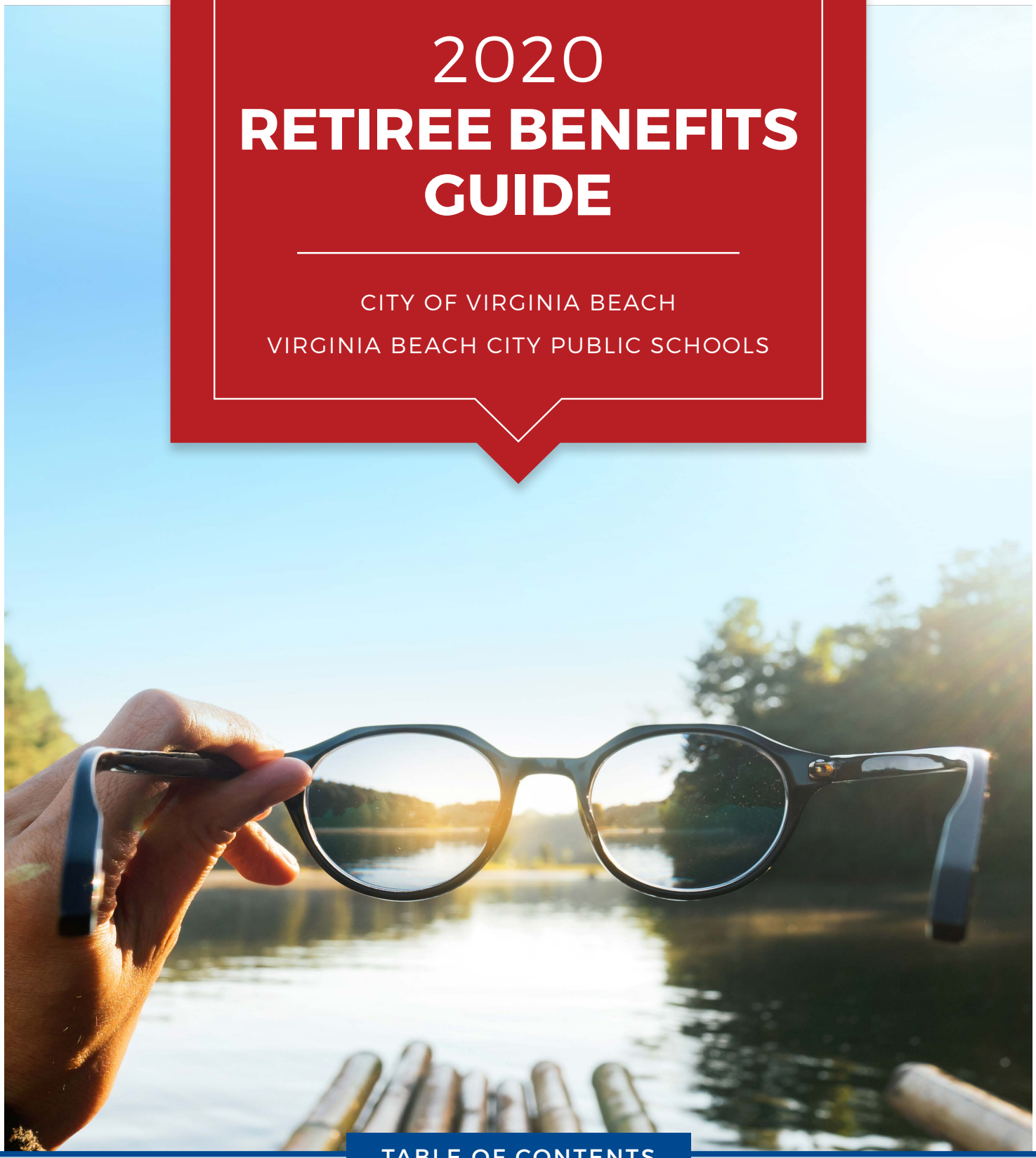
2020 RETIREE BENEFITS GUIDE

CITY OF VIRGINIA BEACH

VIRGINIA BEACH CITY PUBLIC SCHOOLS



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TRANSITIONING YOUR **ACTIVE BENEFITS** TO **RETIREE BENEFITS**

Welcome to the City of Virginia Beach and Virginia Beach City Public Schools' Retiree Benefits Guide. Whether you are thinking about retiring, in the process of retiring or already retired, this guide is for you! In this guide, you will learn about which benefit plans transition, when and how to enroll, and requirements for benefit plan participation.

Your current benefits as an active employee will terminate and you may continue certain benefits upon re-enrollment as a retiree. Some of these benefits are not administered by the Consolidated Benefits Office (CBO) for retirees. Please reference the information in this guide to understand your continuation of coverage.

Benefits that **will discontinue** upon your retirement

- Employee Assistance Program (EAP) & Work-Life Services
- 403(b) Tax Sheltered Account[1]
  - → You should work directly with your advisor to manage your funds
- 457 Deferred Compensation[1] *(Hybrid 457 Cash Match, Commonwealth of Virginia 457 (COV457))*
  - → You should work directly with your advisor to manage your funds
- Long Term Disability[1]
- VLDP (Virginia Local Disability Program)[1]
- WageWorks Flexible Spending Accounts *(Health Care and Dependent Care)*
  - → You can submit claims incurred prior to your retirement date to WageWorks by the end of the month following 90 calendar days after your coverage end date. Any funds remaining after that time will be forfeited.
  - → If you retire between February and December, you can continue to participate in the Health Care FSA on an after-tax basis through the Public Health Service Act (PHSA/COBRA) to get reimbursed for eligible medical expenses with any remaining funds through the end of the plan year in which you retire. You must elect PHSA/COBRA within 60 days of retirement. For more information, please contact the CBO.

[1] For these benefits you may be eligible to utilize them, however you are no longer enrolled/contributing as an active employee.

WHAT ARE **PLAN ELIGIBILITY AND REQUIREMENTS?**

Benefits you may continue by **contacting the vendor directly**:

BENEFIT	VENDOR	HOW TO CONTINUE	CONTACT INFORMATION
Legal Plan	Legal Resources	Complete **Legal Resources Conversion Packet** located on **vbgov.com/benefits** and **send directly to Legal Resources** within 30 calendar days following last day of employment	757.498.1220 or 800.728.5768 **LegalResources.com**
Identity Theft Protection	Legal Resources	Complete **Identity Theft Conversion Packet** located on **vbgov.com/benefits** and **send directly to Legal Resources** within 30 calendar days following last day of employment	757.498.1220 or 800.728.5768 **LegalResources.com**
Basic Life Insurance	Securian Financial	Basic Life Insurance is provided to retirees at no cost. Please review the rules on Basic Life reduction upon your retirement online at **varetire.org**	800.441.2258 **varetire.org** P.O. Box 1193 Richmond, VA 23218-1193
Optional Life Insurance	Securian Financial	Must be enrolled in Optional Life for 5 years prior to retirement to be eligible to elect continuation of coverage. Complete the **Optional Life Conversion Packet** available on **vbgov.com/benefits** and **mail directly to Securian Financial**	800.441.2258 **varetire.org** P.O. Box 1193 Richmond, VA 23218-1193

Benefits the **CBO continues to administer** to eligible[1,2] retirees:

BENEFIT	VENDOR	ACTIVE END DATE	RETIREE EFFECTIVE DATE	HOW YOU RE-ENROLL AS A RETIREE
Dental[1]	MetLife	Last day of the month before your retirement date (for school employees retiring in July and August, benefits will end on August 31st).	First day of your retirement month (school employees retiring in July and August will have a September 1st effective date).	Log in and elect coverage online through BENEFITFOCUS.
Health[2]	Optima Health			Log in and elect coverage online through BENEFITFOCUS.
Health Savings Account[3]	HealthEquity	You remain the account holder; the HSA does not terminate. Your contributions will not continue pre-tax upon retirement.		Log in and elect coverage online through BENEFITFOCUS. Then HealthEquity will reach out to you to set up your savings account.
BEWell (Beach Employee Wellness)[4]	Virgin Pulse *Partnerships with:* • Optima Health • AccordantCare • Sentara • QuitforLife	Last day of the month before your retirement date (including school employees retiring in July and August). You have 30 days to cash out your active account and disconnect any devices from this account.	You can re-enroll within 30 calendar days following your retiree health insurance effective date.[5]	Go to join.virginpulse.com/virginiabeach and re-enroll.

[1] Detailed information on eligibility for retirees can be found on page 4.
[2] Detailed information on eligibility for retirees can be found on page 6.
[3] Must be on Optima POS Basic or POS Standard to be eligible, and may not be covered by any other health coverage. See page 12 for plan eligibility.
[4] You are only eligible for BEWell if you are on the City/School retiree health plan.
[5] There may be a delay for when you can re-enroll on Virgin Pulse depending on when you log in to BENEFITFOCUS to elect your new retiree health insurance.

DENTAL PLAN ELIGIBILITY

ALL of the following conditions **must be met to be eligible to enroll in retiree dental coverage**:

- ☑ Retire under Virginia Retirement System (VRS) from the City of Virginia Beach/Virginia Beach City Public Schools
- ☑ Must not be Medicare-eligible due to age or disability *(except for the first 30 months of Medicare-eligibility due to End Stage Renal Disease)*
- ☑ Must be enrolled in **dental** coverage at the time of retirement
- ☑ Elect coverage within 30 days from first day of retirement[1]
- ☑ Must have the following combined cumulative worked years of employment with the City and/or Schools, based upon hire date:

Hire Date	Years of employment with City and/or Schools of Virginia Beach
Hired before 7.1.2014	No minimum years
Hired on or after 7.1.2014	15 years

1. If you have determined you **ARE ELIGIBLE** to enroll in retiree dental coverage, keep reading this section to learn about your premium cost, dental plan options, how to enroll, and important deadlines.

