

Employee *Benefits* Guide

2024



Cathedral City

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**Click this icon in your benefits guide to watch a video explaining the associated topic.
See page 111 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 104 for more details.

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

Human Resources Contact Information

Contact	Email	Phone
Human Resources Team	HR@cathedralcity.gov	
<ul style="list-style-type: none"> Eugenia Torres HR Manager 	etorres@cathedralcity.gov	760-770-0317
<ul style="list-style-type: none"> AnnMarie Quintanilla HR Specialist 	aquintanilla@cathedralcity.gov	760-202-2408
<ul style="list-style-type: none"> Lidia Buelna HR Specialist 	lbuelna@cathedralcity.gov	760-770-0352
<ul style="list-style-type: none"> Mitzi Mares HR Assistant 	mmares@cathedralcity.gov	760-202-2474

Employee Benefits Programs

Benefits Coordination (Medical, Dental & Vision Insurance)

COBRA Continuation

Flexible Spending Accounts

Voluntary Plan Administration

Deferred Compensation

Employee Assistance Program

Fair Employment Housing Act (FEHA)
Americans for Disabilities Act (ADA)

Family Medical Leave Act (FMLA)

Health Reimbursement Agreement (HRA)

Leave Administration

Life Insurance & Disability Insurance
Long Term & Short Term

Workers' Compensation



Contact Information (continued)

Benefit Information and Contacts:

You may contact the below benefit carriers or visit the following websites to confirm eligibility and verify coverage:

Employee Benefits Program	Phone Number	Web Site
Medical		
• CalPERS	888-225-7377	https://my.calpers.ca.gov
Dental		
• MetLife PPO	800-942-0854	https://mybenefits.metlife.com
• MetLife DHMO Group # 5912460	800-880-1800	https://mybenefits.metlife.com
MetLife VSP – Group # 00826401	800-877-7195	https://mybenefits.metlife.com
FSA & Dependent Childcare		
• Basic	800-372-3539	cda.basiconline.com
Voluntary Benefits		
• Colonial/Building Blocks	775-382-1369	westservice@bbforb.com
Life and Disability		
• Lincoln	800-423-2765	www.lfg.com
Employee Assistance Program (EAP) - New Plan! <i>(EmployeeConnect Plus provided through ComPsych)</i>		
• Lincoln Financial	855-327-4463	www.guidanceresources.com Web ID: Lincoln
Deferred Compensation		
• MissionSquare Retirement - Group # 301408	888-883-8577	www.missionsq.org
• MissionSquare Retirement 401(a) - Group # 106747	888-883-8577	www.missionsq.org
Health Reimbursement Account		
• MidAmerica - HRA	855-329-0095	healthaccounts@myMidAmerica.com
• MidAmerica	800-430-7999	www.midamerica.biz

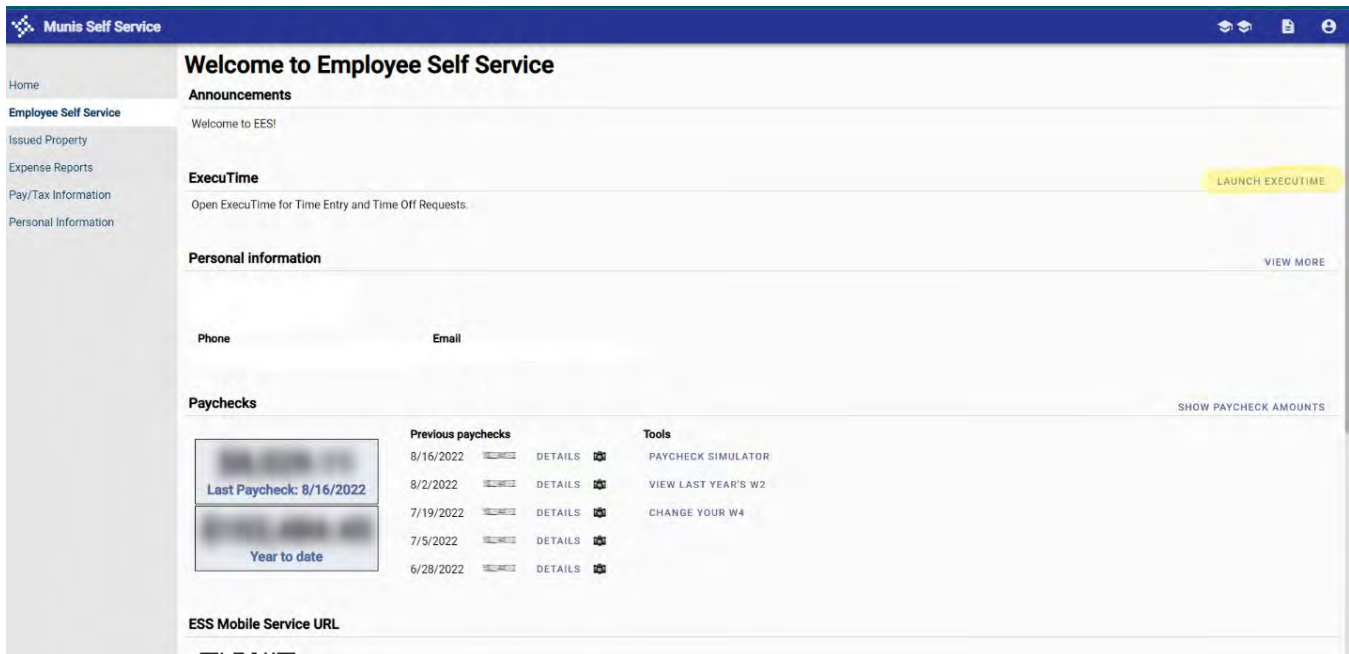


Employee Self Service

Web address: <https://selfservice.cathedralcity.gov/ess>

In ESS and Executime, your user ID should be the same as your Windows login (first initial combined with your last name). If this does not work, please contact IT for assistance.

The link to [Executime](#) is on the right-hand side of the welcome page.



Please review, save and approve your timesheet before you leave on your last day/shift worked before the end of each pay period. Once you have done so, a notification will then be sent to your designated approver to then review and approve for electronic submission to payroll.

Should you have any technical issues accessing ESS and/or Executime, please send an email to ithelpdesk@cathedralcity.gov

Should you have any questions with maneuvering in ESS or Executime, please reach out to your designated department timekeeping point of contact or payroll@cathedralcity.gov.

2024 Pay Period Calendar

JANUARY

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Introduction

As City of Cathedral City employees, you and your family are entitled to a number of valuable benefits. This guide contains important information about these benefits, which are negotiated collectively by your Union representative and the City.

You have 60 days from the date of your initial appointment to enroll, or decline coverage for yourself and eligible family members. Benefits will begin on the 1st of the month after you submit your paperwork and appropriate documentation to the Human Resources Department. If you do not enroll during the initial 60 days and have not experienced a qualifying life event, your enrollment will be subject to a 90-day waiting period or the following Open Enrollment period, whichever comes first.

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

- CalPERS Beneficiary Designation Form
- Lincoln Beneficiary Form
- HBD-12 Health Enrollment Form (if not enrolling, proof of coverage)

Optional Benefit Forms

- Flexible Spending Plan Enrollment form

- Optional Life & Voluntary AD&D insurance form
- Evidence of Insurability form (Required only if enrolling in Life Insurance coverage that exceeds plan limitations)
- Colonial (Meet with Building Blocks))
- Universal Enrollment form (Dental/Vision)

Benefit Choices

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

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



Eligibility and Enrollment

Who Is Eligible for the CalPERS Health Program?

Employees

Eligibility is based on tenure and time base of your qualifying appointment. You must work at least half-time and have a permanent appointment or a “limited term” appointment with a duration of more than six months. If you are a temporary or variable-hour employee, you may be eligible for health coverage due to new provisions in the Public Employee Medical and Hospital Care Act (PEMHCA) that help large contracting employers meet ACA requirements. To check if you meet the expanded eligibility criteria, contact your employer.

Family Members

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

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

Who Is Not Eligible for the CalPERS Health Program?

Ineligible Employees

- Those working less than half time
- Those whose appointment lasts less than six months
- We provide benefits to Limited Term employees because they work full time hours.
- Those classified as “Permanent-Intermittent” who do not meet the hour requirements within the control period

Ineligible Family Members

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

Do Not Enroll Ineligible Family Members

It is against the law to enroll ineligible family members. If you do so, CalPERS will retroactively cancel the enrollment and you may have to pay all costs incurred by the ineligible person from the date the coverage began.

Where to Get Help With Your Health Benefits Enrollment

If you are an active employee, contact your Health Benefits Officer to make all health benefit enrollment changes. Your Health Benefits Officer is usually located in your personnel office or human resources department.

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

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

Retired Cathedral City employees should refer to the Retiree Benefit Guide.

* The Affordable Care Act has provisions which expand eligibility criteria for certain variable-hour employees. For additional information, please contact your employer.

Eligibility and Enrollment (continued)

Spouse

You may add your spouse to your health plan within 60 days of your marriage. You are required to provide a copy of the marriage certificate and the spouse's Social Security Number and Medicare card (if applicable). Your spouse's coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Registered Domestic Partner

You may add your registered domestic partner to your health plan within 60 days of registration of the domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

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

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

Same sex domestic partnerships between persons who are both at least age 18 are eligible to register with the Secretary of State effective January 1, 2020. For more information about domestic partnership registration, visit the Secretary of State's website at www.sos.ca.gov.

Children

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

- Newborn children should be added within 60 days of birth. Coverage is effective from the date of birth.
- Newly adopted children should be added within 60 days of physical custody. Coverage is effective from the date physical custody is obtained.
- Stepchildren or a domestic partner's children under age 26 can be added within 60 days after the date of your marriage or registration of your domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Disabled Children Over Age 26

A child age 26 and over who is incapable of self-support because of a mental or physical condition may be eligible for enrollment. The disability must have existed prior to reaching age 26 and continuously since age 26, as certified by a licensed physician. You are required to complete and submit the Member Questionnaire for the CalPERS Disabled Dependent Benefit form, and the physician must complete and submit a Medical Report for the CalPERS Disabled Dependent Benefit form for CalPERS approval. The initial certification of the Disabled Dependent must occur during one of the following two eligibility periods (whichever applies):

- Within 60 days before and ending 60 days after the child's 26th birthday (member and dependent currently enrolled), **or**
- Within 60 days of a newly eligible employee's initial enrollment in the CalPERS Health Program

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

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

Eligibility and Enrollment (continued)

Dependents in a Parent-Child Relationship

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

You have 60 days from the date you obtained custody of the child to enroll him or her on your health plan. Prior to enrollment of a dependent who is in a parent-child relationship, you must complete and submit an Affidavit of Parent-Child Relationship. You will be required to provide supporting documentation as indicated on the Affidavit of Parent-Child Relationship. Coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

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

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

Split Enrollments

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

Enrolling in Two CalPERS Health Plans

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

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



Eligibility and Enrollment (continued)

Enrollment Type	Copies of Supporting Documentation*	CalPERS Forms
Active Employee – New Enrollment	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Health Benefits Plan Enrollment form Declaration of Health Coverage
Adding a Registered Domestic Partner	<ul style="list-style-type: none"> Declaration of Domestic Partnership from the California Secretary of State's Office Medicare card (if applicable) Social Security Card 	<ul style="list-style-type: none"> Health Benefits Plan Enrollment form Declaration of Health Coverage
Adding a Spouse	<ul style="list-style-type: none"> Marriage Certificate* Medicare card (if applicable) Social Security Card 	<ul style="list-style-type: none"> Health Benefits Plan Enrollment form Declaration of Health Coverage
Adding a Dependent Who is in a Parent-Child Relationship (PCR)	<ul style="list-style-type: none"> Required supporting documentation as indicated on the Affidavit of Parent-Child Relationship. Social Security Card 	<ul style="list-style-type: none"> Affidavit of Parent-Child Relationship Health Benefits Plan Enrollment form Declaration of Health Coverage
Adding/Deleting a Dependent Child	<ul style="list-style-type: none"> Medicare card (if applicable)* Reason for add/delete Birth Certificate Social Security Card 	<ul style="list-style-type: none"> Health Benefits Plan Enrollment form Declaration of Health Coverage
Changing Plans Due to Address Change	<ul style="list-style-type: none"> Include both old and new addresses 	<ul style="list-style-type: none"> Health Benefits Plan Enrollment form Declaration of Health Coverage
Deleting a Registered Domestic Partner due to Termination of Partnership	<ul style="list-style-type: none"> Termination of Domestic Partnership submitted to the California Secretary of State's Office 	<ul style="list-style-type: none"> Health Benefits Plan Enrollment form
Deleting a Spouse Due to Divorce	<ul style="list-style-type: none"> Divorce Decree 	<ul style="list-style-type: none"> Health Benefits Plan Enrollment form
Disabled Child Over Age 26 – Certification	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Member Questionnaire for the CalPERS Disabled Dependent Benefit form Medical Report for the CalPERS Disabled Dependent Benefit form
Enrolling Self or Dependents Due to Loss of Other Health Coverage	<ul style="list-style-type: none"> Certificate of Creditable Coverage, or other proof of loss of coverage Medicare card (if applicable) Birth Certificate (child) Marriage Certificate (spouse) Declaration of Domestic Partnership (domestic partner) 	<ul style="list-style-type: none"> Health Benefits Plan Enrollment form (active) Declaration of Health Coverage (active only) Health Benefits Plan Enrollment for Retirees form

* **Note:** Do not submit original documents as your documentation will not be returned.

Eligibility and Enrollment (continued)

Life Changes and Their Impact on Benefits

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

Name or Address Changes

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

Health Benefits Coverage

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

Marriage

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

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

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

Divorce

Retirement Impact: Your CalPERS benefits are considered community property under California law. To see how this may impact your benefits, review Community Property (PUB38AI PDF) or CalPERS at [888-225-7377](tel:888-225-7377). Your dissolution of marriage revokes a designation you may currently have on file with CalPERS. Review your beneficiary designation. If you need to make changes, log in to your my CalPERS account to make changes online or complete the appropriate designation form.

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

Health Benefits Coverage: You must remove your ex-spouse from your health plan as required by California Public Employees' Retirement Law. Your ex-spouse's entitlement to coverage ends at midnight on the last day of the month that your marriage dissolution is final. Contact Human Resources to modify your health plan. Your employer will need a copy of your divorce decree.

Registered Domestic Partnership

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

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

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



[CLICK HERE](#) to watch
a video on Qualifying
Life Events

Eligibility and Enrollment (continued)

Terminate Domestic Partnership

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

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

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

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

Health Benefits Coverage: You must remove your former domestic partner from your health plan. Their entitlement to coverage ends at midnight on the last day of the month that your partnership termination is final. Contact Human Resources to have your former domestic partner removed from your health plan. Your employer will need a copy of your termination document.

Birth or Adoption

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

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

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

Additional Documents to Consider Updating/Reviewing

- 457 Deferred Comp MissionSquare Beneficiary
- Checks Recipient Designation
- Emergency Contact (in ESS)
- 401(a) - MissionSquare Retirement
- Lincoln Life Insurance (Add, Delete, and/or change Beneficiary)
- Download a Life Changes packet from ESS



Eligibility and Enrollment (continued)

Additional Enrollment Opportunities

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

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

Special Enrollment

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

- **You lose other health coverage:** If you initially declined (or canceled) enrollment for yourself or your dependents (including your spouse) because you had other private or CalPERS health coverage at that time, you may be able to enroll in a CalPERS health plan if the other coverage involuntarily ends. To qualify, you will need to request enrollment within 60 days after the other coverage ends and provide proof that the other coverage has ended.
- **You have new family members:** When you enroll, you must enroll yourself or yourself and all eligible family members. If you later have a new dependent as a result of marriage, domestic partnership registration, birth, change of custody, adoption, or placement for adoption, you may enroll yourself and all eligible dependents within 60 days of that event.

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

Late Enrollment

If you decline or cancel enrollment for yourself or your dependents and the Special Enrollment exceptions do not apply, your right to enroll (or add dependents) will be limited. You will either have to wait for a 90-day period or until the next CalPERS Open Enrollment period. The earliest effective date of enrollment will be the first of the month following the 90-day waiting period or the January 1 following the Open Enrollment period.



Considering Your Health Plan Choices

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

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

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

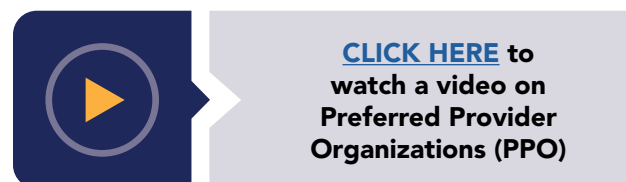
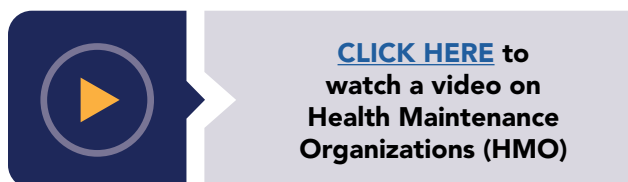
- Which health plan is best for you and your family?
- Which doctors and hospitals do you want to provide your care?

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

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

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

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



Understanding How CalPERS Health Plans Work

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

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

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



2024 Summary of Benefits and Coverage Notice

Choosing your health plan is an important decision. To assist you with this process, each health plan available through the California Public Employees' Retirement System has produced a Summary of Benefits and Coverage (SBC). In addition, the federal government has compiled a glossary of common health insurance terms. Together, these documents provide important information to help you better understand your health benefit coverage and more easily compare health plan options.

To view the SBCs and glossary online, visit www.calpers.ca.gov and select **View Health Plan Rates** to access the **Plans & Rates** page, or visit any of the health plan websites below. To request a free paper copy of the SBC and glossary, contact each health plan directly.

Anthem Blue Cross HMO & EPO

[855-839-4524](tel:855-839-4524)

www.anthem.com/ca/calpers

Blue Shield of California

[800-334-5847](tel:800-334-5847)

www.blueshieldca.com/calpers

California Association of Highway Patrolmen¹

[800-734-2247](tel:800-734-2247)

www.thecahp.org

California Correctional Peace Officers Association¹

[800-257-6213](tel:800-257-6213)

www.ccpoabt.org

Health Net of California

[888-926-4921](tel:888-926-4921)

www.healthnet.com/calpers

Kaiser Permanente

[800-464-4000](tel:800-464-4000)

www.kp.org/calpers

Peace Officers Research Association of California¹

[800-288-6928](tel:800-288-6928)

<http://ibt.porac.org>

PERS Gold and PERS Platinum

[877-737-7776](tel:877-737-7776)

www.anthem.com/ca/calpers

Sharp Health Plan

[855-995-5004](tel:855-995-5004)

www.sharphealthplan.com/calpers

UnitedHealthcare

[877-359-3714](tel:877-359-3714)

www.uhc.com/calpers

Western Health Advantage

[888-942-7377](tel:888-942-7377)

www.westernhealth.com/calpers

¹ To enroll in these health plans, you must belong to the specific employee association and pay applicable dues.

2024 Rates: All Employees

Group Insurance Plan – Health

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

The City offers a cafeteria like plan:

Employees may choose a plan lower than the cap health plan and utilize the difference toward the purchase of dental, vision and/or short-term disability coverage through the City. Any balance due can be deducted from the employee's paycheck on a bi-weekly basis. Any remaining amount stays with the City.

