



2026
EMPLOYEE
BENEFITS *Guide*

INDIO
take center stage

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

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

Please see 63 for more details.

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

Human Resources Contact Information



Employee Benefits Programs	Contact
Benefits Coordination (Medical, Dental & Vision Insurance)	Yvette Villaseñor - Human Resources Analyst
COBRA Continuation	Adriana Rivas - Human Resources Assistant
Flexible Spending Accounts	Yvette Villaseñor - Human Resources Analyst
Voluntary Plan Administration	Yvette Villaseñor - Human Resources Analyst
Deferred Compensation	Yvette Villaseñor - Human Resources Analyst
Employee Assistance Program	Yvette Villaseñor - Human Resources Analyst
Fair Employment Housing Act (FEHA) Americans for Disabilities Act (ADA)	Venez Duong - Senior Human Resources Analyst
Family Medical Leave Act (FMLA)	Venez Duong - Senior Human Resources Analyst
Leave Administration	Venez Duong - Senior Human Resources Analyst
Workers' Compensation	Venez Duong - Senior Human Resources Analyst
Life Insurance & Disability Insurance	Yvette Villaseñor - Human Resources Analyst
Long Term & Short Term	Venez Duong - Senior Human Resources Analyst

Contact	Email	Phone
Human Resources Team		
<ul style="list-style-type: none"> • Andrew Ansoorian Director of Human Resources & Risk Management 	aansoorian@indio.org	760-391-4009
<ul style="list-style-type: none"> • Yvette Villaseñor Human Resources Analyst 	yvillasenor@indio.org	760-541-4437
<ul style="list-style-type: none"> • Venez Duong Senior Human Resources Analyst 	vduong@indio.org	760-391-4066
<ul style="list-style-type: none"> • Adriana Rivas Human Resources Assistant 	arivas@indio.org	760-541-4435
<ul style="list-style-type: none"> • Mayra Hernandez Human Resources Analyst 	mahernandez@indio.org	760-391-4045



Contact Information



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

Benefit Information: www.benefitbridge.com/cityofindio

Plan	Plan Code / Group No.	Phone Number	Web Site
Medical <i>To request a free paper copy of the SBC and glossary, please contact each health plan directly.</i>	<i>Region 3</i> <i>Please contact HR, if you're outside of LA, Riverside, or San Bernardino County and need your Plan Code.</i>		
• Anthem Blue Cross	Select HMO: 508 Traditional HMO: 511	877-737-7776	www.anthem.com/ca/calpers
• Blue Shield	Access+ HMO: 527 Trio HMO: 452	800-334-5847	www.blueshieldca.com/calpers
• Kaiser Permanente	535	800-464-4000	www.kp.org/calpers
• UnitedHealthcare SignatureValue	Alliance: 578 Harmony: 475	Active: 877-359-3714 Retirees: 888-867-5581	www.uhc.com/calpers
• Peace Officers Research Association of California (PORAC)	594	800-655-6397	www.ibtoforac.org
• PERS Gold, Platinum	Gold: 650 Platinum: 659	855-633-4436	includedhealth.com/calpers
Dental			
• Guardian	00070516	877-433-6825	www.guardianlife.com
• Principal	1085489	800-247-4695	www.principal.com
Vision			
• Principal (VSP)	1085489	800-877-7195	www.vsp.com
Employee Assistance Program (EAP)			
• ComPsych		888-628-4824	www.lincoln4benefits.com
Basic Life/AD&D, Optional Life, Long Term Disability (LTD)			
• Lincoln Financial	Life/AD&D/Dependent Life: 000010237317 LTD: 000010237318 Optional Life: 0004000010023487	800-423-2765	www.lfg.com
Flexible Spending Accounts (FSA), Dependent Care and Other Benefits			
• American Fidelity Matthew Fimbres		760-846-6767	matt.fimbres@americanfidelity.com
Deferred Compensation			
• Nationwide Janice D. Nichols	37234001	877-677-3678	nichoj7@nationwide.com



At the City of Indio we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each and every employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all of our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

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

- CalPERS Beneficiary Designation Form
- CalPERS Reciprocal
- **Register on the BenefitBridge Website:**
www.benefitbridge.com/cityofindio
- **If covering dependent(s):** deliver or upload required documents to HR. (documents listed on Page 6).

