City of Newport News

employee benefits guide

2019

YOUR benefits YOUR choice

Our Commitment To You

The City of Newport News remains fully committed to providing our employees high quality employee benefit plans. We believe in not only making an impact in our city, but also with our employees.

With that in mind, the City of Newport News Benefits Plan is designed to recognize the diverse needs of our workforce. Our benefit plans:

- Provide competitive and comprehensive benefit options that allow you to design your own plan based on individual needs;
- Maintain a program that considers individual needs;
- Provide long-term financial security for you and your family.

We encourage you to review all your options before making your benefit elections. Only you can determine which benefits are the best fit for you and your family. We want you to understand all of your options and make informed decisions.

WE'RE PROUD TO HAVE YOU ON OUR TEAM!

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If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 11 for more details.

Benefit Basics

Once you elect your City of Newport News benefit options, your elections remain in effect until the end of the plan year (January 1 through December 31). You may only change coverage due to a Qualified Life Event or Special Enrollment Right and must do so within 30 or 60 days of the event. The City of Newport News encourages you to review all your benefits and make your selections wisely.

Eligibility

You are eligible for the benefits described in this booklet if you are an active, full-time employee starting on the first day of the month following your date of hire. The effective date is the first of the month following 30 days of employment. For example, if a City of Newport News employee is hired on April 15th and the enrollment paperwork is received on the same day, then the effective date would be June 1st. The City of Newport News allows 31 days for the benefit paperwork to be received after the hire date.

Eligible dependents also qualify for medical, dental and vision benefits. These include your:

- Legally married spouse;
- Children up to the end of the month when turning age 26.

Qualified Life Event

Generally, you may only change your benefit elections during the annual enrollment period. However, you can change your benefit elections during the year if you experience a Qualified Life Event. Qualified Life Events include:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or child
- Adoption of your child
- Termination or commencement of your spouse's employment
- Change of employment status by you or your spouse
- Changes in residence or worksite of you, your spouse, or child if the change affects your or their eligibility for the plan in which you are currently enrolled
- Qualification by the Plan Administrator of a Medical Child Support Order
- Entitlement to Medicare or Medicaid
- Legal Guardianship

If you experience a Qualified Life Event, you must notify the City of Newport News Department of Human Resources Benefits Division within 31 days of the change. Depending on the type of change, you may need to provide proof of the change. Proof of change can include a birth certificate, divorce decree, death certificate, or proof from an insurance company or employer of loss of coverage.

If you do not contact the City of Newport News Department of Human Resources Benefits Division within 31 days, you will have to wait until the next annual enrollment period to make changes, unless you have another Qualified Life Event.

Your Benefit Choices

The City of Newport News provides a complete package of benefits to assist you and your family both physically and financially. Some benefits you pay for and other benefit costs are shared between you and the City of Newport News. This helps you select the benefit plans that best fit your needs and lifestyle.

BENEFIT	WHO PAYS
Medical/Prescription Drug	City of Newport News and You
Dental	City of Newport News and You
Vision Exam Only	City of Newport News
Vision	You
Basic Term Life Insurance*—NNERF	City of Newport News
Basic Term Life Insurance*—VRS	City of Newport News & You
Supplemental Term Life Insurance—NNERF	You
Supplemental Term Life Insurance—VRS	You
Whole Life Insurance – NNERF and VRS	You
Short-Term Disability	You
Long-Term Disability—Base	City of Newport News
Long-Term Disability—Buy Up	You
Reimbursement Accounts	You

* For group term life insurance amounts over $50,000, a portion of the premium may be taxed as imputed income.

Benefits of Fitness Program—Fitness Centers

Studies have shown employees who have a planned exercise program require less health care, are less prone to injuries, and experience less stress. To assist you in your quest for an overall healthy lifestyle, you have a choice of three fitness programs; OneLife Fitness, Riverside Wellness & Fitness Center, and The Tom and Ann Hunnicutt Family YMCA. This enables you to choose the fitness center that supports your particular needs.

To enroll or to make changes to their current fitness center election or in the case of a qualified life event, employees must complete the necessary forms with the fitness center facility directly. Membership through the City's program is open to employees, spouses, and their legal dependents.