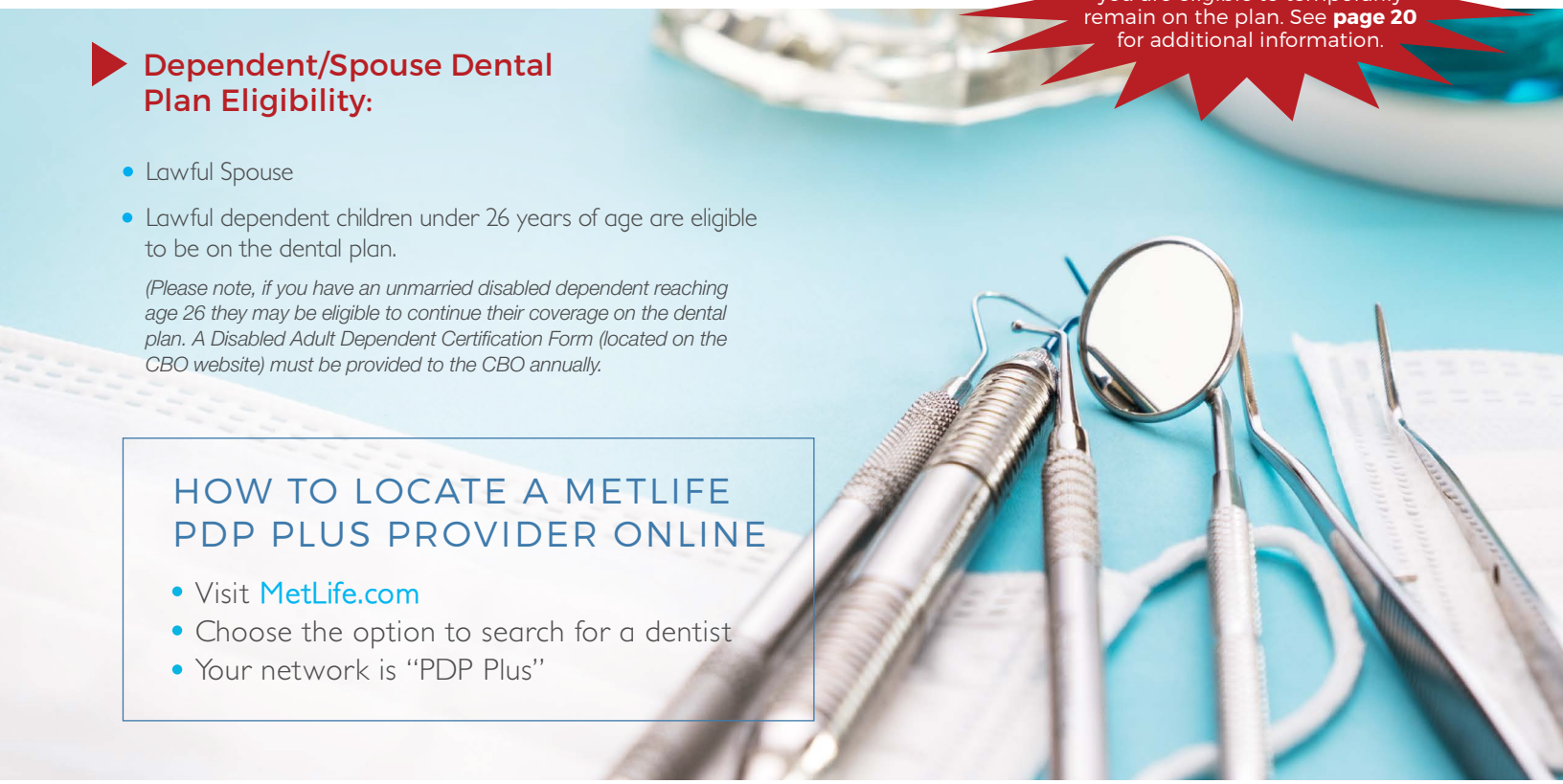
2. If you have determined you are **NOT ELIGIBLE** to enroll in retiree dental coverage, see the following resources for dental coverage options:
   - If you are Medicare eligible - see **page 23**
   - If you are enrolled on the dental plan as an active employee see your Continuation of Coverage Rights under PHSA/COBRA - Visit the 2020 PHSA/COBRA Benefits Enrollment Guide available on the CBO website. (A packet will also be mailed to your home address once your retirement date is processed.)

If you are a **Line of Duty Participant** pending approval, you are eligible to temporarily remain on the plan. See **page 20** for additional information.

Dependent/Spouse Dental Plan Eligibility:

- Lawful Spouse
- Lawful dependent children under 26 years of age are eligible to be on the dental plan.

  (Please note, if you have an unmarried disabled dependent reaching age 26 they may be eligible to continue their coverage on the dental plan. A Disabled Adult Dependent Certification Form (located on the CBO website) must be provided to the CBO annually.



HOW TO LOCATE A METLIFE PDP PLUS PROVIDER ONLINE

- Visit MetLife.com
- Choose the option to search for a dentist
- Your network is "PDP Plus"

[1] For school employees retiring in July or August, the effective date is September 1.

DENTAL: METLIFE

Dental insurance pays a portion of the costs associated with dental care. You can choose from one of two dental plans: MetLife Silver or MetLife Gold.

DENTAL PLAN PREMIUMS (MONTHLY RATE)		
LEVEL OF COVERAGE	SILVER	GOLD
Subscriber Only	$20.05	$32.93
Subscriber + 1 Child	$32.08	$52.24
Subscriber + Children	$42.44	$69.19
Subscriber + Spouse	$42.44	$69.19
Family	$64.01	$104.87

A FRIENDLY REMINDER: MetLife member ID cards are not provided. Use your name and member number (employee's SSN for all covered dependents) to seek dental services. A digital ID card is available via the mobile app and contains the dental group plan and network information.

SUMMARY OF DENTAL PLAN COVERAGE

These **deductibles and coverage levels reflect the Preferred Dentist Program (PDP) in-network care**, and plan frequency limitations apply (for example, 2 cleanings per calendar year, etc.). Out-of-network care, deductibles, and coverage levels **are different**. You can see those values in the full Dental Guide on the CBO website.

	METLIFE SILVER *In-Network*	METLIFE GOLD *In-Network*
Deductible (applies only to type B & C services)	$75 Individual $225 Family	$50 Individual $150 Family
Annual Maximum Benefit per calendar year	$1,000	$1,300
Type A – Prophylaxis/cleanings, oral examinations, topical fluoride applications, space maintainers, x-rays (bitewings), brush biopsies	100% of Negotiated Fee[1]	100% of Negotiated Fee[1]
Type B – Fillings, simple extractions, repair of crown, denture and bridge, oral surgery, pulp caps/pulpotomy, periodontics (non-surgical), sealants, x-rays (full mouth)	60% of Negotiated Fee[1]	80% of Negotiated Fee[1]
Type C – Bridges, dentures, endontics (other than pulp caps/ pulpotomy), crowns, inlays/onlays, implants, periodontics (surgical)	30% of Negotiated Fee[1]	50% of Negotiated Fee[1]
Type D – Orthodontic Diagnostics, orthodontic treatment	No Coverage	50% of Negotiated Fee[1]
Orthodontia Lifetime Maximum Per Person *(Orthodontia maximum includes maximum history from prior employer sponsored dental plan)*	No Coverage	$1,000

[1]Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

HEALTH PLAN ELIGIBILITY

Health plan eligibility and the cost you pay for coverage on the City of Virginia Beach and Virginia Beach City Public Schools' Retiree Health Plan varies.

ALL of the following conditions **must be met to be eligible to enroll in retiree health coverage**:

- ☑ Retire under Virginia Retirement System (VRS) from the City of Virginia Beach/Virginia Beach City Public Schools
- ☑ Must not be Medicare-eligible due to age or disability *(except for the first 30 months of Medicare-eligibility due to End Stage Renal Disease)*
- ☑ Must be enrolled in **health** coverage at the time of retirement
- ☑ Elect coverage within 30 days from first day of retirement[1]
- ☑ Must have the following combined cumulative worked years of employment with the City and/or Schools, based upon hire date:

Hire Date	Years of employment with City and/or Schools of Virginia Beach
▶ Hired before 7.1.2014	▶ No minimum years
▶ Hired on or after 7.1.2014	▶ 15 years

1. If you have determined you **ARE ELIGIBLE** to enroll in retiree health coverage, keep reading this section to learn about your premium cost, health plan options, how to enroll, and important deadlines.

2. If you have determined you are **NOT ELIGIBLE** to enroll in retiree health coverage, see the following resources for health coverage options:
   - If you are Medicare eligible - see **page 23**
   - If you are enrolled on the health plan as an active employee, see your Continuation of Coverage Rights under PHSA/COBRA - Visit the 2020 PHSA/COBRA Benefits Enrollment Guide available on the CBO website. (A packet will also be mailed to your home address once your retirement date is processed.)

If you are a **Line of Duty Participant** pending approval, you are eligible to temporarily remain on the plan. See **page 20** for additional information.

[1] For school employees retiring in July or August, the effective date is September 1.

Dependent/Spouse Health Plan Eligibility:

- Working spouses are **not** permitted on the City/Schools health plan if they are an employee and have access to their own employer group health plan that meets the Affordability and Minimum Essential Services requirement. (If you're not sure whether your spouse's plan meet these requirements, please reference their employer's Marketplace notice.)
- Spouses who are not yet eligible for Medicare due to age or disability are eligible to be on the plan.
- Lawful dependent children under 26 years of age are eligible to be on the health plan. (Please note, if you have an unmarried disabled dependent reaching age 26 they may be eligible to continue their coverage on the health plan. A Disabled Adult Dependent Certification Form (located on the CBO website) must be provided to the CBO annually.)
- Retirees are required to provide proof of legal dependent status for dependents with a different last name from theirs (example: a marriage license (spouse), birth or adoption certificate (child/ren)). Failure to have these documents in your online profile on the BENEFITFOCUS platform will result in benefit coverage ending for non-verified dependents.

HEALTH PLAN EMPLOYER CONTRIBUTION ELIGIBILITY

If you are eligible for the health plan offered by the City of Virginia Beach and Virginia Beach City Public Schools' based on the criteria on **page 6**, your health plan employer contribution is dependent on your hire date and cumulative years of employment as listed below.

