Cal Poly Pomona Foundation

"Quality Service Supporting Quality Education"

2022

Active Benefits Guide

www.foundation.cpp.edu

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The information in this guide is not intended to take the place of or change the official Plan Documents or Evidence of Coverage. In the event the information in this guide differs from the Plan Document, the Plan Document shall prevail.

Foundation Open Enrollment

OVERVIEW

Foundation takes pride in offering its employees a comprehensive benefits package to help meet the needs of its highly diverse workforce. Among the many benefits provided to employees, we offer medical insurance, dental & vision insurance, life insurance, long-term disability, and access to pension benefits and retirement savings plans. A number of optional benefit programs are also available including Tuition Reimbursement, the Computer Purchase Program, a Rideshare program, and a range of supplemental insurance plans offered by AFLAC. This year, we will also be joining VEBA which brings a new no deductible HMO plan with United Healthcare (UHC) as we eliminate the Kaiser Deductible HMO plan. VEBA offers value adds such as a VEBA Resource Center (VHR) and an EAP through Optum at no cost. Check out more information regarding VEBA's added benefits later in this guide. The Basic Life, supplemental Life and AD&D, and Long Term Disability insurance will all be moving to Mutual of Omaha. The Basic life plan will also be enhanced this year adding Accidental Death and Dismemberment insurance as well! In addition to the EAP through Optum, Mutual of Omaha also offers an EAP at no cost.

Foundation continues its commitment with programs and tools to help you make smart choices for your health. We encourage you to visit the Kronos Self Service benefit icon where you can find this year's annual information and the new and current plan designs, rates and providers.

It is important to keep in mind that employees play a major role in the cost of medical insurance and can take steps to reduce the cost by:

- Taking advantage of preventive care benefits, including annual physicals and immunizations.
- When possible, use generic medications and avoid brand name medications.
- Avoid emergency room visits for non-emergency medical services, and instead, visit an "Urgent Care Facility."

OPEN ENROLLMENT STARTS **NOVEMBER 1**.

This year's Open Enrollment takes place beginning **November 1 to November 12th.** All benefit elections will be effective January 1, 2022 through December 31, 2022.

The premiums for healthcare insurance (for employees) are made through payroll deductions on a pre-tax basis. If an employee does not want their premiums deducted on a pre-tax basis, they simply need to contact Employment Services and they will work out a method for the employee to pay their premiums on an after-tax basis.

HEALTHCARE REFORM

All benefited employees who work an average of 30 hours a week or more, must enroll in medical coverage or provide proof they are covered through another medical plan.

The Affordable Care Act (ACA) requires most individuals in the United States (including children) to have some form of qualifying health insurance or pay a penalty in the form of a tax.

- In 2015, the penalty was $325 per person of 2% of income, whichever was higher ($162.50 per child under 18 years of age are still in effect).
- In 2016 and 2017, the penalty became $695 per person or 2.5% of income, whichever is higher ($347.50 per child under 18 years of age are still effect).
- In 2019, there was no more penalty.

Employer-sponsored health insurance, such as the medical coverage offered by the Foundation, satisfies ACA's coverage requirement. Certain government-sponsored coverage, such as Medicare, MediCal and the CHIP program (Children's Health Insurance Program), as well as qualifying individual coverage, also satisfy the requirement for those who are eligible.

Foundation full benefited employees are not eligible for the subsidy through the state or the federal marketplaces because the Foundation offers medical coverage for benefited employees that meet the minimum essential coverage for employees.

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On August 1, 2018, the Centers for Medicare and Medicaid Services (CMS) changed rules that govern short-term, limited duration (STLD) health insurance plans. CMS made it possible for people to stay on a short-term health plan for to up to 364 days. This rule change became effective on October 1, 2018.

This change also reversed a 2017 Obama-era rule that limited short-term health insurance from 364 days to 90 days. The new rules made it possible for states to allow short-term plans to be sold in their state that cover people for up to three years.

EFFECTIVE JANUARY 1, 2021 - NO INDIVIDUAL PLAN MANDATE UNDER FEDERAL, CALIFORNIA DOES HAVE A MANDATE.

Effective January 1, 2020, CA residents must either:

- Have qualifying health insurance coverage
- Obtain exemption from requirement to have coverage
- Pay a penalty when filing state tax returns

UNDERSTANDING THE AFFORDABLE CARE ACT

Overview of the Regulations

On March 23, 2010, the Affordable Care Act (ACA) became federal law. The ACA initiated the most significant changes in the U.S. health care system since Medicare was established in 1965. The new healthcare law is expansive. However, it is based on a few simple principles which are described below:

- If you have health coverage, you can keep it.
- Children under 26 can stay on a parent's health insurance plan.
- If you don't have coverage, you can use the new Health Insurance Marketplace to buy a private insurance plan.
- Pre-existing conditions are covered.
- All insurance plans must offer the ten essential health benefits.

1. **Prescription drugs**
2. **Laboratory Services**
3. **Pediatric Services**
4. **Hospitalization (such as surgery)**
5. **Preventive and Wellness Services and Chronic Disease Management**
6. **Maternity and Newborn Baby Care (care before and after your baby is born)**
7. **Emergency Services, Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment (this includes counseling and psychotherapy)**
8. **Rehabilitative and Habitative Services and Devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills**
9. **Ambulatory patient services (outpatient care you get without being admitted to a hospital)**

ESSENTIAL HEALTH BENEFITS ARE MINIMUM REQUIREMENTS FOR ALL PLANS

Health Insurance Marketplace: If someone you know doesn't have health benefits, Open Enrollment for 2022 health insurance plans through Covered California (www. coveredca.com) begins November 1, 2021 and ends January 31, 2022.

Covered California is a part of the state of California and was created to help you get health coverage to protect yourself and your loved ones. Having insurance can ensure your access to medical care if you get sick or injured so that you can keep your body healthy. It also protects your peace of mind, because you can rest assured that you will have help when you need it most.

New for 2022

BENEFIT INFORMATION

What is new for 2022, you have choices, the Foundation is now offering United Healthcare HMO and the Foundation will continue to offer Kaiser Traditional HMO and Kaiser PPO plans. This year is a passive enrollment which means that if you do not plan on making any changes to your benefits elections, you need not take any action and benefits stay the same. If you choose to change to another plan the Foundation offers or add a family member or remove a family member, you will need to complete and turn in a 2022 Benefits enrollment form and update your benefit information in UKG Ready.

If an employee is not covered through a Foundation sponsored medical plan, the employee must enroll during the annual Open Enrollment period. When an employee does not enroll in Foundation's medical plan they will be required to provide evidence of coverage to Foundation. If an employee is unable to provide evidence of coverage, the employee will automatically be enrolled in the United Healthcare HMO for "employee only" coverage, and the employee will have the employee portion of medical premium deducted from their paycheck. The Foundation will continue to contribute its portion of the healthcare premium.

Newly hired benefited employees are required to enroll in medical coverage within 30 days of employment with the Foundation or provide evidence of existing health insurance coverage. New hires who do not enroll or show evidence of coverage will automatically be enrolled in the United Healthcare HMO plan for "employee only" coverage, and the employee on of medical premium deducted from their paycheck. The Foundation will continue to contribute its portion of the healthcare premium.

