	$10 copay
Emergency Room	$50 copay (waived if admitted)	$50 copay (waived if admitted)
Prescription Drugs	**Express Scripts***	**Kaiser Permanente HMO**
Annual Out-of-Pocket Limit	$6,100 Individual $11,700 Family	$1,500 Individual $3,000 Family (combined with medical)
Pharmacy	**Retail**	**Kaiser Pharmacy**
Generic	$5 copay	$5 copay
Preferred Brand	$20 copay	$15 copay
Non-preferred Brand	$20 copay	N/A
Supply Limit	30 days	100 days
Mail Order	**Express Scripts Home Delivery**	**Kaiser Mail Service**
Generic	$10 copay	$5 copay
Preferred Brand	$40 copay	$15 copay
Non-preferred Brand	$40 copay	N/A
Supply Limit	90 days	100 days

*The Express Scripts prescription drug plan utilizes the following 1) Preferred Generic, 2) Advantage Plus Pharmacy Utilization, and 3) Smart 90. These programs do not apply to the Kaiser HMO plan.

Medical PPO

The City of Irvine also gives you a choice between two PPO medical plans through Blue Shield of California.

Plan Benefits	Blue Shield of California HDHP		Blue Shield of California PPO	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Annual Deductible	$1,500 Individual* / $3,000 Family*		$500 Individual* / $1,000 Family*	
Annual Out-of-Pocket Max	$3,000 Individual* / $6,000 Family*		$1,100 Individual* / $2,800 Family*	
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit				
Primary Provider	$15 after deductible	50% after deductible	$15 copay	50% after deductible
Specialist	$15 after deductible	50% after deductible	$15 copay	50% after deductible
Preventive Services	No charge	50% after deductible	No charge	50% after deductible
Chiropractic Care (26 visits per year)	20% after deductible (up to $50 per visit)	50% after deductible (up to $25 per visit)	20% after deductible (up to $50 per visit)	50% after deductible (up to $25 per visit)
Lab and X-ray	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient Hospitalization	20% after deductible	50% after deductible (up to $600 per day)	20% after deductible	50% after deductible (up to $600 per day)
Outpatient Surgery	20% after deductible	50% after deductible (up to $350 per day)	20% after deductible	50% after deductible (up to $350 per day)
Urgent Care	$15 after deductible	50% after deductible	$15 copay	50% after deductible
Emergency Room	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription Drugs	Blue Shield of California		Express Scripts**	
Annual Out-of-Pocket Limit	$3,000 Individual / $6,000 Family (combined with medical)		$5,500 Individual / $10,400 Family	
Retail Pharmacy	Retail		Retail	
Generic	$5 after deductible	Not covered	$5 copay	
Preferred Brand	$20 after deductible	Not covered	$20 copay	
Non-preferred Brand	$20 after deductible	Not covered	$20 copay	
Supply Limit	30 days	N/A	30 days	
Mail Order	PrimeMail		Express Scripts** Home Delivery	
Generic	$10 after deductible	Not covered	$10 copay	
Preferred Brand	$40 after deductible	Not covered	$40 copay	
Non-preferred Brand	$40 after deductible	Not covered	$40 copay	
Supply Limit	90 days	N/A	90 days	

* For family coverage, the full family deductible must be met before any one family member can receive benefits for covered services. The full family out-of-pocket maximum must be met before the any one family member can receive 100% benefits for covered services.

**The Express Scripts prescription drug plan utilizes the following programs: 1) Preferred Generic, 2) Advantage Plus Pharmacy Utilization, and 3) Smart 90. These programs do not apply to the Blue Shield HDHP plan.

Chiropractic and Acupuncture

Blue Shield

You can visit any participating chiropractors or acupuncturists in California from the ASH Plans network without a referral from your HMO Primary Care Physician. Simply call a participating provider to schedule an initial exam.

The plan covers medically necessary chiropractic and acupuncture services including:

- Initial and subsequent examinations
- Office visits and adjustments (subject to annual limits)
- Adjunctive therapies
- X-rays (chiropractic only)

Benefit Plan Design

Calendar year Maximum	30 Combined Visits
Calendar Year Deductible	None
Calendar year Chiropractic Appliance Benefit	$50

Covered Services	Member Copayment
Acupuncture Services	$10 per visit
Chiropractic Services	$10 per visit
Out-of-network Coverage	None

Kaiser Permanente

Chiropractic Services are covered when provided by a Participating Provider and medically necessary to treat or diagnose Neuromusculoskeletal Disorders.

To obtain covered services, call a Participating Provider to schedule an initial examination. If additional services are required, verification that the Services are Medically Necessary may be required. Your Participating Provider will request any medical necessity determinations. An ASH Plans clinician in the same or similar specialty as the provider of Services under review will decide whether the Services are or were Medically Necessary Services. ASH Plans will disclose to you, upon request, the process that it uses to authorize, modify, delay, or deny a request for authorization. If you have questions or concerns, please contact the ASH Plans Customer Service Department.

Office visit cost share:	$10 copay per visit
Office visit limit:	20 visits per year
Chiropractic appliance benefits:	
If the amount of the appliance in the ASH plan fee schedule exceeds $50, you will pay the amount in excess.*	

*This payment will not apply toward any applicable deductible or out-of-pocket maximum.

Blue Shield and Kaiser Members may contact ASH Plans Member Services at (800) 678-9133 Monday through Friday from 6 a.m. to 5 p.m. for help answering questions, to assist with problems or for help locating a participating chiropractor or acupuncturist.

