EMPLOYEE BENEFITS *Guide*

2026

CITY OF SOUTH LAKE TAHOE

Employee Benefits Guide 2026

General Information

Benefits

Miscellaneous

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

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 43 for more details.

This document summarizes the benefits program. Full details of the benefit plans are contained in the official documents, which will govern in the case of any discrepancies.

Introduction

The City of South Lake Tahoe will offer three Anthem Blue Cross plan options in order for you to choose which is the best for you & your family. For the 2026 plan year, the City will cover the full premium for both the Anthem HDHP 2000 plan, **AND** the Anthem Basic PPO 1000 plan. If an Employee elects the Anthem Premium PPO 500 plan (buy-up option), they will be responsible for a defined portion of the total premium amount.

2026 Core Plan Offerings

- **Anthem Blue Cross –** Medical
  - HDHP 2000
  - Premium PPO 500
  - Basic PPO 1000
- **The Standard –** Dental
  - High Plan
  - Low Plan
- **VSP & EyeMed plans through The Standard –** Vision
- **The Standard**
  - Life and AD&D
  - Disability
- **Health Advocate –** EAP

Voluntary Benefits

- Health Savings Account
- Medical Flexible Spending Account
- Limited Purpose Flexible Spending Account
- Dependent Care Account
- Accident
- Cancer
- Disability
- Group Critical Illness
- Hospital Gap Plan*
- Term Life
- Whole Life

Benefit Choices

The City recognizes that your benefits are an important part of the reason you choose to work here. The City provides a variety of high quality benefits at a reasonable cost to you. Since you have some choices to make, it is important to understand the various programs, which is why this handbook is being provided for you. There are also individual brochures for each of the benefit plans available from Human Resources.

Eligibility

Employees

Employees are eligible for coverage on their day of hire.

Full-time employees working a minimum of 30 hours a week are eligible for coverage under the plan.

The choice for employee and dependent health insurance coverage must be made within the first thirty (30) days of employment or during the annual open enrollment period.

Employees may opt out of the City's health insurance plan by providing Human Resources with written proof of other employer sponsored group coverage.

Active Employment

An employee will be deemed in "active employment" status on:

- Each day you are actually performing services for the City
- Each day of a regular paid vacation
- A regular non-working day, provided you were actively at work on your last preceding scheduled regular working day ***and***
- Any day on which you were absent from work during an approved FMLA leave or solely due to your own health status

Dependents

When enrolling dependents, appropriate documentation and/or proof of dependent status is required by the City and will be requested by Human Resources.

Accepted forms of proof include: Marriage and Birth Certificates, Tax Returns, State Issued Declaration of Domestic Partnership, Adoption Certificate, or Proof of Legal Guardianship.

An eligible dependent of an employee is:

- A legally married spouse
- A registered domestic partner
- A Child, up to age 26.
  For these purposes a "child" will include:
  - Biological Child
  - Stepchildren
  - Children of a registered domestic partner
  - Legally adopted children (including a child for whom legal adoption proceedings have been started)
  - Any other child for whom you are required to provide health plan coverage under a Qualified Medical Child Support Order
  - A disabled child at any age, as long as he/she continues to meet the conditions as defined by Section 12102 of the Americans with Disabilities Act (ADA)

Non-Eligible Dependents

An eligible dependent does not include:

- A spouse following final decree of dissolution or divorce
- Any person who is on active duty in a military service, to the extent permitted by law

Dual Coverage

If you and your spouse are both eligible for coverage under the City's plan as employees:

- You and your spouse may not be covered as both an employee and your spouse's dependent
- Your dependent children may not be covered by both parents

Eligibility (continued)

Change in Dependent Eligibility

It is the employee's responsibility to notify Human Resources within 30 days or sooner of a dependent's change in status that would make the dependent eligible or ineligible for benefit coverage. Some examples of a change in dependent status are birth, death, adoption, or divorce.

Continuation of Coverage (COBRA)

While you must delete your ineligible dependent within 30 days of the loss of eligibility, failure to delete your ineligible dependent within 60 days of loss of eligibility will result in a loss of continuation of coverage rights (COBRA) for your dependents.

Change in Beneficiaries

Certain events in your life such as marriage, divorce, or a death in the family can affect who you name as your designated beneficiary for certain benefits. You may change your beneficiary(ies) at any time. If you wish to do so, you can obtain most beneficiary forms from Human Resources.

You can designate a beneficiary for:

- Basic & Voluntary Life
- Health Savings Account
- Retirement Plan

Coverage Effective Dates

Regular Employees

Medical, Dental and Vision coverage are effective on the date of hire when you complete and return the enrollment form within 30 days of your hire date. Life insurance is effective on the first of the month following the date of hire.

As a new hire, to receive the coverage you want, you must enroll yourself and your eligible dependents within the 30 day eligibility period. If you do not enroll, your next opportunity to change coverage or add dependents will be during the next annual enrollment period, unless you or your dependents experience a qualifying event.

Open Enrollment

During the scheduled open enrollment period, you can select a new medical plan, add or delete dependents without a qualifying event, or enroll in one of the many voluntary plans including life insurance. This is also the time of year to enroll in a medical and/or dependent care flexible spending account. Anyone currently participating in the flexible spending account programs must re-enroll in order to continue coverage in the 2026 plan year.

Supporting documentation will be required by Human Resources to add new dependents.

Changing plans and adding or deleting qualified dependents may affect the premium you pay through payroll deductions. The changes requested will take place effective January 1, 2026.

Medicare While Working

If you are eligible to participate in the City's medical plans as an active employee and wish to continue working after reaching age 65, you have important options to consider when approaching Medicare eligibility. While you are still an active benefited employee under a City medical plan, you may be able to delay enrollment in some parts of Medicare without incurring a late enrollment penalty at a later date. Your City medical plan remains primary to Medicare while you are working.

For details of what's covered under Medicare, how to enroll, and your option regarding Medicare coverage, contact your local Social Security office or visit medicare.gov on the web.

Changes in Coverage

Qualifying Events

You may experience certain events during the plan year that would allow you to change yours or your dependent's medical coverage. If any of the following events occur, you must change your benefit coverage within 30 days of the event:

- Change in your legal marital or domestic partner status, including marriage, death of your spouse/domestic partner, divorce, legal separation or annulment.
- Change in the number of your dependents, including birth, adoption, placement for adoption or death or your dependent.
- Change in your employment status, including termination or commencement of employment of you, your spouse, your domestic partner or your dependent.
- Change in work schedule for you or your spouse/domestic partner, including an increase or decrease in the number of hours of employment, a switch between full-time and part-time status, a strike, lockout or commencement or return from an unpaid leave of absence.
- Your dependent satisfies or no longer meets the eligibility requirements for dependents.
- A change in the place of residence or worksite of you or your spouse/domestic partner (This move must affect your coverage options).
- You, your spouse/domestic partner or your dependents lose COBRA coverage.
- You, your spouse/domestic partner or your dependents enroll for Medicare or Medicaid or lose coverage under Medicare or Medicaid.
- If the plan receives a decree, judgment or court order, including a QMSCSO pertaining to your dependent, you may add the child to the plan or drop the child from the plan.
- A significant change in benefit or cost of coverage for you or your spouse/domestic partner.
- Your spouse/domestic partner employer provides the opportunity to enroll or change benefits during an open enrollment period.

Special Enrollment Rights as Provided by HIPAA

- You initially declined coverage under the plan because you had coverage under another plan, and subsequently incurred a loss of coverage under the other plan.
- Occurrence of certain events such as birth, adoption, placement for adoption or marriage.
- Eligibility for state premium subsidies under the Children's Health Insurance Program or State Children's Health Insurance Program.
- Loss of coverage under Medicaid, The Children's Health Insurance Program or State Children's Health Insurance Program.

