2025 Open Enrollment Benefits Guide

Inside the Guide

Your out-of-pocket contributions for medical, dental, and vision are deducted pre-tax through the City's Premium Only Plan, (POP) if you have dependent coverage. This allows you to lower your taxable income and results in paying less taxes! You are automatically included in this plan unless you sign a waiver form to not participate. If you experience a qualifying event during the year and notify Human Resources within 31-days of the event, your contributions will be automatically adjusted based upon your qualifying event. If you do not inform Human Resources within the 31-day window, you will need to wait until the following annual open enrollment period to adjust your contributions.

A Message from Human Resources at City of Rancho Palos Verdes

City of Rancho Palos Verdes recognizes each employee is our most valuable asset; therefore, we place great importance on the health of you and your family. In our continued effort to promote your well-being, we extend an opportunity for you to participate in our benefits program. This enrollment guide briefly highlights the benefits offered. If you would like more information about any of the benefits described in this guide, please contact the Human Resources Department at (310) 544-5327 or email: humanresources@rpvca.gov.

Summary of Benefits and Changes for 2025

Medical Plans	**Blue Shield & Kaiser: GLP-1 drugs** guidelines will require members to have co-morbidities and other factors for approval for GLP-1 drugs. **Blue Shield Gold Full PPO** Out-of-Packet Maximum will be decreasing; specialist visit copay will be increasing, outpatient diagnostic lab/imaging/pathology services performed at a center or outpatient hospital dept. will be subject to the calendar year deductible; and the pharmacy deductible will be increasing – only applicable for Tiers 2 and 3 drugs. **Blue Shield Silver Savings PPO/HSA** Family per individual deductible is increasing. **Blue Shield (Access+ & Trio) HMOs:** Specialty visits, copays for outpatient diagnostic lab/imaging/pathology services performed at a lab center and outpatient hospital will be increasing. **All Blue Shield Pharmacy plans:** Mail order drug vendor changing from CVS Caremark to Amazon Home Delivery. **All Blue Shield Pharmacy Plans:** To encourage the use of generic and biosimilar drugs, a member must pay the cost difference between the brand drug and its generic equivalent or biosimilar drug plus the applicable copay of the brand drug when member or provider requests the brand drug.
Vision Service Plan	**Frame Allowance increasing to $200 from $160, Elective Contact Allowance increasing to $160 from $150, and VSP retail stores, Visionworks, opened in Culver City and Bell Gardens.**
Hartford: Basic Life/AD&D & Voluntary Life/AD&D and Long Term Disability	
Additional Programs Adopted by the City:	
Health Savings Account (HSA) paired with Blue Shield of CA Silver Savings Full PPO – ***2025 contributions pending.***	
WEX Flexible Spending Accounts – **2025 Limits: Healthcare FSA $3,300; carryover $660**	
Section 125 Plan (POP), AFLAC Plans, Legal Access Plan, Nationwide Pet Insurance, and ScholarShare will continue to be offered.	

Eligibility

Eligible Employees:

If you are a Full-Time employee and Full-Time Equivalent employee defined as working at least 30 hours per week then you are eligible for the City's benefits.

Eligible Dependents:

If you are eligible for our benefits then your dependents are too! In general, eligible dependents include spouse/ same and opposite sex registered domestic partner, and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided.

When Coverage Begins:

Newly hired employees and dependents benefits will be effective on the first of the month following their date of hire. Outside of the initial eligibility period, the City's annual open enrollment period will take place in October/November with coverages effective January 1st.

Qualifying Life Events:

The choices you make during your initial eligibility period and annual open enrollment period will be in place until the NEXT open enrollment period. You cannot change coverage for yourself or add or drop dependents during the year unless you have a qualifying life event. A qualifying event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some qualifying events include:

- Change of legal marital status (i.e. marriage, divorce, dissolution of the registered domestic partnership, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 31-days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 31-days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact Human Resources to make these changes.

HMO Medical Plans*

City of Rancho Palos Verdes will continue to offer medical coverage through Blue Shield of California and Kaiser. The benefit summaries on the following pages are a brief outline of what is offered. Please refer to the evidence of coverage document for complete plan details.

Blue Shield Trio HMO (Platinum Trio HMO 0/20*):

The Blue Shield Trio HMO plan is an innovation as a result of the Affordable Care Act (ACA): It is an accountable care organization (ACO). In an ACO, the focus is on you. Blue Shield works with a network of doctors, hospitals, and Blue Shield who share responsibility for coordinating care for you and your family. Members access Shield Concierge, a team of experts and dedicated customer service representatives who can assist in all aspects of your medical care. You will need to select a primary care physician from the Trio HMO network who will coordinate your medical care including referrals. You can change your physician on a monthly basis by contacting Shield Concierge. Effective January 1, 2025, the Specialist office visit is **increasing to $45** from $40; copay for diagnostic testing for pap at certain facilities is **increasing to $20** from $10 and for diagnostic testing for mammography and all other diagnostic testing is **increasing to $40** from $30.

Blue Shield Access+ HMO (Platinum Access+ HMO 0/20*):

The Blue Shield Access+ HMO plan consists of Blue Shield's full HMO network. You will need to select a primary care physician from the Access+ HMO network. Your physician will coordinate your medical care needs. You can change the physician on a monthly basis by calling member services. **Effective January 1, 2025, the same copay changes in the Trio HMO plan will apply to the Platinum Access+ HMO plan.**

Kaiser HMO (Platinum HMO 90-0/20*):

Kaiser HMO is a staff model HMO plan which means they own their facilities and the providers are salaried employees of Kaiser. You must use Kaiser physicians, hospitals, and other approved health care providers unless you experience a life-threatening situation.

***Note on HMO's**: Due to the HMO physician network service area, these plans are only available to residents within the HMO and DHMO service areas in California.

HMO Medical Comparison

Copay amounts shown indicate member's responsibility.	Blue Shield of California Platinum Trio HMO 0/20		Blue Shield of California Platinum Access+ HMO 0/20	Kaiser Platinum 90 HMO 0/20
Preventive Care	No charge		No charge	No charge
Primary Physician Visit	$20 copay/visit		$20 copay/visit	$20 copay/visit
Specialty Care	**$45 copay/visit**		**$45 copay/visit**	$30 copay/visit
Teladoc	No charge		No charge	No charge
Lab Tests and X-rays	**$20 copay (lab); $40 copay (X-ray)**		**$20 copay (lab); $40 copay (X-ray)**	$20 copay (Lab); $30 copay (X-ray)
Complex Radiology	$30 copay/scan		$30 copay/scan	$100 copay/scan
Urgent Care Facility	$20 copay		$20 copay	$20 copay
Emergency Room Facility	$200 copay; waivied if admitted		$200 copay; waived if admitted	$150 copay; waived if admitted
Impatient Facility	$500/admit.		$500/admit.	$250/day up to 5 days/admit.
Outpatient & Surgical Facility	Ambulatory Surgery Ctr: $100 copay; OP Hospital: $150 copay		Ambulatory Surgery Ctr: $100 copay; OP Hospital: $150 copay	$125 copay/procedure
Vasectomy	No Charge		No Charge	No Charge
Chiropractic	$15 copay; 20 visits per year		$15 copay; 20 visits per year	$20 copay; 20 visits per year
Retail Pharmacy (30 Day Supply)				
Pharmacy Level	Level A	Level B	Not Applicable	Not Applicable
Generic (Tier 1)	$5 copay	$10 copay	$5 copay	$5
Preferred (Tier 2)	$15 copay	$30 copay	$15 copay	$20
Non-Preferred (Tier 3)	$25 copay	$45 copay	$25 copay	$20
Preferred Specialty (Tier 4)	20% up to $250/Rx	20% up to $250/Rx	20% up to $250/Rx	10% up to $250/Rx
Mail Order Pharmacy (90 Day Supply) – Amazon Home Delivery for Blue Shield plans effective 1/1/2025				
Generic (Tier 1)	$10 copay		$10 copay	$10 copay
Preferred (Tier 2)	$30 copay		$30 copay	$40 copay
Non-Preferred (Tier 3)	$50 copay		$50 copay	$40 copay
Preferred Specialty (Tier 4)	20% up to $500/Rx		20% up to $500/Rx	10% up to $250/Rx
Out of Pocket Maximum				
Individual	$2,300		$2,300	$4,500
Family	$4,600		$4,600	$9,000

Note on Trio HMO Pharmacy Levels: Level A pharmacies include CVS Pharmacy, CVS Pharmacy in Target Stores, Costco, and Vons. To find out which pharmacies are in Level B, please call Shield Concierge at (855) 664-5577. A complete list of providers and health and wellness resources may be found at www.blueshieldca.com or www.kp.org. In the event of a conflict between this information and the Carrier's Evidence of Coverage (EOC) booklet, the terms of the EOC will prevail. **Bold attributes denotes change from 2024.**

Employee Bi-Weekly Costs*	Blue Shield Platinum Trio HMO 0/20	Blue Shield Platinum Access+ HMO 0/20	Kaiser Platinum 90 HMO 0/20
You	$0.00	$0.00	$0.00
You + 1 Dependent	$147.36	$174.86	$157.42
You + Family	$234.17	$277.09	$250.45

*Rates shown reflect the City of Rancho Palos Verdes' bi-weekly contributions of 100% of the employee cost and 50% of the dependent cost. Rates are effective and valid from January 1, 2025 through December 31, 2025.