2024 City Contributions			
Health Coverage	Employee Only	Employee + 1	Employee + Family
NonRep/Elected	\$965.00	\$1,875.00	\$2,450.00
CCPMA	\$930.00	\$1,800.00	\$2,300.00
CCPOA	\$1,000.00	\$1,950.00	\$2,600.00
CCPFA/CCFMA	\$1,000.00	\$2,000.00	\$2,600.00
AFSCME	\$1,042.09	\$2,027.56	\$2,688.33

2024 Open Enrollment Payroll Deduction Calculator Region 3 – Los Angeles, Riverside, And San Bernardino Counties Limited Term						
Employee Name:						
Effective Date:	January 1, 2024					
Health Benefits	Plan Type	EE Only	EE+1	EE+2+	Monthly Premium	Bi-Weekly Premium
Anthem HMO Select	HMO	\$841.13	\$1,682.26	\$2,186.94	\$	\$
Anthem HMO Traditional	HMO	\$1,012.67	\$2,025.34	\$2,632.94	\$	\$
Blue Shield Access+	HMO	\$756.65	\$1,513.30	\$1,967.29	\$	\$
Blue Shield Trio	HMO	\$704.69	\$1,409.38	\$1,832.19	\$	\$
Health Net Salud y Mas	HMO	\$630.13	\$1,260.26	\$1,638.34	\$	\$
Kaiser Permanente	HMO	\$865.41	\$1,730.82	\$2,250.07	\$	\$
PERS Platinum	PPO	\$1,131.47	\$2,262.94	\$2,941.82	\$	\$
PERS Gold	PPO	\$785.28	\$1,570.56	\$2,041.73	\$	\$
PORAC	PPO	\$926.00	\$1,863.00	\$2,371.00	\$	\$
United Healthcare SignatureValue Alliance	HMO	\$826.44	\$1,652.88	\$2,148.74	\$	\$
United Healthcare signatureValue Harmony	HMO	\$734.76	\$1,469.52	\$1,910.38	\$	\$
MetLife (Dental & Vision)						
Met Life VSP	VSP	\$8.45	\$18.86	\$18.86	\$	\$
Met Life Dental	HMO	\$17.42	\$32.53	\$51.59	\$	\$
Met Life Dental	PPO	\$40.32	\$77.26	\$129.02	\$	\$
Medical Total					\$	\$
Allowance					\$	\$
Mo. Difference					\$	\$
Pay Period Difference					\$	

Per IRS regulations: any out of pocket cost for your health, dental, and/or vision coverage will be deducted on a pre-tax basis and any cost for your Short-Term Disability coverage will be deducted on a post-tax basis. The calculation remains the same as prior years. When determining your out of pocket costs, we will combine your health, dental and vision rates first then deduct that amount from your applicable allowance. Any remaining funds will be applied to your short-term disability coverage.

2024 CalPERS – EPO & HMO Basic Plans

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

Benefits	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue	Western Health Advantage HMO
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO				Alliance HMO Harmony HMO	
Calendar Year Deductible							
• Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Copay or Coinsurance <i>(excluding pharmacy)</i>							
• Individual	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)
• Family	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)
Hospital							
• Deductible <i>(per admission)</i>	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Surgical Services							
• Outpatient Facility Charge	No Charge	No Charge	No Charge	\$15	No Charge	No Charge	No Charge
Emergency Services							
• Emergency Room Copay	\$50	\$50	\$50	\$50	\$50	\$50	\$50
• Waived if Admitted	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Physician Services							
• Office Visits <i>(copay for each service provided)</i>	\$15	\$15	\$15	\$15	\$15	\$15	\$15
• Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15
• Urgent Care Services	\$15	\$15	\$15	\$15	\$15	\$15	\$15
• Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Surgery/Anesthesia	\$15	\$15	\$15	\$15	\$15	\$15	\$15

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2024 CalPERS – EPO & HMO Basic Plans (continued)

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

Benefits	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue	Western Health Advantage HMO
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO				Alliance HMO Harmony HMO	
Diagnostic X-Ray/Lab							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Prescription Drugs							
• Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Prescription Drug Annual Out of Pocket Max – Individual	\$7,950 (in addition to Medical OOP limit)	\$7,950 (in addition to Medical OOP limit)	\$7,950 (in addition to Medical OOP limit)	\$7,950 (in addition to Medical OOP limit)	\$7,950 (in addition to Medical OOP limit)	\$7,950 (in addition to Medical OOP limit)	\$7,950 (in addition to Medical OOP limit)
• Prescription Drug Annual Out of Pocket Max – Family	\$15,900 (in addition to Medical OOP limit)	\$15,900 (in addition to Medical OOP limit)	\$15,900 (in addition to Medical OOP limit)	\$15,900 (in addition to Medical OOP limit)	\$15,900 (in addition to Medical OOP limit)	\$15,900 (in addition to Medical OOP limit)	\$15,900 (in addition to Medical OOP limit)
• Retail Pharmacy (30-day supply)	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Generic/Tier 1 ¹ : \$5 Brand Preferred/Tier 2 ¹ : \$20 Non-Preferred/Tier 3 ¹ : \$50 Tier 4 ¹ : \$30	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Generic: \$5 Brand: \$20	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50
• Retail Preferred Pharmacy Maintenance Medications (90-day supply)	N/A	Generic/Tier 1 ¹ : \$10 Brand Preferred/Tier 2 ¹ : \$40 Non-Preferred/Tier 3 ¹ : \$100 Tier 4 ¹ : \$60	N/A	N/A	N/A	N/A	N/A
• Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Generic/Tier 1 ¹ : \$10 Brand Preferred/Tier 2 ¹ : \$40 Non-Preferred/Tier 3 ¹ : \$100 Tier 4 ¹ : \$60	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Generic: \$10 Brand: \$40 (31-100 day supply)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100
• Mail order maximum copayment per person per calendar year	\$1,000	\$1,000	\$1,000	N/A	\$1,000	\$1,000	\$1,000

1 Tier Formulary is for BSC Trio HMO only. Tier 1 refers to medications classified as 'Generic'; Tier 2 refers to medications classified as "Preferred Brand"; and Tier 3 refers to medications classified as "Non-Preferred Brand".

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2024 CalPERS – EPO & HMO Basic Plans (continued)

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

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

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2024 CalPERS – PPO Basic Plans

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

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible						
• Individual	\$1,000 ^{1,3}	\$2,500 ³	\$500 ³	\$2,000 ³	\$300	\$600
• Family	\$2,000 ^{2,3}	\$5,000 ³	\$1,000 ³	\$4,000 ³	\$900	\$1,800
Maximum Calendar Year Copay or Coinsurance (excluding pharmacy)						
• Individual	\$3,000 (coinsurance)	Unlimited	\$2,000 (coinsurance)	Unlimited	\$2,000	\$2,000
• Family	\$6,000 (coinsurance)	Unlimited	\$4,000 (coinsurance)	Unlimited	\$4,000	\$4,000
Hospital						
• Deductible (per admission)	N/A	N/A	\$250	\$250	N/A	N/A
• Inpatient	20% ²	40% ⁴	10%	40% ⁴	20%	20% ⁴
• Outpatient Facility/ Surgery Services	20%	40% ⁴	10%	40% ⁴	20%	20% ⁴
Emergency Services						
• Emergency Room Deductible (copay waived if admitted as an inpatient or for observation as an outpatient)	\$50 (applies to hospital emergency room facility charge only)		\$50 (applies to hospital emergency room facility charge only)		N/A	
• Emergency	20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		20%	
• Non-Emergency	20%	40%	10%	40%	50%	
	(payment for physician charges only; emergency room facility charge is not covered)		(payment for physician charges only; emergency room facility charge is not covered)		(for non-emergency services provided by hospital emergency room)	

¹ Incentives available to reduce individual deductible (max. \$500) or family deductible (max. \$1,000) include: getting a biometric screening (\$100 credit); receiving a flu shot (\$100 credit); getting a non-smoking certification (\$100 credit); getting a virtual second opinion (\$100 credit); and getting a condition care certification (\$100 credit).

² Coinsurance waived for deliveries if enrolled in Future Moms Program.

³ Deductible is transferable between PERS Gold and PERS Platinum.

⁴ Of the allowable amount as defined in the EOC.

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2024 CalPERS – PPO Basic Plans (continued)

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

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Physician Services						
• Office Visits (<i>copay for each service provided</i>)	\$35 ¹	40% ³	\$20 ²	40% ³	\$10/\$35 ²	20% ³
• Inpatient Visits	20%	40% ³	10%	40% ³	20%	20% ³
• Outpatient Visits	\$35	40% ³	\$20	40% ³	20%	20% ³
• Urgent Care Visits	\$35	40% ³	\$35	40% ³	\$35	20% ³
• Preventive Services	No Charge	40% ³	No Charge	40% ³	No Charge	
• Surgery/Anesthesia	20%	40% ³	10%	40% ³	20%	20% ³
Diagnostic X-Ray/Lab						
	20% ⁴	40% ³	10% ⁴	40% ³	20%	20% ³

¹ Reduced to \$10 when seen by primary physician

² \$35 for specialist visit

³ Of the allowable amount as defined in the EOC

⁴ For lab services only – no charge when using Quest Diagnostic or Labcorp.

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2024 CalPERS – PPO Basic Plans (continued)

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

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Prescription Drugs						
• Deductible	N/A		N/A		N/A	
• Prescription Drug Annual Out of Pocket Max – Individual	\$2,000		\$2,000		\$2,000	
• Prescription Drug Annual Out of Pocket Max – Family	\$4,000		\$4,000		\$4,000	
• Retail Pharmacy (30-day supply)	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50		Tier 1: \$5 Tier 2: \$20 Tier 3: \$50		Generic: \$10 Brand Preferred: \$25 Non-Preferred: \$45 Compound: \$45	
• Retail Preferred Pharmacy Maintenance Medications (90-day supply)	N/A		N/A		N/A	
• Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100		Tier 1: \$10 Tier 2: \$40 Tier 3: \$100		Generic: \$20 Brand Preferred: \$40 Non-Preferred: \$75	N/A
• Mail Order Maximum Copayment Per Person Per Calendar Year	\$1,000		\$1,000		N/A	
Durable Medical Equipment						
	20%	40% ¹	10%	40% ¹	20%	20% ¹
	(pre-certification required for specific equipment)		(pre-certification required for the purchase of equipment priced at \$1,000 or more)			
Infertility Testing/Treatment						
	50%		50%		50%	50% ²

¹ Of the allowable amount as defined in the EOC

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.

2024 CalPERS – PPO Basic Plans (continued)

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

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Occupational / Physical / Speech Therapy						
• Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		20% (no copay for inpatient PT/OT by a PAR provider)	20% ²
• Outpatient (office and home visits)	20%	40% (Occupational therapy 20%)	10%	40% (Occupational therapy 10%)	\$15 /Office Visit (all other services 20%) ³	20% ²
	(pre-certification required for more than 24 visits)		(Pre-certification required for more than 24 visits)			
Diabetes Services						
• Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies	
• Self-management training	\$20 ¹	40% ²	\$20 ¹	40% ²	\$20	60% ²
Acupuncture						
	\$15/Visit	40% ²	\$15/Visit	40% ²	\$15 / Office Visit (all other services 20%) ³	20% ²
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			
Chiropractic						
• Office Visit	\$15/Visit	40% ²	\$15/Visit	40% ²	\$15 / Office Visit (all other services 20%) ³	20% ²
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			

¹ \$35 for specialist visit

² Of the allowable amount as defined in the EOC

³ Combined 20 visits per calendar year. (Occupational/Physical/Chiropractor) Combined 20 visits per calendar year

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Dental

When it comes to choosing a dental plan, you want benefits that fit the needs of you and your family. MetLife PPO and Dental HMO both offer comprehensive dental coverage, quality care and excellent customer service. The City allows all full-time and permanent part-time employee and their eligible dependents to elect from one of the two plan offerings.

MetLife DHMO

MetLife DHMO is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. In most states, enrollees must select a primary care dentist in the MetLife Dental network from whom they receive treatment as in a traditional dental HMO.

MetLife PPO

MetLife Dental PPO, our preferred provider organization (PPO) plan, provides access to the largest PPO dentist network in the U.S. MetLife Dental dentists agree to accept reduced fees for covered procedures when treating PPO patients. This means your out-of-pocket costs are usually lower when you visit a PPO dentist than when you visit a non-MetLife dentist, but you have the freedom to visit any licensed dentist, anywhere in the world.



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.

Dental (continued)

MetLife Dental DHMO

With the MetLife DHMO Plan, you receive care from your assigned dentist and are informed of copay amounts ahead of time..

Plan Benefits	Dental HMO/Managed Care
General Plan Information	
• Annual Deductible	
– Individual	\$0
– Family	\$0
• Waived for Preventive	N/A
• Annual Plan Maximum	N/A
• Lifetime Orthodontia Plan Maximum	\$1450
Diagnostic and Preventive Services	
• Diagnostic and Preventive	\$0 - \$50 copay
• Oral Exams	100% covered
• Bitewing X-rays	100% covered
• Full Mouth X-rays	100% covered every 36 months
• Cleaning and Scaling	100% covered every six months
• Prophylaxis Treatments	100% covered every six months
• Fluoride Treatments	100% covered
• Space Maintainers	100% covered
• Sealants	\$0 copay
Basic Services	
• Basic	\$0 – \$225 copay
• Oral Surgery (<i>Extractions and Other Surgical Procedures</i>)	\$0 – \$90 copay
• Endodontic Treatment	\$0 – \$160 copay
• Periodontic Treatment	\$0 – \$265 copay
• Re-linings and Re-basings of Existing Removable Dentures	\$0 – \$365 copay
• Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures, Bridgework or Veneers	\$0 – \$350 copay
Major Services	
• Major	\$0 – \$195 copay
• Crowns, Jackets and Cast Restorations	\$0 – \$225 copay
• TMJ	Not covered
• Prosthodontic Benefits (<i>Fixed Bridges, Partial/Complete Dentures</i>)	\$0 – \$195 copay
• Implants	Not covered
Orthodontia Services	
• Orthodontia (<i>Children and adults</i>)	\$0 – \$1,450 copay; see plan document for limitations

For more information on MetLife please visit [metlife.com](https://www.metlife.com).

To look up a dental provider please visit [metlife.com](https://www.metlife.com)

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Dental (continued)

Dental PPO

Although the percentages of Benefits are the same no matter which dentist you choose, your out-of-pocket expenses may be greater if you choose a MetLife PPO Dentist.

Plan Benefits	PPO Plus	
	In-Network	Out-of-Network
General Plan Information		
• Annual Deductible		
– Individual	\$25	\$25
– Family	\$75	\$75
• Waived for Preventive	No	No
• Annual Plan Maximum	\$1,750	\$1,750
• Lifetime Orthodontia Plan Maximum		
Diagnostic and Preventive Services		
• Diagnostic and Preventive	100%	100%
• Oral Exams	100%	100%
• Bitewing X-rays	100%	100%
• Full Mouth X-rays	100%	100%
• Cleaning and Scaling	100%	100%
• Prophylaxis Treatments	100%	100%
• Fluoride Treatments	100%	100%
• Space Maintainers	100%	100%
• Sealants	100%	100%
Basic Services		
• Basic	80%	60%
• Oral Surgery (<i>Extractions and Other Surgical Procedures</i>)	80%	60%
• Endodontic Treatment	80%	60%
• Periodontic Treatment	80%	60%
• Re-linings and Re-basings of Existing Removable Dentures	80%	60%
• Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	80%	60%
Major Services		
• Major	50%	40%
• Crowns, Jackets and Cast Restorations	50%	40%
• TMJ	50%	Not covered
• Prosthodontic Benefits (<i>Fixed Bridges, Partial/Complete Dentures</i>)	50%	40%
• Implants	50%	Not covered; see plan document

For more information on MetLife please visit [metlife.com](https://www.metlife.com).

To look up a dental provider please visit [metlife.com](https://www.metlife.com)

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Vision

The City offers a vision plan through VSP. The plan pays benefits and offers discounts for most vision care expenses you incur while covered by the plan, subject to the maximum amounts shown below. Vision coverage is available for non-sworn full-time and permanent part-time employees and their eligible dependents. If you use VSP providers, your costs for most services and materials are limited to the applicable copays. To find more information on VSP or to locate a provider, please visit vsp.com.

Plan Benefits	MetLife Vision Service Plan (VSP)	
	In-Network	Out-of-Network
General Plan Information		
• Exam	\$10 copay, combined with materials copay	Up to \$45 allowance
• Materials	\$10 copay, combined with materials copay	Not covered
Benefit Frequency		
• Exam	12 months	12 months
• Lenses	12 months	12 months
• Frames	24 months	24 months
• Contacts	12 months	12 months
Covered Services		
• Single Vision Lens	Covered after copay	Up to \$30
• Bifocal Lens	Covered after copay	Up to \$50
• Trifocal Lenses	Covered after copay	Up to \$65
• Lenticular	Covered after copay	Up to \$100
• Basic Progressive	Covered after copay	Up to \$50
Lens Options		
• UV Coating	Covered after copay	Up to \$50
• Tint (<i>Solid and Gradient</i>)	20-25% discounted savings	Up to \$50
• Scratch Resistance	20-25% discounted savings	Up to \$50
• Basic Polycarbonate	20-25% discounted savings	Up to \$50
• Standard Anti-Reflective	\$37 copay	Up to \$50
• Other Add-Ons and Services	Discounts available	Not covered
Contact Lenses		
• Medically Necessary	Covered after copay	Up to \$210 allowance
• Elective	Up to \$130 allowance	Up to \$105 allowance
Other Services		
• Corrective Vision Services (<i>Laser Surgery</i>)	Discount available	
• Second Pair of Glasses	Discount available	

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Basic Life and AD&D

Basic Life

The City of Cathedral City provides Group Life and Accidental Death and Dismemberment Insurance for full-time and permanent part-time employees.

Don't Forget to Name a Beneficiary

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

Basic Life Coverage		
Group	Coverage	AD&D
Elected Officials and Council Members	\$50,000	Yes
All Full-Time and Regular Part-Time Executives, Non-Represented, CCPMA and CCFMA Employees	2x Annual Salary	Yes
All CCPOA Employees	\$150,000	Yes
All CCPFA and AFSCME employees	1x Annual Salary	Yes



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Term Life and AD&D Insurance - Lincoln Financial Group



City of Cathedral City provides this valuable benefit at no cost to you.

All Full-Time and Regular Part-Time Executives, Non-Represented, CCPMA and CCFMA Employees

Life and AD&D Insurance

Safeguard the most important people in your life.

Consider what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like helping to cover everyday expenses, pay off debt, and protect savings. Accidental death and dismemberment (AD&D) insurance provides additional benefits if you die or suffer a covered loss in an accident, such as losing a limb or your eyesight.

At a glance:

- A cash benefit of two times Annual Earnings rounded to the next higher \$1,000 (up to \$400,000) to your loved ones in the event of your death, plus an additional cash benefit if you die in an accident.
- AD&D Plus: If you suffer an AD&D-covered loss in an accident, you may also receive benefits for the following in addition to your core AD&D benefits: coma, plegia, education, childcare, spouse training. Additional conditions are outlined in your policy.
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services.
- *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home.

You also have the option to increase your cash benefit by securing additional coverage at affordable group rates. See the enclosed optional life insurance information for details.

Additional details

Continuation of coverage for ceasing active work: You may be able to continue your coverage if you leave your job for reasons including and not limited to Family and Medical Leave, lay-off, leave of absence, or leave of absence due to disability.

Waiver of premium: This provision relieves you from paying premiums during a period of disability that has lasted for a specified length of time.

Continuation of coverage: You may be able to continue your coverage if you leave your job for any reason other than sickness, injury, or retirement.

Accelerated death benefit: Enables you to receive a portion of your policy death benefit while you are living. To qualify, a medical professional must diagnose you with a terminal illness with a life expectancy of fewer than 12 months.

Conversion: You may be able to convert your group term life coverage to an individual life insurance policy if your coverage decreases or you lose coverage due to leaving your job or for other reasons outlined in the plan contract.

Benefit reduction: Your employee Life/AD&D coverage amount will reduce by 35% when you reach age 70, and an additional 15% of the original amount when you reach age 75. Benefits end when you retire.

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

Term Life and AD&D Insurance (continued)



City of Cathedral City provides this valuable benefit at no cost to you.

All CCPFA and AFSCME Employees

Life and AD&D Insurance

Safeguard the most important people in your life.

Consider what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like helping to cover everyday expenses, pay off debt, and protect savings. Accidental death and dismemberment (AD&D) insurance provides additional benefits if you die or suffer a covered loss in an accident, such as losing a limb or your eyesight.

At a glance:

- A cash benefit of one times Annual Earnings rounded to the next higher \$1,000 (up to \$200,000) to your loved ones in the event of your death, plus an additional cash benefit if you die in an accident.
- AD&D Plus: If you suffer an AD&D-covered loss in an accident, you may also receive benefits for the following in addition to your core AD&D benefits: coma, plegia, education, childcare, spouse training. Additional conditions are outlined in your policy.
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services.
- *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home.