You must have the following combined cumulative worked years of employment with the City and/or Schools, based upon hire date:

Hire Date	Years of Combined Cumulative Service	Health Plan Premium
▶ Hired before 7.1.2014	▶ 25 years with City and/or Schools	See "Health Plan Premiums **WITH** Employer Contribution"
	▶ Less than 25 years with City and/or Schools	See "Health Plan Premiums **WITHOUT** Employer Contribution"
▶ Hired before 7.1.2014	▶ 5 years with a job related disability with the City	See "Health Plan Premiums **WITH** Employer Contribution"
	▶ Less than 5 years with a job related disability with the City	See "Health Plan Premiums **WITHOUT** Employer Contribution"
▶ Hired on or after 7.1.2014	▶ ≥ 15 years with City and/or Schools	See "Health Plan Premiums **WITHOUT** Employer Contribution"
	▶ < 15 years with City and/or Schools	Not applicable (not eligible for coverage)

HEALTH COVERAGE: OPTIMA

Health insurance helps provide coverage for preventive care, pharmacy, and other medical services. Three health plan options are offered through Optima Health: POS Basic, POS Standard and POS Premier. By carefully comparing these three health plan options, you can determine the plan that best fits your needs.

2020 POS BASIC PLAN **ENROLLMENT INCENTIVE**

Anyone who elects the POS Basic Plan and elects a Health Savings Account (HSA) will receive an employer contribution into their HSA up to the following amounts:

- $500 subscriber only
- $1,000 all other tiers (subscriber + child, subscriber + children, subscriber + spouse, subscriber + family)

This account is **not pre-funded**. The employer contribution for 2020 will be placed in your account on a monthly basis throughout the year. The employer contribution is **not provided** to retirees enrolled in the POS Standard or Premier Plans. To learn more about the differences in the health plans, keep reading this section and for HSA information and eligibility see **page 12.**

HEALTH PLAN PREMIUMS

WITH[1] EMPLOYER CONTRIBUTION (MONTHLY RATE)

LEVEL OF COVERAGE	POS **BASIC**	POS **STANDARD**	POS **PREMIER**
Subscriber Only	$121.59	$175.24	$256.24
Subscriber + 1 Child	$178.53	$256.31	$373.76
Subscriber + Children	$255.19	$365.17	$531.22
Subscriber + Spouse	$543.27	$668.27	$857.00
Family	$630.18	$791.65	$1,035.46

HEALTH PLAN PREMIUMS

WITHOUT[1] EMPLOYER CONTRIBUTION (MONTHLY RATE)

LEVEL OF COVERAGE	POS **BASIC**	POS **STANDARD**	POS **PREMIER**
Subscriber Only	$712.15	$765.79	$846.80
Subscriber + 1 Child	$1,032.55	$1,110.33	$1,227.78
Subscriber + Children	$1,459.72	$1,569.70	$1,735.75
Subscriber + Spouse	$1,651.91	$1,776.90	$1,965.63
Family	$2,136.05	$2,297.51	$2,541.33

[1] Eligibility information can be found on page 6.

2020 OPTIMA **HEALTH PLAN COMPARISON SUMMARY OF BENEFITS**

PLAN FEATURES	POS **BASIC**		POS **STANDARD**		POS **PREMIER**	
	*Non-embedded: Must meet the Family Deductible/Out-of-Pocket Max if enrolled in any tier other than Subscriber Only					
	Optima Network/ PHCS Network	Out-of-Network	Optima Network/ PHCS Network	Out-of-Network	Optima Network/ PHCS Network	Out-of-Network
Deductibles (per calendar year)	$2,000 per individual* $4,000 per Family*	$4,000 per individual* $8,000 per Family*	$1,400 per individual* $2,800 per Family*	$2,800 per individual* $5,600 per Family*	$850 per individual $1,700 per Family	$1,700 per individual $3,400 per Family
HSA Eligible	Yes		Yes		No	
HSA Employer Funding	$500 Subscriber Only/$1,000 All other tiers See page 12 for details		No		N/A	
Maximum-Out-of-Pocket (MOOP) (per calendar year)	$4,000 per individual* $8,000 per family*	$6,500 per individual* $13,000 per family*	$3,500 per individual* $7,000 per family*	$5,500 per individual* $11,000 per family*	$3,000 per individual $6,000 per family	$4,500 per individual $9,000 per family
Preventive Care	100%[1]	Covered at 50%[AD]	100%[1]	Covered at 50%[AD]	100%[1]	Covered at 60%[AD]
MDLIVE[2]	Covered at 100%[AD]		Covered at 100%[AD]		Covered at 100%[1]	
SQCN[3] PCP	Covered at 85%[AD]	Covered at 50%[AD]	Covered at 90%[AD]	Covered at 50%[AD]	$20 Co-pay[1]	Covered at 60%[AD]
Non-SQCN PCP	Covered at 75%[AD]	Covered at 50%[AD]	Covered at 80%[AD]	Covered at 50%[AD]	$40 Co-pay[1]	Covered at 60%[AD]
SQCN[3] Specialist	Covered at 85%[AD]	Covered at 50%[AD]	Covered at 90%[AD]	Covered at 50%[AD]	$40 Co-pay[1]	Covered at 60%[AD]
Non-SQCN Specialist	Covered at 75%[AD]	Covered at 50%[AD]	Covered at 80%[AD]	Covered at 50%[AD]	$60 Co-pay[1]	Covered at 60%[AD]
SQCN[3] Maternity Care	Covered at 85%[AD]	Covered at 50%[AD]	Covered at 90%[AD]	Covered at 50%[AD]	$350 Co-pay[1]	Covered at 60%[AD]
Non-SQCN Maternity Care	Covered at 75%[AD]	Covered at 50%[AD]	Covered at 80%[AD]	Covered at 50%[AD]	$500 Co-pay[1]	Covered at 60%[AD]
Diagnostic (x-ray, lab work) & Imaging (CT/PET/MRI)	Covered at 75%[AD]	Covered at 50%[AD]	Covered at 80%[AD]	Covered at 50%[AD]	Covered at 85%[AD]	Covered at 60%[AD]
Inpatient & Outpatient Hospital	Covered at 75%[AD]	Covered at 50%[AD]	Covered at 80%[AD]	Covered at 50%[AD]	Covered at 85%[AD]	Covered at 60%[AD]
Preferred Pharmacy[4] (Walgreens, Walmart/Sams Club)						
Tier 1[5]	$10 Co-pay[AD, 6]		$10 Co-pay[AD, 6]		$10 Co-pay[1]	
Tier 2[5]	$25 Co-pay[AD, 6]		$25 Co-pay[AD, 6]		$25 Co-pay[1]	
Tier 3	Covered at 75%[AD, 6] (Max $50)		Covered at 75%[AD, 6] (Max $50)		Covered at 75%[1] (Max $50)	
Non-Preferred Pharmacy[4]						
Tier 1[5]	$25 Co-pay[AD, 6]		$25 Co-pay[AD, 6]		$25 Co-pay[1]	
Tier 2[5]	$45 Co-pay[AD, 6]		$45 Co-pay[AD, 6]		$45 Co-pay[1]	
Tier 3	Covered at 75%[AD, 6] (Max $75)		Covered at 75%[AD, 6] (Max $75)		Covered at 75%[1] (Max $75)	
Specialty Pharmacy[4]						
	Covered at 75%[AD, 6] (Max $200)		Covered at 75%[AD, 6] (Max $200)		Covered at 75%[1] (Max $200)	

NOTES

[AD] **After Deductible (deductible must be paid first before the plan will provide coverage as indicated)**

[1] Deductible does not apply to this service (plan will provide coverage as indicated and before the deductible has been met)

[2] MDLIVE telemedicine services available with health plan enrollment. For Basic and Standard plans the cost is $39 before you meet your deductible.

[3] Sentara Quality Care Network (to see if your doctors are part of SQCN visit OptimaHealth.com and click on doctor search. Look for doctors with a "CIN" symbol next to his or her name)

[4] Closed Formulary Prescription Drug Benefit (contains specific drugs in each drug class. Non-formulary medications must meet medical necessity criteria through an exception process to be covered)

[5] Or the plan's negotiated cost of the drug, if less

[6] Please note: Prescription medications used to prevent any of the following medical conditions are not subject to the deductible including medications for hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency.

ADDITIONAL **HEALTH PLAN SERVICES** & INFORMATION

Primary Care Physician

- Every new Optima Health member is assigned a Primary Care Physician (PCP) when they enroll. You can view or change the assigned PCP at any time online on OptimaHealth.com. Select "Employer Plans," "POS," "POS with PHCS network." As a friendly reminder you may see a cost savings (see the Summary of Benefits on **page 9**) if you elect a physician in the Sentara Quality Care Network (SQCN). Information on SQCN can be found here: sentaraqualitycarenetwork.com

HEALTH TIP:

Don't forget to keep your Primary Care Physician (PCP) up to date!

EyeMed

- As part of your Optima POS Health Plan coverage, you have a benefit for vision care services and materials provided by EyeMed. Below is a brief summary of your vision benefit (for detailed plan information please see the Optima Health Benefit Information Guide online). **To locate a provider visit OptimaHealth.com and select "Preventive Vision Network (non-Medicaid)."**

EyeMed Vision Care **In-Network Coverage**	
SERVICE	MEMBER COST
Spectacle Exam ***or***	$20 Co-pay
Standard Contact Lens Exam	$40 Co-pay
Lenses (single vision, bifocal, trifocal)	Covered at 100%
Frames	Covered in full up to $150 retail
Contact Lens - Conventional (In lieu of glasses)	Covered in full up to $150 retail (in lieu of glasses)

DID YOU KNOW? Your Optima member card is also your EyeMed member card.

Limited to one pair of frames, lenses (single vision, bifocal, trifocal) OR contact lenses from a participating EyeMed Vision Care Provider (once every 12 months from the date of last exam). Copayments or Coinsurance payments made for vision care services are not applied toward the annual maximum out-of-pocket (MOOP). This means that you will continue to pay when seeking services after the MOOP has been met.

MDLIVE Virtual Care

Receive virtual care, anywhere!

- As part of your Optima POS Health Plan coverage, you have a benefit for telemedicine services provided by MDLIVE. With MDLIVE, you can visit with a doctor 24/7 from your home, office or on the go. MDLIVE's network of Board Certified doctors is available by **phone 866.648.3638** or secure video to assist with non-emergency medical conditions. To access this benefit, log in to your Optima Health member account on OptimaHealth.com or the Optima Health mobile app.