PPO Medical Plans

City of Rancho Palos Verdes will continue to offer medical PPO options through Blue Shield of California. The benefit highlights on the following pages are a brief outline of what is offered. Please refer to the evidence of coverage document for complete plan details.

Blue Shield Gold PPO (Gold Full PPO 500/30):

The Blue Shield (BSC) Gold PPO is a traditional PPO where you can utilize PPO providers (Preferred Providers) and Non-PPO Providers for your health care needs. Effective January 1, 2025 the PPO Out of Pocket Maximum for individual and family coverage will be **decreasing to $7,900/ $15,800** from $8,500/$17,000; PPO Specialist office visit copay is **increasing to $60** from $55; as reflected on the benefits table on page 8. Basic imaging services and other non-invasive diagnostic testing performed at the outpatient department of a PPO hospital will be **subject to the deductible**; currently it does not. If you use a PPO provider, your out of pocket cost at time of service is less than using a Non-PPO provider. There is a calendar year deductible you must satisfy before your co-insurance applies. There is also a separate prescription drug deductible per individual and family for your outpatient prescriptions that fall under Tiers 2 – 4 that will be **increasing to $150/$300** from $100/$200. There is a calendar year out of pocket maximum which is the maximum you pay in deductibles, copays, and coinsurance for most services that protects you from further liability for the remainder of the calendar year if you reach the threshold. The services that you will continue to pay once this threshold is met are for dialysis services from a Non-PPO provider, charges for services that are not covered, and charges above the allowable amount. You can self-refer to a specialist but be sure you know whether they participate in the PPO network to avoid unwanted financial surprises. If you use a Non-PPO provider, you will need to complete a claim form and submit the itemized receipt to BSC for reimbursement and caution of balance billing. Balance billing is the difference between what BSC pays the Non-PPO provider and what the provider bills BSC. The result is the member's financial responsibility can be substantial.

Blue Shield Silver PPO (Silver Savings Full PPO 2300/30%):

The Blue Shield Silver Savings PPO is a high deductible plan that is compatible with a Health Savings Account (HSA) account. Effective January 1, 2025, the PPO Family coverage per person out of pocket maximums are **increasing to $3,300** from $3,200 as reflected on the benefits table on page 9. The Silver Savings PPO plan works like the Gold PPO however most services are subject to one calendar year deductible and it also applies to prescription drugs. Preventive care services are not subject to the deductible. The deductibles, copays, and coinsurance amounts count towards the annual out of pocket maximum as with the Gold PPO plan and the three types of charges described for the Gold PPO also applies should you reach the out of pocket threshold.

The beauty of this plan is the HSA card. As you seek services, you can use your HSA card to pay the fee. Make sure it is used to pay for HSA-eligible items. The IRS regulates the HSA plan and Publication 502 can be referenced to the eligible expenses. Click on this link to access Publication 502: https://www.irs.gov/pub/irs-pdf/p502.pdf. Please refer to the HSA Bank section of this guide for more details.

Gold Full PPO 500/30 Plan

Deductible, copays, and coinsurance amounts shown indicate member's responsibility.	Blue Shield of California Gold Full PPO 500/30	Does the deductible apply?
	PPO Providers	
Preventive Care	No charge	No
Primary Physician Visit	$30 copay/visit	No
Specialty Care	**$60 copay/visit**	No
Teladoc Consultation	No charge	No
Lab Services	Lab Center: $30/visit; Outpatient Dept. of hospital: 20%	No Yes
Imaging	Outpatient radiology center: $50/visit; Outpatient Dept. of hospital: $100/visit – **ded. applies**	No No
Urgent Care Facility	$30 copay/visit	No
Emergency Room Facility	$250/visit + 20%, copay waived if admitted	Yes
Inpatient Facility	20% of all allowed charges	Yes
Outpatient Facility and Surgical Charges	Ambulatory Surgery Center: 20%; Outpatient dept. of hospital: $150/surgery + 20%	Yes Yes
Vasectomy	No Charge	No
Prescription Drugs (Up to a 30-day supply)		
Rx Deductible Per Calendar Year	Only applies to Tiers 2-4 (Retail and Mail Order Rx): **$150/individual; $300/family**	
Generic (Tier 1)	$15 copay	Rx Deductible: No
Preferred (Tier 2)	$50 copay	Rx Deductible: Yes
Non-Preferred (Tier 3)	$80 copay	Rx Deductible: Yes
Preferred Specialty (Tier 4)	30% up to $250/Rx	Rx Deductible: Yes
Mail Order Drugs (Up to a 90-day supply) – Amazon Home Delivery effective 1/1/2025		
Mail Order Rx	2 times the retail pharmacy copay; Tier 4: 30% up to $500/Rx	Rx Deductible: Yes
Calendar Year Deductible		
Individual Coverage	$500	
Family Coverage	Individual in a Family: $500; Family: $1,000	
Out of Pocket Maximum		
Individual Coverage	**$7,900**	
Family Coverage	**Individual in a Family: $7,900;** Family: $15,800	

The PPO benefits highlighted on this page are the plan's coverage when utilizing a contracted Blue Shield of CA PPO Provider. Please refer to the Evidence of Coverage booklet and benefit summary for the non-contracted provider benefits. **Bold attributes denotes change from 2024.**

2025 Bi-Weeky Costs*	Blue Shield Gold Full PPO 500/30
You	$0.00
You + 1 Dependent	$249.95
You + Family	$443.04

*Rates shown reflect the City's bi-weekly contributions of 100% of the employee cost and 50% of the dependent cost. Rates are effective and valid from January 1, 2025 through December 31, 2025.

Silver Savings Full PPO 2300/30% Plan

Deductible, copays, and coinsurance amounts shown indicate member's responsibility.	Blue Shield of California Silver Full PPO 2300/30%	Does the deductible apply?
Preventive Care	No charge	No
Primary Physician Visit	30% of allowed charges	Yes
Specialty Care	30% of allowed charges	Yes
Teladoc Consultation	No charge	Yes
Lab Services	30% of allowed charges	Yes
Imaging	30% of allowed charges	Yes
Urgent Care Facility	30% of allowed charges	Yes
Emergency Room Facility	30% of allowed charges	Yes
Inpatient Facility	30% of allowed charges	Yes
Outpatient Surgery	30% of allowed charges	Yes
Vasectomy	No Charge	Yes
Prescription Drugs (Up to a 30-day supply)		
Generic (Tier 1)	$25 copay	Yes
Preferred (Tier 2)	$75 copay	Yes
Non-Preferred (Tier 3)	$100 copay	Yes
Preferred Specialty (Tier 4)	30% up to $250/Rx	Yes
Mail Order Drugs (Up to a 90-day supply) – Amazon Home Delivery effective 1/1/2025		
Mail Order Rx	2 times the retail pharmacy copay; Tier 4: 30% up to $500	Yes
Calendar year Deductible		
Individual Coverage	$2,300	
Family Coverage	Individual in a Family: **$3,300**; Family: $4,600	
Out of Pocket Maximum		
Individual Coverage	$7,900	
Family Coverage	Individual in a Family: $7,900; Family: $15,800	

The PPO benefits highlighted on this page are the plan's coverage when utilizing a contracted Blue Shield of CA PPO Provider. Please refer to the Evidence of Coverage booklet and benefit summary for the non-contracted or Non-PPO provider benefits. **No changes from 2024.**

2025 Bi-Weekly Costs*	Blue Shield Silver Savings Full PPO 2300/30%
Employee	$0.00
Employee & 1 Dep	$180.68
Employee & 2+ Deps	$289.09

*Rates shown reflect the City's bi-weekly contributions of 100% of the employee cost and 50% of the dependent cost. Rates are effective and valid from January 1, 2025 through December 31, 2025.

HSA Bank, Health Savings Account Administrator

What is a Health Savings Account (HSA)?

An HSA is an IRS-governed account that allows you to set aside money for anticipated medical, dental, and vision expenses that are not covered by your insurance plan on a pre-tax basis. Unused funds will rollover automatically and collect interest on a tax-free basis. There is a mobile app where you can keep track of your account balance and save/store receipts using the camera.

The City's Blue Shield Silver Savings PPO plan is an HSA-compatible medical plan. Members enrolled in this medical plan can enroll in the HSA plan. Note: If you want to stretch your pre-tax dollars, you can participate in the WEX Limited Healthcare Spending Account that will also reimburse for eligible dental, vision, and preventive care expenses.

Who can Have an HSA?