For Blue Shield Members:

Express Scripts Prescription Program

Preferred Generic Program:

Members who obtain a Brand drug when a Generic equivalent is available will be charged the difference between the Brand and the Generic plus the Generic co-pay. If members purchase the generic they will only pay the generic co-pay in place.

Example if member were to purchase the brand instead:

Rx Generic Copay	Generic Drug Price	Brand Drug Price	Difference in Price	Member Cost
$10	$20	$100	$80	$80 + $10 $90

Express Scripts Smart 90 Program:

This program allows members to obtain a 90 day supply of maintenance medications at any Walgreens or CVS pharmacy. Members who fill their maintenance prescriptions with a 90 day supply save money. The Smart90 Program is offered alongside the Express Scripts Mail Order Pharmacy Program and is not a replacement of the existing Mail Order Program.

Advantage Plus Pharmacy Utilization:

This program consists of Prior Authorization, Step Therapy and Quantity Management programs. It is designed to provide optimal savings for the City's employees. Members impacted by this program will receive communications directly from Express Script with instructions how to access their medications.

- **Prior Authorization** ensures clinically appropriate use of medications, ensures medications are used safely: Asks the question: "Is this the right medication for you."
- **Step Therapy** encourages members and physicians to try clinically effective generic medications before trying the more expensive brand medications. Asks the question: "What other medications has the patient taken for this condition?"
- **Drug Quantity** aligns the quantity dispensed with FDA-approved dosage guidelines and other supportive evidence. Asks the question: "Is this the correct quantity (tablets/capsules) of this medication?"

EXPRESS SCRIPTS®

Health Savings Account (HSA)

A Health Savings Account is a tax-advantaged, portable (you own it!) savings account that is offered if you enroll in a qualified health plan (Blue Shield HDHP/HSA).

You contribute pre-tax money to your account to save for out-of-pocket healthcare expenses. Any money that you don't spend grows year after year and can be used in the future, even after you retire. Health Equity administers this account.

ACCOUNT CONTRIBUTIONS

	You Can Contribute
Employee	$3,650
Employee + Family	$7,300
Catch Up Contributions	An additional $1,000 per year at age 55+

USING YOUR MONEY

You can use your account to pay for qualified medical expenses that are not paid for by your high deductible health plan (HDHP). In general, your HSA can be used for these expenses:

- Medically necessary expenses that are not covered by your health plan including deductibles and coinsurance
- Dental care services
- Vision care services
- Prescription drugs
- Over-the-counter (OTC) medications prescribed by your doctor
- Certain medical equipment

Note: Make sure that you keep records of your receipts and any OTC prescriptions in case the IRS requests them.

ELIGIBILITY

You are eligible to open or contribute to an HSA account if you are:

- Enrolled in a qualified health plan (Blue Shield HDHP/HSA)
- Not enrolled in a regular healthcare flexible spending account (you or your spouse)
- Not covered under Medicare, Medicaid or Tricare
- Not someone else's tax dependent

Non-Qualified Expenses

If you use HSA funds for non-qualified expenses before age 65, you will owe a 20% penalty tax PLUS income tax on the withdrawal. After age 65, if you use HSA funds for non-qualified expenses, you will owe income tax only. Visit *irs.gov/publications/p502* for details.

HMO Dental

Regular visits to your dentist can protect more than your smile; they can help protect your health. The City of Irvine provides you with comprehensive coverage through Guardian Life.

Plan Benefits	Guardian Managed Care HMO
Calendar Year Deductible	None
Annual Plan Maximum	Unlimited
Diagnostic and Preventive	
Exams	No charge
Cleaning	No charge
Full Mouth X-rays	No charge
Fluoride Treatment	No charge
Sealants (per tooth)	No charge
Basic Services	
Amalgam Fillings	No charge
Endodontics	
Anterior Root Canal	$70
Bicuspid Root Canal	$80
Molar Root Canal	$140
Periodontics	
Gingivectomy/ Quadrant	$60
Oral Surgery	
Simple Extraction	$5
Impaction	$50 - $80
Major Services	
Crowns (Porcelain/Ceramic)	$100
Crowns (Metal)	$90
Bridges	$110
Complete Denture	$110
Orthodontic Services	$1,975 Child / $2,175 Adult

PPO Dental

Plan Benefits	Guardian PPO Low Plan	Guardian PPO Incentive Plan
Calendar Year Deductible	$50 Individual $150 Family	$25 Individual $75 Family
Annual Plan Maximum	$1,500 per member	$2,000 per member
Diagnostic and Preventive	Plan pays 100%	Plan Year 1 – Plan pays 80% Plan Year 2 – Plan pays 90% Plan Year 3 & after – Plan pays 100%
Basic Services Fillings Root Canals Periodontics	Plan pays 80% after deductible	Plan Year 1 – Plan pays 80% Plan Year 2 – Plan pays 90% Plan Year 3 & after – Plan pays 100%
Major Services	Plan pays 50% after deductible	Plan Year 1 – Plan pays 80% Plan Year 2 – Plan pays 90% Plan Year 3 & after – Plan pays 100%
Orthodontic Services		
Orthodontia	Plan pays 50%	Plan pays 50%
Lifetime Maximum	$1,500 per member	$1,500 per member
Dependent Children	Covered	Covered
Full-time Students	Covered	Covered

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions. The City of Irvine offers you a choice between the base plan and the buy-up plan through Vision Service Plan.

