



2026

BENEFITS GUIDE

WELCOME TO YOUR BENEFITS

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Click this icon in your benefits guide to watch a video explaining the associated topic.
See page [74](#) for a glossary of terms.

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

The information in this brochure is a general outline of the benefits offered under The City of El Monte's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.


HUMAN RESOURCES CONTACT INFORMATION

EMPLOYEE BENEFITS PROGRAMS	CONTACT
Benefits Coordination (Medical, Dental & Vision Insurance)	Delmy Johana Coca-Ambriz - HR/RM Manager Yesenia Gutierrez – HR/RM Analyst
COBRA Continuation	Yesenia Gutierrez – HR/RM Analyst
Flexible Spending Accounts	Yesenia Gutierrez – HR/RM Analyst
Voluntary Plan Administration	Delmy Johana Coca-Ambriz - HR/RM Manager
Deferred Compensation	Yesenia Gutierrez – HR/RM Analyst
Employee Assistance Program	Delmy Johana Coca-Ambriz - HR/RM Manager
Fair Employment Housing Act (FEHA) Americans for Disabilities Act (ADA)	Ruby Romo - HR/RM Analyst
Family Medical Leave Act (FMLA)	Ruby Romo - HR/RM Analyst
Leave Administration	Ruby Romo - HR/RM Analyst
Workers' Compensation	Rigo Gutierrez - HR/RM Director, Ruby Romo - HR/RM Analyst
Life Insurance & Disability Insurance	Delmy Johana Coca-Ambriz - HR/RM Manager

CONTACT	EMAIL	PHONE
Human Resources Team		
<ul style="list-style-type: none"> • Rigo Gutierrez HR/RM Director 	rgutierrez@elmonteca.gov	626-580-2052
<ul style="list-style-type: none"> • Delmy Johana Coca-Ambriz Human Resources & Risk Manager 	dcoca@elmonteca.gov	626-258-8640
<ul style="list-style-type: none"> • Kristen Enomoto Sr. Management Analyst 	kenomoto@elmonteca.gov	626-580-2044
<ul style="list-style-type: none"> • Yesenia Gutierrez Human Resources & Risk Management Analyst 	ygutierrez@elmonteca.gov	626-580-2048
<ul style="list-style-type: none"> • Ruby Romo Human Resources & Risk Management Analyst 	rromo@elmonteca.gov	626-580-2017
<ul style="list-style-type: none"> • Annabel M. Delgado Human Resources & Risk Management Specialist 	amdeltado@elmonteca.gov	626-580-2049
<ul style="list-style-type: none"> • Luis Arevalo Human Resources & Risk Management Specialist 	larrevalo@elmonteca.gov	626-580-2401

CARRIER CONTACT INFORMATION

Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the web site (if available) to access information from providers for the various plans.

PLAN	PHONE NUMBER	WEB SITE
Medical		
<i>(To request a free paper copy of the SBC and glossary, please contact each health plan directly.)</i>		
• Anthem Blue Cross	877-737-7776	www.anthem.com/ca/calpers
• Blue Shield	800-334-5847	www.blueshieldca.com/calpers
• Kaiser Permanente	800-464-4000	www.kp.org/calpers
• UnitedHealthcare Alliance	Active: 877-359-3714 Retirees: 888-867-5581	www.uhc.com/calpers
• Peace Officers Research Association of California (PORAC)	800-288-6928	www.ibtofporac.org
• PERS Platinum, PERS Gold	800-334-5847	www.blueshieldca.com/calpers
• Health Net	888-926-4921	www.healthnet.com/calpers
• Sharp	855-995-5004	https://calpers.sharphealthplan.com
Dental		
• MetLife	800-942-0854	www.metlife.com
Vision		
• EyeMed	866-939-3633	www.eyemed.com
• United Health Care - Spectera	866-414-1959	www.uhc.com
Employee Assistance Program (EAP)		
• Aetna	800-227-1060	resourcesforliving.com Username: El Monte Password: EAP
Basic Life / AD&D		
• The Hartford	800-523-2233	www.thehartford.com
Long Term Disability (LTD)		
• Metlife	800-438-6388	www.metlife.com
Flexible Spending Accounts (FSA), Dependent Care		
• McGriff	800-768-4873	www.mcgriff.com/flex
Voluntary Benefits, Worksite Benefits, and Pet Insurance		
• MetLife	800-438-6388	www.metlife.com
Deferred Compensation		
• Nationwide Guadalupe Ayala	Customer Service: 877-677-3678 Cell: 626-742-0710	ayalag2@nationwide.com
<p>McGriff Journey App <i>(Access valuable benefits and resources in a mobile-friendly way)</i></p> 		

INTRODUCTION

At the City of El Monte, we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each and every employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available.

Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

In order to activate your benefits, complete and submit the following:

- CalPERS Beneficiary Designation Form
- Enroll online via the City's benefits portal, Beacon
- Meet with an Enrollment Counselor
- **If covering dependent(s):** deliver or upload required documents to HR. (documents listed on page 6).

ENROLLMENT AND BENEFIT CHOICES

The City recognizes that your benefits are an important part of the reason you choose to work here. The City provides high quality benefits at a reasonable cost to you. You can choose between different medical plans to meet your individual and family needs. Since you have some choices to make, it is important to understand the various programs. That is why this Benefits Guide is being provided to you. Benefits provided by the City for eligible employees include a choice of CalPERS medical plans, dental plans, vision plans, group life insurance coverage, group disability and optional voluntary benefits.

You have 60 days from the date of your initial appointment to enroll or decline coverage for yourself and eligible family members. Benefits will begin on the 1st of the month after you submit your paperwork and appropriate documentation to the Human Resources Department. If you do not enroll during the initial 60 days, you will be subject to a waiting period until the following open enrollment period.

Any questions you may have regarding the enclosed information can be referred to the corresponding representative listed in the contact information found at the beginning of this guide.



ELIGIBILITY AND ENROLLMENT

WHO IS ELIGIBLE FOR BENEFITS?

Employees

All regular City of El Monte employees working full time, 40 hours per week, may be eligible for benefits. If you are enrolling as a new employee most benefits are effective the 1st of the month following your date of hire. You may also choose to enroll your eligible dependents in many of our benefits.

Spouse (includes same sex domestic partner) and eligible dependent children to age 26 are covered for most plans. Contact the Human Resources Department for specific plan details.

Family Members

The terms “family member” and “dependent” are used interchangeably. Eligible family members include:

- Spouse
- Registered domestic partner
- Children (natural, adopted, domestic partner’s, or step) up to age 26
- Children, up to age 26, if the employee or annuitant has assumed a parent-child relationship and is considered the primary care parent
- Certified disabled dependent children age 26 and older

WHO IS NOT ELIGIBLE FOR THE CALPERS HEALTH PROGRAM?

Ineligible Employees

- Those whose job classification is “Limited-Term/ Intermittent/part-time” (seasonal or temporary)
- Those whose appointment lasts less than six months

Ineligible Family Members

- Former spouses/former registered domestic partners
- Children age 26 and older
- Disabled children over age 26 who were never enrolled or who were deleted from coverage
- Children of a former spouse/former registered domestic partner
- Grandparents
- Parents

DO NOT ENROLL INELIGIBLE FAMILY MEMBERS

It is against the law to enroll ineligible family members.

If you do so, CalPERS will retroactively cancel the enrollment, and you may have to pay all costs incurred by the ineligible person from the date the coverage began.

WHERE TO GET HELP WITH YOUR HEALTH BENEFITS ENROLLMENT

All benefit changes must be done on the through Human Resources.

Once you retire, CalPERS becomes your Health Benefits Officer. As a retiree, you may make changes to your health plan in any of the following ways:

- **Online through my | CalPERS at:**
my.calpers.ca.gov during Open Enrollment
- **By writing to us at:**
P.O. Box 942715
Sacramento, CA 94229-2715
- **By calling us toll free at:**
[888-CalPERS](tel:888-CALPERS) (or [888-225-7377](tel:888-225-7377)).

For general information about health benefits, go to the CalPERS website at www.calpers.ca.gov. The chart on page 6 indicates the forms and supporting documentation needed for most changes.

Spouse

You may add your spouse to your health plan within 30 days of your marriage. You are required to provide a copy of the marriage certificate and the spouse’s Social Security Number and Medicare card (if applicable). Your spouse’s coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

ELIGIBILITY AND ENROLLMENT (CONTINUED)

REGISTERED DOMESTIC PARTNER

You may add your registered domestic partner to your health plan within 30 days of registration of the domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

To add a domestic partner to your health plan, you must register your domestic partnership through the California Secretary of State's Office or equivalent office from another state. Upon registration, that office will provide you with a Declaration of Domestic Partnership.

CalPERS requires that you submit a copy of the approved Declaration of Domestic Partnership, the domestic partner's Social Security number, and a copy of their Medicare card (if applicable).

Same sex domestic partnerships between persons who are both at least age 18 and certain opposite sex domestic partnerships (one partner must be 62 years of age or older and the other partner at least 18 years of age) are eligible to register with the Secretary of State. For more information about domestic partnership registration, visit the Secretary of State's website at www.sos.ca.gov.

CHILDREN

Natural-born, adopted, domestic partners, and stepchildren who are under age 26 may be added to your health plan, as outlined below:

- Newborn children should be added within 30 days of birth. Coverage is effective from the date of birth.
- Newly adopted children should be added within 30 days of physical custody. Coverage is effective from the date physical custody is obtained.
- Stepchildren or a domestic partner's children under age 26 can be added within 30 days after the date of your marriage or registration of your domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

DISABLED CHILDREN OVER AGE 26

A child age 26 and over who is incapable of self-support because of a mental or physical condition may be eligible for enrollment. The disability must have existed prior to reaching age 26 and continuously since age 26, as certified by a licensed physician. You are required to complete and submit the Member Questionnaire for the CalPERS Disabled Dependent Benefit form, and the physician must complete and submit a Medical Report for the CalPERS Disabled Dependent Benefit form for

CalPERS approval. The initial certification of the Disabled Dependent must occur during one of the following two eligibility periods (whichever applies):

- Within 30 days before and ending 30 days after the child's 26th birthday (member and dependent currently enrolled), *or*
- Within 30 days of a newly eligible employee's initial enrollment in the CalPERS Health Program

Upon certification of eligibility, the dependent's coverage must be continuous and without lapse. You will be required to submit an updated questionnaire and medical report for re-certification periodically, upon request.

Note: If the disabled child has a Social Security approved disability, you must provide CalPERS with a copy of his or her Medicare card.

DEPENDENTS IN A PARENT-CHILD RELATIONSHIP

A child other than an adopted, step, or recognized natural child up to age 26 may be added to your health plan if you have assumed parental status or assumed the parental duties as certified at the time of enrollment of the child, and annually thereafter up to the age of 26.

You have 30 days from the date you obtained custody of the child to enroll him or her on your health plan. Prior to enrollment of a dependent who is in a parent-child relationship, you must complete and submit an Affidavit of Parent-Child Relationship. You will be required to provide supporting documentation as indicated on the Affidavit of Parent-Child Relationship. Coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

ELIGIBILITY AND ENROLLMENT (CONTINUED)

For dependents under the age of 19, the annual re-certification will require a copy of the first page of your income tax return from the previous year listing the child as a tax dependent. In lieu of a tax return, for a time not to exceed one tax filing year, you may submit other documents that substantiate the child's financial dependence.

For dependents from age 19 up to age 26, the annual re-certification requires: A copy of the first page of your income tax return from the previous tax year listing the child as a tax dependent; or Documents that substantiate that the child is financially dependent, provided that the child: either lives with you for more than 50 percent of the time, or is a full-time student; and, is dependent upon you for more than 50 percent of his or her support.

SPLIT ENROLLMENTS

When two active or retired members are married to each other or in a domestic partnership, each member can enroll separately. However, when these individuals enroll in a CalPERS health plan in their own right, one parent must carry all dependents on one health plan. Parents cannot split enrollment of dependents. CalPERS will retroactively cancel split enrollments. You may be responsible for all costs incurred from the date the split enrollment began.

ENROLLING IN TWO CALPERS HEALTH PLANS

Dual CalPERS coverage occurs when you are enrolled in a CalPERS health plan as both a member and a dependent or as a dependent on two enrollments. This duplication of coverage is against the law. When dual CalPERS coverage is discovered, the enrollment that caused the dual coverage will be retroactively canceled. You may be responsible for all costs incurred from the date the dual coverage began.

Members may enroll in both a CalPERS health plan and a health plan provided through another employer. For example, a spouse may enroll in a CalPERS plan and in the plan from his or her private employer. In this case, the two plans may coordinate benefits.

ENROLLMENT TYPE	COPIES OF SUPPORTING DOCUMENTATION
Active employee – New enrollment	<ul style="list-style-type: none"> ID, Social Security Card
Adding a registered domestic partner	<ul style="list-style-type: none"> Declaration of Domestic Partnership from the California Secretary of State's Office Medicare card <i>(if applicable)</i>
Adding a spouse	<ul style="list-style-type: none"> Marriage Certificate,* Social Security Card and Medicare card <i>(if applicable)</i> ID
Adding a dependent who is in a parent-child relationship (PCR)	<ul style="list-style-type: none"> Required supporting documentation as indicated on the Affidavit of Parent-Child Relationship.
Adding/deleting a dependent child	<ul style="list-style-type: none"> Medicare card <i>(if applicable)*</i> Reason for add/delete Birth Certificate, social security card(s)
Changing plans due to address change	<ul style="list-style-type: none"> Include both old and new addresses
Deleting a registered domestic partner due to termination of partnership	<ul style="list-style-type: none"> Termination of Domestic Partnership submitted to the California Secretary of State's Office
Deleting a spouse due to divorce	<ul style="list-style-type: none"> Divorce Decree
Disabled child over age 26 – certification	<ul style="list-style-type: none"> Member Questionnaire for the CalPERS Disabled Dependent Benefit form Medical Report for the CalPERS Disabled Dependent Benefit form
Enrolling self or dependents due to loss of other health coverage	<ul style="list-style-type: none"> Certificate of Creditable Coverage, or other proof of loss of coverage Birth Certificate and Social Security Card(s) <i>(Child)</i> Marriage Certificate, ID and Social Security Card <i>(Spouse)</i> Declaration of Domestic Partnership <i>(domestic partner)</i>

ELIGIBILITY AND ENROLLMENT (CONTINUED)

LIFE CHANGES AND THEIR IMPACT ON BENEFITS

Outside of the annual open enrollment period, an employee may change an enrollment election (i.e., add or delete dependents, change level of **coverage**) only if there has been a “major life event.”

NAME OR ADDRESS CHANGES

If you move or change your name or contact information for any reason, including Marriage or Divorce, you must change your name through your employer. That way you will receive all your benefit information in a timely manner.

HEALTH BENEFITS COVERAGE

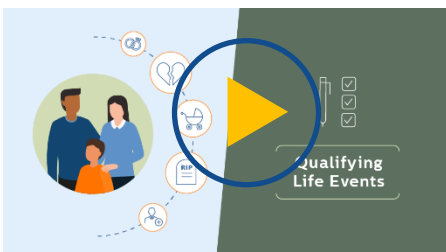
Since you must choose a CalPERS health plan that provides coverage in your work or home ZIP code, a change in your address could mean you have to change plans. You can use our Health Plan Search by ZIP Code online service to see what plans are available in your new ZIP code.

MARRIAGE

Retirement Impact – Your marriage revokes a designation you may have on file. In most instances, you must be married for at least one year prior to your retirement date for survivor benefits to be payable to your spouse. Review your beneficiary designation. If you need to make changes, log in to your myCalPERS account to make changes online or complete the appropriate designation form.

You should also consider establishing a **CalPERS Special Power of Attorney** or reviewing your current one. Read the **CalPERS Special Power of Attorney (PUB 30)** (PDF) publication for more information.

Health Benefits Coverage – Contact Human Resources as soon as possible to add your new spouse and any stepchildren to your health coverage. Your employer will need a copy of your marriage certificate and new spouse’s Social Security number, as well as birth certificates and social security cards for stepchildren.



Click to the left to watch a video on Qualifying Life Events

DIVORCE

Retirement Impact – Your CalPERS benefits are considered community property under California law. To see how this may impact your benefits, review Community Property (PUB38AI PDF) or CalPERS at 888-225-7377.

Your dissolution of marriage revokes a designation you may currently have on file with CalPERS. Review your beneficiary designation. If you need to make changes, log in to your myCalPERS account to make changes online or complete the appropriate designation form.

You may also want to review your current Power of Attorney or consider designating one. Review the **CalPERS Special Power of Attorney (PUB 30)** (PDF) for more information.