Medical – Anthem Blue Cross

Benefits at a Glance	Anthem Blue Cross HDHP 2000		Anthem Blue Cross Premium PPO 500		Anthem Blue Cross Basic PPO 1000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information						
• Annual Deductible	Everything is subject to deductible unless otherwise stated					
– Individual	$2,000	$6,000	$500	$1,500	$1,000	$3,000
– Family	$4,000	$12,000	$1,500	$4,500	$3,000	$9,000
• Coinsurance	80%	60%	80%	60%	80%	60%
• Office Visit/Exam	$20 copay (deductible waived)	60%	$20 copay	60%	$35 copay (deductible waived)	60%
• Outpatient Specialist Visit	$40 copay (deductible waived)	60%	$40 copay	60%	$55 copay (deductible waived)	60%
Annual Out-of-Pocket Limit						
– Individual	$5,000	$15,000	$3,500	$10,500	$5,000	$15,000
– Family	$10,000	$30,000	$7,000	$21,000	$10,000	$30,000
• Deductible included in Out-of-Pocket Limits	Yes	Yes	Yes	Yes	Yes	Yes
• Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Outpatient Services						
• Well-Child Care	100% (deductible waived)	60%	100% (deductible waived)	60%	100% (deductible waived)	60%
• Immunizations	100% (deductible waived)	60%	100% (deductible waived)	60%	100% (deductible waived)	60%
• Well-Woman Exams	100% (deductible waived)	60%	100% (deductible waived)	60%	100% (deductible waived)	60%
• Mammograms	100% (deductible waived)	60%	100% (deductible waived)	60%	100% (deductible waived)	60%
• Adult Periodic Exams with Preventive Tests	100% (deductible waived)	60%	100% (deductible waived)	60%	100% (deductible waived)	60%
• Diagnostic X-Ray and Lab Tests	80%	60%	80%	60%	80%	60%
Maternity Care						
• Pregnancy and Maternity Care *(Pre-Natal Care)*	$20 copay (deductible waived)	60%	$20 copay (deductible waived)	60%	$35 copay (deductible waived)	60%
Inpatient Hospital Services						
• Inpatient Hospitalization	80%	60%	80%	60%	80%	60%
• Pre-Authorization of Services Required	Yes	Yes	Yes	Yes	Yes	Yes
• Semi-Private Room & Board; including Services and Supplies	80%	60%	80%	60%	80%	60%
Surgical Services						
• Outpatient Facility Charge	80%	60%	80%	60%	80%	60%
Emergency Services						

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

Medical – Anthem Blue Cross (continued)

Benefits at a Glance	Anthem Blue Cross HDHP 2000		Anthem Blue Cross Premium PPO 500		Anthem Blue Cross Basic PPO 1000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
• Emergency Room	$150 copay + 20% (copay waived if admitted)	Covered as In-Network	$150 copay + 20% (copay waived if admitted)	Covered as In-Network	$150 copay + 20% (copay waived if admitted)	Covered as In-Network
• Ambulance *(air or ground)*	80%	Covered as In-Network	80%	Covered as In-Network	$50 copay + 20%	Covered as In-Network
Urgent Care						
• Urgent Care Facility	$20 copay (deductible waived)	60%	$20 copay	60%	$35 copay (deductible waived)	60%
Mental Health Benefits						
• Inpatient Care	80%	60%	80%	60%	80%	60%
• Outpatient Care	80%	60%	$20 copay	60%	$35 copay (deductible waived)	60%
Substance Use Disorder						
• Inpatient Care						
– Inpatient Detoxification Services	80%	60%	80%	60%	80%	60%
• Outpatient Care						
– Outpatient Services	80%	60%	$20 copay	60%	$35 copay (deductible waived)	60%
Prescription Drugs						
• Retail						
– Generic	$20 copay	50% coinsurance up to $250	$15 copay	50% coinsurance up to $250	$20 copay	50% coinsurance up to $250
– Brand *(Formulary/Preferred)*	$40 copay	50% coinsurance up to $250	$30 copay	50% coinsurance up to $250	$30 copay	50% coinsurance up to $250
– Brand *(Non-Formulary/ Non-Preferred)*	$60 copay	50% coinsurance up to $250	$50 copay	50% coinsurance up to $250	$50 copay	50% coinsurance up to $250
– Specialty	30% coinsurance up to $250	50% coinsurance up to $250	30% coinsurance up to $250	50% coinsurance up to $250	30% coinsurance up to $250	50% coinsurance up to $250
– Number of Days Supply	30 days	30 days	30 days	30 days	30 days	30 days
• Mail Order						
– Generic	$40 copay	Not covered	$30 copay	Not covered	$40 copay	Not covered
– Brand *(Formulary/Preferred)*	$100 copay	Not covered	$75 copay	Not covered	$75 copay	Not covered
– Brand *(Non-Formulary/ Non-Preferred)*	$150 copay	Not covered	$125 copay	Not covered	$125 copay	Not covered
– Number of Days Supply	90 days	N/A	90 days	N/A	90 days	N/A
Other Services and Supplies						

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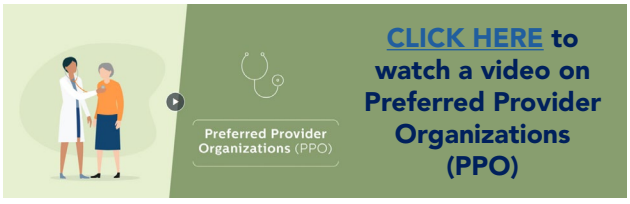
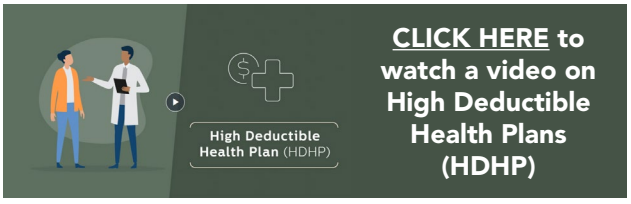
Medical – Anthem Blue Cross (continued)

Benefits at a Glance	Anthem Blue Cross HDHP 2000		Anthem Blue Cross Premium PPO 500		Anthem Blue Cross Basic PPO 1000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
• Durable Medical Equipment and Prosthetic Devices	80%	60%	80%	60%	80%	60%
• Home Health Care	80% limited to 100 visits/cal year	60%	80%; limited to 100 visits/cal year	60%	80%; limited to 100 visits/cal year	60%
• Skilled Nursing or Extended Care Facility	80% limited to 150 visits/cal year	60%; limited to 150 days/cal year	80%; limited to 150 days/cal year	60%; limited to 150 days/cal year	80%; limited to 150 visits/cal year	60%; limited to 150 visits/cal year
• Inpatient Hospice Care	80%	60%	80%	60%	Covered In Full	60%
Chiropractic Services	$20 copay (deductible waived); limited to 30 visits cal year	60%; limited to 30 visits/cal year	$20 copay (deductible waived); limited to 30 visits/cal year	60%; limited to 30 visits/cal year	$35 copay (deductible waived); limited to 30 visits/cal year	60%; limited to 30 visits/cal year
Acupuncture	$20 copay (deductible waived); limited to 20 visits/cal year	60%; limited to 20 visits/cal year	$20 copay (deductible waived); limited to 20 visits/cal year	60%; limited to 20 visits/cal year	$35 copay (deductible waived); limited to 20 visits/cal year	60%; limited to 20 visits/cal year
Infertility						
• Diagnosis	Refer to plan evidence of coverage					
• Treatment	Refer to plan evidence of coverage					
Outpatient Rehabilitative Therapy Services						
• Physical	80%	60%	80%	60%	80%	60%
• Occupational	80%	60%	80%	60%	80%	60%
• Speech	80%	60%	80%	60%	80%	60%



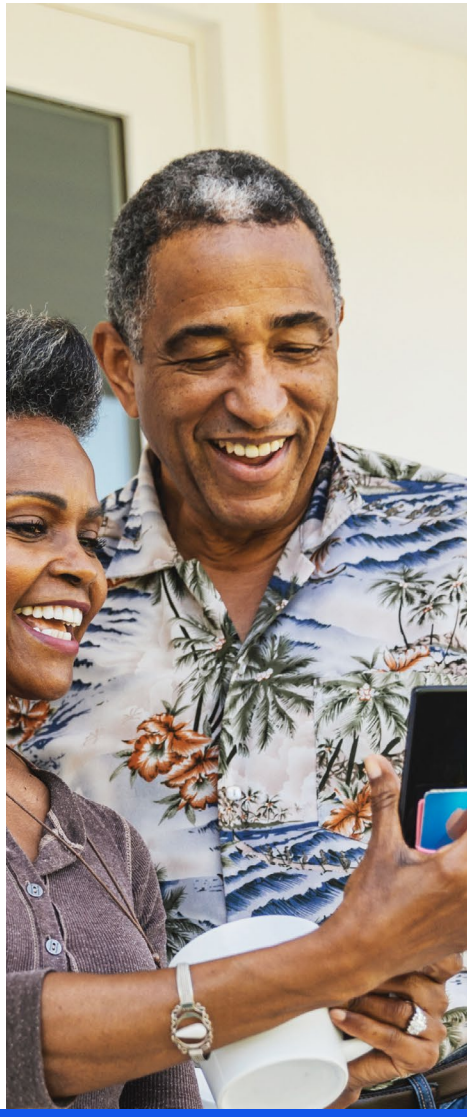


The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

Anthem Live Health Online

Anthem

Receive virtual care and support 24/7 with our Sydney Health app



Now you can connect more easily to the care you need through our **Sydney℠ Health** app. Have a video visit with a doctor on your mobile device or computer with a camera, 24/7.