Plan Benefits	VSP Choice Plan B (Base Plan)		VSP Signature Plan C (Buy-Up Plan)	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Examination				
Benefit	$15 copay	plan pays up to $45	$15 copay	plan pays up to $50
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Materials	$0 copay (combined with exam copay)	See schedule below (in-network limitations apply)	$0 copay (combined with exam copay)	See schedule below (in-network limitations apply)
Eyeglass Lenses				
Single Vision Lens	Plan pays 100% of basic lens	Plan pays up to $30	Plan pays 100% of basic lens	Plan pays up to $50
Bifocal Lens	Plan pays 100% of basic lens	Plan pays up to $50	Plan pays 100% of basic lens	Plan pays up to $75
Trifocal Lens	Plan pays 100% of basic lens	Plan pays up to $65	Plan pays 100% of basic lens	Plan pays up to $100
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames				
Benefit	$130 allowance	$70 allowance	$200 allowance	$70 allowance
Frequency	Once every 24 months	Once every 24 months	Once every 12 months	Once every 12 months
Contacts (Elective)				
Benefit	$130 allowance (copay waived; instead of eyeglasses)	$105 allowance (in-network limitations apply)	$175 allowance (copay waived; instead of eyeglasses)	$105 allowance (in-network limitations apply)
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months

Life and Disability Insurance

If you have loved ones who depend on your income for support, having life, accidental death, and disability insurance can help protect your family's financial security.

BASIC LIFE AND AD&D

Life insurance provides protection for your beneficiary in the event of your death. Eligible, full-time employees automatically receive Basic Life insurance coverage. The benefit amount is outlined in your Memorandum of Understanding. The City also provides all eligible employees with Accidental Death & Dismemberment (AD&D) insurance coverage. This benefit is equal to your life insurance coverage and is paid out if a death or dismemberment is due to an accident.

Basic Life Amount	The benefit amount is outlined in your Memorandum of Understanding.
Basic AD&D Amount	The benefit amount is outlined in your Memorandum of Understanding.

VOLUNTARY LIFE

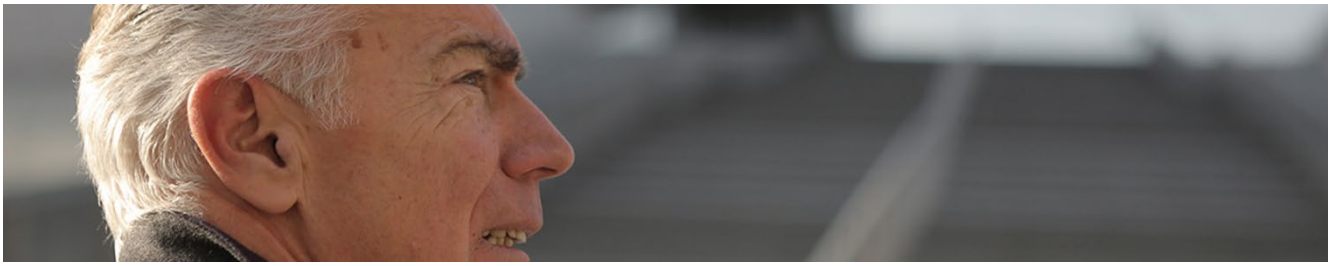
Voluntary Life insurance allows you to purchase additional life insurance. All eligible, full-time employees may enroll in Voluntary Life insurance at affordable group rates. Premiums are determined by your age and will be deducted from your paycheck. If you elect Voluntary Life insurance for yourself, you may also elect coverage for your dependents. Please note, some life amounts may be subject to medical underwriting.

Employee Voluntary Life Amount	Increments of $10,000 up to lesser of 5x covered annual earnings or $500,000
Spouse Voluntary Life Amount	Increments of $5,000 up to lesser of 50% of employee amount or $250,000
Child(ren) Voluntary Life Amount	Amounts of $2,500 or $5,000 (birth to 6 months: $500)

Taxes: Due to IRS regulations, a company-paid life insurance benefit of $50,000 or more is considered a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

Evidence of Insurability: Depending on the amount of voluntary coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.

Life and Disability Insurance



VOLUNTARY AD&D

Voluntary AD&D Insurance allows you to purchase additional accidental death and dismemberment insurance to protect your family's financial security and is paid out if death or covered losses are suffered due to an accident. If you elect Voluntary AD&D for yourself, you may also elect coverage for your dependents.

Employee Voluntary AD&D Amount	Increments of $10,000 up to lesser of 10x covered annual earnings or $500,000
Spouse Voluntary AD&D Amount	Increments of $5,000 up to lesser of 100% of employee amount or $250,000
Child(ren) Voluntary AD&D Amount	Increments of $5,000 up to $50,000

SHORT-TERM DISABILITY (STD)

NEW

If you become disabled and cannot work, your financial security may be at risk. Protecting your income can provide you and your family with peace of mind. Short and Long-term disability insurance is provided to all eligible, full-time employees at no additional cost. Short-Term Disability insurance is available when you are unable to work after 30 days of accident and sickness and you are eligible to receive a benefit of 66 2/3% of your pre disability weekly earnings (up to $2,309).

LONG-TERM DISABILITY INSURANCE (LTD)

When illness or injury make it impossible to work for an extended period of time, full-time employees' income may be continued under the City's LTD plan. If you are disabled for more than 90 days, you could receive a benefit of 66 2/3% of your pre-disability earnings (up to $10,000 per month) until you are able to return to work. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

	Shot-Term Disability	Long-Term Disability
Monthly Benefit Amount	Plan pays 66% of covered monthly earnings	
Maximum Benefit	$2,309 per week	$10,000 per month
Benefits Begin After:		
Accident	30 days of disability	90 days of disability
Sickness	30 days of disability	90 days of disability

*The age at which the disability begins may affect the duration of the benefits.