Optional Benefit Forms

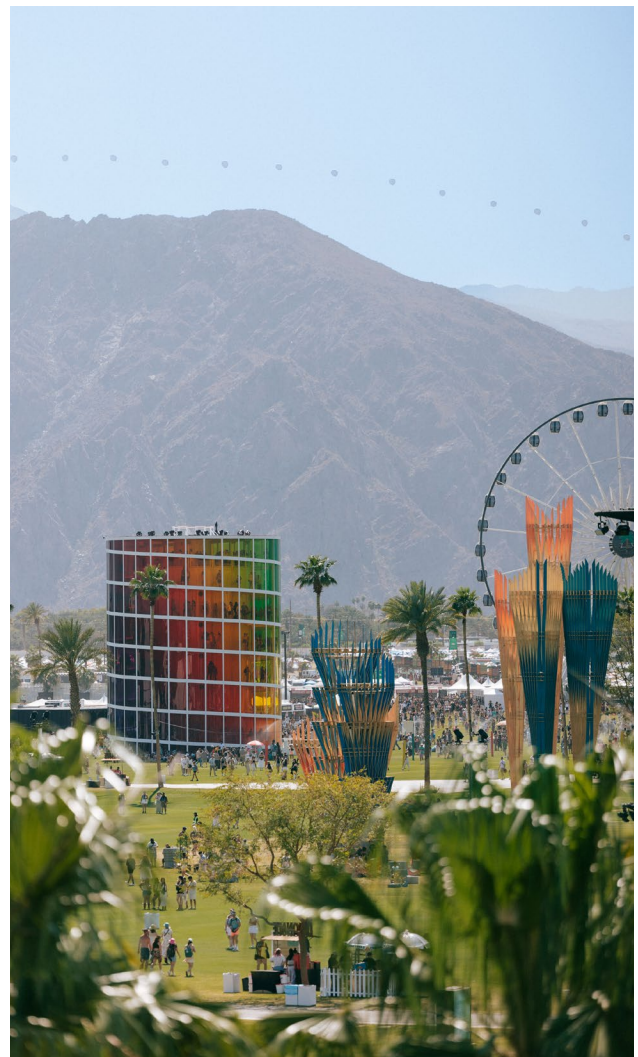
- Flexible Spending Plan Enrollment form

Enrollment and Benefit Choices

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

You have 30 days from the date of your initial appointment to enroll, or decline coverage for yourself and eligible family members. Benefits will begin on the 1st of the month after you submit your paperwork and appropriate documentation to the Human Resources Department. If you do not enroll during the initial 30 days, you will be subject to a waiting period until the following open enrollment period.

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



Eligibility and Enrollment



Who is Eligible for Benefits?

Employees

All regular City of Indio employees working full time may be eligible for benefits. If you are enrolling as a new employee most benefits are effective the 1st of the month following your date of hire. You may also choose to enroll your eligible dependents in many of our benefits. Spouse (includes same sex domestic partner) and eligible dependent children to age 26 are covered for most plans. Contact the Human Resources Department for specific plan details.

Family Members

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

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

Who Is Not Eligible for the CalPERS Health Program?

Ineligible Employees

- Those working less than half time
- Those whose appointment lasts less than six months
- Those whose job classification is "Limited-Term/Intermittent" (seasonal or temporary)
- Those classified as "Permanent-Intermittent" who do not meet the hour requirements within the control period

Ineligible Family Members

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

Do Not Enroll Ineligible Family Members

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

Where to Get Help With Your Health Benefits Enrollment

All benefit changes must be done on the BenefitBridge website.

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

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

For general information about health benefits, go to the CalPERS website at www.calpers.ca.gov. The chart on 6 indicates the forms and supporting documentation needed for most changes.

Spouse

You may add your spouse to your health plan within 30 days of your marriage. You are required to provide a copy of the marriage certificate and the spouse's Social Security Number and Medicare card (if applicable). Your spouse's coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.



Registered Domestic Partner

You may add your registered domestic partner to your health plan within 30 days of registration of the domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

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

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

Same sex domestic partnerships between persons who are both at least age 18 and certain opposite sex domestic partnerships (one partner must be 62 years of age or older and the other partner at least 18 years of age) are eligible to register with the Secretary of State. For more information about domestic partnership registration, visit the Secretary of State's website at www.sos.ca.gov.

