Employee Benefits Guide

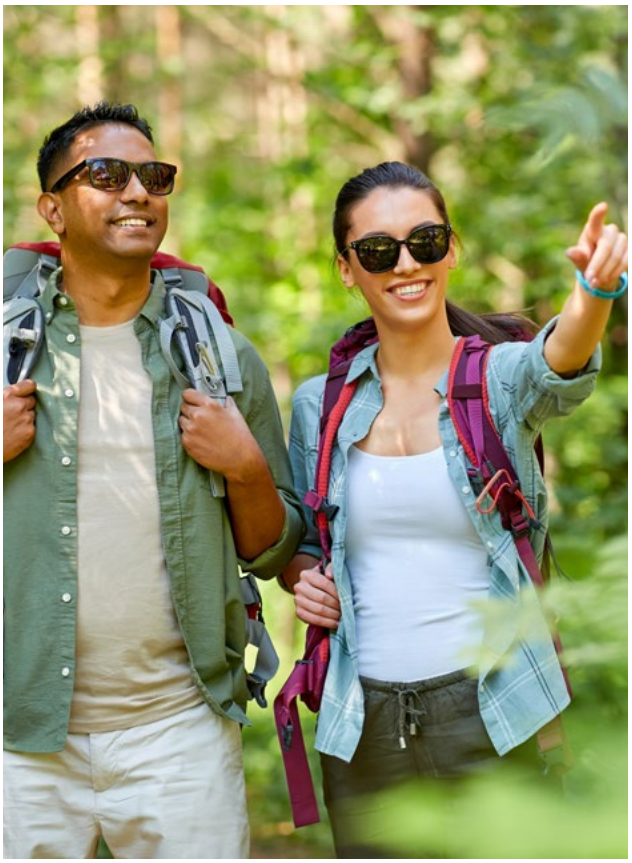
2024

CITY OF PALOS VERDES ESTATES
INCORPORATED 1939
CALIFORNIA

Employee Benefits Guide 2024

General Information

Other Benefits



Click this icon in your benefits guide to watch a video explaining the associated topic. See page 49 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.

Please see page 41 for more details.

The information in this brochure is a general outline of the benefits offered under City of Palos Verdes Estates'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.

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A Message from the City of Palos Verdes Estates

At City of Palos Verdes Estates, 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 plan 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 of our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

Highlights

Medical

Choosing the right health plan is probably one of the most important decisions you can make for you and your family. It is our objective to provide an employee benefit program with a high level of benefits making it easy for you and your dependents to access the medical care you need. Please carefully consider the plan information provided in this document to make the best medical choices for you and your family. Always remember to eat right and get plenty of exercise to feel your best!

Dental

Our dental plan makes dental care more affordable for employees and their families. Remember to choose a dentist contracted with our plan for the biggest dental benefit. Taking care of your mouth, teeth and gums is a big part of making sure you feel your best. Healthy habits like brushing, flossing and seeing your dentist for regular cleanings help prevent problems.

Vision

Eye doctors detect problems in vision, overall eye health, and detect signs of other health conditions like diabetic eye disease, high blood pressure and high cholesterol. We know your eye sight is precious to you and so we provide vision benefits to make sure your trip to the eye doctor is reasonably priced.

Life and AD&D

Life/Accidental Death & Dismemberment protects employees and their families from financial hardship in the event of death or dismemberment. It provides the peace of mind you get when you know your loved ones will be protected if anything happens to you.

Disability

One of the most important assets to you as an employee is the ability to earn an income. The Short Term Disability (STD) plan is designed to continue providing you with a percentage of income if you're unable to work due to a non-occupational sickness or injury. Long Term Disability (LTD) will cover you for a sickness or injury resulting from either occupational and non-occupational losses but your disability benefit will be reduced by the amount you receive from your Workers' Compensation benefit. Disability insurance can help you continue to pay your bills by replacing a portion of your income until you are able to return to work.

Employee Assistance Program

The Employee Assistance Program (EAP) is an employer paid benefit providing resources for everyday living. Employee assistance professionals provide counseling and referral to continued therapy or treatment services anytime you or a family member are seeking to maintain mental and emotional well-being. The EAP can assist with a variety of life's issues.

Fire Districts Association of California Employment Benefits Authority (FDAC EBA) Critical Illness Program

FDAC EBA provides critical illness coverage for employees and your dependent children that enrolled in an FDAC EBA medical plan at no cost. Critical Illness coverage provides a lump-sum benefit upon diagnosis of a covered illness that can be used however you choose - from expenses related to treatment, to deductibles or day-to-day costs of living such as the mortgage or your utility bills.

Voluntary Benefits

Voluntary benefits offer you the opportunity to select from a variety of plan options to help further protect you and your family from illness, injury and loss of life.

Flexible Spending Accounts

If you elect to participate in the Flexible Spending Accounts, you can set aside tax-free dollars each year to cover your eligible out-of-pocket expenses and daycare expenses.

Plan Enrollment

If you decide to enroll in benefit coverage, whether it is during your initial eligibility as a new hire or during open enrollment, you must complete the enrollment process.

Questions? Contact:

Human Resources, Phone: 310.378.0380 Ext. 803,
Email: ccowley@pvestates.org

Enrollment and Eligibility

Enrollment and Qualifying Events

Each year you have the opportunity to make changes to your benefits package during open enrollment. With the exception of certain qualifying events, open enrollment is the only time benefit changes may be made. A qualifying event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some qualifying events include: a change in legal marital status, change in number of dependents, death of a dependent, change in employment status for you or your spouse, and birth or adoption of a child.

If such a change occurs, you must make the changes to your benefits within 30 days of the Qualifying event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the qualifying event may result in your having to wait until the next open enrollment period to make your change; this includes the enrollment of a newborn child. Please contact Human Resources to make these changes.

Who is Eligible?

Permanent, full-time City employees working 80 or more hours per pay period are eligible for the benefits outlined in this overview.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your registered same or opposite sex domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partner. Any premiums for your domestic partner paid for by City of Lynwood are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- **Your children (including natural children, stepchildren, domestic partner's children, adopted children, children fostered under legal custody, and children covered under legal guardianship):**
  - Under the age of 26 are eligible to enroll in coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
  - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Who is Not Eligible?

- Temporary, part-time, or contract employees

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, siblings, aunts/uncles, nieces/nephews, and grandchildren
- Divorced spouses
- Family members residing outside the United States
- Former stepchildren as a result of divorce

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Enrollment and Eligibility (continued)

Dependent Verification

Adding dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You may be required to provide proof of one or more of the following:

- Marriage Certificate or License
- Domestic Partner Affidavit
- Birth Certificate (hospital certificates are not official birth records and will not be accepted as proof of birth)
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children, and children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)
- Additional documentation such as tax returns or utility bills to demonstrate dependent eligibility may be requested

When Can I Enroll?

Coverage for new hires begins the 1st of the month following timely submission of benefit elections. New employees must complete the benefits selection form and return it within 30 days of their hire date. **If you do not return your completed forms by this deadline, your benefits may be delayed**.