You also have the option to increase your cash benefit by securing additional coverage at affordable group rates. See the enclosed optional life insurance information for details.

Additional details

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Waiver of premium: This provision relieves you from paying premiums during a period of disability that has lasted for a specified length of time.

Continuation of coverage: You may be able to continue your coverage if you leave your job for any reason other than sickness, injury, or retirement.

Accelerated death benefit: Enables you to receive a portion of your policy death benefit while you are living. To qualify, a medical professional must diagnose you with a terminal illness with a life expectancy of fewer than 12 months.

Conversion: You may be able to convert your group term life coverage to an individual life insurance policy if your coverage decreases or you lose coverage due to leaving your job or for other reasons outlined in the plan contract.

Benefit reduction: Your employee Life/AD&D coverage amount will reduce by 35% when you reach age 70, and an additional 15% of the original amount when you reach age 75. Benefits end when you retire.

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

Term Life and AD&D Insurance (continued)



City of Cathedral City provides this valuable benefit at no cost to you.

Elected Officials and Council Members

Life and AD&D Insurance

Safeguard the most important people in your life.

Consider what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like helping to cover everyday expenses, pay off debt, and protect savings. Accidental death and dismemberment (AD&D) insurance provides additional benefits if you die or suffer a covered loss in an accident, such as losing a limb or your eyesight.

At a glance:

- A cash benefit of \$50,000 to your loved ones in the event of your death, plus an additional cash benefit if you die in an accident.
- AD&D Plus: If you suffer an AD&D-covered loss in an accident, you may also receive benefits for the following in addition to your core AD&D benefits: coma, plegia, education, childcare, spouse training. Additional conditions are outlined in your policy.
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services.
- *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home.

You also have the option to increase your cash benefit by securing additional coverage at affordable group rates. See the enclosed optional life insurance information for details.

Additional details

Continuation of coverage for ceasing active work: You may be able to continue your coverage if you leave your job for reasons including and not limited to Family and Medical Leave, lay-off, leave of absence, or leave of absence due to disability.

Waiver of premium: This provision relieves you from paying premiums during a period of disability that has lasted for a specified length of time.

Continuation of coverage: You may be able to continue your coverage if you leave your job for any reason other than sickness, injury, or retirement.

Accelerated death benefit: Enables you to receive a portion of your policy death benefit while you are living. To qualify, a medical professional must diagnose you with a terminal illness with a life expectancy of fewer than 12 months.

Conversion: You may be able to convert your group term life coverage to an individual life insurance policy if your coverage decreases or you lose coverage due to leaving your job or for other reasons outlined in the plan contract.

Benefit reduction: Your employee Life/AD&D coverage amount will reduce by 35% when you reach age 70, and an additional 15% of the original amount when you reach age 75. Benefits end when you retire.

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

Term Life and AD&D Insurance (continued)



City of Cathedral City provides this valuable benefit at no cost to you.

All CCPOA Employees

Life and AD&D Insurance

Safeguard the most important people in your life.

Consider what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like helping to cover everyday expenses, pay off debt, and protect savings. Accidental death and dismemberment (AD&D) insurance provides additional benefits if you die or suffer a covered loss in an accident, such as losing a limb or your eyesight.

At a glance:

- A cash benefit of \$150,000 to your loved ones in the event of your death, plus an additional cash benefit if you die in an accident.
- AD&D Plus: If you suffer an AD&D-covered loss in an accident, you may also receive benefits for the following in addition to your core AD&D benefits: coma, plegia, education, childcare, spouse training. Additional conditions are outlined in your policy.
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services.
- *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home.

You also have the option to increase your cash benefit by securing additional coverage at affordable group rates. See the enclosed optional life insurance information for details.

Additional details

Continuation of coverage for ceasing active work: You may be able to continue your coverage if you leave your job for reasons including and not limited to Family and Medical Leave, lay-off, leave of absence, or leave of absence due to disability.

Waiver of premium: This provision relieves you from paying premiums during a period of disability that has lasted for a specified length of time.

Continuation of coverage: You may be able to continue your coverage if you leave your job for any reason other than sickness, injury, or retirement.

Accelerated death benefit: Enables you to receive a portion of your policy death benefit while you are living. To qualify, a medical professional must diagnose you with a terminal illness with a life expectancy of fewer than 12 months.

Conversion: You may be able to convert your group term life coverage to an individual life insurance policy if your coverage decreases or you lose coverage due to leaving your job or for other reasons outlined in the plan contract.

Benefit reduction: Your employee Life/AD&D coverage amount will reduce by 35% when you reach age 70, and an additional 15% of the original amount when you reach age 75. Benefits end when you retire.

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

Long Term Disability

Eligibility

Class 1 – Executives

Class 2 – Non Reps

Class 3 – AFSCME

Class 4 – CCPMA, CCPOA, CCFMA, CCPFA

The City provides Long-Term Disability (LTD) to employees. LTD is designed to provide a monthly benefit in the event you are unable to work due to a covered disability.



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.

Benefit Definitions

- **Benefit Waiting Period:** The period of salary continuation for which you are eligible under the Employer's salary continuation plan, whichever is longer.
- **Benefit Percentage:** Percentage of your (pre-disability) monthly earnings the plan replaces.
- **Maximum Duration:** Maximum length of time the benefit is in effect.
- **Maximum Benefit Duration is to SSNRA (Social Security Normal Retirement Age).** The Maximum Benefit Duration will be determined as follows:
 - **Own Occupation to Age 65** definition of disability. You are considered disabled if you are unable to perform the substantial and material duties of your own occupation or you suffer a 20% or greater loss of earnings.
 - **Partial Disability included.**
 - **Return to Work Incentive.** In supporting a claimant's return to work on a part-time basis, during the first 24 months, benefit payments will be paid in addition to the work earnings paid by the employer. The benefit amount paid will be limited to an amount that does not cause the claimant to earn more than 100% of his/her pre-disability earnings. In essence, you can receive full time pay while working part-time.
 - **Survivor Benefit.** If a claimant dies while LTD benefits are payable and the claimant has been continuously disabled for at least 180 days, a lump sum payment equal to three times the monthly "gross" benefit will be paid to a surviving spouse or to unmarried children under the age of 25.
 - **Reasonable Accommodation.** Up to \$25,000 for modifications made that result in a return to work.
 - 3/12 Pre-existing condition limitation.
 - 24-month limitation for disabilities arising from mental disorders or substance abuse.
 - Conversion included.

Long Term Disability (continued)

Benefits	Summary of Long-Term Disability Benefits			
	Core Plan			
	Executives	Non-Reps	AFSCME	Sworn
Benefit Waiting Period	180 days			
Benefit Percentage	66 2/3%	66 2/3%	60%	60%
Maximum Benefit	\$15,000/month	\$13,000/month	\$10,500/month	\$10,500/month

Age at Disability	Maximum Benefit Period
Less than Age 60	To Age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and Over	12 months



Important

Please contact HR for a copy of your Certificate of Insurance/Summary Plan Document for a complete description of your rights and the terms under the group policy.

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Long Term Disability (continued)



City of Cathedral City provides this valuable benefit at no cost to you.

All Full-Time and Regular Part-Time Executives

Long-term Disability Insurance

Keep getting a check when you're hurt or sick.

You always have bills to pay, even when you can't get to work due to injury, illness, or surgery. Long-term disability insurance helps you make ends meet during this difficult time.

AT A GLANCE:

- A cash benefit of 66.67% of your monthly salary (up to \$15,000) starting after a period of 180 consecutive days of disability, and continues up to the maximum benefit period.
- Includes *EmployeeConnect*SM Plus EAP services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance.
- Program Services include:
 - Unlimited, 24/7 access to information and referrals
 - In-person help for short-term issues; up to six sessions with a counselor per person, per issue, per year.
 - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
 - One free consultation with a financial counselor
 - Online tools, tutorials, videos and much more

ADDITIONAL DETAILS

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the three months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

Coverage Period for Your Occupation: 24 months. After this initial period, you may be eligible to continue receiving benefits if your disability prohibits you from performing any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits may be extended through the end of your maximum coverage period (benefit duration).

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

Long Term Disability (continued)



City of Cathedral City provides this valuable benefit at no cost to you.

All Full-Time and Regular Part-Time Non-Represented Employees

Long-term Disability Insurance

Keep getting a check when you're hurt or sick.

You always have bills to pay, even when you can't get to work due to injury, illness, or surgery. Long-term disability insurance helps you make ends meet during this difficult time.

AT A GLANCE:

- A cash benefit of 66.67% of your monthly salary (up to \$13,000) starting after a period of 180 consecutive days of disability, and continues up to the maximum benefit period.
- Includes *EmployeeConnect*SM Plus EAP services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance.
- Program Services include:
 - Unlimited, 24/7 access to information and referrals
 - In-person help for short-term issues; up to six sessions with a counselor per person, per issue, per year.
 - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
 - One free consultation with a financial counselor
 - Online tools, tutorials, videos and much more

ADDITIONAL DETAILS

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the three months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

Coverage Period for Your Occupation: 24 months. After this initial period, you may be eligible to continue receiving benefits if your disability prohibits you from performing any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits may be extended through the end of your maximum coverage period (benefit duration).

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

Long Term Disability (continued)



City of Cathedral City provides this valuable benefit at no cost to you.

All AFSCME Employees

Long-term Disability Insurance

Keep getting a check when you're hurt or sick.

You always have bills to pay, even when you can't get to work due to injury, illness, or surgery. Long-term disability insurance helps you make ends meet during this difficult time.

AT A GLANCE:

- A cash benefit of 60% of your monthly salary (up to \$10,500) starting after a period of 180 consecutive days of disability, and continues up to the maximum benefit period.
- Includes *EmployeeConnect*SM Plus EAP services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance.
- Program Services include:
 - Unlimited, 24/7 access to information and referrals
 - In-person help for short-term issues; up to six sessions with a counselor per person, per issue, per year.
 - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
 - One free consultation with a financial counselor
 - Online tools, tutorials, videos and much more

ADDITIONAL DETAILS

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the three months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

Coverage Period for Your Occupation: 24 months. After this initial period, you may be eligible to continue receiving benefits if your disability prohibits you from performing any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits may be extended through the end of your maximum coverage period (benefit duration).

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

Long Term Disability (continued)



City of Cathedral City provides this valuable benefit at no cost to you.

All CCPOA, CCPFA, CCFMA, CCPMA Employees

Long-term Disability Insurance

Keep getting a check when you're hurt or sick.

You always have bills to pay, even when you can't get to work due to injury, illness, or surgery. Long-term disability insurance helps you make ends meet during this difficult time.

AT A GLANCE:

- A cash benefit of 60% of your monthly salary (up to \$10,500) starting after a period of 180 consecutive days of disability, and continues up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is later.
- Includes *EmployeeConnect*SM Plus EAP services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance.
- Program Services include:
 - Unlimited, 24/7 access to information and referrals
 - In-person help for short-term issues; up to six sessions with a counselor per person, per issue, per year.
 - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
 - One free consultation with a financial counselor
 - Online tools, tutorials, videos and much more

ADDITIONAL DETAILS

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the three months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

Coverage Period for Your Occupation: 24 months. After this initial period, you may be eligible to continue receiving benefits if your disability prohibits you from performing any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits may be extended through the end of your maximum coverage period (benefit duration).

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

Voluntary Short Term Disability

Eligibility

The City offers Short-Term Disability (STD) to employees. STD is designed to provide a weekly benefit in the event you are unable to work due to a covered disability.

- **Class 1:**
All Full-Time and Regular Part-Time Executives
- **Class 2:**
All Full-Time and Regular Part-Time Non-Represented Employees
- **Class 3:**
All CCPOA and CCPMA employees
- **Class 4:**
All AFSCME Employees
- **Class 5:**
All CCPFA Employees
- **Class 6:**
All CCFMA Employees

Benefit Definitions

- **Benefit Waiting Period:** The period of salary continuation for which you are eligible under the Employer’s salary continuation plan, whichever is longer.
- **Benefit Percentage:** Percentage of your (pre-disability) monthly earnings the plan replaces.
- **Maximum Duration:** Maximum length of time the benefit is in effect.
- **Maximum Benefit:** Maximum weekly benefit less deductible income (Workers’ Compensation, Work Earnings, Social Security, etc.).

Disability can be the single most catastrophic event in a person’s life, clouding the future with confusion and uncertainty. Imagine if your ability to work vanished and you no longer received a paycheck. Would you have answers to the following questions?

- How will I make my house or rent payments?
- How will I pay my other bills?
- Will I have money to meet my children’s needs?

Benefits	Summary of Short-Term Disability Benefits					
	Core Plan					
	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6
Benefit Waiting Period	7 days					
Benefit Percentage	66 2/3%					
Benefit Duration	25 weeks					
Maximum Benefit	\$3,500/week	\$3,000/week	\$3,000/week	\$1,933/week	\$1,975/week	\$2,500/week

Important

Please refer to the Certificate of Insurance/Summary Plan Document for a complete description of your rights and the terms under the group policy.

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Voluntary Short Term Disability (continued)



City of Cathedral City Benefits At-A-Glance

All Full-Time and Regular Part-Time Executives

Voluntary Short-term Disability Insurance

The Lincoln Short-term Disability Insurance Plan:

- Provides a cash benefit when you are out of work for up to 25 weeks due to injury, illness, surgery, or recovery from childbirth
- Features group rates for employees
- Provides a partial cash benefit if you can only do part of your job or work part time
- Offers a fast, no-hassle claims process

Voluntary Short-term Disability	
Weekly benefit amount	66.67% of your weekly salary, limited to \$3,500 per week
Sickness elimination period	7 days
Accident elimination period	7 days
Maximum coverage period	25 weeks

Sickness Elimination Period: You must be out of work for seven days due to an illness before you can collect disability benefits. You can begin collecting benefits on day eight.

Accident Elimination Period: You must be out of work for seven days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day eight.

Recurrent Disability Benefits

If you become disabled for the same condition within 14 days following your prior disability, your benefits will continue under the same claim.

Lincoln Financial Group

Voluntary Short Term Disability (continued)

Additional Plan Benefits

Benefits Integration	Included
Rehabilitation Assistance	Included
Family Income Benefit	Included
Portability	Included

Benefit Exclusions & Reductions

Like any insurance, this short-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- Your disability occurs while you are committing a felony or misdemeanor or participating in a riot

Your benefits may be reduced if you are eligible to receive benefits from:

- Sick pay from your employer
- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers' Compensation

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

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Voluntary Short-term Disability Insurance At-A-Glance

Voluntary Short Term Disability (continued)

Voluntary Short-term Disability Premium Here’s how little you pay with group rates.

Use the employee voluntary short-term disability premium rate table provided to below to calculate your cost and benefit. The following example calculates the monthly cost for an employee with annual earnings of \$35,400.

Note: The maximum weekly covered earnings are equal to the maximum weekly benefit divided by the benefit percentage.

Calculation Example		Example	You	Premium Rate
Step 1	Enter the monthly rate per \$10 of weekly benefit.	\$0.426		\$0.426
Step 2	Enter your weekly earnings. <i>Divide your annual earnings by 52.</i>	\$681		
Step 3	If your weekly earnings are greater than the maximum weekly covered earnings of \$5,250, indicate \$5,250. Otherwise, indicate the amount from Step 2.	\$681		
Step 4	Calculate your weekly benefit. <i>Multiply Step 3 by 0.6667.</i>	\$454		
Step 5	Enter your weekly benefit in increments of \$10. <i>To calculate, divide the amount in Step 4 by 10.</i>	45.4		
Step 6	Calculate your monthly cost. <i>Multiply Step 1 by Step 5.</i>	\$19.34		

This worksheet allows you to approximate your monthly contributions for voluntary short-term disability insurance coverage. Cost of insurance may change in the future due to age and/or coverage amount elected.

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Please see prior page for product information.
Voluntary Short-term Disability Insurance Premium Calculation

STD-ENRO-BRC001

Voluntary Short Term Disability (continued)



City of Cathedral City Benefits At-A-Glance

All Full-Time and Regular Part-Time Non-Represented Employees

Voluntary Short-term Disability Insurance

The Lincoln Short-term Disability Insurance Plan:

- Provides a cash benefit when you are out of work for up to 25 weeks due to injury, illness, surgery, or recovery from childbirth
- Features group rates for employees
- Provides a partial cash benefit if you can only do part of your job or work part time
- Offers a fast, no-hassle claims process

Voluntary Short-term Disability

Weekly benefit amount	66.67% of your weekly salary, limited to \$3,000 per week
Sickness elimination period	7 days
Accident elimination period	7 days
Maximum coverage period	25 weeks

Sickness Elimination Period: You must be out of work for seven days due to an illness before you can collect disability benefits. You can begin collecting benefits on day eight.

Accident Elimination Period: You must be out of work for seven days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day eight.

Recurrent Disability Benefits

If you become disabled for the same condition within 14 days following your prior disability, your benefits will continue under the same claim.

Voluntary Short Term Disability (continued)

Additional Plan Benefits

Benefits Integration	Included
Rehabilitation Assistance	Included
Family Income Benefit	Included
Portability	Included

Benefit Exclusions & Reductions

Like any insurance, this short-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- Your disability occurs while you are committing a felony or misdemeanor or participating in a riot

Your benefits may be reduced if you are eligible to receive benefits from:

- Sick pay from your employer
- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers' Compensation

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Voluntary Short-term Disability Insurance At-A-Glance

Voluntary Short Term Disability (continued)

Voluntary Short-term Disability Premium Here’s how little you pay with group rates.

Use the employee voluntary short-term disability premium rate table provided to below to calculate your cost and benefit. The following example calculates the monthly cost for an employee with annual earnings of \$35,400.

Note: The maximum weekly covered earnings are equal to the maximum weekly benefit divided by the benefit percentage.

Calculation Example		Example	You	Premium Rate
Step 1	Enter the monthly rate per \$10 of weekly benefit.	\$0.426		\$0.426
Step 2	Enter your weekly earnings. <i>Divide your annual earnings by 52.</i>	\$681		
Step 3	If your weekly earnings are greater than the maximum weekly covered earnings of \$4,500, indicate \$4,500. Otherwise, indicate the amount from Step 2.	\$681		
Step 4	Calculate your weekly benefit. <i>Multiply Step 3 by 0.6667.</i>	\$454		
Step 5	Enter your weekly benefit in increments of \$10. <i>To calculate, divide the amount in Step 4 by 10.</i>	45.4		
Step 6	Calculate your monthly cost. <i>Multiply Step 1 by Step 5.</i>	\$19.34		

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Please see prior page for product information.
Voluntary Short-term Disability Insurance Premium Calculation

STD-ENRO-BRC001

Voluntary Short Term Disability (continued)



City of Cathedral City Benefits At-A-Glance

All CCPOA and CCPMA Employees

Voluntary Short-term Disability Insurance

The Lincoln Short-term Disability Insurance Plan:

- Provides a cash benefit when you are out of work for up to 25 weeks due to injury, illness, surgery, or recovery from childbirth
- Features group rates for employees
- Provides a partial cash benefit if you can only do part of your job or work part time
- Offers a fast, no-hassle claims process

Voluntary Short-term Disability	
Weekly benefit amount	66.67% of your weekly salary, limited to \$3,000 per week
Sickness elimination period	7 days
Accident elimination period	7 days
Maximum coverage period	25 weeks

Sickness Elimination Period: You must be out of work for seven days due to an illness before you can collect disability benefits. You can begin collecting benefits on day eight.

Accident Elimination Period: You must be out of work for seven days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day eight.

Recurrent Disability Benefits

If you become disabled for the same condition within 14 days following your prior disability, your benefits will continue under the same claim.

Voluntary Short Term Disability (continued)

Additional Plan Benefits

Benefits Integration	Included
Rehabilitation Assistance	Included
Family Income Benefit	Included
Portability	Included

Benefit Exclusions & Reductions

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Your benefits may be reduced if you are eligible to receive benefits from:

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- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
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- Workers' Compensation

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Voluntary Short-term Disability Insurance At-A-Glance

Voluntary Short Term Disability (continued)

Voluntary Short-term Disability Premium Here's how little you pay with group rates.

