Employee Benefits Guide

2023

BEAUMONT
CALIFORNIA

Employee Benefits Guide 2023

General Information

Core Benefits

Other Benefits

Miscellaneous

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

NEW! See page 55 for a glossary of terms.

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

Please see page 48 for more details.

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

Message from Human Resources

Navigating the benefits that an employer provides can be one of the most daunting challenges for a new employee, particularly if they are just entering employment for the first time. Similarly, once employed, we often make an initial decision on our benefits and rarely revisit them unless there is a sudden need to make a change.

Your Human Resources Division is committed to focusing on ways to ensure that your benefits are clearly explained and assist you in understanding how your benefits work to support you. For both new employees, and those that have been with the City for some time, it is our hope that we can highlight ways that your benefits can assist you in achieving your future goals. To that end, we present to you this benefits guide.

As you make your benefit elections this year, please review and take advantage of the preventative and annual care benefits provided by your plan. **Don't wait until you are sick to use your benefits**.

Rates

Medical

Monthly Rates	Kaiser Premier	Kaiser Basic	HN Blue Shield Premier Trio HMO	HN Blue Shield Basic Trio HMO	Blue Shield Premier EPO	Blue Shield Basic EPO
Employee Only	$870.84	$727.26	$724.07	$667.63	$1,256.48	$1,161.72
Employee Plus Spouse	$1,612.62	$1345.59	$1,660.87	$1,531.05	$2,512.71	$2,323.26
Employee Plus Child(ren)	$1,431.51	$1,194.62	$1,228.49	$1,132.55	$2,324.47	$2,149.18
Employee Plus Family	$1,911.24	$1,594.55	$2,093.23	$1,929.56	$3,580.94	$3,310.90

Dental

Monthly Rates	Guardian Dental	
	Managed Dental Care Plan	PPO
Employee Only	$17.31	$48.60
Employee Plus Spouse	$34.24	$94.06
Employee Plus Child(ren)	$29.23	$113.31
Employee Plus Family	$48.46	$156.40

Vision

Monthly Rates	Guardian Vision
Employee Only	$8.45
Employee Plus Spouse	$15.24
Employee Plus Child(ren)	$15.53
Employee Plus Family	$24.58

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Contact Information

Keenan & Associates Service Team
Contact Information/Functional Responsibilities

Office Locations and Telephone Numbers					
Office	**Address**	**Phone/Fax**	**Website**	**Key Responsibilities**	**License No.**
Riverside Office	4204 Riverwalk Pkwy, Suite 400 Riverside, CA 92505	**Phone (Main):** 951.788.0330 **Phone (Toll Free):** 800.654.8347 **Main Fax:** 951.715.0166	www.keenan.com	Responsible for overall account management, including renewals, contract negotiations, questions and review.	Corporate License No. 0451271
Corporate Office	2355 Crenshaw Blvd., Suite. 200 Torrance, CA 90501	**Phone (Main):** 310.212.3344 **Phone (Toll Free):** 800.654.8102 **Main Fax:** 310.618.0416			

Contact Information (continued)

	Key Services	Phone Number	Website/Email
FDAC EBA Medical			
• Blue Shield - Customer Service	• Claims Questions • Locate a Provider • View eligibility • View Benefits • Print ID cards	800.393.6130	www.blueshieldca.com
• Health Now – Administrative Services *(Blue Shield)*	• Review eligibility • View Claims Detail • Access EOB's	877.356.0666	www.myHNAS.com
• Kaiser – Customer Service	• Claims Questions • Locate a Provider • View eligibility • View Benefits • Print ID Cards	800.464.4000	www.kp.org
Dental **Vision** **Life Insurance** **Short-Term Disability -** *(# 00412430)*			
• Guardian	• Claims Questions • Locate a Provider • View eligibility • View Benefits • Print ID cards	888.600.1600	www.guardiannaytime.com
Employee Assistance Program (EAP)			
• Guardian	• Resource Information • 3 Counseling Sessions • Confidential Services	800.386.7055	lbhworklife.com User Name: WorkLife Password: 70101
• Magellan	• Work-Life Services • Counseling • Emotional & Financial Services	800.368.7426	www.MagellanAscend.com
• The Counseling Team International	• Employee Mental Health and Wellness Services • Critical Incident Stress Management	800.222.9691	www.thecounselingteam.com
Section 125/Flexible Spending Accounts			
• American Fidelity	• Claims • General Support	800.662.1113	www.americanfidelity.com
457 Plan			
• Mutual of Omaha	• Claims • General Support	888.917.7191	www.getretirementright.com
COBRA Benefits			
• Sterling Administration – Josie Jacobo – Beaumont Client Service Specialist	• General Support	800.617.4729 (Option 3 for COBRA)	website: www.sterlingadministration.com email: josefina.jacobo@sterlingadministration.com
Human Resources	550 E. 6th Street, Beaumont, CA 92223	951.769.8520	hr@beaumont.ca.gov
• Kari Mendoza - Administrative Services Director		951.572.3228	karim@beaumontca.gov
• Shay Norville - Administrative Services Manager		951.769.8528	shayn@beaumontca.gov
• Olivia Urtiaga - HR Payroll Technician		951.769.8520	ourtiaga@beaumontca.gov

Open Enrollment

Open Enrollment is your annual opportunity to change your benefit elections without a qualifying event. Changes made during Open Enrollment are effective the following January. It is also your opportunity to drop ineligible dependents without being charged a penalty.

If you add or remove dependents (or obtain or lose other health coverage), submit copies (not originals) of eligibility documentation such as a certified marriage certificate, domestic partner certification, or child's birth certificate. You may mail, email or drop off your eligibility documentation. If you need assistance in making an election online, you may contact Human Resources at 951.769.8258 to schedule an appointment for assistance.

If your premiums exceed the City's Cafeteria Plan contribution for your bargaining unit, the remaining balance due is deducted from paychecks biweekly. In 2023, there are two pay periods where there is an exception to this and benefit costs will not be deducted. These will occur when there is a 3rd check in that month. An easy way to consider this is most benefits have monthly costs. If two payments are made each month, there would be 24 payments. In 2023, there are 26 pay periods, so during two pay periods there is no deduction.

Plan Enrollment

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

Questions?

Contact Human Resources: 951.769.8258

How to Enroll in Health Benefits

Learn about your health benefit options by reading this Benefits Guide.

If you are enrolling as a new employee, new hire eligibility is effective the date of hire.

To enroll, Human Resources will assist in scheduling you to meet with a Benefits Counselor. It will typically take a couple days after your hire date for your account to be established. You must complete your initial elections and submit required eligibility documentation to Human Resources within the 30 day deadline. Submit copies (not originals) of eligibility documentation such as a certified marriage certificate, domestic partner certification, and children's birth certificates. You may mail, email or drop off your documentation and eligibility documentation. If you need assistance in making an election online, you may contact Human Resources at 951.769.8528 to schedule an appointment for assistance.

Eligibility Rules for Health Coverage

The following rules govern which employees and dependents may be eligible for health coverage.

Employee Eligibility

All City of Beaumont employees regularly scheduled to work for thirty (30) hours or more each week.

Dependent Eligibility

Spouse or Domestic Partner

- An eligible employee's spouse or registered domestic partner may be eligible for health coverage. Proof of legal marriage or domestic partnership is required, as well as the dependent's Social Security number.
- Enrollment in the City's health benefits must be completed within 30 days of the date of marriage or partnership.
- A spouse or registered domestic partner can also be added to an employee's coverage during Open Enrollment.
- A spouse or registered domestic partner who is eligible for Medicare must enroll in Medicare at the time they are eligible to avoid paying a higher premium for late enrollment.

Natural Children, Stepchildren, Adopted Children

- An employee's natural child, stepchild, adopted child (including a child placed for adoption) and the natural or adopted child of an employee's enrolled domestic partner are eligible for coverage up to 26 years of age.
- Coverage terminates at the end of the month in which the child turns 26. Eligibility documentation is required upon initial enrollment.

Eligibility Rules for Health Coverage (continued)

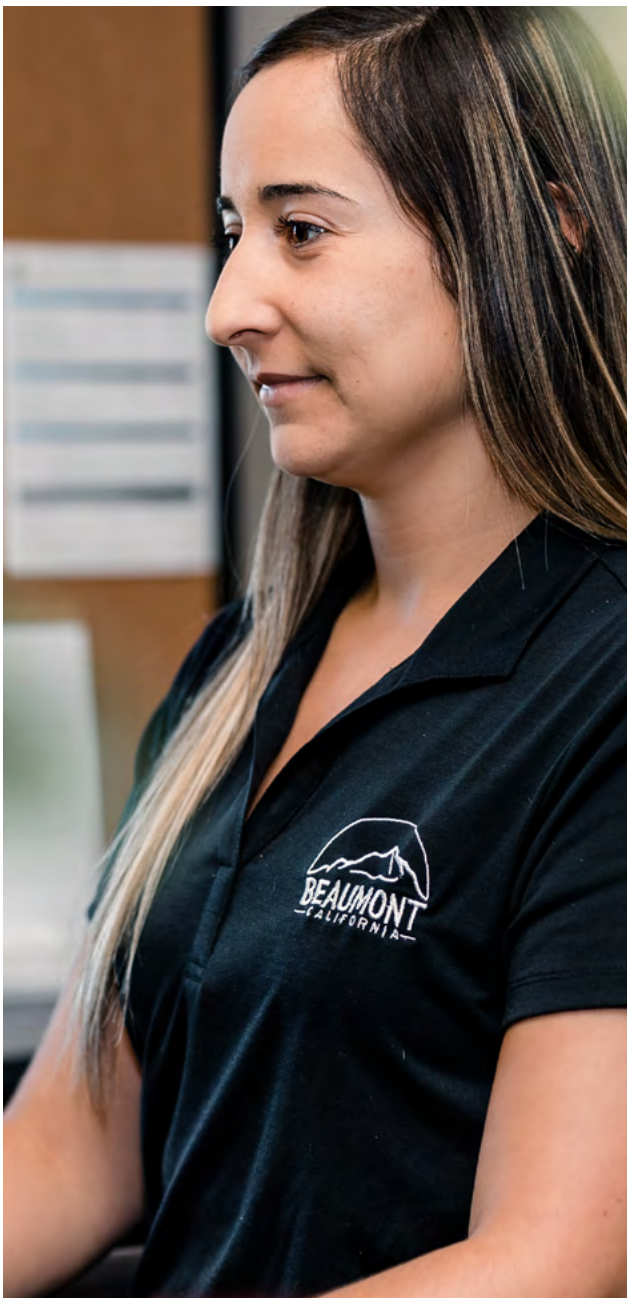
Adult Disabled Children

To qualify a dependent disabled adult child, the adult child must be incapable of self-support because of a mental or physical condition that existed prior to age 26, continuously live with disability after turning 26, and meet each of the following criteria:

1. Disabled adult child ("Adult Child") is enrolled in a City of Beaumont medical plan on his or her 26th birthday; ***and***
2. Adult Child has met the requirements of being an eligible dependent under the selected health plans rules; ***and***
3. Adult Child must have been physically or mentally disabled on the date coverage would have otherwise terminated due to age, i.e. turning 26 years old, and continue to be disabled from age 26 on; ***and***
4. Adult Child is incapable of self-sustaining employment due to the physical or mental disability; ***and***
5. Adult Child is dependent on the employee for substantially all of his or her economic support, and is declared as an exemption on the employee's Federal income tax;
6. The employee is required to comply with their enrolled medical plan's disabled dependent certification process and recertification process every year thereafter or upon request.
7. An Adult Child, who qualifies for Medicare due to a disability should be enrolled in Medicare. Employees must notify Human Resources of the Adult Child's eligibility for Medicare, as well as the Adult Child's subsequent enrollment in Medicare.
8. To maintain ongoing eligibility after the Adult Child has been enrolled, the employee must maintain continuous coverage for the Adult Child through a City health plan each year and must ensure that he or she remains continuously enrolled in Medicare (if eligible) without interruption.
9. A newly hired employee who adds an eligible dependent Adult Child, who is age 26 or older, must meet all requirements listed, except (1.) above and comply with their enrolled medical plan's disabled dependent certification process specified in (6.) within 30 days of employee hire date.

Penalties for Failing to Dis-enroll Ineligible Dependents

Employees must notify Human Resources within 30 days and cancel coverage for a dependent who becomes ineligible. If an employee fails to notify Human Resources and/or fails to cancel coverage, the employee may be held responsible for the costs of the ineligible dependent's health premiums and any medical service provided.



Changing Benefit Elections: Qualifying Events

You may change health benefit elections outside of Open Enrollment if you experience a qualifying event.

To change benefits, you must complete the election change process, including submission of all required documentation, **within 30 calendar days after the qualifying event occurs**.

If the election change process is not completed within 30 days of the date of the qualifying event, you must wait until the next Open Enrollment to make the change. Below are qualifying events that allow you to change your benefit elections.

New Spouse or Domestic Partnership

To enroll a new spouse or domestic partner and eligible children of a spouse or partner, all changes go through Human Resources. You must also submit a copy of a certified marriage certificate or certificate of domestic partnership and birth certificate for each child to Human Resources within 30 days of the legal date of the marriage or partnership. Certificates of partnership must be issued in the United States.

A Social Security number must be provided for each of the family members being enrolled. Proof of Medicare enrollment is also required for a domestic partner who is Medicare-eligible due to age or disability.

Coverage for your spouse or domestic partner will be effective the first day of the month following the submission of the required documentation and the election having been made.

Newborn or Newly Adopted Children

Coverage for an enrolled newborn child will be effective on the first day of the month following the child's date of birth. Coverage for an enrolled adopted child will be effective on the date the first day of the month after the child is placed.

A Social Security number must be provided within 6 months of the date of birth or adoption, or your child's coverage may be terminated.

Legal Guardianship or Court Order

Coverage for a child under legal guardianship or court order shall begin on the first day of the month following the effective date of guardianship or court order.

Divorce, Separation, Dissolution, Annulment

Coverage for an ex-spouse, domestic partner and stepchildren will terminate on the last day of the month in which the event occurred, provided you complete disenrollment within 30 days. Failure to notify Human Resources can result in significant financial penalties equal to the total cost of benefits and services provided for any ineligible dependents.

Loss of Other Health Coverage

Eligible employees and dependents who lose other health care coverage may enroll in City health benefits. Once required documentation is submitted, coverage will be effective on the first day of the next pay period.

Obtaining Other Health Coverage

You may waive City provided health benefits for yourself or a dependent who is covered under other health coverage. If you waive coverage for yourself, coverage for all your enrolled dependents will also be waived.

All required documentation (proof of other coverage must be on letterhead) must be submitted to Human Resources. City coverage will terminate on the last day of the month in which the election is made and documentation received.

Moving Out of Your Plan's Service Area

If your move your residence to a location outside your health plan's service area, you must enroll in a different health plan that offers service based on your new address. Coverage under the new plan will be effective the first day of the month following receipt of required documentation.

Changing Benefit Elections: Qualifying Events (continued)

Death of a Dependent

In the event of the death of a dependent, notify Human Resources as soon as possible and submit a copy of the death certificate within 30 days of the date of death.

Death of an Employee

In the event of an employee's death, the surviving dependent or survivor's designee should contact Human Resources to obtain information about eligibility for survivor health benefits.

After being notified of an employee's death, Human Resources will send instructions to the spouse or partner, including a list of documentation required for enrolling in surviving dependent health coverage.

A surviving spouse or partner who is not enrolled on the deceased employee's health plan at the time of the employee's death may be eligible for coverage, but must wait until Open Enrollment to enroll.

Changing FSA Contributions

Per IRS regulations, some qualifying events may allow you to initiate or modify Flexible Spending Account (FSA) contributions. Contact HR and/or American Fidelity for more information.

Responsibility for Premium Contributions

Change in coverage due to a qualifying event may change premium contributions. Review your paycheck to make sure premium deductions are correct. If the premium deductions are incorrect, contact Human Resources. You must pay any premiums that are owed if premiums were under collected. Similarly, if premiums were overpaid, you may be due a refund. Unpaid premium contributions will result in termination of coverage.

Click here to watch a video on Qualifying Life Events.

Cafeteria Plan Benefits

How Cafeteria Plan Benefits Work

A Cafeteria Plan provides participants the opportunity to receive qualified benefits on a pre-tax basis. The City of Beaumont contributes funds toward Cafeteria Plan benefits for each qualifying employee, which may be spent on a variety of benefit options. Employees may also elect to contribute their wages on a pre-tax basis toward the election of Cafeteria Plan benefits. Since the City makes a contribution, this most often would occur if the premiums for your benefit choices exceed the City's contribution to the Plan. You would then pay the balance via payroll deduction. Medical, Dental, and Vision premium payroll deductions are made on a pre-tax basis.

Cafeteria Plan Options (Except FSAs) Will Roll Forward from 2022 to 2023

If you are not making any changes to benefits elections, and you do not wish to fund an FSA, you do not need to take any action during Open Enrollment. Your current benefit elections (except FSAs) will roll forward into 2023. Please note that if your new premiums exceed the City's contributions, the remaining balance will be paid through a salary reduction.

Cafeteria Plan Options	Tax Status
Medical, Dental, and Vision Plan Premiums	Pre-Tax
Healthcare Flexible Spending Account *(American Fidelity)*	Pre-Tax
Dependent Care Flexible Spending Account *(American Fidelity)*	Pre-Tax
Accident Insurance *(American Fidelity)**	Pre-Tax / Post-Tax
Cancer Insurance *(American Fidelity)**	Pre-Tax / Post-Tax

* When enrolling, American Fidelity will identify pre-tax and post-tax elements of your premium.

Medical

The following medical plan options are available to eligible employees. The City contributes funds that will used to pay toward the cost of your medical premium.

Plan Options

These medical plan options are available to employees and eligible dependents.

Health Maintenance Organization (HMO)

An HMO is a medical plan that offers benefits through a network of participating physicians, hospitals and other healthcare providers. For non-emergency care, you access service through your PCP (Primary Care Provider) or an affiliated urgent care center. Co-pays at the point of service are also set at a contracted rate, which helps to limit out-of-pocket costs. The City of Beaumont offers the following HMO plans:

- Kaiser Premium HMO
- Kaiser Basic HMO
- HN Blue Sheild Premier Trio HMO
- HN Blue Shield Basic Trio HMO

Exclusive Provider Organization (EPO)

An EPO is a medical plan that offers benefits through a limited network of participating physicians, hospitals, and other healthcare providers similar to an HMO. It can be generally be thought of as a hybrid between an HMO and a PPO. Like a PPO, you won't have to select a PCP or have a PCP referral each time you see a specialist. Additionally, an EPO is usually more pocket-friendly than a PPO plan. This is because, if you choose to get care outside of the EPO's network, it usually will not be covered (except in an emergency). The City of Beaumont offers the following EPO plans:

- Blue Shield Premier EPO
- Blue Shield Basic EPO

Preventative Care

Preventative Care is an essential part of your health plan benefits. Most preventative care services are covered at 100%, at no cost to you. Regular use of your preventative care benefits can have a long-lasting effect on your general health, and can help reduce your healthcare costs by identifying your medical problems while they are still inexpensive to treat.

Preventative care includes services such as regular checkups; cholesterol, cancer, and diabetes screenings, family planning and health education (such as contraceptive devices and drugs and counseling); immunizations; breastfeeding support, supplies, and counseling; prenatal care; routine mammograms; routine Pap tests; hearing screenings for newborns; periodic well-child visits; STD screenings and prevention counseling for adolescents; and vision screenings. This list is by no means exhaustive.

With appropriate preventative care, you can often avoid or delay the onset of a condition. Early diagnosis of a condition may also increase the probability that treatment will be effective.