Your benefits will remain unchanged until the next open enrollment period, unless a qualifying event occurs. Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child (30 days)
- Marriage (30 days)
- Loss of other healthcare coverage (30 days)
- Loss of Medicaid or Children's Health Insurance Program (CHIP) (30 days)
- Eligibility for new healthcare coverage (30 days)
- Divorce (30 days)

CLICK HERE to watch a video on Qualifying Life Events

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Medical

2024 Fire Risk Management Services (FRMS) Medical/Rx Plans	Kaiser Premium HMO	Blue Shield Basic EPO	Blue Shield Premium PPO	
Network	In-Network Only	In-Network Only	In-Network	Out-of-Network
Deductible	None	$500 / $150	$15 Copay	30% after ded
Out-of-Pocket Max Ind/Fam	$1,500 / $3,000	$3,000 / $9,000	$2,000 / $6,000	$4,000 / $12,000
Office Primary / Specialist Visit	$15 Copay	$30 Copay	$15 Copay	30% after ded
Urgent Care	$15 Copay	$35 Copay	$15 Copay	30% after ded
Laboratory Outpatient	No Charge	No Charge	10% after ded	30% after ded
X-ray & Diagnostic Imaging	No Charge	No Charge	10% after ded	30% after ded
Imaging *(CT/PET Scans, MRIs)*	No Charge	$100 Copay	10% after ded	30% after ded
Emergency Room	$100 Copay	$150 Copay + 20%	$100 Copay + 10% after ded	$100 Copay + 10% after ded
Hospital Services	No Charge	20% after ded	10% after ded	30% after ded
Inpatient Physician	100%	20% after ded	10% after ded	30% after ded
Outpatient Facility Charge	$15 / occurrence	20% after ded	10% after ded	30% after ded
Rehabilitative Speech Therapy	$15 Copay	$30 Copay	10% after ded	30% after ded
Occupational/Physical Therapy	$15 Copay	$30 Copay	10% after ded	30% after ded
Skilled Nursing Facility	No Charge	No Charge	10% after ded	30% after ded
Mental Health Outpatient	$15 Copay	$30 Copay	$15 Copay	30% after ded
Rx - Deductible	None	None	None	
Generic	$10 Copay	$20 Copay	$10 Copay	$10 Copay + 50% AWP
Formulary Brand	$30 Copay	$30 ($50) Copay	$20 ($35) Copay	$20 ($35) Copay + 50% AWPSpecialty
Specialty Drugs	20% up to $100 per script	20% to $100 per script	20% to $100 per script	20% to $100 per script
Critical Illness Benefit-Employee and Dependent Children Only	$5,000 Lump Sum	$5,000 Lump Sum	$5,000 Lump SumBlue	

CLICK HERE to watch a video on Health Maintenance Organizations (HMO)

CLICK HERE to watch a video on Preferred Provider Organizations (PPO)

CLICK HERE to watch a video on PPO vs HMO

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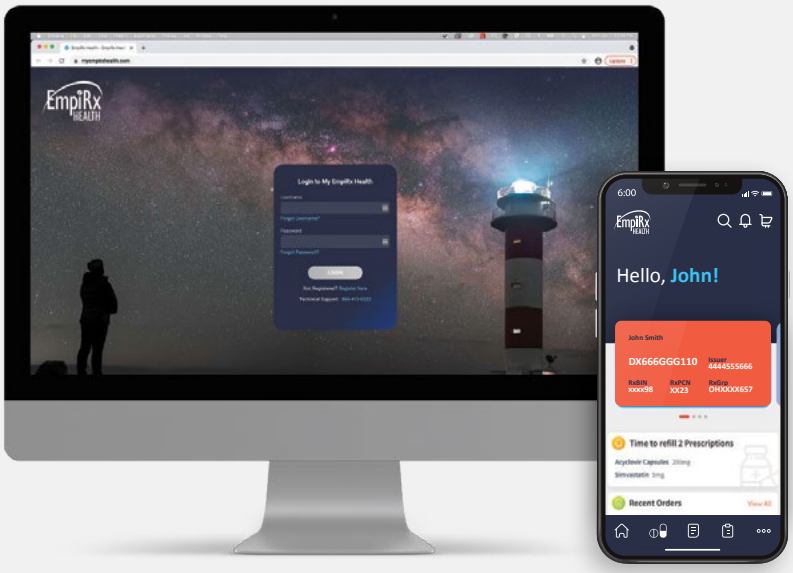
Prescriptions

Manage your prescriptions easily online and on-the-go.



- Prescription History
- Mail-order Refills & Reminders
- Claims Details & History
- Drug Information & Pricing
- Pharmacy Search & Directions
- Benefits Information
- ID Card
- And so much more

Registration is easy. Please visit myempirxhealth.com.

EmpiRx HEALTH

myempirxhealth.com

App available for iOS & Android

myHNAS Online Member Benefits

Welcome to myHNAS!

Access your claims, eligibility, temporary health plan ID card, and other valuable plan information 24/7 through myHNAS. You'll find important documents, links to health-related resources, and answers to frequently asked questions.

Here's what you can do:

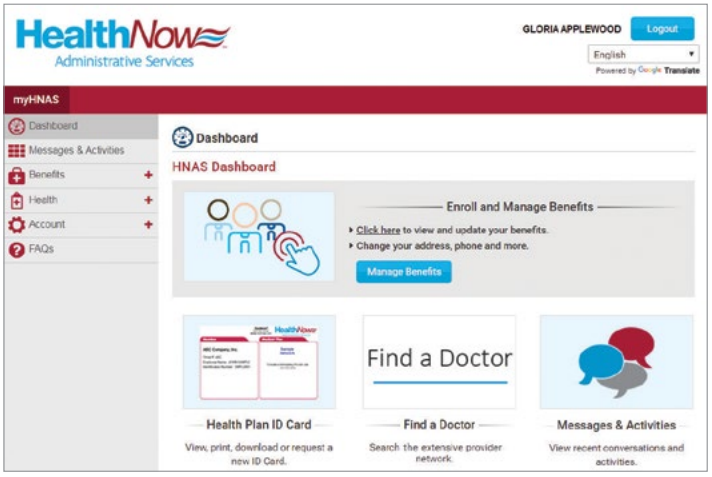
- Review eligibility and plan information for you and your covered dependents
- View claims details for you and your covered dependents*
- Access Explanation of Benefits (EOB) documents related to medical claims
- View, print, or download your current ID card and request new ID cards
- Access an electronic summary of benefits and coverages
- Locate participating doctors or hospitals
- View deductible/accumulator information related to current and past health plan enrollments
- Change your current coverage due to a life event, if applicable

**Privacy rules apply*

Getting started

1. Go to **myHNAS.com**.
2. First-time users, select *Register Now*.
3. Enter the required registration fields and click *Submit*.
4. Read the Term of Service agreement and click *Agree*.
5. Read the Notice of Privacy Practices and click *Agree*.
6. Create a username and password and a security question and answer, then click *Submit*.

   Note: *Your password must include at least six characters and at least one number or symbol (! @ # $ % ^ & * _ + - =).*
7. See your dashboard screen.



HealthNow Administrative Services

myHNAS Mobile

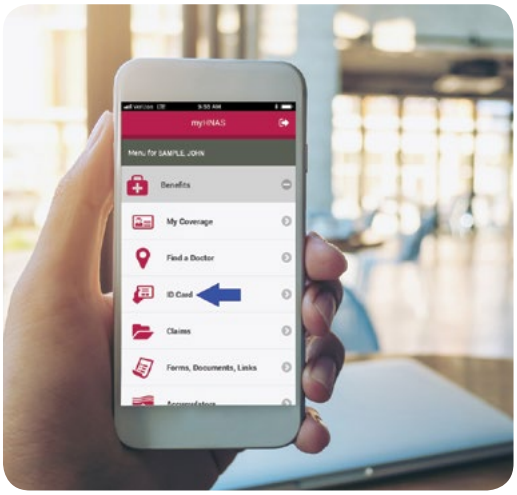
Access on the go!

Have the account information you need, right when you need it most. With the myHNAS mobile app, you can easily access your benefit portal on the go. The mobile app gives you secure access to valuable benefit and plan information anytime you need it. Enjoy all the amenities of the online portal from your Apple or Android device.

Virtual ID card

Carry your virtual ID card in your pocket by using your device to access the myHNAS mobile app. Simply select *ID Card* from the mobile menu, and click *Get ID Card Now*. Your ID card image appears sized on your device screen, easily viewable by your doctor or other provider. This is a valid card and is exactly the same as the most recent card mailed to you. You may use it to access health care services and doctors.

You may also request new ID cards by mail.



Getting started

Already have a myHNAS account? Use your existing myHNAS account username and password to log in to the myHNAS app.

Not registered for a myHNAS account yet?

1. Select *Register*.
2. Enter the required registration fields and tap *Submit*.
3. Read the Terms of Service agreement and tap *Agree*.
4. Read the Notice of Privacy Practices and tap *Agree*.
5. Create a username and password and a security question and answer, and then tap *Submit*.
6. See your menu of services.