Flexible Spending Accounts (FSA)

HEALTH CARE & DEPENDENT CARE FSAs

Health Care & Dependent Care costs can be significant expenses. Flexible Spending Accounts (FSAs) can help offset these costs by saving you taxes. Workterra administers this program. Here's how it works:

- Money is deducted from your paycheck and put into an FSA before federal and state taxes are taken out.
- Money spent on eligible expenses for health care and/or dependent care during the plan year is reimbursed from these accounts.
- Submit a claim form for the expenses or use your Benny card and get reimbursed through your FSA.
- Since you are reimbursed from an account that is not subject to taxes, you save money!
- *You must enroll in your FSAs annually, as the IRS does not allow you to roll over your elections from year to year.*

HEALTHCARE FSA

- Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents.
- You may access your entire annual election from the first day of the plan year and you can set aside a maximum election of $2,750 per year.
- For those employees who **do not** enroll in the Blue Shield HDHP/HSA Plan, you may participate in the General Purpose Health Care FSA, which reimburses for medical, dental, and vision expenses.
- For those employees who **do** enroll in the Blue Shield HDHP/HSA Plan, you may participate in the Limited Health Care FSA, which reimburses for out-of-pocket dental and vision expenses only.
- Why is the Health Care FSA limited for those who enroll in an HSA Plan? - IRS regulations prohibit participation in a General Purpose Health Care FSA when you are making contributions to an HSA Account.

DEPENDENT CARE FSA

- Eligible expenses include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are your tax dependent and are incapable of self-care.
- You can access money only after it is placed into your dependent care FSA account. You can set aside up to $5,000 per household for eligible dependent care expenses for the year.
- All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return.
- If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan.

Flexible Spending Accounts (FSA)

IMPORTANT CONSIDERATIONS

- **Key Dates**
  - **Expenses for Health Care FSA must be incurred by March 15, 2023.**
  - **Expenses for Dependent Care FSA must be incurred by December 31, 2022.**
  - **All Health and Dependent Care FSA claims must be submitted no later than April 30, 2023.**
- Keep your receipts as proof that your expenses were eligible for IRS purposes.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- Unused amounts will be lost at the end of the plan year, so it is very important that you plan carefully before making your election.
- FSA funds can be used for eligible expenses incurred by you, your spouse, and your tax dependents only. Your spouse or tax dependent children do not have to be covered on the City of Irvine's health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents. (Important: questions about the tax status of your dependents should be addressed with your tax advisor)
- Keep your receipts as proof that your expenses were eligible for IRS purposes.
- There's no "crossover" spending allowed between the healthcare and dependent care accounts.

TRANSIT & PARKING REIMBURSEMENT ACCOUNTS

Similar to Health Care and Dependent Care Spending Accounts, Transit and Parking Reimbursement accounts allow you to set aside funds through payroll deduction to pay for work-related transportation and/or parking expenses.

Types of Allowable Expenses

- **Mass Transit/Vanpool - $270 Maximum Monthly Pre-Tax Contribution:** If employees commute to work via mass transit (i.e. public transportation including bus, train or rail systems) or by vanpool, employees can use pre-tax dollars to pay for those mass transit costs related to their commute.
- **Parking - $270 Maximum Monthly Pre-Tax Contribution:** Employees who commute to work by car and pay to park, or commute via mass transit and pay to park at or near the mass transit site, can use pre-tax dollars to pay for parking costs related to their commute to work.

Features of the Transit and Parking Reimbursement Accounts

- Members can change their elected contribution amount on a monthly basis.
- Unused balances can be rolled over month to month.
- You may access your account to check balances and submit claims by visiting the online FSA Portal.
- Submit a claim form for the expenses or use your Benny card and get reimbursed through your FSA.
- As with other tax free accounts, transit and parking accounts are governed by IRS regulations.

Employee Assistance Programs (EAP)

Lincoln Employee Assistance Program – EmployeeConnect

EmployeeConect offers professional, confidential services to help you and your loved ones improve your quality of life. Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with Family, Parenting, Addictions, emotional, legal, financial relationships and stress.

In-person Guidance- Some matters are best resolved by meeting with a professional in person. With EmployeeConnect, you and your family get:

- In-person help for short-term issues (up to 5 sessions with a counselor per person, per issue, per year)
- In-person consultations with lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings.

Unlimited 24/7 assistance – You and your family can access the following services anytime – online, on the mobile app or with a toll-free call:

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

Online resources – EmployeeConnect offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit Guidanceresources.com or download the GuidanceNow mobile app. Online and on the app you will find:

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

Blue Shield LifeReferrals 24/7 EAP

This Employee Assistance Program is available to Blue Shield members only. Blue Shield LifeReferrals 24/7 offers Blue Shield members convenient support to help you meet life's challenges. Blue Shield members are eligible for three face-to-face counseling visits in each six-month period. A simple phone call can connect you to a team of experienced professionals ready to assist you with a wide range of personal, family and work issues. Help is available 24/7, 365 days a year by telephone at 800-985-2405. Other resources are available online at *blueshieldca.com*.

Blue Shield LifeReferrals 24/7 services include:

- Personal Issues
- Financial Issues
- Community Services

Mental Health Benefit

Talkspace

The City of Irvine has partnered with Talkspace to offer complimentary access to Talkspace online therapy.

What is Talkspace?