HEALTH PLAN OPTIONS

The goal of the Foundation is to provide affordable and quality health care benefits to its eligible employees, eligible retirees and their eligible spouses and dependents. Our medical benefits are designed to help maintain wellness and to offer protection to employees and their families from major financial hardship in the event of illness or injury. The Foundation offers a medical plan through the Kaiser Permanente network.

Medical

PPO (PREFERRED PROVIDER ORGANIZATION)

A PPO plan offers a network of healthcare providers you can use for your medical care. Unlike an HMO, a PPO offers you the freedom to receive care from any provider-in or out of network. This means you can see any doctor or specialist, or use any hospital. In addition, no need to choose a Primary Care Physician or Specialist. No referrals are required. A PPO is generally a good option if you want more control over your choices and don't mind paying more for that ability.

HMO (HEALTH MAINTENANCE ORGANIZATION)

Kaiser Permanente's HMO plan offers comprehensive and quality healthcare coverage.

UNITED HEALTHCARE (UHC) HMO

United Healthcare is a comprehensive and quality healthcare coverage. Your doctor's office visits, radiology services, and lab tests are covered at a copay or coinsurance, and most preventive care services are covered at little or no cost to you.

PRE-EXISTING CONDITIONS

For those currently enrolled in a medical plan, there are no "pre-existing condition" limitations.

ANNUAL LIMITS ON ESSENTIAL BENEFITS

Effective for plan years beginning on or after January 1, 2014, health plans are prohibited from placing annual limits on essential health benefits.

MAIL ORDER PHARMACY

To use this benefit, one needs to obtain a new prescription from their doctor and submit to a mail order pharmacy. The first mail order prescription will be processed in 7-14 days; subsequent refills will be processed more quickly. As always, it is important to have a sufficient supply of medication on hand to get through the transition.

Dental

HMO (HEALTH MAINTENANCE ORGANIZATION - DHMO)

The Cigna Dental HMO (DHMO) plan helps to streamline dental care and makes most preventive diagnostic services available at a reasonable cost or no additional cost to the employee, including yearly fluoride treatments for covered children.

PPO (PREFERRED PROVIDER ORGANIZATION - DPPO)

Employees enrolled in the Foundation Dental PPO plan can visit any dentist in or out-of-network and do not need a referral to see a specialist. Access to most preventive services is standard. Benefits are higher when selecting an in-network provider.

Vision

The Foundation Vision Care plan lets employees visit any licensed eye care professional. No worries about in or out-of-network requirements or showing ID cards at the time of service. Foundation Vision Care is a reimbursement plan.

Generally, a Foundation employee becomes eligible for healthcare benefits once they are classified as a “benefited employee.” The effective date of coverage is the first day of the month following the hire date of full-time employment or from when the employee was reclassified as a benefited employee.

ELIGIBILITY

After the initial benefit enrollment, an employee cannot make changes in their election or terminate coverage until the next period of "Open Enrollment," which happens annually (unless the employee qualifies for "Special Enrollment" as outlined below).

If an employee declines coverage, they must complete the Benefits Election Form declining the benefits for themselves and/or their dependents and provide evidence of coverage from their insurance carrier.

Dependent Eligibility

For the purposes of our health insurance coverage, the definition of "dependent" includes a spouse, domestic partner (must be registered with the California State Registry) and children up to 26 years of age. "Children" includes step children, children placed under a "qualified medical child support order," adopted children or children placed for adoption. The effective date for any dependent is the latter of 1) your effective date, or 2) the first of the month following the date you add the dependent. Note: Covered spouses are not (those spouses who have health insurance coverage available through their employer) eligible for Foundation benefits. Contact Employment Services for additional information.

Healthcare Reform

Foundation's health insurance plans will cover children (young adults) until they turn 26 years old. This is true even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student. This is also the case if the young adult is married, although their spouses and children do not qualify. Children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

Adding and Excluding Dependents

Newly acquired dependents may be added to the plan during the year by completing the necessary forms within 30 days from the date the dependent first become eligible. If new dependents are not added within the 30-day period and do not qualify for a Special Enrollment (see below), they will not be eligible to enroll until the next Open Enrollment period.

Special Enrollment Rights

Other than during the annual Open Enrollment period, an Employee may not change coverage unless experiencing a qualified event for a Special Enrollment. Additionally, when an Employee declines enrollment for themselves or dependents (including their spouse) based on having other group medical coverage, that employee may be able to enroll themselves or dependents in this plan - provided they qualify for a "Special Enrollment." The request for enrollment must be made within 30 days of your other group coverage termination or any other qualifying event.

The following are events that qualify for "Special Enrollment."

- **Marriage, annulment, legal separation, divorce or death**
- **Birth, adoption or placement for adoption of a child, death of dependent child**
- **Retirement, or termination of employment**
- **Termination of employment or new employment of a spouse**
- **Change in employment from full-time to part-time or vice versa for you or your spouse**
- **Change in medical coverage by the spouse's or domestic partner company**

Please Note: Loss of eligibility due to failure to pay premiums or termination for cause does not create a special enrollment opportunity.

ADDITONAL INFORMATION REGARDING BENEFITS

Retirement Planning

Foundation retirees who are or were eligible for Foundation's healthcare benefits as a retiree are able to make changes to their healthcare elections annually, including the option to move into and out of a Foundation retiree healthcare plan, without losing eligibility. There are many reasons a retiree might want to remain on one of Foundation's plans one year and opt out of the benefits the next year, and then the next year return to one of Foundation healthcare plans. Of course, there are still some requirements that need to be met in order to opt out and return to Foundation's benefits plan such as re-enrollment needs to be made during an open enrollment period, or if there is a genuine qualifying event such as a loss of healthcare coverage from a spousal plan.

Please make an appointment with Employment Services (Nora Fernandez) if you are thinking about opting out of medical for the 2022 plan year.

Basic Life & AD&D (NEW FOR 2022!) — Offered by Mutual of Omaha — FOUNDATION PAID

Life insurance provides protection for your beneficiary in the event of your death. All full-time benefited employees automatically receive Basic Life and AD&D Insurance coverage. Generally, the benefit amount is one time the employee's annual base salary. Accidental Death and Dismemberment Insurance is also available, which pays a benefit if you survive an accident but have certain serious injuries. It pays an additional amount if you die from a covered accident.

Long Term Disability (LTD) — Offered by Mutual of Omaha — FOUNDATION PAID

When non-work related illness or injury makes it impossible for an employee to work for an extended period of time, eligible employees' income may be continued under the Foundation's LTD Plan. Foundation pays the entire cost of coverage for its eligible employees for this benefit plan. Under the plan, when an eligible employee is disabled for more than 90 days, the employee could receive a benefit of 60% of their basic monthly pay (up to a predetermined maximum amount) until the employee is able to return to work.

Supplemental Life & AD&D — Offered by Mutual of Omaha — EMPLOYEE PAID

Supplemental Life and AD&D insurance can provide money for your family if you die or are diagnosed with a terminal illness. You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more. AD&D Insurance is also available, which pays a benefit if you survive an accident but have certain serious injuries. It pays an additional amount if you die from a covered accident.