Medical Coverage

As we all know, the cost of quality health coverage has increased over the past few years. We all need health care that protects our physical health as well as our financial well-being. The City of Newport News provides the following three medical plans through Anthem BlueCross BlueShield.

Please refer to your ID Card for your Group Number

BENEFIT	PPO		HealthKeepers POS		Lumenos HDHP (HSP) with HSA	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Single Family	 $0 $0	 $500 $1,000	 $0 $0	 $750 $1,500	 $2,700 $5,400	
Out-of-Pocket Maximum Single Family	 $3,000 $6,000	 $4,500 $9,000	 $3,000 $6,000	 $4,000 $8,000	 $3,500 $7,000	 $5,000 $10,000
PCP Office Visit	$25 copay	30% after deductible	$25 copay	30% after deductible	After deductible, 100%	20% after deductible
Specialist Visit	$45 copay	30% after deductible	$45 copay	30% after deductible	After deductible, 100%	20% after deductible
Urgent Care Visit	$45 copay	30% after deductible	$45 copay	30% after deductible	After deductible, 100%	20% after deductible
Preventive Care Services (check-up visits, mammograms, screenings, immunizations)	100%	30% after deductible	100%	30% after deductible	100%	20% after deductible
In-Patient Treatment Services	$500/stay	30% after deductible	$500/stay	30% after deductible	After deductible, 100%	20% after deductible
Out-Patient Treatment Services (OP Surgery)	$250/visit	30% after deductible	$250/visit	30% after deductible	After deductible, 100%	20% after deductible
Emergency Room	$225/visit waived if admitted	$225/visit waived if admitted	$225/visit waived if admitted	$225/visit waived if admitted	After deductible, 100%	After deductible, 100%
Prescription Drugs* **Retail (30-days)** First Tier Second Tier Third Tier Fourth Tier **Mail Order (90-Days)** First Tier Second Tier Third Tier Fourth Tier	 $10 $30 $50 20% to a max of $200 $20 $60 $100 20% to a max of $400	 $10 $30 $50 20% to a max of $200 $20 $60 $100 20% to a max of $400	 $10 $30 $50 20% to a max of $200 $20 $60 $100 20% to a max of $400	 $10 $30 $50 20% to a max of $200 $20 $60 $100 20% to a max of $400	After deductible $10 $30 $50 20% to a max of $200 $20 $60 $100 20% to a max of $400	20% after deductible (no copay) N/A

** Health Savings Plan (HSP) includes the PreventiveRx Plus list of drugs which are covered before the deductible.*

Health Savings Account (HSA)

A benefit for the Lumenos HDHP Health Savings Plan (HSP) coverage is a Health Savings Account (HSA). A HSA is a tax-advantaged health savings account for participants enrolled in a Health Savings Plan. You can use funds in a HSA to help pay for qualified expenses, or save for the future. You may contribute funds to your HSA up to the annual contribution limit (with an additional catch-up contribution for participants age 55 and over) regardless of your Lumenos HDHP (HSP) annual deductible amount. (Special rules may apply for individuals who become newly eligible during the year.) Your contributions can be made on a pre-tax basis through the convenience of salary deferral or by a direct contribution to the HSA Administrator (tax deduction obtained when you file your Federal tax return). Once you reach age 65 or over and enroll in Medicare Part A or B, you cannot continue to make contributions to an HSA; however, you can still make withdrawals.

For 2019, the annual contribution limit is $3,500 for single coverage and $7,000 for other than single coverage. The "catch-up" contribution limit for those who are at least 55 years of age is $1,000.

Any funds in your account at the end of the plan year accumulate and earn non-taxable interest or investment return over the life of the account. The dollars in your HSA are your money—both the City of Newport News contributions and your own—and remain your money even if you leave the City of Newport News. You can take your account with you if you retire or leave your employment.

HSA money rolls over year to year and may earn interest. Since the HSA funds are your money, it is important to keep accurate records and carefully track your account activity to show that your distributions were used to reimburse qualified medical expenses.