Talkspace is an online therapy platform that makes it easy and convenient for you to connect with a licensed behavioral therapist from anywhere, at any time. Talkspace is an online therapy service that connects users to a dedicated therapist from a secure HIPAA-compliant mobile app and web platform. With Talkspace, you can send unlimited text, video, and audio messages to your dedicated therapist via web browser or the Talkspace mobile app. Talkspace is available to the employee and their dependents, ages 13 and older.

How Talkspace Works

Tell us what you're looking for- get to know your preferences and needs for therapy. Talkspace is confidential, secure and private.

Get matched- The Talkspace algorithm suggest 3 potential therapist based on your preferences. Select your ideal match, and begin therapy the very same day.

Message with your therapist on your schedule- Send unlimited text, video and audio messages to your therapist, whenever works best for you. Your therapist will check in daily, 5 days per week. Remember that you'll always connect with the same therapist, unless you request to switch.

Getting Started

Visit talkspace.com/CityofIrvine with keyword COITALK to create your account.

- There is no need to make an appointment or reschedule it because something came up.
- Whether on the go or at home, you can access Talkspace securely via web browser or mobile app.
- Complimentary access to Talkspace is available to employees and their dependents (13+)

Other Programs

CARRUM

Available to Blue Shield PPO and HDHP participants only. Carrum Health is a surgical benefit program. This benefit offers personalized support throughout your surgical experience from top quality hospitals and doctors in California.

When you receive a diagnosis for surgery, you can contact Carrum Health and meet your personal Care Concierge, who will support you throughout the entire surgical experience. Once you compare and select your hospital and surgeon, you will receive clearance for surgery, receive full support preparing for it, get the surgery done, and then recover smoothly, all with the guidance and personalized support from Carrum. For PPO members, surgery deductibles and coinsurance will be waived, and full coverage of travel costs (patient and companion) are covered.

Eligible procedures include:

- Knee Replacement
- Hip Replacement
- Coronary Bypass
- Lumbar Spinal Fusion
- Cervical Spinal Fusion
- Bariatric Surgery
- And more!

Get started at *my.carrumhealth.com/eiahealth*, or by calling your personal Care Concierge at 888-855-7806.

TELADOC

Available to Blue Shield members only. Teladoc's U.S. board-certified doctors are available 24/7/365 to resolve many of your non-emergency medical issues through phone or video consults. When you need care, a Teladoc doctor is just a call or click away. Use Teladoc if you're considering the ER or urgent care for a non-emergency, where you're on vacation, on a business trip, or away from home, or if you need short-term prescription refills.

Consult costs are $10 for the HMO Plan, $15 for the PPO plan (no deductible), and $40 for the HDHP HSA plan (cost reduces to $5 once the deductible has been met). HDHP members must satisfy their deductible first.

Teladoc doctors can treat many medical conditions including:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

Contact Teladoc online at *teladoc.com/bsc*, on the phone at 800-teladoc (835-2362), through e-mail at *membersupport@teladoc.com*, or through Facebook at *facebook.com/teladoc*.

Wellness Programs

Blue Shield - Fitness Your Way

Get healthy and feel good on your own terms with Fitness Your Way. The program offers you the flexibility to work out at any network fitness location, on your time and on a budget that you can live with.

Meet your goals

- View your gym visits online to keep on track and stay motivated.

On your time

- Finding locations is quick and easy.
- Visit any participating location – anytime, anywhere – as often as you would like.

On your budget

- Pay only $25 a month per person.*
- For eligible seniors (age 65+), SilverSneakers offers a no cost fitness benefit.

Get started at *fitnessyourway.tivityhealth.com/bsc* or by calling 888-283-8387, Monday through Friday, 5 a.m. to 5 p.m. Pacific Time.

Wellvolution – Through Blue Shield

Tap into decades of research and leading technology for a more productive and healthy lifestyle. Wellvolution offers the largest curated collection of scientifically- backed apps and programs designed to help you Prevent and reverse disease, manage stress, sleep better, eat healthier, move more, and ditch cigarettes.

Wellvolution offers:

- Online and in-person programs for general well-being and disease reversal
- Personal health coach, taking guesswork out of the health strategy.
- A new way to achieve health goals

To get started visit *www.wellvolution.com*

Kaiser Permanente - Active & Fit Direct

Eat, Breathe, Dream, Fitness

The Active&Fit Direct program allows you to choose from 9,000+ participating fitness centers and YMCAs nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes).

Program offers:

- Online directory maps and locator for fitness centers (available on any device).
- A free guest pass to try out a fitness center before enrolling (where available).
- The option to switch fitness centers to make sure you find the right fit.
- Online tracking from a wide variety of popular wearable fitness devices, apps and exercise equipment.

Learn more: *kp.org/choosehealthy*

ClassPass – Through Kaiser

Get moving with fitness options that fit your schedule and lifestyle, including Pilates, dance, boxing, cardio, strength training and yoga.

- Reduced rates on fitness classes
- Online video workouts at no cost

Visit *kp.org/exercise* for more information.

* Taxes may apply. Individuals must be at least 18 years old to purchase a membership.

UNUM Voluntary Benefit Options

VOLUNTARY LONG TERM CARE

Unum's Long Term Care coverage is offered at group discounted rates to cover costs associated with providing care at home or in a facility as a result of a loss of two Activities of Daily Living (ADL) or as a result of a severe cognitive impairment. Long Term Care Insurance is subject to medical underwriting. Family members can also purchase coverage, including parents (in-laws), grandparents (in-laws), spouses, siblings and adult age children. Family member coverage will also be subject to medical underwriting.