Download myHNAS today!

Download on the App Store

GET IT ON Google Play

HealthNow Administrative Services

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Dental

DELTA DENTAL®

Keep smiling

Delta Dental PPO™

Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **deltadentalins.com**.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.[4] Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can receive significant savings on LASIK procedures and hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist

PPO NON-PPO

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

[5] Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

West Virginia: Learn about our commitment to providing access to a quality dentist network at **deltadentalins.com/about/legal/index-enrollee.html**.

HL_PPO #135419F (rev. 1/23)

Benefit Highlights: Delta Dental PPO™

Plan Benefit Highlights for: Fire Risk Management Services (FRMS)
(City of Palos Verdes Estates)
Group No: 05972 - 01059, 02061 & 09159

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	$50 per person / $150 per family each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P)?	Yes			
Maximums	$1,500 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100%	100%
Basic Services Fillings	90%	80%
Endodontics (root canals) Covered Under Basic Services	90%	80%
Periodontics (gum treatment) Covered Under Basic Services	90%	80%
Oral Surgery Covered Under Basic Services	90%	80%
Major Services Crowns, onlays and cast restorations	60%	50%
Prosthodontics Bridges, dentures and implants	60%	50%

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California	Customer Service	Claims Address
560 Mission St., Suite 1300 San Francisco, CA 94105	888-335-8227	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Revised 9/6/2023

MetLife DHMO

MetLife

SCHEDULE OF BENEFITS

Benefits provided by SafeGuard Health Plans, Inc., a MetLife company

Direct Referral Dental Plan* SG185-CA

This Schedule of Benefits lists the services available to you under your SafeGuard plan, as well as the co-payments associated with each procedure. There are other factors that impact how your plan works and those are included here in the Exclusions & Limitations. SafeGuard is an affiliate of MetLife.

Specialty Care Information: During the course of treatment, your SafeGuard selected general dentist may recommend the services of a dental specialist. Your selected general dentist may refer you directly to a contracted SafeGuard specialty care provider for endodontics, oral surgery, orthodontics, periodontics, or pedodontics; no referral or preauthorization from SafeGuard is required.

* Prior authorization from SafeGuard is required for referrals to participating orthodontists and pediatric specialists. Your selected general dentist will submit all required documentation to SafeGuard and SafeGuard will advise you of the name, address and telephone number of a SafeGuard contracted orthodontist or pediatric specialist in your area.

Code	Service	Co-payment
	Diagnostic Treatment	
D0120	Periodic oral evaluation – established patient	$0
D0140	Limited oral evaluation – problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation – new or established patient	$0
D0171	Re-evaluation – post-operative office visit	$0
D0180	Comprehensive periodontal evaluation – new or established patient	$0
	• Office visit - per visit (including all fees for sterilization and/or infection control)	$5
	Radiographs/Diagnostic Imaging (X-rays)	
D0210	Intraoral – complete series of radiographic images	$0
D0220	Intraoral – periapical first radiographic image	$0
D0230	Intraoral – periapical each additional radiographic image	$0
D0240	Intraoral – occlusal radiographic image	$0
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$0
D0270	Bitewing – single radiographic image	$0
D0272	Bitewings – two radiographic images	$0
D0273	Bitewings – three radiographic images	$0
D0274	Bitewings – four radiographic images	$0
D0330	Panoramic radiographic image	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
	Tests and Examinations	
D0460	Pulp vitality tests	$0

SGM-SOB-SG **Customer Service (800) 880-1800** **01/19**

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SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
D0470	Diagnostic casts	$0
	Preventive Services	
	• *Procedures identified with an asterisk (*) are limited to twice a year, unless medically necessary.*	
D1110	Prophylaxis – adult*	$0
D1120	Prophylaxis – child*	$0
D1206	Topical application of fluoride varnish *	$0
D1208	Topical application of fluoride – excluding varnish	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant – per tooth	$5
D1510	Space maintainer – fixed – unilateral	$25
D1516	Space maintainer – fixed – bilateral, maxillary	$25
D1517	Space maintainer – fixed – bilateral, mandibular	$25
D1520	Space maintainer – removable – unilateral	$35
D1526	Space maintainer – removable – bilateral, maxillary	$35
D1527	Space maintainer – removable – bilateral, mandibular	$35
D1550	Re-cement or re-bond space maintainer	$5
D1555	Removal of fixed space maintainer	$5
	Restorative Treatment	
D2140	Amalgam – one surface, primary or permanent	$10
D2150	Amalgam – two surfaces, primary or permanent	$15
D2160	Amalgam – three surfaces, primary or permanent	$18
D2161	Amalgam – four or more surfaces, primary or permanent	$20
D2330	Resin-based composite – one surface, anterior	$15
D2331	Resin-based composite – two surfaces, anterior	$20
D2332	Resin-based composite – three surfaces, anterior	$30
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$35
D2390	Resin-based composite crown, anterior	$35
D2391	Resin-based composite – one surface, posterior	$65
D2392	Resin-based composite – two surfaces, posterior	$75
D2393	Resin-based composite – three surfaces, posterior	$80
D2394	Resin-based composite – four or more surfaces, posterior	$80
	Crowns	
	• *Replacement limit 1 every 5 years.* • *An additional charge will be applied for any procedure using noble or high noble metal.* • *Cases involving 7 or more crowns in the same treatment plan require additional $125 member fee per unit in addition to co-pay.* • *$75 fee per crown unit above co-pay for porcelain on molars.*	
D2510	Inlay – metallic – one surface	$165
D2520	Inlay – metallic – two surfaces	$165
D2530	Inlay – metallic – three or more surfaces	$165
D2543	Onlay – metallic – three surfaces	$185
D2544	Onlay – metallic – four or more surfaces	$185

SGM-SOB-SG **Customer Service (800) 880-1800**

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
D2740	Crown - porcelain/ceramic	$225
D2750	Crown – porcelain fused to high noble metal	$185
D2751	Crown – porcelain fused to predominantly base metal	$185
D2752	Crown – porcelain fused to noble metal	$185
D2780	Crown – ¾ cast high noble metal	$185
D2781	Crown – ¾ cast predominantly base metal	$185
D2782	Crown – ¾ cast noble metal	$185
D2790	Crown – full cast high noble metal	$185
D2791	Crown – full cast predominantly base metal	$185
D2792	Crown – full cast noble metal	$185
D2794	Crown – titanium	$185
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$0
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$0
D2920	Re-cement or re-bond crown	$0
D2930	Prefabricated stainless steel crown – primary tooth	$25
D2931	Prefabricated stainless steel crown – permanent tooth	$25
D2940	Protective restoration	$0
D2950	Core buildup, including any pins when required	$50
D2951	Pin retention – per tooth, in addition to restoration	$10
D2952	Post and core in addition to crown, indirectly fabricated	$50
D2954	Prefabricated post and core in addition to crown	$30
D2955	Post removal	$10
	Endodontics	
	• *All procedures exclude final restoration.*	
D3110	Pulp cap – direct (excluding final restoration)	$0
D3120	Pulp cap – indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$10
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$30
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$35
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$105
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$115
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$265
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$105
D3346	Retreatment of previous root canal therapy – anterior	$135
D3347	Retreatment of previous root canal therapy - premolar	$175
D3348	Retreatment of previous root canal therapy – molar	$275
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$65
D3352	Apexification/recalcification – interim medication replacement	$65
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	$65
D3410	Apicoectomy – anterior	$180

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
D3421	Apicoectomy - premolar (first root)	$180
D3425	Apicoectomy – molar (first root)	$180
D3426	Apicoectomy (each additional root)	$180
D3430	Retrograde filling – per root	$180
D3450	Root amputation – per root	$95
D3920	Hemisection (including any root removal), not including root canal therapy	$90
	Periodontics	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$90
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$68
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	$250
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	$188
D4249	Clinical crown lengthening – hard tissue	$125
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$300
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$225
D4270	Pedicle soft tissue graft procedure	$250
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$75
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$70
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$50
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$38
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$40
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$60
D4910	Periodontal maintenance	$50
	Removable Prosthodontics	
	• *Replacement limit 1 every 5 years.* • *Relines are limited to 1 every 24 months.* • *Includes up to 3 adjustments within 6 months of delivery.*	
D5110	Complete denture – maxillary	$210
D5120	Complete denture – mandibular	$210
D5130	Immediate denture – maxillary	$225
D5140	Immediate denture – mandibular	$225
D5211	Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$300
D5212	Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	$300
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$300