Important Note: You cannot enroll in the City of Newport News Health Care Reimbursement Account (also known as a flexible spending medical account, page 8) if you are enrolled in the HSA, according to IRS regulations.

Accessing Your HSA funds

If you elect the Lumenos HDHP Health Savings Plan (HSP) with HSA plan, you can access your pre-tax HSA contributions at any time through Health Savings Administrators. The money that you and the City contribute to your account can be used for qualified medical, dental and vision expenses.

Health Savings Account funds

The City of Newport News contributes money on a monthly basis to your HSA to help cover the out-of-pocket expenses you may incur under your deductible. The amount of money contributed depends on your level of coverage:

Your HSA Coverage:	**City's Monthly Contribution:**
Employee Only	$38
Employee & Child	$65
Employee & Spouse	$78
Family	$112

Important Note: You must open your HSA within 30 days of enrolling in the Health Savings Plan. The City contributions are automatically deposited only to open accounts. Failure to open the account could result in a loss of City contributed funds.

Dental Coverage

Group Number
000006125

The City of Newport News Delta Dental Plans cover the four types of dental expenses:

- Diagnostic / Preventive: routine exams and cleaning, fluoride treatments, sealants, and x-rays
- Basic Treatment: fillings and extractions
- Major Treatment: treatment such as crowns and dentures
- Orthodontia

BENEFIT	IN- & OUT-OF-NETWORK
Annual Deductible Single Family	 $50 $150
Diagnostic / Preventive Care	100%
Basic Treatment	80%
Major Treatment	50%
Orthodontia	50%, $1,500 Lifetime Maximum
Annual Maximum Benefit	$2,500

Vision Coverage

Group Number
06113500

Vision coverage continues to be offered through the Vision Service Plan (VSP). All full-time employees are eligible for one free eye exam every year without enrolling in VSP. You must see a VSP provider and you will provide them your Social Security Number. Providers can be located at www.vsp.com. This benefit covers only the employee and not his/her spouse or dependent(s). If you need additional coverage or need coverage for your spouse or dependent(s), you may enroll or change your vision coverage during Open Enrollment. In order to access vision care benefits, simply contact your VSP participating doctor to make an appointment. Identify yourself as a VSP patient. Your Social Security Number is your VSP identification number; however, if you prefer, you may download a member card on the VSP website once you register. The VSP participating doctor will obtain the necessary authorization.

SERVICES	EXAM ONLY		SIGNATURE PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Eye Exam (every calendar year)	$0 copay	Up to $50	$0 copay	Up to $50
Frames (every calendar year)	Not covered	Not covered	$10 materials copay $150 allowance	Up to $70
Lenses (every calendar year)* Single Bifocal Trifocal	Not covered	Not covered	Included in $10 materials copay	 Up to $50 Up to $75 Up to $100
Contacts (every calendar year, in lieu of frames and lenses) Necessary ** Elective	Not covered	Not covered	$130 allowance Up to $60 copay Up to $60 copay	 Up to $105 Up to $105

** covered lenses are 'clear, plastic lenses' only. Discounts are available on cosmetic extras, please contact VSP for additional information*

*** contacts are considered "necessary" in limited situations, please contact VSP for more information*

Life Insurance

CIGNA Term Life
Group Number
FLX-960902

Life insurance is an important part of your financial security, especially if others depend on you for support. Even if you are single, your beneficiary can use your life insurance to pay off your debts – like credit cards, mortgages and other final expenses.

CIGNA Basic Group Term Life is provided to all eligible NNERF employees at no cost. You may have the option to purchase additional coverage through the Voluntary Group Term Life plan for you and your spouse. The following coverage is available to all active full-time NNERF employees.

COVERAGE	BENEFIT
Basic Term Life	• 1x your annual compensation, $350,000 maximum benefit
Voluntary Term Life • For you • For your spouse • For your children	 • 0.5x, 1x, 2x, 3x or 4x annual compensation, $350,000 maximum benefit • 0.5x, 1x or 2x to the lesser of 50% of Employee's amount or $175,000 • $10,000

For VRS employees hired after March 1, 2010, Basic Term Life benefits are provided through the Virginia Retirement System (VRS). For information on these benefits, please refer to http://www.varetire.org/ Pdf/Publications/er-manual-ch5-life-insurance.pdf.