You can contribute to your HSA only if you are enrolled in the Blue Shield Silver Savings PPO plan through the City of Rancho Palos Verdes. You cannot be covered under any other medical plan, including your spouse's plan, or be someone else's tax dependent, and you cannot be enrolled in Medicare (even Part A). If you have an HSA, you cannot be enrolled in a full health care flexible spending account (FSA), including coverage under your spouse's FSA.

How much can you contribute?

The annual contribution limits are set by the IRS and are subject to change annually. **The current annual limits are:**

- **$4,150 for Employee-Only (increase of $300)**
- **$8,300 for Employee + Family (increase of $550)**
- **If you are over age 55, you can contribute an additional $1,000 to your HSA annually.**

The first half is funded on or around January 1st, and the second half is funded on or around April 1st. If you leave the City, the funds in the HSA are yours. You can either convert to an individual HSA through HSA Bank or you can establish your own HSA with another entity and transfer the funds into your new HSA account. Either way, you will be responsible for the monthly administration fee.

Unused amounts in your HSA can be rolled over from one year to the next. Contributions to the account must stop once you are enrolled in Medicare. However, you can keep the money in your account and use it to pay for qualified medical expenses tax-free.

HSA funds are owned by the individual and not the City. We recommend consulting with your tax advisor on HSA tax issues. State tax applies to HSA contributions for residents in California.

You can use your HSA to:

- Pay for current expenses, such as deductibles, prescriptions drugs, plan copays or coinsurance, dental and vision expenses, chiropractic care, or other health care expenses.
- Pay for future health care expenses, even if you are no longer enrolled in the Blue Shield Silver Savings PPO Plan but you can no longer make contributions to the account.

How do I use my HSA?

- Use you HSA funds to pay for **qualified expenses** incurred by your, your spouse, your dependent children, or your Federal Tax dependents.
- Present your member ID card to your in-network provider or when filling prescriptions so network discounts can be applied.
- Use your HSA debit card to pay for eligible expenses as they occur or delay reimbursement.
- Keep your bills and pharmacy receipts. You may need to present them for verification of expenses.

What are eligible expenses?

A qualified, or eligible expense is a health care service, treatment, or item that can be purchased without having to pay taxes. Guidelines for HSA eligible expenses are set by the IRS. Click this link to access Publication 502 which includes eligible HSA expenses: https://www.irs.gov/pub/irs-pdf/p502.pdf. You may also contact **HSA Bank**, the City's HSA administrator at (800) 357-6346.

There are special rules for members who are approaching age 65 and the HSA. If you are actively working, enrolled in the Blue Shield Silver Savings PPO plan, are delaying enrollment in Medicare Parts A, B, and D, and not receiving Social Security Income Benefits, you can continue to contribute and receive the City's contribution. CareCounsel is knowledgeable about these rules and can help you understand these complexities. Their number is (888) 227-3334.

Dental DMO: DeltaCare USA Plan *

City of Rancho Palos Verdes will continue to offer the DeltaCare USA DHMO plan. The DeltaCare DHMO is a Delta Dental plan that consists of a schedule of co-pays for covered dental services. There are no deductibles, claim forms or calendar year maximums. You must receive care from your Primary Care Dentist (PCD) who is part of the DeltaCare USA network. The PCD manages your dental needs and is responsible for referrals to dental specialists. You can change your PCD monthly by calling Delta Dental's Member Services. Be sure to register on the DeltaCare portal where you can have access to your benefits, electronic ID card, a dental provider search, and a wealth of dental wellness information. The DeltaCare DHMO plan is only available in California except for emergency dental issues.

Important Tip! You should take your DeltaCare copay schedule to each appointment to ensure you are charged the correct amount. If you do not want to pay more than the copay, inform your dentist to stay within the schedule prior to performing the dental work to avoid any financial surprises.

Member Services representatives are trained to help you understand your benefits and can assist you with any questions at (800) 422-4234. You can also register on the member portal at www.deltadentalins.com.

***Note on DHMO**: Due to the DHMO dental network service area, this plan is only available to residents in California.

Plan Features	DeltaCare USA Plan 11A DHMO
Calendar Year Deductible	None
Calendar Year Maximum	None
Preventive (Exam, cleanings, x-rays)	$0 copay
Basic (Fillings, oral surgery)	$0 - $280 copay range
Major (Crowns, bridges, dentures)	$0 - $250 copay range
Orthodontia (Costs shown do not include set up and retention fees)	
Adults	$1,900 copay
Dependent Child(ren) to age 19	$1,700 copay
Waiting Periods	None

A complete list of dental providers and health and wellness resources may be found at www.deltadentalins.com.

2025 Bi-Weekly Costs*	DeltaCare USA DHMO
You	$0.00
You + 1 Dependent	$2.88
You + Family	$5.93

*Rates shown reflect the City's bi-weekly contribution of 100% of the employee cost and 50% of the dependent cost. Rates are effective and valid from January 1, 2025 through December 31, 2025.

Dental PPO Plan

The City will continue to offer the dental PPO plan through Delta Dental. The Delta Dental PPO plan is designed to provide enhanced dental coverage using both the PPO and Premier networks combined. The Delta Dental PPO plan allows you the freedom to use PPO providers where the greatest cost savings is achieved and the Delta Premier providers who are Non-PPO providers with filed fees with Delta Dental, and non-Delta Dental affiliated providers who have the least cost savings and balance billing applies. If you use a non-Delta Dental affiliated provider, you will need to submit a claim to Delta Dental for reimbursement. It is recommended to have your dentist submit a pre-determination of benefits for dental treatment that costs $300 or more and is of a non-emergency nature. You can also use the Cost Estimator Tool to look up prices for dental procedures and compare the cost of Delta Dental providers. These will make you an informed consumer and will allow you to better budget for the treatment. Member Services representatives are trained to help you understand your benefits and can assist you with any questions at (888) 335-8227.

Coinsurance amounts represent what the carrier pays.	**Delta Dental PPO Plan**		
	PPO Provider	**Premier Provider**	**Non-Delta Dental Affiliated**
Calendar Year Deductible			
Individual	$0	$25	$25
Family	$0	$75	$75
Waived for Preventive Care?	N/A	Yes	Yes
Calendar Year Maximum Benefit			
Per Person / Family	$0	$2,000	$1,500
Preventive	$0	100%	100%
Basic	$0	80%	80%
Major	$0 - $250	50%	50%
Orthodontia			
Benefit Percentage	50%		
Benefit per Adult & Child	$2,000 per individual per lifetime		

A complete list of dental providers and health and wellness resources may be found at www.deltadentalins.com.

2025 Bi-Weekly Costs*	**Delta Dental PPO**
Employee	$0.00
Employee & 1 Dep	$9.75
Employee & 2+ Deps	$20.52

*Rates shown reflect the City's bi-weekly contribution of 100% of the employee cost and 50% of the dependent cost. Rates are effective and valid from January 1, 2025 through December 31, 2025.

Delta Dental Value-Adds

The Delta Dental plans have useful value-added services. This is a list of some the resources:

For PPO Plans: Virtual Consult allows members to schedule a real-time virtual visit with a Delta Dental dentist by typing deltadentalvirtualconsult.com into the internet browser. This is a convenient service especially if you have an urgent dental need and it's after hours. The dentist will be able to perform an examination and review your responses to a health questionnaire and prescribe medication to manage the pain or infection, if needed. **This consultation is not subject to frequency limitations but the calendar year maximum applies.** Please read the flyer for more details.

For PPO Plans: Toothpic is a dental app that will allow you to submit 6-photo guide pictures of your teeth and gums to a Delta Dental dentist. Within 6 to 24 hours you will receive a personalized report of any observations, recommendations, and instructions for further treatment if necessary. **This consultation is not subject to frequency limitations but the calendar year maximum applies.** Download the app through the Apple Store or Google Play. Please read the flyer for more details.

For PPO Plans: Don't forget about **SmileWay®**, the wellness service for PPO dental members with certain chronic conditions who can obtain additional periodontal services. The member will login to their portal at www.deltadentalins.com and register. After registering there is an "Optional Benefits" tab to select then hit "Opt In". Self-attestation to one of the conditions is required after opting in. You will be able to access, at your dentist's discretion, the expanded periodontal services that consists of one periodontal scaling and root planning and any combination of four of the following services: prophylaxis, periodontal maintenance procedure, and scaling in presence of moderate to severe gingival inflammation annually. These benefits are in lieu of the regular dental benefits and will be covered at 100% subject to the deductible and calendar year maximum. Read the flyer for more details.

For PPO and DHMO Plans: BrushSmart™ is a dental wellness service website. Members will login into brushsmart.org to register to access discounts on Philips Sonicare dental products as well as, OralB, and Quip dental products. In addition to the discounts, members can access information and tips on how to keep their teeth and gums healthy as you scroll through the website. Please read the flyer for more details.