Use the employee voluntary short-term disability premium rate table provided to below to calculate your cost and benefit. The following example calculates the monthly cost for an employee with annual earnings of \$35,400.

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Step 1	Enter the monthly rate per \$10 of weekly benefit.	\$0.426		\$0.426
Step 2	Enter your weekly earnings. <i>Divide your annual earnings by 52.</i>	\$681		
Step 3	If your weekly earnings are greater than the maximum weekly covered earnings of \$4,500, indicate \$4,500. Otherwise, indicate the amount from Step 2.	\$681		
Step 4	Calculate your weekly benefit. <i>Multiply Step 3 by 0.6667.</i>	\$454		
Step 5	Enter your weekly benefit in increments of \$10. <i>To calculate, divide the amount in Step 4 by 10.</i>	45.4		
Step 6	Calculate your monthly cost. <i>Multiply Step 1 by Step 5.</i>	\$19.34		

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Please see prior page for product information.
Voluntary Short-term Disability Insurance Premium Calculation

STD-ENRO-BRC001

Voluntary Short Term Disability (continued)



City of Cathedral City Benefits At-A-Glance

All AFSCME Employees

Voluntary Short-term Disability Insurance

The Lincoln Short-term Disability Insurance Plan:

- Provides a cash benefit when you are out of work for up to 25 weeks due to injury, illness, surgery, or recovery from childbirth
- Features group rates for employees
- Provides a partial cash benefit if you can only do part of your job or work part time
- Offers a fast, no-hassle claims process

Voluntary Short-term Disability	
Weekly benefit amount	66.67% of your weekly salary, limited to \$1,933 per week
Sickness elimination period	7 days
Accident elimination period	7 days
Maximum coverage period	25 weeks

Sickness Elimination Period: You must be out of work for seven days due to an illness before you can collect disability benefits. You can begin collecting benefits on day eight.

Accident Elimination Period: You must be out of work for seven days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day eight.

Recurrent Disability Benefits

If you become disabled for the same condition within 14 days following your prior disability, your benefits will continue under the same claim.

Voluntary Short Term Disability (continued)

Additional Plan Benefits

Benefits Integration	Included
Rehabilitation Assistance	Included
Family Income Benefit	Included
Portability	Included

Benefit Exclusions & Reductions

Like any insurance, this short-term disability insurance policy does have some exclusions. You will not receive benefits if:

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- Your disability occurs while you are committing a felony or misdemeanor or participating in a riot

Your benefits may be reduced if you are eligible to receive benefits from:

- Sick pay from your employer
- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers' Compensation

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Voluntary Short-term Disability Insurance At-A-Glance

Voluntary Short Term Disability (continued)

Voluntary Short-term Disability Premium Here’s how little you pay with group rates.

Use the employee voluntary short-term disability premium rate table provided to below to calculate your cost and benefit. The following example calculates the monthly cost for an employee with annual earnings of \$35,400.

Note: The maximum weekly covered earnings are equal to the maximum weekly benefit divided by the benefit percentage.

Calculation Example		Example	You	Premium Rate
Step 1	Enter the monthly rate per \$10 of weekly benefit.	\$0.426		\$0.426
Step 2	Enter your weekly earnings. <i>Divide your annual earnings by 52.</i>	\$681		
Step 3	If your weekly earnings are greater than the maximum weekly covered earnings of \$2,900, indicate \$2,900. Otherwise, indicate the amount from Step 2.	\$681		
Step 4	Calculate your weekly benefit. <i>Multiply Step 3 by 0.6667.</i>	\$454		
Step 5	Enter your weekly benefit in increments of \$10. <i>To calculate, divide the amount in Step 4 by 10.</i>	45.4		
Step 6	Calculate your monthly cost. <i>Multiply Step 1 by Step 5.</i>	\$19.34		

This worksheet allows you to approximate your monthly contributions for voluntary short-term disability insurance coverage. Cost of insurance may change in the future due to age and/or coverage amount elected.

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Voluntary Short-term Disability Insurance Premium Calculation

STD-ENRO-BRC001

Voluntary Short Term Disability (continued)



City of Cathedral City Benefits At-A-Glance

All Full-Time CCPFA Employees

Voluntary Short-term Disability Insurance

The Lincoln Short-term Disability Insurance Plan:

- Provides a cash benefit when you are out of work for up to 25 weeks due to injury, illness, surgery, or recovery from childbirth
- Features group rates for employees
- Provides a partial cash benefit if you can only do part of your job or work part time
- Offers a fast, no-hassle claims process

Voluntary Short-term Disability

Weekly benefit amount	66.67% of your weekly salary, limited to \$1,975 per week
Sickness elimination period	7 days
Accident elimination period	7 days
Maximum coverage period	25 weeks

Sickness Elimination Period: You must be out of work for seven days due to an illness before you can collect disability benefits. You can begin collecting benefits on day eight.

Accident Elimination Period: You must be out of work for seven days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day eight.

Recurrent Disability Benefits

If you become disabled for the same condition within 14 days following your prior disability, your benefits will continue under the same claim.

Voluntary Short Term Disability (continued)

Additional Plan Benefits	
Benefits Integration	Included
Rehabilitation Assistance	Included
Family Income Benefit	Included
Portability	Included

Benefit Exclusions & Reductions

Like any insurance, this short-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- Your disability occurs while you are committing a felony or misdemeanor or participating in a riot

Your benefits may be reduced if you are eligible to receive benefits from:

- Sick pay from your employer
- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers' Compensation

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Voluntary Short-term Disability Insurance At-A-Glance

Voluntary Short Term Disability (continued)

Voluntary Short-term Disability Premium Here’s how little you pay with group rates.

Use the employee voluntary short-term disability premium rate table provided to below to calculate your cost and benefit. The following example calculates the monthly cost for an employee with annual earnings of \$35,400.
Note: The maximum weekly covered earnings are equal to the maximum weekly benefit divided by the benefit percentage.

Calculation Example		Example	You	Premium Rate
Step 1	Enter the monthly rate per \$10 of weekly benefit.	\$0.426		\$0.426
Step 2	Enter your weekly earnings. <i>Divide your annual earnings by 52.</i>	\$681		
Step 3	If your weekly earnings are greater than the maximum weekly covered earnings of \$2,962, indicate \$2,962. Otherwise, indicate the amount from Step 2.	\$681		
Step 4	Calculate your weekly benefit. <i>Multiply Step 3 by 0.6667.</i>	\$454		
Step 5	Enter your weekly benefit in increments of \$10. <i>To calculate, divide the amount in Step 4 by 10.</i>	45		
Step 6	Calculate your monthly cost. <i>Multiply Step 1 by Step 5.</i>	\$19.17		

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Voluntary Short Term Disability (continued)



City of Cathedral City Benefits At-A-Glance

All CCFMA Employees

Voluntary Short-term Disability Insurance

The Lincoln Short-term Disability Insurance Plan:

- Provides a cash benefit when you are out of work for up to 25 weeks due to injury, illness, surgery, or recovery from childbirth
- Features group rates for employees
- Provides a partial cash benefit if you can only do part of your job or work part time
- Offers a fast, no-hassle claims process

Voluntary Short-term Disability	
Weekly benefit amount	66.67% of your weekly salary, limited to \$2,500 per week
Sickness elimination period	7 days
Accident elimination period	7 days
Maximum coverage period	25 weeks

Sickness Elimination Period: You must be out of work for seven days due to an illness before you can collect disability benefits. You can begin collecting benefits on day eight.

Accident Elimination Period: You must be out of work for seven days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day eight.

Recurrent Disability Benefits

If you become disabled for the same condition within 14 days following your prior disability, your benefits will continue under the same claim.

Voluntary Short Term Disability (continued)

Additional Plan Benefits

Benefits Integration	Included
Rehabilitation Assistance	Included
Family Income Benefit	Included
Portability	Included

Benefit Exclusions & Reductions

Like any insurance, this short-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- Your disability occurs while you are committing a felony or misdemeanor or participating in a riot

Your benefits may be reduced if you are eligible to receive benefits from:

- Sick pay from your employer
- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers' Compensation

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Voluntary Short-term Disability Insurance At-A-Glance

Voluntary Short Term Disability (continued)

Voluntary Short-term Disability Premium Here’s how little you pay with group rates.

Use the employee voluntary short-term disability premium rate table provided to below to calculate your cost and benefit. The following example calculates the monthly cost for an employee with annual earnings of \$35,400.

Note: The maximum weekly covered earnings are equal to the maximum weekly benefit divided by the benefit percentage.

Calculation Example		Example	You	Premium Rate
Step 1	Enter the monthly rate per \$10 of weekly benefit.	\$0.426		\$0.426
Step 2	Enter your weekly earnings. <i>Divide your annual earnings by 52.</i>	\$681		
Step 3	If your weekly earnings are greater than the maximum weekly covered earnings of \$3,750, indicate \$3,750. Otherwise, indicate the amount from Step 2.	\$681		
Step 4	Calculate your weekly benefit. <i>Multiply Step 3 by 0.6667.</i>	\$454		
Step 5	Enter your weekly benefit in increments of \$10. <i>To calculate, divide the amount in Step 4 by 10.</i>	45.4		
Step 6	Calculate your monthly cost. <i>Multiply Step 1 by Step 5.</i>	\$19.34		

This worksheet allows you to approximate your monthly contributions for voluntary short-term disability insurance coverage. Cost of insurance may change in the future due to age and/or coverage amount elected.

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Please see prior page for product information.
Voluntary Short-term Disability Insurance Premium Calculation

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Voluntary Life and AD&D

Voluntary Life Insurance with Accidental Death and Dismemberment (AD&D)

Summary of Benefits

All Full-Time and Regular Part-Time Employees

Life Benefit	Employee	Spouse/Domestic Partner	Dependent
	Employee must elect coverage for Spouse/Domestic Partner or dependents to be eligible.		
Amount	Choice of \$10,000 increments	Choice of \$5,000 increments	Age 1 Day to age 26: \$10,000
Minimum Amount	\$10,000	\$5,000	\$10,000
Maximum Amount	\$500,000 limited to 5 times your annual salary	\$250,000 limited to 50% of employee amount	\$10,000
Guarantee Issue for Newly Eligible Employee	\$150,000	\$30,000	
Current Eligible Employees	You or your Spouse/Domestic Partner may elect or increase insurance coverage equal to 2 benefit levels on a guaranteed acceptance basis during your company's defined annual open enrollment period, provided that you or your Spouse/Domestic Partner have not been previously declined, withdrawn, or pending for coverage.		
AD&D Benefit	Employee	Spouse/Domestic Partner	
Amount	Optional coverage can be purchased by you for additional premium. Benefit amount equal to the life amount elected by you.	Same as employee	
Benefit Reduction	Employee	Spouse/Domestic Partner	
Benefits will reduce:	35% at age 70; Additional 15% of original amount at age 75; Benefits terminate at retirement	35% at Employee Age 70; Additional 15% of original amount at Employee Age 75 Benefits terminate at Employee Retirement	
Eligibility	Employee	Spouse/Domestic Partner and Dependents	
	All employees in an eligible class.	Cannot be in a period of limited activity on the day coverage takes effect.	
Additional Benefits			
See Definition:	Accelerated Death Benefit		
See Definition:	Portability		
See Definition:	Conversion		
See Definition:	Accident Plus		
See Definition:	Seat Belt, Airbag,and Common Carrier		

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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 Life and AD&D (continued)

Definitions

Accelerated Death Benefit: Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.

AD&D: Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable. This insurance is optional and can be purchased by you and your Spouse/Domestic Partner.

Accident Plus: If loss occurs due to an accident, you may also receive the following Accident Plus benefits: Coma, Plegia, Repatriation, Education, Spouse/Domestic Partner Training, & Child Care. Refer to your certificate for more details.

Conversion: If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.

Guarantee Issue: For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance, and it will be provided at your own expense.

Limited Activity: A period when a Spouse/Domestic Partner or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.

Portability: If coverage has been in force for at least 12 months, you may continue coverage for a specified period of time after your employment by paying the required premium. Portability is available if you cease employment for a reason other than total disability or retirement at Social Security Normal Retirement Age. A written application must be made within 31 days of your termination.

Seat Belt, Airbag, and Common Carrier: If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to \$10,000 or 10% of the principal sum, whichever is less. If loss occurs for you due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.

Term Life: Benefit provided to the designated beneficiary upon the death of the insured. The benefit is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.

Exclusion: Suicide: Benefits will not be paid if the death results from suicide within 1 year after coverage is effective. May apply if employee contributes toward the premium.

Additional Benefits

LifeKeysSM: Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.

TravelConnectSM: Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

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Voluntary Life and AD&D (continued)

Monthly Employee Premium Life Premium for Sample Benefit Amounts

Employee and Spouse/Domestic Partner premiums are calculated separately. Spouse/Domestic Partner premiums will be calculated based on the Spouse Age Refer to Program Specifications for your maximum benefit amounts. Benefits and premium amounts reflect age reductions.

Monthly RATE Per \$1000	Age	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
0.0720	<25	\$0.72	\$1.44	\$2.16	\$2.88	\$3.60	\$4.32	\$5.04	\$5.76	\$6.48	\$7.20
0.0720	25-29	\$0.72	\$1.44	\$2.16	\$2.88	\$3.60	\$4.32	\$5.04	\$5.76	\$6.48	\$7.20
0.0810	30-34	\$0.81	\$1.62	\$2.43	\$3.24	\$4.05	\$4.86	\$5.67	\$6.48	\$7.29	\$8.10
0.1170	35-39	\$1.17	\$2.34	\$3.51	\$4.68	\$5.85	\$7.02	\$8.19	\$9.36	\$10.53	\$11.70
0.1800	40-44	\$1.80	\$3.60	\$5.40	\$7.20	\$9.00	\$10.80	\$12.60	\$14.40	\$16.20	\$18.00
0.3110	45-49	\$3.11	\$6.22	\$9.33	\$12.44	\$15.55	\$18.66	\$21.77	\$24.88	\$27.99	\$31.10
0.4860	50-54	\$4.86	\$9.72	\$14.58	\$19.44	\$24.30	\$29.16	\$34.02	\$38.88	\$43.74	\$48.60
0.7520	55-59	\$7.52	\$15.04	\$22.56	\$30.08	\$37.60	\$45.12	\$52.64	\$60.16	\$67.68	\$75.20
1.1610	60-64	\$11.61	\$23.22	\$34.83	\$46.44	\$58.05	\$69.66	\$81.27	\$92.88	\$104.49	\$116.10
1.8990	65-69	\$18.99	\$37.98	\$56.97	\$75.96	\$94.95	\$113.94	\$132.93	\$151.92	\$170.91	\$189.90
3.1280	70-74	\$6,500	\$13,000	\$19,500	\$26,000	\$32,500	\$39,000	\$45,500	\$52,000	\$58,500	\$65,000
		\$20.33	\$40.66	\$61.00	\$81.33	\$101.66	\$121.99	\$142.32	\$162.66	\$182.99	\$203.32
3.1280	75-79	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
		\$15.64	\$31.28	\$46.92	\$62.56	\$78.20	\$93.84	\$109.48	\$125.12	\$140.76	\$156.40
3.1280	80-99	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
		\$15.64	\$31.28	\$46.92	\$62.56	\$78.20	\$93.84	\$109.48	\$125.12	\$140.76	\$156.40

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:

Use this formula to calculate premium for benefit amounts over \$100,000

Example:	Age	Monthly Rate Per 1000	X	Benefit In \$1,000's	=	Monthly Cost
	35	0.1170	X	150	=	\$17.55
			X		=	

Dependent Children
Benefit Monthly Rate:

\$10,000
\$1.50

Premium covers all dependent children regardless of the number of children.

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 Life and AD&D (continued)

Monthly Spouse/Domestic Partner Premium Life Premium for Sample Benefit Amounts

Employee and Spouse/Domestic Partner premiums are calculated separately. Spouse/Domestic Partner premiums will be calculated based on the Spouse Age Refer to Program Specifications for your maximum benefit amounts. Benefits and premium amounts reflect age reductions.

Monthly RATE Per \$1000	AGE	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
0.0720	<25	\$0.36	\$0.72	\$1.08	\$1.44	\$1.80	\$2.16	\$2.52	\$2.88	\$3.24	\$3.60
0.0720	25-29	\$0.36	\$0.72	\$1.08	\$1.44	\$1.80	\$2.16	\$2.52	\$2.88	\$3.24	\$3.60
0.0810	30-34	\$0.41	\$0.81	\$1.22	\$1.62	\$2.03	\$2.43	\$2.84	\$3.24	\$3.65	\$4.05
0.1170	35-39	\$0.59	\$1.17	\$1.76	\$2.34	\$2.93	\$3.51	\$4.10	\$4.68	\$5.27	\$5.85
0.1800	40-44	\$0.90	\$1.80	\$2.70	\$3.60	\$4.50	\$5.40	\$6.30	\$7.20	\$8.10	\$9.00
0.3110	45-49	\$1.56	\$3.11	\$4.67	\$6.22	\$7.78	\$9.33	\$10.89	\$12.44	\$14.00	\$15.55
0.4860	50-54	\$2.43	\$4.86	\$7.29	\$9.72	\$12.15	\$14.58	\$17.01	\$19.44	\$21.87	\$24.30
0.7520	55-59	\$3.76	\$7.52	\$11.28	\$15.04	\$18.80	\$22.56	\$26.32	\$30.08	\$33.84	\$37.60
1.1610	60-64	\$5.81	\$11.61	\$17.42	\$23.22	\$29.03	\$34.83	\$40.64	\$46.44	\$52.25	\$58.05
1.8990	65-69	\$9.50	\$18.99	\$28.49	\$37.98	\$47.48	\$56.97	\$66.47	\$75.96	\$85.46	\$94.95
3.1280	70-74	\$3,250	\$6,500	\$9,750	\$13,000	\$16,250	\$19,500	\$22,750	\$26,000	\$29,250	\$32,500
		\$10.17	\$20.33	\$30.50	\$40.66	\$50.83	\$61.00	\$71.16	\$81.33	\$91.49	\$101.66
3.1280	75-79	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
		\$7.82	\$15.64	\$23.46	\$31.28	\$39.10	\$46.92	\$54.74	\$62.56	\$70.38	\$78.20
3.1280	80-99	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
		\$7.82	\$15.64	\$23.46	\$31.28	\$39.10	\$46.92	\$54.74	\$62.56	\$70.38	\$78.20

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:

Use this formula to calculate premium for benefit amounts over \$50,000

Example:	Age	Monthly Rate Per 1000	X	Benefit In \$1,000's	=	Monthly Cost
	35	0.1170	X	150	=	\$8.78
			X		=	

Dependent Children
Benefit Monthly Rate:

\$10,000
\$1.50

Premium covers all dependent children regardless of the number of children.

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 Life and AD&D (continued)

Monthly Employee Life Premium With Accidental Death & Dismemberment Life Premium for Sample Benefit Amounts

Monthly Employee Premium

Life and Accidental Death and Dismemberment Premium for sample benefit amounts. Employee and Spouse/Domestic Partner premiums are calculated separately. Refer to Program Specifications for your maximum benefit amounts. Benefits and premium amounts reflect age reductions.