A Voluntary Whole Life plan is offered to all full-time employees regardless of the retirement plan in which they participate (NNERF or VRS). The amount of coverage for employees and their spouses is available for employees to purchase based on age as of the policy date (as shown below).

COVERAGE	BENEFIT	
Employee	Ages 18-55: $5,000 to $150,000	Ages 56-70: $5,000 to $100,000
Spouse	Ages 18-55: $5,000 to $25,000	Ages 56-70: $5,000 to $15,000

Disability Insurance

CIGNA LTD
Group Number
FLK-980047

Chances are you do not see yourself as becoming disabled when you think about your life five or ten years from now. Surprisingly, a number of people across the country find themselves hurt or sick and unable to work each year due to a non-work-related illness or injury.

The City of Newport News offers Long-Term Disability (LTD) through CIGNA Life to all eligible employees at no cost to the employee. An LTD Buy-Up benefit is also available. Employees may also elect Voluntary Short-Term Disability (STD) insurance. **Please Note:** VRS Hybrid employees after their first year of employment transition to The Standard, a VRS VLDP comparable disability program.

COVERAGE	BENEFIT
Voluntary Short-Term Disability	• Covers up to 50% of weekly base salary • Benefit begins on the 30th day of injury or illness
Long-Term Disability	• Covers 40% of basic monthly earnings up to a $8,750 monthly benefit • Benefit begins after 90 days of disability
Long-Term Disability—Buy-Up	• Increases coverage to 50% of basic monthly earnings up to a $10,000 monthly benefit • Benefit begins after 90 days of disability

Reimbursement Accounts

Reimbursement Accounts work like a savings account - each pay period a pre-tax payroll deduction is deposited into your Health Care and/or Dependent Care Reimbursement Account. When you need money to cover an eligible out-of-pocket expense, you make a pre-tax "withdrawal" by using your Reimbursement Account Benefits Card or completing a claim form and providing proper documentation such as pharmacy receipts, detailed bills or explanation of benefits [EOB]. Reimbursement Accounts (also known as flexible spending accounts) are administered by Flexible Benefits Administrators.

Important Note: You cannot enroll in the City of Newport News Health Care Reimbursement Account if you are enrolled in the High Deductible Health Plan and contribute to an HSA, according to IRS regulations.

ACCOUNT	USE FOR	CONTRIBUTION
Health Care Reimbursement Account	Most medical, dental and vision care expenses not covered under the plan (like prescriptions, co-payments, deductibles, and eyeglasses)	$100 annual minimum $2,650 annual maximum
Dependent Care Reimbursement Account	Dependent care expenses (like daycare, before or after school programs, or elder day care programs) so you and your spouse can work or attend school full-time	$100 annual minimum $5,000 annual maximum
Private Insurance Reimbursement Account	Premiums with a private insurance company when the insurance policy is carried individually. Eligible plans include Tricare Prime Plans, individual dental, vision and health insurance, Medicare supplemental, Medicare Part B, and COBRA premiums	

Benefits Card for Health Care Reimbursement Account

You can access your Health Care Reimbursement Account funds through a Benefits Card. The Benefits Card gives you instant access to your Health Care Reimbursement Account, and you can use the Benefits Card to make payment for your eligible health care expenses where Mastercard® is accepted.

How To File A Paper Claim

Health Care Reimbursement Account

In addition to accessing your funds to make a payment for an eligible health care expense with the Benefits Card, you can also complete a claim form online through Flexible Administrators. You will need to include a receipt or bill from the service provider with the form of payment.

Dependent Care Reimbursement Account

In order to be reimbursed from your Dependent Care Reimbursement Account, you will need to complete a claim form online through Flexible Administrators. You will need to include a receipt from the dependent care provider with the form of payment. Dependent care expenses can only be reimbursed up to your account balance at the time you submit your claim.