To learn more, visit myltcguide.com/cityofirvine or call 877-286-2852.

VOLUNTARY CRITICAL ILLNESS

The UNUM Critical Illness benefit provides eligible employees the option to purchase insurance that can pay a lump sum benefit at the diagnosis of a covered illness. Benefit amounts are available at $10,000 or $15,000. Coverage is also available for your spouse and/or dependent children. An enhanced wellness benefit is also included that can pay $75 per calendar year if a covered health screening test is performed.

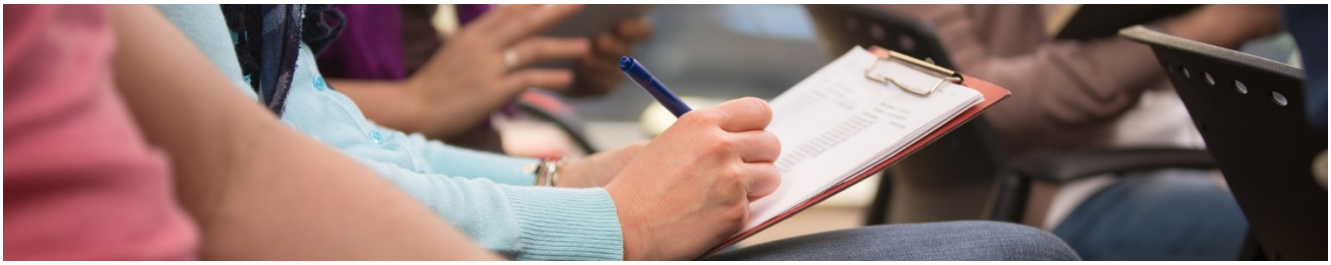
Examples of covered conditions include heart attack, cancer (optional rider), coronary artery bypass surgery, major organ failure, benign brain tumor, stroke, blindness, end-stage renal (kidney) failure, coma and permanent paralysis. NOTE: You can use this coverage more than once if you experience multiple conditions.

VOLUNTARY ACCIDENT

The accident plan provides supplemental coverage to your current medical plan and helps with the out-of-pocket expenses associated with on and off-the-job accidents and injuries, including copays, deductibles, coinsurances and other out-of-pocket expenses. You can purchase coverage for you and your dependents. Examples of covered injuries and expenses include:

- Cuts and broken bones
- Paralysis
- Emergency room
- Burns
- Torn ligaments
- Eye injuries
- Ruptured discs
- Accidental death
- Physical therapy
- Hospitalization

Cost of Coverage



PRE-TAX DEDUCTIONS

Your medical, dental, and vision contributions will be made through payroll deductions and paid on a pre-tax basis. That is, you do not pay taxes on the portion of your income that goes toward your benefit contributions. If you do not want your contributions deducted on a pre-tax basis, please notify Payroll.

Federal tax treatment of your premium payments is different if you are covering a domestic partner. For more information, contact Payroll at 949-724-6270.

WAIVING OF COVERAGE

Employees may waive participation in the City's health benefit program. The employee will be required to waive medical, dental and vision coverage and must provide proof that they have medical coverage under another group insurance plan.

In order to waive coverage, please contact benefits@cityofirvine.org.

COST FOR EMPLOYEES

Follow the steps below to determine your monthly payroll deduction:

1. Select medical plan (Kaiser, Blue Shield HMO, Blue Shield PPO or Blue Shield HDHP HSA PPO)
2. Select medical coverage level (i.e. SINGLE, TWO-PARTY, FAMILY)
3. Select dental plan (Guardian DHMO, Guardian Low PPO or Guardian Incentive PPO)
4. Select dental coverage level (i.e. Single, Two-Party, Family)

Example:

If you elect Blue Shield HMO family medical coverage with Guardian Low PPO family dental coverage your monthly payroll deduction would be $161.56.

Note: Full-time employees electing employee only coverage for medical and dental receive a $150/month stipend (subject to taxes).

2022 Monthly Payroll Deductions

KAISER HMO* WITH GUARDIAN DENTAL

KAISER HMO COVERAGE LEVEL	DENTAL PLAN	DENTAL COVERAGE LEVEL	MONTHLY PAYROLL DEDUCTION
SINGLE	Guardian DHMO	Single Two-Party Family	$10.92 $10.92 $10.92
	Guardian Low PPO	Single Two-Party Family	$31.62 $71.92 $117.26
	Guardian Incentive PPO	Single Two-Party Family	$65.90 $124.50 $190.40
TWO-PARTY	Guardian DHMO	Single Two-Party Family	$19.78 $19.78 $19.78
	Guardian Low PPO	Single Two-Party Family	$80.78 $106.82 $140.44
	Guardian Incentive PPO	Single Two-Party Family	$115.04 $159.40 $213.58
FAMILY	Guardian DHMO	Single Two-Party Family	$29.64 $29.64 $29.64
	Guardian Low PPO	Single Two-Party Family	$90.64 $116.68 $150.30
	Guardian Incentive PPO	Single Two-Party Family	$124.90 $169.26 $223.44