Monthly RATE Per \$1000	AGE	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
0.0920	<25	\$0.92	\$1.84	\$2.76	\$3.68	\$4.60	\$5.52	\$6.44	\$7.36	\$8.28	\$9.20
0.0920	25-29	\$0.92	\$1.84	\$2.76	\$3.68	\$4.60	\$5.52	\$6.44	\$7.36	\$8.28	\$9.20
0.1010	30-34	\$1.01	\$2.02	\$3.03	\$4.04	\$5.05	\$6.06	\$7.07	\$8.08	\$9.09	\$10.10
0.1370	35-39	\$1.37	\$2.74	\$4.11	\$5.48	\$6.85	\$8.22	\$9.59	\$10.96	\$12.33	\$13.70
0.2000	40-44	\$2.00	\$4.00	\$6.00	\$8.00	\$10.00	\$12.00	\$14.00	\$16.00	\$18.00	\$20.00
0.3310	45-49	\$3.31	\$6.62	\$9.93	\$13.24	\$16.55	\$19.86	\$23.17	\$26.48	\$29.79	\$33.10
0.5060	50-54	\$5.06	\$10.12	\$15.18	\$20.24	\$25.30	\$30.36	\$35.42	\$40.48	\$45.54	\$50.60
0.7720	55-59	\$7.72	\$15.44	\$23.16	\$30.88	\$38.60	\$46.32	\$54.04	\$61.76	\$69.48	\$77.20
1.1810	60-64	\$11.81	\$23.62	\$35.43	\$47.24	\$59.05	\$70.86	\$82.67	\$94.48	\$106.29	\$118.10
1.9190	65-69	\$19.19	\$38.38	\$57.57	\$76.76	\$95.95	\$115.14	\$134.33	\$153.52	\$172.71	\$191.90
3.1480	70-74	\$6,500	\$13,000	\$19,500	\$26,000	\$32,500	\$39,000	\$45,500	\$52,000	\$58,500	\$65,000
		\$20.46	\$40.92	\$61.39	\$81.85	\$102.31	\$122.77	\$143.23	\$163.70	\$184.16	\$204.62
3.1480	75-79	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
		\$15.74	\$31.48	\$47.22	\$62.96	\$78.70	\$94.44	\$110.18	\$125.92	\$141.66	\$157.40
3.1480	80-99	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
		\$15.74	\$31.48	\$47.22	\$62.96	\$78.70	\$94.44	\$110.18	\$125.92	\$141.66	\$157.40

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:

Use this formula to calculate premium for benefit amounts over \$50,000

Age	Monthly Rate Per 1000	X	Benefit In \$1,000's	=	Monthly Cost
35	0.1370	X	150	=	\$20.55
		X		=	

Dependent Children
Benefit Monthly Rate:

\$10,000
\$1.50

Premium covers all dependent children regardless of the number of children.

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 Life and AD&D (continued)

Monthly Spouse/Domestic Partner Premium Life With Accidental Death and Dismemberment Premium for Sample Benefit Amounts

Monthly Employee and Spouse Premium

Employee and Spouse/Domestic Partner premiums are calculated separately. Spouse/Domestic Partner premiums will be calculated based on the Spouse Age Refer to Program Specifications for your maximum benefit amounts. Benefits and premium amounts reflect age reductions. Benefits and premium amounts reflect age reductions.

Monthly RATE Per \$1000	AGE	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
0.0920	<25	\$0.46	\$0.92	\$1.38	\$1.84	\$2.30	\$2.76	\$3.22	\$3.68	\$4.14	\$4.60
0.0920	25-29	\$0.46	\$0.92	\$1.38	\$1.84	\$2.30	\$2.76	\$3.22	\$3.68	\$4.14	\$4.60
0.1010	30-34	\$0.51	\$1.01	\$1.52	\$2.02	\$2.53	\$3.03	\$3.54	\$4.04	\$4.55	\$5.05
0.1370	35-39	\$0.69	\$1.37	\$2.06	\$2.74	\$3.43	\$4.11	\$4.80	\$5.48	\$6.17	\$6.85
0.2000	40-44	\$1.00	\$2.00	\$3.00	\$4.00	\$5.00	\$6.00	\$7.00	\$8.00	\$9.00	\$10.00
0.3310	45-49	\$1.66	\$3.31	\$4.97	\$6.62	\$8.28	\$9.93	\$11.59	\$13.24	\$14.90	\$16.55
0.5060	50-54	\$2.53	\$5.06	\$7.59	\$10.12	\$12.65	\$15.18	\$17.71	\$20.24	\$22.77	\$25.30
0.7720	55-59	\$3.86	\$7.72	\$11.58	\$15.44	\$19.30	\$23.16	\$27.02	\$30.88	\$34.74	\$38.60
1.1810	60-64	\$5.91	\$11.81	\$17.72	\$23.62	\$29.53	\$35.43	\$41.34	\$47.24	\$53.15	\$59.05
1.9190	65-69	\$9.60	\$19.19	\$28.79	\$38.38	\$47.98	\$57.57	\$67.17	\$76.76	\$86.36	\$95.95
3.1480	70-74	\$3,250	\$6,500	\$9,750	\$13,000	\$16,250	\$19,500	\$22,750	\$26,000	\$29,250	\$32,500
		\$10.23	\$20.46	\$30.69	\$40.92	\$51.16	\$61.39	\$71.62	\$81.85	\$92.08	\$102.31
3.1480	75-79	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
		\$7.87	\$15.74	\$23.61	\$31.48	\$39.35	\$47.22	\$55.09	\$62.96	\$70.83	\$78.70
3.1480	80-99	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
		\$7.87	\$15.74	\$23.61	\$31.48	\$39.35	\$47.22	\$55.09	\$62.96	\$70.83	\$78.70

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:

Use this formula to calculate premium for benefit amounts over \$50,000

Example:	Age	Monthly Rate Per 1000	X	Benefit In \$1,000's	=	Monthly Cost
	35	0.1370	X	75	=	\$10.28
			X		=	
Dependent Children Benefit Monthly Rate:						
	\$10,000					
	\$1.50					

Premium covers all dependent children regardless of the number of children.

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.

LifeKeys - Offered by Lincoln Financial Group

Term Life Insurance/Support Services

Handling Life, Handling Loss – LifeKeys® Services Help You Meet Life's Challenges

When you choose life insurance, you're planning for your family's future – assuring their comfort and securing their plans. With Lincoln Term Life Insurance, you can also access services that make a real difference now as well as in the future. LifeKeys services, included with all Lincoln Term Life and Accidental Death and Dismemberment Insurance policies, provide assistance to you, your family and your beneficiaries.

For You And Your Family

EstateGuidance® Will Preparation

Create your will online — easily and economically. Follow a step-by-step guide through the entire process, and then use online instructions to execute your will. You can:

- Name an executor to manage your estate
- Choose a guardian for your children
- Specify wishes for your property
- Provide funeral and burial instructions

GuidanceResources® Online

GuidanceResources® Online is the place to go for articles, tutorials, streaming videos and "Ask the Expert" personal responses on topics such as:

- Law and regulations
- Health and wellness
- Money and investments
- Work and education
- Family and relationships
- Leisure and home

Identity Theft

Identity theft is one of the fastest-growing crimes in the U.S. Be sure you have the information you need to recognize and prevent it. Our online resource helps you:

- Spot the warning signs
- Take steps to protect your cell phone, computer and tax records from fraud
- Lessen the damage and repair your credit if identity theft occurs
- Link to essential resources such as credit reporting bureaus, the FBI Internet Crime Complaint Center, ID Theft Resource Center, and more

Beneficiary Services

If you develop a terminal illness and access your Accelerated Death Benefit, you will be able to use beneficiary services. Services are available for up to one year after a loss, and include:

- A combination totaling six in-person sessions for grief counseling, or legal or financial information **and**
- Unlimited phone counseling

Assistance at a Difficult Time

Make sure your loved ones have the support they need, should you pass away. Unlimited phone contact with master's-level grief counselors lets your beneficiaries access information, advice and referrals for topics such as:

- Grief and loss
- Stress, anxiety and depression
- Memorial planning information
- Concerns about children and teens

Financial Services

Your beneficiaries can call one of our certified financial specialists or use online tools and resources whenever they need help with essential topics such as:

- Estate planning
- Budgeting
- Debt
- Bankruptcy
- Investments

LifeKeys - Offered by Lincoln Financial Group

Legal Support

If your beneficiaries need quick legal information, they can call one of our in-house attorneys. Or, if they need in-depth information, guidance or representation, we'll refer them to a qualified attorney in their area. They will be eligible for a free 30-minute consultation as well as a 25% reduction in customary legal fees thereafter. They'll get expert guidance on areas such as:

- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents beneficiaries need

Support with Day-to-Day Concerns

Through good times and bad, everyone can use assistance. LifeKeys® services provide in-depth information and guidance – on virtually any topic you can name. Your beneficiaries can call for a quick answer or take advantage of specialists who will do the research for them and provide a comprehensive, customized booklet of information.

Topics include:

- Planning a memorial service
- Finding child care or elder care
- Selecting a mortgage
- Moving and relocation
- Making major purchases



To access LifeKeys services: Call [855-891-3684](tel:855-891-3684) or visit [GuidanceResources.com](https://www.GuidanceResources.com) (First-time user: Web ID = LifeKeys)

Travel Insurance – Lincoln Financial Group

Travel Assistance Services User Guide

Travel Made Easier

You know your Lincoln Life Insurance coverage helps protect your family's financial future ... but did you know it also includes helpful services you can use right now?

Those services include the TravelConnectSM program, which provides a wealth of travel, medical and safety-related services you can access while traveling. Lincoln has partnered with UnitedHealthcare Global, a worldwide leader in travel assistance, to make this valuable benefit available.

- For travel more than 100 miles from home
- Business and leisure travel
- Staff and resources provide 24/7 travel support

Medical emergency evacuation and transportation
Includes arrangement and payment for transportation of the patient to the nearest medical facility able to treat the injury or illness. Once the patient can travel home, includes arrangement and payment for the trip.

Dependent Child Transportation

If a medical emergency leaves no covered parents available, includes arrangement and payment for a dependent child's trip home or arrangement and payment for a family member to travel to and care for the child.

Travel Treatment Monitoring

Includes care management when a traveler has a medical emergency; services are available until the traveler is released or sent to a hometown hospital. Services vary from case to case but can include: medical record requests and reviews to ensure treatment is appropriate; intermediary services; medical translation services for the patient and/or the family; and communication between the patient and family back home.

...And much more

- Destination info - weather, currency and more
- Emergency travel arrangements and funds transfer
- Lost or stolen travel documents assistance
- Language translation services
- Medical and dental referrals
- Assistance with corrective lenses or medical device replacement
- Arrangement for the delivery of medications, vaccines or blood
- Updates to family, employer and/or home physician
- Repatriation of a deceased traveler
- Security and political evacuation assistance

For a complete list of services provided, please reach out to your benefits department.



GLOBAL
ASSISTANCE

Travel ConnectSM

Life/AD&D

UHC Global ID #: 322541



Notice to Physicians/Hospitals: Call immediately for benefits verification and procedures. Call 24 hours a day (multilingual). If you do not have access to a phone, email for assistance: assistance@uhcglobal.com

Travel assistance services are subject to specific terms, conditions and limitations. A program description is available at www.Lincoln4Benefits.com.

To use TravelConnectSM services, call UnitedHealthcare Global at [800-527-0218](tel:800-527-0218) or [410-453-6330](tel:410-453-6330), and provide them with ID number 322541.

TravelConnectSM travel assistance services are provided by UnitedHealthcare Global, Baltimore, MD. UnitedHealthcare Global is not a Lincoln Financial Group[®] company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations. Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. In New York, insurance products (policy series GL1101) are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group[®] companies. Product availability and/or features may vary by state. Limitations and exclusions apply. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.

Employee Assistance Program (EAP)

Contact Us... Anytime, Anywhere

No-cost, confidential solutions to life's challenges.



Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts



Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care



Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more
- Need representation? Get a free 30-minute consultation and a 25% reduction in fees.



Financial Resources

Our financial experts can assist with a wide range of issues. Talk to us about:

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more



Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 855-327-4463

TDD: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultantSM, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com

App: GuidanceResources® Now

Web ID: Lincoln

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

Contact Your GuidanceResources® Program

Call: 855-327-4463

TDD: 800.697.0353

Online: guidanceresources.com

App: GuidanceResources® Now

Web ID: Lincoln

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Building Blocks for Business

City of Cathedral City

Colonial & FSA Benefit Booklet



A Building Blocks Benefit Advisor will assist you with your enrollment via a Screen Share Enrollment Session which requires access to a computer and internet.



Receive membership to the **WellCard Savings Program!**

After completing your enrollment session with a Building Blocks Benefit Advisor, you will receive your membership login information to the WellCard Savings Program!

You and your family will have access to receive discounts on Medical, Pharmacy, Vision & Dental Care, Health & Wellness, Pet Discounts, and more!



The Following Benefits are Now Available!



★ Accident

For a covered accident, policyholders receive cash benefits for use as they see fit.



Cancer

The cancer plan is designed to pay cash benefits that can be used to help offset cancer-related expenses.



★ Critical Illness

Helps with medical expenses related to a covered serious health event.



★ Short-Term Disability

In the case of an illness or injury, it helps you maintain your standard of living and helps you pay your bills.



★ Medical Bridge/Hospital Confinement

Pays cash amounts to help with the non-covered expenses of a hospital stay.



Life Insurance

Helps you get the peace of mind knowing your family is taken care of.



Flexible Spending Account (FSA)

Allows you use pre-tax dollars to pay for eligible expenses for you, your spouse, and your dependents.



*All benefits with this symbol have
Guaranteed Issue available for New Enrollees!*

**Contact a Building Blocks representative to
schedule your enrollment session today!**



Call: 775-382-1287

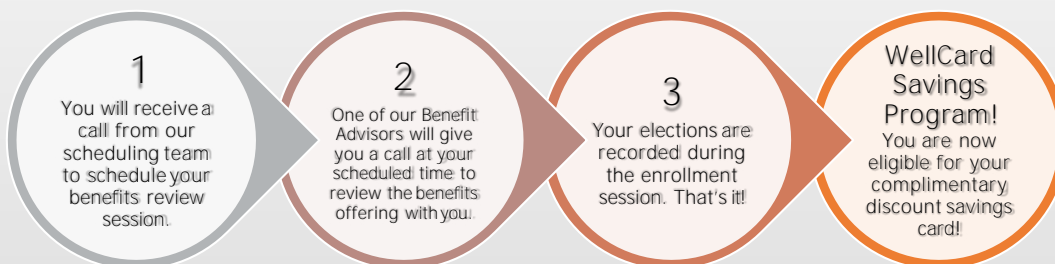


Email: scheduling@bbforb.com

Building Blocks for Business (continued)

Colonial Life Enrollment FAQ

Building Blocks Easy, Virtual Enrollment Process



FAQs:

Q: What is a "Non-Discriminatory Enrollment"?

A: A non-discriminatory enrollment means that all employees complete their enrollment session, regardless of their election choices, to ensure that all employees have received the same benefit offering and enrollment experience to make an educated decision on their benefits.

Q: Do I have to complete an enrollment call with a Benefit Advisor?

A: Yes! All benefit eligible employees complete the enrollment session to ensure non-discrimination. Once everyone has completed their call, everyone is eligible to receive access to the WellCard Savings Program.

Q: Do I have to purchase an Colonial Life policy to get my WellCard Savings?

A: No! During the non-discriminatory enrollment process, all employees that complete their enrollment session, regardless of their election choices, will receive access to the WellCard Savings Program.

Q: How long is the enrollment call?

A: Enrollment calls typically take anywhere from 10 – 25 minutes, depending on how many questions you have. We block out 30 minutes for each enrollment call to ensure we have enough time to answer all your inquiries.

Q: How does Building Blocks get my information?

A: Your employer provides some of the employment specific information in regards to collecting census, which is used to configure the enrollment software. All other information is collected from you securely during the session; this makes it possible to customize your enrollment call with only the options that make the most sense for you and your lifestyle. It also ensures that your enrollment call is quick and easy, allowing you to get back to work as soon as possible!

Q: How is my information handled?

A: All information is transmitted and stored in a secure format. We take privacy very seriously! We never share your information with third parties and will only contact you regarding your enrollment session or any service matters related to your policies.

Q: When can I have my enrollment call?

A: The benefit of working in a virtual environment means more flexibility in scheduling. You may schedule your call at work, at home, or even your off days if availability permits. Our team of caring professionals are here to accommodate you any way we can.

Q: What is a virtual enrollment?

A: Our Benefit Advisors can complete your enrollment over the phone, and if you have a computer, they can even share their screen with you! Our virtual enrollments are an interactive session where we will review the benefit offerings and be able to answer any questions you may have.

Q: How is my election collected?

A: Your election is collected electronically by a digital signature, either over a recorded phone line or an electronic signature through the screen share.

Q: Why am I getting a call from a Nevada area code (702 or 775)?

A: Building Blocks' corporate office is located in Nevada, which is why you will receive calls from a Nevada area code.



Flexible Spending Accounts - BASIC



FSA *by BASIC*



Employers know an attractive benefits package is important to entice and retain high quality job candidates. For businesses evaluating which benefits to offer, a Flexible Spending Account (FSA) plan can be a cost-effective way to provide value for both employers and employees.

An FSA is an employer-owned savings account where employees choose an annual dollar amount to contribute, on a pre-tax basis, to pay for out-of-pocket health and dependent care expenses. Any money added to their account is untaxed with a savings of 15%-40%. Additionally, by offering this benefit, employers save 7.65% (the combined Social Security and Medicare tax rate) on the value of contributions to the FSA.

1

A mature FSA plan can yield more dollars in tax savings than it costs to administer your plan.

2

FSA plans can include Medical FSA, Dependent Care FSA, Limited Purpose FSA, and Premium Only Plans (POP).



[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 Accounts - BASIC (continued)



Superior Service

While BASIC harnesses the power of superior technology, we still believe in old-fashioned customer service like answering our phones. Even with our self-service features, participants often need to speak with a real person. Calling us is convenient on our toll-free direct customer service line. (Available between 9:00 a.m. – 7:00 p.m. ET Monday thru Friday)

- We reduce your HR department's burden with electronic file (EDI) feeds from a wide variety of systems.
- BASIC FSA covers all your compliance obligations, including a customized Plan Document, reimbursement eligibility and verification, Summary Plan Description (SPD), administration manual, non-discrimination testing, and IRS Form 5500 filing (if required).



Medical FSAs got a lot more flexible in 2020 due to the CARES Act and increased eligible products. Over-the-counter (OTC) medications are once again eligible, as well as the addition of menstrual products such as tampons, pads, liners, and cups.

A New Way to Manage Benefits

Employee benefits are now easier to manage than ever before with BASIC's state-of-the-art Consumer Driven Accounts system. You may now offer your employees over 30 integrated benefit accounts to meet their varied needs, all with no extra work required on your end.

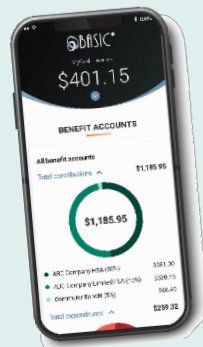
BASIC's one-stop solution allows you to manage all your benefit plans on one card, one website, and one mobile app for the utmost convenience.

You have the power to create a custom benefit program tailored to your employees' specific needs. Choose from a wide range of healthcare benefit accounts like FSA, Simple HRA, or HSA, and combine them with Dependent Care, Transit, Wellness Rewards, and Education Reimbursement accounts – all on a single platform.

The BASIC Card & MyCash

With MyCash, when an employee requests a reimbursement, funds are immediately processed and placed in an account that's available on their BASIC card. No more delays!

The BASIC Card is smart enough to pay for eligible items from benefit accounts and ineligible expenses (e.g., milk, gum, or other ancillary expenses) from a participant's MyCash account.



The BASIC Benefits Mobile App With Picture to Pay

In three quick steps, participants can pay their medical bills directly to healthcare providers with our "Picture to Pay" feature. No paper, no postage, no hassle.

1. Snap a picture of the bill
2. Submit via the BASIC benefits app
3. BASIC pays the bill from the appropriate benefit account



For more information about any of our services or to speak with a sales consultant call 800.444.1922 x 3 or visit basiconline.com.

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FSAGUIDE



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 Accounts - BASIC (continued)

WHAT IS A FLEXIBLE SPENDING



Flexible Spending Accounts (FSA) are part of Section 125, established by the IRS. Section 125 allows employees to set aside money for future medical and child care costs on a pre-tax basis.

A Medical FSA can be used to cover:

- Insurance deductibles
- Co-payments and coinsurance
- Prescriptions
- Dental or vision expenses
- Over-the-counter medicine
- Menstrual products
- PPE (e.g., masks, hand sanitizer)

SAVINGS

You save between 15%-40% by not having to pay federal, most state and local taxes, as well as Social Security and Medicare taxes for every dollar elected for an FSA.