Preventative Care Starters

1. You can obtain a recommended list of preventative health care for an individual your sex and age by going to www.cdc.gov/prevention.
2. Contact your health care provider to schedule your preventative care and learn about the services they offer you to live a healthy lifestyle. Also, don't forget to take care of your teeth and eyes with routine dental and vision checks.
3. Explore new ways of managing stress, eating healthy, managing your weight and adopting healthy behavior that support your total good health and well-being.

Medical Plan Comparisons

2023 HMO Plans

Plan Benefits	HMO			
	Kaiser Permanente		Blue Shield	
	Basic	Premier	Basic Trio	Premier Trio
Annual Out-of-Pocket Limit *(Individual/Family)*	$3,000/$6,000	$1,500/$3,000	$3,000/$6,000	$1,500/$3,000
Annual Deductible *(Individual/Family)*	$500/$1,000	$0	$500/$1,000	$0
Primary Care Visits	$20/visit	$15/visit	$20/visit	$15/visit
Most Specialist Visits	$40/visit	$15/visit	$40/visit	$15/visit
Preventative Care Visits	$0	$0	$0	$0
Prenatal Care	$0	$0	$0	$0
Urgent Care Services	$20/visit	$15/visit	$20/visit	$15/visit
Outpatient Services	10% coinsurance after plan deductible	$15/per procedure	10%	$0
Most X-rays and Laboratory Tests	$10	$0	$10	$0
Hospital Services	10% coinsurance after plan deductible	$0	10%	$0
Emergency Room Visits	10% coinsurance after plan deductible	$100/visit	10%	$100/visit
Ambulance Services	$150/trip	$100/trip	$150/trip	$100/trip
Prescription Drug Coverage:	30-day supply	100-day supply	30-day supply	30-day supply
• Most Generic Tier-1	$10	$10	$20	$10
• Most Brand Name Tier-2	$30	$30	$60	$30
• Most Specialty Tier-4	20% up to $150,	20% up to $100, 30-day supply	20% up to $250	20% up to $750
Home Health Care	100 visits/no charge	100 visits/no charge	100 visits/$20 per visit	100 visits/$15 per visit

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

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Medical Plan Comparisons (continued)

2023 EPO Plans

Plan Benefits	EPO	
	Blue Shield	
	Basic EPO	Premier EPO
Annual Out-of-Pocket Limit *(Individual/Family)*	$3,000/$9,000	$1,500/$4,500
Annual Deductible *(Individual/Family)*	$500/$1,500	$0
Primary Care Visits	$30/visit	$15/visit
Most Specialist Visits	$30/visit	$15/visit
Preventative Care Visits	$0	$0
Prenatal Care	$30/visit	$15/visit
Urgent Care Services	$60/visit	$15/visit
Outpatient Services	$30/visit	$15/visit
Most X-rays and Laboratory Tests	$0	$0
Hospital Services	20% coinsurance	$250/admit
Emergency Room Visits	$150/visit & 20% coinsurance	$100/visit
Ambulance Services	$100/trip	$100/trip
Prescription Drug Coverage:	34-day supply	34-day supply
• Most Generic Tier-1	$20	$10
• Most Brand Name Tier-2	$30	$20
• Most Specialty Tier-4	20% up to $100	20% up to $100
Home Health Care	100 visits/$30 per visit	100 visits/$15 per visit

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

Click here to watch a video on PPO vs HMO.

Dental

2023 Dental Plan Benefits

The City provides dental benefits through Guardian which offers both a Managed Care Program and PPO Plan. Eligible employees may use Cafeteria funds or contribute on a pre-tax basis to enroll in dental benefits through Guardian.

PPO-Style Dental Plans

A PPO-style dental plan allows you to visit any in-network or out-of-network dentist. The plan pays higher benefits (and you pay less) when you visit an in-network PPO dentist. Benefits are classified into four tiers of service, which determines the percentage of the cost that is covered under the plan.

Managed Care Dental Plans

Under a Managed Care plan, you enjoy negotiated discounts from our network dentists. You pay a fixed copay for each covered service. Out-of-network visits are not covered.

If You Enroll in the PPO Dental Benefit, Save Money By Choosing a PPO Dentist

Guardian has multiple dental networks. Ask your dentist if they are on the Guardian Preferred Provider Organization (PPO Plan). Choosing a PPO network dentist will save you money. You can also choose a dentist outside of this network. However, many services may be covered at a lower percentage, so you pay more.

Also ask your dentist about costs before receiving services. You can request a pre-treatment estimate of costs before you receive care.

Find a Network Dentist

You can find a network dentist by going to Guardian's website at www.guardiananytime.com. You'll need to enter your zip code and select which network you are on.

Dental (continued)

2023 Dental Monthly Premiums and Benefits at a Glance

	Managed Dental Care	PPO	
		In-Network	Out-of-Network
Plan Year Deductible			
• Individual	No Deductible	$50	$50
• Family Limit		3/Family	3/Family
• Waived		Preventive	Preventive
Charges covered for you *(coinsurance)*	Network only		
• Preventive Care	You pay a copay for each covered procedures. See "Plan Details" for more information.	100%	100%
• Basic Care		90%	80%
• Major Care		60%	50%
• Orthodontia		50%	50%
Annual Maximum Benefit		$1,500	$1,000
		Combined In-Network and Out of Network maximum of $1000 with an additional $500 of benefit in Network.	
Preventive Services Exempt from Maximum	N/A	Yes	
Maximum Rollover	Maximum Rollover is not applicable for this plan type.	Yes	
• Rollover Threshold		$500	
• Rollover Amount		$250	
• Rollover In-network Amount		$350	
• Rollover Account Limit		$1,000	
Lifetime Orthodontial Maximum	N/A	$1,500	
Office Visit Copay	$0	None	
Dependent Age Limits	26	26	

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Vision

Vision Plan Benefits

Vision Plan Benefits

Eligible employees may use Cafeteria funds or contribute on a pre-tax basis to enroll in vision benefits through Guardian Vision.

Employees and their enrolled dependents may visit either an in-network doctor or out-of-network doctor. To obtain the most value, however, an in-network doctor should be used. To obtain information on doctor's within vision network, you may go to www.guardiananytime.com and select "Find an eye doctor".

Accessing Your Vision Benefits

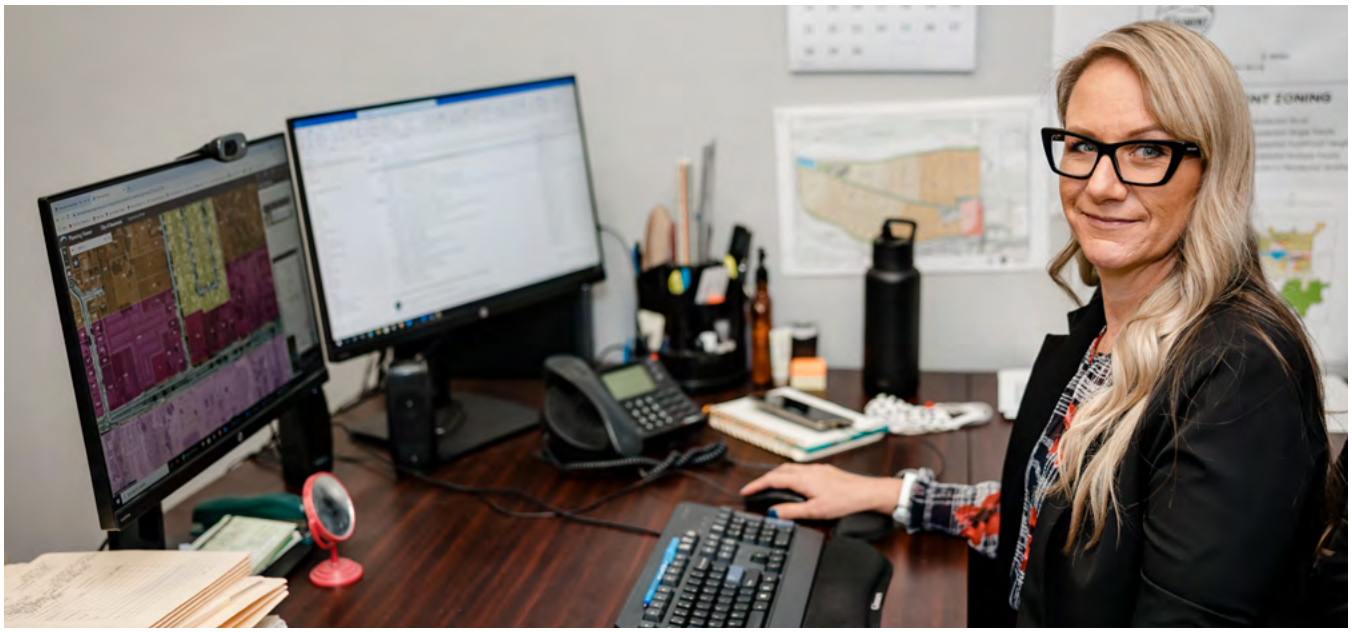
Once enrolled, you will get an ID card. If you lose your ID card or need to print a new one, you may do so by going to www.guardiananytime.com.

Vision Plan Limits and Exclusions

One set of contacts or eyeglass lenses every 12 months. You now have the option to select a new frame every 12 months on the plan up to $130 and additional discounts apply if you stay within the network.