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$300
D5410	Adjust complete denture – maxillary	$0
D5411	Adjust complete denture – mandibular	$0
D5421	Adjust partial denture – maxillary	$0
D5422	Adjust partial denture – mandibular	$0
D5520	Replace missing or broken teeth – complete denture (each tooth)	$30
D5630	Repair or replace broken retentive clasping materials – per tooth	$35
D5640	Replace broken teeth – per tooth	$30
D5650	Add tooth to existing partial denture	$30
D5660	Add clasp to existing partial denture - per tooth	$45
D5710	Rebase complete maxillary denture	$75
D5711	Rebase complete mandibular denture	$75
D5720	Rebase maxillary partial denture	$75
D5721	Rebase mandibular partial denture	$75
D5730	Reline complete maxillary denture (chairside)	$50
D5731	Reline complete mandibular denture (chairside)	$50
D5740	Reline maxillary partial denture (chairside)	$50
D5741	Reline mandibular partial denture (chairside)	$50
D5750	Reline complete maxillary denture (laboratory)	$65
D5751	Reline complete mandibular denture (laboratory)	$65
D5760	Reline maxillary partial denture (laboratory)	$65
D5761	Reline mandibular partial denture (laboratory)	$65
D5820	Interim partial denture (maxillary)	$75
D5821	Interim partial denture (mandibular)	$75
D5850	Tissue conditioning, maxillary	$10
D5851	Tissue conditioning, mandibular	$10
	Crowns/Fixed Bridges - Per Unit • *Replacement limit 1 every 5 years.* • *An additional charge will be applied for any procedure using noble or high noble metal.* • *Cases involving 7 or more crowns and/or fixed bridge units in the same treatment plan require additional $125 member fee per unit in addition to co-pay.* • *$75 fee per crown/bridge unit above co-pay for porcelain on molars.*	
D6210	Pontic – cast high noble metal	$185
D6211	Pontic – cast predominantly base metal	$185
D6212	Pontic – cast noble metal	$185
D6214	Pontic – titanium	$185
D6240	Pontic – porcelain fused to high noble metal	$185
D6241	Pontic – porcelain fused to predominantly base metal	$185
D6242	Pontic – porcelain fused to noble metal	$185
D6750	Retainer crown – porcelain fused to high noble metal	$185
D6751	Retainer crown – porcelain fused to predominantly base metal	$185
D6752	Retainer crown – porcelain fused to noble metal	$185

SGM-SOB-SG **Customer Service (800) 880-1800**

Dental (continued)

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
D6780	Retainer crown – ¾ cast high noble metal	$185
D6781	Retainer crown – ¾ cast predominantly base metal	$185
D6782	Retainer crown – ¾ cast noble metal	$185
D6790	Retainer crown – full cast high noble metal	$185
D6791	Retainer crown – full cast predominantly base metal	$185
D6792	Retainer crown – full cast noble metal	$185
D6794	Retainer crown – titanium	$185
D6930	Re-cement or re-bond fixed partial denture	$0
	Oral Surgery	
	• *Includes routine post operative visits/treatment.* • *Surgical removal of impacted teeth not covered unless pathology (disease) exists.* • *Surgical removal of wisdom tooth/third molar for orthodontic reasons only is not covered.*	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	$50
D7220	Removal of impacted tooth – soft tissue	$75
D7230	Removal of impacted tooth – partially bony	$100
D7240	Removal of impacted tooth – completely bony	$125
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$130
D7250	Removal of residual tooth roots (cutting procedure)	$75
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110
D7280	Exposure of an unerupted tooth	$200
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	$0
D7286	Incisional biopsy of oral tissue – soft	$0
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$35
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$10
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$40
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$20
D7960	Frenulectomy – aka frenectomy or frenotomy – separate procedure not incidental to another procedure	$40
D7963	Frenuloplasty	$40
D7971	Excision of pericoronal gingiva	$25
	Orthodontics	
	• *Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention. Treatment extending beyond such time periods will be subject to a per-office-visit charge of $25.* • *Orthodontic treatment plan and records (pre/post x-rays, photos, study*	

SCHEDULE OF BENEFITS (continued)

Code	Service	Co-payment
	models) are covered at a cost of $250.	
D8020	Limited orthodontic treatment of the transitional dentition	$725
D8030	Limited orthodontic treatment of the adolescent dentition	$725
D8040	Limited orthodontic treatment of the adult dentition	$725
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,695
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,695
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,695
D8660	Pre-orthodontic treatment examination to monitor growth and development	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250
D8693	Re-cement or re-bond fixed retainers	$0
	Adjunctive General Services	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$0
D9120	Fixed partial denture sectioning	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$0
D9440	Office visit – after regularly scheduled hours	$35
D9630	Drugs or medicaments dispensed in the office for home use	$15
D9951	Occlusal adjustment – limited	$15
D9952	Occlusal adjustment – complete	$50
D9986	Missed appointment (less than 24-hr notice)	Not to exceed $25
D9987	Cancelled appointment (if less than 24-hr notice, see D9986)	$0

Dental Terminology Definitions

These definitions are designed to give you a "layman's understanding" of some dental terminology in order for you to better understand your plan; they are not full descriptions.

Amalgam:	A silver filling
Anterior:	Teeth that are in the front of the mouth
Bicuspid:	Most people have eight bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.
Bridge:	A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).
Crown:	A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials (noble, high noble), base metal, porcelain or porcelain and metal.
Endodontics:	Procedures that treat the nerve or the pulp of the tooth due to injury or infection.
Oral Surgery:	Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.
Orthodontics:	Braces and other procedures to straighten the teeth.
Periodontics:	Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).
Posterior:	Teeth that set towards the back of the mouth, including molars and bicuspids (premolars).
Primary Teeth:	The first set of teeth ("baby" teeth).
Prophylaxis:	Scaling and polishing of teeth by removal of the plaque above the gum line.
Prosthodontics:	The restoration of natural and/or the replacement of missing teeth with artificial substitutes.
Quadrant:	One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).
Resin-based Composite:	Tooth-colored (white) fillings

Exclusions and Limitations

Exclusions

1. Services performed by a general dentist or specialty care dentist, not contracted with SafeGuard, without prior approval by SafeGuard (except for out of area emergency services).
2. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.
3. Dental procedures initiated prior to the member's eligibility under this Plan or started after the member's termination from the Plan.
4. Any dental services, or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the SafeGuard Selected General Dentist.
5. Dental procedures or services performed solely for cosmetic purposes or solely for appearance.
6. Orthognathic surgery.
7. General anesthesia or intravenous sedation.
8. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
9. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse, or neglect.
10. Treatment of malignancies, cysts, or neoplasms.
11. Procedures, appliances, or restorations whose main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
12. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
13. Precision attachments.
14. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
15. Dental services required while serving in the Armed Forces of any country or international authority or relating to a declared or undeclared war or acts of war.
16. Services considered unnecessary or experimental in nature.
17. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.
18. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member including, but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.

Exclusions and Limitations (continued)

Limitations

1. Cleanings (prophylaxis) and fluoride treatments are limited to twice a year, unless medically necessary.
2. An additional charge will be applied for any procedure using noble or high noble metal.
3. Relines are limited to one every twenty four (24) months.
4. Full-mouth X-rays: Once every three (3) years, unless medically necessary.
5. Periodontal maintenance procedures (following active periodontal therapy) are limited to 2 in a 12-month period.
6. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a SafeGuard Benefit Plan. Replacements will be a benefit only if the existing denture is unsatisfactory and can not be made satisfactory as determined by the SafeGuard contracted general dentist.
7. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption.
8. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
9. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.
10. There is a $75 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.
11. Surgical removal of wisdom teeth/third molar for orthodontic reasons only is not a covered benefit.
12. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.
13. Surgical removal of impacted teeth is not a covered benefit unless pathology (disease) exists.
14. The co-payments listed for endodontic procedures do not include the cost of final restoration.