Reimbursement Accounts Worksheet

This worksheet will assist you in calculating how much to elect for health and dependent care expenses for you and your family members. It is important to plan how much you elect into your Reimbursement Accounts, because if you have money left in the account at the end of the plan year, you will FORFEIT YOUR UNUSED BALANCE IN ACCORDANCE WITH IRS REGULATIONS.

HEALTHCARE REIMBURSEMENT ACCOUNT

Medical/Dental/Vision Expenses

List the Amount You Spend for:	Prior Year Actual Expenses	Projected Expenses
Deductibles	$	$
Coinsurance/Copayments	$	$
Prescription Drug Copays and Deductibles	$	$
Vision Care (eye exams, glasses, contact lenses and supplies)	$	$
Well-Child Care	$	$
Maintenance for Chronic Medical Conditions	$	$
Orthodontic Services	$	$
Other (any approved IRS expenses)	$	$
Total	**$**	**$**

PROJECTED HEALTH CARE REIMBURSEMENT ELECTION **$**

DEPENDENT CARE REIMBRUSEMENT ACCOUNT

Dependent Care Expenses

List the Amount You Spend for:	Prior Year Actual Expenses	Projected Expenses
In-Home Day Care	$	$
Day Care Center	$	$
Nursery School	$	$
Summer Day Camp	$	$
After School Care	$	$
Total	**$**	**$**

PROJECTED DEPENDENT CARE REIMBURSEMENT ELECTION **$**

Retirement Plan

The City of Newport News has two retirement plans that address specific groups of employees. Depending on your hire date, you would participate in one of the two plans.

1. **Newport News Employees' Retirement Fund (NNERF)** – This plan consists of active full-time employees hired before March 1, 2010 who did not opt in to the Virginia Retirement System (VRS). For detailed additional information, please refer to the City Code (Chapter 31).
2. **Virginia Retirement System (VRS)** – This plan consists of full-time rehires and new hires on or after March 1, 2010 and those prior active full-time employees who opted to change to VRS. For additional information, please refer to www.varetire.org.

For additional questions regarding the **NNERF**, please contact the Benefits Office in the Finance Department at 757-926-3929.

For additional questions regarding the **VRS**, please contact the Department of Human Resources Benefits Division at 757-926-1850.

Employee Assistance Plan (EAP)

The EAP can help you find solutions for everyday challenges of work and home, along with more serious issues affecting emotional and physical well-being. You have access to professional counselors 24 hours a day. This benefit is automatically provided to all employees and family members at no cost. Optima EAP is the carrier for this benefit and can be reached at 800-899-8174 or www.OptimaEAP.com.

Paid Holidays

The City of Newport News is pleased to provide our full-time employees time off for the following holidays:

- New Years Day (January 1)
- Dr. Martin Luther King Day
- George Washington's Birthday
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving Day
- Friday following Thanksgiving Day
- Afternoon of Christmas Eve*
- Christmas Day
- Any other hours as designated by City Council

**** Provided that day falls during the normal Monday through Friday workweek.***

Paid Personal Leave (PPL)

Paid personal leave covers vacation, absences for personal business and some medical leave. Regular, full-time employees and 24-hour fire employees earn PPL according to the following Bi-weekly accrual schedule:

YEARS OF SERVICE	FULL-TIME EMPLOYEES*	24-HOUR FIRE EMPLOYEES*
Up to 5 years	6 hours	9.25 hours
Over 5 years	7.5 hours	11.75 hours
Over 10 years	8.5 hours	12.5 hours
Over 15 years	9 hours	13 hours
Over 20 years	9.25 hours	14 hours

*At least 80 hours (112 for 24-hour firefighters) must be used each fiscal year or the difference is transferred to PML.

Paid Medical Leave (PML)

Paid medical leave can be used for certain personal and family medical-related absences. Regular full-time employees accrue 2.75 hours biweekly and 24-hour fire employees accrue 7.5 hours biweekly .

Legal Notices - The Federal government requires that we provide each employee with the following information in the Benefits Guide

Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current City of Newport News Anthem coverage will be affected.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with City of Newport News and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information:

City of Newport News Department of Human Resources Benefits Division
700 Town Center Drive, Suite 200 Newport News, VA 23606
(757) 926-1850

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Newport News changes. You also may request a copy of this notice at any time.