COMMON CONDITIONS THEY TREAT:

- Allergies
- Addictions
- Bronchitis
- Cold & Flu
- Depression
- Infections
- Rashes
- Urinary Tract Infections

HEALTH PLAN ENROLLMENT	OUT-OF-POCKET COST
POS **BASIC** PLAN	**$39** before the annual deductible is met, and then covered at 100%
POS **STANDARD** PLAN	
POS **PREMIER** PLAN	Covered at 100%

OptumRx - Prescription Drug Coverage

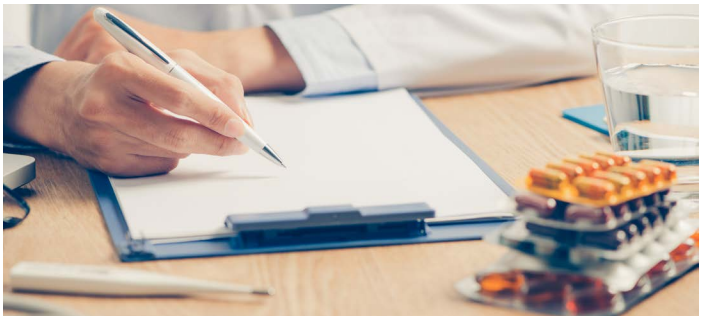
- Prescription drug coverage managed by OptumRx is provided when you are enrolled in the Optima Health Plan. Your Prescription Drug Benefit is a closed formulary, which means it contains specific drugs in each drug class, and non-formulary medications must meet medical necessity criteria through an exception process to be covered. As a friendly reminder, here are all the ways you can fill your prescriptions:

1 At a Participating Pharmacy

- Don't forget! Your prescription coverage has preferred pharmacies (Walgreens, Walmart and Sam's Club) where you can save money while filling your prescriptions. **You also are able to pick up to a 90 day supply** at these locations. (Up to a 30 day supply at all other participating pharmacies.)

2 OptumRx Home Delivery

- Home delivery is great for maintenance medications you may be on such as high-blood pressure, cholesterol, etc.
- By signing up for home delivery your medication is delivered right to your mailbox (standard shipping at no cost), your medication could cost less, and you will receive reminders so you remember to refill.
- To learn more, visit **optimahealth.com/members** or call OptumRx home delivery at **866.244.9113**



3 Specialty Drug Pharmacy - Proprium

- Medications under this service are not routinely available at retail pharmacies and frequently must be ordered so there will be minimal disruption, if any.
- If you require specialty medications or supplies, your doctor will help you get started with Proprium.
- Convenient home delivery for a 30 day supply of specialty medications, such as injectables.

Diabetic Services

Reduced Co-pays

- Employees may be eligible for reduced co-pays on diabetic medications with participation in the Diabetes Disease Management Program. For more information call BEWell at **757.263.1060**.

Included Diabetic Supplies & Equipment

- FDA approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy.
- Insulin, syringes, and needles are covered under the Optima Health Plan's Prescription Drug Benefit for the applicable Co-pay or Co-insurance per 31 day supply.
- An annual diabetic eye exam is covered from an Optima Health Plan Provider, a participating EyeMed Provider, or a Non-Plan Provider at the applicable specialist office visit Co-pay or Co-insurance amount.

Access This Benefit for Meters, Strips and Lancets with the Following Providers:

HOME CARE DELIVERED
800.867.4412

EDGEPARK MEDICAL SUPPLIES
888.394.5375

HEALTH SAVINGS ACCOUNT (HSA): HEALTHEQUITY

You must be enrolled in an Optima POS Basic or POS Standard plan to be eligible for the Health Savings Account (HSA). HSAs are not pre-funded (which means you will only be reimbursed up to the balance in your account at the time you submit a claim) and funds deposited do not forfeit and belong to the retiree. HSA balances earn tax-free interest and can be used to pay for qualified medical expenses.

HSA Eligibility:

The IRS requires that you:

- Are covered by an HSA - qualified health plan (POS Basic or POS Standard, see page 9);
- Have no other health coverage (such as other health plan, Medicaid, Medicare (Part A and/or B), military health benefits, medical FSAs);
- Cannot be claimed as a dependent on another person's tax return.

Here is how you get started with an HSA:

1 Select an HSA-qualified health plan

- POS Basic or POS Standard *(See page 9)*

2 Add money to your HSA

- Fund your HSA by transferring money into your account through the HealthEquity member portal. To take full advantage of tax savings and to build a reserve for the future, it is suggested that you maximize your contributions as set by the IRS.

3 Watch your HSA grow

- Your federally-insured HSA earns tax-free[1] interest. Maximize your tax-free earning potential by investing HSA funds using the convenient online investment tool.[2]

4 Use your HSA for qualified medical expenses

- After enrollment you will receive a welcome kit with a HealthEquity debit card for easy access to your funds.
- HSA funds can be used for a variety of qualified medical, dental, and vision expenses.

There is a $1.45 monthly administration fee on HSA accounts.

EXAMPLES OF ELIGIBLE EXPENSES

Acupuncture • Birth control • Chiropractor • Contact lenses
Dental treatment • Fertility enhancement • Hearing aids
Lab Work • Medical supplies • Physical exams • Prescriptions
Prescription eyeglasses • Orthodontia • Radiology
Stop-smoking programs • Surgery (non-cosmetic) • Therapy

For an expanded list of eligible medical expenses, easy to understand videos, and calculators visit:
WWW.HEALTHEQUITY.COM
and click on "HSA."

HEALTH SAVINGS ACCOUNT

2020 HSA Contribution Limits[3]:

$3,550 – Subscriber only **$7,100** – All other tiers (subscriber + one or more individuals)

[1] HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-free with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

[2] Investments available to HSA holders are subject to risk, including the possible loss of the principal invested and are not federally-insured or guaranteed by HealthEquity. HealthEquity does not provide financial advice.

[3] If you are age 55 or older you may contribute an additional $1,000 on top of the allowed contribution limits.

GET CONNECTED **WITH BEWELL!**

BEWell
BEACH EMPLOYEE WELLNESS

If you continue the health insurance coverage as a retiree, you are eligible to participate in the wellness program! Beach Employee Wellness (BEWell) is a program that encourages participation in healthy behaviors and activities by making them easy and stress-free! BEWell is powered by Virgin Pulse, a dynamic, creative, and individualized platform that provides tools to keep you energized about wellness. You'll earn points for daily interactions, tracking exercise, health screenings, and more! The points you earn translate into rewards, and you can **earn up to $500 a year!**

Sign Up
It's quick and easy to enroll today!

1. Through an internet browser (computer or mobile), visit join.virginpulse.com/VirginiaBeach
2. Click "SIGN ME UP!"
3. Under "Choose your country" select United States and be sure to read and check off the agreements!
4. Fill in the requested demographic information
5. Click "LET'S GET STARTED!"
6. Congratulations, you're enrolled!
7. Follow the tutorials & start earning points today!

Already enrolled in the Virgin Pulse platform?
Nice work! Stay motivated or get moving!

1. Make sure you are checking in with Virgin Pulse daily!
2. Track healthy behaviors, nutrition, sleep & more
3. Take advantage of BEWell's support programs to earn points
4. See all the ways to earn points inside the BEWell Guide or log in to your account, visit the Rewards tab, & select How to Earn
5. Strive for Level 4 every quarter!

Forgot your Virgin Pulse password?
- Click "Forgot Password" on the log in page OR
- Call Virgin Pulse at 888.671.9395

If you are a new retiree, you must re-enroll

Additional Programs & Support Services

Get the support you need to improve or maintain your health and earn BEWell rewards for your participation.

- OPTIMA HEALTH - DISEASE MANAGEMENT
  - Diabetes Disease Management
  - Respiratory Disease Management
  - Cardiovascular Disease Management
  - AccordantCare™
- OPTIMA HEALTH - PARTNERS IN PREGNANCY
- QUIT FOR LIFE® - TOBACCO CESSATION

Note: this list is not inclusive—there are even more ways to earn points. Log in to see how!

STAY CONNECTED! Each quarter, BEWell sends out an informative newsletter to your home address. You will find quarterly events, program spotlights, and other updates inside.

HOW DOES THE **CBO KEEP IN TOUCH?**

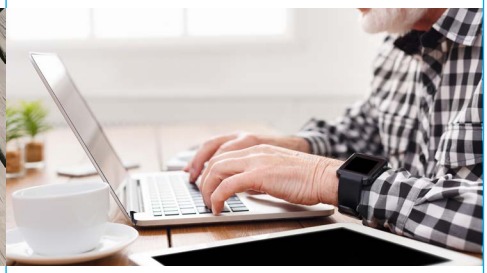
The Consolidated Benefits Office communicates important benefit information and updates differently for retirees! See the chart below to understand the different methods.

AS AN **ACTIVE EMPLOYEE** YOU RECEIVED:	AS A **RETIREE** YOU WILL RECEIVE:
Semi-Monthly e-Bulletins	Quarterly Retiree Newsletters mailed to your home address
Quarterly BEWell Beat emails	Quarterly BEWell Beat mailed to your home address
Intranet site (vbcps.sharepoint.com or Beachnet)	**vbgov.com/benefits** Visit this page frequently for benefit material, upcoming events, and announcements.

IMPORTANT! PLEASE KEEP YOUR ADDRESS CURRENT!

Benefit vendors and the CBO will use your address on file to mail you important documents and other information. To update your address, please complete the Retiree Name and Contact Change Packet available on the retiree page of **vbgov.com/benefits**.

WHEN CAN I **ENROLL IN BENEFITS?**

Initial Enrollment Period	*After Initial Enrollment Period*	
NEW RETIREES	QUALIFYING LIFE EVENTS	OPEN ENROLLMENT
You have **30 calendar days** following your retirement date to go online into the BENEFITFOCUS platform to elect your health and/or dental benefits. **If you do not elect coverage at the time of your retirement, you will be ineligible to reinstate coverage at a later date.** Please note that once you are Medicare-eligible, you are no longer eligible to continue health and/or dental coverage through Virginia Beach City and Schools (unless you became Medicare-eligible within the last 30 months due to End Stage Renal Disease). Please wait 10 days after your retirement date to log in to BENEFITFOCUS, as your username and password may not be functional yet.	Certain events in your life (i.e. marriage, birth, divorce, gain or loss of coverage due to a job change, etc.) **may** allow you to make changes to your benefit plan(s). If you experience a qualifying life event during the plan year it is important that you make the changes online within 30 calendar days following the qualifying life event date, even if the supporting documentation is not yet available. If you have any questions, contact the Consolidated Benefits Office (CBO).	Open Enrollment is offered annually (usually in the fall) to give you the opportunity to review and make changes to your benefits and covered dependents. It is important to review information the Consolidated Benefits Office sends to you as it provides information on plan design updates, new plan year premiums, and vendor changes. Taking the time to review benefit information during this time will ensure that you are making the best, most informed decisions for you and your family.
		