Employee Assistance Program (EAP) — Offered by Mutual of Omaha — FOUNDATION PAID

When you're feeling stressed, worried or having a tough time, you may want someone to talk to. You and your dependents can seek help from master's level EAP professionals who are available 24/7/365. EAP professionals can assist with issues like stress, parenting, anxiety, depression, any issue affecting your wellbeing, dealing with illness, relationship or family issues and much more! You have 3 face-to-face visits available to you at no cost. To get connected with an EAP professional, you can call 1-800-316-2796.

Coverage for Clinical Trial Participants

With health care reform, plans can't deny people from participating in clinical trials. They also can not limit coverage of routine patient costs for items and services in connection with the trial. The PPACA says that they must not discriminate against a policyholder because of a clinical trial.

Approved clinical trials are phase I, II, III or IV clinical trials that are for prevention, detection or treatment of cancer or another life-threatening disease.

Health Premium Rates

HEALTH PREMIUM RATES January 1, 2022 through December 31, 2022 The rates shown below apply to the first two pay periods of each month (deducted in 24 equal periods annually)							
	*Coverage Code	TOTAL MONTHLY PREMIUM	Foundation Monthly Contribution (Non Flex Dollars)	Employee Monthly Contribution (Non Flex Dollars)	***Employee Payroll Deduction (First two pay periods of each month) (Non Flex Dollars)	TOTAL MONTHLY PREMIUM	COBRA (Monthly +2)
MEDICAL PLANS							
Kaiser PPO	(1)	$1,229.50	$625.00	$604.50	$302.25	$1,229.50	$1,254.09
www.multiplan.com/kaiser	(2)	$2,458.98	$1,248.00	$1,210.98	$605.49	$2,458.98	$2,508.16
	(3)	$3,479.46	$1,766.00	$1,713.46	$856.73	$3,479.46	$3,549.05
Kaiser HMO	(1)	$602.79	$602.79	-	-	$602.79	$614.85
www.kaiserpermanente.org	(2)	$1,205.58	$1,205.58	-	-	$1,205.58	$1,229.69
	(3)	$1,705.90	$1,705.90	-	-	$1,705.90	$1,740.02
UHC HMO	(1)	$595.00	$595.00	-	-	$595.00	$606.90
www.whyuhc.com/csveba	(2)	$1,190.00	$1,190.00	-	-	$1,190.00	$1,213.80
	(3)	$1,684.00	$1,684.00	-	-	$1,684.00	$1,717.68
DENTAL PLANS							
Foundation PPO	(1)	$62.00	$62.00	$0	$0		$63.24
www.firstdentalhealth.com	(2)	$107.00	$107.00	$0	$0		$109.14
	(3)	$162.00	$162.00	$0	$0		$165.24
Cigna	(1)	$22.75	$22.75	$0	$0		$23.24
DHMO - C609	(2)	$36.94	$36.94	$0	$0		$37.68
www.cigna.com	(3)	$51.22	$51.22	$0	$0		$52.24
VISON PLAN							
You many use any provider	(1)	$12.00	$12.00	$0	$0		$12.24
	(2)	$21.00	$21.00	$0	$0		$21.42
	(3)	$32.00	$32.00	$0	$0		$32.64

Notes:

Medical Only:
(1) Employee Only
(2) Employee with 1 Dependent
(3) Employee + Family

Dental & Vision:
(1) Employee Only
(2) Employee with 1 Dependent
(3) Employee with 2 or more Dependents

***Health Premiums and/or Cash for Benefits are processed the first two pay periods of each month.

OPEN ENROLLMENT for all health plans is typically during the month of November effective January 1st.

Kaiser & UHC HMO Health Plans

Choosing the Right Plan

The Foundation is proud to offer three medical plans: one **NEW** United Healthcare (UHC) HMO, one Kaiser HMO, and one Kaiser PPO . These plans not only provide coverage for illness and injury, they also allow you and your family to focus on staying well.

The Kaiser and UHC HMO plans are Health Maintenance Organizations, a managed health network. Out of network visits are NOT covered unless it is an emergency. All specialist visits are directed by your HMO primary care physician. Authorization is required for some services. Under the Kaiser PPO (Preferred Provider Organization) plan, there are in-network or "contracted" and out-of-network or "non-contracted" providers. This means members can seek services from any provider. Also, you can see a specialist without a referral. However, use caution and be sure you understand the full costs associated with out of network care to protect yourself from unexpected costs. If you go outside the network, you may be required to file your own claims, gain approval from the insurance carrier before receiving services, and pay the difference between the amount covered by your plan and the amount charged by your doctor. This is known as "balance billing" and cannot be controlled by the insurance carrier. Some states have laws against balance billing.

With the Kaiser HMO, Kaiser Permanente offers a model of care where all services are rendered within their facilities. You choose a primary care physician but do have access to all providers within their network. One of the great things about Kaiser is most services can be rendered within the same building – for example, you see your doctor and they prescribe a medication, you can typically go to the pharmacy located in the same building without having to drive to another location!

With the UHC HMO, you are required to select a Primary Care Physician within a participating Medical Group in United Healthcare's Alliance network. Each family member may choose their own primary care physician. The following medical groups are contracted under UHC's Alliance network: Mercy Physicians, Primary Care Associates, Rady's Children, Scripps, and UCSD. We recommend you visit UHC's website to see if your preferred provider is contracted in network.

Covered Services	**Kaiser Traditional**		**UHC Traditional**	
Network/Group #	Kaiser / 27585		Alliance / TBD	
Website	www.kaiserpermanente.org		www.uhc.com	
Office Visits/Specialist	$20 copay		$10 copay	
Prescription Drug	**Plan Pharmacy (30 day supply)**	**Mail Order (100 day supply)**	**Plan Pharmacy (30 day supply)**	**Mail Order (90 day supply)**
Many brand name drugs come in generic. You many need to ask your doctor for a generic prescription to get the lower copay.	Generic: $15 copay	Generic: $30 copay	Generic: $15 copay	Generic: $30 copay
	Brand: $30 copay	Brand: $60 copay	Preferred Brand: $30 copay	Preferred Brand: $60 copay
	Specialty: $60 copay	Specialty: N/A	Non Preferred Brand: $45 copay	Non Preferred Brand: $90 copay
Emergency Services (waived if admitted)	$75 / visit		$100 / visit	
Ambulance Services	No Charge		No Charge	
Urgent Care	$20 copay		$10 copay	
Deductible				
	The accumulation period for this plan is 1/1/2022-12/31/22			
Individual	$0		$0	
Family	$0		$0	
Out of Pocket Maximum				
	The accumulation period for this plan is 1/1/2022-12/31/22			
Individual Maximum	$1,500		$1,500	
Family Maximum	$3,000		$3,000	
Lifetime benefit Maximum	None		None	
Routine Physical Exams	$20 / visit		$10 copay	
Chiropractor/Acupuncture	$10 / visit		$10 / visit	
	20 combined visits/calendar year		Unlimited	
Hospital Services				
Inpatient	$250 / admission		No Charge	
Outpatient - Surgery performed in an ambulatory surgery center	$20 / procedure		No Charge	
Outpatient Surgery in a Hospital				
Outpatient Lab & XRay	No Charge		No Charge	
Mental Health/Substance Abuse				
Inpatient - detoxification	$250 / admission		No Charge	
Outpatient	$20 / visit		$10 / visit	
Monthly Employee Cost	See Rate Sheet		See Rate Sheet	