Children

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

- Newborn children should be added within 30 days of birth. Coverage is effective from the date of birth.
- Newly adopted children should be added within 30 days of physical custody. Coverage is effective from the date physical custody is obtained.
- Stepchildren or a domestic partner's children under age 26 can be added within 30 days after the date of your marriage or registration of your domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Disabled Children Over Age 26

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

- Within 30 days before and ending 30 days after the child's 26th birthday (member and dependent currently enrolled), **or**
- Within 30 days of a newly eligible employee's initial enrollment in the CalPERS Health Program

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

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

Dependents in a Parent-Child Relationship

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

You have 30 days from the date you obtained custody of the child to enroll him or her on your health plan. Prior to enrollment of a dependent who is in a parent-child relationship, you must complete and submit an Affidavit of Parent-Child Relationship. You will be required to provide supporting documentation as indicated on the Affidavit of Parent-Child Relationship. Coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Eligibility and Enrollment (continued)



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

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

Split Enrollments

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

Enrolling in Two CalPERS Health Plans

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

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

Enrollment Type	Copies of Supporting Documentation*
Active employee – New enrollment	<ul style="list-style-type: none"> ID, Social Security Card
Adding a registered domestic partner	<ul style="list-style-type: none"> Declaration of Domestic Partnership from the California Secretary of State’s Office Medicare card (if applicable)
Adding a spouse	<ul style="list-style-type: none"> Marriage Certificate,* Social Security Card and Medicare card (if applicable) ID
Adding a dependent who is in a parent-child relationship (PCR)	<ul style="list-style-type: none"> Required supporting documentation as indicated on the Affidavit of Parent-Child Relationship.
Adding/deleting a dependent child	<ul style="list-style-type: none"> Medicare card (if applicable)* Reason for add/delete Birth Certificate, social security card(s)
Changing plans due to address change	<ul style="list-style-type: none"> Include both old and new addresses
Deleting a registered domestic partner due to termination of partnership	<ul style="list-style-type: none"> Termination of Domestic Partnership submitted to the California Secretary of State’s Office
Deleting a spouse due to divorce	<ul style="list-style-type: none"> Divorce Decree
Disabled child over age 26 – certification	<ul style="list-style-type: none"> Member Questionnaire for the CalPERS Disabled Dependent Benefit form Medical Report for the CalPERS Disabled Dependent Benefit form
Enrolling self or dependents due to loss of other health coverage	<ul style="list-style-type: none"> Certificate of Creditable Coverage, or other proof of loss of coverage Birth Certificate and Social Security Card(s) (Child) Marriage Certificate, ID and Social Security Card (Spouse) Declaration of Domestic Partnership (domestic partner)

* **Note:** Do not submit original documents as your documentation will not be returned. All changes must be made via the Benefit Bridge Website: www.benefitbridge.com/cityofindio.

City of Indio Online Benefits Enrollment is easy with BenefitBridge!

Need Help?

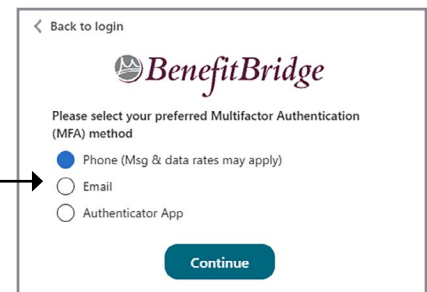
For all questions related to your benefits, please contact your employer's benefits administrator. For BenefitBridge technical assistance **only**, please contact BenefitBridge Customer Care at 800.814.1862; Mon – Fri, 8:00 a.m. – 5:00 p.m., PST or email benefitbridge@keenan.com.

A Multifactor Authentication (MFA) code is required to confirm your identity each time before you can log in to the system. Below are instructions to help you obtain your MFA code.

Registration and Login

Already have login credentials?

1. Login to BenefitBridge at www.benefitbridge.com/cityofindio
2. For your first login only, you will be asked to change your password.
 - If you have forgotten your password, click on **Forgot User Name/Password?** And follow the prompts.
3. The MFA selection popup will appear.
4. Select the MFA method you would like to use and select "Continue".
5. Different popup windows will appear, depending on your selection.



MFA Methods:

1. Select your preferred Multifactor Authentication Method: **Phone, Email or Authenticator App** and follow the prompts.