For PPO and DHMO Plans: Remember you have access to discounts on hearing aids through **Amplifon** and discounts on LASIK eye surgery through **QualSight**. You can refer to their flyer for more details. Call them at the following phone numbers to ask questions or learn how to access the discounts:
Amplifon: P: (888) 779-1429 Website link: amplifonusa.com/lp/deltadentalins
QualSight: P: (855) 248-2020 Website link: qualsight.com/-delta-dental

How do I search for a primary care dentist (PCD) online?
Go to www.deltadentalins.com
Use the "Find a Provider" feature on the webpage. Select the dental network from the dropdown menu:

- **DeltaCare USA for the DeltaCare HMO**

How do I search for PPO or Premier dentists online?
Go to www.deltadentalins.com
Use the "Find a Provider" feature on the webpage.
Select the dental network from the dropdown menu:

- **Delta Dental PPO for PPO providers**
- **Delta Dental Premier for Premier providers**

Vision

Sight, it's a beautiful thing and not to be taken for granted. Whether you want to be incognito and wear contact lenses or stand out in the crowd with the latest stylish frames, this vision plan has you covered. Go anywhere in the network for an exam, but we suggest you use a major retail chain when getting your frames and lenses. Please see page 15 for the January 1, 2025 enhancements.

Your vision benefits are provided by Vision Service Plan (VSP) using the Choice Network and Retail Partners. The VSP Choice Network offers 29,000 doctors and 50,000 access points to choose from throughout the United States. Similarly to your medical and dental plans, your out-of-pocket expenses are significantly reduced when you seek care from an in-network VSP Choice network provider and retail partners. Simply find a participating provider and make an appointment. Your vision care provider will confirm your benefits and eligibility prior to your visit. To find a Choice network provider, visit www.vsp.com and click on the "Find a Doctor" tab or call 800-877-7195.

Member is responsible for deductible, copays and amounts over allowances	**Vision Service Plan (VSP) Choice Plan**
Deductible	
Routine Eye Exam (Annual)	No charge
Retinal Imaging	$20 copay
Materials	No charge for the 1st / $20 copay for the 2nd pair of glasses
Contact Lens Exam & Fitting	Up to $60 copay
Benefit Frequency	12 months for exam, lenses, frame, and contacts; resets January 1st
Lenses	
Single Vision Lenses	No charge
Lined Bifocal & trifocal Lenses	No charge
Poly Carbonate Lenses	No charge – only for covered dependent children
Other Lens Options	Scratch resistant and UV coatings
Frames (in lieu of contacts)	
Frames	**$200 allowance**, 20% savings in excess of the allowance (available at VSP providers office, Retail Partners, Visionworks (excludes the 20% savings), and Eyeconic, the online store).
Featured Frame Brands	Add $50 allowance towards frames that are on the VSP Featured Frame list, 20% savings on amount over allowance (excludes Retail Partners)
2nd Pair Benefit	**$200 allowance**, 20% savings in excess of the allowance; Featured Frames applies
Contacts (in lieu of glasses)	
Medically Necessary Elective Contacts	Covered in full **$160 allowance** from $150 allowance
2025 Bi-Weekly Costs*	**Vision Service Plan (VSP)**
Employee	$0.00
Employee & 1 Dep	$2.20
Employee & 2+ Deps	$7.74

Bold attributes denotes change from 2024.

*Rates shown reflect the City's bi-weekly contribution of 100% of the employee cost and 50% of the dependent cost. Rates are effective and valid from January 1, 2025 through December 31, 2025.

Vision Value-Adds

Vision Service Plan (VSP) has also provided some valuable value-adds over the last few years. This is a recap of some the resources:

LightCare™: Allows members who do not use their frame and lens allowances for the year to use towards ready-to-wear, non-prescription sunglasses or ready-to-wear, non-prescription blue light filtering glasses from your in-network VSP provider, Costco, or Eyeconic, the online store (www.eyeconic.com).

Essential Medical Eye Care: Allows members to see their in-network VSP provider for their medical eye care conditions not limited to glaucoma, pink eye, and vision issues related to diabetes. There is a $20 copay per visit.

Discounts on laser correction surgery: Allows members to access discounts on laser eye correction through VSP-contracted laser vision center if they are deemed to be eligible for laser correction. Members go through a VSP Laser VisionCare network doctor to schedule a complimentary screening to be deemed a viable candidate.

Discounts on hearing aids: Allows members to access discounts on hearing aids, full 3-year manufacturer warranty, 1 year of follow-up visits, and 80 free batteries per non-rechargeable hearing aid through TruHearing. Call (866) 929-7912 with questions and you can check your hearing at www.TruHearing.com/VSP.

Why Vision Insurance?
Did you know that eyesight is rated the most valuable of the five senses? It's true. That is why protecting your eyesight should be a major concern to you. Eye doctors detect problems in vision, overall eye health, and detect signs of other health conditions like diabetic eye disease, high blood pressure and high cholesterol.

Enhancements Effective January 1, 2025
Frame Allowance will **increase to $200** from $160. Contact allowance will **increase to $160** from $150. VSP has opened their retail stores in California called "Visionworks". Currently they are in parts of Orange, Riverside, and San Bernardino counties and now in Culver City and Bell Gardens. Register on www.vsp.com to look up VSP providers including their Visionworks stores.

Scan this QR Code to access the VSP For Me page. It provides general information on the VSP features including the Enhanced Featured Frame brands:

Flexible Spending Accounts (FSAs)

The Flexible Spending Account (FSA) plan is administered by WEX Inc. The City provides you with the opportunity to pay for out-of-pocket health care and dependent care expenses on a pre- tax basis through a Flexible Spending Account (FSA) administered by WEX Health. If you are enrolled on the Blue Shield of California Silver Full PPO/HSA Savings 2300/30% medical plan, you are only eligible to participate in the Dependent Care and Limited Purpose Health Care Flexible Spending Account (see below).

How an FSA works:

During open enrollment or when you first become eligible, you decide how much money you want to contribute for the year. You only have one opportunity per year to enroll, unless you have a qualifying life event. The amount you designate for the year is taken out of your paycheck in equal installments each pay period and placed in your FSA. Estimate expenses carefully. Be conservative in your calculations because of the "use it or lose it" aspects of an FSA: if you do not incur eligible expenses for the full amount you elected to put into your FSA, the remaining balance in your account will be forfeited (IRS regulations). If you elect to participate in an FSA, you cannot make changes or revoke your election for the entire plan year unless you have a qualifying event in accordance with Internal Revenue Code Section 125. As an FSA participant you will receive a debit card that you can use at time of transaction.

Health Care Flexible Spending Account

The Health Care FSA allows you to set aside pre-tax dollars towards medical, dental, and vision expenses. For a complete list of eligible expenses click on this link to WEX: htttps://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/ or visit www.IRS.gov/Pub502 for Publication 502. Expenses must be incurred during the plan year and must not be eligible for reimbursement from insurance policies or any other source. Expenses can be incurred by you, your spouse, or any dependent (if you furnished over one half of the dependent's support during the plan year). The **2025** maximum amount you can contribute to the Health Care Flexible Spending account is **$3,300** (**increase** from $3,200 in 2024). You will have access to your entire annual election starting on January 1st and there is a carryover feature that allows you carryover up to **$660** (**increase** from $640 in 2024) of unused money to reduce the risk of "losing unused funds" at the end of the year.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account allows you to set aside up to $5,000 per year if you are single or married and filing taxes jointly; $2,500 if you are married and filing taxes separately. This account can be used to reimburse yourself for expenses related to dependent care services that allow you and your spouse (if you are married) to work or attend school (day-care centers, babysitters, adult day care for dependent adults living in your home). You can click on this link to WEX's interactive search: https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses. Unlike the Health Care Flexible Spending Account, you will not have access to the full annual election from January 1st. You will have access to the funds that have been payroll deducted at the time you seek your reimbursement. There is a 2.5-month grace period

that allows you to use your unused money remaining at the end of the plan year within the first 2.5 months of the following year. This grace period allows you an extended opportunity to use unused funds at the end of the plan year.

All full-time employees, regardless of their health plan election, are eligible to participate in the Dependent Care FSA.

Deposits made into your spending account are made on a pre-tax basis, which means you don't pay federal, Social Security, or most state taxes on the income you set aside. The total amount that you deposit is deducted from your pay in equal amounts throughout the year. When you have an eligible expense, you file a claim and are reimbursed from your account and you don't pay taxes on that reimbursement either. Note that unlike the Health Care FSA and the Limited Purpose Health Care FSA, the Dependent Care FSA only allows you to receive reimbursement up to what has been deducted from your paycheck at the time of your reimbursement request.

Limited Purpose Health Care Flexible Spending Account

This FSA plan is for employees enrolled in the Blue Shield Silver Savings PPO - HSA qualified medical plan. Only dental, vision, and preventive care expenses can be reimbursed through this account. For a complete list of eligible expenses (only for dental, vision, and preventive care), visit www.IRS.gov/Pub502 to refer to eligible preventive care, dental, and vision services. Expenses must be incurred during the plan year and must not be eligible for reimbursement from insurance policies or any other source. Expenses can be incurred by you, your spouse, or any dependent (if you furnished over one half of the dependent's support during the plan year). The 2025 maximum amount you can contribute to the Limited *Health Care Flexible Spending account is **$3,300 (increase** from $3,200 in 2024). You will have access to your entire annual election starting on January 1st and there is a carryover feature that allows you carryover up to **$660 (increase** from $640 in 2024) of unused money to reduce the risk of "losing unused funds" at the end of the year. Just like the Health Care Flexible Spending Account, you have access to your entire election on January 1st.