EFFECTIVE DATE:	EFFECTIVE DATE:	EFFECTIVE DATE:
First (1st) day of your **retirement**, or for school employees retiring in July or August, the effective date is September 1.	First (1st) day of the month following the qualifying life event date. Some exceptions apply – for example, when adding a newborn within 30 calendar days of birth, benefit changes are effective on the birth date.	Open Enrollment elections will become effective January 1st of the next plan year.

DON'T FORGET! When Open Enrollment (OE) occurs you should go back into the BENEFITFOCUS platform and review your benefits to ensure they do not require re-election. There may be times when your eligibility window occurs before or after OE.

When you are electing your benefits for the current plan year, you will need to ensure you log back in and re-elect or elect benefits for the upcoming calendar year. This may feel redundant, however certain plans require re-election.

The CBO has a partnership with BENEFITFOCUS to provide an online platform where you may elect the majority of your benefits. Follow the directions below on how to access the platform.

HOW TO **ENROLL**

1 Log in to the BENEFITFOCUS Platform

ATTENTION NEW RETIREES!

As a friendly reminder, you may not access the platform until your retirement date has passed (but before your 30 calendar days following your retirement date is up!)

LOGGING IN VIA **WEB BROWSER** FROM YOUR COMPUTER, TABLET, OR MOBILE DEVICE

- Go to vbgov.com/benefits/enroll
- Click on "Retiree"
- Make sure to use your correct username and password:
  - USERNAME:
    City Retirees: COVB_Employee ID (example: COVB_1234)
    School Retirees: VBCPS_Employee ID (example: VBCPS_1234)
  - PASSWORD:
    If you **haven't** logged in with these credentials, your **temporary password** is:
    - → Last name + last four digits of your SSN (example: Smith9999)
    - → Once you log in with these credentials you will be prompted to create your own unique password

    If you **have** logged in with these credentials, your password is the same

LOGGING IN VIA **THE BENEFITFOCUS MOBILE APP**

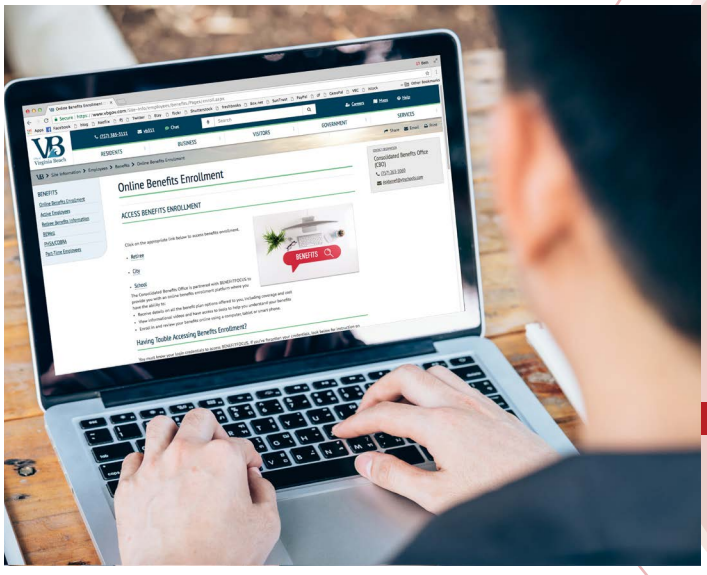
- Download the app from the App Store (Apple) or Google Play (Android)
- Enter Your Company ID: **VABeachBenefits**
- Make sure to use your correct username and password:
  - USERNAME:
    City Retirees: COVB_Employee ID (example: COVB_1234)
    School Retirees: VBCPS_Employee ID (example: VBCPS_1234)
  - PASSWORD:
    If you **haven't** logged in with these credentials, your **temporary password** is:
    - → Last name + last four digits of your SSN (example: Smith9999)
    - → Once you log in with these credentials you will be prompted to create your own unique password

    If you **have** logged in with these credentials, your password is the same

2 Make Your Benefit Elections!

You must elect or decline each benefit - no skipping!

Once elections are made, review your enrollment to ensure all of your dependents are added to each plan you wish to cover them on.



ARE YOU MAKING THE RIGHT DECISION?

Check out the **HEALTH PLAN COMPARISON TOOL** when you are choosing your health plan!

While you're enrolling on BENEFITFOCUS, you can use a customizable tool to predict how much each health plan will cost you out-of-pocket. You can tailor your estimated cost based on how you expect your family to use the plan. For example, if you know you're expecting a baby and will have an inpatient hospital stay, regularly use three prescription drugs, or if you're scheduling an outpatient procedure, you can enter that in to get a projection of costs in each health plan.

TO ACCESS:

Click: "Personalize your estimated cost"
Select: Group average data or customize usage

(National data is also available but will be less accurate.)

3 View The Benefits You've Elected!

Once you submit your enrollment you will receive a confirmation screen. You can view and print an Employee Benefits Summary Report from the platform at any time and retain it for your records.

NEED **HELP?**

CBO staff is available to assist you with enrolling and understanding your benefits!

Consolidated Benefits Office

Email: Benefits@vbschools.com *(This mailbox is routinely checked throughout the day during business hours.)*

Call: 757.263.1060 *(To speak to staff members and to confirm our office hours and holiday observance schedule.)*

Visit: 641 Carriage Hill Road, Virginia Beach, VA 23452
(We are located at Plaza Annex and staff will be able to answer your benefit questions as well as provide you with an iPad so you can complete your enrollment.)

No Computer Access?

You can access a computer at the following places:

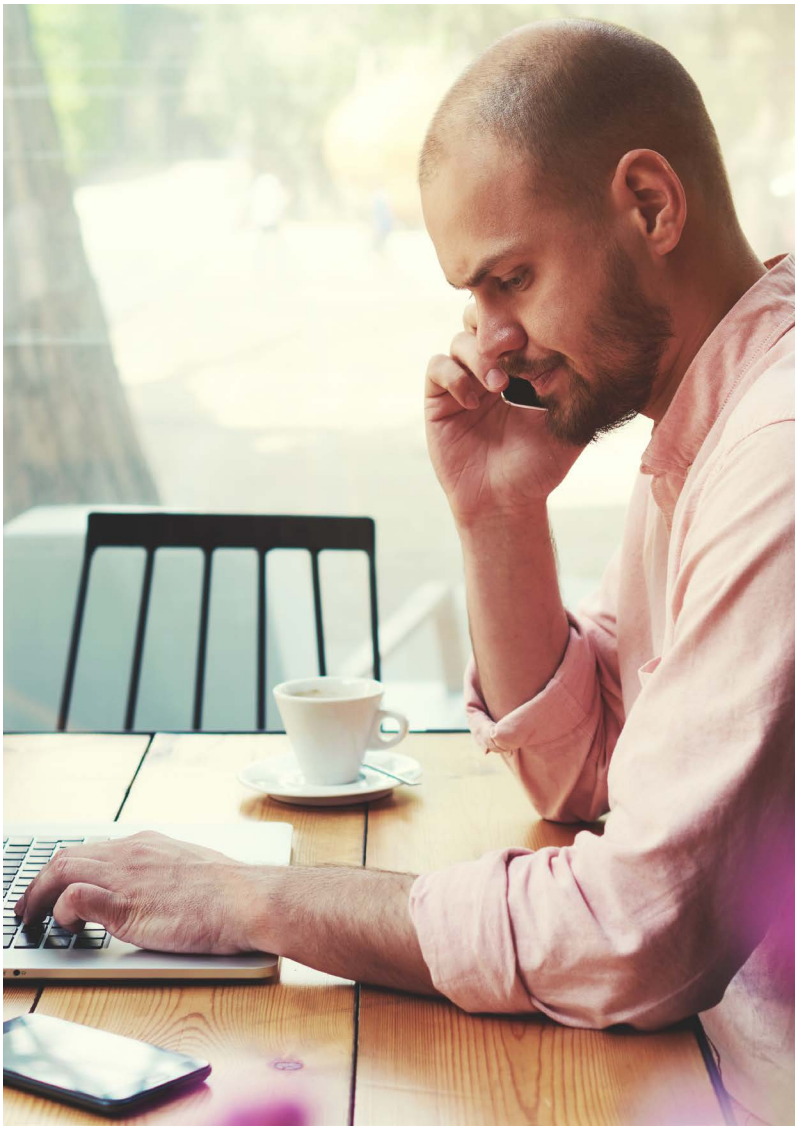
HEALTH STATIONS:

- Bayside Rec. Center
- Bow Creek Rec. Center
- Building 19
- Building 30
- Central Library
- Distribution Services
- Glenwood Bus Garage
- Great Neck Rec. Center
- Harpers Bus Garage
- Kempsville Rec. Center
- Laskin Road Annex
- Parks & Rec. Landscape Services
- Plaza Annex
- Princess Anne Rec. Center
- Public Utilities - Dam Neck
- Public Works Waste Management
- Pungo-Blackwater Library
- School Administration Building
- Seatack Rec. Center
- Williams Farm Rec. Center

PUBLIC LIBRARIES:

(Virginia Beach library account members only)

- Bayside Special Service Library
- Central Library
- Great Neck Area Library
- Joint Use Library
- Kempsville Area Library
- Oceanfront Area Library
- Princess Anne Area Library
- Pungo-Blackwater Library
- Windsor Woods Area Library



RETIREE **PAYMENT & BILLING INFORMATION**

VRS Health Insurance Credit

Certain School and City positions are eligible to receive a health insurance credit if health/dental premium amounts are reported to VRS. Please view the chart below for information and criteria for this VRS credit:

	ELIGIBLE SCHOOL RETIREES	ELIGIBLE CITY RETIREES
Years of Creditable Service	15	15
Eligible positions	Administrative, Teacher, Teacher's Assistant, Secretarial, Nursing*	Employees of the General Registrar, Treasurer, Commissioner of Revenue, Clerk of the Circuit Court, Attorney for the Commonwealth, Sheriff, Sheriff's Deputy, a Constitutional Officer, or an employee of a local Social Services Board*
Amount for each year of service	$4.00	$1.50
Per month maximum	No maximum	$45

* Retirees approved for a disability retirement are also eligible for the credit and receive the maximum credit regardless of length of service. The health insurance credit can be applied to another individual health, dental, pharmacy, or vision plan for which you are covered.