*Medical and VSP Choice Plan B Single Vision

2022 Monthly Payroll Deductions

BLUE SHIELD HMO* WITH GUARDIAN DENTAL

BLUE SHIELD HMO COVERAGE LEVEL	DENTAL PLAN	DENTAL COVERAGE LEVEL	MONTHLY PAYROLL DEDUCTION
SINGLE	Guardian DHMO	Single Two-Party Family	$13.62 $13.62 $13.62
	Guardian Low PPO	Single Two-Party Family	$74.62 $100.66 $134.28
	Guardian Incentive PPO	Single Two-Party Family	$108.88 $153.24 $207.42
TWO-PARTY	Guardian DHMO	Single Two-Party Family	$28.68 $28.68 $28.68
	Guardian Low PPO	Single Two-Party Family	$89.68 $115.72 $149.34
	Guardian Incentive PPO	Single Two-Party Family	$123.94 $168.30 $222.48
FAMILY	Guardian DHMO	Single Two-Party Family	$40.90 $40.90 $40.90
	Guardian Low PPO	Single Two-Party Family	$101.90 $127.94 $161.56
	Guardian Incentive PPO	Single Two-Party Family	$136.16 $180.52 $234.70

*Medical and VSP Choice Plan B Single Vision

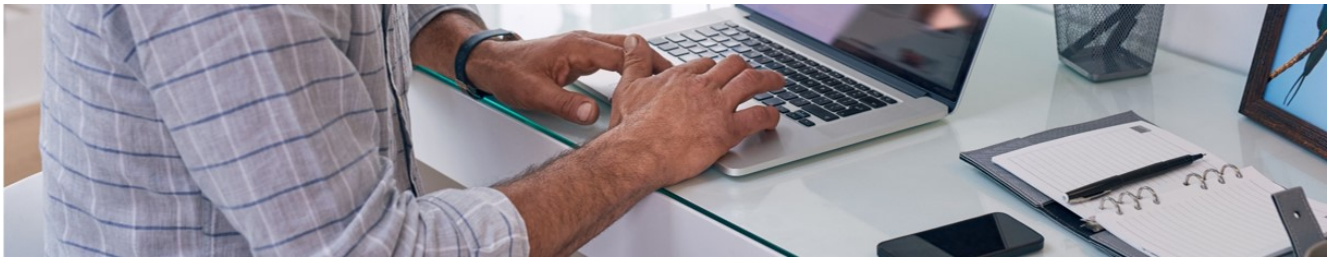
2022 Monthly Payroll Deductions

BLUE SHIELD PPO* WITH GUARDIAN DENTAL

BLUE SHIELD PPO COVERAGE LEVEL	DENTAL PLAN	DENTAL COVERAGE LEVEL	MONTHLY PAYROLL DEDUCTION
SINGLE	Guardian DHMO	Single Two-Party Family	$362.72 $376.96 $388.68
	Guardian Low PPO	Single Two-Party Family	$423.72 $464.00 $509.34
	Guardian Incentive PPO	Single Two-Party Family	$457.98 $516.58 $582.48
TWO-PARTY	Guardian DHMO	Single Two-Party Family	$1,441.04 $1,455.28 $1,467.00
	Guardian Low PPO	Single Two-Party Family	$1,502.04 $1,542.32 $1,587.66
	Guardian Incentive PPO	Single Two-Party Family	$1,536.30 $1,594.90 $1,660.80
FAMILY	Guardian DHMO	Single Two-Party Family	$2,064.06 $2,078.30 $2,090.02
	Guardian Low PPO	Single Two-Party Family	$2,125.06 $2,165.34 $2,210.68
	Guardian Incentive PPO	Single Two-Party Family	$2,159.32 $2,217.92 $2,283.82

*Medical and VSP Choice Plan B Single Vision

2022 Monthly Payroll Deductions

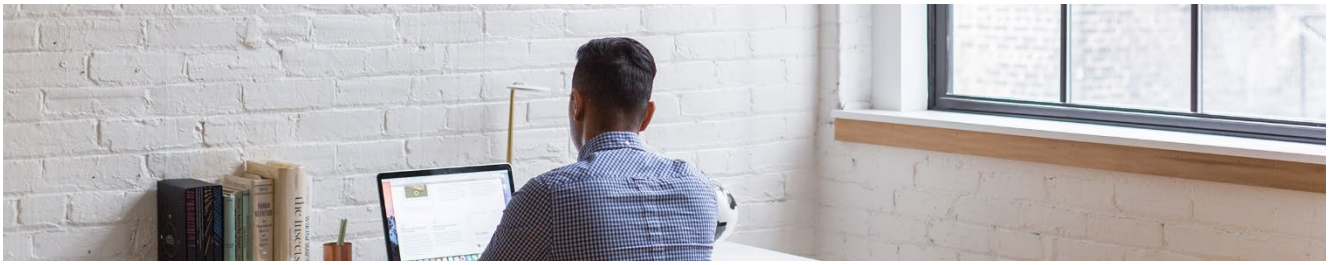


BLUE SHIELD HDHP HSA* WITH GUARDIAN DENTAL

BLUE SHIELD HDHP HSA COVERAGE LEVEL	DENTAL PLAN	DENTAL COVERAGE LEVEL	MONTHLY PAYROLL DEDUCTION
SINGLE	Guardian DHMO	Single Two-Party Family	$257.68 $271.92 $283.64
	Guardian Low PPO	Single Two-Party Family	$318.68 $358.96 $404.30
	Guardian Incentive PPO	Single Two-Party Family	$352.94 $411.54 $477.44
TWO-PARTY	Guardian DHMO	Single Two-Party Family	$1,218.00 $1,232.24 $1,243.96
	Guardian Low PPO	Single Two-Party Family	$1,279.00 $1,319.28 $1,364.62
	Guardian Incentive PPO	Single Two-Party Family	$1,313.26 $1,371.86 $1,437.76
FAMILY	Guardian DHMO	Single Two-Party Family	$1,741.02 $1,755.26 $1,766.98
	Guardian Low PPO	Single Two-Party Family	$1,802.02 $1,842.30 $1,887.64
	Guardian Incentive PPO	Single Two-Party Family	$1,836.28 $1,894.88 $1,960.78