At the end of the plan year for all three Flexible Spending Accounts, there is a 90-day run out period. This is the time allowed for you to submit expenses that were incurred during the plan year as well as any outstanding substantiation being requested by WEX. The run-out period runs concurrently with the 2.5 month grace period that applies to the Dependent Care FSA plan.

If you currently participate in the full scope FSA then change your medical plan to the Blue Shield Silver Savings PPO and establish an HSA, you may elect the limited purpose FSA and remaining funds from your full scope FSA will automatically be rolled over to prevent you from losing your funds.

Click on the following useful resources:

FSA Calculator

WEX Eligible Expenses List

FSA Store to Shop for Eligible Expenses

WEX Online Portal for Plan Participants

Group Basic Term Life & AD&D

The City provides full-time employees and eligible part-time employees with basic group life and accidental death and dismemberment (AD&D) insurance through The Hartford and pays the full cost of this benefit. The basic AD&D coverage matches the basic life benefit.

Plan Features	Basic Group Life/AD&D For Employees
Employee Benefit Amount	2 times your annual salary ($10,000 minimum/$350,000 maximum)
*Spouse	$5,000
*Child(ren) age 6 months to age 26	$2,000
*Child(ren) birth to 6 months	$1,000

*Spouse and children have basic life only (no AD&D) – Spouse and children life/AD&D are not available to part-time employees.

Age reduction starts at age 65 where the benefit reduces by 35% then at age 70 it reduces by 50% of the pre-age 65 benefit.

Voluntary Term Life & AD&D

The City also provides full-time employees the option to purchase additional life and accidental death and dismemberment (AD&D) insurance through The Hartford. Newly eligible employees can enroll up to the guarantee issue amounts without underwriting approval. All amounts are subject to underwriting approval if coverage was waived when you were initially eligible and wish to enroll in the future. This is 100% employee-paid.

Plan Features	Voluntary Term Life/AD&D Maximum	Guarantee Issue Amount***
Employee*	$10,000 increments to the lesser of $300,000 or 3 times your annual salary	$100,000****
Spouse**	$5,000 increments not to exceed $100,000	$25,000****
Note: Voluntary AD&D does not apply to Child(ren)		
Child(ren)	Birth to 6 months: $1,000; 6 months to age 26: $5,000	N/A

*Employee must be enrolled in order for dependents to qualify for plan participation.

**Elected spousal benefit amount cannot exceed 50% of the employee elected benefit amount.

***Guarantee issue amounts only apply to those employees and their dependents electing coverage as new hires.

****For applicants under age 70.

Age reduction starts at age 65 where the benefit reduces by 35% then at age 70 reduces by 50% of the pre age 65 benefit. Part-time employees are not eligible for voluntary life/AD&D.

Reminder: Please remember to keep your beneficiary information current. You can do this anytime during the year but open enrollment is a good time to check. You can complete the Hartford Beneficiary Designation form and return it to Human Resources.

Please refer to the following pages for the Voluntary Life and AD&D bi-weekly rates for employees, spouse/domestic partner, and child(ren). Please note the Voluntary Life and AD&D plans are bundled (if you elect Voluntary Life, you will get Voluntary AD&D) and the spouse/domestic partner's rate is based upon the employee's age and the employee needs to be covered in order for the spouse and/or child(ren) to have coverage.

Voluntary Life and AD&D Rates for Employee & Spouse/Domestic Partner (Bi-Weekly Rates)

EMPLOYEE VOLUNTARY TERM LIFE AND AD&D INSURANCE (Bi-Weekly Premium Amount per Pay Period)												
Benefit	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$0.38	$0.32	$0.34	$0.44	$0.60	$0.91	$1.38	$1.95	$2.49	$3.54	$6.03	$16.81
$20,000	$0.76	$0.65	$0.68	$0.88	$1.20	$1.83	$2.77	$3.90	$4.98	$7.09	$12.06	$33.62
$30,000	$1.14	$0.97	$1.02	$1.32	$1.80	$2.74	$4.15	$5.86	$7.48	$10.63	$18.10	$50.43
$40,000	$1.51	$1.29	$1.37	$1.75	$2.40	$3.66	$5.54	$7.81	$9.97	$14.18	$24.13	$67.24
$50,000	$1.89	$1.62	$1.71	$2.19	$3.00	$4.57	$6.92	$9.76	$12.46	$17.72	$30.16	$84.05
$60,000	$2.27	$1.94	$2.05	$2.63	$3.60	$5.48	$8.31	$11.71	$14.95	$21.27	$36.19	$100.86
$70,000	$2.65	$2.26	$2.39	$3.07	$4.20	$6.40	$9.69	$13.67	$17.45	$24.81	$42.23	$117.66
$80,000	$3.03	$2.58	$2.73	$3.51	$4.80	$7.31	$11.08	$15.62	$19.94	$28.36	$48.26	$134.47
$90,000	$3.41	$2.91	$3.07	$3.95	$5.40	$8.22	$12.46	$17.57	$22.43	$31.90	$54.29	$151.28
$100,000	$3.78	$3.23	$3.42	$4.38	$6.00	$9.14	$13.85	$19.52	$24.92	$35.45	$60.32	$168.09
$110,000	$4.16	$3.55	$3.76	$4.82	$6.60	$10.05	$15.23	$21.48	$27.42	$38.99	$66.36	$184.90
$120,000	$4.54	$3.88	$4.10	$5.26	$7.20	$10.97	$16.62	$23.43	$29.91	$42.54	$72.39	$201.71
$130,000	$4.92	$4.20	$4.44	$5.70	$7.80	$11.88	$18.00	$25.38	$32.40	$46.08	$78.42	$218.52
$140,000	$5.30	$4.52	$4.78	$6.14	$8.40	$12.79	$19.38	$27.33	$34.89	$49.62	$84.45	$235.33
$150,000	$5.68	$4.85	$5.12	$6.58	$9.00	$13.71	$20.77	$29.28	$37.38	$53.17	$90.48	$252.14
$160,000	$6.06	$5.17	$5.46	$7.02	$9.60	$14.62	$22.15	$31.24	$39.88	$56.71	$96.52	$268.95
$170,000	$6.43	$5.49	$5.81	$7.45	$10.20	$15.54	$23.54	$33.19	$42.37	$60.26	$102.55	$285.76
$180,000	$6.81	$5.82	$6.15	$7.89	$10.80	$16.45	$24.92	$35.14	$44.86	$63.80	$108.58	$302.57
$190,000	$7.19	$6.14	$6.49	$8.33	$11.40	$17.36	$26.31	$37.09	$47.35	$67.35	$114.61	$319.38
$200,000	$7.57	$6.46	$6.83	$8.77	$12.00	$18.28	$27.69	$39.05	$49.85	$70.89	$120.65	$336.18
$210,000	$7.95	$6.78	$7.17	$9.21	$12.60	$19.19	$29.08	$41.00	$52.34	$74.44	$126.68	$352.99
$220,000	$8.33	$7.11	$7.51	$9.65	$13.20	$20.10	$30.46	$42.95	$54.83	$77.98	$132.71	$369.80
$230,000	$8.70	$7.43	$7.86	$10.08	$13.80	$21.02	$31.85	$44.90	$57.32	$81.53	$138.74	$386.61
$240,000	$9.08	$7.75	$8.20	$10.52	$14.40	$21.93	$33.23	$46.86	$59.82	$85.07	$144.78	$403.42
$250,000	$9.46	$8.08	$8.54	$10.96	$15.00	$22.85	$34.62	$48.81	$62.31	$88.62	$150.81	$420.23
$260,000	$9.84	$8.40	$8.88	$11.40	$15.60	$23.76	$36.00	$50.76	$64.80	$92.16	$156.84	$437.04
$270,000	$10.22	$8.72	$9.22	$11.84	$16.20	$24.67	$37.38	$52.71	$67.29	$95.70	$162.87	$453.85
$280,000	$10.60	$9.05	$9.56	$12.28	$16.80	$25.59	$38.77	$54.66	$69.78	$99.25	$168.90	$470.66
$290,000	$10.98	$9.37	$9.90	$12.72	$17.40	$26.50	$40.15	$56.62	$72.28	$102.79	$174.94	$487.47
$300,000	$11.35	$9.69	$10.25	$13.15	$18.00	$27.42	$41.54	$58.57	$74.77	$106.34	$180.97	$504.28
SPOUSE/DOMESTIC PARTNER VOLUNTARY TERM LIFE AND AD&D INSURANCE (Bi-Weekly Premium Amount per Pay Period)												
Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$100,000	$4.02	$3.42	$3.65	$4.66	$6.37	$9.74	$14.77	$20.91	$26.72	$37.98	$64.71	$180.37