Vision (continued)

	Guardian Vision Plan - VSP Choice Network	
	In-Network	Out-of-Network
Copay		
• Exams Copay	$10	
• Materials Copay	$25	
Sample of Covered Services *(payment listed after copay if applicable)*		
• Eye Exam	$0	Amount over $39
• Single Vision Lenses	$0	Amount over $23
• Lined Bifocal Lenses	$0	Amount over $37
• Lined Trifocal Lenses	$0	Amount over $49
• Lenticular Lenses	$0	Amount over $64
• Frames	80% of amount over $130	Amount over $46
• Contact Lenses *(Elective)*	Amount over $130	Amount over $100
• Contact Lenses *(Medically Necessary)*	$0	Amount over $210
• Contact Lenses *(Evaluation and Fitting)*	15% of UCR	No Discounts
• Cosmetic Extras	Average 20%-25% off retail prices	No Discounts
• Glasses *(Additional pair of frames and lenses)*	20% off retail price	No Discounts
• Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional prices	No Discounts
Service Frequencies		
• Eye Exam	Every 12 Months	
• Contacts or Lenses	Every 12 Months	
• Frames	Every 12 Months	
Dependent Age Limits	26	



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Flexible Spending Accounts (FSAs)

An FSA account is a form of Cafeteria Plan benefit, funded by salary reduction, that reimburses employees for expenses for certain qualified benefits incurred by you, your legal spouse, or qualifying child or relative. Medical expenses of domestic partners cannot be reimbursed under a healthcare FSA according to current IRS regulations. The City's FSAs are administered by American Fidelity.

FSA enrollment is required each year. You must re-enroll in an FSA account every Open Enrollment if you want to continue this benefit for the next plan year. If you do not re-enroll, your FSA will terminate at the end of the plan year. Enrollment in an FSA can be completed through American Fidelity direct enrollment. You must contact American Fidelity at 800.654.8489 to coordinate your enrollment.

If you are enrolled in an FSA and go on a leave of absence, you must contact Human Resources. Taking a leave of absence will affect your FSA contributions and reimbursement period.

Healthcare FSA

A Healthcare FSA can help pay for medical expenses. This includes medical, pharmacy, dental, and vision copayments, other dental and vision care expenses, acupuncture, chiropractic care, hearing aids/batteries, insulin, laser eye surgery, and many other healthcare expenses. If you have a specific injury or trauma, expenses related to massage therapy may be eligible if your medical practitioner provides a letter recommending the treatment for that condition. Expenses for many common household items are also eligible, such as bandages, gauze, and sunscreen (with SPF 15 or higher). Additionally, many over the counter medications are eligible if your physician writes a prescription for the item. Even durable medical equipment such as crutches, walkers, and wheelchairs may be eligible. For a list of eligible expenses, visit https://americanfidelity.com/claims/fsa-hsa-eligibility-list/.

Childcare/Eldercare Dependent Care FSA

A Dependent Care FSA can help pay for qualifying child care and elder care expenses, such as certified children's day care, pre-school, day camp, before/after school programs, as well as adult day care for elders. The dependent care expenses must be incurred in order to enable you (and, if married, your spouse) to work, not merely as an elective choice. Children must be under age 13. For a list of eligible expenses, visit https://americanfidelity.com/claims/dependent-care-account-eligibility-list/.

Click here to watch a video on Flexible Spending Accounts (FSA).

Group Term Life and AD&D

At the City of Beaumont, we believe we should offer our employees the opportunity to provide for their family's future, rather than leave it to chance. The City provides eligible employees a group term life insurance policy through Guardian that includes Accidental Death & Dismemberment (AD&D) coverage. Employees may also supplement this by purchasing additional coverage.

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

	Basic
Employee Benefit	Your employer provides $50,000 Basic Term Life coverage for all full-time employees
Accidental Death and Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage
Spouse/Domestic Partner Benefit	N/A
Child Benefit	N/A
Guarantee Issue	Guarantee Issue coverage up to $50,000 per employee
Premiums	Covered by the City of Beaumont if you meet eligibility requirements
Portability	Yes, with age and other restrictions, including evidence of insurability
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes with restrictions; see certificate of benefits.
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes
Waiver of Premiums: Premiums will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met.
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	50% at age 70, 75% at age 75

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

457 Plan, Voluntary Deferred Compensation Plan & Social Security Alternative

The City of Beaumont utilizes Mutual of Omaha to support retirement planning needs.

All employees may participate in the City's voluntary deferred compensation plan where each employee contributes from their gross wages.

Part-time, temporary and seasonal employees, who are not members of the City's existing retirement system, will be enrolled in the City's social security alternative plan offered through Mutual of Omaha with a minimum required contribution of 6.25%.

Impact Financial Advisors work with small to mid-sized professional and service businesses, their owners, and employees. They aim to help clients position their assets efficiently and effectively to achieve their financial goals and provide confidence while preparing for unforeseen risk.

	Basic
Eligibility Requirements	Employees are immediately eligible to participate in the plan.
Enrollment	Enrollment periods are daily after eligibility requirements are met.
Your contributions	Your contributions and earnings are always 100% yours. You may contribute 1 – 100 percent of your compensation up to the maximum permitted. For 2022 the maximum contribution limit is $20,500. For those 50 years of age and older, you may contribute an additional $6,500 as a catch up contribution.
Investment Options	You may direct your savings into various investment options chosen by your plan. Your company has chosen StoryLine Managed Account Services as your default fund. Learn more about your plans default fund in the available prospectus for this program.
Investment Changes	You may change your investment choices for future contributions or transfer money between funds through the secure website or by calling the interactive voice response system. Please refer to the Additional Resources page for detailed information. Changes made by 4:00 p.m. Eastern Standard Time each day will generally occur on the same business day.
Distribution Events	Some events may include: reaching 59 ½ , retirement, death, disability, and termination of employment. See your plan's Summary Plan Description for a complete list of events.
Loans	Your plan also allows for loans.

Retirement Plan

The City of Beaumont is a member of the California Public Employees' Retirement System.

Classic Members	3% at age 60
New Members	2% at age 62
Safety Police Employees: Classic Members	3% at age 50
Safety Police Employees: New Members	2.7% at age 57

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

RETIREMENT SERVICES

Retirement Plan Account Access

In today's busy world, we understand your time is important. Thanks to our online services, you may access and manage your retirement plan account when it's convenient for you – from home, work or on the go – with these valuable tools.

Participant Website

The information on this site will help you make informed decisions about your retirement savings **AND** your transactions are safe and secure. You may access:

- Account balance information
- Investment election changes*
- Transfers among current funds*
- Deferral percentage changes*
- Loan requests*
- Statements on demand
- Fund performance information
- Distribution requests*
- Retirement planning tools
- Interactive Retirement Outlook calculator

*Available if plan allows

TO ACCESS THE SITE:

- Enter getretirementright.com[/URL] in your browser
- Click on "Sign In"
- Log in with your Username and Password *(If you have not used the website before, click on "Get Started")*

Mobile App

Wherever you are, you'll have access to your account with our mobile app, READY**SAVE**™:

- Available on IOS and Android
- Spanish language option
- Secure biometric login including face ID
- Personalized monthly retirement outlook
- View balance, rate of return, investments, activity, and more

Available to download via the Apple Store or Google Play. Prior to accessing the app, you must register via the website.

Participant Service Center
1-888-917-7191

Use the digital options to make changes to your account at any time, or connect with a service representative, available 8 a.m. – 8 p.m. EST Monday through Friday.

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Mutual of Omaha Retirement Services

457 Plan, Voluntary Deferred Compensation Plan & Social Security Alternative (continued)

GetRetirementRight.com

Investments offered through a group variable annuity contract (Forms 902-GAQC-09, 903-GAQC-14, 903-GAQC-14 FL, 903-GAQC-14 MN, 903-GAQC-14 OR, 903-GAQC-14 TX, or state equivalent) underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, in all states except New York. In New York, Companion Life Insurance Company, Melville, NY 11747 underwrites the group variable annuity (Form 903-GAQC-17NY).

Each company accepts full responsibility for their respective contractual obligations but does not guarantee contributions or investment returns except as to the Guaranteed Account and the Lifetime Guaranteed Income Account (LGIA) as provided under the contract. All guarantees are based on the underwriting company's financial strength and claims paying ability. Restrictions apply. The LGIA is not available in Nevada or New York. Availability may vary by plan. Neither United of Omaha Life Insurance Company, Companion Life Insurance Company, nor their representatives or affiliates offer investment or legal advice in connection with the contract.

Group variable annuities are long-term investment vehicles designed to accumulate tax-deferred money for retirement. Distributions may be subject to ordinary income tax and, if taken prior to age 59½, a 10% federal tax penalty may apply. Investing involves risk, including possible loss of principal.

You should carefully consider investment objectives, risks, fees and expenses prior to selecting investments for your account. This and other important information can be found on your enrollment materials or participant website. Read this information carefully.

Mutual of Omaha Retirement Services is a marketing name for the Retirement Plans Division of Mutual of Omaha Insurance Company.

RETIREMENT SERVICES

BOOST YOUR BALANCE

By Increasing Contributions

Increasing your retirement contributions — even by a small amount — can make a big difference.

Three Easy Ways to Boost Your Balance

Split your raise/bonus with your retirement fund. If you get a 3% raise, increase your 401(k) contribution by 1%. You'll increase your take home pay *and* your retirement savings.

Learn from last year's tax return. If you got a tax refund, make a change so you're paying less in taxes and put that money to work in your retirement account.

Maximize your company match. Make sure you're contributing enough to get all of the match. It's free money.

Small Change, Big Difference

Let's say you earn $40,000 annually with a bi-weekly salary of $1,538.50 before taxes and you contribute 3% of your salary to your 401(k). After 30 years, your total savings would be more than $97,000.*

But check out what happens if you increase your contribution to 6% — your total savings would be nearly $200,000!*

*Assumed 6% growth rate. Contributions and returns rounded to the nearest dollar. The above illustration is hypothetical and for educational purposes only. Your actual results will vary.

As you can see from the following chart, even a small change can make a big difference in the long run.

Total Savings	3% Contribution	6% Contribution
5 years	$6,950	$13,390
10 years	$16,251	$32,502
20 years	$45,353	$90,707
30 years	$97,471	$194,944

Calculator used: https://www.bankrate.com/calculators/savings/compound-savings-calculator-tool.aspx

Three Options to Increase Your Contributions

- Log on to www.getretirementright.com/[Company URL]
- Call a Mutual of Omaha Service Representative at 888-917-7191
- Contact your company's HR Administrator

Scan here to view more retirement education topics.