Visit with a doctor for common health concerns

Doctors are available anytime, with no appointments or long wait times. They can help you with these types of conditions:

- COVID-19
- Flu
- Cold and fever
- Minor rashes
- Sore throat
- Headaches

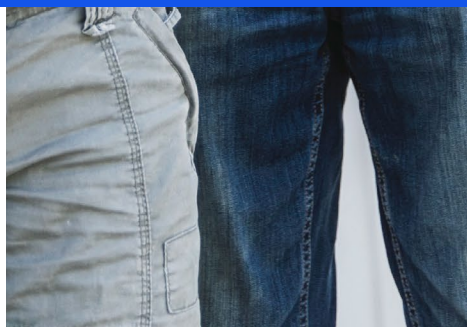
During your video visit, the doctor will assess your condition, provide a treatment plan, and send prescriptions to the pharmacy of your choice, if needed.[1]

What people say about virtual care visits[2]

89% said the doctor they saw was professional and helpful

92% thought the doctor understood their concerns

92% were able to book a virtual visit sooner than an in-person visit



How to download our Sydney Health app:

sydney™

Download on the App Store

GET IT ON Google Play

Scan the QR code with your phone's camera or visit the App Store® or Google Play™.

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Anthem Live Health Online (continued)

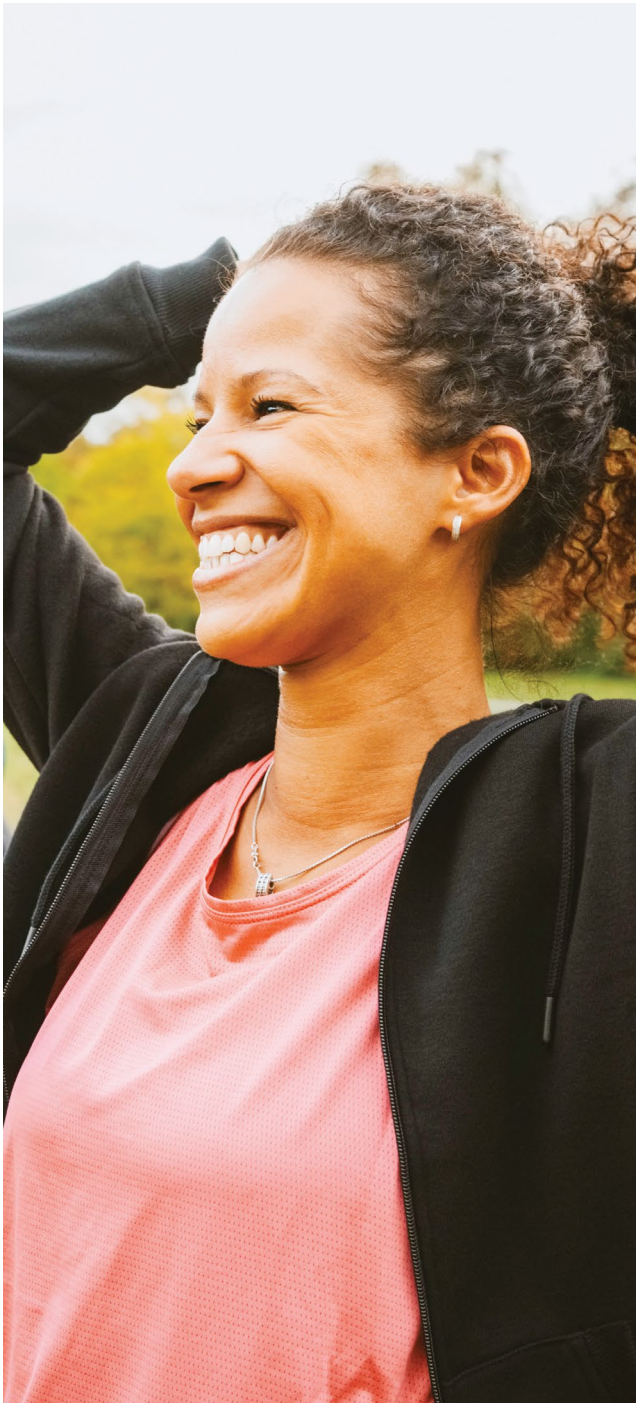
Here's how to access the program through virtual care:

Download our no-cost **Sydney Health** app.

1. Register (if you haven't yet) and log in.
2. Once you register, your username and password are the same for our app and **anthem.com/ca**.
3. Select **Care** and then select **Virtual Care**.

Visit **anthem.com/ca**.

1. Register (if you haven't yet) and log in.
2. Once you register, your username and password are the same for **anthem.com/ca** and our **Sydney Health** app.
3. From the **Care** tab, select **Virtual Care** in the drop down menu. Then, click **Video Visit Options**.



1 Prescription availability is defined by physician judgment.

2 Based on Sydney Health utilization trends from top national clients.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2024 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Anthem Sydney Health Mobile App

Anthem

The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney℠ Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige **el idioma de la aplicación**. También puedes visitar **anthem.com/es/ca**.

Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.

Scan the QR code to download the Sydney Health app.

You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

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Anthem Nurseline

Protecting your health and wellness

Discover no-cost programs that can help

Your health plan comes with programs to help you confidently care for your well-being. It doesn't matter what health issues you may be experiencing or even what stage of life you're in — there is a program for everyone.

ConditionCare

Managing chronic conditions, such as asthma, diabetes, chronic obstructive pulmonary disease (COPD), or heart disease requires extra care and attention. To help you be at your best, the ConditionCare program offers free resources, including:

- 24/7 phone access to nurses who can address your health questions and concerns.
- Support from healthcare professionals to help you reach your health goals.
- Educational guides and useful tools to help you learn more about a certain condition.

Connect with the support you need

- 24/7 NurseLine: **800-337-4770**
- ConditionCare: **866-962-0957**
- Find Building Healthy Families in your plan's mobile health app.

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Anthem Nurseline (continued)

Building Healthy Families

Whether trying to conceive, expecting a child, or in the thick of raising young children, Building Healthy Families offers personalized, digital support to help each family navigate their unique journey. You can find Building Healthy Families in your plan's mobile health app to do things like:

- Track baby's feedings, diaper changes, and developmental milestones.
- Monitor prenatal health risks and receive updates on your pregnancy progress.
- Explore a library with thousands of educational articles and videos.
- Connect with one-on-one pregnancy support in the app or over the phone.

24/7 NurseLine

When your allergies flare up on the weekend or your little one spikes a fever at 3 a.m., you can ask a registered nurse for advice by calling 24/7 NurseLine. Nurses are ready any time of the day or night to:

- Answer your questions.
- Recommend where to go for care when your doctor isn't available.
- Help you find healthcare professionals in your area.
- Enroll you and your dependents in health management programs.
- Remind you about important preventive screenings and exams.

Enroll today

1. Visit **anthem.com/ca** or log in to Sydney Health.
2. Find *Featured Programs* at the bottom of the homepage.
3. Select **View All** then choose the **Building Healthy Families** tile.

You can also scan this QR code with your phone's camera to get started.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Anthem Well-Being Solutions

Focus on your well-being and earn rewards up to $200

The more activities you complete, the greater your reward

The Wellbeing Solutions program connects you with easy-to-use digital health and wellness tools that can help you stay your best. When you complete any of the activities listed below sponsored by your employer, you'll earn rewards to put toward electronic gift cards for select retailers. You choose the activities you'd like to complete to receive the maximum of $200.