The savings really add up.



Without an FSA		With an FSA	
Gross taxable wage	\$500.00	Gross taxable wage	\$500.00
Federal, FICA & State Tax	-113.25	Group Insurance premium contribution	-40.00
Group Insurance premium contribution	-40.00	Average weekly out-of-pocket medical expenses	-50.00
Take home pay	\$346.75	Taxable wage	\$410.00
Average weekly out-of-pocket medical expenses	-50.00	Federal, FICA & State Tax	-92.86
Amount left to spend	\$296.75	Amount left to spend	\$317.14
FSA Tax Savings per week			\$20.39

• Assuming 15% Federal tax, 7.65% FICA Tax (Social Security and Medicare)

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ACCOUNT?



MEDICAL FSA



Below is an example of how a current participant calculated the amount they elected for medical FSA. Be sure to base YOUR estimate on known expenses.

The full amount of your medical election is available for reimbursement upon the first day of your plan year.

When you incur an eligible out-of-pocket expense, submit your itemized documentation to BASIC and receive a tax free reimbursement.

	Charges	Savings
Deductible	\$500	\$113
Co-pays	\$450	\$101
Prescriptions	\$480	\$108
Contacts/Vision services	\$220	\$49
Dental	\$100	\$22
Over-the-counter items	\$75	\$16
Total	\$1825	\$409

• Assuming 15% Federal tax, 7.65% FICA Tax (Social Security and Medicare)

IRS regulations govern the eligibility of claims which include those that are not fully covered by a health care plan and are prescribed by a physician or other licensed professional, primarily for preventing, treating or mitigating a physical defect or illness. The IRS does not allow reimbursement for the following: cosmetic surgery, insurance premiums, teeth bleaching / whitening, nutritional supplements/vitamins, marriage counseling, debt counseling, eyeglass sun clips and prepayment of services. For more details, refer to IRS Publication No. 502.

CAN YOU HAVE AN FSA AND HSA AT THE SAME TIME?

If you participate in a standard Medical FSA, neither you nor your spouse (if applicable) are permitted to make or receive contributions to an HSA.

LIMITED PURPOSE FSA

IRS regulations do, however, allow a Limited Purpose FSA to be utilized in conjunction with an HSA.* The difference between Medical FSAs and Limited Purpose FSAs are the eligible expenses. A Limited Purpose FSA can only be used for dental and/or vision expenses.

During the FSA plan year, if you or your spouse enroll in a HDHP with an HSA option, you are not permitted to change your FSA plan type or make HSA contributions.

You cannot 'double-dip' and use funds from your Limited Purpose FSA and your HSA to cover the same expense(s).

An HSA does not impact your eligibility for a Dependent Care FSA.

* Not all employers choose to participate in a Limited Purpose FSA. Please refer to your enrollment materials or talk to your HR department.

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QUALIFIED EXPENSES

IRS regulations govern the eligibility of items and claims. As a FSA Administrator, BASIC helps ensure that you and your employer stay within these regulations.

MEDICAL, DENTAL & VISION

Co-pays
Co-insurance
Deductibles

MEDICAL*

Acupuncture
Chiropractor
Podiatrist
Doctor fees
Office visit
Prescriptions
Hospital bills
Laboratory fees
Medic alert bracelet
Dermatologist
Immunizations
Obstetrical expenses
Routine physicals
X-rays
Well baby checkups

DIABETIC SUPPLIES*

Insulin
Glucometer
Syringes/Needles
Test Strips

HEARING*

Hearing exam
Hearing aids
Special batteries

THERAPY*

Physical therapy
Learning disability
Psychologist fees for medical care
Psychiatric care

VISION*

Glasses
Eye exam
Contact lenses
Contact solution
Prescription sunglasses
LASIK surgery
Visine and eye drops
Reading glasses
Eyeglass repair kits
Orthokeratology
Seeing eye dog (buying, training, and maintaining)

DENTAL*

Orthodontic
Dentures/bridge/crowns
Fluoride treatments & seals
Cleanings and fillings
Root canals
Extractions
Dental x-rays
Occlusal guards
Reconstruction/implants

BIRTH CONTROL DEVICES*

Condoms
Prescriptions
Sterilization

PHYSICAL IMPAIRMENTS*

Wheelchair
Crutches
Walker
Custom made orthopedic shoes and inserts

SPECIAL NEEDS*

Transportation to and from doctor/hospital (call for current mileage rates and guidelines)

OVER-THE-COUNTER ITEMS*

Acid controllers
Acne medication
Antibiotic products
Anti-diarrheas/gas
Anti-itch/insect bite
Antiparasitic treatments
Baby rash creams
Band-aids
Carpal tunnel wrist supports
Cold sore remedies
Cold/hot packs for injuries
Cough, cold & flu
Digestive aids
Feminine anti-fungal/anti-itch
Hemorrhoidal preps
Home pregnancy tests
Incontinence supplies
Laxatives
Liquid adhesive for small cuts
Nasal strips
Pain relief
Sleep aids & sedatives
Stomach remedies
Stop smoking programs/items
Sunscreen

MENSTRUAL PRODUCTS*

Tampons
Pads and liners
Menstrual cups



Visit <https://www.basiconline.com/wp-content/uploads/2011/08/CDA-Ops-13-Medical-FSA-Election-Worksheet.pdf> for a qualified expense worksheet to help you estimate your out of pocket costs.

Flexible Spending Accounts - BASIC (continued)

PERSONAL PROTECTIVE EQUIPMENT (PPE)*

Personal protective equipment (PPE) for the primary purpose of preventing the spread of the Coronavirus Disease 2019 is now an eligible expense.

Masks
Hand sanitizer
Sanitizing wipes

* PLEASE NOTE:

This list is a broad overview of eligible expenses; not all services provided by a provider or practitioner are eligible under the IRS regulations.

Please call BASIC regarding your specific item or treatment, prior to election, to confirm eligibility.



EXPENSES THAT REQUIRE A LETTER OF MEDICAL NECESSITY

The IRS allows reimbursement of the following, with a copy of the physician's statement of medical necessity, that includes the specific product/service and a diagnosis. Treatment cannot be for general health or well being. A copy needs to be submitted with every reimbursement request and a new letter needs to be reinstated every 12 months.

Health club fees/gym memberships
Nutritional supplements/vitamins
Massage therapy

Weight loss programs (i.e. Weight Watchers and Jenny Craig) - Program fees are eligible but food portions are not.



EXAMPLES OF INELIGIBLE EXPENSES

The IRS does not allow reimbursement for the following:

Cosmetic surgery
Insurance premiums
Marriage/debt counseling
Eyeglass sun clips
Eyeglass or contact warranty
Prepayment of services
Special (dietary) foods
Personal care items
Diapers
Deodorant
Chapstick
Face cream or moisturizers
Eye serums or wrinkle creams
Teeth bleaching/whitening
Toothbrushes/toothpaste
Floss/flossing devices
Mouthwash
Protein shakes/meal replacement



CALCULATE SAVINGS

Use our calculator to estimate the size of your tax saving, annually or per pay check, when you choose to participate in BASIC FSA!

<https://www.basiconline.com/fsasavingscalculator>

Flexible Spending Accounts - BASIC (continued)



DEPENDENT CARE FSA

Plan contribution maximums vary between employers and range from \$5,000 to \$10,500. Check with your employer for your specific plan’s specific contribution limit. Just as with Medical FSA, you save between 15%-40% by not having to pay federal, most state and local taxes, as well as Social Security and Medicare taxes for every dollar elected for Dependent Care FSA.

Unlike a Medical FSA, Dependent Care FSA is a pay-as-you-go account. Funds are not advanced by your employer.

Without an FSA		With an FSA	
Gross taxable wage	\$500.00	Gross taxable wage	\$500.00
Federal, FICA & State Tax	-113.25	Dependent care election (\$5,000 divided by 52 weeks)	-96.15
Take home pay	\$386.75	Taxable wage	\$403.85
Average weekly out-of-pocket medical expenses	-96.15	Federal, FICA & State Tax	-91.47
Amount left to spend	\$290.60	Amount left to spend	\$312.36
FSA Tax Savings per week			\$21.78
Annual Savings			\$1,132.56

• Assuming 15% Federal tax, 7.65% FICA Tax (Social Security and Medicare)

DEPENDENT ELIGIBILITY

- You and your spouse must be employed or actively seeking employment or attending school full time.
- Child must be a dependent under 13 years of age* and be in your custodial care more than 50% of the calendar year. Once your child turns 14 during the plan year, expenses are no longer eligible for reimbursement.
- A spouse or dependent who is incapable of self-care and regularly spends at least eight hours per day in your home (i.e. an invalid parent).

SERVICE REQUIREMENTS

- Provider may not be a minor child or dependent for income tax purposes (i.e. an older child).
- Service provider must claim payments as income and comply with state regulations.
- Services must be for the physical care of the child, not for education, meals, etc.
- Overnight camps are not eligible for reimbursement.
- Expenses paid for Pre-K are eligible but kindergarten and higher is not.

* Consolidated Appropriations Act, 2021: Employers can allow unused dependent care FSA amounts for children until they turn age 14, at least through the end of the 2021 plan year. Please check with your HR Department for confirmation that your plan allows adopted that provision.

If you qualify for the Child Care Credit, the same IRS rules apply. If you have 2 or more children and spend more than \$5,000 for child care, you may have additional tax credits available to you. For more details, refer to IRS Publication No. 503

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Flexible Spending Accounts - BASIC (continued)

ADDITIONAL DETAILS

PLAN RULES ARE COMPANY SPECIFIC

While this booklet provides general information about Medical and Dependent Care FSA plans, recent legislation aimed at providing relief for plan participants means plan rules will vary significantly between employers. The Consolidated Appropriations Act (CAA), 2021 and the American Rescue Plan Act (ARPA) give employers significant flexibility in plan design for plans years ending in 2020/2021.

Optional relief provisions include increased DCFSA plan limits, unlimited carryover, extended grace period, unrestricted mid-year election changes and new enrollment, and increased dependent age limit from 13 to 14 for a child that turned 14 in 2020 or 2021.

For information regarding your plan specifics, contact your company's Benefits Coordinator.



A New Way to Manage Benefits

Employee benefits are now easier to manage than ever before with BASIC's state-of-the-art Consumer Driven Accounts (CDA) system.

BASIC's one-stop solution allows you to manage all your benefit plans on one card, one website, and one mobile app for the utmost convenience.

The BASIC Card & MyCash

When participants request a reimbursement, funds are immediately processed and placed in an unrestricted account called MyCash. Those funds are available on the BASIC card to use anywhere MasterCard is accepted. **No more delays!**

The BASIC Card is smart enough to pay for eligible items from benefit accounts and ineligible expenses (e.g., milk, gum, or other ancillary expenses) from a participant's MyCash account.

The BASIC benefits Mobile App With Picture to Pay the Provider

In three quick steps, participants can pay their medical bills directly to healthcare providers with our "Picture to Pay" feature. Not to be confused with requesting a reimbursement, which is also a feature in the BASIC benefits app. **No paper, no postage, no hassle.**

1. Snap a picture of the bill (only if you have not paid the bill yet)
2. Submit via the BASIC benefits app
3. BASIC pays the bill from the appropriate benefit account

You can learn more about BASIC CDA at www.basiconline.com/cda.

If you have questions at any time, call 800-372-3539 and speak to a BASIC FSA Customer Service Rep.

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Flexible Spending Accounts - BASIC (continued)

BASIC CDA



Dependent Care Eligible Expenses

Tax Savings

A Dependent Care Flexible Spending Account (DCFSA) is a pretax benefit that allows reimbursement for qualified dependent care expenses. Qualified expenses include care for a dependent child under the age of 13 and/or care for your spouse or adult dependent who is physically or mentally unable to care for themselves.

How It Works

Plan participants specify a certain dollar amount to contribute from their paychecks per pay period to their DCFSA. Unlike a Medical FSA, DCFSAs are a pay-as-you-go account, meaning funds are not advanced by the employer. DCFSA election amounts can change or stop during the year if expenses change.

Below is a partial list of eligible and ineligible expenses. All expenses are listed in IRS Publications 503 at www.irs.gov.



Eligible Expenses

- Adult daycare
- After-school care/program²
- Au pair or nanny salary
- Babysitting in your home/ someone else's home¹
- Babysitting by your non-tax dependent relative¹
- Before-school care/ program²
- Care when one parent works days and other parent works nights¹
- Care while living in a foreign country¹
- Care while looking for work
- Care while on family, personal, or medical leave
- Care while you/spouse is working at self-employment¹
- Child daycare or day camp²
- Custodial elder care¹
- Day nursing care¹
- Employer-provided on-site daycare²
- Federal employment taxes (FICA, FUTA) of care provider
- Household services related to dependent care
- In-home care¹
- Nighttime care¹
- Nursery school fees or tuition
- Payroll taxes related to eligible dependent care
- Preschool fees or tuition
- Room and board for caregiver, au pair, or nanny
- Senior daycare¹
- Sick child care¹
- Specialized daycare
- Transportation to and from by the care provider

Ineligible Expenses

- Child care while performing volunteer work
- Educational, learning, or study skills services
- Field trips or sleep-away camp
- Household services (housekeeper, cook, etc.)
- Kindergarten/school tuition
- Meals, food, or snacks
- Medical care or expenses
- Nursing home care for dependent adult(s)
- Summer school

¹: Care must be work-related. Restrictions may apply. See IRS Publication 503 for more details.

²: Primary purpose must be custodial care and not educational in nature. See IRS Publication 503 for more details.



800.372.3539
<https://cda.basiconline.com>
basiconline.com/CDA

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Flexible Spending Accounts - BASIC (continued)

MEDICAL FSA ELECTION WORKSHEET

EXPENSE	ESTIMATED COST	EXPENSE	ESTIMATED COST	EXPENSE	ESTIMATED COST
MEDICAL*		OVER-THE-COUNTER ITEMS*		DIABETIC SUPPLIES*	
Acupuncture	\$	Acid controllers	\$	Insulin	\$
Chiropractor	\$	Acne medication	\$	Glucometer	\$
Podiatrist	\$	Antibiotic products	\$	Syringes/Needles	\$
Deductible	\$	Anti-diarrheas/gas	\$	Test Strips	\$
Co-pays	\$	Anti-itch/insect bite	\$	THERAPY*	
Doctor fees	\$	Antiparasitic treatments	\$	Physical therapy	\$
Office visit	\$	Baby rash creams	\$	Learning disability	\$
Prescriptions	\$	Band-aids	\$	Psychologist fees for medical care	\$
Hospital bills	\$	Carpal tunnel wrist supports	\$	Psychiatric care	\$
Laboratory fees	\$	Cold sore remedies	\$	PHYSICAL IMPAIRMENTS*	
Medic alert bracelet	\$	Cold/hot packs for injuries	\$	Wheelchair	\$
Dermatologist	\$	Cough, cold & flu	\$	Crutches	\$
Immunizations	\$	Digestive aids	\$	Walker	\$
Obstetrical expenses	\$	Feminine anti-fungal / anti-itch	\$	Custom made orthopedic shoes and inserts	\$
Routine physicals	\$	Hemorrhoidal preps	\$	SPECIAL NEEDS*	
X-rays	\$	Home pregnancy tests	\$	Transportation to and from doctor/hospital (call for current mileage rates and guidelines)	\$
Well baby checkups	\$	Incontinence supplies	\$	COLUMN #3 TOTAL	\$
HEARING*		Laxatives	\$	EXAMPLES OF INELIGIBLE EXPENSES	
Hearing exam	\$	Liquid adhesive for small cuts	\$	The IRS does not allow reimbursement for the following:	
Hearing aids	\$	Nasal strips	\$	Cosmetic surgery	
Special batteries	\$	Pain relief	\$	Insurance premiums	
VISION*		Sleep aids & sedatives	\$	Marriage/debt counseling	
Glasses	\$	Stomach remedies	\$	Eyeglass sun clips	
Eye exam	\$	Stop smoking programs/items	\$	Eyeglass or contact warranty	
Contact lenses	\$	Sunscreen	\$	Prepayment of services	
Contact lens solution	\$	MENSTRUAL PRODUCTS*		Special (dietary) foods	
Prescription sunglasses	\$	Tampons		Personal care items	
LASIK surgery	\$	Pads and liners		Diapers	
Visine and eye drops	\$	Menstrual cups		Deodorant	
Reading glasses		BIRTH CONTROL DEVICES*		Chapstick	
DENTAL*		Condoms	\$	Face cream or moisturizers	
Orthodontic	\$	Prescriptions	\$	Teeth bleaching/whitening	
Dentures/bridge/crowns	\$	Sterilization	\$	Tooth brushes/toothpaste	
Fluoride treatments & seals	\$	COLUMN #2 TOTAL	\$	Floss/flossing devices	
Cleanings and fillings	\$				
Root canals	\$				
Extractions	\$				
COLUMN #1 TOTAL	\$				

EXPENSES THAT REQUIRE A LETTER OF MEDICAL NECESSITY

The IRS allows reimbursement of the following with a copy of the physician's statement of medical necessity that includes the specific product/service and a diagnosis. Treatment cannot be for general health or well being. A copy needs to be submitted with every reimbursement request and a new letter needs to be reinstated every 12 months.

EXPENSE	ESTIMATED COST
Health club fees/ gym memberships	\$
Nutritional supplements/vitamins	\$
Massage therapy	\$
Weight loss programs (i.e. Weight Watchers and Jenny Craig) - Program fees are eligible but food portions are not.	\$
COLUMN #4 TOTAL	\$

ESTIMATED EXPENSES	
COLUMN 1	\$
COLUMN 2	\$
COLUMN 3	\$
COLUMN 4	\$
TOTAL ESTIMATED EXPENSES	\$

* Please note: This list is a broad overview of eligible expenses; not all services provided by a provider or practitioner are eligible under the IRS regulations. Please call BASIC regarding your specific item or treatment to confirm eligibility.

You may also want to review the [IRS Publication 502](#) for Medical Expenses for additional examples.



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Colonial Life Voluntary Benefits

Accident Insurance



Accidents happen in places where you and your family spend the most time – at work, in the home and on the playground – and they're unexpected. How you care for them shouldn't be.

In your lifetime, which of these accidental injuries have happened to you or someone you know?

- Sports-related accidental injury
- Broken bone
- Burn
- Concussion
- Laceration
- Back or knee injuries
- Car accidents
- Falls & spills
- Dislocation
- Accidental injuries that send you to the Emergency Room, Urgent Care or doctor's office

Colonial Life's Accident Insurance is designed to help you fill some of the gaps caused by increasing deductibles, co-payments and out-of-pocket costs related to an accidental injury. The benefit to you is that you may not need to use your savings or secure a loan to pay expenses. Plus you'll feel better knowing you can have greater financial security.

Accident 1.0-Preferred with Health Screening Benefit-CA

What additional features are included?

- Worldwide coverage
- Portable
- Compliant with Healthcare Spending Account (HSA) guidelines

Will my accident claim payment be reduced if I have other insurance?

You're paid regardless of any other insurance you may have with other insurance companies, and the benefits are paid directly to you (unless you specify otherwise).

What if I change employers?

If you change jobs or leave your employer, you can take your coverage with you at no additional cost. Your coverage is guaranteed renewable as long as you pay your premiums when they are due or within the grace period.

Can my premium change?

Colonial Life can change your premium only if we change it on all policies of this kind in the state where your policy was issued.

How do I file a claim?

Visit coloniallife.com or call our Customer Service Department at 1.800.325.4368 for additional information.

Colonial Life Voluntary Benefits (continued)

Benefits listed are for each covered person per covered accident unless otherwise specified.

