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Health Benefits Overview

January 1, 2024 - December 31, 2024

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General Information

What is a “Copayment”?

- A copayment is a pre-determined amount you must pay out-of-pocket when seeing a service provider. It is paid directly to the provider and is due at the time services are rendered.

What is a “Deductible”?

- A deductible is a pre-determined amount that is paid by you before the insurer begins to pay.

What is “Coinsurance”?

- Coinsurance is the percentage paid by the insurer and the percentage paid by you after you have met the deductible.

What is “Precertification”?

- Certain services, such as hospitalization or outpatient surgery, may require prior authorization with your insurer to verify coverage for those services. When required, your participating physician must obtain a precertification for you prior to your treatment.

Where can I find my in-network provider?

- Directories of participating service providers may be found on your insurer’s website. If you do not have internet access, you may call member services to find an in-network provider near you.

Should I use an Urgent Care Center or the Emergency Room?

- Urgent Care Centers are another great alternative to the Emergency Room when your doctor’s office is closed. The co-payments are less that an Emergency Room visit.

Helpful Tools

Visit www.myCIGNA.com

- Online access to claim and benefit information
- Resources for managing your health care including Cost and Quality, Health Management, and Medical Research
- Find and compare providers

If you prefer phone, call the number on the back of your ID card

- Toll free 24/7/365 live access to representatives who will help you understand your benefits
- Access to registered nurses who can provide you with guidance using the Health Information Line
- Confirm coverage of you or your enrolled dependents
- Get additional information on your prescription plan or access processed claims
- Learn more about service that are offered to you

Mobile Apps- Stay connected using Cigna Apps

- myCigna App manages your healthcare and gives access to providers, deductibles and claim information
- Coach by Cigna App focuses on exercise, food, sleep, stress, weight
- Cigna Wellbeing App focuses on wellness tools and health tips
- Cigna Compass Mobile App gives personalized guidance to your healthcare journey

Ways to save on Benefit Costs

- Stay in-network
- Use Convenience Care and Urgent Care Centers instead of the Emergency Room
- Use generic instead of brand named prescriptions

Infertility Benefit

- Zygote Intrafallopian Transfer (ZIFT), Gamete Intrafallopian Transfer (GIFT), and In Vitro Fertitilization (IVF) (excludes cryopreservation) ,
- lifetime max benefit of $10,000.
- Please see your HR team for full benefit.

Medical Coverage Option

Provided by: Cigna | 800-244-6224 | www.mycigna.com

Healthcare Services	OAP HSA Advantage A Plan 1
Name of Network	**Cigna HSA**
Calendar Year Deductible	
Individual	$1,600*
Family	$3,200*
Annual Out-of-Pocket Maximum (Includes deductible, copays, coinsurance)	
Individual	$2,600
Family	$5,200
Coinsurance (Coins) (Amount paid after deductible is met)	
You pay…..	10%
Copays	
Primary Care Physician	Deductible + Coinsurance
Specialist	Deductible + Coinsurance
Chiropractic	Deductible + Coinsurance
Telemedicine	Deductible + Coinsurance
Adult and Child Wellness Exams	100% Covered
Hospital Services	
Inpatient Hospital Per Admission	Deductible + Coinsurance
Emergency Room	Deductible + Coinsurance
Urgent Care	Deductible + Coinsurance
Diagnostic Services	
Independent Facility– Lab / X-ray	Deductible + Coinsurance
Independent Facility– Adv Imaging (CT, PET, MRI)	Deductible + Coinsurance
Prescription Drugs	
Retail (30-day supply) Generic Drugs Brand Drugs Non-Preferred Brand Drugs Mail Order (90-day supply)	DEDUCTIBLE APPLIES $10 Copay $50 Copay $80 Copay 2.5x's Copay
Non-Network	
Calendar Year Deductible	$3,000 Individual / $6,000 Family
Out of Pocket Max	$5,200 Individual / $10,400 Family
Coinsurance	50%