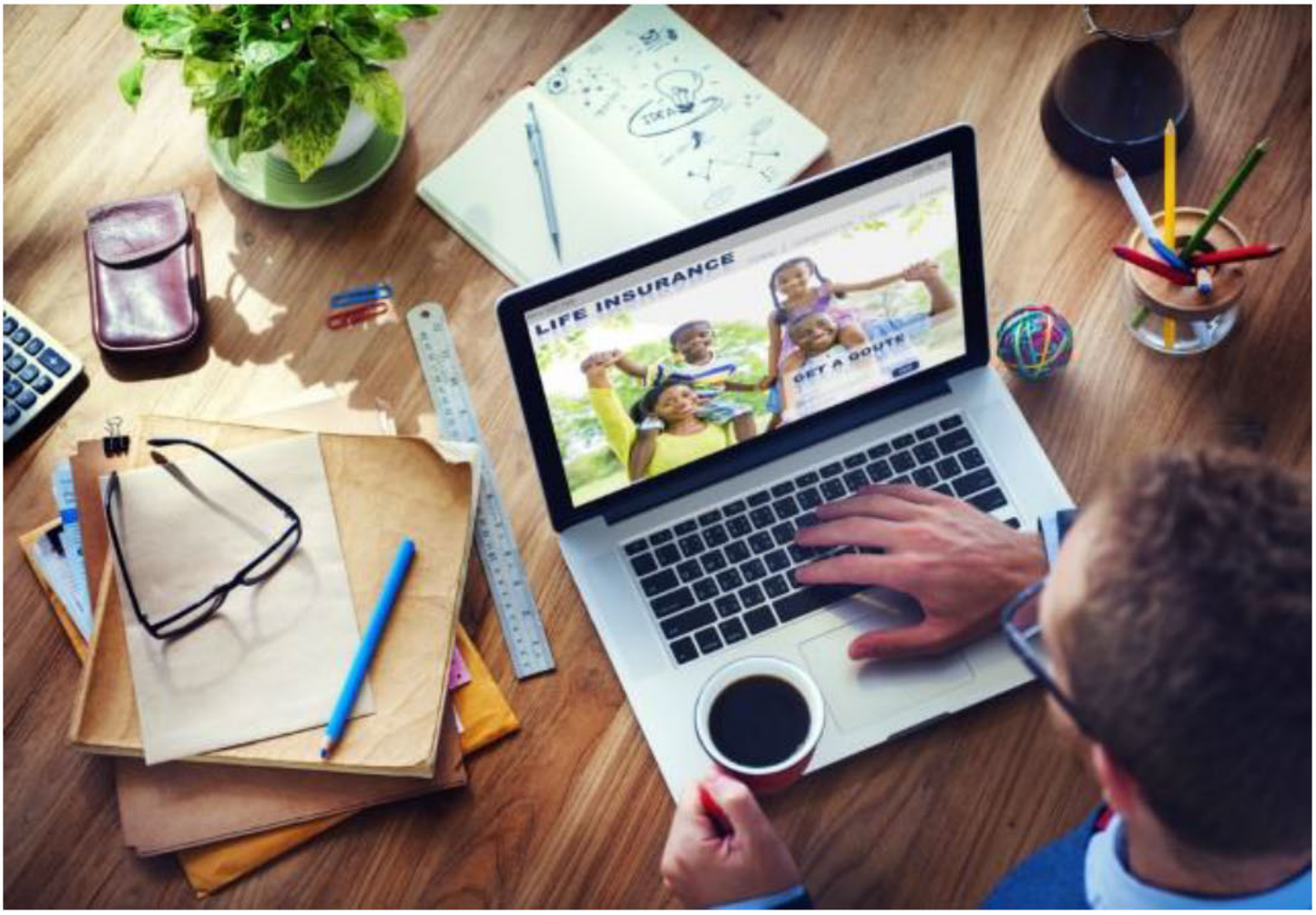
Voluntary Life Rate for Child(ren)

CHILD(REN) VOLUNTARY LIFE INSURANCE Premium Amount per Dependent Unit per Pay Period	
Benefit Amount	Cost For All Children
$5,000	$0.13

Long Term Disability

The City provides full-time employees with long-term disability income benefits through The Hartford and pays the cost of this coverage. This is a great benefit to have because it will protect a portion of your paycheck if you become disabled by a covered illness or injury both on-and-off the job. Part-time employees are not eligible for voluntary life/AD&D. Part-time employees are not eligible for this long term disability plan.

Plan Features	Long Term Disability
Waiting Period (before benefit is paid)	90 days
Benefit percentage	66.67%
Maximum monthly benefit	$10,000
Minimum monthly benefit	$100
Benefit duration	Social Security Normal Retirement Age



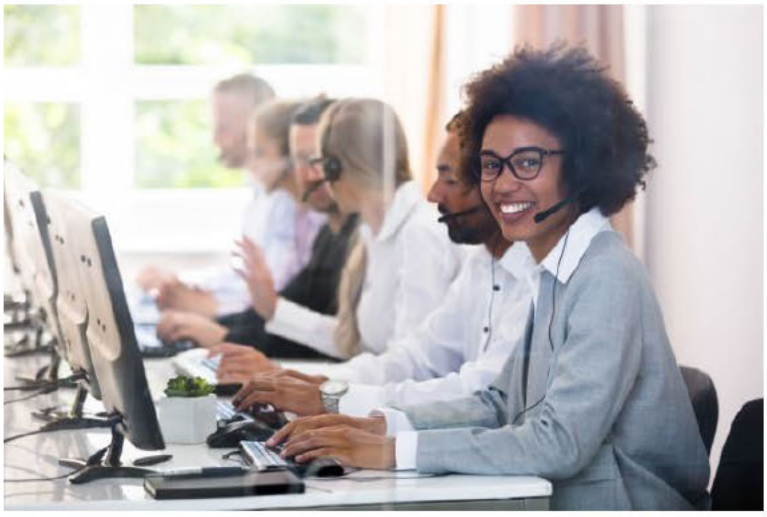
CareCounsel Resources (Member Advocates)

Sometimes healthcare can be confusing. CareCounsel provides assistance as your personal healthcare advocate when you need it. When you call CareCounsel, you get confidential support, benefits assistance, claims troubleshooting, health plan issue resolution, help locating qualified healthcare resources, and healthcare advocacy. Being part of the Stanford Health System, you will have access to a medical librarian who will be able to provide information based upon their medical library a medical condition. CareCounsel is an independent organization and is not part of your health plans and they can help you navigate the complexities of your health plan benefits.

How CareCounsel Can Help?

CareCounsel is knowledgeable about the City's medical, dental, and vision plans. Your Member Care Specialist can coach you on how to be a more proactive, informed partner in healthcare decision-making. They will listen to your concerns, answer questions, guide you to appropriate resources, and intervene on your behalf with issues that confuse or frustrate you. Open enrollment is a perfect time to use CareCounsel!

Resources for Your Health Care Needs



Some of the areas where CareCounsel can help are:

- Understanding Open Enrollment options
- Choosing a health plan for your family
- Selecting doctors and hospitals
- Troubleshooting claims problems
- Obtaining care or referrals
- Finding resources for a health condition
- Understanding your benefits
- Addressing quality-of-care concerns
- Communicating effectively with doctors
- Getting the most of your healthcare dollars
- Certified medical librarian can access to the Stanford Health Library for information on new diagnosis and treatment options
- Educating people about Medicare (preparation and requirements)

A Note About CareCounsel Services

CareCounsel is different from your health plan. CareCounsel does not provide medical advice or treatment but serves as an advocate to help you get your needs met. To ensure your privacy, the City has contracted with CareCounsel to provide you with confidential assistance. CareCounsel does not share identifying information without your consent, unless required by law. For more information, go to www.carecounsel.com or call (888) 227-3334.

Employee Assistance Plan (EAP)

Life does not always go smoothly. All of us experience times when a personal problem or crisis affects the way we function at work or home. Your Employee Assistance Program (EAP) is a problem-solving resource available to you and your household members. A professional counselor will assist you in assessing your situation, finding options, making choices or locating further help.

The EAP is offered through Aetna Resources For Living (RFL). This coverage is available to all employees including part-time employees, their household members, and children until age 26.

It's free... The City covers the cost of the initial assessment, additional problem-solving sessions and referral services. You have up to **8-sessions** per issue per individual per year. If there is a need for further counseling or treatment, your counselor will help you explore various options. You can have in-person or telehealth consultations by first calling with your request or you can utilize TalkSpace which has a chat feature. TalkSpace will require a separate registration to get started.

It's confidential... Services are completely confidential and available 24 hours/7 days a week, 365 days a year. No one at work will know you have chosen to seek help unless you choose to tell them. Nothing concerning your use of EAP services will appear in your personnel file.