Orthodontic Exclusions and Limitations

1. Orthodontic treatment must be provided by a SafeGuard Selected General Dentist or contracted orthodontist in order for the co-payments listed in the Schedule of Benefits to apply.
2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a per-office-visit charge of $25 dollars.
3. The following are not included as orthodontic benefits:
   a). Repair or replacement of lost or broken appliances;
   b). Retreatment of orthodontic cases;
   c). Treatment in progress at inception of eligibility;
   d). Interceptive orthodontics;
   e). Changes in treatment necessitated by an accident;
   f). Treatment involving:
      1). Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
      2). Hormonal imbalances or other factors affecting growth or developmental abnormalities;
      3). Treatment related to temporomandibular joint disorders;
      4). Lingually placed direct bonded appliances and arch wires (“invisible braces”); and
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.

Dental (continued)

Language Assistance

As a SafeGuard member you have a right to free language assistance services, including interpretation and translation services. SafeGuard collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require language assistance or would like to inform SafeGuard of your preferred language, please contact SafeGuard at (800) 880-1800.

Como miembro de SafeGuard usted tiene derecho a recibir servicios gratuitos de asistencia en idiomas. Esto incluye servicios de interpretación y traducción. SafeGuard recaba la información sobre sus preferencias de idioma, raza, y etnia de manera que nos podamos comunicar eficazmente con nuestros afiliados. Si necesita asistencia en su idioma o quiere informarle a SafeGuard sobre su idioma de preferencia, comuníquese con SafeGuard al (800) 880-1800.

作為**SafeGuard**的會員，您有權獲得免費語言服務，包括口譯和筆譯。**SafeGuard**收集並保存有關您的語言選擇、人種和族裔方面的資料，以便我們更有效地與會員溝通。如果您需要語言方面的協助，或希望將您選擇的語言告訴**SafeGuard**，可通過電話或網站與**SafeGuard**聯絡，電話是**(800) 880-1800**。

Vision

A Look at Your VSP Vision Coverage

With VSP and Fire Risk Management Services (PLAN C 10/20 $180/$150), your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

Value and savings you love.
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.
With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.
Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.
You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!
Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with Exclusive Member Extras. At your appointment, just tell them you have VSP.

vsp vision care

More Ways to Save

Extra
$20
to spend on Featured Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

See all brands and offers at **vsp.com/offers**.

+

Up to
40%
Savings on lens enhancements‡

Create an account today.
Contact us: **800.877.7195** or **vsp.com**

Vision (continued)

Your VSP Vision Benefits Summary

Fire Risk Management Services (PLAN C 10/20 $180/$150) and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature
EFFECTIVE DATE:
01/01/2024

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$20**	
FRAME[+]	• $200 featured frame brands allowance • $180 frame allowance • 20% savings on the amount over your allowance • $100 Walmart®/Sam's Club®/Costco® frame allowance	Included in Prescription Glasses	Every 12 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		
YOUR COVERAGE GOES FURTHER IN-NETWORK			
With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.			

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

Flexible Spending Account

FLEXIBLE SPENDING ACCOUNT (FSA)

An FSA empowers you to set aside pre-tax money from every paycheck to help pay for qualified medical expenses. Choose a HealthEquity FSA and unlock these amazing benefits.

PUT MORE MONEY IN YOUR POCKET

Each dollar you contribute to your FSA is tax-deductible.[1] That means you could potentially save as much as 30 percent or more on qualified medical expenses.[2] Don't think of it as money deducted from your paycheck—think of it as money added to your wallet.

GET YOUR MONEY RIGHT AWAY

Let's say you plan to contribute the IRS maximum to your FSA. You'll have access to the entire amount on the first day of the plan year. Take advantage. Spend now, contribute later.

SPEND BEYOND THE DOCTOR'S OFFICE

Even though your FSA doesn't rollover, most members spend all their FSA dollars before the year ends. That's because you can use FSA dollars to cover a huge list of qualified medical expenses, including over-the-counter meds and menstrual care products.[3]

See a full list of eligible medical expenses at **HealthEquity.com/QME**

Know your options

- FSA elections can only be made during open enrollment (unless you have a qualifying life event)
- Choose the amount you want to contribute, then your employer will deduct that amount pre-tax in equal parts from each paycheck over 12 months
- Unused FSA dollars are forfeited to your employer, so it's important to plan ahead

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

[2]Based on average federal income and payroll taxes. Estimate for illustrative purposes only.

[3]Eligible expenses may vary by plan design. Your employer determines which expenses are eligible for reimbursement. Please review plan documents carefully and consult your benefits team for a full list of eligible expenses. It is the member's responsibility to ensure eligibility requirements as well as if they are eligible for the expenses submitted.

CLICK HERE to watch a video on Flexible Spending Accounts (FSA)

HRA, FSA, HSA numbers are reflected for the 2023 calendar year. 2024 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2024 year should keep this in mind.

Flexible Spending Account (continued)

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Aflac

MAYBE YOU'VE HAD AN FSA BEFORE, BUT YOU'VE NEVER HAD AN FSA LIKE THIS

Get support 24/7

Call us day or night. Our US-based service team measures success by problems solved. We'll do whatever it takes.

Say goodbye to hassle

Log in and manage everything via our simple mobile app.[4] Want to submit a claim? Easy. Just snap a photo and you're on your way.

Stay informed

Check out our vast library of webinars, tutorials, videos, calculators, and more. You'll find tips and tricks to make the most of your FSA.

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For more than two decades we've empowered some of the biggest companies in the world—and the smartest savers on the block.

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[4]Accounts must be activated via the HealthEquity website in order to use the mobile app.

HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life changing decisions.

Dependent Care Flexible Spending Account

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DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)

A DCFSA empowers you to set aside pre-tax money from every paycheck to help pay for dependent care expenses. A qualifying 'dependent' may be a child under age 13, a disabled spouse, or an older parent in eldercare.

COVER MORE THAN YOU THINK

Even though DCFSAs don't rollover, most members spend all their DCFSA dollars before the year ends. That's because you can use DCFSA dollars to cover a wide variety of eligible dependent care expenses,[1] including:

- Daycare, nursery school, and preschool
- Summer day camp
- Before or after school programs
- Elder daycare
- Virtual day camps and childcare

PUT MORE MONEY IN YOUR POCKET

Each dollar you contribute to your DCFSA is tax-deductible.[2] That means you could potentially save as much as 30 percent or more on qualified expenses.[3] Don't think of it as money deducted from your paycheck—think of it as money added to your wallet.

Know your options

- DCFSA elections can only be made during open enrollment (unless you have a qualifying life event)
- Choose the amount you want to contribute, then your employer will deduct that amount pre-tax in equal parts from each paycheck over 12 months
- Unused DCFSA dollars are forfeited to your employer, so it's important to plan ahead

[1]Eligible expenses may vary by plan design. Your employer determines which expenses are eligible for reimbursement. Please review plan documents carefully and consult your benefits team for a full list of eligible expenses. It is the member's responsibility to ensure eligibility requirements as well as if they are eligible for the expenses submitted.

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

[3]Based on average federal income and payroll taxes. Estimate for illustrative purposes only.

Dependent Care Flexible Spending Account (continued)

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MAYBE YOU'VE HAD A DCFSA BEFORE, BUT YOU'VE NEVER HAD A DCFSA LIKE THIS

Get support 24/7

Call us day or night. Our US-based service team measures success by problems solved. We'll do whatever it takes.

Say goodbye to hassle

When you use the WageWorks mobile app, you can have your dependent care provider sign receipts right from your mobile device.

Stay informed

Check out our vast library of webinars, tutorials, videos, calculators, and more. You'll find tips and tricks to make the most of your DCFSA.

JOIN MILLIONS OF FLEXIBLE SPENDERS

For more than two decades we've empowered some of the biggest companies in the world—and the smartest savers on the block.