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
Companion Life Insurance Company
Mutual of Omaha Affiliates

605225

457 Plan, Voluntary Deferred Compensation Plan & Social Security Alternative (continued)

Investment options are offered through a group variable annuity contract (Forms 902-GAQC-09, 903-GAQC-14, 903-GAQC-14 FL, 903-GAQC-14 MN, 903-GAQC-14 OR, 903-GAQC-14 TX, or state equivalent) underwritten by United of Omaha Life Insurance Company for contracts issued in all states except New York. United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175 is licensed nationwide except in New York. Companion Life Insurance Company, Melville, NY 11747 is licensed in New York and underwrites the group variable annuity (Form 903-GAQC-17 NY). Each company accepts full responsibility for each of their respective contractual obligations under the contract but does not guarantee any contributions or investment returns except as to the Guaranteed Account and the Lifetime Guaranteed Income Account as provided under the contract. Specific features of the Lifetime Guaranteed Income Account vary by state. Restrictions apply. The Lifetime Guaranteed Income Account is not available in Nevada or New York. Neither United of Omaha Life Insurance Company, Companion Life Insurance Company, nor their representatives or affiliates offers investment advice in connection with the contract.

Group variable annuities are long-term investment vehicles designed to accumulate money on a tax-deferred basis for retirement purposes. Distributions may be subject to ordinary income tax and, if taken prior to age 59½, a 10% federal tax penalty may apply. Investing in a group variable annuity involves risk, including possible loss of principal.

Mutual of Omaha Retirement Services is a marketing name for the Retirement Plans Division of Mutual of Omaha Insurance Company.

Prior to selecting investment options for your retirement account, you should consider the investment objectives, risks, fees and expenses of each option carefully. For this and other important information, you should review your enrollment materials or the participant website. Read this information carefully.

Save for what matters—your way.

Mutual of Omaha

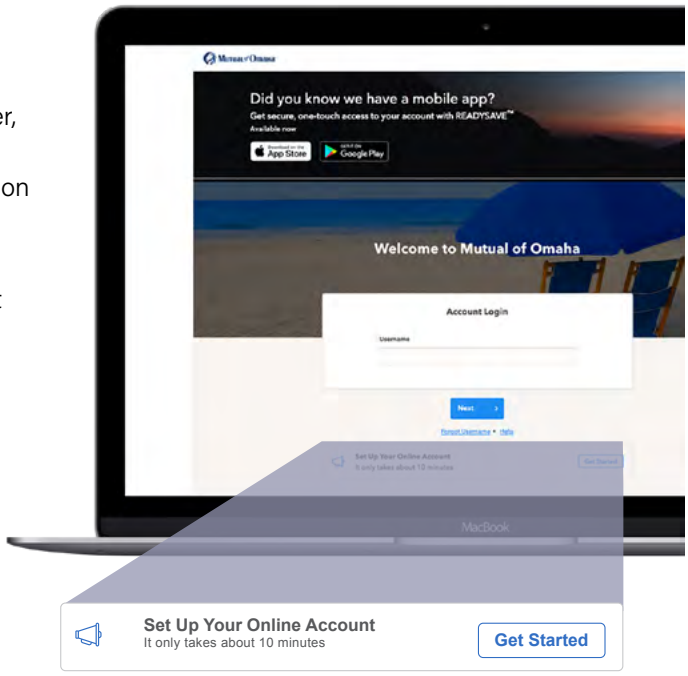
Digital tools make it easy.

Get started from your desktop or mobile browser.

Visit your employee website: **getretirementright.com**

Need to register? Click **Get Started** to gain access to your online account:

1. Verify it's you: Enter your Social Security number, date of birth, and zip code.
2. Create a username and choose a security question to answer if you forget your login details.
3. Confirm your email address.
4. Select a security image and phrase to display at log in. When your image and phrase appear together, you'll know you're on the secure employee website.
5. Create your new password, then click **Submit** to complete your registration.



Once you've registered, log in to:

- Choose your statement delivery preference (default is paperless)
- Enter your beneficiary*
- Opt-in for automatic account rebalancing*

You're all set! Don't forget to visit your employee website—or the READY**SAVE**™ mobile app—at any time to update your savings rate* and manage your investment lineup.

Take smart steps with personalized insights.

Project potential monthly retirement income based on your current savings strategy.

Model different scenarios, such as saving more or changing your expected retirement age, with **Retirement Outlook**. Include outside assets in addition to your retirement plan to see your full financial picture.

Adjust your savings rate at any time to stay on track with your goals and timeline to retirement.

Feel good about your progress.

Track your personal rate of return over time and review your recent contribution activity.

Monitor your fund performance to see how your savings are invested.

Save for what matters—on the go—with READY**SAVE**™

Download the mobile app.

Access your account securely with a single touch.

Manage your account from anywhere: Check your balance, monitor investments, and change your savings rate quickly and easily.

Log in often to see new features and insights.

Available for iOS and Android™. Also available in Spanish.

Download on the App Store

GET IT ON Google Play

The mobile app and website have different functionality—use them both for the best overall experience.

Wherever you are in your retirement journey, you can gain insights along the way that will help you build confidence as you save for your future.

Give us a call
888-917-7191
M-F, 8:00 a.m. – 8:00 p.m. ET

Employee website
getretirementright.com

*Plan features may vary.
Images are for illustrative purposes only.

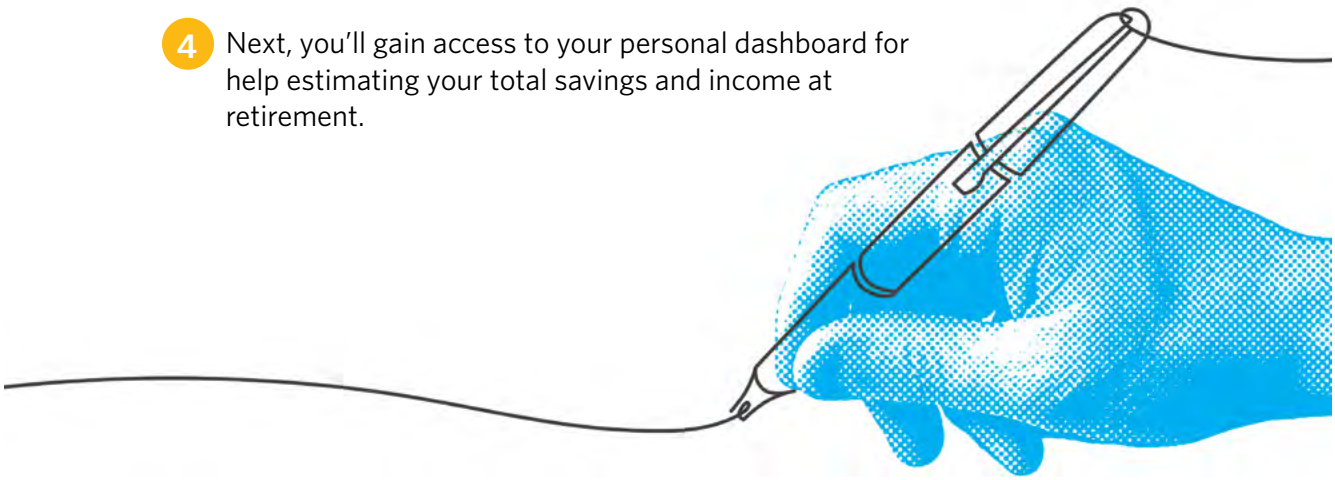
CITY OF BEAUMONT ELIGIBLE 457 PLAN,

Welcome to StoryLine!

Your company has selected StoryLine as an investment option for you.

Once you've enrolled, you may customize your path to retirement by following the simple steps below:

1. Visit stadionstoryline.com/enroll and complete the form using the following enroll code: 813622
2. Once logged in, complete a few short questions to let us know how you feel about investment risk.
3. Your answers generate a risk profile which we use to select the portfolio that's appropriate for you. If you're happy with the result, **ACCEPT & CONFIRM** at the bottom of the page.
4. Next, you'll gain access to your personal dashboard for help estimating your total savings and income at retirement.



stadion retirement

Investments are subject to risk and any of Stadion's strategies may lose value.
SMM-042018-324

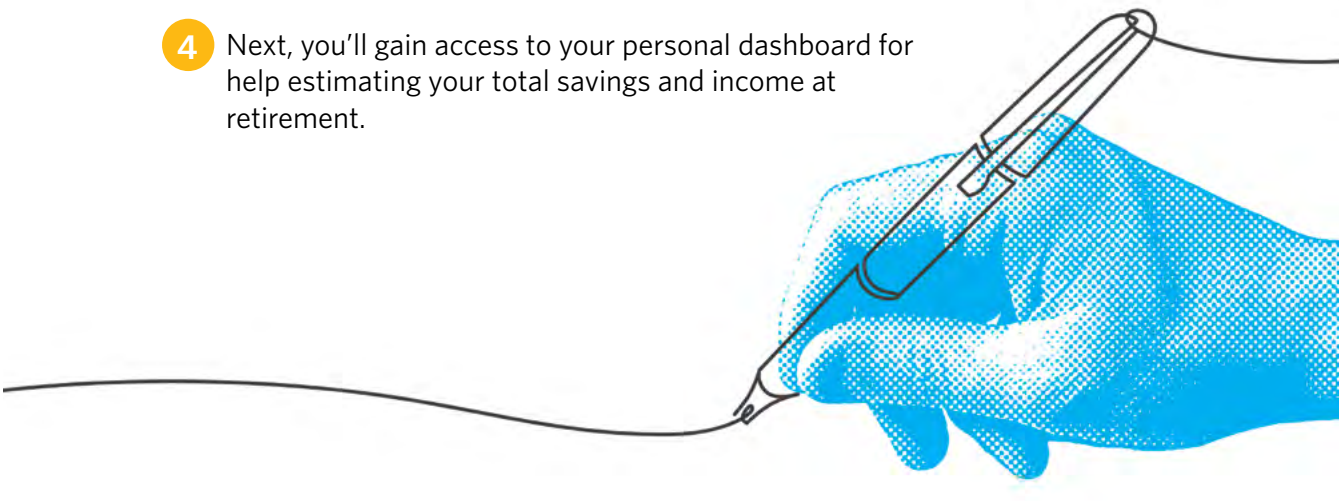
CITY OF BEAUMONT 401(A),

Welcome to StoryLine!