Kaiser PPO Health Plan

2022 Benefit Summary	PPO Plan 13906 NCR / 13907 SCR	
	Participating Provider Tier[15] *	**Non-Participating Provider Tier***
	Precertification is required for certain services†	
The Accumulation Period for this Plan is **Calendar Year**		
Maximum benefit while insured	Unlimited	
	Insured pays	
Deductible per accumulation period	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family
Out-of-Pocket Maximum per accumulation period	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Hospital care	$250 copayment per admission, then	$500 Copayment per admission, then
Room, board, and critical care units	20%	40%
Imaging, including X-rays and lab tests	20%	40%
Transplants	20%	40%
Physician, surgeon, and surgical services	20%	40%
Nursing care, anesthesia, and inpatient prescribed drugs	20%	40%
Birth Services[7]	20%	40%
Outpatient care		
Physician office visits	$35 Copayment[3]	40%
Specialty care	$35 Copayment[3]	40%
Telehealth visits[8]	$35 Copayment[3]	40%
Preventive screening services	No Charge[3]	40%[3]
Routine adult physical exam	No Charge[3][4]	Not Covered
Well-child preventive care visits	No Charge[5]	40%[5]
Family planning visits	$35 Copayment[3]	40%
Prenatal care[6]	No Charge[3]	40%[3]
Outpatient Surgery	$100 Copayment, then 20% per procedure	$150 Copayment, then 40% per procedure
Lab Test and Imaging, including X-rays	20%	40%
Hearing exams	No Charge[3]	Not Covered
Occupational, physical, respiratory, and speech therapy visits	20%	40%
Health Education	No Charge[3]	40%
Diabetic Day Care Management Classes	No Charge[3]	40%[3]
Emergency Care[16] (Emergency Copayment waived if admitted)	$150 Copayment per visit, then 20%	

2022 Benefit Summary	PPO Plan 10225 NCR / 10226 SCR	
	Participating Provider Tier[14] *	**Non-Participating Provider Tier***
	Precertification is required for certain services†	
	Insured pays	
Emergency Ambulance Service[16]	40%	40%
Medically Necessary Non-emergency Ambulance Service	40%	40%
Urgent Care	$55 Copayment[3]	40%
Prescriptions[9]	**MedImpact Pharmacies[10][16]**	**Non-Participating Pharmacy**
Generic drugs (30-day supply)	$15 Copayment	Not covered
Brand drugs (30-day supply)	$40 Copayment	Not covered
Contraceptive drugs	No charge	Not covered
Specialty drugs[11]	30% with $250 per prescription maximum	Not covered
Mail-order generic drugs (maximum benefit of a 100-day supply)	$30 Copayment	Not covered
Mail-order brand drugs (maximum benefit of a 100-day supply)	$80 Copayment	Not covered
Mental health care		
Inpatient hospitalization	$250 Copayment per admission, then 20%	$500 Copayment per admission, then 40%
Outpatient individual visits	$35 Copayment[3]	40%[3]
Outpatient group visits	$17 Copayment[3]	40%[3]
Substance use disorder treatment		
Inpatient hospitalization	$250 Copayment per admission, then 20%	$500 Copayment per admission, then 40%
Outpatient individual therapy visits	$35 Copayment[3]	40%[3]
Outpatient group therapy visits	$17 Copayment[3]	40%[3]
Durable medical equipment	30%[13]	50%[13]
Diabetic Equipment and Supplies[14]	30%	30%
Prosthetics, orthotics, and special footwear	20%	40%
Additional benefits		
Care in a skilled-nursing facility (60-day combined limit per benefit period)	$250 Copayment per admission, then 20%	$500 Copayment per admission, then 40%
Home health care (100-day combined limit per accumulation period)	20%[3]	20%[3]
Hospice care	20%	40%
Fertility services	20%[3][12]	40%[3][12]

Vision & Dental Benefits

VISION You may use any provider	
FREQUENCY	
Eye Examination	Once A Year
Frame	Once A Year
Lenses	Once A Year
Contact Lenses (in lieu of lenses)	Once A Year
EXAM	
Dilation when necessary	$75.00 reimbursement
STANDARD LENSES	
Single Vision	$75.00 reimbursement
Bifocal	$140.00 reimbursement
Trifocal	$140.00 reimbursement
Lenticular	$145.00 reimbursement
Progressive	$100.00 reimbursement
FRAMES	
	$400.00 reimbursement
CONTACT LENSES	
In lieu of lenses	$450.00 reimbursement
* Vision reimbursement Plan. Member submits claims to HealthScope for reimbursement.	

DENTAL PPO First Dental Health Network		
	IN NETWORK	**OUT OF NETWORK**
ANNUAL MAXIMUM	**$3,500 / MEMBER**	**$2,000 / MEMBER**
DEDUCTIBLE Individual/Family	**$50/$150**	**$50/$150**
PREVENTIVE	**100%**	**100%**
Oral exams, routine cleaning, X-rays, Fluoride application, Sealants, Space Maintainers		
BASIC SERVICES	**75%**	**75%**
Fillings, Oral Surgery - all except simple extractions, Oral Surgery - simple extractions		
MAJOR SERVICES	**50%**	**50%**
Crowns, Root canal therapy/endodontics, Periodontal scaling and root planting, Dentures, Bridges, Inlays/Onlays, Prosthesis over implant		
DENTAL IMPLANTS	**50% UP TO $3,500***	**50% UP TO $2,000***
ORTHODONTICS	**50% UP TO $3,500***	**50% UP TO $2,000***
* Lifetime Maximum for Orthodontics and Implants		

www.firstdentalhealth.com

Dental & Vision Benefits (cont.)

CIGNA DENTAL HMO - IN STATE ONLY	
ANNUAL MAXIMUM	**Unlimited**
DEDUCTIBLE (Individual/Family)	None
OFFICE VISIT (Per Patient, Per Office Visit in Additional to any other Applicable Patient Charges)	$5.00
PREVENTIVE	
Exams X-Rays	No Charge
Prophylaxis	No Charge
RESTORATIVE SERVICES	CoPay Applies
Amalgam – 3 surface, permanent	No Charge
Resin based composite – 3 surface, Anterior	CoPay Applies
PERIODONTICS	CoPay Applies
Periodontal scaling & root planning, per quadrant (4 or more teeth)	$15 CoPay
Gingivectomy or gingivoplasty per quadrant	$15 CoPay
ENDODONTICS	
Pulp Capping	No Charge
Root Canal – Molar	$40-$100 CoPay
ORAL SURGERY	
Single Tooth Extraction	No Charge
Removal of impacted tooth, partial bony	$30 CoPay
Removal of impacted tooth, complete bony	$40 CoPay
CROWNS & BRIDGES	
Crown – full cast noble metal	$60 CoPay
Crown – porcelain fused to predominately base metal	$60 CoPay
PROSTHETICS (DENTURES)	
Partial Denture – Upper	$85 CoPay
Partial Denture – Lower	$85 CoPay
ORTHODONTICS	
Adolescent	$1600 CoPay
Adult	$1800 CoPay

Toll-free numbers and websites

Kaiser – HMO	1-800-464-4000	kaiserpermanente.org
UHC – HMO	1-800-624-8822	whyuhc.com/csveba
CIGNA DHMO Plan	1-800-244-6224	cigna.com
PPO Dental Plan	1-800-229-2156	firstdentalhealth.com
Vision Plan	1-800-229-2156	healthscopebenefits.com
Life and AD&D Plans	1-800-377-9000	mutualofomaha.com
Long Term Disability Plan	1-800-377-9000	mutualofomaha.com
EAP—Mutual of Omaha	1-800-316-2796	mutualofomaha.com/eap
EAP—Optum	1-888-625-4809	LIveandworkwell.com (access code: VEBA)

FLEXIBLE SPENDING ACCOUNT—HEALTHCARE

A Flexible Spending Account, or FSA, is an employee benefit that allows you to conveniently save and pay for you and your family's healthcare expenses. The income you choose to contribute to your FSA becomes tax exempt, giving you extra cash to help pay for upcoming healthcare or dependent care costs, as well as the inevitable unexpected expenses.