Patient Protection Disclosure

Anthem BlueCross BlueShield generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact:

City of Newport News Department of Human Resources Benefits Division
700 Town Center Drive, Suite 200 Newport News, VA 23606
(757) 926-1850

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

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

City of Newport News Department of Human Resources Benefits Division
700 Town Center Drive, Suite 200 Newport News, VA 23606
(757) 926-1850

Women's Health and Cancer Rights Act of 1998 Annual Notice

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

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

These benefits will be provided subject to the same deductibles/coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator:

City of Newport News Department of Human Resources Benefits Division
700 Town Center Drive, Suite 200 Newport News, VA 23606
(757) 926-1850

Newborns' and Mothers' Health Protection Act of 1996

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

Special Enrollment Notice

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

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

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact:

City of Newport News Department of Human Resources Benefits Division
700 Town Center Drive, Suite 200 Newport News, VA 23606
(757) 926-1850

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, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp\ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and 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	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	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.

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including Open Enrollment and special enrollment rights.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you should take into account that you have special enrollment rights under Federal law. You may qualify for a special enrollment period (within 30 days after your group health coverage ends) for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued 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, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify City of Newport News of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability
An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

Second Qualifying Event
An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?
To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

How much does COBRA continuation coverage cost?
Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA continuation coverage be made? First payment for continuation coverage
If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election.

(This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact City of Newport News to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Periodic payments for continuation coverage
After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of the month for that coverage period. The Plan will send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments
Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

City of Newport News, Finance Department
2400 Washington Avenue, 7th Floor Newport News, VA 23607
757-926-3929

For more information
This notice does not 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 summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact:

City of Newport News Department of Human Resources Benefits Division
700 Town Center Drive, Suite 200 Newport News, VA 23606
(757) 926-1850

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

Health Information Privacy Practices

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

The effective date of this Notice of City of Newport News Group Benefit Plan Health Information Privacy Practices (the "Notice") is January 1, 2019.

City of Newport News Group Benefit Plan (the "Plan")[1] provides health benefits to eligible employees of City of Newport News (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, and COBRA qualified beneficiaries, if any, and their respective dependents. The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your physical or mental health condition, the provision of health care to you, or payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

Receipt of Your PHI by the Company and Business Associates

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

How the Plan May Use or Disclose Your PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities,[2] obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.

- Underwriting, premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.[3]

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation. The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at
any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.[4]

The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail. You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights With Respect to Your PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction On Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you,

in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred prior to April 14, 2003, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information

The Plan has designated the Department of Human Resources Benefits Division as its contact persons for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at:

LaTessa Davis

City of Newport News Department of Human Resources Benefits Division

700 Town Center Drive, Suite 200 Newport News, VA 23606 (757) 926-1808

[1] See Note 1 above.

[2] The rules allow for plans to make specified, limited disclosures to collection agencies. This information is omitted because very few plans pursue collection in that manner.

[3] It is permissible for health plans to make other disclosures to law enforcement officials for the purpose of voluntarily assisting in law enforcement efforts. the plan).

[4] 45 CFR §164.520(b)(1)(ii)(E), The privacy rules also allow a health plan to prohibit revocation when an authorization is obtained prior to enrollment for purposes of establishing eligibility, and applicable law allows for the insurer to contest coverage. This information is omitted from this sample Notice because most health plans are not permitted to make eligibility determinations based on health status.