*Deductible increased from $1,500 individual / $3,000 Family

Medical plan rates

Based on your bi-weekly deduction

Who is covered	OAP HSA Advantage A Plan 1
Employee	$0.00
Employee + Spouse	$245.97
Employee + Child(ren)	$209.08
Employee + Family	$455.08

This Benefits-At-A-Glance booklet is designed to provide basic information to employees on benefit plans and programs available January 1, 2024-December 31, 2024. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan Description (SPD). This booklet does not constitute an SPD or Plan Document as defined by the Employee Retirement Income Security Act (ERISA).

Dental Coverage PPO

Provided by: Cigna | **800-244-6224** | **www.mycigna.com**

PPO dental plans give you freedom to use in-network or out-of-network dentists. Since network providers offer reduced contracted rates, you save money by using network providers for all your dental needs. All benefits received from out-of-network dentists are subject to "maximum allowable charge" fees. Any amount that exceeds this fee is the patient's responsibility.

PPO Dental Services	HIGH PLAN In-Network	LOW PLAN In-Network
Annual Maximum Benefit	$1,750	$1,250
Calendar Year Deductible	$0	$0
PREVENTATIVE PROCEDURES:		
Routine Exams Teeth Cleaning Bitewing X-rays Full Mouth X-rays Fluoride Treatments (under age 19)	Plan pays 100%	Plan pays 100%
BASIC PROCEDURES:		
Fillings Periodontics Oral Surgery - Simple Root Canal Therapy	Plan pays 80%	Plan pays 80%
MAJOR PROCEDURES:		
Oral Surgery - Complex Crowns and Bridges Full & Partial Dentures	Plan Pays 50%	Plan pays 50%
OUT OF NETWORK:	**HIGH PLAN Out-of-Network**	**LOW PLAN Out-of-Network**
Annual Maximum Benefit Calendar Year Deductible Preventative/Basic/Major	$1,750 $0 100%* / 80%* / 50%*	$1,250 $0 100%* / 80%* / 50%*

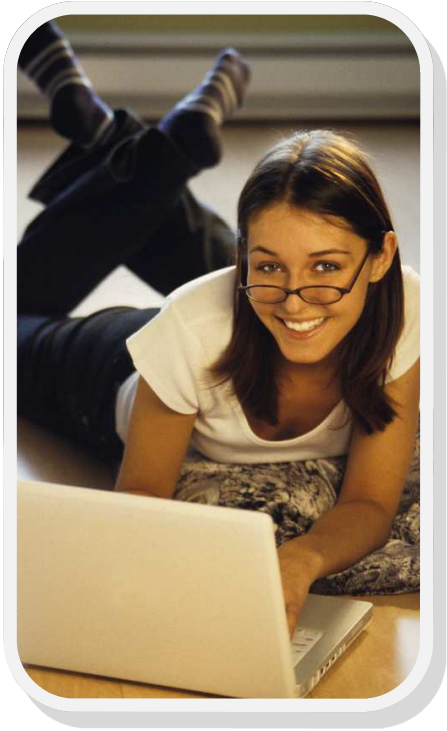
* Maximum Allowable Charge

Dental plan rates based on your bi-weekly deduction

Who is covered	HIGH PLAN	LOW PLAN
Employee	$0.94	$0.00
Employee + One	$11.09	$9.25
Employee + Two or More	$26.98	$24.15

Vision Coverage

Provided by: Cigna | **800-244-6224** | **www.mycigna.com**



This plan covers eye exams, prescription lenses and frames, or contact lenses for you and your dependents when you receive services from in-network or out-of-network providers. As you can see from the table below, staying in-network cuts costs down and gives you more of a benefit.

To find a participating provider log on to www.mycigna.com.