Health Benefits Coverage – You must remove your ex-spouse from your health plan as required by California Public Employees’ Retirement Law. Your ex-spouse’s entitlement to coverage ends at midnight on the last day of the month that your marriage dissolution is final.

Contact Human Resources to modify your health plan. Your employer will need a copy of your divorce decree.

REGISTERED DOMESTIC PARTNERSHIP

To find out more about registering a domestic partner, visit the Secretary of State website.

Retirement Impact – Your domestic partnership revokes a designation you may have on file. Review your beneficiary designation. If you need to make changes, log in to your myCalPERS account to make changes online, or complete the appropriate designation form depending on if you’re still working or retired:

Health Benefits Coverage – Contact Human Resources as soon as possible to add your domestic partner and their children to your health coverage. Your employer will need a copy of your certificate of domestic partnership registration.

ELIGIBILITY AND ENROLLMENT (CONTINUED)

TERMINATE DOMESTIC PARTNERSHIP

To find out more about terminating a domestic partnership, visit the Secretary of State website.

Retirement Impact – Your CalPERS benefits are considered community property under California law. To see how this may impact your benefits, review Community Property (PUB 38A) (PDF). CalPERS will need a copy of your property settlement agreement.

The termination of your domestic partnership revokes a designation you may have on file. Review your beneficiary designation. If you need to make changes, log in to your myCalPERS account to make changes online or complete the appropriate designation form.

You may also want to review your current Power of Attorney or consider designating one. Review the CalPERS Special Power of Attorney (PUB 30) (PDF) for more information.

Health Benefits Coverage – You must remove your former domestic partner from your health plan. Their entitlement to coverage ends at midnight on the last day of the month that your partnership termination is final.

Contact Human Resources to have your former domestic partner removed from your health plan. Your employer will need a copy of your termination document.

BIRTH OR ADOPTION

See what details should be taken care of if you have or adopt a child.

Retirement Impact – The birth or adoption of a child revokes a beneficiary designation you may currently have on file. Review your beneficiary designation. If you need to make changes, log in to your myCalPERS account to make changes online, or complete the appropriate designation forms.

Health Benefits Coverage – Contact Human Resources as soon as possible to add your new child to your health coverage. Your employer will need a copy of the birth certificate or adoption papers, and a copy of your new child's Social Security number.

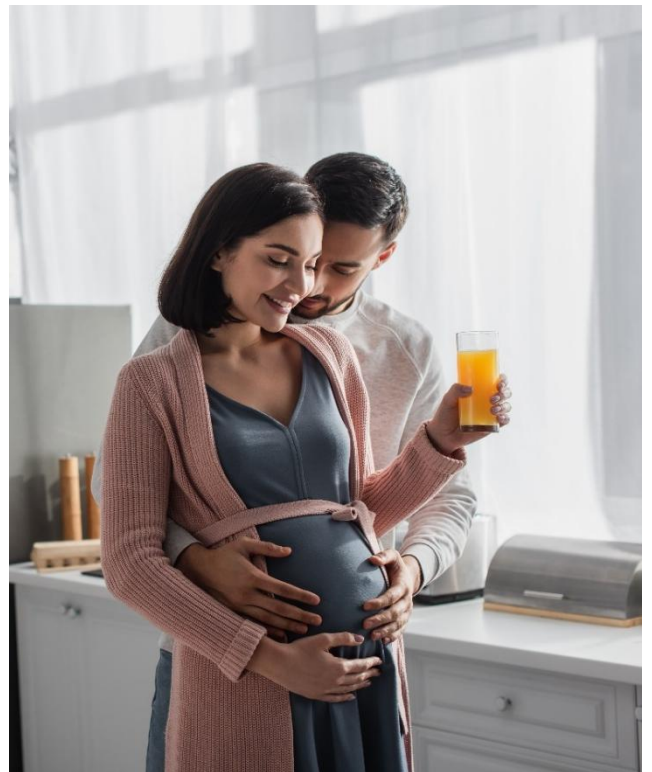
ADDITIONAL DOCUMENTS TO CONSIDER UPDATING/REVIEWING

- 457 Deferred Comp Nationwide Beneficiary
- Checks Recipient Designation
- Emergency Contact

ADDITIONAL ENROLLMENT OPPORTUNITIES

New employees and their dependents may initially enroll in a CalPERS health plan as indicated in the previous sections. Additional enrollment options and guidelines are described below.

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) to improve portability and continuity of health insurance coverage in the group insurance markets. HIPAA requirements for CalPERS took effect in 1998. HIPAA offers two provisions for employees and family members to enroll in CalPERS health plans outside of the initial enrollment period and the Open Enrollment period.



ELIGIBILITY AND ENROLLMENT (CONTINUED)

SPECIAL ENROLLMENT

Special Enrollment refers to certain types of enrollment after your initial enrollment, but outside of the Open Enrollment period. You may need Special Enrollment under the following circumstances:

You lose other health coverage: If you initially declined (or canceled) enrollment for yourself or your dependents (including your spouse) because you had other private or CalPERS health coverage at that time, you may be able to enroll in a CalPERS health plan if the other coverage involuntarily ends. To qualify, you will need to request enrollment within 30 days after the other coverage ends and provide proof that the other coverage has ended.

You have new family members: When you enroll, you must enroll yourself or yourself and all eligible family members. If you later have a new dependent as a result of marriage, domestic partnership registration, birth, change of custody, adoption, or placement for adoption, you may enroll yourself and all eligible dependents within 30 days of that event.

The effective date for a Special Enrollment is the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

LATE ENROLLMENT

If you decline or cancel enrollment for yourself or your dependents and the Special Enrollment exceptions do not apply, your right to enroll (or add dependents) will be limited. You will have to wait until the next CalPERS Open Enrollment period. The earliest effective date of enrollment will be January 1st following the Open Enrollment period.



HOW TO ENROLL ONLINE

ACCESSING THE BEACON

The below steps will assist you in logging into The Beacon to review your 2026 plan year benefits.

Step 1: Click on the link below to access The Beacon login page:

<https://app.thebeaconselect.com/CityOfElMonte>

You can also copy and paste the above link into your internet browser.

Step 2: Fill in your username and password

In the Employee ID or SSN field please enter your Social Security Number

In the PIN field, please enter the last 4 digits of your SSN and the last 2 numbers of your birth year. For example, if your SSN is 555-69-7896 and you were born on September 1, 1965, you would enter 789665 as your PIN.

Your Benefits Enrollment

To use this website, you must have your employee ID or Social Security Number and your confidential Personal Identification Number (PIN). If you have questions or need help, please contact your Human Resources Department.

Employee ID or SSN:

PIN:

.....

By entering your Employee ID or Username and Personal Identification Number, you are agreeing to the [Terms of Use](#).

[FORGOT PASSWORD](#) [Log in](#)

Step 3: Review your benefit elections.

What would you like to do?

- Change my beneficiary
- Review forms that I signed
- Find a document or form
- Change my PIN

Click on “Change my beneficiary” to review or change your beneficiaries.

Click on “Review forms that I signed” and scroll to the bottom to access your confirmation statement.

CONSIDERING YOUR HEALTH PLAN CHOICES

The City of El Monte offers several different medical plan options; Health Maintenance Organizations (HMO) or Preferred Provider Organizations (PPO) for all full-time employees and their eligible dependents through CalPERS.

Selecting a health plan for yourself and your family is one of the most important decisions you will make. This decision involves balancing the cost of each plan, along with other features, such as access to doctors and hospitals, pharmacy services, and special programs for managing specific medical conditions. Choosing the right plan ensures that you receive the health benefits and services that matter to you.

If you are a new Cal PERS member or you are considering changing your health plan during Open Enrollment, you will need to make two related decisions:

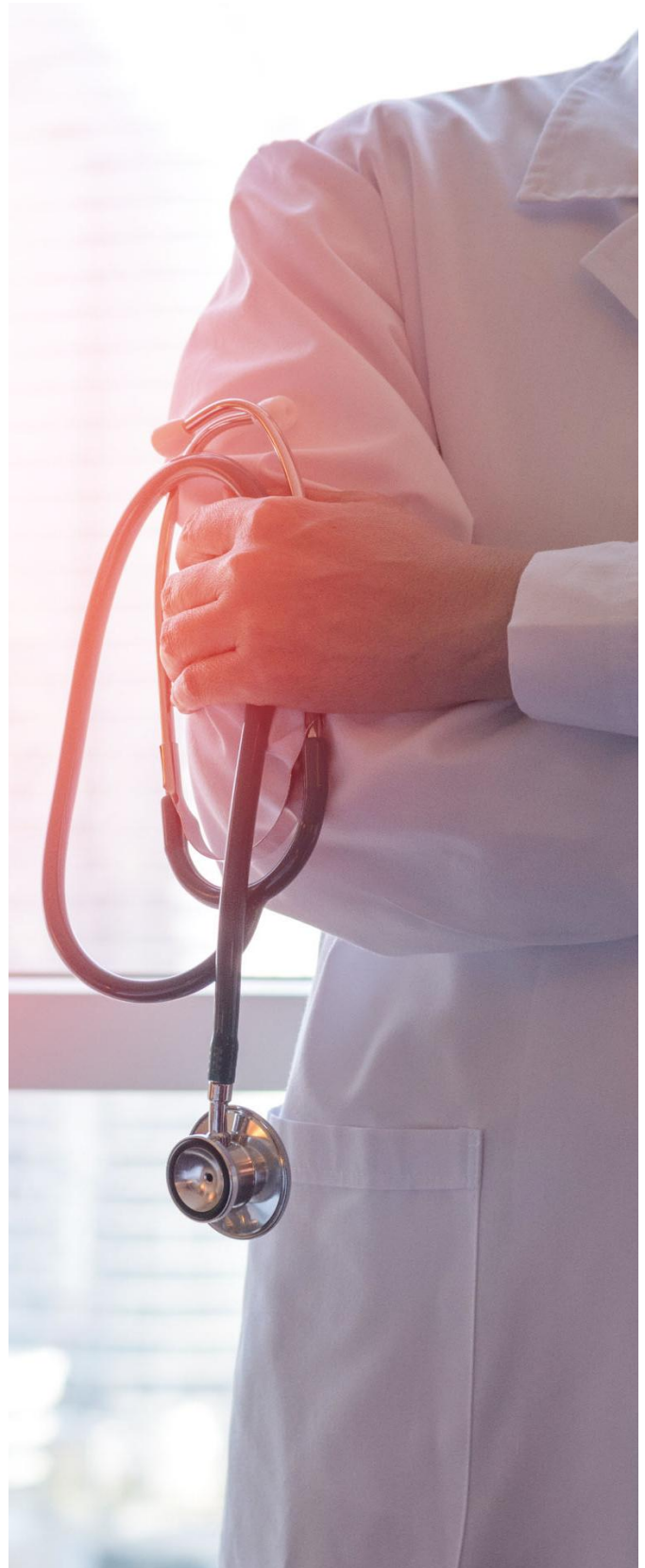
- Which health plan is best for you and your family?
- Which doctors and hospitals do you want to provide your care?

The combination of health plan and providers that is right for you depends on a variety of factors, such as whether you prefer a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO); your premium and out-of-pocket costs; and whether you want to have access to specific doctors and hospitals.

We realize that comparing health plan benefits, features, and costs can be complicated. This section provides information that can simplify your decision-making process. As you begin that process, the following are some questions you should ask:

- **Do you prefer to receive your health care from an HMO or PPO?** Your preference will impact the plans available to you, your access to health care providers, and how much you pay for certain services. See the chart on the next page for a summary of the differences among plan types¹.
- **What are the costs (premiums, co-payments, deductibles, and coinsurance)?**
- **Does the plan provide access to the doctors and hospitals you want?** Contact health plans directly for this information. See the “Health Plan Directory”

1. Note that in a few counties where access to HMOs is limited, a third option, Exclusive Provider Organization (EPO), is available. An EPO provides benefits similar to an HMO with PPO features.



UNDERSTANDING HOW CALPERS HEALTH PLANS WORK

The following chart will help you understand some important differences among health plan types.

FEATURES	HMO	PPO
Accessing health care providers	<ul style="list-style-type: none"> Contracts with providers (<i>doctors, medical groups, hospitals, labs, pharmacies, etc.</i>) to provide you services at a fixed price 	<ul style="list-style-type: none"> Gives you access to a network of health care providers (<i>doctors, hospitals, labs, pharmacies, etc.</i>) known as preferred providers
Selecting a primary care physician (PCP)	<ul style="list-style-type: none"> Most HMOs require you to select a PCP who will work with you to manage your health care needs¹ 	<ul style="list-style-type: none"> Does not require you to select a PCP
Seeing a specialist	<ul style="list-style-type: none"> Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests 	<ul style="list-style-type: none"> Allows you access to many types of services without receiving a referral or advance approval
Obtaining care	<ul style="list-style-type: none"> Generally, requires you to obtain care from providers who are a part of the plan network Requires you to pay the total cost of services if you obtain care outside the HMO's provider network without a referral from the health plan (<i>except for emergency and urgent care services</i>) 	<ul style="list-style-type: none"> Encourages you to seek services from preferred providers to ensure your coinsurance and co-payments are counted toward your calendar year out-of-pocket maximums² Allows you the option of seeing non-preferred providers, but requires you to pay a higher percentage of the bill³
Paying for services	<ul style="list-style-type: none"> Requires you to make a small co-payment for most services 	<ul style="list-style-type: none"> Limits the amount preferred providers can charge you for services Considers the PPO plan payment plus any deductibles and co-payments you make as payment in full for services rendered by a preferred provider

1. Your PCP may be part of a medical group that has contracted with the health plan to perform some functions, including treatment authorization, referrals to specialists, and initial grievance processing.
2. Once you meet your annual deductible and co-insurance, the plan pays 100 percent of medical claims for the remainder of the calendar year; however, you will continue to be responsible for co-payments for physician office visits, pharmacy, and other services, up to the annual out-of-pocket maximum.
3. Non-preferred providers have not contracted with the health plan; therefore, you will be responsible for paying any applicable member deductibles or coinsurance, plus any amount in excess of the allowed amount



Click above to watch a video on Health Maintenance Organizations (HMO)



Click above to watch a video on Preferred Provider Organizations (PPO)



Click above to watch a video on PPO vs HMO

RATES

GROUP INSURANCE PLAN – HEALTH, DENTAL AND VISION

Employees and their qualified dependents become eligible on the first day of the month following month of hire.

INSURANCE PLAN	MONTHLY		
	SINGLE	2-PARTY	FAMILY
MEDICAL RATES			
Region 2 - Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura			
Anthem Select	\$1,016.32	\$2,032.64	\$2,642.43
Anthem Traditional	\$1,158.26	\$2,316.52	\$3,011.48
Blue Shield Access+	\$1,052.89	\$2,105.78	\$2,737.51
Blue Shield Trio	\$936.58	\$1,873.16	\$2,435.11
Health Net Salud y Más	\$879.57	\$1,759.14	\$2,286.88
Kaiser CA	\$987.69	\$1,975.38	\$2,567.99
Sharp	\$916.20	\$1,832.40	\$2,382.12
UnitedHealthcare Alliance	\$950.99	\$1,901.98	\$2,472.57
UnitedHealthcare Harmony	\$857.14	\$1,714.28	\$2,228.56
PERS Platinum	\$1,426.24	\$2,852.48	\$3,708.22
PERS Gold	\$956.28	\$1,912.56	\$2,486.33
PORAC	\$1,057.00	\$2,127.00	\$2,708.00
Region 3 - Los Angeles, Riverside, and San Bernardino			
Anthem Select	\$962.68	\$1,925.36	\$2,502.97
Anthem Traditional	\$1,128.53	\$2,257.06	\$2,934.18
Blue Shield Access+	\$917.91	\$1,835.82	\$2,386.57
Blue Shield Trio	\$852.56	\$1,705.12	\$2,216.66
Health Net Salud y Más	\$740.11	\$1,480.22	\$1,924.29
Kaiser CA	\$969.05	\$1,938.10	\$2,519.53
UnitedHealthcare Alliance	\$870.76	\$1,741.52	\$2,263.98
UnitedHealthcare Harmony	\$765.51	\$1,531.02	\$1,990.33
PERS Platinum	\$1,431.81	\$2,863.62	\$3,722.71
PERS Gold	\$960.03	\$1,920.06	\$2,496.08
PORAC	\$1,057.00	\$2,127.00	\$2,708.00

* Blue Shield Trio is only available in select locations. Ensure your zip code and provider are participating prior to selecting this plan.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

2026 RATES: FULL-TIME EMPLOYEES (CONTINUED)

GROUP INSURANCE PLAN – HEALTH, DENTAL AND VISION (CONTINUED)

Employees and their qualified dependents become eligible on the first day of the month following month of hire.