Healthcare FSA.
Used for certain qualified out-of-pocket expenses not covered by your health plan.

- Out-of-pocket deductible
- Office visit copays
- Out-of-pocket dental
- Orthodontia
- Vision and hearing
- Prescriptions

Here's why you should enroll.

- Fast, daily claim reimbursement
- Online claim filing & account access
- mSAVE ™ mobile app for Apple & Android
- mSAVE debit card

Here's how much you can save.
Savings will be determined based on your federal and state tax rates. On average, people save between 20 – 35% on money contributed to an FSA.

What happens if I don't use all my FSA money this year?
Your employer allows up to $500 of unused rollover dollars from your FSA into the next plan year.

Visit msave.maestrohealth.com
Registration ID: Select "Card Number" and enter the 16-digit number on your mSAVE debit card.

Plan Year Start: 1/1/2022
Plan Year End: 12/31/2022
Annual Election Max: $2,750

Questions? Let us help.
888.488.5054 | questions@maestrohealth.com | maestrohealth.com

BENEFIT ACCOUNTS

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FLEXIBLE SPENDING ACCOUNT—DEPENDENT CARE

What is a Dependent Care Flexible Spending Account (FSA)?

A Flexible Spending Account, or FSA, is an employee benefit that allows you to conveniently save and pay for certain types of expenses pre-tax. The Dependent Care FSA is used for expenses paid to care for qualified dependents that allows you to work.

- Daycare
- Nursery or preschool tuition
- Nannies
- Before & after school care
- Day camps

Plan Year: 01/01/2022-12/31/2022
Plan Year Maximum: $5,000

How do I sign up?

You must sign up for the Dependent Care FSA every year at open enrollment.

Learn more at:

msave.maestrohealth.com

How much can I save?

You can save hundreds. Regardless of how much you elect to contribute, you'll decrease your taxable income and increase your spendable income! It's a win-win!

Questions? Let us help.

888.488.5054 | questions@maestrohealth.com | maestrohealth.com

CALPERS

1 2

CalPERS

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SEARCH

3 Home | Active Members | Retirees | Employers

my|CalPERS Log In

2016 Health Rates Now Available

Know your choices. Make an informed decision and choose a CalPERS health plan that's right for you.

View the Rates

4

I Want To . . .

- Attend Training & Events
- Calculate My Retirement Estimate
- Change My Address
- Estimate Service Credit Cost
- Find a Job
- Learn About Long-Term Care
- Review Health Plan Rates
- Update My Beneficiary
- View Board Meeting Agendas
- Visit a Regional Office

Life Events

- Birth or Adoption
- Death or Terminal Illness
- Domestic Partnership
- Injury/Disability
- Leave of Absence
- Leaving CalPERS Membership
- Marriage or Divorce
- Name or Address Changes
- Retirement
- Returning to Work

View All

Forms & Publications

- Beneficiary Designation (PDF)
- Facts at a Glance (PDF)
- Health Benefit Summary (PDF, 1.44 MB)
- Planning Your Service Retirement (PUB 1) (PDF)
- Service Credit Purchase Options (PUB 12) (PDF)
- Service Retirement Application (PUB 43) (PDF)
- Tax Withholding Election (PDF)

View All

5 **News**

- CalPERS to Host Forum to Examine Topic of Diversity in Business and Finance
- CalPERS Highlights Outcome of Proxy Voting Initiatives
- David Crane Swings and Misses About CalPERS Investment Return

6 **Events**

Aug 5	School Employer Advisory Committee Meeting
Aug 17-19	Board Meeting
Sep 14 - Oct 9	Open Enrollment

7 **Subscribe**

By Email for Newsletters and Alerts

Enter Email Address | Subscribe

8 **Follow**

By Social Network

9 **Videos**

CalPERS Educational Forum 2015

CalPERS Educational Forum 2015
0:29

What is a CBEE?
2:58

CalPERS Supplemental Income 457 Plan
7:43

View CalPERSNetwork Videos

CalPERS Facts

The CalPERS Pension Buck

CalPERS income over the last 20 years (as of June 2014) demonstrates that every dollar spent on public employee pensions comes from the following sources:

67¢ CalPERS investment earnings
21¢ CalPERS employers
12¢ CalPERS members

CalPERS Members

As of June 30, 2014

Inactive Members
Active Members
Retirees & Beneficiaries

View All

CALPERS (cont.)

CalPERS Website

CalPERS' improved website makes it easier for you to access the information you need quickly and easily. Whether you're still working, retired, or an employer, our website has the information you're looking for. Visit calpers.ca.gov and discover for yourself what our site has to offer.

Use these tips to get the most out of our CalPERS website:

1. Find out how to reach us, get directions to our headquarters or Regional Offices, or make a public records request. You can also submit your questions and comments online.
2. Get accurate and relevant results with the Search function powered by Google.
3. Choose a category from **Home**, **Active Members**, **Retirees**, **Employers** that is tailored to your specific needs.
4. Select a quick link for direct access to the top tasks and frequently requested areas of our website. Attend training or learn about long-term care, report a life event such as a birth, adoption, marriage or a domestic partnership, or download a form or publication such as the Service Retirement application.
5. View the latest CalPERS news.
6. Find out the dates for important events such as Open Enrollment or upcoming Board meetings.
7. Sign up to receive emails for newsletters and alerts.
8. Follow us on the various social media channels to engage with us and receive current information.
9. View our videos about current issues and CalPERS benefits. Learn general facts about CalPERS.

PARS 457 (B) Optional

FACTS ABOUT THE PLAN

- ✓ Cal Poly Pomona Foundation, Inc. approved the establishment of a PARS 457(b) Deferred Compensation Plan for vacation and sick deferral effective July 1, 2002. The plan was amended effective January 1, 2009 to allow for voluntary salary deferrals.
- ✓ The PARS 457(b) plan is designed to supplement your current CalPERS retirement benefits.
- ✓ The Foundation has implemented this plan through PARS, Public Agency Retirement Services.