Aetna RFL is only a phone call away at (800) 342-8111 or you can go to their website at www.resourcesforliving.com and enter **username:** [redacted] with the **password:** [redacted]

Here are some areas where the EAP can assist:

- Anxiety
- Family Issues
- Relationship Support
- Depression
- Grief and Loss
- Self-esteem and personal development
- Substance Misuse
- Work/life balance
- Financial Advice (telephonically)
- Legal Advice (telephonically)
- ID Theft Recovery Services
- Daily Life Assistance Services such child care, parenting and adoption; Care for older adults; Caregiver support, School and financial aid research; Pet care; and much more services

aetna

Aetna Resources For Living℠

AFLAC Plans

The City offers individual plans through AFLAC. Their plans are employee-paid through payroll deductions. The following summarizes the plans:

Accident Insurance

- Covered on and off-the-job accidents large and small.
- Pays towards injuries, office visits, physical therapy, hospitalization & more
- Great for active families
- Pays you an annual $60 wellness benefit for the family per calendar year.

Cancer/Specified Disease Insurance

- Covers internal cancer, Clarke's Level III or higher as well as skin cancer.
- Pays a lump sum benefit upon initial diagnosis of $6,000 which builds by $500 each year as one is cancer free.
- Pays a cancer screening benefit for every covered person for $100 per calendar year.

Critical Illness Insurance

- Covers Heart Attack, Stroke, End State Renal Failure, etc...
- Pays $10,000 lump sum benefit if triggered
- Pays half the benefit for recurrence
- Guarantee issue so pre-existing conditions are accepted.

Hospital Indemnity Insurance

- Excellent coverage for any hospital related stay
- Can help prevent high deductibles and out-of-pocket expenses from derailing life's plans
- Pays you a Physician visit benefit for the employee (3 visits) or family (6 visits) at $25 per calendar year.

Short Term Disability Insurance

- Pays you an income when you can't work due to illness for off-the-job injury.
- Benefits available from $500-$6,000 per month for up to 6 or 12 months per disability
- Pays starting Day 1 for any off-the-job injury and after 7 days for an illness.

If you would like to see more information, ask a few questions, look at your existing coverage, or enroll in your AFLAC Benefits, please click on this link to schedule an appointment on the City's AFLAC portal: https://www.aflacenrollment.com/CityofRanchoPalosVerdes/A8Q953318743 (click on the "Get Started" button).

Aflac®

Legal Access Plan

You and your family deserve to feel prepared and confident when facing a legal matter. The Family Legal Protection Plan offers exclusive access to legal benefits like discounted hourly rates, flat rates and covered services for common legal matters. When you enroll into the Family Legal Protection Plan, legal coverage is extended to your spouse and all children up to age 23. Also, specific benefits, like Estate Planning, are extended to your parents and spouse's parents.

Legal matters can be stressful and Legal Access Plans is there to help every step of the way. We have a team of member specialists who have access to our advanced attorney matching technology that can help find the right attorney with expertise for your legal matter. To learn more about the Family Legal Protection Plan and the legal benefits you will get, please visit www.legaleaseplan.com/city-rpv or you can call our Member Service center at (800) 248-9000 between the hours of 5AM - 5PM PST.

*Cost to participate in the Family Legal Protection Plan is $5.54 per paycheck based upon a bi-weekly payroll deduction.

Nationwide Pet Insurance

Pet insurance provides a financial safety net for unexpected veterinary expenses. With pet insurance, you can focus on giving your pet the best care possible, instead of focusing on the cost of treatment from any licensed veterinarian or animal hospital. Your pets are covered for:

- Accidents and injuries
- Illness and disease
- Cancer
- Hereditary conditions
- Spaying and neutering
- Poisonings
- Dental cleanings
- Flea and tick preventives
- Vaccinations

Rate will vary based upon plan selection and is set up as a direct-bill versus payroll deduction. You can access the virtual pet booth at: https://www.petinsurance.com/copenenroll507090 to learn more about the program and to obtain a no-obligation quote for dogs and cats. You can also call Nationwide Pet Insurance at (877) 738-7874. Please note for avian and exotic pets, you will need to call the 877 number to obtain a quote.

ScholarShare 529 College Savings Plan

College tuition increases every year. ScholarShare is a 529 College Savings plan that helps families save for college via a direct deposit through payroll. It offers 100% tax-free growth and low fees, making the most of every dollar you save. You set your contribution amounts that fit your budget. You can learn more at www.ScholarShare529.com or call (800) 544-5248. If you are interested in this type of plan, you can contact Heath Polzer, Consultant at (949) 623-2916 or email heath.polzer@tiaa.org.

Important Contacts

Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

Carrier Customer Service Information:

COVERAGE	CARRIER	PHONE NUMBER	WEBSITE
Medical	Blue Shield of California	Trio HMO: (855) 664-5577 Access+ HMO: (800) 256-1915 PPO Plans: (800) 256-1915	www.blueshieldca.com
HSA Account paired with BSC Silver Savings PPO	HSA Bank	(800) 357-6246	www.HSABank.com
Medical	Kaiser Permanente	(800) 464-4000	www.kp.org
Dental PPO	Delta Dental	(888) 335-8227	www.deltadentalins.com
Dental DHMO	Delta Dental	(800) 422-4234	www.deltadentalins.com
Vision	Vision Service Plan	(800) 877-7195	www.vsp.com
Flexible Spending Accounts (FSAs)	WEX Health	(866) 451-3399	www.wexinc.com Select "HSA, FSA, HRA/Wellness & Commuter"
COBRA Administration	WEX Health	(866) 451-3399	www.cobralogin.wexhealth.com
Employee Assistance Plan (EAP)	Aetna Resources For Living	(800) 342-8111	https://resourcesforliving.com Username: [redacted] Password: [redacted]
Life/AD&D	Hartford	(888 563-1124	https://mybenefits.thehartford.com/login
Long Term Disability (LTD)	Hartford	(800) 289-9140	https://mybenefits.thehartford.com/login
Legal Plan	Legal Access Plan	(800) 248-9000	www.legaleaseplan.com/city-rpv
AFLAC	AFLAC	(800) 992-3522	www.aflac.com ricky_shih@us.aflac.com
Pet Insurance	Nationwide Pet Insurance	(877) 738-7874	https://www.petinsurance.com/openenrollI507090/
529 College Savings	ScholarShare	(800) 544-5248	www.scholarshare.com
Advocacy Resources	CareCounsel	(888) 227-3334	www.carecounsel.com

This brochure summarizes the benefit plans that are available to City of Rancho Palos Verdes eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

Important Legal Notices

If you (an/or your dependents) have Medicare or 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 33 for more details

Women's Health Cancer Rights Act Of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. To obtain more information on WHCRA benefits, please call or email the Human Resources Department.

Newborns Act Disclosure - Federal

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice Of Special Enrollment Rights

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 you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

Patient Protection Model Disclosure

Blue Shield of California and Kaiser Permanente HMO plans generally 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, Blue Shield of California or Kaiser Permanente will designate one for you based upon your residential zip code. For information on how to select a primary care provider, and for a list of the participating primary care providers, go to www.blueshieldca.com or www.kp.com.

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

You do not need prior authorization from Blue Shield of California or from any other person (including a primary care provider) in order 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, visit Blue Shield's website at www.blueshieldca.com or Kaiser's website at www.kp.com.

Contact Information

Questions regarding any of this information can be directed to:
City of Rancho Palos Verdes Human Resources Department
30940 Hawthorne Boulevard
Rancho Palos Verdes, California 90275
Phone: (310) 544-5332
Email: humanresources@rpvca.gov

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/**.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

Effective Date: October 1, 2024

City of Rancho Palos Verdes
Human Resources Department – Privacy Contact
30940 Hawthorne Boulevards
Rancho Palos Verdes, CA 90275
Phone: (310) 544-5332; Email: humanresources@rpvca.gov

WEX Health -Flexible Spending Accounts (FSAs)
WEX Health Privacy Officer
4321 20th Avenue S.
Fargo, North Dakota 58103
Phone: (866) 451-3399

Important Notice from City of Rancho Palos Verdes 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 Rancho Palos Verdes 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:

1. **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.**

2. **City of Rancho Palos Verdes has determined that the prescription drug coverage offered by the Blue Shield of California HMO and PPO Plans and Kaiser HMO Plan for the 2025 plan year, 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 Rancho Palos Verdes coverage may be affected. You should contact either CareCounsel or Human Resources if you are thinking about enrolling in a Medicare Part D plan.

If you do decide to join a Medicare drug plan and drop your current City of Rancho Palos Verdes coverage, be aware that you and your dependents may be able to get this coverage back during the annual open enrollment period or in the case of a special enrollment opportunity.

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 Rancho Palos Verdes and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed at the end of this section for further information. Note: You'll get this notice each year in the Fall. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Rancho Palos Verdes 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'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call (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 1-800-325-0778).