INSURANCE PLAN	MONTHLY			SEMI-MONTHLY		
	EE ONLY	EE+1	FAMILY	EE ONLY	EE+1	FAMILY
Dental Rates						
MetLife DHMO	\$16.82	\$33.64	\$49.59	\$8.41	\$16.82	\$24.80
MetLife DPPO	\$56.70	\$113.63	\$163.08	\$28.35	\$56.82	\$81.54

INSURANCE PLAN	MONTHLY			SEMI-MONTHLY		
	EE ONLY	EE+1	FAMILY	EE ONLY	EE+1	FAMILY
Vision Rates						
EyeMed	\$8.03	\$15.36	\$22.60	\$4.02	\$7.68	\$11.30
UHC Spectera	\$5.52	\$5.52	\$5.52	\$2.76	\$2.76	\$2.76

GROUP TERM LIFE		
	MONTHLY	SEMI-MONTHLY
\$6,000	\$1.53	\$0.77
\$12,000	\$3.06	\$1.53
\$25,000	\$6.38	\$3.19
\$50,000	\$12.75	\$6.38

CAFETERIA CONTRIBUTIONS

The City offers a cafeteria like plan:

- Employee may select any medical health, dental, vision, group term life, and voluntary benefit options.
- Any remaining balance due will be deducted from the employee’s paycheck on a semi-monthly basis.

CAFETERIA CONTRIBUTIONS		
REPRESENTATION	MONTHLY	SEMI-MONTHLY
City Manager/Executives/Elected Officials:	\$1,991.00	\$995.50
PMMA/POA:	\$1,990.33	\$995.17
GMMU/GU:	\$1,991.00	\$995.50

2026 CALPERS – BASIC PLANS

CalPERS Health Plan Benefit Comparison Basic Plans (EPO & HMO)

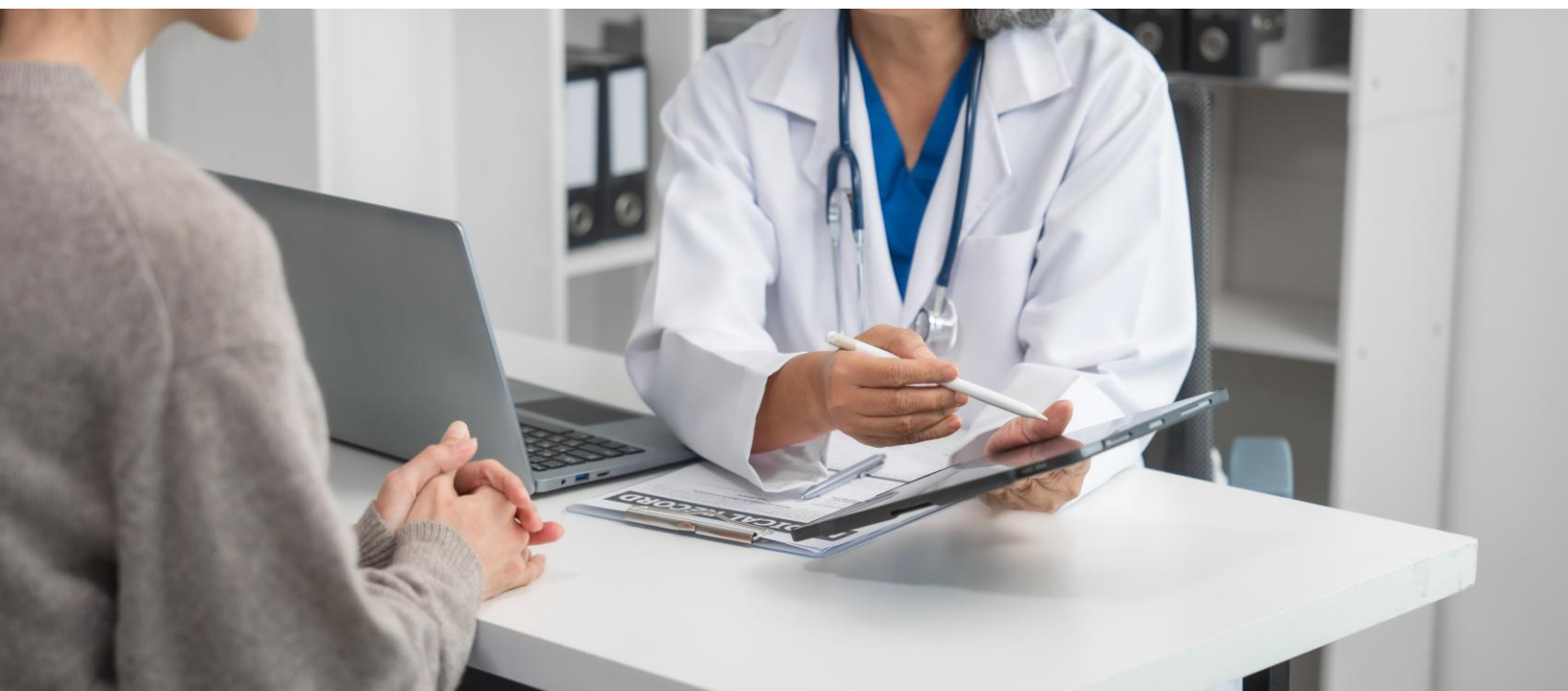
For more details about the benefits provided by a specific plan, refer to that plan's *Evidence of Coverage* (EOC) booklet.
All benefits subject to regulatory approval.

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance & Harmony	Western Health Advantage HMO
Calendar Year Deductible							
Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Copay or Coinsurance (excluding pharmacy)							
Individual	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)
Family	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)
Hospital (Including Mental Health and Substance Abuse)							
Deductible (per admission)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Facility/ Surgery Services	No Charge	No Charge	No Charge	\$15	No Charge	No Charge	No Charge



2026 CALPERS – BASIC PLANS (CONTINUED)

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance & Harmony	Western Health Advantage HMO
Emergency Services							
Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Emergency (copay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Non-Emergency (copay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Physician Services (Including Mental Health and Substance Abuse)							
Office Visits (copay for each service provided)	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Urgent Care Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Surgery/Anesthesia	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-ray/Lab	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge



2026 CALPERS – BASIC PLANS (CONTINUED)

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance & Harmony	Western Health Advantage HMO
Prescription Drugs							
Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Retail Pharmacy (30-day supply)	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50 Tier 4: \$30	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Generic: \$5 Brand: \$20	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50
Retail Preferred Pharmacy Maintenance Medications (90-day supply)	N/A	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100 Tier 4: \$60	N/A	N/A	N/A	N/A	N/A
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100 Tier 4: \$60	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Generic: \$10 Brand: \$40 (31-100 day supply)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100
Mail order maximum copayment per person per calendar year	\$1,000	\$1,000	\$1,000	N/A	\$1,000	\$1,000	\$1,000
Durable Medical Equipment	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge



2026 CALPERS – BASIC PLANS (CONTINUED)

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance & Harmony	Western Health Advantage HMO
Infertility Testing/ Treatment	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges
Occupational / Physical / Speech Therapy							
Inpatient (hospital or skilled nursing facility)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient (office and home visits)	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Diabetes Services							
Glucose monitors	Coverage varies	No Charge	Coverage varies	No Charge	Coverage varies	Coverage varies	Coverage varies
Self-management training	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Acupuncture	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)
Chiropractic	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic combined 20 visits per calendar year)
Pregnancy & Maternity Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge



2026 CALPERS – BASIC PLANS (CONTINUED)

CalPERS Health Plan Benefit Comparison Basic Plans (PPO & Association Plans)

For more details about the benefits provided by a specific plan, refer to that plan's *Evidence of Coverage* (EOC) booklet.
All benefits subject to regulatory approval.

Benefits	PPO Basic Plans				Association Plans					
	PERS Gold		PERS Platinum		CAHP		PORAC		CCPOA	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO		
Calendar Year Deductible										
Individual	\$1,000 ^{1,3}	\$2,500 ³	\$500 ³	\$2,000 ³	N/A		\$300	\$600	N/A	
Family	\$2,000 ^{1,3}	\$5,000 ³	\$1,000 ³	\$4,000 ³	N/A		\$900	\$1,800	N/A	
Maximum Calendar Year Copay or Coinsurance (excluding pharmacy)										
Individual	\$3,000 (coinsurance)	Unlimited	\$2,000 (coinsurance)	Unlimited	\$3,000 (coinsurance)	Unlimited	\$2,000	\$2,000	\$1,500 (copay)	
Family	\$6,000 (coinsurance)	Unlimited	\$4,000 (coinsurance)	Unlimited	\$6,000 (coinsurance)	Unlimited	\$4,000	\$4,000	\$4,500 (copay)	
Hospital (Including Mental Health and Substance Abuse)										
Deductible (per admission)	N/A		\$250		N/A		N/A		N/A	
Inpatient	20% ²	40% ⁴	10%	40% ⁴	10%	Varies	20%	20% ⁴	\$100/admission	
Outpatient Facility/ Surgery Services	20%	40% ⁴	10%	40% ⁴	10%	40% ⁴	20%	20% ⁴	\$50	

- Incentives available to reduce individual deductible (max. \$500) or family deductible (max. \$1,000) include getting a biometric screening (\$100 credit), receiving a flu shot (\$100 credit), getting a non-smoking certification (\$100 credit), getting a virtual second opinion (\$100 credit), and getting a condition care certification (\$100 credit).
- Coinsurance waived for deliveries if enrolled in Included Health's maternity program
- Deductible is not transferable between PERS Gold and PERS Platinum.
- Of the allowable amount as defined in the EOC

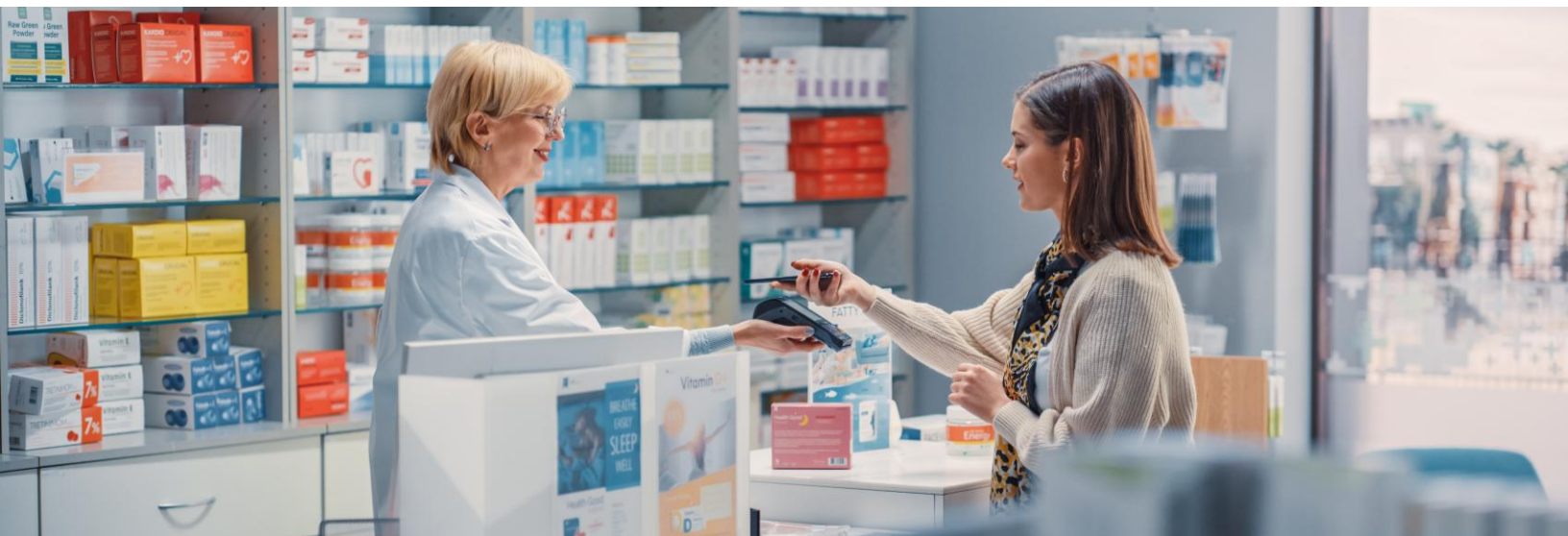
2026 CALPERS – BASIC PLANS (CONTINUED)

Benefits	PPO Basic Plans				Association Plans					
	PERS Gold		PERS Platinum		CAHP		PORAC		CCPOA	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO		
Emergency Services										
Emergency Room Deductible	\$50 (applies to hospital emergency room facility charge only)		\$50 (applies to hospital emergency room charges only)		\$50 (copay reduced to \$25 if admitted on an inpatient basis)		N/A		N/A	
Emergency	20% (applies to other services such as physician, X-ray, lab, etc.)		10% (applies to other services such as physician, X-ray, lab, etc.)		10% (applies to other services such as physician, X-ray, lab, etc.)		20%		\$75	
Non-Emergency	20%	40%	10%	40%	\$50+10%	\$50+40%	50% (for non-emergency services provided by hospital emergency room)		\$75	
	(payment for physician charges only; emergency room facility charge is not covered)		(payment for physician charges only; emergency room facility charge is not covered)		(copay reduced to \$25 if admitted on an inpatient basis)					
Physician Services (including Mental Health and Substance Abuse)										
Office Visits (copay for each service provided)	\$35 ¹	40% ³	\$20 ²	40% ³	\$20 ⁵	10% ³	\$10/\$35 ²	20% ³	\$15	
Inpatient Visits	20%	40% ³	10%	40% ³	10%	40% ³	20%	20% ³	No Charge	
Outpatient Visits	\$35	40% ³	\$20	40% ³	10% ⁵	40% ³	20%	20% ³	\$15	
Urgent Care Visits	\$35	40% ³	\$35	40% ³	\$20 ⁵	40% ³	\$35	20% ³	\$15	
Preventive Services	No Charge	40% ³	No Charge	40% ³	No Charge	40% ³	No Charge		No Charge	
Surgery/Anesthesia	20%	40% ³	10%	40% ³	10%	40% ³	20%	20% ³	No Charge	
Diagnostic X-ray/Lab	20% ⁴	40% ³	10% ⁴	40% ³	10%	40% ³	20%	20% ³	No Charge	

1. Reduced to \$10 when seen by primary physician
2. \$35 for specialist visit
3. Of the allowable amount as defined in the EOC
4. For lab services only – no charge when using Quest Diagnostic or Labcorp.
5. For non-mental health visits only – no charge for visits with a mental health provider

2026 CALPERS – BASIC PLANS (CONTINUED)

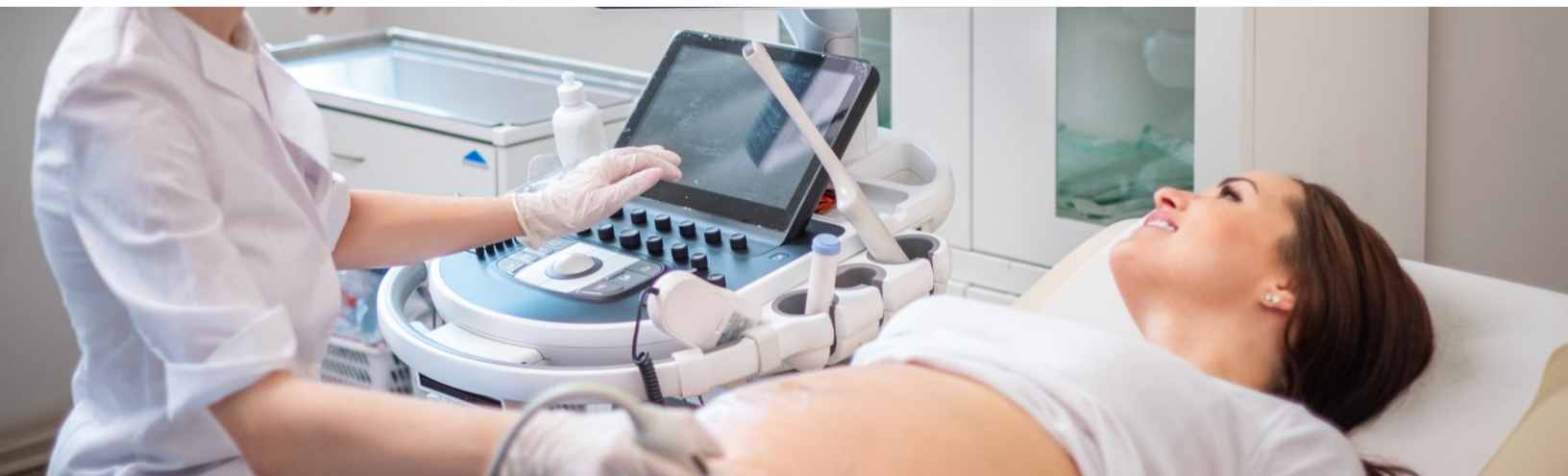
Benefits	PPO Basic Plans				Association Plans				
	PERS Gold		PERS Platinum		CAHP		PORAC		CCPOA
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	
Prescription Drugs									
Deductible	N/A		N/A		N/A		N/A		Tier 2, 3, and 4: \$50 (not to exceed \$150/family)
Retail Pharmacy (30-day supply)	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50		Tier 1: \$5 Tier 2: \$20 Tier 3: \$50		Generic: \$5 Formulary: \$20 Non-Formulary: \$50		Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$45 Compound: \$45		Tier 1: \$10 Tier 2: \$25 Tier 3 and 4: \$50
Retail Preferred Pharmacy Maintenance Medications (90-day supply)	N/A		N/A		Generic: \$10 Formulary: \$40 Non-Formulary: \$100		N/A		Tier 1: \$30 Tier 2: \$75 Tier 3 and 4: \$150
Mall Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100		Tier 1: \$10 Tier 2: \$40 Tier 3: \$100		Generic: \$10 Formulary: \$40 Non-Formulary: \$100		Generic: \$20 Brand Formulary: \$40 Non-Formulary: \$75	N/A	Tier 1: \$20 Tier 2: \$50 Tier 3 and 4: \$100
Mail order maximum copayment per person per calendar year	\$1,000		\$1,000		N/A		N/A		N/A
Durable Medical Equipment	20%	40% ¹	10%	40% ¹	10%	40% ¹	20%	20% ¹	No Charge
	(pre-certification required for specific equipment)		(pre-certification required for the purchase of equipment priced at \$1,000 or more)						