CONTRIBUTIONS INTO THE PLAN

VACATION AND SICK LEAVE CONVERSION

Vacation and Sick Leave Eligibility Requirements

1. Be employed by the Foundation on or after the most recent fiscal year ended as a regular full-time benefited employee.
2. Have completed 4 years of service with the Foundation and taken a minimum of 40 hours of vacation over the previous 12 months.
3. Have completed an Election Form during the annual Open Enrollment Period (August).

Amount of Vacation Conversion

- You must have accumulated over 160 unused vacation hours.
- You may elect to convert any percentage of your unused vacation hours over the 160 hours.
- You cannot convert more than 100 hours of vacation in any year.

Amount of Sick Leave Conversion

- You must have accumulated over 320 unused sick leave hours
- You may elect to convert any percentage of your unused sick hours over the 320 hours.
- You cannot convert more than 100 hours of sick leave in any year.

VOLUNTARY SALARY DEFERRALS

Eligibility Requirements

1. Be employed by the Foundation as a full-time, part-time or temporary employee (excluding student employees), for at least 12 months prior to participating in the plan.
2. Have submitted a completed Voluntary Salary Deferral Agreement to the Foundation Employment Services Office.

Amount of Conversion

- 24 times a year, the Foundation will withhold the contribution amount specified on the employee's Voluntary Salary Deferral Agreement.
- 24 times a year, the Foundation will make the contribution to the plan.
- The deferral amount will remain in full force and effect until modified or cancelled by the employee by submitting a new Voluntary Salary Deferral Agreement

403 (B) Optional

WHAT IS A 403(B) PLAN?
A 403(b) is a tax advantage retirement savings plan. Simply put, employee salary deferrals are placed into a 403(B) plan and those deferrals are made “pre-tax”. Those deferrals are allowed to grow tax deferred until the money is withdrawn from the plan, and it is taxed at that time.

WHO CAN PARTICIPATE IN THE FOUNDATION’S 403(B) PLAN?
Generally, any Foundation employee who works at least 20 hours a week on an average can participate. However, by definition that excludes student employees.

CAN I TAKE A LOAN FROM THE PLAN?
The Foundation’s 403(B) plan defers the questions to the specific vendor who manages your account. Each vendor has its rules and while some vendors permit loans others do not.

CAN I ROLL OVER THE FUNDS INTO OR OUT OF THE 403(B)?
Generally; yes, Foundation’s 403(B) accepts roll-overs from other 403(B) plans, and allows a participant to roll their funds into another 403(B).

WHO ARE THE AUTHORIZED VENDORS REGARDING WHERE MY MONEY WILL BE HELD?
Currently, the below vendors are the authorized at the Foundation for 403(B) custodial accounts.

Please keep in mind the above information is intended to be general and the Plan Document will apply in all cases. If you have any question regarding your activated account please feel free to contact Diane Maldonado at 909-869-2246; all other questions; please contact Nora Fernandez at 909-869-4378.

AFLAC - Optional

Aflac for Cal Poly Pomona Foundation

Are you — or your employees — among the 57% of Americans who've had to pay an unexpected medical bill?[1] Did you think, "But I have health insurance. I should be covered?" That's why there's Aflac. We can pay you cash directly[2] to help cover that bill or any other expense you may have. Aflac helps provide you with peace of mind when you need it most.

These Aflac supplemental plans are now available to you.

Accident :
Accidents happen. When a covered accident happens to you, our accident insurance policy pays you cash benefits to help with the unexpected medical and everyday expenses that begin to add up almost immediately.

Lump Sum Cancer :
If you are diagnosed with cancer, an Aflac lump sum cancer insurance policy will pay a lump sum amount directly to you unless otherwise assigned.

Short-Term Disability :
How would you pay your bills if you're disabled and can't work? An Aflac short-term disability insurance policy can help provide you with a source of income while you concentrate on getting better.

Dental :
Keep a bright, healthy smile with Aflac's dental insurance policy. Our policy provides benefits for dental care.

Aflac Plus Rider :
The Aflac Plus Rider pays a lump sum benefit amount along with additional benefits when you are diagnosed with a covered health event.

Lump Sum Critical Illness :
It's good to be prepared. Aflac lump sum critical illness insurance will pay a lump sum amount to you if you experience a covered health event.

Hospital Confinement Indemnity :
Hospital stays are expensive. An Aflac hospital confinement indemnity insurance policy can help ease the financial burden of hospital stays by providing cash benefits.

Whole or Term Life :
With Aflac's whole life or term life insurance, you can rest easy knowing that your family will have financial security when they need it most.

To learn more, contact your Aflac agent, KASANDRA STEELY, at kasandra_steely@us.aflac.com or 714-742-5663.

[1]NORC AmeriSpeak Onmibus Survey: Surprise Medical Bills. August 16-20, 2018.
https://www.norc.org/PDFs/Health%20Care%20Surveys/Surprise%20Bills%20Survey%20August%202018%20Topline.pdf – accessed March 30, 2020. [2]Unless otherwise assigned.
This is a brief product overview only. Coverage may not be available in all states. Benefits/premium rates may vary based on plan selected. Optional riders may be available at an additional cost. The policy/certificate has limitations and exclusions that may affect benefits payable. Refer to the specified policy/certificate for complete details, benefits, limitations, and exclusions. For availability and costs, please contact your local Aflac agent.
Individual coverage is underwritten by Aflac. Group coverage is underwritten by Continental American Insurance Company (CAIC), a wholly-owned subsidiary of Aflac Incorporated. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, coverage underwritten by Continental American Life Insurance Company. For individual coverage in New York or coverage for groups sitused in New York, coverage is underwritten by Aflac New York. Continental American Insurance Company I Columbia, SC. WWHQ I 1932 Wynnton Road I Columbus, GA 31999.
Z200331 EXP 5/21

AFLAC (cont.)

Get help with expenses health insurance doesn't cover

1 **Aflac is help with expenses health insurance doesn't cover:** Health insurance pays doctors and/or hospitals. Aflac pays cash directly to you, unless you tell us otherwise. You can use your benefits your way — whether it's for leftover medical bills or any other expense that affects your financial security.

2 **Aflac belongs to you, not your company:** When you have an Aflac policy, it's yours. You own it. Even if you change jobs or retire, you can take your Aflac policy with you.

3 **Aflac is affordable:** Our products flex to meet individual needs and budgets. We'll be there to help in your time of need when you're hurt or sick. And, Aflac rates don't go up even when you file a claim.

4 **Aflac processes claims quickly:** Aflac provides prompt service and fast payment of qualified claims to help you pay your bills. While you're focusing on your health, we focus on getting you cash as quickly as possible.

5 **Aflac is accountable:** Aflac has been named to Ethisphere's list of World's Most Ethical Companies[1] 14 years in a row, *FORTUNE's* list of *100 Best Companies to Work For*[2] for 20 consecutive years and *FORTUNE's* list of *World's Most Admired Companies*[3] 19 times.

6 **Aflac cares:** For more than 25 years, Aflac has dedicated its heart and philanthropic mission to helping children with cancer. Since 1995, Aflac has raised and donated more than $140 million to the Aflac Cancer and Blood Disorders Center of Children's Healthcare of Atlanta. Much of Aflac's support comes from its independent sales agents who contribute donations from their monthly commission checks, as well as Aflac employees who contribute each month through payroll deduction.