Activity Type	Activities	Amount
Preventive care	Have an annual preventive wellness exam or well woman exam with your doctor	$25
	Get an annual cholesterol test[1]	$20
	Have a colorectal cancer screening (ages 45 and older)	$25
	Have a routine mammogram (women ages 40 to 74)	$25
	Have an annual eye exam[2]	$25
	Get an annual flu shot	$20

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Anthem Well-Being Solutions (continued)

Activity Type	Activities	Amount
Condition management programs	ConditionCare: Work one on one with your health coach and earn rewards for participating in and completing the program[3]	Up to $50 ($20/$30)
	Building Healthy Families: Support is available through the Sydney℠ Health app wherever you are in your family planning process, such as trying to conceive or raising your toddler[4]	Up to $40 ($10/$10/$10/$10)
	Well-being Coach – Weight Management: Receive one-on-one coaching by phone as you complete your goal to earn a reward[5]	$25
	Well-being Coach – Tobacco Cessation: Receive one-on-one coaching by phone as you complete your goal to earn a reward[6]	$25
Digital & wellness activities	Log in to your Anthem account	$5
	Connect a fitness or lifestyle device	$5
	Complete a health assessment and receive tailored health recommendations	$20
	Complete action plans around eating healthy, weight management, and physical activity	Up to $25 ($5 per action plan)
	Track your steps	Up to $60 ($2 per 50,000 steps tracked)
	Complete Well-being Coach digital daily check-ins[7]	Up to $20 ($4 per milestone)
	Update your contact information	$10

Well-being Coach can help you meet your goals

The Well-being Coach digital coaching app offers you 24/7 personalized support. Well-being Coach can help you maintain a healthy weight, quit tobacco, and improve your nutrition, exercise habits, mindfulness, and sleep. If you need extra support with weight management or quitting tobacco, talk to a certified health coach.

Earn rewards

Here's how and when you'll earn rewards for completing the activities already mentioned.

Preventive care: Simply visit your doctor for any of the screenings or appointments listed in the chart. Your rewards are added to your account after your claim is processed, which may take up to 60 days.

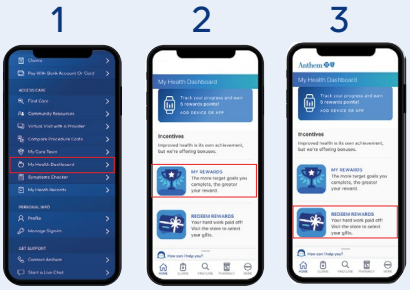
Condition management: Rewards are added to your account as you meet certain benchmarks or complete a program. Programs include: ConditionCare (for asthma, diabetes, and heart or lung conditions), Building Healthy Families, and Well-being Coach for weight management and tobacco cessation.

Digital and wellness activities: Log in to the Sydney Health app or **anthem.com/ca** to complete available activities, such as taking a health assessment, participating in the Well-being Coach digital program, and tracking your steps. Rewards are added to your account as activities are completed.

Anthem Well-Being Solutions (continued)

Use your rewards toward electronic gift cards for select retailers.

1. To view your rewards, open the Sydney Health app or go to **anthem.com/ca**. Next, go to *My Health Dashboard*.
2. Select **My Rewards**.
3. Select **Redeem Rewards** to see how much you've earned. Use your rewards toward electronic gift cards from popular retailers, including Amazon, Uber, Gap Options (all brands), Apple, Target, The Home Depot, and TJ Maxx. The minimum gift card amount is set by each individual retailer.



Download the Sydney Health mobile app by scanning this QR code with your phone's camera.

Do you have questions?

Log in at **anthem.com/ca** or open the Sydney Health app. Then go to *My Health Dashboard* and select **My Rewards** to learn more. You can also call Member Services at the number on your ID card.

1 Annual cholesterol test eligibility: men 35 years and older, women 40 years and older with a full cholesterol (lipid) panel.

2 Annual eye exam reward is available if employer provides vision coverage through **Anthem**.

3 Adult members identified as moderate or high risk are eligible for ConditionCare and may receive a reward for participation in 1 of 5 ConditionCare programs and completion for 1 of 5 ConditionCare programs: (chronic obstructive pulmonary disease [COPD], coronary artery disease [CAD], asthma, diabetes, and congestive heart failure [CHF]. Rewards include: $20 for program participation and $30 for program completion.

4 Building Healthy Families milestone completion dates: BHF Pregnancy Screener must be completed in first trimester; at least 1 of 6 mini assessments must be completed by one day prior to delivery; postpartum assessment must be completed by 56 days after delivery. Rewards include: $10 for profile completion; $10 for a BHF Pregnancy Screener; $10 for completing at least 1 of 6 mini assessments; $10 for a postpartum assessment.

5 Well-being Coach Weight Management program (telephonic) is available for members who are identified as high risk based on a body mass index (BMI) of 30 or higher.

6 Well-being Coach Tobacco Cessation program (telephonic) is available for members who are identified as high risk based on any tobacco usage.

7 Members may earn rewards for completing quarterly Well-being Coach digital milestones while logging daily check-in activities on the app. Daily check-in reward values: first check-in: $4; next 15 check-ins during first quarter: $4; 25 check-ins during second through fourth quarters: $4 each quarter. Log in to Sydney Health or **anthem.com/ca** to download the Well-being Coach digital app. Well-being Coach is provided by Lark Health.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2024

We encourage you to actively participate in your rewards program. Rewards earned should be redeemed before the end of the current plan year. Unused rewards are forfeited three months after the end of your plan year. Make sure to redeem them before then.

All preventive care activities are claims-based, which means your completion is determined when a claim is processed. Medical waivers apply to claim-based activities.

Rewards eligibility applies only to subscribers and their enrolled spouse/domestic partner. Members must be active on the plan and their activity must take place during the plan year. A subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.

The reward amount you receive may be considered income to you and subject to state and federal taxes in the tax year it is paid. You should consult a tax expert with any questions regarding tax obligations.

Electronic gift card availability may vary. The list of retailers available for electronic gift card rewards redemption is subject to change. Log on to anthem.com/ca or open the Sydney Health app to explore the electronic gift card options available to you.

Anthem Active & Fit

Active&Fit DIRECT™

Thousands of Fitness Options

- Choose from **12,700+ standard gyms** for just **$28/mo.**[1]
- Plus, **8,800+ premium exercise studios with 20% - 70% discounts** at most locations.[1]

Flexible & Affordable

- **No long-term contracts.** Switch gyms or cancel with ease.
- Join multiple gyms and get a **discount**.[2]

Go Beyond the Gym

- **1:1 well-being coaching** to help you reach your health goals at no additional cost.
- Get Fit at Home™ for free with **12,000+ on-demand workout videos** before you enroll.

$0 Enrollment Fee With Code: FITFORFALL[3]

Standard Fitness Network — 24 Hour Fitness · Gold's Gym · EoS Fitness · the Y · Crunch · CHUZE FITNESS · ANYTIME FITNESS · + More

Premium Fitness Network — STRETCH LAB · YOGASIX · CLUB PILATES · F45 · RUMBLE · pure barre · + More

Get Started by logging in to your member website and clicking on the link for Discounts.

[1] Monthly fees are subject to applicable enrollment fees and taxes. Costs for premium exercise studios exceed $28/mo. plus applicable enrollment fees and taxes. Fees vary based on premium fitness studios selected.

[2] Members may purchase multiple standard and premium gym memberships with a $5 discount off the monthly fee for each membership purchased after their first.

[3] $28 enrollment fee waived for standard and premium gyms 10/1/2024 12:01 a.m. - 11/30/2024 11:59 p.m. PT.

Anthem Preventive Care

Anthem

Use your preventive care benefits

Stay healthy and catch problems early for easier treatment

Our health plans offer all the preventive care services and immunizations below at no cost to you[1]. You won't have to pay anything when you use a doctor, pharmacy, or lab in your plan's network. If you go to doctors or facilities outside your plan, you may have to pay out of pocket.

If you are not sure which exams, tests, or shots are right for you, talk to your doctor.