2026 CALPERS – BASIC PLANS (CONTINUED)

Benefits	PPO Basic Plans				Association Plans					
	PERS Gold		PERS Platinum		CAHP		PORAC		CCPOA	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO		
Infertility Testing/ Treatment	50%		50%		Not Covered		50%	50% ²	50% of Allowed Charges	
Occupational / Physical / Speech Therapy										
Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		10%	40%	20%	20% ²	No Charge	
Outpatient (office and home visits)	20%	40%; Occupational therapy: 20%	10%	40%; Occupational therapy: 10%	10%	40%	20%	20% ²	No Charge	
	(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)					
Diabetes Services										
Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies		No Charge	
Self-management training	\$20 ¹	40% ²	\$20 ¹	40% ²	\$20	60% ²	\$20	60% ²	\$15	
	\$15/visit	40% ²	\$15/visit	40% ²	10%	40% ²	20%	20% ²		
Acupuncture	(acupuncture/chiropractic combined 20 visits per calendar year)		(acupuncture/chiropractic combined 20 visits per calendar year)		(acupuncture/chiropractic combined 30 visits per calendar year)		(acupuncture/chiropractic combined 20 visits per calendar year)		N/A	
Chiropractic	\$15/visit	40% ²	\$15/visit	40% ²	10%	40% ²	20%	20% ²	\$15 exam (up to 20 visits per calendar year) chiropractic appliances benefit: \$50	
	(acupuncture/chiropractic combined 20 visits per calendar year)		(acupuncture/chiropractic combined 20 visits per calendar year)		(acupuncture/chiropractic combined 30 visits per calendar year)		(acupuncture/chiropractic combined 20 visits per calendar year)			
Pregnancy & Maternity Care	20%	40%	10%	40%	90%	60%	80%	80%	No Charge	

1. \$35 for specialist visit
2. Of the allowable amount as defined in the EOC



OBTAINING HEALTH CARE QUALITY INFORMATION

Following is a list of resources you can use to evaluate and select a doctor and hospital.

HOSPITALS

CalQualityCare

<https://www.caregiver.org/connecting-caregivers/services-by-state/california/>

From hospitals to home care, [CalQualityCare](https://www.caregiver.org/connecting-caregivers/services-by-state/california/) makes it easy to find providers and compare the quality of health care in California.

U.S. Department Of Health And Human Services

www.medicare.gov/hospitalcompare

Hospital Compare has information about the quality of care at over 4,000 Medicare-certified hospitals across the country.

The Leapfrog Group

www.leapfroggroup.org

This is a coalition of health purchasers who have found that hospitals meeting certain standards have better care results.

DOCTORS AND MEDICAL GROUPS

Medical Board of California

www.mbc.ca.gov

This is the California State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.

Have you done a checkup on your doctor's license? The Medical Board of California encourages consumers to check up on their doctor's license. Such a checkup is simple and helps you make an informed choice when

choosing a doctor. To determine a doctor's status, go to the Medical Board's website at www.mbc.ca.gov or if you do not have a computer, call [800-633-2322](tel:800-633-2322) and Medical Board staff will look up the doctor for you.

Office of the Patient Advocate

www.opa.ca.gov

This website includes a State of California-sponsored "Report Card" that contains additional clinical, and member experience data on HMOs, PPOs and medical groups in California.

Benefit Comparison Charts

The benefit comparison charts on pages 17–24 summarize the benefit information for each plan.

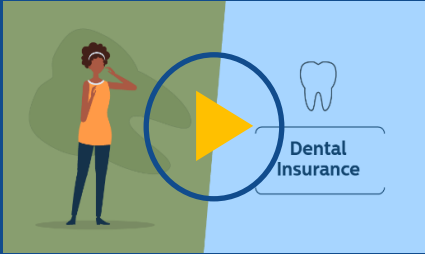
For more details, see each plan's Evidence of Coverage (EOC) booklet.



DENTAL

METLIFE DENTAL PPO PLAN

	PPO PLAN OPTION	
	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible (<i>Individual/Family</i>)	\$50 / \$150	\$50 / \$150
Waived for Preventive	Yes	No
Annual Plan Maximum	\$1,000	\$1,000
Waiting Period	None	None
Reimbursement Schedule	Based on PPO contracted fees	90th UCR
Diagnostic & Preventive	100%	100%
Basic Services	100%	100%
Major Services	50%	50%
Orthodontia Services		
<ul style="list-style-type: none"> Lifetime Plan Maximum 	\$1,500	\$1,500
<ul style="list-style-type: none"> Eligibility 	Adults and dependent children to age 26	



Click to the left to watch a video on Dental Benefits

DENTAL (CONTINUED)

METLIFE MET50 HMO PLAN

The No Problem Plan

- No Deductibles
- No Annual Maximums
- No Limitations on Most Pre-Existing Conditions
- No Waiting Periods to See a Dentist

See Your Savings

Compare your costs with MetLife Met50 HMO to average dental fees:

SAMPLE TREATMENT PLAN	AVG. FEE*	WITH MET50	YOUR SAVINGS
Exams	\$83	No Charge	\$83
Cleanings	\$138	No Charge	\$138
Full Mouth x-rays	\$193	No Charge	\$193
Filling, 1 Surface	\$216	No Charge	\$216
Root Canal, Single	\$1,535	\$30	\$1,505
Crown, PFM	\$1,658	\$50	\$1,608
Total	\$3,823	\$80	\$3,743

	MET50 ALL EMPLOYEES
Diagnostic & Preventive	Various co-pays apply
Basic Services	Various co-pays apply
Major Services	Various co-pays apply
Orthodontia Services	
• Dependent Children	\$1,450
• Adults	\$1,450
• Lifetime Plan Maximum	Unlimited

- 2016 National Dental Advisory Service for 92663

MetLife offers comprehensive dental benefits through hundreds of independently owned and operated dental offices conveniently located throughout California.

SPECIALTY COVERAGE

All general dentists may not be capable of performing each of the services listed herein and based upon a Member's condition, certain procedures may not be within the scope of practice or ability of a general dentist. In such a case, the general dentist will refer the Member to a MetLife participating dental specialist. Your costs for the services of a dental specialist may vary, based upon the coverage option selected by your group.

DENTAL (CONTINUED)

METLIFE MET50 HMO PLAN (CONTINUED)

MET50

The following is a partial list of dental services that are covered benefits, at the specified copayment, when provided by a participating MetLife general dentist. Participating dentists may be found online at www.metlife.com.

SERVICES	YOUR COPAYMENT
Preventive	
• Office visit	No Charge
• Oral examination	No Charge
• Intraoral x-rays, complete series	No Charge
• Bitewing x-rays, single film	No Charge
• Panoramic x-ray	No Charge
• Prophylaxis (<i>teeth cleaning</i>)	No Charge
• Topical fluoride (<i>child</i>)	No Charge
• Oral Hygiene	No Charge
Routine Services	
• Amalgam, One surface	No Charge
• Amalgam, Two surfaces	No Charge
• Amalgam, Three surfaces	No Charge
Restorations	
• Resin, one surface anterior	No Charge
• Resin, two surface anterior	No Charge
• Extraction, single tooth	No Charge
Oral Surgery	
• Surgical removal of erupted tooth	No Charge
• Removal of impacted tooth, soft tissue	\$10
• Removal of impacted tooth, partially bony	\$30
• Surgical incision with drainage of abscess, intraoral soft tissue	\$15
Endodontics	
• Pulp cap, direct	No Charge
• Pulp cap, indirect	No Charge
• Therapeutic pulpotomy	No Charge
• Root canal, anterior	\$45
• Root canal, bicuspid	\$70
• Root canal, molar	\$190
Periodontics	
• Gingivectomy or gingivoplasty, 4 or more contiguous teeth, per quadrant	\$35
• Scaling & root planing, per quadrant	\$12

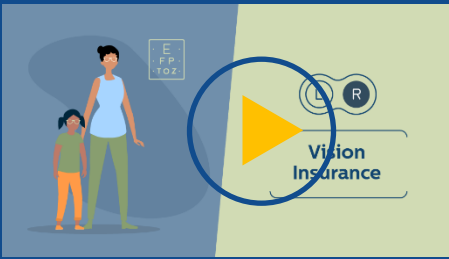
SERVICES	YOUR COPAYMENT
Major	
• Crowns	
– Porcelain fused to base metal (<i>not for molars</i>)	\$50
– Porcelain fused to base metal (<i>for molars</i>)	\$50
• Full cast base metal	\$50
• 3/4 cast metallic	\$50
Dentures & Prosthodontics	
• Complete upper or lower denture	\$100
• Upper or lower partial denture, resin base	\$100
• Upper or lower partial denture, cast metal base with resin saddles	\$100
• Replace missing or broken teeth, complete denture, each tooth	\$10
Implants	
• Surgical placement of implant body (<i>endosteal</i>)	\$1,005
• Prefab. abutment (<i>includes placement</i>)	\$245
• Abutment supported porcelain/ceramic crown	\$685
• Abutment supported retainer, porcelain/ ceramic fixed partial denture	\$680
Orthodontics (Standard 24-month case)	
• Full-banded, upper and lower, to age 19	\$1,450
• Full-banded, upper and lower, adults	\$1,450
• Banded, upper or lower, children & adults	\$250
• Consultation	No Charge
Cosmetic Benefits	
• Tooth colored fillings, one surface, back tooth	\$25
• Labial veneer (<i>porcelain laminate</i>), laboratory	\$350
• Night guards, soft, includes lab fee	\$85

VISION

UHC/SPECTERA AND EYEMED

	UHC BENEFITS - SPECTERA (AVAILABLE TO GENERAL UNIT EMPLOYEES ONLY)		EYEMED	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Co-pay				
• Examination	\$0 co-pay	Up to \$40	\$10 co-pay	Up to \$47
• Materials	\$0 co-pay	Varies by Lens	\$0 co-pay	Varies by Lens
Benefit Frequency				
• Examination		12 months		12 months
• Lenses		12 months		12 months
• Frames		12 months		12 months
• Contacts		12 months		12 months
Lenses				
• Single Vision Lens	\$0 co-pay	Up to \$40	\$0 co-pay	Up to \$48
• Bifocal Lens	\$0 co-pay	Up to \$60	\$0 co-pay	Up to \$69
• Trifocal Lens	\$0 co-pay	Up to \$80	\$0 co-pay	Up to \$85
• Lenticular	\$0 co-pay	Up to \$80	\$0 co-pay	Up to \$125
Contact Lenses				
• Medically Necessary	\$0 co-pay	Up to \$210	\$0 co-pay	Up to \$210
• Elective	\$200 allowance	Up to \$105	\$150 allowance; 15% off balance over \$150	Up to \$150
Frames	\$200 allowance	Up to \$45	\$150 allowance; 20% off balance over \$150	Up to \$105

Remember with EyeMed employees and dependents have access to Freedom Pass! Freedom Pass allows employees and dependents purchasing frames at Target Optical to receive an unlimited frame allowance. Note in order to access benefit employees and/or dependents must present their “buck slip” with coupon code, see HR for a Freedom Pass.



Click above to watch a video on Vision Benefits





BASIC LIFE & AD&D

BASIC LIFE AND AD&D

The City of El Monte provides full-time employees with the option to enroll in Basic Life and Accidental Death and Dismemberment Insurance at the employee's cost. Coverage options range from \$6,000 to \$50,000, with no medical history required.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

Supplemental life insurance can provide your dependents with a lifetime of financial security, and upon your death, can be used to pay off your debts- like credit cards and your mortgage - or other expenses that could burden your family.

What is Accidental Death & Dismemberment Insurance?

It is similar to regular Life insurance. If you die in an accident, your beneficiary will receive the amount of your AD&D coverage in addition to your Life Insurance benefit. Part of the benefit may be paid to you if you lose a limb or the ability to see. For more information about accident insurance, please see your Summary Plan Description.

Don't Forget to Name a Beneficiary

A beneficiary is the person or persons who will be paid if you die while covered by the plan. A person becomes your beneficiary only if you have named them when you enrolled. If you are married and not naming your spouse as the beneficiary, the spouse must sign an acknowledgement. You may change your beneficiary at any time by completing a Change Form in Human Resources.

BASIC LIFE & AD&D (CONTINUED)

BASIC LIFE AND AD&D - PAID FOR BY THE EMPLOYEE

	THE HARTFORD ALL EMPLOYEES	MONTHLY
Life and AD&D		
• Employee		
– Class 1:	\$6,000	\$1.53
– Class 2:	\$12,000	\$3.06
– Class 3:	\$25,000	\$6.38
– Class 4:	\$50,000	\$12.75
Dependent Life (Optional)		
• Spouse (cost is per unit)	\$1,500	\$0.60
• Child (cost is per unit)	\$1,500	\$0.60
• Applies to Both Life and AD&D	No	N/A
Reduction of Benefits		
• Age 70 and Older	50%	N/A

ADDITIONAL SUPPLEMENTAL LIFE & AD&D - PAID BY THE EMPLOYEE

	METLIFE ALL EMPLOYEES
Life/AD&D Benefit Amount	
• Employee	Multiples of \$5,000 to \$500,000
• Spouse	Multiples of \$5,000 to \$250,000 (not to exceed employee's benefit)
• Child	Increments of \$5,000 up to \$10,000
Reduction of Benefits	
• Age 70 and Older	50%



457 DEFERRED COMPENSATION PLAN

The City of El Monte's 457 Plan offers you the opportunity to defer a specific amount of your paycheck on a pretax basis through a payroll deduction. It's a great way to save for your retirement years! Taxes are deferred until withdrawal. Like a 401(k), your money grows tax deferred until retirement when it is taxed as ordinary income when withdrawn.

Nationwide Retirement Solutions

Guadalupe (Lupita) Ayala | 818-798-8159 | ayalag2@nationwide.com | www.NRSforu.com

CalPERS RETIREMENT SYSTEM

SERVICE RETIREMENT

Your retirement formula is determined by your employer's contract with CalPERS. Your benefit factor is the percentage of pay to which you are entitled for each year of service. It is determined by your age at retirement and the retirement formula that was contracted by the City of El Monte with CalPERS. Contact your Human Resources or CalPERS to determine your retirement formula.

RETIREMENT FORMULAS

	TIER I*	TIER II**
Local Miscellaneous	2% @ 55	2% @ 62
Local Safety	3% @ 50	2.7% @ 57

* Annuity based on employee's highest paid year

** Annuity based on average of employee's three (3) highest paid consecutive years

California Public Employees' Retirement System

[888-225-7377](tel:888-225-7377) | www.calpers.ca.gov

PUBLIC AGENCY RETIREMENT SYSTEM (PARS)

SERVICE RETIREMENT

Unit employees hired on or before July 1, 2008, may be eligible to participate in PARS. The PARS benefit is for City of El Monte service only. In order to be eligible for the PARS benefit, the employee must have at least five (5) years' service as a regular employee of the City of El Monte and retire immediately thereafter. This supplemental retirement benefit provides a "3% @ 55" Formula through a "1% @ 55" formula furnished by PARS, coupled with the "2% at 55" formula furnished by CalPERS.