Initial Care

- Accident Emergency Treatment..... \$125
- Ambulance\$200
- X-ray Benefit.....\$30
- Air Ambulance..... \$2,000

Common Accidental Injuries

Dislocations (Separated Joint)	Non-Surgical	Surgical
Hip	\$2,200	\$4,400
Knee (except patella)	\$1,100	\$2,200
Ankle – Bone or Bones of the Foot (other than Toes)	\$880	\$1,760
Collarbone (Sternoclavicular)	\$550	\$1,100
Lower Jaw, Shoulder, Elbow, Wrist	\$330	\$660
Bone or Bones of the Hand	\$330	\$660
Collarbone (Acromioclavicular and Separation)	\$110	\$220
One Toe or Finger	\$110	\$220

Fractures	Non-Surgical	Surgical
Depressed Skull	\$2,750	\$5,500
Non-Depressed Skull	\$1,100	\$2,200
Hip, Thigh	\$1,650	\$3,300
Body of Vertebrae, Pelvis, Leg	\$825	\$1,650
Bones of Face or Nose (except mandible or maxilla)	\$385	\$770
Upper Jaw, Maxilla	\$385	\$770
Upper Arm between Elbow and Shoulder	\$385	\$770
Lower Jaw, Mandible, Kneecap, Ankle, Foot	\$330	\$660
Shoulder Blade, Collarbone, Vertebral Process	\$330	\$660
Forearm, Wrist, Hand	\$330	\$660
Rib	\$275	\$550
Coccyx	\$220	\$440
Finger, Toe	\$110	\$220

Your Colonial Life policy also provides benefits for the following injuries received as a result of a covered accident.

- Burn (based on size and degree) \$1,000 to \$12,000
- Coma\$10,000
- Concussion \$60
- Emergency Dental Work\$75 Extraction, \$300 Crown, Implant, or Denture
- Lacerations (based on size).....\$30 to \$500

Requires Surgery

- Eye Injury\$300
- Tendon/Ligament/Rotator Cuff.....\$500 - one, \$1,000 - two or more
- Ruptured Disc\$500
- Torn Knee Cartilage\$500

Surgical Care

- Surgery (cranial, open abdominal or thoracic) \$1,500
- Surgery (hernia)\$150
- Surgery (arthroscopic or exploratory)\$200
- Blood/Plasma/Platelets\$300

Colonial Life Voluntary Benefits (continued)

Transportation/Lodging Assistance

If injured, covered person must travel more than 50 miles from residence to receive special treatment and confinement in a hospital.

- Transportation \$500 per round trip up to 3 round trips
- Lodging (family member or companion) \$125 per night up to 30 days for a hotel/motel lodging costs

Accident Hospital Care

- Hospital Admission* \$1,000 per accident
- Hospital ICU Admission* \$2,000 per accident
- * We will pay either the Hospital Admission or Hospital Intensive Care Unit (ICU) Admission, but not both.*
- Hospital Confinement \$225 per day up to 365 days per accident
- Hospital ICU Confinement \$450 per day up to 15 days per accident

Accident Follow-Up Care

- Accident Follow-Up Doctor Visit \$50 (up to 3 visits per accident)
- Medical Imaging Study \$150 per accident
(limit 1 per covered accident and 1 per calendar year)
- Occupational or Physical Therapy \$25 per treatment up to 10 days
- Appliances \$100 (such as wheelchair, crutches)
- Prosthetic Devices/Artificial Limb \$500 - one, \$1,000 - more than 1
- Rehabilitation Unit \$100 per day up to 15 days per covered accident, and 30 days per calendar year.
Maximum of 30 days per calendar year

Accidental Dismemberment

- Loss of Finger/Toe \$750 – one, \$1,500 – two or more
- Loss or Loss of Use of Hand/Foot/Sight of Eye \$7,500 – one, \$15,000 – two or more

Catastrophic Accident

For severe injuries that result in the total and irrecoverable:

- Loss of one hand and one foot
 - Loss of both hands or both feet
 - Loss or loss of use of one arm and one leg or
 - Loss or loss of use of both arms or both legs
- Loss of the sight of both eyes
 - Loss of the hearing of both ears
 - Loss of the ability to speak
- Named Insured \$25,000 Spouse \$25,000 Child(ren) \$12,500

365-day elimination period. Amounts reduced for covered persons age 65 and over.
Payable once per lifetime for each covered person.

Accidental Death

	Accidental Death	Common Carrier
● Named Insured	\$25,000	\$100,000
● Spouse	\$25,000	\$100,000
● Child(ren)	\$5,000	\$20,000

Colonial Life Voluntary Benefits (continued)

Health Screening Benefit

● \$50 per covered person per calendar year

Provides a benefit if the covered person has one of the health screening tests performed. This benefit is payable once per calendar year per person and is subject to a 30-day waiting period.

Tests include:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- Carotid doppler
- CEA (blood test for colon cancer)
- Cervical Cancer Screening
- Chest x-ray
- Colonoscopy
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Skin cancer biopsy
- Thermography
- Virtual colonoscopy

Mammography\$200

- For one baseline mammogram if the covered person is between the ages of 35 and 39;
- One mammogram every two years if the covered person is 40 to 49 years of age, or more frequently if recommended by the covered person’s physician; and
- One mammogram each year if the covered person is 50 years of age or older.

My Coverage Worksheet (For use with your Colonial Life benefits counselor)

Who will be covered? (check one)

- ☐ Employee Only ☐ Spouse Only ☐ One Child Only ☐ Employee & Spouse
- ☐ One-Parent Family, with Employee ☐ One-Parent Family, with Spouse ☐ Two-Parent Family

When are covered accident benefits available? (check one)

- ☐ On and Off -Job Benefits ☐ Off -Job Only Benefits

EXCLUSIONS

We will not pay benefits for losses that are caused by or are the result of: or illegal occupations; sickness; suicide or self-inflicted injuries; war or armed conflict; in addition to the exclusions listed above, we also will not pay the Catastrophic Accident benefit for injuries that are caused by or are the result of: birth; intoxicants.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy form Accident 1.0-HS-CA. This is not an insurance contract and only the actual policy provisions will control.

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Accident 1.0-Preferred with Health Screening Benefit-CA

Colonial Life Voluntary Benefits (continued)



Cancer insurance helps provide financial protection through a variety of benefits. These benefits are not only for you but also for your covered family members.



For more information, talk with your benefits counselor.

Cancer Insurance Level 3 Benefits

BENEFIT DESCRIPTION	BENEFIT AMOUNT
Air ambulance Transportation to or from a hospital or medical facility <i>[max. of two trips per confinement]</i>	\$2,000 per trip
Ambulance Transportation to or from a hospital or medical facility <i>[max. of two trips per confinement]</i>	\$250 per trip
Anesthesia Administered during a surgical procedure for cancer treatment	
■ General anesthesia	25% of surgical procedures benefit
■ Local anesthesia	\$40 per procedure
Anti-nausea medication Doctor-prescribed medication for radiation or chemotherapy <i>[\$200 monthly max.]</i>	\$50 per day administered or per prescription filled
Blood/plasma/platelets/immunoglobulins A transfusion required during cancer treatment <i>[\$10,000 calendar year max.]</i>	\$175 per day
Bone marrow donor screening Testing in connection with being a potential donor <i>[once per lifetime]</i>	\$50
Bone marrow or peripheral stem cell donation Receiving another person's bone marrow or stem cells for a transplant <i>[once per lifetime]</i>	\$750
Bone marrow or peripheral stem cell transplant Transplant you receive in connection with cancer treatment <i>[max. of two bone marrow transplant benefits per lifetime]</i>	\$7,000 per transplant
Cancer vaccine An FDA-approved vaccine for the prevention of cancer <i>[once per lifetime]</i>	\$50
Companion transportation Companion travels by plane, train or bus to accompany a covered cancer patient more than 50 miles one way for treatment <i>[up to \$1,200 per round trip]</i>	\$0.50 per mile
Egg(s) extraction or harvesting/sperm collection and storage Extracted/harvested or collected before chemotherapy or radiation <i>[once per lifetime]</i>	
■ Egg(s) extraction or harvesting/sperm collection	\$1,000
■ Egg(s) or sperm storage (cryopreservation)	\$350
Experimental treatment Hospital, medical or surgical care for cancer <i>[\$15,000 lifetime max.]</i>	\$300 per day
Family care Inpatient or outpatient treatment for a covered dependent child <i>[\$2,500 calendar year max.]</i>	\$50 per day
Hair/external breast/voice box prosthesis Prosthesis needed as a direct result of cancer	\$350 per calendar year
Home health care services Examples include physical therapy, occupational therapy, speech therapy and audiology; prosthesis and orthopedic appliances; rental or purchase of durable medical equipment <i>[up to 30 days per calendar year]</i>	\$100 per day
Hospice (initial or daily care) An initial, one-time benefit and a daily benefit for treatment <i>[\$15,000 lifetime max. for both]</i>	
■ Initial hospice care <i>[once per lifetime]</i>	\$1,000
■ Daily hospice care	\$50 per day

Colonial Life Voluntary Benefits (continued)



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BENEFIT DESCRIPTION	BENEFIT AMOUNT
Hospital confinement Hospital stay (including intensive care) required for cancer treatment	
■ 30 days or less	\$250 per day
■ 31 days or more	\$500 per day
Lodging	\$75 per day
Hotel/motel expenses when being treated for cancer more than 50 miles from home [70-day calendar year max.]	
Medical imaging studies	\$175 per study
Specific studies for cancer treatment [350 calendar year max.]	
Outpatient surgical center	\$300 per day
Surgery at an outpatient center for cancer treatment [900 calendar year max.]	
Private full-time nursing services	\$125 per day
Services while hospital confined other than those regularly furnished by the hospital	
Prosthetic device/artificial limb	\$2,000 per device or limb
A surgical implant needed because of cancer surgery [payable one per site, \$4,000 lifetime max.]	
Radiation/chemotherapy	
Weekly benefit [max. once per week]	
■ Injected chemotherapy by medical personnel	\$750
■ Radiation delivered by medical personnel	\$750
Monthly chemotherapy benefit [max. once per month]	
■ Self-injected	\$300
■ Pump	\$300
■ Topical	\$300
■ Oral hormonal [1-24 months]	\$300
■ Oral hormonal [25+ months]	\$150
■ Oral non-hormonal	\$300
Reconstructive surgery	\$60 per surgical unit
A surgery to reconstruct anatomic defects that result from cancer treatment [up to \$3,000 per procedure, including 25% for general anesthesia]	
Second medical opinion	\$300
A second physician's opinion on cancer surgery or treatment [once per lifetime]	
Skilled nursing care facility	\$100 per day
Confinement to a covered facility after hospital release [max. of 30 days per covered person per calendar year]	
Skin cancer initial diagnosis	\$400
A skin cancer diagnosis while the policy is in force [once per lifetime]	
Supportive or protective care drugs and colony stimulating factors	\$150 per day
Doctor-prescribed drugs to enhance or modify radiation/chemotherapy treatments [1,200 calendar year max.]	
Surgical procedures	\$60 per surgical unit
Inpatient or outpatient surgery for cancer treatment [5,000 max. per procedure]	
Transportation	\$0.50 per mile
Travel expenses when being treated for cancer more than 50 miles from home [up to \$1,200 per round trip]	
Waiver of premium	Is available
No premiums due if the named insured is disabled longer than 90 consecutive days	

The policy has limitations and exclusions that may affect benefits payable. Most benefits require that a charge be incurred. Coverage may vary by state and may not be available in all states. For cost and complete details, see your benefits counselor.

This chart highlights the benefits of policy form CanAssist-CA. This chart is not complete without form number 101481.

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10-15 | 101484-CA

Colonial Life Voluntary Benefits (continued)



Specified Critical Illness Insurance



For more information,
talk with your
benefits counselor.

If you're diagnosed with a covered critical illness, specified critical illness insurance from Colonial Life can help with your expenses, so you can concentrate on what's most important – your treatment, care and recovery.

Face amount: \$ _____

Critical illness benefit

For the diagnosis of this covered critical illness condition: ¹	This percentage of the face amount is payable:
Heart attack (myocardial infarction)	100%
Stroke	100%
End-stage renal (kidney) failure	100%
Major organ failure	100%
Permanent paralysis due to a covered accident	100%
Coma	100%
Blindness	100%
Coronary artery bypass graft surgery/disease ²	25%

The maximum benefit amount for this policy is 3x the face amount for the named insured for all covered persons combined. The policy will terminate when the maximum benefit amount for specified critical illness has been paid.

Subsequent diagnosis of a different critical illness³

If you receive a benefit for a specified critical illness, and later you are diagnosed with a different specified critical illness, the original percentage of the face amount is payable for that particular specified critical illness.

Subsequent diagnosis of the same critical illness³

If you receive a benefit for a specified critical illness, and later you are diagnosed with the same specified critical illness, 25% of the original face amount is payable. Critical illness conditions that do not qualify are: coronary artery bypass graft surgery/disease.²

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Colonial Life Voluntary Benefits (continued)



Individual Short-Term Disability Insurance



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You never know when a disability could impact your way of life. Fortunately, there's a way to help protect your income. If an injury or sickness prevents you from earning a paycheck, disability insurance can provide a monthly benefit to help you cover your ongoing expenses.

Can you afford to not protect your paycheck?

You don't have the same lifestyle expenses as the next person. That's why you need disability coverage that can be customized to fit your specific needs.

After calculating your monthly expenses, your benefits counselor can help you complete the benefits worksheet.

ESTIMATED MONTHLY EXPENSES	AMOUNT
Mortgage or rent	\$
Utilities (electric/gas, phone, water, TV, Internet)	\$
Transportation costs (gas, car payments)	\$
Food	\$
Health (medical needs and prescription drugs)	\$
Other	\$
TOTAL	\$

Benefits worksheet

How much coverage do I need?

Monthly benefit amount for off-job injury and off-job sickness: _____
Choose a monthly benefit amount between \$400 and \$6,500.*

If your plan includes on-job injury/sickness benefits, the benefit is 50% of the off-job amount.

How long will I receive benefits?

Benefit period: _____ months
The partial disability benefit period is three months.

When will my total disability benefits start?

After an injury: _____ days After a sickness: _____ days

*Subject to income requirements

ISTD3000 BASE



Colonial Life Voluntary Benefits (continued)

Product information

Total disability definition

Totally disabled or total disability means that as a result of sickness or injury, you are not able to perform with reasonable continuity, the substantial and material acts necessary to perform your usual occupation in the usual and customary way, and you choose not to work at any occupation.

How partial or residual disability works

If you are able to return to work part-time after at least 1 day of being paid for a total disability, you may be able to still receive 50% of your total disability benefit.

Waiver of premium

We will waive your premium payments after 90 consecutive days of a covered disability.

Geographical limitations

If you are disabled while outside of the United States, Canada or Mexico, you may receive benefits for up to 60 days before you have to return to the U.S. in order to continue receiving benefits.

Issue age

Coverage is available from ages 17 to 74.

Keep your coverage

You can keep your coverage to age 75 at no additional cost, even if you change jobs, as long as you pay your premiums when they are due.

Premium

Your premium is based on your age when you purchase coverage and the amount of coverage you are eligible to buy. Your premium will not change as you age.*



For more information, talk with your benefits counselor.

EXCLUSIONS AND LIMITATIONS

We will not pay benefits for losses that are caused by, contributed to by or occur as the result of: alcoholism or drug addiction, cosmetic surgery, felonies or illegal occupation, flying, hazardous avocations, intoxicants and controlled substances, racing, professional sports, suicide or injuries which you intentionally do to yourself, war or armed conflict. We will not pay for losses due to you giving birth within the first nine months after the coverage effective date of the policy. We will not pay for loss when the disability is a pre-existing condition as described in the policy.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy form ISTD3000-CA and rider form ISTD3000-ADIB-CA. Coverage may vary by state and may not be available in all states. This is not an insurance contract and only the actual policy and rider provisions will control.

*Premiums can be changed only if we change them on all policies in the state where they are issued.

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5-16 | 101629-CA

Colonial Life Voluntary Benefits (continued)



Term Life Insurance

Help protect the people who depend on you

If something happened to you, the last thing your family should have to worry about is financial burdens. Funeral expenses, medical bills and taxes could be just the beginning. How would they cover ongoing living expenses, such as a mortgage, utilities and health care?

Plan for the future with term life insurance from Colonial Life & Accident Insurance Company.

The advantages of term life insurance

- Level death benefit.
- Lower cost option compared with cash value insurance.
- Coverage for specified periods of time, which can be during high-need years.
- Benefit for the beneficiary that is typically free from income tax.

Benefits and features

- Guaranteed premiums do not increase during the term.
- Coverage is guaranteed renewable to age 95 as long as premiums are paid when due.
- You can convert it to cash value insurance.
- Portability allows you to take it with you if you change jobs or retire.
- An accelerated death benefit is included.



Your cost will vary based on the level of coverage you select.

Talk with your Colonial Life benefits counselor for information about what level of coverage would work best for you.

TERM LIFE 1000



Colonial Life Voluntary Benefits (continued)

Benefits worksheet

For use with your Colonial Life
benefits counselor

HOW MUCH COVERAGE DO YOU NEED?

☐ **YOU** \$ _____
FACE AMOUNT

Select the term period

- ☐ 10-year term
☐ 20-year term
☐ 30-year term

☐ **SPOUSE** \$ _____
FACE AMOUNT

Select the term period

- ☐ 10-year term
☐ 20-year term
☐ 30-year term

Select any optional riders:

- ☐ Spouse term life rider
\$ _____ face amount
for _____-year term period
- ☐ Children's term life rider
\$ _____ face amount
- ☐ Waiver of premium benefit rider
- ☐ Accidental death benefit rider

To learn more,
talk with your Colonial Life
benefits counselor.

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Cash value policy conversion

You can convert your policy to a Colonial Life cash value life insurance policy any time through age 75 (unless you have used the accelerated death benefit or waiver of premium benefit rider) with no evidence of insurability. Premiums will be based on your age at the time you convert your policy.

Accelerated death benefit

If you are diagnosed with a terminal illness, you can request up to 75% of the policy's death benefit, not to exceed \$150,000. We deduct a fee only if you use the benefit, and your death benefit will then be reduced by the amount you receive. In addition, there may be tax consequences for receiving the accelerated benefit; ask your tax advisor for advice. Please refer to your policy for details.

Spouse coverage options

Two options are available for spouse coverage at an additional cost:

1. **Spouse term life policy:** Offers guaranteed premiums and level death benefits equivalent to those available to you – whether or not you buy a policy for yourself.
2. **Spouse term life rider:** Add a term rider for your spouse to your policy, up to a maximum death benefit of \$50,000; 10-year and 20-year are available (20-year rider only available with a 20- or 30-year term policy).

Dependent coverage

You may add a children's term life rider to cover all of your eligible dependent children with up to \$10,000 in coverage each for one premium. The children's term life rider may be added to either the primary or spouse policy, not both.

Waiver of premium benefit rider

This rider waives all premiums (for the policy and any riders) if you become totally and permanently disabled before the age of 65. To be considered permanent, your total disability must continue with no interruptions for at least six consecutive months. Premiums waived by this rider do not have to be repaid. This rider is available for the spouse policy as well, subject to home office approval.

Accidental death benefit rider

This rider provides an additional benefit to the beneficiary if the insured dies as a result of an accident before age 70. The benefit doubles if the injury resulting in death occurs while insured is a fare-paying passenger on a public conveyance, such as a commercial aircraft or taxicab. An additional seatbelt benefit is also payable.

EXCLUSIONS AND LIMITATIONS

If the insured commits suicide within two years (one year in CO and ND) from the coverage effective date, whether he is sane or insane (not applicable in AZ), we will not pay the death benefit. We will terminate this policy and return the premiums paid, without interest. In MO, should death occur as a result of suicide, our company is responsible only for the return of premiums paid when application is made with intent to commit suicide.

You will receive a policy summary or illustration (whichever is applicable to your state) when your policy is issued if this policy has exclusions, limitations or reductions of benefits. For costs and complete details, call or write your Colonial Life benefits counselor or the company. This brochure is applicable to policy forms TERM1000, R-TERM1000-ADB, R-TERM1000-CTR, R-TERM1000-STR, R-TERM1000-WAIVER (and applicable state variations, for example: TERM1000-TX, R-TERM1000-ADB-TX-1, R-TERM1000-CTR-TX, R-TERM1000-STR-TX and R-TERM1000-WAIVER-TX-1). See your Colonial Life benefits counselor for additional information specific for your state. This coverage contains limitations and exclusions that may affect benefits payable. Product may vary by state.