Preventive care vs. diagnostic care: Knowing the difference

Preventive care helps protect you from getting sick. If your doctor recommends services when you have no symptoms, that's preventive care. **Diagnostic care** is when you have symptoms, and your doctor recommends services to determine what's causing those symptoms.

Adult preventive care

General preventive physical exams, screenings, and tests (all adults):

- Alcohol and drug misuse: related screening and behavioral counseling
- Anxiety, depression, and suicide risk screenings
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet and physical activity
- High blood pressure (hypertension) screening
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) levels screening
- Colorectal cancer screenings, including fecal occult blood test, barium enema, flexible sigmoidoscopy (exam of the large intestine), screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)[2]
- Diabetes screening (type 2)[3]
- Exercise interventions to prevent falls in adults over age 65

Anthem Preventive Care (continued)

- Hepatitis B virus (HBV) screening for people at increased risk of infection
- Hepatitis C virus (HCV) screening
- Height, weight, and body mass index (BMI) measurements
- Human immunodeficiency virus (HIV): screening and counseling; and the necessary services for adults and adolescents at high risk of HIV acquisition, who are prescribed preexposure prophylaxis (PrEP)
- Interpersonal and domestic violence: screening and counseling
- Lung cancer screening for adults aged 50 to 80 years who have a 20 pack year (packs per day X years of smoking) smoking history and currently smoke or have quit within the past 15 years[2]
- Obesity: related screening and counseling[3]
- Sexually transmitted infections: related screening and counseling
- Syphilis infection screening for persons who are at increased risk
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening

Women's preventive care:

- Breast cancer screenings, including exams, mammograms
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling[4,5,6,7]
- Chlamydia and gonorrhea screening
- Contraceptive (birth control) counseling
- BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing for women with personal family history of breast, ovarian, tubal, or peritoneal cancer[8]
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Human papillomavirus (HPV) screening[5]
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, HIV, healthy weight, preeclampsia, and depression[5]
- Urinary incontinence screening
- Well-woman visits

Immunizations:

- Diphtheria, tetanus, and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps, and rubella (MMR)
- Meningococcal (meningitis)
- Monkeypox and/or smallpox (at risk)
- Pneumococcal (pneumonia)
- Respiratory syncytial virus (RSV)
- Severe acute respiratory syndrome coronavirus 2 (SARS CoV 2)(COVID-19)
- Varicella (chickenpox)
- Zoster (shingles)

The preventive care services listed above are recommendations of the Affordable Care Act (ACA) and are subject to change. They may not be right for every person. Ask your doctor what's right for you.
This sheet is not a contract or policy with Anthem Blue Cross. If there is any difference between this sheet and the group policy, the group policy provisions will rule. Please see your combined evidence of coverage (EOC) and disclosure form or certificate for exclusions and limitations.

Anthem Preventive Care (continued)

Child preventive care

Preventive physical exams, screenings, and tests:

- Anemia screening
- Anxiety, depression, and suicide risk screenings
- Autism Spectrum Disorder (ASD) screening
- Blood pressure screening
- Cervical dysplasia (abnormal cell growth on the cervix) screening
- Cholesterol and lipid (fat) levels screening
- Development and behavior screening
- Hearing screening up to 21 years
- Height, weight, and BMI measurements
- Hemoglobin or hematocrit (blood count) screening
- Hepatitis B screening
- HIV screening
- Lead testing
- Newborn screening
- Obesity: related screening and counseling
- Ocular prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive medication: newborns
- Oral (dental health) assessment, when done as part of a preventive care visit
- Sexually transmitted infections: related screening and counseling
- Skin cancer behavioral counseling for those ages 6 months to 24 years with fair skin
- Sudden cardiac arrest/death risk assessment
- Tobacco, alcohol, and drug use assessments
- Vision screening for those ages 6 months to 5 year[9]

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type B (HIB)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Respiratory syncytial virus (RSV)
- Rotavirus
- Severe acute respiratory syndrome coronavirus 2 (SARS CoV 2)(COVID-19)
- Whooping cough

Anthem Preventive Care (continued)

Pharmacy item coverage

For 100% coverage of your over-the-counter (OTC) drugs and other pharmacy items listed here, you must:

- Meet certain age requirements and other rules
- Receive and fill prescriptions from doctors, pharmacies, or other healthcare professionals in your plan's network
- Have prescriptions, including for OTC items

Women's preventive drugs and other pharmacy items (age appropriate):

- Breast cancer risk-reducing medications, such as tamoxifen, raloxifene, and aromatase inhibitors, that follow the U.S. Preventive Services Task Force criteria[2]
- Contraceptives, including generic prescription drugs and OTC items like female and male condoms and spermicides[7,8]
- Folic acid for women who are planning to become pregnant
- Low-dose aspirin (81 mg) for pregnant women who have an increased risk of preeclampsia

Adult preventive drugs and other pharmacy items (age appropriate):

- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening for members ages 45 to 75
- Generic low-to-moderate dose statins for members ages 40 to 75 who have one or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Preexposure prophylaxis (PrEP) for the prevention of HIV and the required services for adults and adolescents at high risk of HIV acquisition
- Tobacco cessation products, including all FDA-approved brand-name and generic OTC and prescription products, for members ages 18 and older

Child preventive drugs and other pharmacy items (age appropriate):

- Dental fluoride varnish to prevent tooth decay in children ages 5 and younger
- Fluoride supplements for children starting at 6 months for children whose water supply is deficient in fluoride

If you'd like more help understanding your preventive care benefits, call the Member Services number on your health plan ID card. For a complete list of covered preventive drugs under the Affordable Care Act, view the Preventive ACA Drug List flyer, available at anthem.com/ca/pharmacyinformation.

1 The range of preventive care services covered at no cost share when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by Health Resources and Services Administration (HRSA) guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your certificate of coverage or call the Member Services number on your ID card.

2 You may be required to receive preapproval for these services.

3 The Centers for Disease Control and Prevention (CDC)-recognized diabetes prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

4 Breast pumps and supplies must be purchased from suppliers or retailers in your plan's network for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.

5 This benefit also applies to those younger than age 19.

6 You may pay a share of the cost for other prescription contraceptives, based on your drug benefits. Your cost share may be waived if your doctor decides that using the multisource brand or brand name is medically necessary.

7 Counseling services for breastfeeding (lactation) can be provided or supported by a doctor or facility in your plan's network, such as a pediatrician, OB-GYN, or family medicine doctor, and hospitals with no member cost share (deductible, copay, or coinsurance). Contact the provider to see if such services are available.

8 Check your medical policy for details.

9 Some plans cover additional vision services. Please see your contract or certificate of coverage for details.

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Health Savings Account

The City will contribute to an HSA account with Health Equity when you enroll in the High Deductible Health Plan. You also have the option of contributing pre-tax dollars to your account as long as the maximum contribution does not exceed the IRS amount allowed for the 2026 year.

An HSA is a voluntary savings account established for reimbursement of qualified medical expenses. HSAs were created to provide individuals with a tax saving benefit for certain medical expenses when covered under a HDHP.

The Health Equity platform will integrate with claims processed by Anthem Blue Cross giving you an easy way to pay your out of pocket expenses directly from your HSA.

An HSA is not a medical plan with a carrier. It is an individual account established for your contributions and expenses. It is able to reimburse the same category of eligible expenses as a Medical Flexible Spending Account, however your maximum available reimbursement is limited to your account balance.

Among the benefits of an HSA are:

- Contributions are exempt from Federal (not State) taxes;
- Interest and earnings are exempt from Federal taxes;
- Distributions are tax free when used for qualified medical expenses as listed under IRS Code 213 (d) such as copays, deductibles, dental vision expenses and more;
- Assets roll over from year to year – no "use it or lose it";
- You can change the contribution at any time;
- The HSA is portable, so you can use the assets even if you leave the City's employment.

In order to be eligible to receive or contribute to an HSA, you must:

- Be enrolled in an HDHP;
- Have no other non-HDHP health coverage;
- Not be enrolled in Medicare Part A or Part B
- Have not received VA medical benefits at any time over the past three months;
- Not be able to be claimed as a dependent on someone else's tax return;
- Not be contributing to a general purpose medical Flexible Spending Account (FSA). However, you may contribute to a limited purpose medical FSA for qualifying dental and vision expenses only, and also contribute to an HSA.