RETIREMENT FORMULAS

	TIER I
Local Miscellaneous	1% @ 55

Public Agency Retirement System (PARS)

[800-731-7884](tel:800-731-7884) | www.pars.org

MCGRIFF EMPLOYEE BENEFIT SOLUTIONS

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts are great cost savings tools to help with common medical expenses not covered by your major medical insurance and/or dependent care expenses. You can elect a portion of your pay to be deducted, on a pre-tax basis, from each paycheck to use for reimbursement of qualified out-of-pocket expenses throughout the plan year.

Flexible Spending Account Savings Example

WITH FSA		WITHOUT FSA
\$30,000	Annual Gross Income	\$30,000
- \$2,400	Healthcare FSA Election	\$0
- \$2,500	Dependent Care Account Election	\$0
\$25,100	Taxable Gross Income	\$30,000
- \$5,020	Estimated Federal Tax (20%)	- 6,000
- \$1,920.15	Estimated FICA (7.65%)	- 2,295
\$18,159.85	Annual Net Income	\$21,705
\$0	Cost of Medical Expenses	- \$2,400
\$0	Cost of Dependent Care Expenses	- \$2,500
\$18,159.85	Spendable Income	\$16,805

With an FSA, potential annual savings in this example is: \$1,354.85

By using an FSA to pay for eligible expenses, you can reduce your taxable income which will result in additional spendable income.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (HEALTHCARE FSA)

A Healthcare FSA allows you to allocate money on a pre-tax basis to reimburse yourself for qualified medical expenses for you and your family. Qualified expenses include anything from co-payments, medical deductibles, prescriptions and much more.

- **Maximum Annual Election:** Internal Revenue Code allows up to \$3,400 per plan year, but your employer will determine amount.
- **Carryover:** You are allowed to carryover \$680 of unused fund over to the following year.

Examples of Eligible Expenses for Healthcare FSA

- Copays/coinsurance Deductibles
- Dental treatments
- Diabetic supplies
- Prescription drugs and medicines
- Eye exams, eyeglasses, contact lenses, contact lens solution and enzyme Flu shots
- Immunizations
- Lab fees
- Laser/Lasik/RK surgery
- Medical exams
- Orthodontia
- Psychiatric care
- Wheelchair
- X-rays

For a more information, please visit
www.mcgriff.com/flex

MCGRIFF EMPLOYEE BENEFIT SOLUTIONS

(CONTINUED)

BENEFITS DEBIT CARD

McGriff will provide a Benefits Debit Card to all employees who elect to participate in a Healthcare FSA (where offered by your employer.) The debit card gives immediate, convenient access to Healthcare FSA funds at the point of sale for prescriptions, copays, and other common qualified medical expenses. The card can only be used for the Healthcare FSA and is not available for the DCA.

USING YOUR BENEFITS DENTAL CARD

Simply swipe your card like you would with any other credit card. Whether at the doctor's office or the dentist, the amount of your eligible expenses will be automatically deducted from your Healthcare FSA. Save ALL receipts!

CARDS FOR HEALTHCARE FSA CAN BE USED AT:

- Health care related facilities which include:
 - Hospitals, physician offices, dental offices, vision offices; **and**
 - Merchants participating in the Inventory Information Approval System (IIAS).
- The card is for medical expenses only; dependent day care expenses are not eligible.
- The card cannot be used for over-the-counter drugs filled with a prescription. You will need to file a manual claim for these types of expenses.

Snap. Submit. And Go!

When using your Benefits Debit Card to pay for an eligible expense, you may need to retain documentation to verify the expense. The McGriff Benefit Access App makes this easy.

- Snap a photo of the itemized receipt with your phone.
- Submit the photo of the itemized receipts* within the app when you receive notification that a receipt is needed to verify your expense.
- Go! After submitting your verification and its review, you will be able to view the status of your reimbursement within the app.
- *The Internal Revenue Code (IRC) requires proof of the eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.

ACTIVATING YOUR CARD

You will receive your card at your home address and may begin using your card on the first day of your plan year. Your card will need to be activated when you use it for the first time for an eligible expense.

DEPENDENT CARE ACCOUNT (DCA)

A Dependent Care Account allows you to allocate money on a pre-tax basis to reimburse yourself for dependent care expenses that allow you (and your spouse) to work.

Reimbursement is permitted only after the services have been provided and the expense has been paid. As dependent care contributions are withheld from your paycheck and placed into the account, these funds become available for reimbursement requests. Submit the entire amount of your dependent care expense after the care is provided, even if it exceeds your monthly contribution amount, to maximize reimbursement opportunities. This allows you to build up a "pool" of submitted expenses, with pending amounts ready for reimbursement as soon as your next contribution is received and deposited into your account.

- **Minimum Annual Election:** Determined by your employer.
- **Maximum Annual Election: New for 2026** the IRC allows a maximum of \$7,500 per year, the employer may set the maximum equal to or lower than this amount.



MCGRIFF EMPLOYEE BENEFIT SOLUTIONS

(CONTINUED)

EXAMPLES OF ELIGIBLE DEPENDENT CARE EXPENSES

- After-school care or extended day programs Nanny expenses
- Baby-sitter inside or outside participant's household
- Custodial or elder care expenses if the qualifying individual still spends at least 8 hours each day in the employee's household
- Dependent Day Care center* expenses pre-kindergarten/nursery school expense
- Expenses paid to a non-dependent relative of participant to care for the child
- Summer day camp if the primary purpose of the expense is custodial in nature and not educational

* A Dependent Care Center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, regardless of whether the center is run for profit.

Regardless of whether you participate in the Dependent Care Account under the Section 125 Plan or claim the Dependent Care credit on your income tax return, you must provide the Internal Revenue Service with the name, address and taxpayer identification number (TIN) or Social Security number of your dependent care provider(s) by completing either Schedule 2 of Form 1040A or Form 2441 and the current instructions given by the IRS for preparing your annual income tax return. Failure to provide this information to the IRS could result in loss of the pre-tax treatment of your Dependent Day Care FSA contributions or loss of the Dependent Care Tax Credit.

FSA FUND AVAILABILITY

Healthcare FSA

Your full annual election is available to you on the first day of the plan year.

Dependent Care Account

Unlike the Healthcare FSA, the entire elected amount is not available on the first day of the plan year, but rather as contributions are received.

IMPORTANT FSA NOTES:

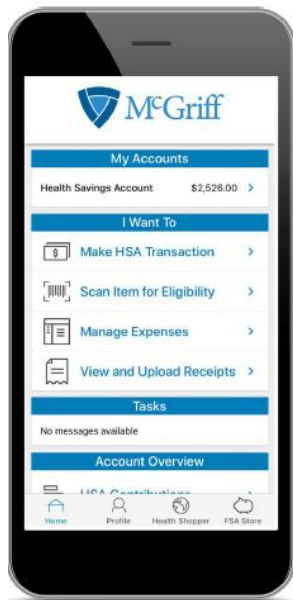
- Participants are generally allowed a 90-day run-off period after the plan year ends to submit claims for expenses that occurred during the plan year but were not yet submitted.
- If you are a new employee entering the FSA during a plan year, reimbursement is only available for expenses and services provided after you begin your participation in the FSA.
- If you are enrolled in the Healthcare FSA and take a leave of absence during the plan year, you may (subject to your employer's plan):
 1. Prepay the contributions on a pre-tax basis, **or**
 2. Continue the contributions by remitting them to your employer. Pre-tax contributions may continue if you continue to receive enough pay, **or**
 3. Prorate the unpaid contributions over the remaining pay periods when you return to work.
- Failure to make all elected contributions will result in termination of your account as of the date contributions ceased.
- Healthcare FSAs must comply with COBRA and generally must offer COBRA continuation rights to qualified beneficiaries who lose Healthcare FSA coverage due to certain qualifying events. For most Healthcare FSAs, COBRA may be offered upon a qualifying event only if you have a balance remaining in your Healthcare FSA. The balance is generally calculated by subtracting the reimbursements made prior to the qualifying event from the annual election. If eligible, you may choose to continue your contributions by either sending your contributions to your employer on an after-tax basis each pay period, or you may choose to make a pre-tax contribution for your remaining elections for the plan year from your final pay or severance pay. Expenses incurred while contributions are being made are eligible for reimbursement. Coverage generally may not continue beyond the current plan year. If you do not elect COBRA, only expenses incurred during the period of employment are reimbursable. Coverage under the Healthcare FSA ceases when the contributions cease.

MCGRIFF EMPLOYEE BENEFIT SOLUTIONS

(CONTINUED)

MOBILE CONVENIENCE

For ultimate convenience, get 24/7 access, direct from your tablet or mobile device with McGriff Benefit Access. Our mobile application allows you to manage your reimbursement accounts and insurance benefits, all from the palm of your hand.



McGriff Benefit Access Features

- Manage claims
- Receive account alerts
- Maintain personal information
- View account balance
- Prepare for enrollment
- Submit receipt documentation

Getting started:

- Download McGriff Benefit Access on your smart device.
- Register using your name, zip code and Social Security Number.

IF YOU ALREADY HAVE AN ONLINE ACCOUNT, YOUR USERNAME AND PASSWORD WILL BE THE SAME FOR MCGRIFF BENEFIT ACCESS.

ONLINE CONTROL

From your laptop or desktop, access all of your McGriff Benefits accounts from one portal.

- Visit and click on www.mcgriff.com/flex button.
- Register using your name, zip code and Social Security Number.

CLAIM. THREE EASY WAYS.

1. Mobile

- Use McGriff Benefit Access to manage your reimbursement accounts

2. Online

- Log in to your account by visiting www.mcgriff.com/flex

3. Mail or fax

- Download a claim form at www.mcgriff.com/flex
- Follow the instructions on the form to mail or fax to us.

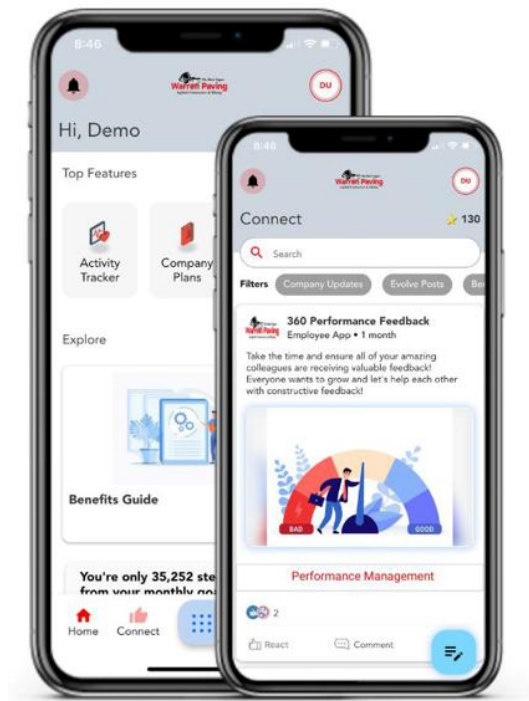
P.O. Box 6400
Greenville, SC 29606
Fax: 252-293-9048

Please allow one business day after you enroll before registering for your account.

MCGRIFF JOURNEY APP

24/7 ACCESS TO YOUR MOST IMPORTANT COMPANY RESOURCES

Navigate your employee journey with the app! This is your one-stop-shop for company resources such as payroll, benefits and more. The app is here to help maximize your benefits and make educated decisions.



All of your **benefits information** and **provider contacts** in one place



Make educated decisions to help you **save money**



Join your community and access **important messages** 24/7



Prioritize your overall **well-being** and reach your goals

Download the app today!



INSTRUCTIONS:

1. Download the app by scanning the QR code.
2. From your computer browser, go to <http://mcgriffjourney.strivebenefits.com/> and click on sign up.
3. Choose email or text to receive a One-Time-Password (OTP)
4. Check your email or mobile device to retrieve your OTP.
5. Enter your OTP, create your new password, and login.



Securely access and set up your account in a few steps.

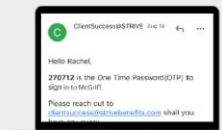
- 1 From your browser, go to [your solution](#) and click sign up.



- 2 Choose email or text to receive a One-Time-Password (OTP)



- 3 Check your email or mobile device to retrieve your OTP.



- 4 Enter your OTP, create your new password, and login.





VOLUNTARY SHORT-TERM DISABILITY INCOME INSURANCE

How do you pay for your mortgage, bills, food and other monthly expenses? If your paycheck stopped today, could you maintain your current lifestyle?

Metlife Short-Term Disability Income Insurance is designed to help protect you if you become disabled and cannot work due to a covered Accidental Injury or Sickness.

How the Plan Works

If you become disabled due to a covered accident or sickness, Short-Term Disability Income Insurance will pay the disability benefit once you have satisfied the elimination period. Your benefit amount is 60% on your pre-disability weekly earnings. The maximum weekly benefit is \$1,500.

Benefits Begin (Elimination Period)

For the Short-Term Disability Income plan, benefits can begin after 14 days. Benefits are payable for a covered Injury or Sickness up to 11 weeks, based on the plan your employer has selected. Refer to your employer’s plan and your Certificate for details regarding benefit amounts and more.

Eligibility

All Active Full-Time Employees working at least 40 hours per week. Applicant’s eligibility for this program may be subject to insurability. It is your responsibility to see the enrollment representative once you have satisfied your employer’s waiting period.

COVERAGE FEATURE	WHAT IT MEANS TO YOU
Benefit Paid Directly to You, Regardless of Other Coverage	Use the money however best fits your financial needs, regardless of other insurance.
Age at Entry	Your premiums will be based on the date your policy becomes effective.
Accidental Death Benefit	Receive a benefit if you die as the direct result of an Accidental Injury and death occurs within 90 days after the date of the Accidental Injury.
Competitive Premiums	Your monthly premiums could be paid with only one hour of a week’s paycheck.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.
Physician Benefit	Receive a benefit if you receive treatment by a Physician due to a covered Injury.
Accidental Death Benefit	Receive a benefit if death occurs as a direct result of an Injury within 90 days after the Injury.
Guaranteed Issue	First-time eligible employees may be able to receive coverage without being subject to insurability.
Age at Entry Premiums	Premiums will be based on the date your policy becomes effective.

Limitations, exclusions, and waiting periods apply. Refer to your policy for complete details. This product is inappropriate for people who are eligible for Medicaid coverage.

METLIFE (CONTINUED)

Long Term Disability Insurance (LTD) can help protect your income if you are unable to work due to a major injury, chronic condition, cancer or extended illness. LTD can help you cover essential living expenses, protect your savings, your home and other assets, and help you avoid having to borrow money from friends or family. Coverage is easily accessible, and the monthly payments are made directly to you. You can use the money for whatever you like, from groceries and gas to your mortgage or rent. While disabilities may be unexpected, they don't have to be financially devastating.

LONG TERM DISABILITY – METLIFE (PAID FOR BY THE CITY)

	METLIFE
Benefit Percentage	Class 1 – 66 2/3% Class 2 – 66 2/3% Class 3 – 60%
Monthly Benefit Maximum	Class 1 – City Manager: \$12,500 Class 2 – Executive: \$10,000 Class 3 – Management Employees and Elected Officials: \$2,100
Minimum Monthly Benefit	\$100
Elimination Period	90 days
Definition of Disability	During the elimination period and the next 24 months, you are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue your Usual Occupation in the usual and customary way. Own Occ is the entire time for this class.
Pre-Existing Conditions Limitations	12 months for conditions treated within the 3 months prior to effective date of coverage

VOLUNTARY LONG TERM DISABILITY – METLIFE (PAID FOR BY THE EMPLOYEE)

	METLIFE
Eligibility	All Active Full Time Employees working at least 40 hours per week
Benefit Percentage	60%
Monthly Benefit Maximum	\$10,000
Minimum Monthly Benefit	\$100
Elimination Period	90 days
Definition of Disability	During the elimination period and the next 24 months, you are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue your Usual Occupation in the usual and customary way.

METLIFE (CONTINUED)

ACCIDENT INSURANCE

Whether a weekend warrior with an active lifestyle or just a busy family, accidents can happen anytime, anywhere, without warning. Being prepared for the unexpected can make all the difference.

MetLife Accident Insurance policy provides you a solution for those unforeseen accidents that life sometimes delivers. Our Accident Insurance is designed to help pay for the unexpected medical expenses an individual may incur for the treatment of covered injuries received in an accident.