Your company has selected StoryLine as an investment option for you.

Once you've enrolled, you may customize your path to retirement by following the simple steps below:

1. Visit stadionstoryline.com/enroll and complete the form using the following enroll code: 225497
2. Once logged in, complete a few short questions to let us know how you feel about investment risk.
3. Your answers generate a risk profile which we use to select the portfolio that's appropriate for you. If you're happy with the result, **ACCEPT & CONFIRM** at the bottom of the page.
4. Next, you'll gain access to your personal dashboard for help estimating your total savings and income at retirement.



stadion retirement

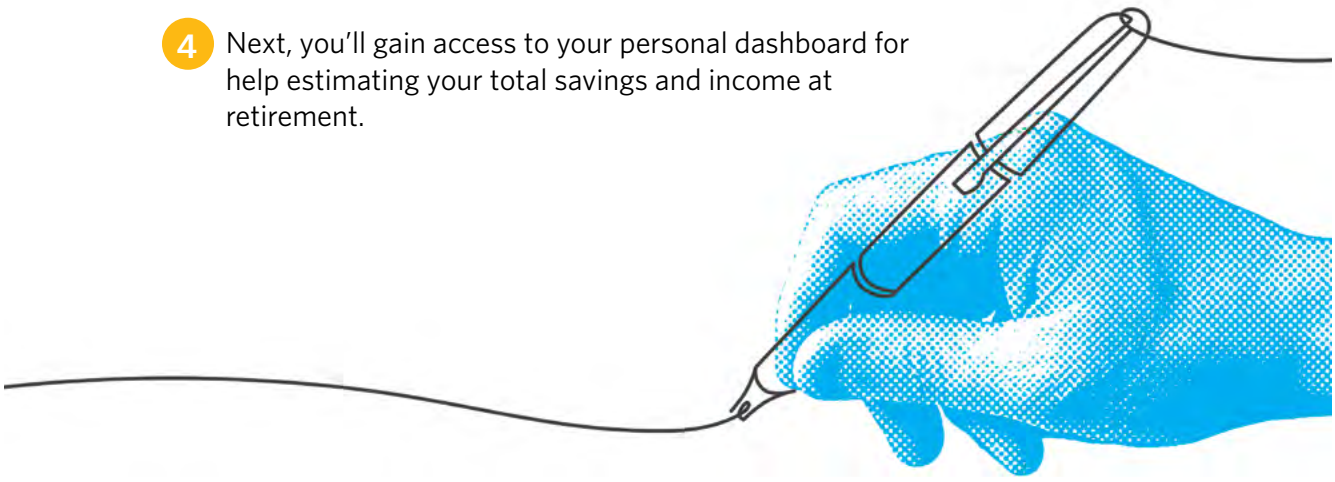
CITY OF BEAUMONT 457 FICA ALTERNATIVE RET PL,

Welcome to StoryLine!

Your company has selected StoryLine as an investment option for you.

Once you've enrolled, you may customize your path to retirement by following the simple steps below:

1. Visit stadionstoryline.com/enroll and complete the form using the following enroll code: 283085
2. Once logged in, complete a few short questions to let us know how you feel about investment risk.
3. Your answers generate a risk profile which we use to select the portfolio that's appropriate for you. If you're happy with the result, **ACCEPT & CONFIRM** at the bottom of the page.
4. Next, you'll gain access to your personal dashboard for help estimating your total savings and income at retirement.



stadion retirement

Investments are subject to risk and any of Stadion's strategies may lose value.
SMM-042018-324

Short Term Disability

The City of Beaumont does not contribute to State Disability Insurance and offers full time employee's Short Term Disability Insurance coverage through Guardian. This plan is paid for by the City of Beaumont.

Guardian®

Watch our video
How short term disability insurance can supplement your income.

Short term disability insurance

Disability insurance covers a part of your income, so you can pay your bills if you're injured or sick and can't work.

Disability may be more common than you might realize, and people can be unable to work for all sorts of different reasons. There are times when many disabilities can be caused by Illness, including common conditions like heart disease and arthritis. However, many disabilities aren't covered by workers' compensation.

Who is it for?

If you rely on your income to pay for everyday expenses, then you should probably consider disability insurance. It helps ensure that you'll receive a partial income if you're injured or too sick to work.

What does it cover?

Many disability insurance plans pay out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

Why should I consider it?

Accidents happen, and you can't always anticipate if or when you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills in the event of being unable to collect your normal paycheck.

You will receive these benefits if you meet the conditions listed in the policy.

Partial income replacement

Mike injures his back in a bicycle accident and can't work for 13 weeks.

Unpaid time off work: **13 weeks**

Elimination period: **1 week**

After a 1-week elimination period following his accident, Mike's Guardian Short Term Disability policy kicks in and replaces **$400** of his weekly income for the remaining **12 weeks** of his rehabilitation.

This gives him a total of **$4,800** to cover his expenses while he's unable to work.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

CITY OF BEAUMONT
ALL ELIGIBLE FULL-TIME EMPLOYEES
2021-117408 (03/23)

Kit created 11/09/2022
Group number: 00412430

19

Guardian®

Your short term disability coverage

	Short-Term Disability
Coverage amount	60% of salary to maximum $3000/week
Maximum payment period: Maximum length of time you can receive disability benefits.	104 weeks
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 15
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 15
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue $3000 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months look back; 12 months after 26 week limitation

UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

- **Earnings definition:** Your covered salary excludes bonuses and commissions.

CITY OF BEAUMONT
ALL ELIGIBLE FULL-TIME EMPLOYEES

Kit created 11/09/2022
Group number: 00412430

Guardian®

Your short term disability coverage

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of Insurability may be required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.
- You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
- For Short-Term Disability coverage, benefits for a disability caused or contributed to by a pre-existing condition are limited, unless the disability starts after you have been insured under this plan for a specified period of time. We do not pay short term disability benefits for any job-related or on-the-job injury, or conditions for which Workers' Compensation benefits are payable.
- We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability.
- This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department.
- If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA, DC PFML and WA PFML.

Contract # GP-1-STD-15-1.0 et al.

Guardian's Group Short Term Disability Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Plan documents are the final arbiter of coverage.
Policy Form #GP-1-STD07-1.0, et al, GP-1-STD-15

CITY OF BEAUMONT
ALL ELIGIBLE FULL-TIME EMPLOYEES

Kit created 11/09/2022
Group number: 00412430

Employee Assistance Programs

The City of Beaumont values the health and wellness of employees and offers several options for employee assistance.

Guardian®

Employee Assistance Program Overview

Our comprehensive WorkLifeMatters Employee Assistance Program[1], available through Integrated Behavioral Health, provides you and your family members with confidential, personal and web-based support on a wide variety of important and relevant topics — such as stress management, dependent/elder care, nutrition, fitness, and legal and financial issues.

Employee assistance program (EAP) consultative services

- **Telephonic Counseling** — Unlimited, 24/7 consultations with master's and doctoral-level counselors
- **Face-to-face Counseling** — Up to 3 visits per employee/household member per year
- **Bereavement** — Support available through telephonic or face-to-face sessions; online resources available on EAP website
- **Tobacco Cessation Coaching** — Unlimited telephonic support and resources to assist with tobacco cessation; refers members directly to the American Lung Association's Quit program
- **EAP Website Resources** — Comprehensive website that includes articles, videos, FAQs, etc.; additionally, individuals can chat online with an EAP Consultant or email an EAP Counselor through the website
- **College Planning Resources** — Expert assistance in finding the right college that fits your child academically, socially and financially, provided by College Planning USA

Work/life assistance & resources

- **WorkLife Services** — Unlimited 24/7 access to WorkLife Specialists (subject matter experts) in the areas of: family and care giving, health and wellness, emotional well-being, daily living, and balancing work/life responsibilities
- **Child and Elder Care Referral** — Unlimited telephonic consultation with a WorkLife Specialist (part of WorkLife Services)
- **Employee Discounts** — Access to discounts on a large number of products and services, from gym memberships to dental, vision and pharmacy items, entertainment, restaurants, computers, cars, and much more
- **Webinars, Podcasts, Articles and FAQs** — Various topics available on the EAP website

Legal/financial assistance & resources

- **Legal Consultation** — Unlimited telephonic support and free initial 30-minute face-to-face consultation with an attorney, includes a 25% discount on attorney services thereafter; online legal forms; extensive online law library
- **Financial Consultation** — Unlimited telephonic support for financial problems or planning needs; 30 days of financial coaching; extensive online financial library and calculators
- **ID Theft** — Free consultation with a trained Fraud Resolution Specialist that will assist with ID theft resolution and education; ID theft educational materials available online
- **Will Prep** — Online self-service documents available on EAP website; 30-minute consultation (part of Legal Consultation offering) can be used for estate planning/will preparation
- **Legal Document Preparation** — Online self-service documents available on the EAP website
- **Tax Consultation** — Tax questions only can be answered as part of the Financial Consultation offering
- **Online Self-Service Documents** — Examples include, but are not limited to: Living Trust, Will, Power of Attorney, Deeds

lbhworklife.com

User Name: WorkLife
Password: 70101
Phone: 1-800-386-7055
Available 24 hours a day, 7 days a week[2]

The Guardian Life Insurance Company of America

guardianlife.com

New York, NY

2020-113075 (12/22)

[1] WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer. WorkLifeMatters Program is not an insurance benefit and may not be available in all states.
[2] Office hours: Monday-Friday 6 a.m.–5 p.m. PST. GUARDIAN® and the GUARDIAN G® logo are registered service marks of The Guardian Life Insurance Company of America® and are used with express permission.

Your life's journey—made easier

No matter where you are on your journey, there are times when a little help can go a long way toward achieving your goals. From checking off daily tasks to working on more complex issues, your program offers a variety of services, resources and tools to help make your life a little easier.