VRS-45 Form

- The CBO will submit a form to VRS on your behalf for your health and/or dental benefit deductions to be taken from your retirement check. For any month that you pay CBO directly for premiums or if you have individual benefit plans you wish to apply the credit towards you must submit the VRS-45 Request for Health Insurance Credit form (available on **varetire.org**) directly to VRS.

Making Payments

- Payment for your health and/or dental benefits will be deducted from your Virginia Retirement System (VRS) check, unless premium costs are greater than the total amount of your check.
  - → In this instance, payment by personal check is required and full premium payments must be paid by the due date specified.
- Allow time for your pension deductions to process. Please be prepared to send payment by check if your pension has not deducted.

REVIEWING YOUR **VRS RETIREMENT CHECK**

Tips for reviewing your VRS Retirement Check

- Be sure to review your Health and/or Dental deductions from your Virginia Retirement System (VRS) check. As a friendly reminder, your premiums will be deducted from your retirement check in arrears. (Example: January premium payments are taken in February.)
- Please compare the retirement statement you receive to the benefits you elected on BENEFITFOCUS to ensure that the deductions taken are accurate.
- You will not receive a statement from VRS every month.
- Typically, you only receive a Statement of Monthly Retirement Benefits and Deduction Statement:

  → **Upon initial set-up of your retirement account (this is done before receiving your first retirement check as a new retiree)**

  → **When a change is made during the year**

  → **At the beginning of a new calendar year (January/ February) for the upcoming plan year.**

Look for the following sections on your statement from VRS

1 Description

- Your monthly benefit will show in the Gross Benefit Column and your Year-to-Date amount will be shown in the last column.

2 Deductions

- Your State and Federal taxes, FICA, and any other deductions.

3 Health Insurance

- Your health and dental deductions will be listed here combined. VRS does not list the health and dental deduction amounts separately. The amount listed is the total deduction amount. For example, if your health care premium for 2020 is $256.24 and your dental premium is $32.93, you would see: "Health Insurance: $289.17."

4 Health Insurance Credit

This is where VRS lists the amount of your health credit if eligible. If you would like to learn more about the Health Insurance Credit, please visit the VRS website at **varetire.org**.

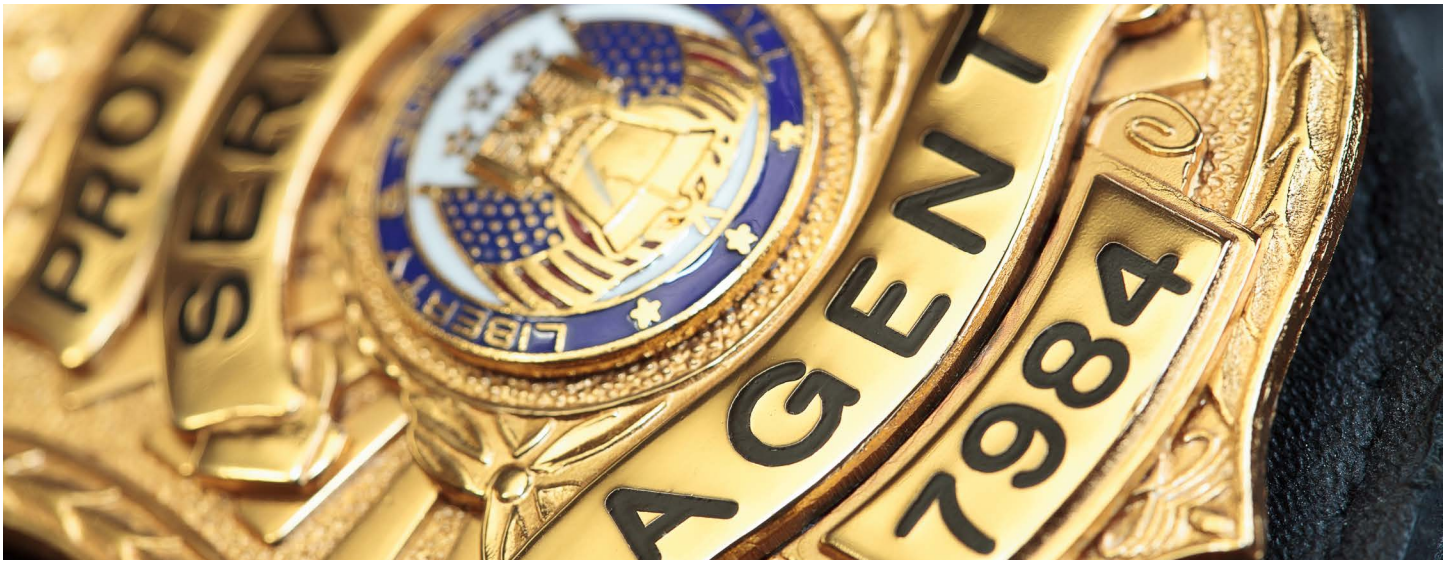
AFTER **ENROLLMENT**

View the chart below to see when you'll receive important benefit documents.

BENEFIT	WILL I RECEIVE A CARD?	WANT QUICKER ACCESS?
Health *(Optima Health)*	Yes. A physical card will be mailed to you.	Access your member card on OptimaHealth.com and in their mobile app, Optima Health.
Health Savings Account *(HealthEquity)*	Only if you are a first-time enrollee or if your current card has expired. If you enrolled in the POS Basic Health plan, you will see the employer contribution placed in your account monthly throughout the year.	Access your account on HealthEquity.com and in their mobile app, HealthEquity Mobile.
Dental *(MetLife)*	No. Cards are not provided. Use your name and member number (your SSN) to seek dental services.	Access your account on MetLife.com/dental and in their mobile app, MetLife US App, where a digital ID card is available containing the dental group plan and network information.

A NOTE ON **LINE OF DUTY BENEFITS**

Once the CBO is notified of your approval for Line of Duty Act (LODA) health coverage benefits, you will transition from the City of Virginia Beach health plan onto the Commonwealth of Virginia health plan managed by the Department of Human Resource Management (DHRM). At that time, you will receive a letter from the CBO outlining when your health (including vision and pharmacy) and/or dental coverage through the City of Virginia Beach will be terminating and also some helpful information as you transition to the new health plan managed by DHRM. If you have any questions or concerns regarding this transition, please contact the CBO at **757.263.1060**. Please direct any questions regarding the new health plan directly to DHRM at **LODA@dhrm.virginia.gov** or visit **valoda.org/benefits**.



FRIENDLY REMINDERS FROM THE CBO

- Submit **retirement paperwork** no sooner than **4 months** prior to your retirement.
  School employees: Submit to the CBO
  City employees: Submit to City Payroll
- **Note:** You must include the Years of Employment Notification Form or you will only receive credit for years of employment with the entity from which you are retiring (City of Virginia Beach or Virginia Beach City Public Schools) for determining an employer contribution towards health coverage.

- Log in to **BENEFITFOCUS** to print your benefit enrollment information to know what you are enrolled in as an active employee since you will not be able to view your active benefits after your retirement.

- If you are a BEWell member, log in to your Virgin Pulse account and spend any **PulseCash** you have remaining and disconnect any fitness devices from Virgin Pulse. When you retire, as long as you remain on the health plan, you'll be eligible to continue Virgin Pulse, but it will be a new account as a retiree so you must re-enroll and sync any fitness devices you have to that new account.

- Fill any outstanding **prescriptions**. When your benefits terminate, there will be a period of time that you may not have instant access to your insurance coverage. Make sure to fill any prescriptions you have so you don't have to go without before you get your new insurance cards.

- Since you are terminating active coverage, you'll receive **termination notices** and a **PHSA/COBRA** (or continuation of coverage) packet. Don't be alarmed! If you elect health plan coverage as a retiree, there is no lapse in coverage. The continuation of coverage packet is important to review if you are ineligible for coverage as a retiree or the employer contribution, or if you wish to temporarily extend additional benefits such as your Flexible Spending Account.

IMPORTANT! Please keep your address current! Benefit vendors and the CBO will use your address on file to mail you important documents and other information. To update your address, please complete the Retiree Name and Contact Change Packet available on the retiree page of **vbgov.com/benefits.**

SSN

Social Security Numbers (SSN) are required for all dependents you wish to cover on your benefit plans. This is a requirement for health plans under the Patient Protection and Affordable Care Act (PPACA) for 1095-C reporting. Please make sure all SSNs are accurate.

- If your **dependent's SSN** is incorrect, please correct it by clicking "edit dependent" and amend the incorrect SSN on the BENEFITFOCUS platform.
- If **your SSN** is incorrect, please contact the Consolidated Benefits Office.

MEDICARE

Once you become Medicare-eligible, you are no longer eligible to continue your health and/or dental insurance through the City of Virginia Beach and Virginia Beach City Public Schools.*

When are you eligible for Medicare?

- If you receive benefits from Social Security, in most cases, you automatically receive Medicare Part A & B the first day of the month you turn 65.
- If you are under age 65 and disabled, you automatically get Part A & B after you receive disability benefits from Social Security for 24 months.
- If you have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's Disease), you automatically get Part A & B the month your disability benefits begin.

When can you sign up for Medicare if you do not automatically receive the benefits?

- **Initial Enrollment Period:** When you are first eligible for Medicare. This is a 7 month period that begins 3 months before the month you turn age 65, includes the month you turn age 65, and ends 3 months after that.
- **General Enrollment Period:** Between January 1 and March 31 each year. Your coverage will begin July 1 following receipt of application. You may have to pay a higher premium if you do not enroll when you first become eligible.
- **Special Enrollment Period:** If you wait to enroll in Medicare because –
  - → You or your spouse are currently working and are covered by a group health plan as an employee or the spouse of an employee
  - → You are disabled and you or your family member are working and are covered by a group health plan.

You can sign up for Part B any time while you have group health plan coverage based on current employment or during the 8 month period that begins the month after the employment ends, or the group health plan coverage ends, whichever happens first.

If you don't enroll in Part B when you are first eligible, you may have to wait until the next enrollment period, experience a lapse in coverage, and pay a penalty for as long as you have Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period you could have had Part B, but didn't sign up for it.