Accident Insurance Benefits

With MetLife, you'll have a choice of two plans (called the "Low Plan" and the "High Plan") that provide payments regardless of any other insurance payments you may receive¹. Here are just some of the covered events/services².

Benefit Payment Example

Kathy's daughter, Molly, was riding her bike to school. On her way there she fell to the ground, was knocked unconscious, and was taken to the local emergency room (ER) by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

Covered Event ³	Benefit Amount
Ambulance (ground)	\$400
Emergency Care	\$200
Physician Follow-Up (\$100 x 2)	\$200
Medical Testing	\$200
Concussion	\$500
Broken Tooth (repaired by crown)	\$300
Benefits paid by MetLife Group Accident Insurance	\$1,800

Benefit amount is based on a sample MetLife plan design. Actual plan design and benefits may vary.

Questions & Answers

Q. How do I enroll?

A. Enroll for coverage at Employer website.

Q. Who is eligible to enroll for this accident coverage?

A. You are eligible to enroll yourself and your eligible family members!⁴ You need to enroll during your Enrollment Period and to be actively at work for your coverage to be effective.

Q. How do I pay for my accident coverage?

A. Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?

A. Yes, you can take your coverage with you.⁵ You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Q. Who do I call for assistance?

A. Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST. Or visit our website: mybenefits.metlife.com.

METLIFE (CONTINUED)

HOSPITAL INDEMNITY INSURANCE

Hospital stays can be pricey and often unexpected. Even quality healthcare plans don't cover all expenses, so taking steps to help protect yourself can make a big difference. While in the hospital, you'll likely need various treatments, tests and therapies to get up and about again. Expenses like plan deductibles, co-pays for doctor visits and extra costs for out-of-network care can add up fast. Having help with the financial support you may need when the time comes means less worry for you and your family.

Subcategory	Benefit Limits (Applies to Subcategory)	Benefit	Low Plan	High Plan
Hospital Benefits				
Admission Benefit	4 time(s) per calendar year ¹	Admission	\$500	\$1,000
		ICU Supplemental Admission (Benefit paid concurrently with the Admission benefit when a Covered Person is admitted to ICU)	\$500	\$1,000
Confinement Benefit	31 days per calendar year ICU Supplemental Confinement will pay an additional benefit for 31 of those days	Confinement ⁴	\$100	\$200
		ICU Supplemental Confinement (Benefit paid concurrently with the Confinement benefit when a Covered Person is admitted to ICU)	\$100	\$200
Confinement Benefit for Newborn Nursery Care	3 day(s) per confinement	Confinement Benefit for Newborn Nursery Care ⁵	\$50	\$100
Other Benefits				
Health Screening Benefit ⁷	1 time(s) per calendar year per covered person	Health Screening	\$50	\$50

¹ If a covered person is readmitted within 90 days for the same or related sickness/injury for which we paid an Admission Benefit, an additional Admission Benefit is not payable.

⁴ If the Admission Benefit is payable for a Confinement, the Confinement Benefit will begin to be payable the day after Admission.

⁵ Payable for the period of newborn confinement for a newborn child who is not sick or injured.

⁷ In certain states, the Health Screening Benefit is provided by MetLife Consumer Services as a separate service and is not part of the insurance coverage. This does not impact the Health Screening Benefit's availability, cost, or the way in which the service is accessed. The covered health screenings are: Routine health check-up exam (annual physical exam), biopsies for cancer, blood chemistry panel, blood test to determine total cholesterol, blood test to determine triglycerides, bone marrow testing, breast MRI, breast ultrasound, breast sonogram, cancer antigen 15-3 blood test for breast cancer (CA 15-3), cancer antigen 125 blood test for ovarian cancer (CA 125), carcinoembryonic antigen blood test for colon cancer (CEA), carotid doppler, complete blood count (CBC), chest x-rays, clinical testicular exam, colonoscopy, coronavirus testing, dental exam, digital rectal exam (DRE), Doppler screening for cancer, Doppler screening for peripheral vascular disease, Echocardiogram, electrocardiogram (EKG), electroencephalogram (EEG), endoscopy, eye exam, fasting blood glucose test, fasting plasma glucose test, flexible sigmoidoscopy, hearing test, hemocult stool specimen, hemoglobin A1C, human papillomavirus (HPV) vaccination, immunization, lipid panel, mammogram, oral cancer screening, pap smears or thin prep pap test, prostate-specific antigen (PSA) test, serum cholesterol test to determine LDL and HDL levels, serum protein electrophoresis, skin cancer biopsy, skin cancer screening, skin exam, stress test on bicycle or treadmill, successful completion of smoking cessation program, tests for sexually transmitted infections (STIs), thermography, two hour post-load plasma glucose test, ultrasounds for cancer detection, ultrasound screening of the abdominal aorta for abdominal aortic aneurysms and virtual colonoscopy. For groups situated in CA, the following health screenings are also included: any cervical cancer screening test approved by the federal Food and Drug Administration upon approval by the Covered Person's Physician, a human papillomavirus test that is approved by the federal Food and Drug Administration and any generally medically accepted cancer screening tests approved by the Federal Food and Drug Administration.

Q. How do I enroll?

A. Enroll for coverage at Employer website.

Q. Who is eligible to enroll for this Hospital Indemnity coverage?

A. You are eligible to enroll yourself and your eligible family members. ^c You need to enroll during your Enrollment Period and be actively at work for your coverage to be effective. Dependents to be enrolled may not be subject to a medical restriction as set forth in the Certificate. Some states require the insured to have medical coverage.

Q. How do I pay for my Hospital Indemnity coverage?

A. Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?

A. Yes, you can take your coverage with you. You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer cancels the group policy and offers you similar coverage with a different insurance carrier. ^d

Q. What is the coverage effective date?

A. The coverage effective date is 01/01/2026.

Q. Who do I call for assistance?

A. Please call MetLife directly at 1-800-GET-MET8 (1-800-438-6388) and talk with a benefits consultant. Or visit our website:

www.mybenefits.metlife.com

METLIFE (CONTINUED)

CRITICAL INCIDENT w/ CANCER INSURANCE

Surviving a critical illness, such as a heart attack or stroke, can come at a high price. With advances in technology to treat these diseases, the cost of treatment rises more and more every year. Even with medical insurance, the out-of-pocket expenses associated with a critical illness can affect anyone's finances.

Metlife Critical Illness Insurance can be the solution that helps you and your family focus on recovery and may help you with paying bills. Our plan can assist with the expenses that may not be covered by major medical insurance.

Eligible Individual	Benefit Amount	Requirements
Coverage Options		
Employee	\$10,000, \$15,000, \$20,000, \$30,000, \$40,000, or \$50,000	Coverage is guaranteed provided you are actively at work. ¹
Spouse/Domestic Partner²	50% of the Employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. ¹
Dependent Child(ren)³	50% of the Employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. ¹

Benefit Payment

Your plan pays a lump-sum **Initial Benefit** upon the first verified diagnosis of a Covered Condition. Your plan also pays a lump-sum **Recurrence Benefit⁴** for a subsequent verified diagnosis of certain Covered Conditions as shown in the table below. A Recurrence Benefit is only available if an Initial Benefit has been paid for the same Covered Condition. There is a Benefit Suspension Period that applies to Recurrence Benefits. In addition, there is a Benefit Suspension Period that applies to Initial Benefits for different conditions. Please refer to the table below for the percentage benefit payable for each Covered Condition.

Covered Conditions	Initial Benefit	Recurrence Benefit
Autism Spectrum Disorder Category		
Autism Spectrum Disorder <i>payable for a dependent child for a diagnosis of any severity</i>	25% of Benefit Amount	NONE
Benign Tumor Category		
Benign Brain Tumor	100% of Benefit Amount	100% of Initial Benefit
Cancer Category		
Invasive Cancer	100% of Benefit Amount	100% of Initial Benefit
Non-Invasive Cancer	25% of Benefit Amount	100% of Initial Benefit
Skin Cancer	5% of Benefit Amount, but not less than \$250	100% of Initial Benefit, but not less than \$250
Coronary Artery Disease Category		
Coronary Artery Bypass Graft (CABG) - <i>where surgery involving either a median sternotomy or minimally invasive procedure is performed</i>	50% of Benefit Amount	100% of Initial Benefit
Childhood Disease Category		
Cerebral Palsy	100% of Benefit Amount	NONE
Cleft Lip or Cleft Palate	100% of Benefit Amount	NONE

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. This product is inappropriate for people who are eligible for Medicaid coverage. Group Critical Illness is only offered on an after-tax basis.

METLIFE (CONTINUED)

CRITICAL ILLNESS AND CANCER INSURANCE

Cystic Fibrosis	100% of Benefit Amount	NONE
Diabetes (Type 1)	100% of Benefit Amount	NONE
Down Syndrome	100% of Benefit Amount	NONE
Sickle Cell Anemia	100% of Benefit Amount	NONE
Spina Bifida	100% of Benefit Amount	NONE
Functional Loss Category		
Coma	100% of Benefit Amount	100% of Initial Benefit
Loss of: Ability to Speak; Hearing; or Sight	100% of Benefit Amount	NONE
Paralysis of 2 or more limbs	100% of Benefit Amount	100% of Initial Benefit
Heart Attack Category		
Heart Attack	100% of Benefit Amount	100% of Initial Benefit
Sudden Cardiac Arrest	50% of Benefit Amount	NONE
Infectious Disease Category		
<i>For a benefit to be payable, the covered person must have been treated for the disease in a hospital for 3 consecutive days.</i>		
Bacterial Cerebrospinal Meningitis	25% of Benefit Amount	100% of Initial Benefit
COVID-19	25% of Benefit Amount	NONE
Diphtheria	25% of Benefit Amount	100% of Initial Benefit
Encephalitis	25% of Benefit Amount	100% of Initial Benefit
Legionnaire's Disease	25% of Benefit Amount	100% of Initial Benefit
Malaria	25% of Benefit Amount	100% of Initial Benefit
Necrotizing Fasciitis	25% of Benefit Amount	100% of Initial Benefit
Osteomyelitis	25% of Benefit Amount	NONE
Rabies	25% of Benefit Amount	NONE
Tetanus	25% of Benefit Amount	100% of Initial Benefit
Tuberculosis	25% of Benefit Amount	100% of Initial Benefit
Kidney Failure Category		
Kidney Failure	100% of Benefit Amount	NONE
Major Organ Transplant Category		
Major Organ Transplant <i>For bone marrow, heart, lung, pancreas, and liver</i>	100% of Benefit Amount	NONE
Progressive Disease Category		
ALS	100% of Benefit Amount	NONE
Alzheimer's Disease	100% of Benefit Amount	NONE
Multiple Sclerosis	100% of Benefit Amount	NONE
Muscular Dystrophy	100% of Benefit Amount	NONE
Parkinson's Disease (Advanced)	100% of Benefit Amount	NONE
Systemic Lupus Erythematosus (SLE)	100% of Benefit Amount	NONE
Severe Burn Category		
Severe Burn	100% of Benefit Amount	100% of Initial Benefit
Stroke Category		
Stroke	100% of Benefit Amount	100% of Initial Benefit
Transient Ischemic Attack	10% of Benefit Amount	NONE

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage.** The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected.

METLIFE (CONTINUED)

WHOLE LIFE

Whole Life Insurance can help protect your loved ones for your entire life, not just while you're working. Whole Life Insurance is permanent coverage you own; it can never be cancelled, even if your health changes.¹

Available coverage is subject to certain minimums and maximums summarized in the Lifetime Coverage Limits table below.

Guaranteed Issue maximums are available in the employee's initial period of eligibility by answering "Yes" to the question ("Are you at work on a full-time basis, performing your usual duties?"). After the initial enrollment period guaranteed issue maximums are subject to change.

		Guaranteed Issue	Subject to Medical Evidence of Insurability ²
Proposed Insured	Ages	Defined Benefit Certificates (Min – Max)	Defined Benefit Certificates (Min – Max)
Employee	17-70	\$10,000 - \$200,000	\$105,000 – \$5,000,000

Spouses/Domestic Partners and children.³

		Guaranteed Issue
Proposed Insured	Ages	Defined Benefit Riders (Min – Max)
Spouse/ Domestic Partner	18-70	\$5,000 – \$25,000
Children (15 days- 26 years old)	15 days - 26	\$5,000 – \$10,000*

*Guaranteed Issue available for children at \$5,000-10,000 Face Amount Value only.

- Accelerated Death Benefit for Terminal Illness Rider^{4,6}** Automatically included in all policies at no additional cost. The Accelerated Death Benefit due to Terminal Illness Rider pays up to 80% of the death benefit amount (with any balance payable upon final claim). Conditions and restrictions may apply. Any outstanding loans will reduce the cash value and death benefit.

Frequently Asked Questions

Who is eligible to apply for this coverage?

You, your spouse/domestic partner and children.³

How do I pay for my coverage?

Premiums will be conveniently paid through payroll deduction, so you don't have to worry about writing a check or paying a bill. If you should change jobs or retire before the certificate becomes paid up, you simply pay the monthly premium directly to MetLife by automatic bank draft or monthly bill.

Will my Whole Life Insurance premium increase?

Premiums for employee coverage are guaranteed to remain level until you reach age 70 or 20 years if purchased at age 51+, at which point your coverage will be paid up at an amount equal to 33% of the original face amount.

Can I apply for this coverage without having to answer medical questions or take a medical exam?

Because this coverage is available through your employment, you can qualify for coverage if you are actively-at-work and answer a work status question.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. This product is inappropriate for people who are eligible for Medicaid coverage. The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected.

METLIFE PET INSURANCE



Benefit Overview



Pets make your family whole. Cover them with Pet Insurance.

Help cover the costs of vet visits, accidents, illness and more.

Why is pet insurance important?

Now more than ever, pets are playing a significant role in our lives, and it is important to keep them safe and healthy. **Help make sure your furry family members are protected against unplanned vet expenses for covered accidents or illnesses with MetLife Pet Insurance.**¹

- A small monthly payment can help you prepare for unexpected vet expenses down the road
- More than 6 in 10 pet owners said their pet has had an emergency medical expense²
- 24% of pet parents have credit card or personal loan debt to cover pet health and vet costs³
- Average annual cost for a routine vet visit is **\$212 for a dog** and **\$160 for a cat**; and average annual cost for a surgical vet visit is **\$426 for a dog** and **\$214 for a cat**⁴
- Pet insurance may not cover pre-existing conditions

...so there's no better time than now to protect your furry family members.

To get a quote or enroll go to www.metlife.com/getpetquote or call 1 800 GET-MET8.

What's covered?⁵

- accidental injuries
- illnesses
- exam fees
- surgeries
- medications
- ultrasounds
- hospital stays
- X-rays and diagnostic tests

Coverage⁵ also includes

- hip dysplasia
- hereditary conditions
- congenital conditions
- chronic conditions
- alternative therapies
- holistic care
- and much more!

METLIFE PET INSURANCE (CONTINUED)

Pet Insurance

Pet insurance can help reimburse you for covered unexpected veterinary expenses for your pet.

How does MetLife Pet Insurance¹ work?



Select and enroll in the coverage that's best for you and your pet



Download our mobile app



Take your pet to the vet



Pay the bill and send it with your claim to us via our mobile app, online portal, email, fax or mail



Receive reimbursement⁵ by check or direct deposit if the claim expense is covered under the policy

Why Choose MetLife?

- Flexible product offerings with straightforward pricing and options, group discounts,⁷ customizable limits and deductible savings⁸
- Quick 3-step enrollment and hassle-free claims experience with most claims processed within 10 days⁹
- Multi-channel support options with our experienced team of pet advocates that have been serving pet parents and their communities for more than 15 years¹⁰

To get a quote or enroll, go to www.metlife.com/getpetquote or call 1 800 GET-MET8.