Key features

- Provided at no cost to you and your household members
- Includes up to 3 counseling sessions
- Completely confidential service provided by a third party

Counseling

Access a nationwide network of licensed counselors for support with challenges such as stress, anxiety, grief, substance misuse, relationships, parenting and more. Counseling is confidential and available in-person, by text message, live chat, phone or video conference.

Lifestyle coaching

Define and reach your goals with the support of a coach. Coaches can help with personal improvement, healthy eating, weight loss and more. Coaches are available by phone or video.

Digital emotional wellness tools

Take advantage of proven programs to help manage anxiety, stress, depression, pain, sleep, substance misuse or recovery and more. Personalized and interactive with self-directed activities, uplifting stories, videos and daily inspiration help you live your best life.

LifeMart® discount center

Save money on nationally recognized brand-name products and services, all in one convenient location.

Work-Life Services

Save time and money on life's most important needs. Specialists provide expert guidance and personalized referrals to service providers including childcare, adult care, education, home improvement and more. The website includes webinars, live talks and articles focused on key life events and day-to-day challenges.

Financial wellness, Legal services and Identity theft resolution

Meet with experts that can help you take control of your finances, resolve legal issues such as estate planning and family law, restore credit; research specific topics and/or print your own state-specific legal forms.

Member website

Learn more about the services and resources available through your program. The member website makes it easy for you to explore services, find providers, learn more about emotional health and wellness topics, see what mobile apps are available and more.

Get started today! Call your Employee Assistance Program at 1-800-368-7426 (TTY 711) to be connected with the right resource or professional or visit MagellanAscend.com to browse all of the services available.

Employee Assistance Programs (continued)

SERVICES PROVIDED BY

THE COUNSELING TEAM INTERNATIONAL

BEHAVIORAL HEALTH AND WELLNESS SERVICES

Counseling services provide professional and confidential assistance. Under a contract with your agency, TCTI provides this service at no cost or co-pay to employees and their eligible family members. Counseling services are available in-house or 24/7/365 via telephone. Some of the most common issues discussed are related to marriage, family and interpersonal relationships, depression, stress management, anger management, alcohol/substance abuse and grief/bereavement, including many others.

TRAINING AND EMPLOYEE DEVELOPMENT

TCTI provides a wide variety of training classes that can serve as a proactive measure and follow-up tool for any department or agency within the field of public safety. TCTI's classes will provide participants with the skills and information necessary to maximize their ability to function as a team and to continue developing their careers. Classes can be tailored to fit your agency's specific needs and time restrictions.

PEER SUPPORT PROGRAM DEVELOPMENT AND CONSULTATION SERVICES

TCTI provides assistance to departments and agencies looking to start their own Peer Support team. Valuable informational material is provided and TCTI will assign a Peer Support Coordinator to provide consultation support and assistance with the interview process of new Peer Supporters. Training classes are also available for those becoming a Peer Supporter and current Peer Supporters who need advanced/refresher training.

For more information, please contact us at:
(800) 222-9691 or www.thecounselingteam.com

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The Counseling Team International. 30 Years Dedicated to Serving Those Who Serve.

SERVICES PROVIDED BY

THE COUNSELING TEAM INTERNATIONAL

CRITICAL INCIDENT STRESS MANAGEMENT/STAND-BY-STATUS

TCTI specializes in critical incident stress management, particularly as it applies to trauma. Mental health professionals are available on-call 24/7/365 and our services range from phone consultations to on-site debriefing and counseling services. We are always available for consultation and support, and are currently used by various agencies for a variety of critical incident situations.

HOSTAGE NEGOTIATOR CRISIS SUPPORT

TCTI provides specialized crisis support services for hostage/crisis negotiators due to the high levels of stress they experience, both during and after situations of hostage or crisis negotiations. TCTI's mental health professionals are trained crisis negotiators and can be a resource to the on-site negotiators, as well as provide the support needed to help them effectively manage the stress of these traumatic events.

PRE-HIRE PSYCHOLOGICAL TESTING

TCTI provides psychological testing services for those entering the field of public safety. This testing process involves written examinations and a psychological screening completed by a licensed clinical psychologist. It is meant to assess the emotional stability of candidates to determine if they are suitable for the job. This process meets POST standards.

ORGANIZATIONAL DEVELOPMENT

TCTI partners with "The Organizational Network", a team that specializes in creating organizations that bring out the best in their employees. Customized interventions are designed to achieve desired results, and services that include job matching, strategic planning, customer service, and conflict resolution are available.

PEER SUPPORT/SUPERVISOR COACH APP
NOW AVAILABLE FOR DOWNLOAD!

Download on the App Store

ANDROID APP ON Google play

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Accident and Cancer Insurance

Employees may elect group Accident Insurance and/or Cancer Insurance through American Fidelity. Election of these insurance plans can be made through American Fidelity. You must schedule an appointment to meet with American Fidelity and enroll.

When enrolling, American Fidelity will identify pre-tax and post-tax elements of your premium. Cafeteria Plan contributions may be used to pay for only the pre-tax portion of your premium. The post-tax premium will need to be paid via payroll deduction.

Accident Insurance

American Fidelity Accident Insurance is designed to help cover some of the expenses that can result from a covered accident. The plan includes three levels of coverage that may be elected; Basic, Enhanced, and Enhanced Plus. Benefits are paid on accident-related expenses such as emergency treatment, non-emergency treatment, hospital admissions and in-patient stays, medical imaging, ambulance and transportation costs, and family member lodging and meals. Additionally, there are a number of specific types of medical treatment for which benefits may be paid on expenses.

Cancer Insurance

American Fidelity Cancer Insurance is designed to help ease the impact on your finances if you or a family member unexpectedly faces a cancer diagnosis. You may elect from an individual, single parent family plan, or family plan. Additionally, plans include three levels of coverage that may be elected; Basic, Enhanced, and Enhanced Plus. Benefits are paid on cancer-related expenses such as diagnostic screening and prevention, medical treatment, imaging, and laboratory costs, hospital admissions and in-patients stays, pharmacy costs, ambulance and transportation costs, surgical costs, second and third opinion costs, and other continuing costs beyond treatment.

Critical Illness

The City of Beaumont, provides health benefits through an employee benefit association that offers critical illness insurance at no cost to eligible employees and their dependents enrolled in a City medical plan.

GROUP CRITICAL ILLNESS INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

In the US, an estimated 40 out of 100 men and 39 out of 100 women will develop cancer during their lifetime.[1]

Fire Districts Association of California Employment Benefits Authority

Facing a serious illness can be challenging both emotionally and financially. Major medical insurance may pick up most of the tab, but can still leave out-of-pocket expenses that add up quickly. Critical Illness insurance can provide a lump-sum benefit upon diagnosis of a covered illness that can be used however you choose - from expenses related to treatment, to deductibles or day-to-day costs of living such as the mortgage or your utility bills.

To learn more about Critical Illness insurance, visit
www.thehartford.com/employee-benefits/employees

COVERAGE INFORMATION

Benefit amounts for covered illnesses are based on the coverage amount in effect for you or an insured dependent at the time of diagnosis.

BENEFITS & FEATURES

COVERAGE AMOUNTS	
Employee Coverage Amount	$5,000
Child(ren) Coverage Amount	25% of the employee coverage amount
COVERED ILLNESSES	**BENEFIT AMOUNTS**
CANCER CONDITIONS	
Invasive Cancer*	100% of coverage amount
Non-invasive Cancer	25% of coverage amount
VASCULAR CONDITIONS	
Heart Attack* (Myocardial Infarction); Heart Failure/Transplant*; Stroke*	100% of coverage amount
Coronary Artery Bypass Graft	25% of coverage amount
OTHER SPECIFIED CONDITIONS	
End Stage Renal Failure; Major Organ Failure/Transplant*; Paralysis	100% of coverage amount
ADDITIONAL BENEFITS	**BENEFIT AMOUNTS**
Recurrence – Pays a benefit for a subsequent diagnosis of conditions marked with an asterisk (*)	50% of original benefit amount
FEATURES	**DETAILS**
Coverage Maximum – Primary Insured	500% of coverage amount
Ability Assist® EAP[2]– 24/7/365 access to help for financial, legal or emotional issues	
HealthChampion[SM3] – Administrative and clinical support following serious illness or injury	

PREMIUMS

Your employer pays 100% of the premium for your (employee) and your dependents' coverage.[4]

ASKED & ANSWERED

WHO IS ELIGIBLE?
You are eligible for this insurance if you are enrolled in an FDAC EBA group health insurance plan.

Your child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

AM I GUARANTEED COVERAGE?
This insurance is guaranteed issue coverage – it is available without having to provide information about your or your family's health.[5]

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?
Your employer pays 100% of the premium for your (employee) and your dependents' coverage.

WHEN CAN I ENROLL?
Your employer will automatically enroll you and your dependent(s) for this coverage.

WHEN DOES THIS INSURANCE BEGIN?
This insurance will become effective for you and your dependent child(ren) on the effective date for your FDAC EBA group health insurance plan.

You must be actively at work with your employer on the day your coverage takes effect. Your child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

WHEN DOES THIS INSURANCE END?
This insurance will end when you or your dependent(s) no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?
Yes, you can take this coverage with you. Coverage may be continued for you and your dependent(s) under a group portability policy. The specific terms and qualifying events for conversion and portability are described in the certificate.

[1]Cancer Facts and Figures, 2020. American Cancer Society: https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2020/cancer-facts-and-figures-2020.pdf, as viewed on October 14, 2020.

[3]AbilityAssist® services are offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right

[4] HealthChampion℠ services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue these services at any time. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information. HealthChampion℠ specialists are only available during business hours. Inquiries outside of this timeframe can either request a call-back the next day or schedule an appointment.

[4]Rates and/or benefits may be changed on a class basis. Rates are based on the age of the insured person and increase on your birthday as you enter each new age category.