Vision Coverage Rates:
Based on your bi-weekly deduction

Who is covered	Vision Plan
Employee	$0.00
Employee + Spouse	$2.60
Employee + Child(ren)	$2.66
Employee + Family	$5.80

Vision Services	In-Network	Out-of-Network
Eye Exams	$10 Copay	Up to $45 Reimbursement
Frequency	12 months	12 months
BASIC LENSES		
Frequency	12 months	12 months
Single vision	$25 Copay	Up to $32 Reimbursement
Bifocal vision	$25 Copay	Up to $55 Reimbursement
Trifocal vision	$25 Copay	Up to $65 Reimbursement
FRAMES*		
Frequency	12 months	12 months
Benefit	$130 allowance	Up to $71 Reimbursement
CONTACTS*		
Frequency	12 months	12 months
Benefit	$130 allowance	Up to $105 Reimbursement

*Contacts and frames cannot be purchased in the same year

Disability Coverage

Provided by: New York Life | *800-225-5695* | *www.newyorklife.com*

Short-Term Disability

If you become disabled because of a non-occupational illness or injury and cannot work, you can be covered by the short-term disability insurance policy. Benefits can begin on the 1st day following an accident and the 8th day of a sickness. The short-term disability plan replaces up to 60% of your basic weekly earnings, with a maximum weekly benefit of $1,000. You can receive short-term disability benefits for up to 13 weeks.

City of DeBary provides eligible employees Short-Term Disability at NO COST.

Long-Term Disability

If you become unable to perform your regular job duties for an extended period of time due to sickness, or accidental injury, you can be covered by the long-term disability (LTD) policy.

Your income replacement benefit would equal 60% of your basic monthly earnings. The maximum monthly benefit you can receive is $5,000. Benefits begin after you have been unable to work for 90 days due to a covered sickness or accident and will continue to be paid for up to 2 years in own occupation.

Your LTD benefit will be reduced by any disability income you receive from other sources, such as Social Security, worker's compensation, and/or state disability plans, to provide you with a combined monthly benefit equal to 60% of your basic monthly earnings.

The LTD plan contains a pre-existing condition exclusion. The exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought care within the 3 month period prior to the effective date of coverage and the disability begins within 12 months of the effective date of coverage.

City of DeBary provides eligible employees Long-Term Disability at NO COST.

Basic Life/AD&D Coverage

Provided by: New York Life | *800-225-5695* | *www.newyorklife.com*

Basic Life/AD&D Life insurance protects your family or other beneficiaries in the event of your death. The death benefit helps replace the income you would have provided and can help meet important financial needs. It can help pay your mortgage, rent, run your household, send your children to college, pay off debts, etc.

City of DeBary provides eligible employees $50,000 Basic Life Insurance and AD&D at no cost.

The following are attached to this group term life insurance policy:

- Accelerated Life Benefit
- Seatbelt-Air Bag Benefit
- Waiver of Premium
- Conversion

Reduction Schedule:

35% at age 65
60% at age 70
75% at age 75

Guarantee Issue $50,000, Minimum Benefit Amount $50,000, Maximum Benefit Amount $50,000
To find more information, refer to your Certificate of Benefits.

Qualifying Life Events

If you experience any of the below qualifying life events, you must contact Human Resources within 30 days of the event to be able to make changes to your benefits. Proof of the event is required in order to successfully make the requested changes to your plans.

⇒ Marriage	⇒ Divorce or legal separation (subject to State regulations)
⇒ Death of spouse, child or other qualified dependent	⇒ Birth or adoption of child
⇒ Loss of other group coverage	⇒ Change in employment status for employee, spouse or dependent
⇒ Change in residence due to an employment transfer	⇒ Change of dependent status

Voluntary Life/AD&D Coverage

Provided by: New York Life | *800-225-5695* | *www.newyorklife.com*

Summary of Voluntary Life Insurance

If you chose to enroll in voluntary life insurance, you may also insure your spouse and eligible dependent children up to the age of 26. A summary of your life insurance coverage is listed in the table below, if you should have questions on this policy see your Cigna Certificate of Benefits, or visit www.mycigna.com.