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

Date:	October 1, 2024
Name of Entity/Sender:	City of Rancho Palos Verdes
Dept./Office:	Human Resources Department
Address:	30940 Hawthorne Boulevard Rancho Palos Verdes, CA 90275
Phone Number/Email:	(310) 544-5332; Email: humanresources@rpvca.gov

If you would like to learn more about Medicare, please feel free to contact **CareCounsel**!

Phone: 888-227-3334; Monday – Friday, 6:30am – 5:00pm

Email: staff@carecounsel.com

Website: https://carecounsel.com

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

For people who live in California, you may be eligible for assistance in paying your employer health plan premiums. Contact your State for more information on eligibility.

CALIFORNIA-Medi-Cal
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

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

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

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

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

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

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

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

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

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer - sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name City of Rancho Palos Verdes	4. Employer Identification Number (EIN) 95-2867872	
5. Employer address 30940 Hawthorne Boulevard	6. Employer phone number (310) 544-5200	
7. City Rancho Palos Verdes	8. State CA	9. ZIP code 90275
10. Who can we contact about employee health coverage at this job? Human Resources Department		
11. Phone number (if different from above) (310) 544-5332	12. Email address humanresources@rpvca.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ■ Some employees. Eligible Employees are:

  Employees who are benefits-eligible based upon their MOU, and Part-Time employees how meet the ACA criteria. Contact Human Resources to check if you meet the criteria.

- With respect to dependents:

  ■ We do offer coverage. Eligible dependents are:

  Spouse, registered domestic partner, Children (natural, adopted, registered domestic partner's or step) up to age 26; Grandchild, up to age 26 if the employee has a Court-order; and certified disabled dependent children age 26 and older.

  ☐ We do not offer coverage.

■ If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

*Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, www.HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit www.HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

• An employer - sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

*** Continuation Coverage Rights Under COBRA ***

Introduction

You are getting this notice because you gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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 31-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?

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 your coverage under the Plan because of the following qualifying events:

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

If you 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 his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct; The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child no longer meeting the eligibility definition of an eligible "dependent child" per the health plan.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events within 31-days:

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

For all <u>other</u> qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Human Resources Department within 60 days of when the qualifying event occurs. You must provide this notice to the Human Resources Department within the required timeframes in order to comply with Federal Law.

How is COBRA continuation provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started 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.

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

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medi-Cal, 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.

If you have questions…

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact identified at the end of this section.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the City's Human Resources Department 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 City's Human Resources Department and to WEX Health, the City's COBRA Administrator.

Plan contact information
Human Resources Department, Phone: (310) 544-5332; Email: humanresources@rpvca.gov

** California Cal-COBRA Medical Extension **

Beginning July 1, 2004 (AB1401), Federal COBRA participants may qualify for an extension of medical benefits through the insurance carrier. This extension allows all California residents the opportunity to continue their Federal COBRA coverage for an additional 18 months through Cal-COBRA, for a total of 36 months of medical continuation coverage. The cost for the additional 18 months of Cal-COBRA coverage is 110% of the cost of coverage. **If you are enrolled in Federal COBRA for Medical, 3 months prior to end of your 18-months of Federal COBRA, you should call the Cal-COBRA Units of either Blue Shield at (800) 228-9476 or Kaiser at (800) 464-4000 to request your Cal-COBRA rates.** This will allow for a smooth transition, should you decide to enroll in Cal-COBRA. Once you elect Cal-COBRA, your medical carrier will administer the coverage which means you will pay premium directly to the medical carrier. WEX will no longer be involved.

HealthCare Reform Information

The Patient Protection and Affordable Care Act
Starting in 2020 Californians must have medical coverage that meet the benefit level and cost standards set by the state.

How does California's individual state mandate for insurance impact me?
Californians must have health insurance starting in 2020 or they will have to pay a penalty with their state income tax return.

What happens if I don't have coverage?
Individuals who don't have the required coverage will have to pay a penalty with their **state** income tax return. California residents must either:

- Have qualifying health insurance coverage, or
- Pay a penalty when filing a state tax return, or
- Get an exemption from the requirement to have coverage

What kinds of employer-provided coverage will meet the health coverage requirements?
Most employer-provided medical plans will meet the requirement. This includes PPOs, HMOs, and high deductible health plans.

What is Covered California and are there advantages to buying coverage on my own?
Covered California is an online marketplace to help Californians shop for insurance. Some individuals and families who make less than a certain amount a year may qualify for a government premium subsidy to help pay for health care costs.

Individuals and families with the option to obtain affordable health insurance from their employer will not be eligible to apply for a subsidy. Additionally, you will not be able to buy coverage through Covered California with pre-tax dollars.

Do the City of Rancho Palos Verdes' medical plans meet the individual state mandate standards?
All of the Blue Shield medical plans and Kaiser HMO plan offered by the City provide the Minimum Essential Coverage and meet the Minimum Value Standards.

Is there an online glossary of health care and medical terms to help me understand my plans?
Click the following for health care terminology: https://www.healthcare.gov/sbc-glossary/. This is a valuable resource to reference as you review the medical options in this guide.

The City of Rancho Palos Verdes' medical plans meet all the legal eligibility and affordability requirements under the Affordable Care Act (ACA) and individual state mandate standards. You do not need to take any action outside of the usual enrollment activities through the City.

2025 Benefit Contributions (No Change from 2024)

Benefit Type	Plan Name	Coverage Level	Monthly Premium	City Paid	Employee Paid	Deduction Per Paycheck
Medical	Blue Shield Silver PPO + HSA	Employee	$782.94	$782.94	-	-
Medical	Blue Shield Silver PPO + HSA	Employee +1	$1,565.86	$1,174.40	$391.46	$180.68
Medical	Blue Shield Silver PPO + HSA	Family	$2,035.65	$1,409.29	$626.35	$289.09
Medical	Blue Shield Gold PPO 500 Ded. (No HSA)	Employee	$1,330.83	$1,330.83	-	-
Medical	Blue Shield Gold PPO 500 Ded. (No HSA)	Employee +1	$2,413.93	$1,872.38	$541.55	$249.95
Medical	Blue Shield Gold PPO 500 Ded. (No HSA)	Family	$3,250.67	$2,290.75	$959.92	$443.04
Medical	Blue Shield Platinum Access+ HMO	Employee	$808.54	$808.54	-	-
Medical	Blue Shield Platinum Access+ HMO	Employee +1	$1,566.27	$1,187.40	$378.87	$174.86
Medical	Blue Shield Platinum Access+ HMO	Family	$2,009.24	$1,408.89	$600.35	$277.09
Medical	Blue Shield Platinum Trio HMO*	Employee	$681.04	$681.04	-	-
Medical	Blue Shield Platinum Trio HMO*	Employee +1	$1,319.59	$1,000.32	$319.28	$147.36
Medical	Blue Shield Platinum Trio HMO*	Family	$1,695.77	$1,188.40	$507.36	$234.17
Medical	Kaiser HMO	Employee	$728.38	$728.38	-	-
Medical	Kaiser HMO	Employee +1	$1,410.53	$1,069.45	$341.07	$157.42
Medical	Kaiser HMO	Family	$1,813.66	$1,271.02	$542.64	$250.45
Dental	Delta Dental PPO	Employee	$48.32	$48.32	-	-
Dental	Delta Dental PPO	Employee +1	$90.58	$69.45	$21.13	$9.75
Dental	Delta Dental PPO	Family	$137.25	$92.79	$44.47	$20.52
Dental	DeltaCare DHMO	Employee	$15.46	$15.46	-	-
Dental	DeltaCare DHMO	Employee +1	$27.95	$21.71	$6.25	$2.88
Dental	DeltaCare DHMO	Family	$41.17	$28.32	$12.86	$5.93
Vision	Vision Plan	Employee	$21.23	$21.23	-	-
Vision	Vision Plan	Employee +1	$30.77	$26.00	$4.77	$2.20
Vision	Vision Plan	Family	$54.75	$37.99	$16.76	$7.74
EAP	Aetna RFL EAP	Per Employee Per Month	$1.74	$1.74	-	-

***Medical Opt-Out Monthly Amount: $340.52**

(Cash-in-lieu = 1/2 x lowest medical rate* for "Employee Only" coverage)

*2025 Lowest cost medical plan = Blue Shield Platinum Trio HMO

Note: COBRA rates for the medical plans are determined based upon the age of the separating employee and each covered dependent at the time of separation.

Blue Shield medical plans increased 6%; Kaiser HMO increased 7%; Delta Dental Plans remain unchanged; VSP remained unchanged.
2025 FSA Limits: $3,300 Healthcare; $660 Carryover $5,000 Dependent Care.
2025 Deferred Compensation Limit: $23,500. Employees age 50 or older may contribute an additional $7,500 for a total of $31,000.

City of Rancho Palos Verdes

30940 Hawthorne Boulevard

Rancho Palos Verdes, CA 90275

This brochure summarizes the benefit plans that are available to City of Rancho Palos Verdes eligible employees and their dependents. Official plan documents, policies, and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.