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5962f NS 05/21

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP CRITICAL ILLNESS INSURANCE

LIMITATIONS AND EXCLUSIONS

The benefits payable are based on the insurance in effect on the date of the diagnosis of a covered illness, subject to the definitions, limitations, exclusions and other provisions of the policy.

You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

Benefit Separation Periods. If a covered person is diagnosed with a covered illness, and is subsequently diagnosed with another covered illness, the following separation periods apply between benefit payments. If the subsequent diagnosis is for: 1) A different, non-related covered illness than the first diagnosis (e.g. a cancer illness then a vascular illness), then a 3 month separation period applies; 2) A covered illness that is related to the first (e.g. two vascular illnesses, like heart attack and stroke), then a 6 month separation period applies; 3) The same covered illness as the first (e.g. two heart attacks) as allowed by the Recurrence Benefit, then a 12 month separation period applies.

Exclusions. This insurance does not provide benefits for any loss that results from or is caused by:

- Suicide, attempted suicide or intentionally self-inflicted injury, whether sane or insane
- War or act of war, declared or undeclared
- A covered person's participation in a felony, riot or insurrection
- A covered person's engaging in any illegal occupation
- A covered person's service in the armed forces or units auxiliary to them

General Limitations. Benefits under the policy are not payable for any covered illness:

- Diagnosed prior to the effective date of insurance for a covered person (except for newborn children)
- Diagnosed during an applicable benefit separation period
- For which a covered person has already received a benefit payment under the policy, unless the covered illness is included in a recurrence provision
- For which a covered person has already received a benefit payment under the recurrence provision

In addition, benefits are not payable for any critical illness not included as a covered illness in your certificate.

NOTICES

THIS POLICY PROVIDES LIMITED BENEFITS FOR SPECIFIED DISEASES ONLY.

This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage. In New York: This policy provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

Please note: For residents of CA, GA, NJ and NY, since this is a limited benefit health product, persons without comprehensive health benefits from an individual or group health insurance policy or an HMO, or an employer plan providing essential health benefits are not eligible for this insurance. In addition, NY residents covered by another Critical Illness or specified disease plan are not eligible for coverage. For residents of CT, ID, ME, NH, and WV, a person covered by any Title XIX program (Medicaid or any similar name) is not eligible for this insurance.

5962f NS 05/21 Critical Illness Form Series includes GBD-2600, GBD-2700, or state equivalent.

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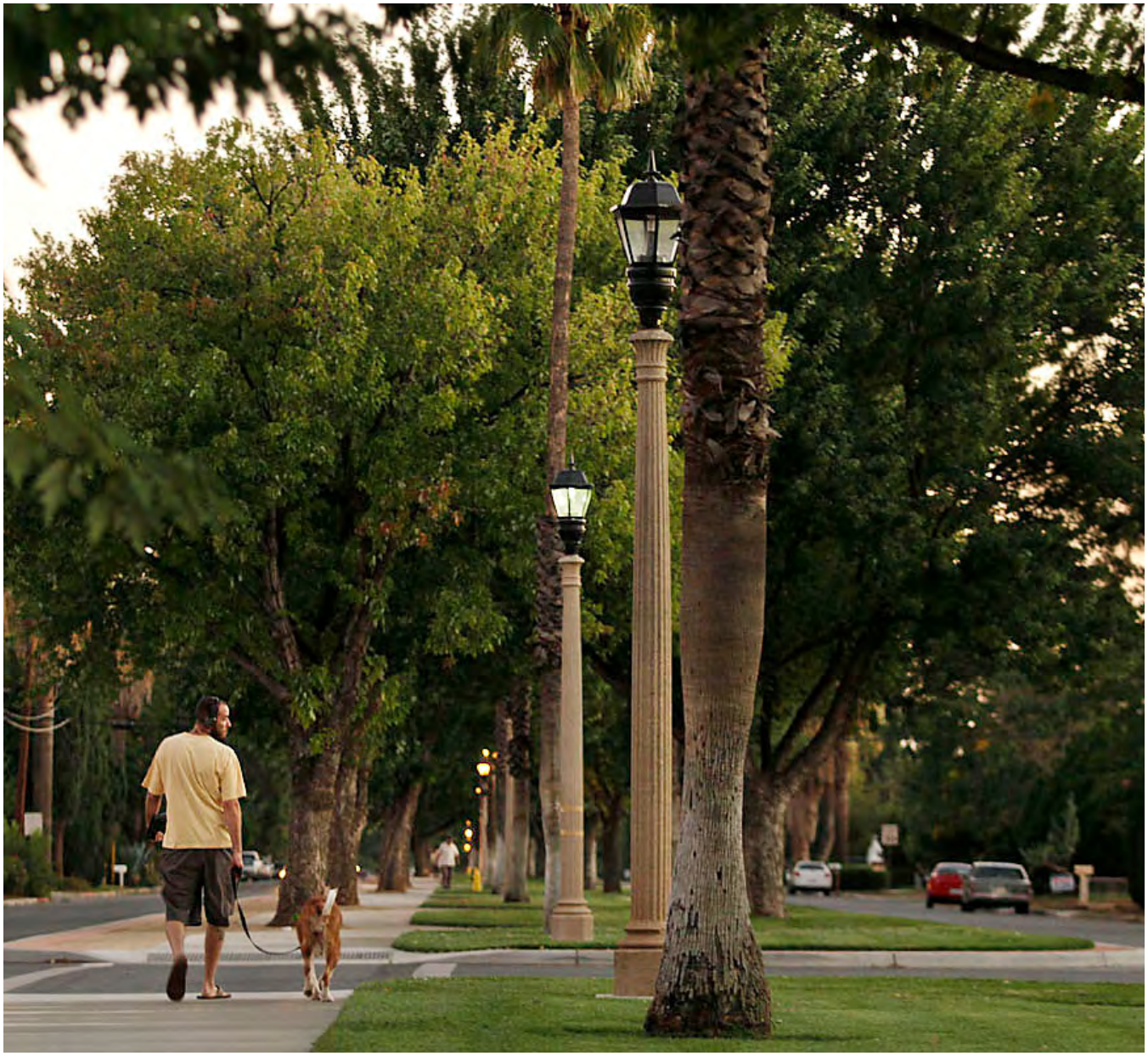
Wellness Reimbursement

A permanent full-time employee shall be eligible for reimbursement of eligible expenses up to but not exceeding fifty dollars ($50) for each full month the employee has been employed. Eligible expenses shall be: health/fitness club dues, purchase of pre-approved exercise/fitness equipment, chiropractic services, weight loss/management programs (including specialty supplements directly related to the program), and fitness-related classes (such as yoga or sports which may be offered through a community/recreation center).

It will be the responsibility of the employee to submit requests for reimbursement to the Human Resources department in order to receive reimbursement. The City shall pay this reimbursement quarterly under the City reimbursement policy.

Each participating employee is solely liable and responsible for any and all personal injuries, and shall fully indemnify the City. The City assumes no liability for injury or compensation for employee participation in this program, nor is this a mandated program or a job requirement.



2023 Payroll & Holiday Calendar

January

2 - New Year's Day Observed

16 - Martin Luther King Jr. Day

February

20 - President's Day

May

29 - Memorial Day

July

4 - Independence Day

September

4 - Labor Day

October

9 - Indigenous People Day

November

10 - Veteran's Day

23 - Thanksgiving Day

24 - Friday After Thanksgiving

December

22 - Christmas Eve Observed

25 - Christmas Day Observed

29 - New Year's Eve Observed

JANUARY

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FEBRUARY

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NOVEMBER

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DECEMBER

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Pay Period End

Pay Period End & Holiday

Pay Day

Pay Day & Holiday

Holiday

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 certain 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.

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 951.769.8528.

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, www.blueshieldca.com or www.kp.org..

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, www.blueshieldca.com or www.kp.org.

Networks/Claims/Appeals

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

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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.

Important Notices (continued)

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

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

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

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

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

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

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

Important Notices (continued)

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

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

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

Important Notices (continued)

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 Government Plans/District Hospitals] 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 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 considered to be made on the date it is sent to the Plan or Plan Administrator.

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

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

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

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

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 for eligibility for such assistance.

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

For information about Special Enrollment Rights, please contact:

Human Resources

HR@Beaumontca.gov

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

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

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

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

Important Notices (continued)

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

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

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

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

You should also know that if you drop or lose your current coverage with City Of Beaumont and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

REMEMBER

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January, 2023
Name of Entity / Sender:	City of Beaumont
Contact:	Human Resources Department
Address:	550 E. 6th Street Beaumont, California 92223
Phone:	951.769.8528

Important Notices (continued)

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

City Of Beaumont 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 HR@beaumontca.gov

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California will begin November 1, 2022, and is anticipated to end on January 31, 2023. Open Enrollment for most other states will begin on November 1 and close on January 15 of each year. Some states have expanded the open enrollment period beyond January 15, 2023 for coverage to begin in 2023. Notably, Covered California continues its special enrollment periods for coverage beginning in 2023.

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 9.12% (for 2023) of your household income for the year, then that coverage is not Affordable. 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 a 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.

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 Beaumont	**4. Employer Identification Number (EIN)** 95-6000676	
5. Employer address 550 E. 6th Street	**6. Employer phone number** 951.769.8528	
7. City Beaumont	**8. State** CA	**9. ZIP code** 92223
10. Who can we contact about employee health coverage at this job? Human Resources Department		
11. Phone number (if different from above)	**12. Email address:** **HR@Beaumontca.gov**	

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

Important Notices (continued)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility.

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

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

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

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

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

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

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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800-457-4584

Important Notices (continued)

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

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

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

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

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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840
TTY: 617-886-8102

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

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

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

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

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

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

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

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

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

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844-854-4825

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

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

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462

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

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

Important Notices (continued)

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

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800-440-0493

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

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp/
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

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

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

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

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

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, 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. 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 will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

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

Plan Year

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

Preferred Provider

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

Premium

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

Preventive Care

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

Qualifying Life Event

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

Skilled Nursing Care

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

Urgent Care

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

Click here to watch a video on Benefits Key Terms Explained.