Summary of Insurance	
Guaranteed Issue	$120,000
Minimum Benefit Amount	$10,000
Maximum Benefit Amount	Lesser of $500,000 or 5x's Salary
Increments of…	$10,000
Spouse Coverage	Not to exceed 100% of EE benefit
Spouse Guarantee Issue	$30,000 (Terms at 70)
Maximum Benefit Amount	$250,000
Increments of...	$5,000
Child(ren) Coverage	
Birth to 6 months	$500
Age 6 months to 26 years	$1,000—$10,000

Additional Information

- Age reduction scale:
  - 35% of original amount at age 65
  - 60% of original amount at age 70
  - 75% of original amount at age 75
- Age-bracketed premiums: Premiums increase on plan anniversary after you enter next 5 year age group
- Evidence of Insurability (EOI) form Is required for employees who do not enroll during their initial eligibility period
- Enrolled Employees may increase their benefit by 1 increment up to Guaranteed Issue without EOI

If your age is...	Your cost for each $1,000 of supplemental life and AD&D is...
<20	$0.097
20-29	$0.129
30-34	$0.129
35-39	$0.149
40-44	$0.196
45-49	$0.276
50-54	$0.414
55-59	$0.642
60-64	$0.963
65-69	$1.604
*70-74	$3.229
75-79	$6.482
80-84	$12.838
85-89	$23.634
90-94	$38.537
95+	$58.477

*Spouse Coverage terms at age 70

Dependent Children Monthly Cost:

If your coverage level is...	Your cost for each $1,000 of supplemental life and AD&D is...
Child Life	$0.24

How to figure your voluntary life cost per paycheck:

1. Indicate your elected benefit amount (EBA)
2. Divide EBA by $1,000
3. Enter age rate from cost table
4. Multiply Step 2 by Step 3
5. Multiply Step 4 by 12 then divide by 26 to calculate your cost per paycheck

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA) Notice

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage.

This Information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having other health insurance coverage at the time of your eligibility to participate, you may enroll yourself or your dependents at a future point, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of such an event.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

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

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your Plan Administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at (312)353-0900. If you have any questions about this notice or the law, please contact your Plan Administrator at the number or location provided in your benefits booklet or Summary Plan Description.

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

Notice of Privacy Practices: Plan administrators, clearinghouses, business associates, and health care providers that transmit health information electronically or use electronic health records may not redistribute or unlawfully use electronic health records without permission from the insured. The insured may request information on how their electronic records are distributed, how frequently they are distributed, and who they are distributed to by contacting the U.S. Department of Health and Human Services.

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. If rewards for participating in a wellness program are available, they are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your plan administrator and they will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Health Insurance Marketplace Coverage Notice

The Health Insurance Marketplace is available to assist you as you evaluate health insurance options for you and your family. This notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer. The Marketplace is designed to help you find private health insurance and compare private health insurance options. You may also be eligible for a new kind of tax credit under section 36B of Internal Revenue Code that could potentially lower your monthly premium. If you purchase a qualified health plan through the Marketplace, you may lose the employer contribution (if any) to any health benefit plan offered by your employer and all or a portion of that contribution may be excludable from income for federal income tax purposes . More information on the health insurance Marketplace may be found at https://www.healthcare.gov.

Patient Protection Disclosure

If your plan generally requires or 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. Until you make this designation, the plan may designate one for you. For more information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator. If your plan requires or allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your plan provides coverage for obstetric and/or gynecological care and requires the designation of a primary care provider by a participant or beneficiary, you do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator.

Women's Health & Cancer Rights Act of 1998

The Women's Health and Cancer Act (WHCRA) requires group health plans to provide participants with notices of their rights under WHCRA, to provide certain benefits in connection with a mastectomy, and to provide other protections for participants undergoing mastectomies. If you have had or are going to have a mastectomy , you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For Individuals receiving mastectomy –related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.
- These benefits will be provided subject to the same deductibles and coinsurance amounts applicable to other medical and surgical benefits provided under the health plan offered by your employer.