Enroll today. Talk to your benefits team.

866.735.8195 | HealthEquity.com/Learn

Life/AD&D, Short Term Disability and Long Term Disability

Plan Benefits	Reliance Standard Life Insurance Company Basic Life and AD&D
Eligible Class	Employees
Coverage Amount	1 x Annual Earnings
Maximum Benefit	$200,000
Age Reduction	None

Plan Benefits	Reliance Standard Life Insurance Company Short Term Disability (STD)
Elimination Period	
• Non-Occupational Accident	30 days
• Non-Occupational Sickness	30 days
Definition of Disability	"Disabled" means you are: (1) unable to do the material duties of your job; and (2) not doing any work for payment; and (3) under the regular care of a physician.
Weekly Benefit Maximum	$2,309
Minimum Weekly Benefit	$25
Maximum Period of Payment	22 weeks

Plan Benefits	Reliance Standard Life Insurance Company Long Term Disability (LTD)
Elimination Period	180 Days
Benefit Percentage	60%
Monthly Benefit Maximum	$10,000
Minimum Monthly Benefit	Greater of 10% or $100
Definition of Disability	You cannot perform the material duties of your own occupation for the first 3 years after disability. After 3, years, you continue to be disabled if you cannot perform material duties to any occupation.
Survivor Benefit	If you pass away while on disability, an amount equal to 6 times your last monthly benefit is paid to your survivor (spouse).
Maximum Period of Payment	To Social Security Normal Retirement Age

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.

Voluntary Group Term Life and AD&D Insurance

Plan Highlights

Voluntary Group Term Life and AD&D Insurance

City of Palos Verdes Estates

ELIGIBILITY

All Active Full-Time Employees working 30 hours or more per week, except for any person working on a temporary or seasonal basis.
Dependents are:

- Your legal spouse who is not legally separated or divorced from you
- Your legally-recognized domestic or civil union partner
- Your unmarried financially dependent children birth to 26 years.
- A person may not have coverage as both an Employee and Dependent.
- Only one insured spouse may cover dependent children.

BENEFIT AMOUNT

Choose from a minimum of $10,000 to a maximum of $100,000 in $10,000 increments; subject to a salary cap of 10 times base annual earnings.

Spouse: Choose from a minimum of $10,000 to a maximum of $100,000 in $10,000 increments.

Child(ren): Birth but less than 6 months: $1,000; 6 months through age 26: $10,000.

GUARANTEED ISSUE

Initial eligibility period only

Employee:
Under age 60: $50,000
Age 60 but less than age 70: $50,000
Age 70 and over: none
Spouse:
Under age 60: $10,000
Age 60 but less than age 70: none
Age 70 and over: none
Child(ren): $10,000

CONTRIBUTION REQUIREMENTS

Coverage is 100% Employee Paid.

AD&D SCHEDULE

For Accidental Loss of	Amount Payable
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing	100%
One Hand or One Foot	50%
Sight of One Eye	50%
Speech or Hearing	50%

BENEFIT REDUCTION DUE TO AGE

(Applicable to employee / spouse coverage)

At Age	Face Amount Reduces To
75-79	60% of available or in force amount at age 74
80-84	35% of available or in force amount at age 74
85-89	27.5% of available or in force amount at age 74
90-94	20% of available or in force amount at age 74
95-99	7.5% of available or in force amount at age 74
100 +	5% of available or in force amount at age 74

RATES

See attached Rate Sheet

FEATURES

- Living Benefit
- Portability
- Waiver of Premium

reliancestandard
LIFE INSURANCE COMPANY

www.reliancematrix.com

Reliance Standard Plans
Voluntary and Dependent Life and AD&D Insurance
Premium Table

Plan Holder: City of Palos Verdes Estates

Scheduled Benefit: Each eligible employee may elect an amount of insurance shown in the table below.

For employees age 75 and older: Benefit amounts are reduced according to the age-based reduction chart shown in the Supplemental Life brochure.

Employee Premiums: To find your premium:
- Determine your age band: Your age = your age at your last birthday.
- Select a benefit amount (employees age 75 and older: see above comment).
- Rate changes as insured moves from one age bracket to the next.

Monthly Premiums

Benefit Amount	Age 18-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$10,000	$1.51	$1.51	$1.47	$1.98	$3.06	$4.95	$7.92	$13.30	$17.68	$27.22	$55.58
$20,000	$3.02	$3.02	$2.94	$3.96	$6.12	$9.90	$15.84	$26.60	$35.36	$54.44	$111.16
$30,000	$4.53	$4.53	$4.41	$5.94	$9.18	$14.85	$23.76	$39.90	$53.04	$81.66	$166.74
$40,000	$6.04	$6.04	$5.88	$7.92	$12.24	$19.80	$31.68	$53.20	$70.72	$108.88	$222.32
$50,000	$7.55	$7.55	$7.35	$9.90	$15.30	$24.75	$39.60	$66.50	$88.40	$136.10	$277.90
$60,000	$9.06	$9.06	$8.82	$11.88	$18.36	$29.70	$47.52	$79.80	$106.08	$163.32	$333.48
$70,000	$10.57	$10.57	$10.29	$13.86	$21.42	$34.65	$55.44	$93.10	$123.76	$190.54	$389.06
$80,000	$12.08	$12.08	$11.76	$15.84	$24.48	$39.60	$63.36	$106.40	$141.44	$217.76	$444.64
$90,000	$13.59	$13.59	$13.23	$17.82	$27.54	$44.55	$71.28	$119.70	$159.12	$244.98	$500.22
$100,000	$15.10	$15.10	$14.70	$19.80	$30.60	$49.50	$79.20	$133.00	$176.80	$272.20	$555.80

Dependent Child(ren) Monthly Premiums:

Benefit Amount	Premium
$10,000	$1.74

(One rate and benefit amount for all eligible children in family, regardless of number)

PREMIUM CALCULATION (Add your elections here):

Employee Premium	
Dependent Child(ren) Premium	
Total Premium	

(Rates are calculated as of coverage effective date and are based on insured's age in relation to Plan anniversary date. Billed rates may be higher if, at application, the person is at the highest age in an age band).

Please read this important information:

- **You may not have coverage as both an employee and as a dependent.**
- **Only one insured spouse may cover the eligible dependent children.**

Rates are subject to change.

Employee Assistance Program

Emotional wellbeing and work-life balance resources to keep you at your best

Halcyon EAP offers expert guidance to help you and your family address and resolve everyday issues.

In-the-moment support
Reach a licensed clinician by phone 24/7/365 for immediate assistance.

Financial expertise
Consultation and planning with a financial counselor.

Legal consultation
By phone or in-person with a local attorney.

Short-term counseling
Access up to **three (3) no-cost counseling sessions every six (6) months**, in-person or via video, to resolve stress, depression, anxiety, work-related pressures, relationship issues or substance abuse.

Convenience resources
Referrals for child and elder care, home repair, housing needs, education, pet care and so much more.

Confidentiality
Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.

Your web portal and mobile app

- The one-stop shop for program services, information and more.
- Discover on-demand training to boost wellbeing and life balance.
- Find search engines, financial calculators and career resources.
- Explore thousands of articles, tip sheets, self-assessments and videos.

Convenient, on-the-go support

- **Textcoach®**
  Personalized coaching with a licensed counselor on mobile or desktop.
- **Animo**
  Self-guided resources to improve focus, wellbeing and emotional fitness.
- **Virtual Support Connect**
  Moderated group support sessions on an anonymous, chat-based platform

Start with Navigator

Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator survey. You'll immediately receive personalized guidance to access support and resources.

Halcyon EAP

Download the mobile app today!

1-888-425-4800

halcyoneap.com
group code:
frms

AFLAC Supplemental Insurance

Get help with expenses health insurance doesn't cover

Aflac for City of Palos Verdes Estates

Who hasn't been blindsided by an unexpected medical bill? That's why there's Aflac. We can help take care of the expenses health insurance doesn't cover, so you can take care of everything else.