1. Pet Insurance offered by MetLife Pet Insurance Solutions LLC is underwritten by Independence American Insurance Company ("IAIC"), a Delaware Insurance company, headquartered at 485 Madison Avenue, NY, NY 10022, and Metropolitan General Insurance Company ("MetGen"), a Rhode Island Insurance company, headquartered at 700 Quaker Lane, Warwick, RI 02886, in those states where MetGen's policies are available. MetLife Pet Insurance Solutions LLC is the policy administrator authorized by IAIC and MetGen to offer and administer pet insurance policies. MetLife Pet Insurance Solutions LLC was previously known as PetFirst Healthcare, LLC and in some states continues to operate under that name pending approval of its application for a name change. The entity may operate under an alternate, assumed, and/or fictitious name in certain jurisdictions as approved, including MetLife Pet Insurance Services LLC (New York and Minnesota), MetLife Pet Insurance Solutions Agency LLC (Illinois), and such other alternate, assumed, or fictitious names approved by certain jurisdictions.
2. Delfino D. 42% of Millennials Have Been In Debt for Their Pet. LendingTree website. <https://www.lendingtree.com/personal/pet-financing/average-pet-debt/>. Accessed April 22, 2020.
3. Kushner-Hebert K. Americans willing to spend as much on pets' health care as their own. Benefits PRO website. <https://www.benefitspro.com/2019/08/16/americans-willing-to-spend-as-much-on-pets-health-care-as-their-own/?sireturn=20210518161752>. Posted August 16, 2019
4. 2019-2020 APPA National Pet Owners Survey.
5. Provided all terms of the policy are met. Application is subject to underwriting review and approval. Like most insurance policies, insurance policies issued by IAIC and MetGen contain certain deductibles, co-insurance, exclusions, exceptions, reductions, limitations, and terms for keeping them in force. For costs, complete details of coverage and exclusions, and a listing of approved states, please contact MetLife Pet Insurance Solutions LLC.
6. Reimbursement options include: 70%, 80%, 90% and 100%. In addition, there is also a 50% option for MetGen underwritten policies only and a 65% for IAIC underwritten policies only.
7. This discount is not available in Tennessee. This discount is only available to individuals who are eligible members or employees of an entity that has arranged for MetLife to offer pet insurance to its population. (For IAIC underwritten policies, the discount is 10% for Groups > 1000 lives and 5% for Groups 51-999 lives. For MetGen underwritten policies, this discount is 10% for Employer Groups of all sizes and 5% for Associations of all sizes.)
8. Your pet's deductible automatically decreases by \$25 (for IAIC underwritten policies) or \$50 (for MetGen underwritten policies) each policy year that you don't receive a claim reimbursement. May not be available in all states.
9. 80% of claims are processed within 10 days or less.
10. MetLife Pet Insurance Solutions LLC (fka "PetFirst Healthcare, LLC"), a MetLife company, has over 15 years of experience serving pet parents.

DISABILITY & LEAVES OF ABSENCE

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 and applicable state law (collectively, “FMLA”) generally affords eligible employees: (1) the right to leave without pay for up to

a maximum of 12 weeks in 12 months for qualifying circumstances; (2) continuation of health coverage during the leave period at the same cost as during active employment; (3) reinstatement of other benefits upon return from the leave; and (4) restoration of individual’s position or an equivalent one upon return from leave.

FMLA qualifying circumstances include time off: (1) to care for the employee’s child, or placement for adoption or foster care; (2) to care for the employee’s spouse, child or parent who has serious health condition; or (3) for a

serious health condition that renders the employee unable to perform his/her job. The 12-month period used by the City of El Monte to determine an employee’s allowable FMLA leave is the 12-month period measured backward from the date an employee’s FMLA request begins.

PREGNANCY DISABILITY LEAVE (PDL)

All employees, regardless of how long they have been with the City are entitled to Pregnancy Disability Leave for up to four months for each pregnancy. PDL applies when a pregnant woman is disabled by pregnancy, childbirth or related medical conditions according to her health care provider. PDL occurs at the same time as FMLA.

CALIFORNIA FAMILY RIGHTS ACT (CFRA)

The CFRA allows for 12 weeks of unpaid leave for all of the same reasons as FMLA, except CFRA does not include pregnancy or related medical conditions within the definition of a serious health condition. This is the most significant difference between the FMLA and the CFRA. The result is that if a woman’s pregnancy precludes her from performing her job (i.e., her absence from work is medically necessary because she is disabled by pregnancy), she is entitled to FMLA leave and PDL, but no CFRA leave. When the child is born, the woman may choose to remain on Pregnancy Leave until the disability ends and then begin CFRA leave to bond with her newborn.

The distinction between the FMLA and the CFRA does not increase the maximum amount of time a woman may be out of work due to pregnancy. The maximum amount of leave is four months (for PDL/FMLA), plus 12 weeks for CFRA/FMLA leave to care for a newborn.

MILITARY FAMILY LEAVE (MFL)

On 1/28/08, President Bush signed into law the National Defense Authorization Act for FY 2008 (NDAA), Public Law 110-181. Section 585(a) of the NDAA amended the FMLA to provide eligible employees working for covered employers two important new leave rights related to military service:

- 1. New Qualifying Reason for Leave.** Eligible employees are entitled up to 12 weeks of leave for “any qualifying exigency” because a spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. Until “any qualifying exigency” is fully defined, employers are encouraged to provide this type of leave to qualifying employees.
- 2. New Leave Entitlement.** An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to a combined total of 26 weeks of FMLA leave in a single 12-month period to care for the service member. This provision became effective immediately upon enactment. Additional FMLA and Military Family Leave information is available on <https://www.dol.gov/whd/fmla>.

EMPLOYEE ASSISTANCE PROGRAM

AETNA (PAID FOR BY THE CITY)

AETNA EMPLOYEE ASSISTANCE PROGRAM (EAP) ALL EMPLOYEES	
NUMBER OF VISITS	6 SESSIONS PER PERSON PER INCIDENT
Included Services	6 face-to-face counseling session per issue on the following topics:
	<ul style="list-style-type: none"> • Depression, anxiety and stress • Substance abuse • Relationship problems • Workplace conflicts • Home maintenance referrals • Living with chronic health conditions • Child and elder care and more
	30-minute initial telephonic consultation per financial issue; with unlimited follow-up telephonic consultations on the following topics:
	<ul style="list-style-type: none"> • Budgeting • Debt/credit management • Retirement planning • Saving for college • Mortgage and auto loans • Bankruptcy and more
	30 minute in-person or telephonic consultation per legal issue on the following topics:
	<ul style="list-style-type: none"> • Family conflicts, divorce or alimony • Landlord/tenant disputes • Wills, estates and Power of Attorney • Bankruptcy • IRS concerns • Consumer and small claims matters • DUI and other criminal cases
	Other resources include:
	<ul style="list-style-type: none"> • Personalized guidance for family care • Catalogue of resources available online and through the mobile app • Video, talk, and chat therapy available through Talkspace • Identity theft services with a 60-minute consultation

The challenges you face each day can overwhelm you. Your home life, your happiness and your performance at work all can suffer. We can help. Your Employee Assistance Program (EAP) and WorkLife Services Benefit provides confidential support for those everyday challenges, and for more serious problems. It's available around the clock anytime you need it.

HOW TO USE THE EAP

Follow these simple steps to access EAP services:

1. Call the toll-free number at [800-342-8111](tel:800-342-8111), 24 hours a day, 7 days a week.
2. You will be connected with a licensed EAP counselor who will help you determine the most appropriate type of assistance to resolve your concerns.
3. If the resources required are beyond the scope of the EAP, the employee assistance counselor can refer you to additional services available through your insurance plan or community-based services.
4. Visit the website: resourcesforliving.com and use username: El Monte and password: EAP

EMPLOYEE ASSISTANCE PROGRAM (CONTINUED)



Employee Assistance Program

To access services:

1-800-342-8111 (TTY: 711) / resourcesforliving.com

Username: El Monte / Password: EAP

City of El Monte

Resources for Living is an employer-sponsored program, available at no cost to you and all members of your household. Children living away from home are covered up to age 26.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional wellbeing support



You can access up to 6 counseling sessions per issue each year. You can also call us 24 hours a day for in-the-moment emotional well-being support.

Counseling sessions are available face-to-face, online with televideo, or chat therapy. Services are free and confidential. We're always here to help with a wide range of issues including:

- Anxiety
- Relationship support
- Depression
- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Self-esteem and personal development
- Substance misuse and more

Daily life assistance



Competing day-to-day needs can make it tough to know where to start. Call us for personalized guidance. We'll help you find resources for:

- Child care, parenting and adoption
- Care for older adults
- Caregiver support
- School and financial aid research
- Special needs
- Pet care
- Community resources/basic needs
- Home repair and improvement
- Summer programs for kids
- Household services and more

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Resources for Living

EMPLOYEE ASSISTANCE PROGRAM (CONTINUED)



Legal services



You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Civil/criminal law
- Elder law and estate planning
- Divorce
- Wills and other document preparation
- Real estate transactions
- Mediation services

If you opt for services beyond the initial consultation you can get a 25 percent discount. You also have free access to legal documents and forms on your member website.

*Services must be related to the employee or an eligible household member. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services.

Financial services



Simply call for a free 30-minute phone consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions

You can get a 25 percent discount on tax preparation services. You also have access to financial articles, calculators and a financial assessment on your member website.

*Services must be for financial matters related to the employee or an eligible household member.

Online resources



Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Videos and podcasts
- Articles, blogs and self-assessments
- Mobile app
- Child and adult care provider search tool
- Live and on-demand webinars and more

Discount Center

Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more.

Mind Companion Self-care

You have access to evidence-based support tools to help manage depression, anxiety, stress, substance misuse and more.

Additional services



Chat therapy — Send secure text messages to your counselor, who will respond within one working day up to five days a week. A week of texting counts as one session. You can also schedule to meet online for 30-minute televideo sessions. Each televideo session counts as one visit. Work on the same kinds of issues you'd see a counselor face-to-face to talk about.

Identity theft services — One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

For legal disclaimers, visit rfl.com/Disclaimers.

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Resources for Living

THE HARTFORD LIFE INSURANCE ASSISTANCE

BENEFICIARY ASSIST® COUNSELING SERVICES



GETTING THROUGH A LOSS IS HARD. GETTING SUPPORT TO COPE IS EASY.

The loss of a loved one can leave you feeling overwhelmed. In addition to grief, you may have financial and legal worries. Questions you can't easily answer alone. And maybe some unresolved issues. If you're covered under The Hartford's **Group Life or Accident Insurance policy**, you have access to Beneficiary Assist® counseling services provided by ComPsych.†

PROFESSIONAL HELP AFTER A LOSS OR TERMINAL ILLNESS.

Beneficiary Assist provides you, your eligible beneficiaries and immediate family members with unlimited 24/7 phone access to help related to the death of yourself or a loved one. That includes:

- Legal advice, financial planning and emotional counseling for up to one year from the date the claim is filed.

- Up to five face-to-face sessions or equivalent professional time for one service or a combination.

HANDLING A SPECTRUM OF NEEDS WITH COMPASSION AND EXPERTISE.

Because Beneficiary Assist covers a spectrum of concerns, you and your beneficiaries will have a convenient, single source for the following needs. Emotional or grief counseling. ComPsych GuidanceExperts™ are master's and doctoral level clinicians who'll listen to your concerns with compassion and refer you to the right resources for:

- Grief and loss.
- Stress, anxiety and depression.
- Relationship/marital conflict.
- Problems with children.
- Job pressures.
- Substance abuse.

continued



THE HARTFORD LIFE INSURANCE ASSISTANCE (CONTINUED)

BENEFICIARY ASSIST® COUNSELING SERVICES



CASE ILLUSTRATION: SOLID FOOTING.²

Greg's sudden death at the age of 42 came as an enormous blow to his wife, Sharon. Besides the shock and grief, Sharon had to struggle with debt and claims to Greg's estate by children from a former marriage. She went back and forth between anger and depression.

Through Beneficiary Assist, she was able to link up with counselors who listened compassionately and referred her to a grief expert. She also used the legal and financial counseling resources to get solid answers to complex questions.

FINANCIAL INFORMATION AND RESOURCES.

With loss often come tough financial decisions. Share your concerns with certified public accountants and certified financial planners for assistance with:

- Managing a budget.
- Estate closure.
- Retirement impacts.
- Tax questions.
- Getting out of debt.

LEGAL SUPPORT AND RESOURCES.

When legal uncertainties arise, get the help you need. Attorneys are available for private consultations for the following:

- Estate and probate.
- Debt and bankruptcy.
- Real estate transactions.
- Family law.

If additional legal representation is needed beyond the face-to-face visits, you can be referred to a qualified attorney in your area. You may qualify for a 25 percent reduction in the attorney's customary fees by using the ComPsych Network.

REACH OUT.

Find out more about Beneficiary Assist counseling services by calling **1-800-411-7239**. It's a service you'll be glad to have when you need it.

Prepare. Protect. Prevail.®

Visit us at [THEHARTFORD.COM/EMPLOYEEBENEFITS](https://www.thehartford.com/employeebenefits)



The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries including trading companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home office is Hartford, CT.

¹ Beneficiary Assist® is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time.

² This case illustration is fictitious and for illustrative purposes only.

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THE HARTFORD LIFE INSURANCE ASSISTANCE (CONTINUED)

ESTATEGUIDANCE® WILL SERVICES



CREATE A SIMPLE WILL FROM THE CONVENIENCE OF YOUR DESKTOP.

Whether your assets are few or many, it's important to have a will. It's the only way to ensure that your intentions will be honored in the event of your death. A will states your wishes about who will inherit your property, who will be the guardian of your children, and who will manage your estate. Without a will, those decisions may be left to others.

AN EASY AND EMPOWERING SOLUTION.

As a covered employee under a Hartford Group Life insurance policy, you have access to EstateGuidance® Will Services provided by ComPsych®.¹ It helps you create a simple, legally binding will quickly and conveniently online, saving you the time and expense of a private legal consultation. Other advantages include:

- Online assistance from licensed attorneys should you have questions.
- The ability to save drafts for up to six months. During this period, you can revise your will at no cost, as long as you haven't already printed or downloaded it.

- Additional estate planning services are also available for purchase, including the creation of living wills and trusts, guidance about divorce proceedings, and durable power of attorney.

QUICK ANSWERS TO KEY QUESTIONS.

Where there's a will, there are bound to be questions. Here are answers to four common ones.

“Isn't will preparation complicated?”

Not with EstateGuidance®. You'll be asked a series of questions online that are used to compose your will. In many states, you need only add your signature to make the will valid.

“What if I have questions as I'm creating my will?” The online education center provides answers regarding family law. You can also access fully licensed attorneys who'll respond to you online.

“What about my privacy?” All information is kept secure and confidential with the latest encryption technology.²

continued



THE HARTFORD LIFE INSURANCE ASSISTANCE (CONTINUED)

ESTATEGUIDANCE® WILL SERVICES



CASE ILLUSTRATION: THE FINAL WORD.³

Laura was the single parent of a six-year-old daughter, Amy. She worried that if she were to die, her modest but hard-earned assets would not be available to her daughter.

The cost of a legal will seemed beyond her means until she discovered EstateGuidance® through her group life insurance provider. With it, she was able to appoint her older sister as executor of her will and name her brother and sister-in-law as Amy's legal guardians. She felt better knowing that she would have the final word in protecting her daughter's best interests.

“So, what happens if I don't create a will?”

The state, not you, would decide how your property is distributed. In most states, all of your community and joint property would pass to your spouse if you have one. Separate property is passed according to a complex order of distribution, regardless of your loved ones' wishes. By drafting a will, you can spare them a potentially awkward and contentious situation.

GOOD INTENTIONS AREN'T ENOUGH.

You might have the best of intentions, but without a will, they aren't legally binding. Take this opportunity to put your intentions into action.

Visit

WWW.ESTATEGUIDANCE.COM/WILLS

today. Use this code: **WILLHLF**. Then follow the easy steps below:

1. Access The Hartford's EstateGuidance® Will Services online.
2. Sign in to the secure site by entering the access code.
3. Follow the instructions and create your will.
4. Download the final will to your computer and print.
5. Obtain signatures and determine if your will should be notarized.

Prepare. Protect. Prevail.®

Visit us at THEHARTFORD.COM/EMPLOYEEBENEFITS

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home office is Hartford, CT.

†EstateGuidance® is offered through The Hartford by ComPsych® Corporation. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. A simple will does not cover credit shelter trust, printing or certain other features. These features are available at an additional cost to you.

‡The EstateGuidance® website is secured with a GoDaddy.com Web Server Certificate. Transactions on the site are protected with up to 256-bit Secure Sockets Layer encryption.

§This case illustration is fictitious and for illustrative purposes only.

Services may not be available in all states.

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THE HARTFORD LIFE INSURANCE ASSISTANCE (CONTINUED)

FUNERAL PLANNING AND CONCIERGE SERVICES



ADDED PEACE OF MIND WHEN IT'S NEEDED THE MOST.

The death of a loved one is one of life's most stressful situations. Quick, often costly decisions must be made while emotions are at their peak. Yet, how many people know how to plan a funeral? That's why your employer offers a funeral planning and concierge service through The Hartford's **Group Life Insurance program** - provided by Everest,¹ the first to offer this service nationwide.

THE RESOURCES TO HELP YOU MAKE CONFIDENT, INFORMED DECISIONS.

Everest's advisors help families understand all of their options and put them into action while staying within their budget. Here are the services they offer you, your spouse/partner and children under the age of 26.