References and Resources			
Medical Plan	Anthem	www.anthem.com	PPO/POS: 800-451-1527 Lumenos HDHP (HSP): 800-582-6941 All Plans: 833-592- 9956
HSA Administrator	Health Savings Administrators	www.healthsavings.com	888-354-0697
Dental Plan	Delta Dental of Virginia	www.deltadentalva.com	800-237-6060
Vision Plan	VSP	www.vsp.com	800-877-7195
Reimbursement Accounts	Flexible Benefits Administrators	www.flex-admin.com	800-437-FLEX
457 Retirement Plan	ICMA-RC	www.icma.org	800-669-7400
Employee Assistance Plan	Optima EAP	www.OptimaEAP.com Username: optima	800-899-8174 757-363-6777
Life Insurance—NNERF	CIGNA	www.cigna.com	800-36-CIGNA
Life Insurance—Virginia Retirement System (VRS)	Minnesota Life	www.varetire.org	800-441-2258
Life Insurance-Whole Life	Boston Mutual	www.bostonmutual.com	English: 877-624-2249 Ext. 222 Spanish: 877-314-6319 Ext. 223 Email:clientservices@bostonmutual.com
Disability	Cigna	www.cigna.com	800-36-CIGNA
Enrollment	Human Resources Division	www.nnva.gov/benefits	757-926-1850

2019 Summary of Monthly Rates

Full-time employees are eligible for benefits. *Employees are eligible for a 20% incentive if they are smoke and tobacco free.

Anthem – Medical

PPO	City Pays	Employee with Incentive	City Pays	Employee without Incentive
Employee	$506.65	$161.68	$506.64	$202.12
Employee + 1 Child	$825.30	$295.75	$825.30	$324.69
Employee + Spouse	$1,069.27	$344.81	$1,069.27	$431.02
Family	$1,406.01	$437.79	$1,406.01	$547.24
HEALTHKEEPERS	**City Pays**	**Employee with Incentive**	**City Pays**	**Employee without Incentive**
Employee	$510.07	$83.66	$510.07	$104.58
Employee + 1 Child	$831.69	$133.96	$831.69	$167.45
Employee + Spouse	$1,075.17	$182.75	$1,075.17	$228.44
Family	$1,415.66	$223.36	$1,415.66	$279.20
Lumenos HDHP (HSP)	**City Pays**	**Employee with Incentive**	**City Contribution to HSA**	**Employee without Incentive**
Employee	$422.90	$0.00	$38.00	$15.60
Employee + 1 Child	$680.03	$15.00	$65.00	$18.75
Employee + Spouse	$893.24	$30.00	$78.00	$37.50
Family	$1,152.11	$45.00	$112.00	$56.25

Delta Dental – Dental

PPO + Premier	City Pays	Employee Pays
Employee	$20.70	$8.00
Employee + 1	$37.60	$15.00
Family	$64.65	$25.00

VSP

Vision	City Pays	Employee Pays
Employee	$1.00	$8.00
Employee + 1	$2.00	$13.00
Family	$2.00	$23.00

*** Please refer to the Personnel Administrative Manual 1402 for policy guidelines.**

2019 Summary of Monthly Rates

Fitness Centers for Active Full-Time Employees

YMCA	Employee Pays
Employee/Spouse Only	$30.00
Both Employee + Spouse	$50.00
Employee + Children	$53.00
Family (Employee, Spouse and Child(ren))	$58.00
One Life Fitness	**Employee Pays**
Employee/Spouse Only	$25.00
Both Employee + Spouse	$50.00
Employee + Child	$50.00
Employee + Spouse + Child	$75.00
Employee + Spouse + Children	$89.00
Riverside Wellness & Fitness Center	**Employee Pays**
Employee	$28.00
Employee + Spouse	$56.00
Employee + Child (child under age 18)	$51.00
Family	$28.00 per Adult and $23.00 per Child

2019 Summary of STD and LTD

The City of Newport News provides active, full-time employees the option to purchase a Short-Term Disability (STD) Benefit. The Benefit provides 50% income replacement of their weekly salary up to a maximum weekly benefit of $1,000.

The City of Newport News provides a Core Long-Term Disability (LTD) Benefit of 40% of monthly income replacement to a maximum benefit of $3,500 per month, to all active, full-time employees at no cost to the employee. The City also allows active, full-time employees to purchase additional LTD coverage of up to 50% of their monthly pay to a maximum monthly benefit of $5,000.

For more information on Short-Term and Long-Term Disability benefits and cost, please contact the Department of Human Resources Benefits Division at 757-926-1850 or by email at benefits@nnva.gov.