To learn more or to apply for coverage contact:

KASANDRA STEELY

714-742-5663 | kasandra_steely@us.aflac.com

[1]Ethisphere Magazine, Quarter 1, 2018; [2]FORTUNE 100 Best Companies to Work For and [3]World's Most Admired Companies are registered trademarks of Time Inc. and are used under License. FORTUNE and Time Inc. are not affiliated with, and do not endorse products or services of Aflac coverage is underwritten by Aflac. In New York, coverage is underwritten by Aflac New York.
WWHQ I 1932 Wynnton Road I Columbus, GA 31999.
Z181172 EXP 5/21

CHUBB

LifeTime Benefit Term

Cal Poly Pomona Foundation Plan Features

- Affordable permanent Life & Long Term Care insurance that lasts a lifetime – Guaranteed
- Guarantee Issue for New Employees of up $75,000 for Life Insurance & $225,000 for Long Term Care Insurance
- Modified Guarantee Issue for Spouse & Guarantee Issue for Dependents
- Life Insurance premiums guaranteed for life
- Long Term Care benefits equal to 3x your death benefit amount. That's up to 75 months of care for nursing home, assisted living and home care!
- Earns Paid-Up Insurance
- Death Benefit and LTC Benefit is fully paid-up prior to age 100
- Plan is portable with locked in life insurance rates Guaranteed
- Accelerated Death Benefit for terminal illness included
- Enroll today for minimum coverage & Guarantee your future insurability for years to come

How LifeTime Benefit Term with Long Term Care Works

A 45-year old non-smoker can purchase $50,000 of coverage including the Accelerated Death Benefit for Long Term Care, Death Benefit Restoration, and Terminal Illness for $15.09 per week.

$50,000

Long Term Care benefit of $2,000 (4% of 50,000) per month would be available for up to 75 months. That's $150,000 in available benefits for Long Term Care.

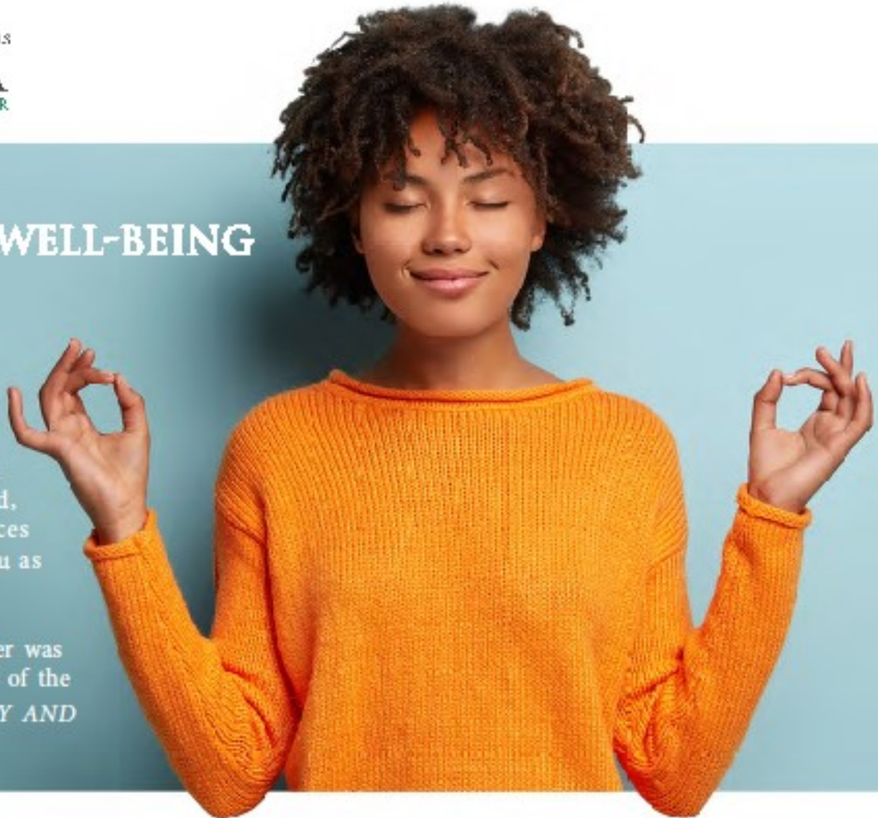
$150,000 (75 mo.)

At retirement you can continue paying premiums to keep the full $50,000 death benefit and $150,000 Long Term Care benefit, OR at any time you may choose to take the paid-up benefits and stop paying premiums. This example shows paid-up benefits available at age 65.

$13,919 Paid-up Death Benefit

$41,757 Paid-up LTC Benefit

EMPLOYEE ASSISTANCE PROGRAM



VEBA EMOTIONAL WELL-BEING RESOURCES

We are living in some pretty stressful times right now, which may be taking a toll on our emotional health. If you are feeling overwhelmed, check out the free resources you have available to you as a VEBA member.

The VEBA Resource Center was designed to help take care of the whole you – *MIND, BODY AND SPIRIT.*

OPTUM EAP

The free Optum EAP benefit offers VEBA members confidential access to personalized care and self-help resources. Optum's experts can help with stress, medication questions, life events like divorce, or legal issues. VEBA members receive five free visits per concern.

Learn more at **liveandworkwell.com** (access code: VEBA). Visit Optum's site for an online pre-authorization form or call **888-625-4809**.

Optum also offers a free community emotional support line at **866-342-6892**. Anyone can call 24 hours, 7 days a week, to speak to a professionally trained mental health expert.

PSYCH CENTERS AT SAN DIEGO

Need an appointment through EAP immediately? Psych Centers at San Diego (PCSD) telehealth services are here to help. You can take advantage of group therapy and personalized therapy sessions through your Optum EAP benefit.

Expedited appointments are available. You will first have to get an authorization code from EAP. Then, call PCSD to schedule an appointment within one week. Here's how:

1. Contact Optum at 888-625-4809 or VEBA Advocacy at 888-276-0250 or email advocacy@mcgregorinc.com to obtain an authorization code
2. Call PCSD at 619-528-4600 ext. 7878 with your authorization code to schedule your appointment

3 WAYS TO CONNECT WITH THE VEBA RESOURCE CENTER

1. **ONE-ON-ONE APPOINTMENT WITH A CARE NAVIGATOR**
   Our holistic nurses help connect you with the resources you need.
2. **PERSONALIZED HEALTH COACHING**
   Individual care from VRC experts on nutrition, exercise, dieting, and flexibility.
3. **LIVE CLASSES THROUGHOUT THE WEEK**
   From yoga to cooking to meditation, we'd love to have you join us! Check out our online schedule!

Visit our VRC channels for Well-Being Resources and Updates

VEBA RESOURCE CENTER—WELLNESS BENEFITS

The VEBA Resource Center is a safe and convenient environment that supports VEBA members as they build their way to a healthier life. We understand everyone's journey is unique, and we help our members find resources that are centered around them and are there to support them every step of the way.

Welcome to the Virtual VRC!

The VRC has gone virtual! We are offering all employees over 200 group and individual monthly classes ranging from Cardio, Yoga, Mindfulness, Finance, Nutrition and much more!

VEBA Members have:

- Access to personalized sessions with a VRC provider to support your individual health goals!
- Access to 1:1 appointments with a Care Navigator, a Regitered Nurse who specializes in holistic health, and can help refer you to classes and programs in our organization and within your health care system to meet specific needs and goals.