EVEREST SERVICES

24/7 Advisor Assistance

- Round-the-clock access to Everest Advisors.
- Assistance with all funeral planning issues.

PriceFinderSM Research Reports

- The only nationwide database of funeral home prices.
- Detailed local funeral home price comparisons.
- Unlimited access to reports available on demand via the Web site.

Online Planning Tools

- Unlimited use of Everest's online planning, research, and knowledge tools.
- Create simple or detailed funeral plans using various reference materials, including 10 key decisions everyone should make.
- Information can be stored, updated, retrieved and printed on demand.

continued



THE HARTFORD LIFE INSURANCE ASSISTANCE (CONTINUED)

FUNERAL PLANNING AND CONCIERGE SERVICES



CASE ILLUSTRATION: A SHOULDER TO LEAN ON.²

April had always thought that she and her husband would spend their golden years together. So when he began to lose his battle with pancreatic cancer, she was completely unprepared. However, April had a knowledgeable and trusted resource: Everest services were included as part of her insurance program.

Her Everest advisor assisted with every aspect of the funeral planning process, giving April peace of mind during this stressful time. And she received an expedited life insurance payment within a week of her husband's death, which helped ease many of the family's financial pressures. Everest's services relieved April of some of the stress that comes with loss, allowing her to focus on her family.

EVEREST SERVICES *con't*

At-Need Family Support

- Concierge services at or near the time of death provided by Everest's licensed funeral directors, who offer as much or as little assistance as the family desires.
- Communication of the plan with the funeral home of choice, removing the family from a sales-focused environment.
- Pricing information presented to the family in an easy-to-understand format.
- Negotiation of the funeral costs with the funeral home, often resulting in significant financial savings.

Express Claim Processing

- Includes Express Pay, an innovative claims payment service that can deliver benefits in as little as 48 hours.
- Allows your beneficiary to use the insurance proceeds to pay for immediate funeral expenses.

A TRUSTED ADVISOR DURING THE WORST OF TIMES.

We can't always predict, but we can prepare. Find out more about The Hartford's Funeral and Concierge Services by calling **1-866-854-5429**.

Or visit **WWW.EVERESTFUNERAL.COM/HARTFORD** and use this code: **HFEVLC**.

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The Hartford[®] is The Hartford Financial Services Group, Inc. and its subsidiaries including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home office is Hartford, CT.

¹ Funeral Concierge Services are offered through Everest Funeral Package, LLC (Everest). Everest and the Everest logo are service marks of Everest Funeral Package, LLC. PriceFinder is a service mark of Everest Information Services, LLC. Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest ReGroup, Ltd., Everest Reinsurance Company or any of their affiliates. The Hartford is not responsible and assumes no liability for the services provided by Everest Funeral Package, LLC as described in these materials.

² This case illustration is fictitious and for illustrative purposes only.

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THE HARTFORD TRAVEL AND ID THEFT PROTECTION

TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES



TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES.

EVEN THE BEST PLANNED TRIPS CAN BE FULL OF SURPRISES.

The best laid travel plans can go awry, leaving you vulnerable and, possibly, unable to communicate your needs. When the unexpected happens far from home, it's important to know whom to call for assistance.

If you are covered under a Hartford Group Policy, you and your family have access to Travel Assistance Services provided by Europ Assistance USA.¹

With a local presence in 200 countries and territories around the world, and numerous 24/7 assistance centers, they are available to help you anytime, anywhere.

GOOD TO GO: MULTILINGUAL ASSISTANCE 24/7.

Whether you're traveling for business or pleasure, Travel Assistance services are available when you're more than 100 miles from home for 90 days or less.^{2,3}

As long as you contact Europ Assistance USA at the time of need, you could be approved for up to \$1 million in covered services.⁴

SERVICES FROM HERE TO THERE.

Travel Assistance begins even before you embark, with pre-trip information, and continues throughout your trip. See the list of services in the chart on the back of this page.

IDENTITY THEFT ASSISTANCE, TOO.

Identity theft, America's fast growing crime, victimizes almost 10 million American consumers each year.⁵ Europ Assistance USA helps protect you and your family from its consequences 24/7,² at home and when you travel.

In addition to prevention education, this service provides advice and help with administrative tasks resulting from identity theft.

continued



THE HARTFORD TRAVEL AND ID THEFT PROTECTION

TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES			
EMERGENCY MEDICAL ASSISTANCE ⁶	PRE-TRIP INFORMATION	EMERGENCY PERSONAL SERVICES ⁷	IDENTITY THEFT ASSISTANCE
<ul style="list-style-type: none"> • Medical referrals • Medical monitoring • Medical evacuation • Repatriation • Travelling companion assistance • Dependent children assistance • Visit by a family member or friend • Emergency medical payments • Return of mortal remains 	<ul style="list-style-type: none"> • Visa and passport requirements • Inoculation and Immunization requirements • Foreign exchange rates • Embassy and consular referrals 	<ul style="list-style-type: none"> • Medication and eyeglass prescription assistance • Emergency travel arrangements⁹ • Emergency cash⁸ • Locating lost items • Bail advancement 	<ul style="list-style-type: none"> • Prevention Services <ul style="list-style-type: none"> - Education - Identity Theft Resolution Kit • Detection Services <ul style="list-style-type: none"> - Fraud alert to three credit bureaus • Resolution Guidance and Assistance <ul style="list-style-type: none"> - Credit information review - ID Theft Affidavit Assistance - Card replacement • Personal Services <ul style="list-style-type: none"> - Translation - Emergency cash advance[*]

* Cash advance available when theft occurs 100 miles or more from your primary residence. Must be secured by a valid credit card.

CASE ILLUSTRATION: HELP A WORLD AWAY.⁸

As a Human Resource Professional, Tammy had always been on the coordinating end of travel services helping her company's employees; but when her daughter was hurt while traveling with her school group in Italy, she suddenly found herself in a different position.

Using the travel assistance medical referral, medical monitoring, and repatriation services from Europ Assistance USA, Tammy's daughter was able to receive immediate medical treatment and was evacuated within 48 hours. The Europ Assistance USA Case Manager helped Tammy through some of the most stressful days she's experienced as a mother and provided care for her daughter when she couldn't.

What to have ready: Your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number and your company policy number, which can be obtained through your Human Resources department.

Have a serious medical emergency? Please obtain emergency medical services first (contact the local "911"), and then contact Europ Assistance USA to alert them to your situation.

Call: **1-800-243-6108** Collect from other locations: **202-828-5885** Fax: **202-331-1528**

Travel Assistance Identification Number: **GLD-09012**

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¹ Travel Assistance and Identity Theft services are provided by Europ Assistance USA. Europ Assistance USA is not affiliated with The Hartford and is not a provider of insurance services. Europ Assistance USA may modify or terminate all or any part of the services at any time without prior notice. None of the benefits provided to you by Europ Assistance USA as a part of the Travel Assistance and Identity Theft services are insurance. This brochure, the Travel Assistance and Identity Theft service Terms and Conditions of Use, and the Identity Theft Resolution Kit constitute your benefit materials and contain the terms, conditions, and limitations relating to your benefits. These services may not be used for business or commercial purposes or by any person other than the individual insured under The Hartford's group insurance policy. The Hartford is not responsible and assumes no liability for the goods and services described in these materials.

² Coverage includes spouse (or domestic partner) and dependent children under age 25.

³ Services are available in every country of the world. Depending on the current political situation in the country to which you are traveling, EA may experience difficulties providing assistance, which may result in delays or even the inability to render certain services. It is your responsibility to inquire, prior to departure, whether assistance services is available in the countries where you are traveling.

⁴ The Combined Single Limit (CSL), or amount of money available to the insured under a Hartford Group policy the Travel Assistance Program, is \$1 million. One service or a combination of the services may exceed the CSL. The insured is responsible for payment of any expenses that exceed the CSL. Note: Certain Accidental Death and Dismemberment programs may offer different CSLs. Please consult with your Human Resources Manager for more details.

⁵ www.hartford.com/personal-credit/identity-theft-and-fraud/identity-theft-facts-page, viewed on 6/25/25.

⁶ In a medical emergency, Europ Assistance USA pays for assistance as described herein, but you are personally responsible for paying your medical/hospital expenses.

⁷ Europ Assistance USA provides the described personal services to you in an emergency, but you are personally responsible for the cost of air fare not approved as medically necessary by the attending physician; food, hotel and car expenses; and attorney fees. Emergency cash advances and bail advancement require your personal satisfactory guarantee of reimbursement provided through a valid credit card.

⁸ This case illustration is fictitious and for illustrative purposes only.

⁹ Emergency cash is charged as a cash advance, and emergency airline tickets are charged as a purchase to your credit card account and are all subject to that account's finance rates.

DISCLAIMER: Service Exclusions and Limitations: Europ Assistance USA (EA) services are eligible for payment or reimbursement by EA only if EA was contacted at the time of the services and arranged and/or preapproved services. Certain terms, conditions and exclusions apply; for further information refer to the Website listed or call EA at the number provided.

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IMPORTANT NOTICES

As part of City of El Monte’s compliance obligations, City of El Monte must provide certain legal notices to its U.S. benefits eligible employees. The required disclosure notices included within this Benefit Guide are:

- Medicaid and the Children’s Health Insurance Program (CHIP) Notice
- Medicare Part D Notice
- Health Insurance Marketplace
- COBRA General Notice
- Your Rights and Protections Against Surprise Medical Bills
- Women’s Health and Cancer Rights Act
- Newborns’ and Mothers’ Health Protection Act of 1996 (Newborns’ Act)
- HIPAA and Privacy

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, 2024. 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) Program http://dhcs.ca.gov/hipp Phone: 1-916-445-8322 Fax: 1-916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-MEDICAID	COLORADO-HEALTH FIRST COLORADO (COLORADO’S MEDICAID PROGRAM) & CHILD HEALTHPLAN 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://dhss.alaska.gov/dpa/Pages/medicaid/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 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-MEDICAID	
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	

IMPORTANT NOTICES

FLORIDA-MEDICAID	MINNESOTA-MEDICAID
Website: https://www.flmedicaidptprecovery.com/flmedicaidptprecovery.com/hipp/index.html Phone: 1-877-357-3268	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
GEORGIA-MEDICAID	MISSOURI-MEDICAID
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 1-678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 1-678-564-1162, Press 2	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005
INDIANA-MEDICAID	MONTANA-MEDICAID
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: http://dphs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
IOWA-MEDICAID AND CHIP (HAWKI)	NEBRASKA-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: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
KANSAS-MEDICAID	NEVADA-MEDICAID
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY-MEDICAID	NEW HAMPSHIRE-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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 1-603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA-MEDICAID	NEW JERSEY-MEDICAID AND CHIP
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE-MEDICAID	NEW YORK-MEDICAID
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: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS-MEDICAID AND CHIP	NORTH CAROLINA-MEDICAID
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 1-919-855-4100
	NORTH DAKOTA-MEDICAID
	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
	OKLAHOMA-MEDICAID AND CHIP
	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

IMPORTANT NOTICES

OREGON-MEDICAID	VERMONT-MEDICAID
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA-MEDICAID	VIRGINIA-MEDICAID AND CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND-MEDICAID AND CHIP	WASHINGTON-MEDICAID
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1-401-462-0311 (Direct Rite Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA-MEDICAID	WEST VIRGINIA-MEDICAID AND CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://dhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 1-304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA-MEDICAID	WISCONSIN-MEDICAID AND CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS-MEDICAID	WYOMING-MEDICAID
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
UTAH-MEDICAID AND CHIP	
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137

IMPORTANT NOTICES

Medicare Part D Notice

Important Notice from City of El Monte about your Prescription Drug Coverage & 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 El Monte 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 El Monte has determined that the prescription drug coverage offered by CalPERS 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 through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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 El Monte coverage will not be affected. You can keep this coverage if you elect Part D and this plan may coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current City of El Monte 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 City of El Monte 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 on the following page for further information.

IMPORTANT NOTICES

Medicare Part D Notice

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, 2026

NAME OF ENTITY/SENDER: City of El Monte

CONTACT-POSITION/OFFICE: Human Resources

ADDRESS: 11333 Valley Blvd., El Monte, CA 91731

PHONE NUMBER: 626-580-2040

IMPORTANT NOTICES

HIPAA Privacy and Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, 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 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 after the marriage, birth, adoption, or placement for adoption.

If you wish to decline coverage for yourself or your eligible dependent(s), you will be required to complete the appropriate section on your election form. Please note that you or your dependent(s) must be enrolled in a benefit plan during the initial enrollment period in order to avoid being considered a Late Enrollee. You and/or your dependent(s) may qualify under a Late Enrollee Exception if you declined coverage during the initial enrollment period because you had other coverage under another employer's medical benefits plan and coverage under that employer's medical benefits plan ends. An employee or dependent who requests enrollment after the initial enrollment period will be considered to be a Late Enrollee unless the person qualifies under a Late Enrollee Exception.

This is a brief statement regarding your HIPAA special enrollment rights and does not fully explain these rights. You should read the insurance carrier's Summary Plan Description for a more detailed description of your HIPAA special enrollment rights.

HIPAA and Privacy

City of El Monte recognizes the confidentiality of you and your enrolled dependents' personal health information, and we are committed to keeping that information private. In addition to our commitment, the Federal Health Insurance Portability and Accountability Act (HIPAA) establishes privacy rules for individually identifiable health information. For a copy of the privacy notice, please contact Human Resources.

IMPORTANT NOTICES

Women’s Cancer Rights and Newborns’ Act

In accordance with the Women’s Health and Cancer Rights Act of 1998 (“WHCRA”), your coverage under the City of El Monte medical plans provides benefits for mastectomy-related services, including reconstruction and surgery to improve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Our medical plans will not restrict benefits if:

- .You or your dependent received benefits for a mastectomy, and;
- .You or your dependent elected breast reconstruction in connection with the mastectomy. Benefits will not be restricted provided that the breast reconstruction is performed in a manner determined in consultation with you or your dependent’s physician and may include:
 - 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 all stages of mastectomy, including lymphedemas

If you would like more information on WHCRA benefits, please contact Delmy Human Resources or visit <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/whcra.pdf>

Newborns’ and Mothers’ Health Protection Act of 1996 (Newborns’ 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 as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you would like more information on the Newborns’ Act, please contact Human Resources or visit <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/newborns-act.pdf>

IMPORTANT NOTICES

Your Rights and Protections Against Surprise Medical Bills

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **can’t** be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

IMPORTANT NOTICES

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - ◇ Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - ◇ Cover emergency services by out-of-network providers.
 - ◇ Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - ◇ Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact (800) 985-3059.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

IMPORTANT NOTICES

Model COBRA Continuation Coverage General Notice Instructions

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do *not* need to include this instruction page with the model general notice.

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebssa.opr@dol.gov and reference the OMB Control Number 1210-0123.

OMB Control Number 1210-0123

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

****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.

IMPORTANT NOTICES

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 [*choose and enter appropriate information: must pay or aren't required to 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."

IMPORTANT NOTICES

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;
- 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

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. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

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.

IMPORTANT NOTICES

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, Medicare, 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 period¹ 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.

IMPORTANT NOTICES



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved OMB
No. 1210-0149 (expires
12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% 1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income..2

1 Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023. 2 An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

IMPORTANT NOTICES

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's 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.

GLOSSARY

AFFORDABLE CARE ACT AND PATIENT PROTECTION (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

ALLOWED AMOUNT

Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

BALANCE BILLING

When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you.

BRAND NAME DRUG

The original manufacturer’s version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

CLAIM

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

COINSURANCE

A percentage of costs you pay “out-of-pocket” for covered expenses after you meet the deductible.

COPAYMENT (COPAY)

A fee you have to pay “out-of-pocket” for certain services, such as a doctor’s office visit or prescription drug.

COMPREHENSIVE COVERAGE

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

DEDUCTIBLE

The amount you pay “out-of-pocket” before the health plan will start to pay its share of covered expenses.

FORMULARY

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

GENERIC DRUG

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

GLOSSARY (CONTINUED)

HEALTH SAVINGS ACCOUNT (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

IN-NETWORK

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

NON-PREFERRED PROVIDER

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

OUT-OF-POCKET MAXIMUM

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

OUT-OF-NETWORK

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

OUT-OF-POCKET LIMIT

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

PLAN YEAR

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

PREFERRED PROVIDER

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

PREMIUM

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

PREVENTIVE CARE

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

QUALIFYING LIFE EVENT

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

SKILLED NURSING CARE

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

URGENT CARE

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.



The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by your employer. The text contained in this Summary was taken from various summary plan descriptions and benefits information. While every effort was taken to report your benefits, discrepancies or errors accurately are always possible. In case of a discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this Summary, contact Human Resources.

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