For more information about Medicare, please visit: medicare.gov/ or you can call 1-800-MEDICARE.

*If you are Medicare-eligible due to End Stage Renal Disease, you may remain on the City/Schools' plan for 30 months after becoming Medicare-eligible.

INDIVIDUAL COVERAGE OPTIONS & COMMUNITY RESOURCES

Individual Coverage Options

- **The Health Insurance Marketplace:** If you choose not to elect coverage on the COVB or VBCPS health plan or are not eligible, exhaust PHSA/COBRA continuation coverage, or have another qualifying event (such as marriage or birth of a child), you may want to explore your other coverage options with the Health Insurance Marketplace. Visit HealthCare.gov to find the latest, most accurate information about the Marketplace and available plans.

  For more information, you can also call the Marketplace Call Center toll-free at 800.318.2596 (TTY users should call 855.889.4325) or find help in your area by visiting Localhelp.healthcare.gov.

- **Cover Virginia - Connecting Virginians to Affordable Health Care:**
  - **FAMIS** is Virginia's health insurance program for children. It makes health care affordable for children of eligible families. FAMIS covers all the medical care growing children need to avoid getting sick, plus the medical care that will help them if they do get sick or get hurt. Dental services for children enrolled in FAMIS are provided through Smiles For Children program.
  - **MEDICAID** enables states to provide medical care for public assistance recipients and medically needy persons (i.e. persons of low income who can meet their maintenance needs but have insufficient income to provide the cost of medical care). The program is financed by state and federal funds.

  For additional information and eligibility requirements for the Cover Virginia programs, contact: Cover Virginia 855.242.8282 or visit coverva.org.

- **MetLife TakeAlong Dental Plan:** If you choose not to elect your current dental coverage or are no longer eligible for coverage through COVB or VBCPS, the MetLife TakeAlong Dental Plan may be a great option for you. This is an individual dental insurance policy that is purchased independently and provides continuous coverage for you and/or your family. MetLife offers three great plans to select from with various dental benefit coverage levels to help you choose the best plan that suits you and/or your family's needs!

  For more information or to enroll, call MetLife at 1.844.2METDEN (1.844.263.8336) or visit metlifetakealongdental.com. When prompted, provide MetLife with the following referral code: VBTAD65.

Community Resources

SENIOR RESOURCES

The following agencies and organizations are available to help plan, administer, and provide services and advocates for senior citizens and their caregivers. The organizations can help assist with counseling for Medicare, Medicaid, long term care insurance, legal and financial information.

- SENIOR SERVICES OF SOUTHEASTERN VIRGINIA
  757.461.9481 | ssseva.org
- SENIOR NAVIGATOR
  866.393.0957 | seniornavigator.org
- CITIZENS' COMMITTEE TO PROTECT THE ELDERLY
  citizenscommittee.org

LOCAL HEALTH/ DENTAL CLINICS

A Free Clinic is a private, nonprofit, community-based or faith-based organization that provides quality health care at little or no charge to low income, uninsured people through heavy use of volunteer health professionals and partnerships with other health-related organizations.

- BEACH HEALTH CLINIC (VIRGINIA BEACH)
  757.428.5601 | beachhealthclinic.org
- CHESAPEAKE CARE CLINIC (CHESAPEAKE)
  757.545.5700 | chesapeakecare.org
- H.E.L.P INC. (HAMPTON)
  757.727.2577 | helpushelpu.org
- PARK PLACE DENTAL CLINIC
  757.965.4224 | parkplaceclinic.org

*For additional clinic locations, please visit **vafreeclinics.org**.*

LEGAL NOTICES

The following pages are mandatory notices that the City of Virginia Beach and Virginia Beach City Public Schools are required to provide to retirees. The contents of the information may or may not apply to you. If you have any questions about these notices, please contact the Consolidated Benefits Office at 757.263.1060 or email Benefits@vbschools.com.

01 | Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

You have the right to:

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

YOUR CHOICES

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

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

OUR USES AND DISCLOSURES

We may use and share your information as we:

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

YOUR RIGHTS

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information in this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

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

In these cases, you have both the right and choice to tell us to:

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

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

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

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

Help manage the health care treatment you receive

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

Run our organization

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

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

Pay for your health services

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

Administer your plan

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

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

Help with public health and safety issues

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

Do research

We can use or share your information for health research.

Comply with the law

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

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

OUR RESPONSIBILITIES

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

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

If you have any questions regarding this notice or the subjects addressed in it, please contact:

Consolidated Benefits Office / Director of Benefits
2512 George Mason Drive
Virginia Beach, VA 23456
757.263.1060
Benefits@vbschools.com
January 1, 2020

02 | Continuation Coverage Rights Under PHSA

Introduction
This notice contains important information about your right to The Public Health Service Act ("PHSA") continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains PHSA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

PHSA continuation coverage can become available to you when you would otherwise lose your group health plan (the Plan) coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan Document or contact the Plan Administrator.

What is PHSA Continuation Coverage?
PHSA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, PHSA 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 PHSA continuation must pay for PHSA continuation coverage.

What are Qualifying Events?
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 becomes ineligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to City of Virginia Beach or Virginia Beach City Public Schools, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is PHSA Coverage Available?
The Plan will offer PHSA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is 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, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events *For divorce, legal separation, or a dependent child losing eligibility; you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Consolidated Benefits Office, Virginia Beach City Public Schools, 2512 George Mason Drive, Virginia Beach, VA 23456. Main Office Number: 757.263.1060.*

How is PHSA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, PHSA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect PHSA continuation coverage. Covered employees may elect PHSA continuation coverage on behalf of their spouses, and parents may elect PHSA continuation coverage on behalf of their children. Coverage shall be available to qualified beneficiaries if election of coverage is made within sixty (60) days of the date coverage under the Plan would ordinarily terminate after a qualifying event. See Plan Document for further details.

PHSA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both) divorce or legal separation, or a dependent child losing eligibility as a dependent child, PHSA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, PHSA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, PHSA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, PHSA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of PHSA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of PHSA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of PHSA continuation coverage and must last at least until the end of the 18-month period of continuation coverage, provided that the Plan Administrator for the City of Virginia Beach and Virginia Beach City Public Schools is notified timely of the disability, as described above.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 18 months of PHSA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of PHSA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. The act also provides that your continuation coverage may be cut short prior to the expiration of the 18, 29, or 36 month period for any of the following five reasons:

1. The City of Virginia Beach or Virginia Beach City Public Schools no longer provides any group health coverage to any employee;
2. The premium for your continuation coverage is not timely paid (within the applicable grace period);
3. You become covered under another group health plan (as an employee or otherwise) that does not contain any pre-existing condition exclusion or limitation applicable to the individual health coverage, which ended no more than 62 days before coverage under the new plan began.
4. You become entitled to Medicare;
5. Coverage has been extended for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage is provided subject to your eligibility for coverage under the Plan. Once your continuation coverage terminates for any reason, it cannot be reinstated.

Under the PHSA, you may be required to pay up to 102 percent of the applicable premium during the 18 or 36 month period of continuation coverage. However, during the additional 11 months of continuation coverage (for disability), you may be required to pay up to 150 percent of the applicable premium.

At the end of the 18, 29, or 36 month continuation coverage period, you must be allowed to enroll in an individual conversion health plan if one is provided under the group health/dental/flexible spending account/vision/employee assistance plan(s).

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA/PHSA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?
The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov. Coverage through the Health Insurance Marketplace may cost less than COBRA/PHSA continuation coverage. Being offered COBRA/PHSA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?
You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA/PHSA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA/PHSA continuation coverage?
If you sign up for COBRA/PHSA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA/PHSA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA/PHSA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA/PHSA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA/PHSA continuation coverage, you cannot switch to COBRA/PHSA continuation coverage under any circumstances.

Can I enroll in another group health plan?
You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA/PHSA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA/PHSA continuation coverage.

What factors should I consider when choosing coverage options?
When considering your options for health coverage, you may want to think about:

- PREMIUMS: Your previous plan can charge up to 102% of total plan premiums for COBRA/PHSA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- PROVIDER NETWORKS: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- DRUG FORMULARIES: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- SEVERANCE PAYMENTS: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA/PHSA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1.866.444.3272 to discuss your options.
- SERVICE AREAS: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- OTHER COST-SHARING: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information
This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your plan document or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your plan document, contact the Consolidated Benefits Office.

Plan Contact Information
Consolidated Benefits Office
Virginia Beach City Public Schools
2512 George Mason Drive, Virginia Beach, VA 23456
757.263.1060

For more information about your rights under COBRA/PHSA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's website at www.dol.gov or call their toll-free number at 1.866.444.3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes
To protect you and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

Plan Contact Information
Consolidated Benefits Office
Virginia Beach City Public Schools
2512 George Mason Drive, Virginia Beach, VA 23456
757.263.1060

03 | Newborns And Mothers Health Protection Act

Group health plans and 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, plan 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).