Even if you are no longer eligible to contribute to an HSA, whether you switch from a HDHP or leave the City employment, your HSA account remains active for the reimbursement of qualified medical expenses until it is depleted. Non medical withdrawals are considered taxable income and will have a 20% penalty if you are under 65.

Deductible minimums and contribution maximums are set by the IRS each year. For the 2026 plan year:

Minimum Deductibles

- **Individual:** $1,700
- **Family:** $3,400

Contribution Maximums

An additional $1,000 can be contributed over the age of 55.

- **Individual:** $4,400
- **Family:** $8,750

Dental

The City offers two comprehensive PPO dental plans through The Standard.

By selecting an in-network provider on http://www.standard.com/services, you can reduce your out-of-pocket costs. Charges exceeding the PPO fee schedule when using out-of-network providers will be the patient's responsibility.

Type of Benefit	The Standard Dental – Low Option		The Standard Dental – High Option	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Deductible	$100 per person $300 per family each cal year (Preventive service are not subject to the deductible)		$100 per person $300 per family each cal year (Preventive service are not subject to the deductible)	
Calendar Year Maximum	$1,000		$1,500	
Preventive				
• Exams and Cleanings	100%	100%	100%	100%
• Full Mouth X-Ray Series or Panoramic X-Ray	100%	100%	100%	100%
• Bitewing X-Rays	100%	100%	100%	100%
• Sealants	100%	100%	100%	100%
Basic Restorative				
• Anterior Composite *(ADA 2330)*	80%	80%	80%	80%
• Molar Root Canal *(ADA 3330)*	80%	80%	80%	80%
• Periodontic Treatment *(ADA 4210)*	80%	80%	80%	80%
• Surgical Extraction *(ADA 7210)*	80%	80%	80%	80%
Major Restorative				
• Crown *(ADA 2750)*	80%	80%	80%	80%
• Denture *(ADA 5100/5120)*	80%	80%	80%	80%
• Fixed Bridge Crown *(ADA 6750)*	80%	80%	80%	80%
Orthodontics				
• Comprehensive Treatment *(ADA 8070, 8080, 8040)*	Not covered		Not covered	

Note: Out-of-Network Dentists are covered at the applicable coinsurance level of the PPO fee schedule.

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

Vision

The City offers two vision plans with VSP & EyeMed through The Standard. Make your benefit go further by selecting in-network providers. Go to www.standard.com/services to find a provider near you.

Plan Benefits	VSP	
	In-Network	Out-of-Network
Frequency of Services		
• Vision Exam	Once every 12 months	
• Eyeglass Lenses	Once every 12 months	
• Frames	Once every 12 months	
• Contact Lenses	Once every 12 months	
• Contact Lens Fitting	Once every 12 months	
Copay *(per Insured)*		
• Vision Exam	$10	$45 allowance
• Eyeglass Lenses/Frames	$10	$30 allowance
• Contact Lens Fitting	$60	N/A
Benefits and Allowances		
• Vision Exam		
– Ophthalmologist	100%	$45 allowance
– Optometrist	100%	$45 allowance
• Materials – Lenses		
– Single Vision	100%	$30 allowance
– Progressive	Covered at lined bifocal level	N/A
– Bifocals	100%	$50 allowance
– Trifocals	100%	$65 allowance
– Lenticular	100%	$100 allowance
• Materials – Frames *(in lieu of contacts)*	$150 allowance	$70 allowance
• Contacts *(in lieu of frames)*		
– Non-Elective	100%	$210 allowance
– Elective	$150 allowance	$120 allowance

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

Vision (continued)

Make your benefit go further by selecting in-network providers. Go to www.standard.com/services to find a provider near you.

Plan Benefits	EyeMed	
	In-Network	Out-of-Network
Frequency of Services		
• Vision Exam	Once every 12 months	
• Eyeglass Lenses	Once every 12 months	
• Frames	Once every 12 months	
• Contact Lenses	Once every 12 months	
• Contact Lens Fitting	Once every 12 months	
Copay *(per Insured)*		
• Vision Exam	$10	$35 allowance
• Eyeglass Lenses/Frames	$10	$30 allowance
• Contact Lens Fitting	$40	N/A
Benefits and Allowances		
• Vision Exam		
– Ophthalmologist	100%	$35 allowance
– Optometrist	100%	$35 allowance
• Materials – Lenses		
– Single Vision	100%	$25 allowance
– Progressive	$65 allowance	Not covered
– Bifocals	100%	$40 allowance
– Trifocals	100%	$55 allowance
– Lenticular	20% discount	Not covered
• Materials – Frames *(in lieu of contacts)*	$150 allowance	$75 allowance
• Contacts *(in lieu of frames)*		
– Non-Elective	100%	$200 allowance
– Elective	$150 allowance	$120 allowance

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

Disability

The City's disability plans are covered by The Standard.

Short-Term Disability (STD)	
Benefit Percentage	66.67% of Total Weekly Earnings
Maximum Weekly Benefit	$2,500
Minimum Weekly Benefit	$25
Elimination Period	7 Days

Long-Term Disability (LTD)	
Benefit Percentage	66.67% of Total Monthly Earnings
Maximum Monthly Benefit	$10,000
Minimum Monthly Benefit	$100
Elimination Period	90 Days
Maximum Benefit Duration	(Determined by your age when disability begins): Age 60 or younger = 60 Months Age 61 = 48 Months Age 62 = 42 Months Age 63 = 36 Months Age 64 = 30 Months Age 65 = 24 Months Age 66 = 21 Months Age 67 = 18 Months Age 68 = 15 Months Age 69 or older = 12 Months

CLICK HERE to watch a video on Disability Insurance

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

Life and AD&D

Basic Life and AD&D

The City provides all employees a Basic Life & AD&D plan at no cost. The coverage is provided by The Standard. The plan will pay the following amount to your beneficiary at the time of death:

- **$200,000:** Class 1 - City Manager/Attorney
- **$50,000:** Class 2 - All Others, excluding Temporary Employees

The AD&D benefit is equal to the amount of the Basic Life coverage.

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 assigned them through the ADP portal. If you are married and not naming your spouse as the beneficiary, the spouse must sign an acknowledgement.

Voluntary Life and AD&D

All employees enrolled in Basic Life and AD&D have the opportunity to gain greater financial security by supplementing their City paid Basic Life and AD&D coverage.

Coverage for employees can be purchased in units of $5,000. You can apply for as many units as you want up to a maximum of 5x your base salary rounded to the next $5,000 or $300,000, whichever is less.

To be eligible for up to $50,000 without evidence of insurability (health/or physical exam), you must enroll yourself and your dependents within 31 days of the date you initially become eligible.

- **Spouse:** Coverage for your spouse can be purchased in units of $5,000 up to a maximum of $150,000. Maximum guaranteed issue is $30,000.
- **Children:** Coverage for your child(ren) older than 6 months is available without evidence of insurability up to $10,000. Children 14 days to 6 months are eligible for $250 of coverage without evidence of insurability.

Employee Assistance Program

Health Advocate provides confidential, professional short-term counseling services for you and your eligible family members. The plan provides 6 visits/per incident per year for you & your family members.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26 and all household members can contact master's-degreed clinicians 24/7 by phone, online, live chat, email and text. There's even a mobile EAP app. Receive referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to six face-to-face assessment and counseling sessions per issue. EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. They can save you hours of research time by providing referrals to important needs like education, adoption, travel, daily living and care for your pet, child or elderly loved one.

Contacting Health Advocate

Services are available to you 24 hours a day, seven days a week. Visit healthadvocate.com/standard6 or call 877-851-1631. You will find a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

Flexible Spending Accounts

Health Equity will administer the Flexible Spending and Dependent Daycare Accounts. These accounts permit employees to set money aside on a pre-tax basis, via payroll deduction, for eligible medical, dental, vision, or dependent care expenses not covered by insurance or other benefit plans. A new enrollment is required each year, even if you do not plan to change the amount(s) set aside. Except for a change in status event, the only time you can enroll, change, or stop your FSA is during Open Enrollment.

Employees enrolled in a Health Savings Account (HSA) are not eligible to contribute to a general purpose medical reimbursement account. However, they may contribute to a limited purpose medical reimbursement account for qualifying dental and vision expenses only. Please contact Human Resources for more information.