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4-16 | 64815-10

Colonial Life Voluntary Benefits (continued)

Colonial Life
The benefits of good hard work.®



Whole Life Insurance

You can't predict your family's future, but you can be prepared for it.

You like to think that you'll be there for your family in the years to come. But if something happened to you, would your family have the income they need?

It's not easy to think about such serious circumstances, but it's important to make sure your family is financially protected. You can gain peace of mind with Colonial Life's Whole Life Insurance.

What is whole life insurance?

Whole life insurance can help provide protection for you and those who depend on you. You won't have to worry about becoming uninsurable later in life, and your premiums won't increase as you get older.

With whole life insurance, you receive a guaranteed death benefit as long as premiums are paid, which can help with funeral costs and other immediate expenses. Also, throughout the life of the policy, you can access its cash value through a policy loan and use the money for emergencies. The loan should be repaid to protect the policy's value.

What are the advantages of Colonial Life's Whole Life Insurance?

- Your premiums will never increase because of changes in your health or age.
- You can take the policy with you even if you change jobs or retire, with no increase in premium.
- A guaranteed purchase option means you can purchase additional whole life coverage — without having to answer health questions — at three different points in the future.
- With the accelerated death benefit, you can request up to 75 percent of your benefit to a maximum of \$150,000 if you are diagnosed with a terminal illness.*
- An immediate \$3,000 claim payment can help your designated beneficiary pay for funeral costs or other expenses.



**30% of Americans
(70 million) know they
need more life insurance.**

Facts About Life, LIMRA 2015



**Your cost will vary based on the
level of coverage you select.**

Talk with your Colonial Life benefits counselor for information about what level of coverage would work best for you.

WHOLE LIFE 1000

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Colonial Life Voluntary Benefits (continued)

Benefits worksheet

For use with your Colonial Life
benefits counselor

HOW MUCH COVERAGE DO YOU NEED?

☐ **YOU** \$ _____
FACE AMOUNT

Select the option:

- ☐ Paid-up at age 65
☐ Paid-up at age 95

☐ **SPOUSE** \$ _____
FACE AMOUNT

Select the option:

- ☐ Paid-up at age 65
☐ Paid-up at age 95

☐ **JUVENILE** \$ _____
FACE AMOUNT

Select any optional riders:

- ☐ Spouse term life rider
\$ _____ face amount
for _____-year term period
- ☐ Children's term life rider
\$ _____ face amount
- ☐ Waiver of premium benefit rider
- ☐ Accidental death benefit rider

To learn more,
talk with your Colonial Life
benefits counselor.

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Product options

Paid-up at age 65 or paid-up at age 95

These two plan design options allow you to select what age your premium payments will end. You can choose to have your policy paid up when you reach age 65 or 95.

Guaranteed purchase option

If you are age 55 or younger when you purchase the policy, you have the option to purchase additional whole life coverage – without having to answer health questions – at three different points in the future. You may purchase up to your initial face amount, not to exceed a total combined maximum of \$100,000 for all options.

Additional coverage options

Spouse whole life policy

This policy offers a guaranteed death benefit, guaranteed level premiums and guaranteed cash value accumulation – whether or not you buy a policy on yourself.

Spouse term life rider

You can purchase term life coverage for your spouse, with a maximum death benefit of up to \$50,000. 10-year and 20-year coverage periods are available, based on the policy you select. You can choose to convert this coverage to a cash value policy within certain time periods later on – without having to answer health questions.

Juvenile whole life policy

You can purchase a policy while children are young and premiums are lower – whether or not you buy a policy on yourself. You may also increase the coverage when the child is 18, 21 and 24 without providing proof of good health. The plan design is paid-up at age 65.

Children's term life rider

You may purchase up to \$10,000 in term life coverage for each of your eligible dependent children and pay one premium. You can later convert this coverage to a cash value life insurance policy – without having to answer health questions. You can add this additional coverage to either the primary or the spouse policy, but not both.

Waiver of premium benefit rider

Your premiums on the whole life policy and any riders attached to it will be waived if you become totally disabled before the policy anniversary following your 65th birthday and you satisfy the six-month elimination period. You must resume premium payments once you are no longer disabled.

Accidental death benefit rider

This rider pays an additional benefit if you die as a result of an accident before age 70. The benefit doubles if the accident occurs while you are a fare-paying passenger. An additional 25% of the accidental death benefit will be paid if you die due to an injury sustained while driving or riding in a private passenger vehicle and you are wearing a seat belt.

*Any payout would reduce the death benefit.

EXCLUSIONS AND LIMITATIONS

If the insured commits suicide within two years (one year in ND) from the coverage effective date or the date of reinstatement (not applicable in AR), whether he is sane or insane (not applicable in AZ), we will not pay the death benefit. We will terminate this policy and return the premiums paid, minus any loans and loan interest to you. Product may vary by state. For costs and complete details of the coverage, call or write your Colonial Life benefits counselor or the company.

This brochure is applicable to policy forms:

ICC08-WL-GPO-95/ WL-GPO-95/ WL-GPO-95-rev/ICC12-WLGPO-95
ICC07-WL-NGPO-65/ WL-NGPO-65/ WL-NGPO-65-rev/ICC12-WL-NGPO-65
ICC07-WL-NGPO95/ WL-NGPO-95/ WL-NGPO-95-rev/ ICC12-WL-NGPO-95
ICC08-WL-GPO-65/ WL-GPO-65/ WL-GPO-65-rev/ ICC12-WL-GPO-65
ICC16-WL1000J/ WL1000J and applicable state variations.

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Colonial Life Voluntary Benefits (continued)

Whole Life

Comprehensive Long-Term Care Insurance Rider

Nursing or Residential Care Facility, Home Care and Respite Care Insurance

The rider is available and can be purchased at an additional cost to provide for flexible use of the Whole Life policy's death benefit.

Colonial Life's Comprehensive Long-Term Care Insurance Rider provides your employees with two kinds of insurance protection in one convenient Whole Life policy – life insurance benefits and long-term care benefits.

The Comprehensive Long-Term Care Insurance Rider reduces the Whole Life policy death benefit to provide monthly indemnity payments to help pay for the insured's long-term care services needed as a result of a chronic illness, serious accident, sudden illness, or cognitive impairment. The maximum benefit amount is equal to the policy death benefit, less any indebtedness.

Benefits

Care Setting	Monthly Benefit
Nursing or Residential Care Facility	Monthly indemnity benefit of 6% of the Death Benefit, less any policy debt, as of the end of the elimination period.
Home Care	Monthly indemnity benefit of 4% of the Death Benefit, less any policy debt, as of the end of the elimination period.
Respite Care	0.2% of Death Benefit per day for up to 21 calendar days each calendar year

Features

- Benefit Payment Structure allows the employee to protect their savings and assets and have more choice in where long-term care is received. It provides coverage for all care settings, including the home.
- Advances the Whole Life death benefit in indemnity payments to help pay for the long-term care services needed as a result of the insured's inability to perform at least two of the six Activities of Daily Living (ADLs), or the insured's requiring substantial supervision due to severe cognitive impairment.
- Claim payments are made monthly (Respite care is paid daily) and are a percentage of the death benefit.
- **Terminates on the first to occur:** base policy terminates; when the owner requests termination of the rider; or the date the death benefit is exhausted from long-term care benefit payments.
- 90 calendar day elimination period (does not apply to Respite Care benefit).
- Six-month pre-existing conditions limitation period.
- Built-in Waiver of Premium due to payments of the long-term care benefit. Waives all premiums for the rider and the Whole life policy, when long-term care benefits are being paid. However, premium payments will not be waived if you are only receiving Respite Care Benefits.

Eligibility Requirements

- **Issue ages for employees and spouses:**
- **Paid-Up at Age 65:** 16-45
- **Paid-Up at Age 95:** 16-79
- May be added to a Whole Life plan during the initial sale.

Premium Information

Premiums are per thousand, unisex, tobacco distinct, and based on face amount and age.

Colonial Life Voluntary Benefits (continued)

What is Not Covered

Preexisting Conditions Limitation

There is a six (6) month waiting period for coverage of Preexisting Conditions that are disclosed on the application for the rider. No benefits will be paid for any benefit period that results from a Preexisting Condition not disclosed in the application and that starts during the first six (6) months after the effective date of the rider.

Plan Exclusions

The rider does not provide benefits for:

- a chronic illness caused by:
 - war or any act of war, whether declared or undeclared, or service in the armed forces or units auxiliary thereto, that occurs while the rider is in force;
 - suicide, whether or not the person had mental capacity to control what he or she was doing, attempted suicide, or intentionally self-inflicted injury;
 - the participation in a felony, for which the insured has been convicted under state or federal law, riot or insurrection; **and**
- treatment for alcoholism or drug addiction;
- any services received outside the United States, its territories or possessions or Canada;
- a chronic illness caused by aviation in the capacity of a non-fare paying passenger;
- services for which there is no charge in the absence of insurance;
- care, treatment or services provided by an immediate family member who is you, your spouse, the insured, the insured's spouse, and anyone related to you or the insured as a parent, child, sister or brother. In-laws are not considered immediate family members;
- services for which benefits are available under Medicare or other governmental programs (except Medi-Cal or Medicaid); **or**
- any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no fault law.

Definitions

Elimination Period means the first 90 calendar days of the Benefit Period. No benefits are payable for care or service received during this time. The 90 calendar days need not be continuous; however, it must be entirely within one benefit period.

Pre-existing Condition means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services, within the six months preceding the effective date of the rider.

Long-Term Care Rider Sample Monthly Premiums

Paid-Up at Age 65 Plan

Issue Age	Monthly Sample Premium per \$1,000 Death Benefit
	Uni-Tobacco
25	\$0.01
35	\$0.02
45	\$0.04

Long-Term Care Rider Sample Monthly Premiums

Paid-Up at Age 95 Plan

Issue Age	Monthly Sample Premium per \$1,000 Death Benefit
	Uni-Tobacco
25	\$0.01
35	\$0.02
45	\$0.03
55	\$0.06
65	\$0.14

Colonial Life Voluntary Benefits (continued)

Samples Rates

Deductions per year: 12

Accident 1.0 for CA

Applicable to policy forms ACCIDENT 1.0-HS and ACCIDENT 1.0-NS

- On/Off-Job Accident Coverage

	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Basic with health screening	17-64	\$21.11	\$29.87	\$29.73	\$38.50
Preferred with health screening	17-64	\$25.67	\$35.91	\$37.19	\$47.42
Premier with health screening	17-64	\$31.03	\$43.26	\$44.22	\$56.44

Individual Disability - ISTD3000 for CA AA Risk Class

Applicable to policy form Individual Disability

- Off Job Injury & Off Job Sickness with Health Screening Rider

6 Month Benefit Period

ELIMINATION PERIOD	ISSUE AGE	\$1,000*	\$2,000*	\$3,000*	\$4,000*
14 days Injury/14 days Sickness	17-49	\$34.30	\$65.70	\$97.10	\$128.50
	50-64	\$45.30	\$87.70	\$130.10	\$172.50
	65-74	\$54.20	\$105.50	\$156.80	\$208.10
30 days Injury/30 days Sickness	17-49	\$21.60	\$40.30	\$59.00	\$77.70
	50-64	\$32.20	\$61.50	\$90.80	\$120.10
	65-74	\$40.20	\$77.50	\$114.80	\$152.10

*monthly benefit amount

Cancer Assist for CA

Applicable to policy form CanAssist

- with \$100 Health Screening Benefit

COVERAGE LEVEL	ISSUE AGE	NAMED INSURED	EMPLOYEE AND SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Level 2	17-75	\$22.30	\$34.85	\$22.60	\$35.15
Level 3	17-75	\$27.45	\$45.70	\$27.90	\$46.15

Critical Illness 1.0 for CA

Applicable to policy form CI-1.0

- with Subsequent Diagnosis Coverage, Health Screening Benefit

Non-Tobacco Rates

	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$10,000	17-24	\$7.05	\$10.70	\$7.05	\$10.70
	25-29	\$7.75	\$11.90	\$7.75	\$11.90
	30-34	\$8.55	\$13.20	\$8.55	\$13.20
	35-39	\$10.95	\$16.80	\$10.95	\$16.80
	40-44	\$12.55	\$19.20	\$12.55	\$19.20
	45-49	\$15.55	\$23.80	\$15.55	\$23.80
	50-54	\$19.15	\$29.40	\$19.15	\$29.40
	55-59	\$23.05	\$35.30	\$23.05	\$35.30
	60-64	\$27.95	\$42.90	\$27.95	\$42.90

Applicable to policy forms ICC07-WL-NGPO-65, ICC07-WL-NGPO-95, ICC08-WL-GPO-65, ICC08-WL-GPO-95, WL-NGPO-65, WL-NGPO-95, WL-GPO-65, WL-GPO-95, ICC16-WL10001 and WL10001

Whole Life 1000 for CA

- Adult Base Plan Paid-Up at Age 65, Comprehensive Long-Term Care Insurance Rider

Non-Tobacco Rates

ISSUE AGE	\$25,000	\$50,000	\$75,000	\$100,000
20	\$21.12	\$39.87	\$50.00	\$65.66
25	\$23.73	\$45.17	\$58.56	\$77.08
30	\$28.85	\$55.54	\$73.31	\$96.75
40	\$47.46	\$93.33	\$129.93	\$172.24

Term Life 1000 for CA

Applicable to policy form Term1000

- 10 Year Term Base Plan

Non-Tobacco Rates

ISSUE AGE	\$10,000	\$25,000	\$50,000	\$100,000
50	\$7.82	\$13.56	\$23.12	\$42.25
57	\$11.09	\$21.73	\$39.46	\$74.91
59	\$12.69	\$25.73	\$47.46	\$90.91
62	\$15.63	\$33.08	\$62.16	\$120.33
64	\$18.11	\$39.27	\$74.54	\$145.08

Health Reimbursement Arrangement (HRA) FAQs

The City shall make a contribution to an employee Health Reimbursement Arrangement (HRA) and associated fixed dollar cost of administration. This contribution is for active employees only and shall cease when the employee leaves City employment.

- **Council Members and Elected Officials hired after August 1, 2019; \$100 per month**
- **CCPOA members hired after July 1, 2020; \$100 per month**
- **CCPFA members hired after August 1, 2020; \$125 per month**
- **CCFMA members hired after August 1, 2020; \$150 per month**
- **AFSCME members hired after November 1, 2020; \$165 per month**
- **Non-Represented Employees hired after August 1, 2019; \$150 per month**
- **CCPMA members hired after August 1, 2019; \$100 per month**

Class A – Upon Funding

What is a Health Reimbursement Arrangement (HRA)?

A Health Reimbursement Arrangement is an interest-bearing, employer-funded account created in your name to reimburse you tax-free in retirement for eligible medical expenses and premiums. Your employer makes deposits while you are employed, but you will not be able to access funds until retirement or separation of service, having met your employer's vesting requirements.

Do I have to enroll?

You were automatically enrolled by your employer. No action is necessary on your part.

When will I be vested?

You are 100% vested in your account, meaning you own your account.

What are the benefits of an HRA?

- Employer deposits are tax-free (not subject to FICA, Federal, or State income taxes), so you receive 100% of the value of each benefit dollar.
- Deposits earn interest tax-free.
- Reimbursements from the plan are tax-free for eligible medical expenses and premiums for you, your spouse, and any qualifying dependents, if applicable.
- Account balance rolls over each year and there is no time frame by when you must submit expenses for reimbursement.
- Once you have access, you have the flexibility to choose which eligible expenses and when to submit for reimbursement.

How often will my employer contribute to my account?

Your employer is making deposits to your account on a monthly basis during your active employment. For detailed information regarding contribution amounts and timing, please contact your employer.

Where are funds invested?

Funds are invested in a fixed annuity with a guaranteed rate of return. Investments are provided by American United Life Insurance Company®, a OneAmerica® Company (AUL). For more information on your investments, please visit www.oneamerica.com.

How often will I receive account statements?

You will receive paper statements on a quarterly basis.

Can I make contributions to my HRA?

Only an employer can fund an HRA. You cannot contribute.

Can I move HRA funds to another plan?

The funds deposited in your account must stay within your employer-sponsored HRA plan.

Can I name a beneficiary?

No. However, a surviving spouse or qualifying dependent will still be able to access funds for eligible medical expenses and premiums. If you do not have a surviving spouse or qualifying dependent, the executor of your estate or trustee can use your remaining funds to reimburse eligible medical expenses and premiums not previously submitted on your behalf, including expenses related to your death. If an account balance still remains, the balance will forfeit back to the employer.

Health Reimbursement Arrangement FAQs (continued)

Are there any fees?

No, there are no fees associated with your account.

Will I receive additional information once I am able to access my funds?

Yes. Once you are able to access your funds, you will receive information about the eligible medical expenses, reimbursement process, and all necessary forms.

Questions?

If you have questions regarding your plan, please contact MidAmerica Administrative & Retirement Solutions (MidAmerica), the plan administrator, at [855-329-0095](tel:855-329-0095) or email us at healthaccounts@myMidAmerica.com.

If submitting paper forms, send to:

MidAmerica Administrative & Retirement Solutions
Attn: HRA Department
P.O. Box 24927
Lakeland, Florida 33802
Fax: 863.577.4460
claims@myMidAmerica.com

For investment or plan information related questions, please contact your Keenan & Associates Representative at [800-444-9995](tel:800-444-9995), ext. 3671



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 Cathedral City 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 Cathedral City does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMLHA)

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 760-770-0317.

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, contact your individual CalPERS medical plan customer service number on the back of your medical ID card.

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

You do not need prior authorization from 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, contact your individual CalPERS medical plan customer service number on the back of your medical ID card.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with your individual CalPERS medical plan. 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.

Notice of Extended Coverage to Children Covered as Students

Michelle's Law generally extends eligibility for group health benefit plan coverage to a dependent child over age 26, who, as a condition of coverage, is enrolled in an institution of higher education. Please review the following information with respect to your dependent child's rights in the event student status is lost.

Michelle's Law requires the Plan to allow extended eligibility in some cases for a covered child over age 26, who would lose eligibility for Plan coverage due to loss of full-time student status.

Important Notices (continued)

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child means a child over age 26 who is a dependent of a plan participant and who is eligible under the terms of the Plan based on their student status and enrollment at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.*
- *Medically necessary leave of absence means a leave of absence or any other change in enrollment:*
 - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
 - Which is medically necessary; and,
 - Which causes the dependent child to lose student status under the terms of the Plan.

The dependent child's treating physician must provide written certification of medical necessity (i.e., a certification that the dependent child suffers from a serious illness or injury that necessitates a leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- *One year after the first day of the leave of absence; or*
- *The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).*

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

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.

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.

Important Notices (continued)

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.

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.

Important Notices (continued)

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.

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 period¹ to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

IF YOU HAVE QUESTIONS

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>

Important Notices (continued)

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.

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.

Important Notices (continued)

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:

Eugenia Torres
Human Resources Manager
760-770-0317

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

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

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or 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.**
- **CalPERS has determined that the prescription drug coverage offered by CalPERS Medical Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

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

If you do decide to join a Medicare drug plan and drop your current City of Cathedral City coverage, be aware that you and your dependents will be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with City of Cathedral City 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.

Important Notices (continued)

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 City of Cathedral City 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).

Date: September 15, 2023
Name of Entity / Sender: City of Cathedral City
Contact: Eugenia Torres
Address: 68700 Avenida Lolo Guerrero
Cathedral City, CA 92234
Phone: 760-770-0317

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

City of Cathedral City 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 please contact AnnMarie Quintanilla, at 760.202.2408.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about City of Cathedral City 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 Cathedral City	4. Employer Identification Number (EIN) 95-3674780	
5. Employer address 68700 Avenida Lalo Guerrero	6. Employer phone number 760-770-0317	
7. City Cathedral City	8. State CA	9. ZIP code 92234
10. Who can we contact about employee health coverage at this job? AnnMarie Quintanilla, Human Resources Specialist		
11. Phone number (if different from above) 760-202-2408	12. Email address hr@cathedrality.gov	

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@MyAKHIPPP.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.flmedicaidtplecovery.com/flmedicaidtplecovery.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: 800-457-4584 IOWA – 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: KIHIPPPROGRAM@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: HHSHIPPPProgram@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 Rlte 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