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1.877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1.866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – MEDICAID

Website: http://myalhipp.com/
Phone: 1.855.692.5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1.866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – MEDICAID

Website: http://myarhipp.com/
Phone: 1.855.MyARHIPP (855.692.7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1.800.221.3943/State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1.800.359.1991/State Relay 711

FLORIDA – MEDICAID

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1.877.357.3268

GEORGIA – MEDICAID

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678.564.1162 ext 2131

INDIANA – MEDICAID

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1.877.438.4479
All other Medicaid Website: http://www.indianamedicaid.com
Phone: 1.800.403.0864

IOWA – MEDICAID

Website: http://dhs.iowa.gov/Hawki
Phone: 1.800.257.8563

KANSAS – MEDICAID

Website: http://www.kdheks.gov/hcf/
Phone: 1.785.296.3512

KENTUCKY – MEDICAID

Website: https://chfs.ky.gov
Phone: 1.800.635.2570

LOUISIANA – MEDICAID

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1.888.695.2447

MAINE – MEDICAID

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1.800.442.6003
TTY: Maine relay 711

MASSACHUSETTS – MEDICAID & CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1.800.862.4840

MINNESOTA – MEDICAID

Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1.800.657.3739

MISSOURI – MEDICAID

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

MONTANA – MEDICAID

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1.800.694.3084

NEBRASKA – MEDICAID

Website: http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – MEDICAID

Website: https://dhcfp.nv.gov
Phone: 1.800.992.0900

NEW HAMPSHIRE – MEDICAID

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603.271.5218
Toll free number for the HIPP program: 1.800.852-3345, ext 5218

NEW JERSEY – MEDICAID & CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1.800.701.0710

NEW YORK – MEDICAID

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1.800.541.2831

NORTH CAROLINA – MEDICAID

Website: https://medicaid.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – MEDICAID

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1.844.854.4825

OKLAHOMA – MEDICAID & CHIP

Website: http://www.insureoklahoma.org
Phone: 1.888.365.3742

OREGON – MEDICAID & CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1.800.699.9075

PENNSYLVANIA – MEDICAID

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1.800.692.7462

RHODE ISLAND – MEDICAID & CHIP

Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347, or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID

Website: https://www.scdhhs.gov
Phone: 1.888.549.0820

SOUTH DAKOTA – MEDICAID

Website: http://dss.sd.gov
Phone: 1.888.828.0059

TEXAS – MEDICAID

Website: http://gethipptexas.com/
Phone: 1.800.440.0493

UTAH – MEDICAID & CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1.877.543.7669

VERMONT – MEDICAID

Website: http://www.greenmountaincare.org/
Phone: 1.800.250.8427

VIRGINIA – MEDICAID & CHIP

Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1.800.432.5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1.855.242.8282

WASHINGTON – MEDICAID

Website: https://www.hca.wa.gov/
Phone: 1.800.562.3022 ext. 15473

WEST VIRGINIA – MEDICAID

Website: http://mywvhipp.com/
Toll-free phone: 1.855.MyWVHIPP (1.855.699.8447)

WISCONSIN – MEDICAID & CHIP

Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1.800.362.3002

WYOMING – MEDICAID

Website: https://wyequalitycare.acs-inc.com/
Phone: 307.777.7531

To see if any other states have added a premium assistance program since January 31, 2019, 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

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

05 | *Notice of Creditable Prescription Drug Coverage*

This notice is intended for individuals eligible for Medicare Part D. You are eligible for Medicare Part D if you are enrolled in Medicare Part A and/or Part B.

This notice has information about your current prescription drug coverage with the Optima Health POS Premier, POS Standard and POS Basic health plans with the City of Virginia Beach and the School Board of the City of Virginia Beach and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll.

At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

There are two important things you need to know about current coverage available to you through the City of Virginia Beach and the School Board of the City of Virginia Beach and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare Prescription Drug Plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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.
- The City/Schools has determined that the prescription drug coverage offered by the POS Premier, POS Standard and POS Basic health plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

If you are enrolled in the POS Premier, POS Standard or POS Basic health plans through the City/Schools your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, and therefore, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

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

If you do decide to enroll in a Medicare prescription drug plan, you may remain on the City/Schools health plan and this plan will coordinate with Part D coverage. If you drop your City/Schools health plan with prescription drug coverage, available through the health plans, be aware that you and your dependents may not be able to get this coverage back. Active employees and their spouses may enroll in the City/Schools health plans, thereby obtaining the prescription drug coverage, as a new hire or during annual open enrollment with an effective date of coverage of January 1st; however, retirees that drop the City/School coverage will be ineligible to return to the health plan and will not have access to the prescription drug coverage through the City/Schools. 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. The City/Schools provide prescription drug coverage through the health plans. The POS Premier, POS Standard and POS Basic health plans provide prescription drug coverage with the following pharmacy plan design:

2020 Plan Year: January 1, 2020 - December 31, 2020

Preferred Pharmacy Network (Walgreens, Walmart or Sam's Club):
Tier 1: $10 maximum copayment**
Tier 2: $25 maximum copayment**
Tier 3: Covered at 75% (maximum $50)**
****90-Day Supply:** Offered when filling within Preferred Pharmacy Network

Non-Preferred Pharmacy:
Tier 1: $25 Copay
Tier 2: $45 Copay
Tier 3: Covered at 75% (Maximum $75)

Mail Order Pharmacy (90-day supply) - OptumRx Home Delivery: 866.244.9113
Tier 1: $25 Copay
Tier 2: $60 Copay
Tier 3: Covered at 75% (Max. $125)
Specialty Drugs* - Covered at 75% (maximum $200)

**Medications that require management and monitoring, special handling/storage, delivery via injection, inhalation or oral administration are only available through Proprium mail order pharmacy.*

Pharmacy Deductible:

Optima Health POS Premier: Deductible does not apply to these services (plan will provide coverage as indicated and before the deductible has been met).

Optima POS Standard and POS Basic: After deductible (deductible must be paid first before the plan will begin to provide coverage)
A list of available drugs within each tier level is available at www.optimahealth.com or on the CBO intranet site.

You should also know that if you drop or lose your coverage with the City/Schools and do not enroll in Medicare prescription drug coverage within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without creditable prescription drug coverage, your monthly premium will go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have creditable 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 enroll.

For more information regarding this notice or your current prescription drug coverage, please contact the Consolidated Benefits Office at 757.263.1060 or Benefits@vbschools.com.

Additional information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare if you are Medicare eligible. You may also be contacted directly by Medicare prescription drug plans. For more information about these Medicare prescription drug plans please contact:

- www.medicare.gov
- Your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) and for personalized help
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). Visit SSA online at www.socialsecurity.gov or call them at 800.772.1213 (TTY 800.325.0778).

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).

City of Virginia Beach and School Board of the City of Virginia Beach
Linda C. Matkins, Director of Benefits
Consolidated Benefits Office
2512 George Mason Drive
Virginia Beach, VA 23456
757.263.1060

06 | Women's Health And Cancer Rights Act of 1998

Your plan as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy- related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call your plan administrator at 757.687.6141 or 866.509.7567 for more information. You may also call the Department of Labor's Employee Benefits Security Administration at 866.444.3272.

07 | Health Coverage Non-Discrimination Notice

Discrimination is Against the Law
The Health Plan of the City of Virginia Beach and the School Board of the City of Virginia Beach complies with applicable Federal, State and local laws and policies, and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity or military service. The Health Plan of the City of Virginia Beach and the School Board of the City of Virginia Beach does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity or military service.

The Health Plan of the City of Virginia Beach and the School Board of the City of Virginia Beach:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Linda Matkins, Director of Benefits at 757.263.1060 or linda.matkins@vbschools.com.

If you believe that The Health Plan of the City of Virginia Beach and the School Board of the City of Virginia Beach has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity or military service, you can file a grievance with: Linda Matkins, Director of Benefits; Virginia Beach City Public Schools, 2512 George Mason Drive, Virginia Beach, VA 23456; phone: 757.263.1060, fax: 757.263.1123; linda.matkins@vbschools.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Linda Matkins, Director of Benefits is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

08 | Notice Regarding Wellness Program

BEWell (Beach Employee Wellness) is a voluntary wellness program available to all employees and retirees on the health plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to participate in certain health-related activities.

If you are an eligible employee or retiree and choose to participate in the wellness program you will be eligible to receive an incentive of up to $500 a year (or up to $125 quarterly) for participating in health-related activities such as:

- Completing a health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease).
- Completing an annual health screening where you will be asked to complete a blood test for glucose and cholesterol levels as well as tests for blood pressure and body mass index (BMI).
- Completing online activities like tracking your fitness, sleep or nutrition through compatible trackers.
- Turning in proof of a performed cancer screening for a pap, mammogram, prostate, or colorectal exam.
- Participating in disease and condition management or tobacco cessation programs.

Although you are not required to participate in the wellness program, only eligible employees and retirees who do so will receive the incentive based upon the number of points earned. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting BEWell at 757.263.1060 or email BEWell@vbschools.com.

The information gathered from your participation in the health-related activities listed above will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as targeted outreach for programs that may be of interest to you based on your health status. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the City of Virginia Beach and Virginia Beach City Public Schools may use aggregate information it collects to design a program based on identified health risks in the workplace, BEWell will never disclose any of your personal information either publicly or to the employer; except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only entities who will receive your personally identifiable health information are Virgin Pulse, Optima Health and BEWell in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decisions. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact:

Consolidated Benefits Office
ATTN: BEWell
2512 George Mason Drive
Virginia Beach, VA 23456
phone: 757.263.1060
email: BEWell@vbschools.com

VENDOR **CONTACT INFORMATION**

Access benefit plan resources! Download mobile apps from the App Store (Apple) or Google Play (Android).

BENEFITS ENROLLMENT PLATFORM: BENEFITFOCUS

- *View and update benefits enrollment*

Access: vbgov.com/benefits/enroll

HEALTH PLAN: Optima Health

- *View member ID cards*
- *Find doctors and urgent care centers*
- *Access claims and plan information*
- *Access MDLive*

Website: optimahealth.com
Phone: 757.687.6141

VISION CARE: EyeMed Members

(Vision care included with health plan enrollment)

- *Search for providers*
- *View member ID card*
- *Check claims status*

Website: eyemedvisioncare.com
Phone: 866.939.3633

HEALTH SAVINGS ACCOUNT (HSA): HealthEquity Mobile

- *View account balances and claims status*
- *Send payments and reimbursements*

Website: healthequity.com
Phone: 866.346.5800

BEACH EMPLOYEE WELLNESS (BEWELL): Virgin Pulse

- *Track healthy behaviors*
- *View upcoming events*
- *Redeem points for rewards!*

Website: member.virginpulse.com
Phone: 888.671.9395

DENTAL PLAN: MetLife US App

- *Search for providers*
- *View member ID card*
- *View plan and claim summary*

Website: metlife.com/dental
Phone: 800.942.0854

CONTACT INFORMATION

PHONE
757.263.1060

FAX
757.263.1123

EMAIL
Benefits@vbschools.com

PHYSICAL ADDRESS
641 Carriage Hill Road
Virginia Beach, VA 23452

MAILING ADDRESS
2512 George Mason Drive
Virginia Beach, VA 23456

WEB ACCESS

WEBSITE
www.vbgov.com/benefits

BENEFITS ENROLLMENT
www.vbgov.com/benefits/enroll

Please note: *This guide does not represent a contractual agreement. The City of Virginia Beach and Virginia Beach City Public Schools reserve the right to modify, amend, or terminate health and retirement benefits as they apply to all future, current, and/or retired employees. The Administrator of each benefit plan has the discretionary authority to determine eligibility for benefits and to interpret the plan's terms.*