Aflac supplemental insurance

Our product portfolio is as broad as your needs, with individual and group plans that help cover the expected – and unexpected – that's sure to come life's way.

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

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

Cancer/Specified-Disease: Aflac's cancer/specified-disease insurance policy can help you and your family better cope financially if a positive diagnosis of cancer ever occurs.

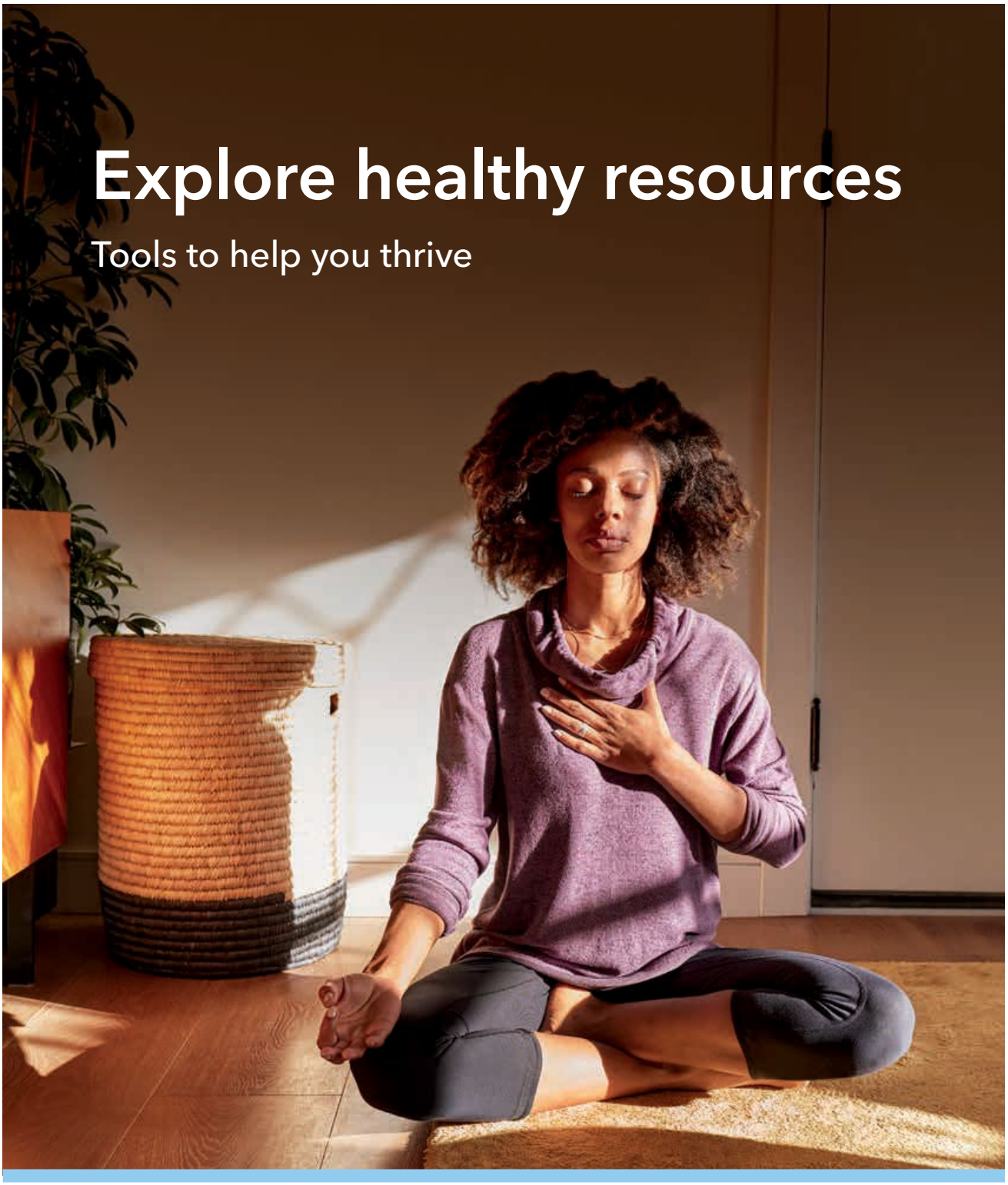
Critical Illness (Specified Health Event): An Aflac specified health event insurance policy is designed to help with the costs of treatment if you experience a covered health event.

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

To learn more, contact your Aflac agent, Tommy Fleeson, CA #0E78792, at tommy_fleeson@us.aflac.com or 949.307.2601.

Aflac.

Landing page URL: https://www.aflacenrollment.com/CityofPalosVerdesEstates/BQ5431057925



KAISER PERMANENTE®

Manage your care online

See how easy it is to stay on top of your care. When you register at **kp.org**, you get the most out of your membership – and can manage your health anytime, anywhere.[1]

Take charge of your care

Your connection to great health and great care is only a click away on **kp.org**. When you register for an online account, you can access many time-saving tools and tips for healthy living. Visit **kp.org** anytime, anywhere, to:

- View most lab test results
- Refill most prescriptions
- Choose your doctor based on what's important to you, and change anytime
- Email your Kaiser Permanente doctor's office with nonurgent questions
- Schedule and cancel routine appointments
- Print vaccination records for school, sports, and camp
- Manage a family member's health[2]

Register now – it's easy

You can register online at **kp.org** or on the Kaiser Permanente mobile app. Just follow the sign-on instructions. You'll need your health/medical record number, which you can find on your Kaiser Permanente ID card.

kp.org/register
kp.org/registreseahora (en español)

Download the Kaiser Permanente app

You can also use the Kaiser Permanente mobile app to register for an online account, message your doctor's office with nonurgent questions, find doctors and locations, view upcoming appointments, and more.

kp.org/mobile
kp.org/movil (en español)

Making the switch to great care is easy

Are you new to Kaiser Permanente? Thinking about joining? It's simple to get started with your new plan – and we're here to walk you through it. Get started with Kaiser Permanente at **kp.org/easyswitch**.

1. These features are available when you get care from Kaiser Permanente facilities. **2.** Online features change when children reach age 12. Teens are entitled to additional privacy protection under state laws. When your child turns 12 years old, you will still be able to manage care for your teen, with modified access to certain features. **3.** This value-added service is an extra service provided by entities other than Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS), and is neither offered nor guaranteed under any KFHP-MAS contract. This entity may change or discontinue offering this service at any time. KFHP-MAS disclaims any liability for the service provided by this entity. **4.** Please note that the ChooseHealthy program is not insurance. You should check any insurance benefits you have before using this discount program, as those benefits may result in lower costs to you than using this discount program. The ChooseHealthy program provides for discounts from participating specialty health care providers. You are obligated to pay for all services from those providers, but will receive a discount from those participating providers for services included in the program. The ChooseHealthy program also provides access to the Active&Fit Direct program, which provides discounted access to fitness centers. The ChooseHealthy program does not make any payments directly to those participating providers or to the Active&Fit Direct program. The ChooseHealthy program has no liability for providing or guaranteeing services and assumes no liability for the quality of services rendered. Discounts on products and services available through the ChooseHealthy program are subject to change; please consult the website for current availability.

Get wellness support

Take advantage of these convenient perks – from personal health coaching to reduced rates on alternative medical therapies.

Live healthier with helpful resources[3]

With our wellness resources, you'll get tools, tips, and information to help you create positive changes in your life. Our complimentary resources can help you:

- Lose weight
- Eat healthier
- Quit smoking
- Reduce stress
- Manage ongoing conditions like diabetes or depression

kp.org/health-wellness
kp.org/salud-bienestar (en español)

Connect to a wellness coach

If you need more support, we offer Wellness Coaching by Phone at no cost. You'll work one-on-one with your personal coach to make a plan to help you reach your health goals.

kp.org/wellnesscoach

Join health classes

With all kinds of health classes and support groups offered at our facilities, there's something for everyone. Classes vary at each location, and some may require a fee.

kp.org/classes
kp.org/clases (en español)

Enjoy reduced rates

Get reduced rates on a variety of health-related products and services through The ChooseHealthy® program.[4] These include:

- Active&Fit Direct – members pay $25 per month (plus a one-time $25 enrollment fee) for access to a national network of more than 10,000 fitness centers
- Up to 25% off a contracted provider's regular rates for:
  - Acupuncture
  - Chiropractic care
  - Massage therapy

kp.org/choosehealthy

Take time for self-care

Manage stress, improve your mood, sleep better, and more with the help of wellness apps, available at no cost to adult members.

kp.org/selfcareapps

Colorado state law requires that an access plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider services. To obtain a copy, please call Member Services or visit kp.org.