*Medical and VSP Choice Plan B Single Vision

2022 Monthly Payroll Deductions



VISION (BASE PLAN)

VSP Choice Plan B	Monthly Employee Deduction
EMPLOYEE ONLY	Included with Medical
EMPLOYEE + 1	$8.16
EMPLOYEE + FAMILY	$17.32

VISION (BUY-UP PLAN)

VSP Signature Plan C	Monthly Employee Deduction
EMPLOYEE ONLY	$5.86
EMPLOYEE + 1	$20.94
EMPLOYEE + FAMILY	$37.90

Important Plan Notices and Documents

CURRENT HEALTH PLAN NOTICES

Notices that must be provided to plan participants on an annual basis are available in this enrollment guide.

- Medicare Part D Notice
  Describes options to access prescription drug coverage for Medicare eligible individuals.
- Women's Health and Cancer Rights Act
  Describes benefits available to those that will or have undergone a mastectomy.
- Newborns' and Mothers' Health Protection Act
  Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- HIPAA Notice of Special Enrollment Rights
  Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- Notice of Choice of Providers
  Notifies you about the plan's requirement that you name a Primary Care Physician (PCP).
- Notice of Privacy Practices.
  Describes how health information about you may be used and disclosed.

COBRA CONTINUATION COVERAGE

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

CURRENT PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available on Workterra and the intranet and include:

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The following SBCs are available on Workterra and the intranet.

- Kaiser HMO
- Blue Shield HMO
- Blue Shield PPO
- Blue Shield HDHP HSA PPO

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact Human Resources.

Summary Plan Descriptions

A Summary Plan Description (SPD) is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries. City of Irvine Group Health Plan Summary Plan descriptions are available.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the City of Irvine Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Current Health Plan 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. If you would like more information on WHCRA benefits, contact the carriers directly using the contact information on page 36.

NOTICE OF CHOICE OF PROVIDERS

The Blue Shield and Kaiser HMO plans generally require/allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the Blue Shield and Kaiser HMO plans designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the carriers directly using the contact information on page 36. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Blue Shield or Kaiser HMO plans, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the carriers directly using the contact information on page 36.

Current Health Plan Notices

NEWBORNS' AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator using the contact information on page 36.

HIPAA NOTICE OF PRIVACY PRACTICES

We maintain the HIPAA Notice of Privacy Practices for the City of Irvine describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the Human Resources Department. HIPAA Privacy Notices that pertain to the plans may be obtained by contacting your insurance carrier directly using the contact information on page 36.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

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

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

Current Health Plan Notices

MEDICARE PART D NOTICE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

Current Health Plan Notices

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 the City of Irvine and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information about This Notice or Your Current Prescription Drug Coverage…

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

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2022 – December 31, 2022
Name of Entity/Sender:	City of Irvine
Contact-Position/Office:	Human Resources
Address:	One Civic Center Plaza, Irvine, CA 92606
Phone Number:	949-724-6044

For Assistance

MyBenefits.Life

MyBenefits.Life is a free app and website that includes much of the information that's included in this overview, but in a place that's always at your fingertips - your smartphone or computer. MyBenefits.Life is available for Android and iPhone.

Web: CityofIrvine.mybenefits.life
App: App Store or Google Play
Employer Key: IRVINEFT

HUMAN RESOURCES

If you have additional questions or if you need assistance, contact the following Human Resources staff:

CITY OF IRVINE HUMAN RESOURCES CONTACTS	
Julia Brooks 949-724-6044 *benefits@cityoforvine.org*	Deirdre Hoagland 949-724-6217 *benefits@cityoforvine.org*

Plan Contacts

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

Carrier/ Administrator	Phone Number	Website
Workterra Call Center	888-327-2770	*workterra.net*
Human Resources	949-724-6067	*benefits@cityofirvine.org*
Kaiser Permanente	800-464-4000	*kp.org*
Blue Shield of California	855-256-9404	*blueshieldca.com*
Express Scripts Pharmacy Benefits Manager (Blue Shield members)	800-711-0917	*express-scripts.com*
Blue Shield HealthEquity HSA	877-857-6810	*healthequity.com*
Guardian Dental HMO	800-273-3330	*guardiananytime.com*
Guardian Dental PPO	800-541-7846	*guardiananytime.com*
Vision Service Plan (VSP)	800-877-7195	*vsp.com*
Lincoln Financial EAP	888-628-4824	*GuidanceResources.com* *Username: LFGSupport* *Password: LFGSupport1*
Lincoln Financial Life and AD&D	800-423-2765 Mention Group ID 800010	*LincolnFinancial.com*
Lincoln Financial STD and LTD	866-783-2255 Mention City of Irvine	*LincolnFinancial.com*
Workterra FSA	888-327-2770	*workterra.lh1ondemand.com*
UNUM Voluntary Benefits	800-635-5597	*unum.com*
Long Term Care	877-286-2852	*https://cityofirvine.myltcguide.com/*
Teladoc (Blue Shield members)	800-835-2362	*teladoc.com/bsc*
Carrum (Blue Shield members)	888-855-7806	*mycarrumhealth.com/eiahealth*
Talkspace	Tech Support- Partners-support@talkspace.com	*Talkspace.com/cityofirvine* *Keyword: COITALK*

Notes

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