Please keep this information with your other group health plan documents. If you have any questions about the Plan's coverage of mastectomies and reconstructive surgeries, please contact the Human Resources Department.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

Cobra provides eligible individuals and their dependents who would otherwise lose group health coverage as a result of a qualifying life event with an opportunity to continue group health coverage for a limited time period under certain circumstances such as:

- voluntary or involuntary job loss
- reduction in the hours worked
- transition between jobs
- death
- divorce
- and other qualifying life events

If you are entitled to elect COBRA coverage, you will have 60 days (starting on the date you are furnished the election notice or the date you would lose coverage) to choose whether or not to elect continuation coverage. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

COBRA generally requires that group health plans sponsored by groups with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

The duration of COBRA extends from the date of the qualifying event for a limited period of 18 or 36 months. The length of time depends on the type of qualifying life event that gave rise to the COBRA rights. A plan, however, may provide longer periods of coverage beyond the maximum period required by law.

COBRA Continuation coverage may be terminated earlier than the end of the maximum period for any of the following reasons:

- premiums are not paid in full on a timely basis
- the employer ceases to employ any group health plan
- a qualified beneficiary begins coverage under another group health plan after electing continuation coverage;
- a qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage;
- a qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage.

If you decide to terminate your COBRA coverage early, you generally won't be able to get a Marketplace plan outside of open enrollment period. For more information on alternatives to COBRA coverage or to find out how COBRA is administered at your workplace reach out to your HR Representative or Plan administrator.

USERRA (Uniformed Services Employment and Remployment Rights Act)

Reemployment Rights: You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your employer receives advance written or verbal notice of your service;
- you have five years or less of cumulative service in the uniformed services while with that particular employer;
- you return to work or apply for reemployment in a timely manner after conclusion of service; and
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to be free from discrimination and retaliation: If you are a past or present member of the uniformed service, have applied for membership in the uniformed service, or are obligated to serve in the uniformed service then an employer may not deny you initial employment, reemployment, retention in employment, promotion or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection: If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement:

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

•For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

- If you file a complaint with VETS and VETS in unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

Note: The rights listed here may vary depending on the circumstances.

Notice of Grandfathered Status

One or more of the health plans offered by your employer could be considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Employee Rights Under the Family and Medical Leave Act (FMLA)

Leave Entitlements: Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness. An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule. Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections: While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions. An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements: An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave: Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities: Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility. Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement: Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint: 1-866-4-USWAGE (1-866-487-9243) or www.dol.gov/whd

Newborn's and Mothers' Health Protection Act

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

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, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Programhttp://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://health.alaska.gov/dpa/Pages/default.aspx	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 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MAINE-Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY 617-886-8102
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahippPhone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.govPhone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.govMedicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.govPhone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chipPhone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-selecthttps://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone:1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.htmlPhone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Creditable

Important Notice from City of Debary

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Debary 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:

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.

City of Debary has determined that the prescription drug coverage offered by the (Carrier Name) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current City of Debary coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. The City of Debary health plan will determine and pay benefits first, before Medicare Part D, then Medicare Part D will determine benefit based on any remaining balance.

OAP HSA

$10

$50

$80

If you do decide to join a Medicare drug plan and drop your current City of Debary coverage, be aware that you and your dependents will only be able to get this coverage back during the next annual enrollment period or at the time you experience a status change that allows you to elect coverage, if earlier.

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

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

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

Contact the person listed below for further information.

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

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage: Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	1/1/2023
Name of Entity / Sender:	City of Debary
Contact / Position:	Wendy Cullen
Address:	16 Colomba Rd. DeBary, FL - 32713
Phone Number:	386 - 601 - 0217