Services covered under your health plan are provided and/or arranged by Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 1300 SW 27th St., Renton, WA 98057

Learn more about your health

More information is just a click away. Use these interactive tools and reference guides to find answers to your health questions and help you make decisions about your care.

Drug encyclopedia	Look up detailed descriptions of thousands of drugs, including possible side effects. **kp.org/medications** | **kp.org/medicamentos** (en español)
Health encyclopedia	Explore more than 40,000 pages of in-depth information on health conditions, related symptoms, and treatment options. **kp.org/health** | **kp.org/salud** (en español)
Health guides	Stay informed on popular health subjects or discover something new through our healthy living guides, available in English and Spanish. **kp.org/livehealthy** | **kp.org/vidasaludable** (en español)
Interactive tools and calculators	Take an interactive quiz or enter your information into one of our calculators to learn more about your health. **kp.org/calculators**
Medical test directory	Learn more about your options for common tests and procedures, along with their risks and benefits. **kp.org/healthdecisions**
Natural Medicines Comprehensive Database®	Find answers to your questions about dietary supplements, vitamins, minerals, and other natural products. **kp.org/naturalmedicines** | **kp.org/medicinasnaturales** (en español)
Recipes	Get inspired to prepare delicious, healthy dishes. Browse recipes by category – like vegetarian dishes, soups, or desserts – or by what's in season. **kp.org/foodforhealth**
Symptom checker	Use our interactive visual aid to gauge your symptoms. Click on the body part that's troubling you and learn what to do next. **kp.org/symptoms** | **kp.org/sintomas** (en español)
Videos and podcasts	Look, listen, and learn about your health and well-being. Watch videos or download health-related, guided meditation podcasts. **kp.org/video** | **kp.org/audio**

KAISER PERMANENTE®

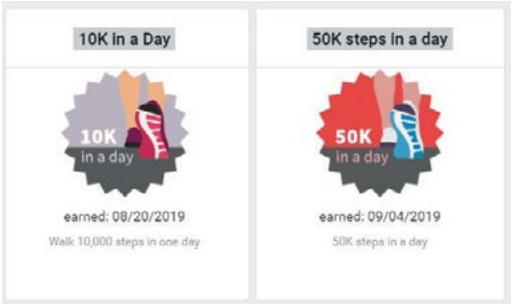
648220516 June 2021

myHNAS Wellness Tools

Your myHNAS member site is a central point for employer-sponsored health and wellness services. Depending on your plan, you may have access to a health risk assessment quiz, wellness programs, incentive rewards, and other features.

You can:

- Complete simple questions to obtain a profile of your current health status.
- Get personalized recommendations and actions for setting health goals.
- Connect to a device to track steps and activity.
- Access interactive learning about popular health topics.
- Participate in healthy activities with your colleagues.
- Earn badges and incentive rewards, if applicable.



To access wellness services:

1. Go to **myhnas.com** and log in.
2. Select *Wellness* from the left-hand menu and click the service you wish to access.

14922_HNAS_9_19

HealthNow Administrative Services

Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Discrimination is Against the Law

City of Palos Verdes Estates complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). City of Palos Verdes Estates does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 844.580.6856 for more information.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact HealthNow or Kaiser.

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

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

HealthNow or Kaiser.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Blue Shield of California and Kaiser Permanente. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (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.

Important Notices (continued)

The right to COBRA continuation coverage was created by 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 federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

If you are an employee, you will become a Qualified Beneficiary if you lose 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 are the spouse of an employee, you will 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 their 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 employment ends for any reason other than their 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."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Important Notices (continued)

Each notice must include all of the following items: the covered employee's full name, address, phone number, and Social Security Number; the full name, address, phone number, and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

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 on behalf of their dependent 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.

DISABILITY EXTENSION OF THE 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. This 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. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of 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 receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (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 the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

Important Notices (continued)

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

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

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

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

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

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

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

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.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Important Notices (continued)

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage. See the Summary Plan Description or contact the Plan Administrator for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination to remain eligible for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

FRMS Customer Service Center
frmsjpa@keenan.com
844.580.6856

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

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

Important Notices (continued)

- **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 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.**
- **FRMS has determined that the prescription drug coverage offered by EmpiRx and Kaiser**
- **Permanente is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current the City of Palos Verdes Estates coverage will not be affected. If you keep this coverage and elect Medicare, the City of Palos Verdes Estates coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current the City of Palos Verdes Estates 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 the City of Palos Verdes Estates 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 (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information. **Note:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Palos Verdes Estates changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will 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 your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 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 800-772-1213 (TTY 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).

Important Notices (continued)

Date: 01/01/2024

Name of Entity / Sender: City of Palos Verdes Estates

Contact: Carol Cowley

Address: 340 Palos Verdes Drive W.
Palos Verdes Estates, CA 90274

Phone: 310-378-0380 Ext. 803

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

City of Palos Verdes Estates Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact FRMS Customer Service Center at 844.580.6856.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about City of Palos V in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Open Enrollment for health insurance coverage through Covered California will begin on November 1, 2023, and end on January 31, 2024. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

Open Enrollment for most other states begins on November 1 and closes on January 15 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.healthcare.gov.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 8.39% (for 2024) of your household income for the year, then that coverage for you is not Affordable. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan. If you receive premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

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

STATES WITH INDIVIDUAL MANDATE

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Important Notices (continued)

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name City of Palos Verdes Estates	**4. Employer Identification Number (EIN)** 20-3180738	
5. Employer address 340 Palos Verdes Drive W.	**6. Employer phone number** 310-378-0380 Ext. 803	
7. City Palos Verdes Estates	**8. State** CA	**9. ZIP code** 90274
10. Who can we contact about employee health coverage at this job? Carol Cowley		
11. Phone number (if different from above)	**12. Email address** ccowley@pvestates.org	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

Important Notices (continued)

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 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 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, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678-564-1162, press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800-457-4584IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

Important Notices (continued)

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884
HIPPA Phone: 800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877-524-4718
Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888-342-6207 (Medicaid hotline) or
855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840 | TTY: Massachusetts relay 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800-657-3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP Program Toll-Free Phone: 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888-828-0059

Important Notices (continued)

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-Free Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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
877-267-2323, Menu Option 4, Ext. 61565

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.

CLICK HERE to watch a video on Benefits Key Terms Explained

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		
• Kaiser	800.464.4000	www.kp.org
• Health Now	877.356.0666	www.hnas.com
• Blue Shield	800.219.0030	www.blueshieldca.com
• EmpiRx	877.262.7435	www.empirxhealth.com
Dental		
• Delta Dental PPO	888.335.8227	deltadentalins.com
• MetLife DHMO	800.880.1800	mybenefits.metlife.com
Vision		
• Vision Service Plan (VSP)	800.877.7195	vsp.com
Section 125A		
• WageWorks	877.924.3967	wageworks.com
Basic Life/AD&D, Voluntary Life/AD&D		
• Reliance Standard Life Insurance Company	800.644.1103	www.rsli.com
Employee Assistance Program (EAP)		
• Halcyon	888.425.4800	halcyoneap.com **Group code:** frms
Critical Illness Supplemental Insurance		
• The Hartford	800.523.2233	www.thehartford.com/employee-benefits/employee
Aflac		
• Tommy Fleeson	949.307.2601	tommy_fleeson@us.aflac.com
FRMS Customer Service Center		
• Customer Service	844.580.6856	frmsjpa@keenan.com
ASi COBRA Administration		
• Customer Service	866.777.1320	www.asibenefits.com