Flexible Spending Account

The FSA allows you to set aside pre-tax money to pay for out-of-pocket expenses incurred by you for yourself, your spouse or your eligible dependents up to age 26 that are not paid by your insurance or reimbursed by any other benefit plan. Expenses for children that do not qualify as an IRS dependent are generally not allowed, per Federal law. Expenses include, but are not limited to, insurance copays, deductibles, dental or vision expenses, pharmacy bills, and other similar out-of-pocket costs. Up to $680 can be carried over to the 2027 plan year for unused amounts. Any amount exceeding $680 will be forfeited. An important IRS exclusion is that treatments, services, and surgeries that are performed for cosmetic reasons are not reimbursable from a Flexible Spending Account.

Dependent Daycare Account

You may set aside pre-tax dollars to pay for qualified childcare or dependent care expenses that are necessary for you and your spouse to continue working or going to school full-time. A new dependent care contract for automatic reimbursement is also required every year.

Amount of Contribution

With the FSA, you may set aside up to $3,400 per calendar year to pay for qualified unreimbursed health expenses. For dependent day care, you may defer up to $7,500 ($3,750 if you are married and file separate tax returns) to pay for qualified dependent care expenses.

Claim Reimbursement

You have three options, use the prepaid benefits card, submit claims forms or access your account at www.HealthEquity.com to pay Anthem Blue Cross claims directly.

Using the prepaid card gives you an easy, automatic way to pay for qualified health care/benefits expenses. The card lets you electronically access the pre-tax amounts set aside in your Flexible Spending Account. The card works like a MasterCard or Visa. When you have eligible expenses at a place that accepts MasterCard or Visa, simply use your card. The amount of your eligible purchases will be automatically deducted from your account.

Flexible Spending Accounts (continued)

Election Changes

The only time you may make any type of change in your deduction elections is during Open Enrollment, or within 30 days of a "change in status" event. Remember: IRS guidelines require that any change you request must be on account of, consistent with, and correspond to your "change in status" event. All changes are on a prospective basis only.

Social Security

Your election may reduce your Social Security contributions. However, the reduction is generally small. You may wish to contact your tax advisor prior to making your election.

If You Leave City Employment

Your contributions will cease when your employment ends. The Plan shall reimburse any eligible expenses which were incurred during your coverage in the plan year, less benefits already paid during the plan year. For dependent care expenses, the plan reimburses up to the amount of your contribution for benefits less benefits paid, and for medical expenses incurred prior to your employment termination up to the amount of your annual benefit, less benefits paid.

Depending on the timing of the event and your remaining balance available to you, post employment expenses may be eligible for claim reimbursements if you elect to continue contributions on a post-tax basis through COBRA, but only for the balance of the plan year. Information regarding COBRA options for the Medical Reimbursement Account, if you qualify, will be sent to your mailing address after your employment ends.

HRA, FSA, HSA numbers are reflected for the 2022 calendar year. 2023 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2023 year should keep this in mind.

Voluntary Benefits – Colonial Life

Accident

Whether a weekend warrior with an active lifestyle or the stay at-home type, accidents can happen anytime, anywhere, without warning. Being prepared for the unexpected can make all the difference.

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

Eligibility

It is your responsibility to see the Colonial Life representative once you have satisfied the City's waiting period.

How the Plan Works

Our Accident Insurance policy pays according to a wide-ranging schedule of benefits. In addition, the policy provides 24-hour coverage for accidents that occur both on and off the job. All benefits are only paid as a result of injuries received in an accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a physician. All benefits are paid once per covered person per covered accident unless otherwise specified in the Limitations and Exclusions section.*

Health Screening and Sickness Hospital Confinement Benefit

When you have a hospital stay for a covered sickness, this benefit can help with associated medical costs that your health insurance may not cover. Benefits are also available to help pay for preventive tests and services. Coverage options are available for you, your spouse and eligible dependent children.

Coverage Feature	What it Means to You
Plan Options	Choose the plan to meet your financial needs.
Four Choices of Coverage: Individual, Individual and Spouse, Individual and Child, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers all types of covered injuries.
Accident Emergency Treatment Benefit	Receive a benefit when emergency treatment in a Physician's office or emergency room occurs within 72 hours of a covered accident.
Benefit Paid Directly to You, to use as you see fit	Use the benefit however best fits your financial needs.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
24-Hour Coverage	You are covered on or off the job.
Guaranteed Renewable	Keep your coverage as long as premiums are paid as required.
Additional Coverage Options	Enhance the base plan by adding an optional rider.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

* Premium and amount of Benefits may vary dependent upon Plan selected.

Limitations, exclusions and waiting periods apply. Refer to your policy for complete details. This product is inappropriate for people who are eligible for Medicaid coverage. The company has the right to change premiums by class (AO-03 Series).

Voluntary Benefits – Colonial Life (continued)

Cancer

A cancer diagnosis may be overwhelming. Even with a good medical plan, the out-of-pocket costs of cancer treatment, such as travel, childcare, and loss of income are considerable and may not be covered.

Colonial Life's Cancer Insurance can help offer financial protection so you can focus your attention on fighting cancer. We offer plans that can help assist with out-of-pocket costs often associated with a cancer diagnosis.

Eligibility

It is your responsibility to see the Colonial Life representative once you have satisfied the City's waiting period.

How the Plan Works

Our plan is designed to help cover expenses if you are diagnosed with a covered cancer. With over 20 benefits available to you, this plan provides benefits for the treatment of cancer, transportation, hospitalization and more. We provide the money directly to you, to be used however you see fit.

Optional Riders

Enhance your base plan with the following riders:

- Initial diagnosis of cancer rider - Pays a one-time, lump-sum benefit for the initial diagnosis of cancer.
- Initial diagnosis of cancer progressive payment rider - Provides a lump-sum payment of $50 for each month the rider has been in force after the waiting period and before cancer is first diagnosed.
- Specified disease hospital confinement rider - Pays $300 per day if you or a covered family member is confined to a hospital for treatment for one of the 34 specified diseases covered under the rider.

Coverage Feature	What it Means to You
Plan Options	Choose the plan to meet your financial needs.
Three Choices of Coverage: Individual, Single Parent Family, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers a wide range of treatments.
Benefit Paid Directly to You	Use the money however best fits your financial needs.
Guaranteed Renewable	Keep your coverage as long as premiums are paid as required.
Transportation and Lodging	Receive benefits if you travel more than 50 miles from your home using the most direct route for covered treatment.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by choosing from a selection of optional riders.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

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

Voluntary Benefits – Colonial Life (continued)

Group Critical Illness

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

Colonial Life's Critical Illness Insurance can be the solution that helps you and your family focus on recovery, and may help you with paying bills. Our plans can assist with the expenses that may not be covered by standard medical insurance.

How the Plan Works

If you are diagnosed with a covered Critical Illness, such as a heart attack or stroke, this plan is designed to pay a lump sum benefit amount to help cover expenses. Also, this plan offers a recurrent diagnosis benefit that can provide an additional Critical Illness benefit amount after the second occurrence date of the specified Critical Illness.

Guaranteed Issue

You are guaranteed issue the 1st time this benefit is offered to you.

Guaranteed Renewable

You are guaranteed the right to renew your base policy as long as you pay premiums when due or within the premium grace period. We have the right to increase premiums by class.

Coverage Feature	What it Means to You
Plan Options	Choose from various benefit amounts and customize with optional riders.
Four Choices of Coverage: Individual, Individual & Spouse, Single Parent Family, or Family	Choose the coverage that fits your lifestyle.
Wellness Benefit	Receive a benefit for your annual health screening test.
Benefit Paid Directly to You	Use the benefit however best fits your financial needs.
Multiple Critical Illness Benefits	You will be covered for twelve (12) different critical illnesses.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by adding an optional rider.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

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

Voluntary Benefits – Colonial Life (continued)

Term Life Insurance

Life insurance is an important piece of a strong financial plan. While there is no complete replacement for the loss of a loved one, Colonial Life's Term Life Insurance can help protect your family in your absence. It provides short-term coverage at a very competitive price. For those on a limited budget, Term Life Insurance can help fill temporary needs.