There are several ways the VRC can bring value to your district or bargaining unit. We are centered around our clients and member's needs, which means we can develop personalized plans to support your employees in living healthy, happy lives!

Examples include:

- Breathing and meditation exercises led by certified mindfulness & yoga therapists to start the workday
- Stretching zoom break led by our certified yoga therapists
- Zumba for Zoom Fatigue led by our Certified Zumba Instructor
- Customized finance classes around first time home buying, refinancing, or upgrading into a larger home led by our Certified Finance Partners
- Health and Wellbeing content (articles, videos, etc.) that can be sent out to your staff through your existing channels (newsletters, social media, etc.)

www.vebaresourcecenter.com

Visit our VRC channels for Well-Being Resources and Updates

VEBA RESOURCE CENTER

California Schools VEBA presents

VEBA Resource Center

Stress Reduction, Nutrition & Cooking, Movement, Education

The VEBA Resource Center provides support and encouragement without judgement.

WELCOME!

The VEBA Resource Center offers a variety of resources to help support and encourage your journey to a healthier and happier life. Your journey starts with the help of a registered nurse, focused on a holistic approach, who will be your Care Navigator. Together, you will create a personalized well-being plan that includes the resources described below, as well as referrals to other services and personal follow-up to keep you on track.

Stress Reduction

Stress is dangerous to your health and well-being. The VEBA Resource Center offers a variety of services to help you reduce the stress in your life, now and in the future. They include acupuncture, mindfulness, meditation, counseling and self-advocacy. Enjoy our beautiful and calming treatment rooms to get the most out of each visit.

Nutrition & Cooking

You are what you eat, that's why a healthy diet is key to your good physical and mental health. The VEBA Resource Center offers hands-on cooking classes, nutrition counseling and healthy recipes. Our modern kitchen inspires even the most inexperienced cooks!

Movement

Exercise is proven to enhance the mind-body connection. The VEBA Resource Center offers a variety of fitness programs to fit your style. From yoga and circuit exercise to strength training and more, we'll help you get moving in our brand new and fullyequipped gym that includes a shower and changing room.

Education

Learning how to care for your mind and body helps you make better choices for a healthy and happy life. The VEBA Resource Center offers a wide array of educational classes intended to address everyday problems and determine a call to action.

**Please note that all visits to the VEBA Resource Center are strictly confidential.*

1843 Hotel Circle South, San Diego, CA 92108

619-398-4220 • vrc@mcgregorinc.com • vebaresourcecenter.com

VEBA Added Benefits— NEW FOR 2022!

VEBA RESOURCE CENTER—YOUR CARE NAVIGATOR

VEBA Resource Center

YOUR CARE NAVIGATOR

CONTACT A VEBA CARE NAVIGATOR TODAY, BECAUSE YOU'RE WORTH IT!

Together, you and your VEBA Care Navigator will create a plan for a healthy body, mind and spirit.

YOUR ADVOCATE FOR GOOD HEALTH

Your experience at the VEBA Resource Center starts with a visit to your Care Navigator, a registered nurse focused on a holistic approach. Share your unique story, values and experiences with your Care Navigator and together, you will create a tailored plan for a healthy body, mind and spirit. Your Care Navigator is your greatest health advocate who will work on your behalf to make sure you receive the help you need to reach your goals. Your Care Navigator will help you stay accountable and pick you up if you slip— always without judgement—because the goal is to make you healthier and happier!

CARE NAVIGATOR SERVICES

Here are some of the services your Care Navigator will provide:

- Conduct an integrative health and well-being assessment
- Co-create a tailored care plan, with you, to address your overall health and well-being needs and goals (e.g. physical, psychosocial, financial and legal)
- Guide members to find appropriate resources
- Offer immediate in-house resources
- Schedule follow-up appointments (phone or in-person) to monitor and help implement your personalized care plan
- Motivate members to overcome obstacles or barriers to living their best lives
- Support and encourage members, who are already experts in their personal needs, to build on individual strengths

Contact a Care Navigator to start your journey toward a healthier and happier you!

**Please note that all visits to the VEBA Resource Center are strictly confidential.*

1843 Hotel Circle South, San Diego, CA 92108
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2022 ANNUAL NOTICES

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

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

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

contact information for a Health Insurance Marketplace in your area.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
Cal Poly Pomona Foundation		95-2417645
5. Employer address		6. Employer phone number
3801 W Temple Avenue, Building 55		909-869-4378
7. City	8. State	9. ZIP code
Pomona	CA	91768
10. Who can we contact about employee health coverage at this job?		
Employment Services		
11. Phone number (if different from above)	12. Email address	
909-869-4378	FDNHR@cpp.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    All benefited employees working an average of 30 hours a week or more

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Spouse/Register Domestic Partner, Dependent Child(ren) to age 26, any child(ren) for whom you are required to provide coverage under a qualified medical child support or court order, step children, or adopted child(ren) or child(ren) placed for adoption

  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

GENERAL NOTICE OF COBRA RIGHTS
**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Employment Services Manager - Nora Fernandez
Phone: 909-869-4378

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

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

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 1 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) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

Important Notice from Cal Poly Pomona Foundation About Your Prescription Drug Coverage and Medicare

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This Notice Applies to You (or Dependent) ONLY if such person is (1) enrolled in a group medical plan offered by Cal Poly Pomona Foundation AND (2) eligible for 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 Cal Poly Pomona Foundation 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. **Cal Poly Pomona Foundation has determined that the prescription drug coverage offered by the Cal Poly Pomona Foundation Health Plan 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 Cal Poly Pomona Foundation coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will 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 Cal Poly Pomona Foundation 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 at 909-869-4378. 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 Cal Poly Pomona Foundation 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:	January 1, 2022
Name of Entity/Sender:	Cal Poly Pomona Foundation
Contact--Position/Office:	Employment Services
Address:	3801 W Temple Avenue, Building 55, Pomona CA 91768
Phone Number:	909-869-4378

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT NOTICE

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

NOTICE OF PATIENT PROTECTIONS

Kaiser & UHC Health Plans generally requires 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, Cal Poly Pomona Health Plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit United Healthcare or Kaiser's websites or call the carrier customer service phone number on the back of your medical ID card.

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

You do not need prior authorization from Kaiser or UHC 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 visit United Healthcare or Kaiser's websites or call the carrier customer service phone number on the back of your medical ID card.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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 and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward 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 a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact Employment Services at 909-869-4378.

WELLNESS PROGRAM DISCLOSURE (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

WELLNESS PROGRAM DISCLOSURE (HIPAA)

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program 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 us at Employment Services and we 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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

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

If you would like more information on WHCRA benefits, contact Employment Services at 909-869-4378.

CONTACT US

Employment Services
Phone: 909-869-4378
Fax: 909-869-3716
Email: FDNHR@cpp.edu

Cal Poly Pomona Foundation, Inc.
3801 W. Temple Ave. , Bldg 55
Pomona - CA 91768

The information in this guide is not intended to take the place of or change the official Plan Documents or Evidence of Coverage. In the event the information in this guide differs from the Plan Document, the Plan Document shall prevail.