Life insurance provided by your employer is an important benefit. However, it may not be enough protection to provide for your loved ones.

A term life policy can help supplement your existing coverage and can assist in meeting financial demands, should you need it. Plus, this is an individual policy which means you own it and can take it with you to a different job or in retirement.

Financial Protection for You

Colonial Life's Term Life Insurance is a great option for your working and earning years when expenses are usually at their highest.

With our term life insurance, premiums will remain the same for the initial term period selected.* The death benefit will not change for the life of the policy, and death benefits are generally paid tax free.

Employee Issue Ages	
Ages 17-49	10 Year Term
Ages 17-60	20 Year Term
Ages 17-50	30 Year Term
Employee Issue Maximum	
Ages 17-49	$200,000
Ages 50-65	$25,000
Spouse/Domestic Partner Issue (Ages and Maximums)	
Ages 17-49	$50,000
Ages 50-65	$25,000

* Premiums are subject to increase upon renewal.

Voluntary Benefits – Colonial Life (continued)

Whole Life Insurance

It's important to prepare for the unexpected and help ensure your loved ones will be financially protected in the event of a tragedy. Your life insurance benefit can help replace your income and help your family meet important financial needs like funeral expenses, everyday living costs, and college.

Colonial Life's Whole Life Insurance provides protection for your entire life. It's an individual policy, which means you own it and can take it with you when you leave employment or when you retire to age 121. The premium and amount of protection stay the same as long as the policy is in force, provided premiums are paid as required.

Flexibility When You Need It

By choosing a Whole Life Policy, you have flexibility to adjust your benefits when needed. Cash value flexibility features include:

- Take a **Cash Surrender** and terminate your Policy. With this option, you will receive a check equal to your plan's current available cash value. In many situations, cash surrenders may be paid tax free.*
- **Partial Surrender:** You can withdraw a small portion of the policy's cash value in the form of cash, in exchange for a proportional-reduction to the policy's available cash value and the face amount.
- **Loans:** You can borrow against your cash value at a competitive 8% loan interest rate.

Discontinue Your Premium While Keeping Your Coverage Active

- **Same Amount of Coverage - Shorter Length of Time:** Under the **Extended Term Insurance** provision, your policy's original face amount (minus outstanding loans or accelerated benefit payments) will now only be guaranteed for a specific term of time. In addition, your premium is "paid in full" until your new extended term period expires, terminating your policy.
- **Coverage to Age 121 - Smaller Guaranteed Benefit Amount:** You may rest easy knowing you are covered for your entire life by utilizing the **Reduced Paid-Up Provision** and reducing your original death benefit to a smaller amount. Enjoy being premium-free while having the security of guaranteed lifetime coverage, just at a reduced benefit amount. Plus your cash value will continue to accumulate.

Employee Issue Age and Maximum	
Ages 17-49	$200,000
Ages 50-65	$100,000
Ages 66-70	$10,000
Child/Grandchild Issue Age and Maximum	
Ages 1 month - 26	$50,000
Spouse/Domestic Partner Issue (Ages and Maximums)	
Ages 17-49	$50,000
Ages 50-65	$25,000

Note: Face amounts vary based on issue age. Issuance of coverage may be subject to responses received to a few medical questions.

As long as the cash surrender does not exceed the total premiums received under the policy since inception. Please consult your tax consultant for your specific situation

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

The City of South Lake Tahoe 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). The City of South Lake Tahoe does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for a 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 achiev\e 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 560) 542-6050.

Patient Protections

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

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

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

Networks/Claims/Appeals

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

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to receive 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.

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 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 the Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

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

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

Important Notices (continued)

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

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

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

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

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

IF YOU HAVE QUESTIONS

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

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

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.

[1] http://www.socialsecurity.gov/

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or a 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:

City of South Lake Tahoe
Human Resources
(530) 542-6050

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

The City of South Lake Tahoe 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 Human Resources at (530) 542-6050.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about City of South Lake Tahoe 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 begins on November 1 of each year and ends on January 31 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com, 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 9.96% (for 2026) 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.

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 South Lake Tahoe	**4. Employer Identification Number (EIN)** 94-1610868	
5. Employer address 1901 Airport Road, Suite 205	**6. Employer phone number** (530) 542-6050	
7. City South Lake Tahoe	**8. State** CA	**9. ZIP code** 96150
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	**12. Email address** ebuckman@cityofslt.us	

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.

Notice of Creditable Coverage: Information About Medicare Part D and Your Prescription Drug Coverage

City of South Lake Tahoe has determined that the prescription drug coverage offered by the City of South Lake Tahoe on average for all plan participants, expected to pay out the same or more than what the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Please read this notice carefully and keep it where you can find it. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. NOTE: You are responsible for providing this notice to all Medicare eligible family members (or those about to become Medicare eligible).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends three months after the month in which he or she turned 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, when you finally do enroll, you may be subject to a late enrollment penalty added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases based on the number of full, uncovered months during which you went without either Medicare Part D or without "Creditable" prescription drug coverage from another plan, such as our plan.

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from October 15 through December 7 of each year, as well as during what is known as a "Medicare Special Enrollment Period" which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage. Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available. Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before you enroll in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

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 South Lake Tahoe coverage will not be affected. If you keep this coverage and elect Medicare, the City of South Lake Tahoe] coverage will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current City of South Lake Tahoe coverage, be aware that you and your dependents may be unable to get this coverage back.

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances, some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would reduce their payment to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

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

If you are Medicare eligible and 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 creditable coverage. For example, if you go 19 months without creditable coverage, your premium may be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) the entire time you have Medicare prescription drug coverage.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

If you have questions about your Medicare eligibility or how you can get help to pay for it, you can call the Social Security Administration at 1-800-772-1213 or visit www.socialsecurity.gov.

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, dial 1-877-KIDS-NOW, or visit www.insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance with paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA - Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS - Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (1-855-692-7447)

CALIFORNIA - Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 1-916-445-8322
Fax: 1-916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/chp
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

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

INDIANA - Medicaid
Website: https://www.in.gov/medicaid/ or
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid & CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
HIPP Phone: 1-888-346-9562

Important Notices (continued)

KANSAS - Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPAA Phone: 1-800-967-4660

KENTUCKY - Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://www.chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.Program@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA - Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE - Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS - Medicaid & CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA - Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA - Medicaid
Website: http://www.accessnebraska.ne.gov/
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA - Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY - Medicaid & CHIP
Medicaid Website:
https://www.nj.gov/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 1-609-631-2392
CHIP Website: https://njfamilycare.dhs.state.nj.us/
CHIP Phone: 1-800-701-0710 (TTY 711)

NEW YORK - Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA - Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP
Website: http://www.insureoklahoma.org/
Phone: 1-888-365-3742

OREGON - Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid & CHIP
Website: https://www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

Important Notices (continued)

TEXAS - Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH - Medicaid & CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT - Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA - Medicaid & CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 1-304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid & CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

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

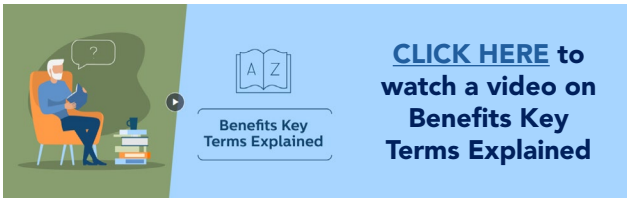
A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

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.



Contact Information

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

Plan	Phone Number	Website/Email
Medical		
• Anthem Blue Cross	855-333-5730	www.anthem.com/ca
	Network Name: Prudent Buyer PPO	
FSA and HSA		
• Health Equity	866-346-5800	www.healthequity.com/wageworks
Dental		
• The Standard	800-547-9515	www.standard.com/services
Vision		
• The Standard VSP/EyeMed	EyeMed: 866-289-0614 VSP Call Center: 800-877-7195	www.standard.com/services
Disability Insurance		
• The Standard	800-378-6053	www.standard.com
Life Insurance		
• The Standard	800-628-8600	www.standard.com
Employee Assistance Program (EAP)		
• Health Advocate	877-851-1631	www.healthadvocate.com/standard6
Voluntary Plans		
• Colonial Life	925-759-6027	www.colonialLife.com/individuals
Travel Assistance		
• The Standard	800-872-1414	medservices@assistamerica.com