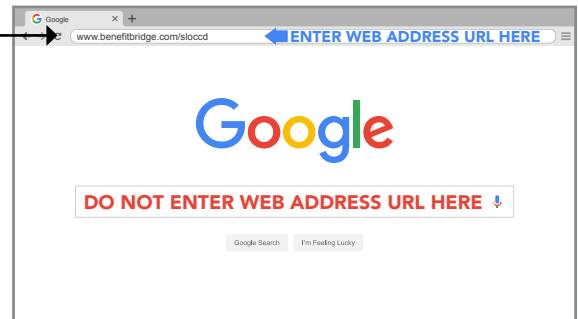
Download the Authenticator App

- Download the Microsoft Authenticator app (or the authenticator app of your choice) to your phone device using the Google Play Store or the Apple App Store.

NOTE: If you do not have a phone number or email listed in BenefitBridge, those options **will not be available** to you as preferred methods. Please contact your Benefits department to have your phone number and email address updated in BenefitBridge.

Need to create login credentials?

1. In the **address bar**, type www.benefitbridge.com/cityofindio (Not in the Bing, Google, Yahoo search engine field)
2. Click the **Enter** key, then follow the instructions below to register:
 - **STEP 1:** Select "Register" to **Create an Account**
 - You will need to create an account using your first and last names as they appear on your payroll statement.
 - **STEP 2:** Create a **Username** and **Password**
 - **STEP 3:** Select a picture, as instructed. You will be redirected to the User Login page to sign in.
 - **STEP 4:** Follow instructions in the **MFA Methods** section above.



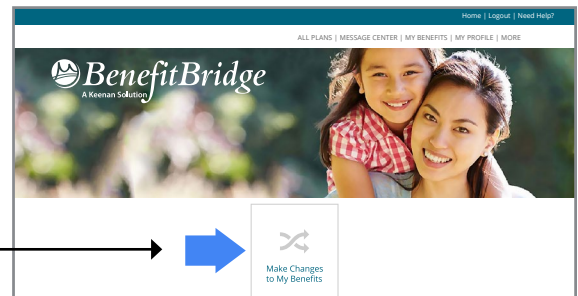
Enrolling in Benefits

Access your enrollment via the "Make Changes to My Benefits" button

For BenefitBridge technical assistance only,
please contact BenefitBridge Customer Care at

800.814.1862

Monday – Friday, 8:00 AM - 5:00 PM, PST or
email benefitbridge@keenan.com.





Life Changes and Their Impact on Benefits

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

Name or Address Changes

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

Health Benefits Coverage

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

Marriage

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

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

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

Divorce

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

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

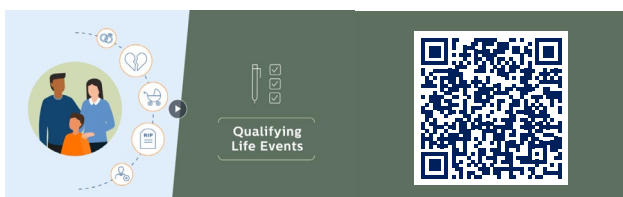
Health Benefits Coverage: You must remove your ex-spouse from your health plan as required by California Public Employees' Retirement Law. Your ex-spouse's entitlement to coverage ends at midnight on the last day of the month that your marriage dissolution is final. Contact Human Resources to modify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

Registered Domestic Partnership

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

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

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



Eligibility and Enrollment (continued)



Terminate Domestic Partnership

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

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

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

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

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

Birth or Adoption

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

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

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

Additional Documents to Consider Updating/Reviewing

- 457 Deferred Comp ICMA/Nationwide/Pentegra Beneficiary
- Checks Recipient Designation
- Emergency Contact
- Lincoln Life Insurance (Add, Delete, and/or change Beneficiary)

Additional Enrollment Opportunities

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

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

Special Enrollment

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

You lose other health coverage: If you initially declined (or canceled) enrollment for yourself or your dependents (including your spouse) because you had other private or CalPERS health coverage at that time, you may be able to enroll in a CalPERS health plan if the other coverage involuntarily ends. To qualify, you will need to request enrollment within 30 days after the other coverage ends and provide proof that the other coverage has ended.

You have new family members: When you enroll, you must enroll yourself or yourself and all eligible family members. If you later have a new dependent as a result of marriage, domestic partnership registration, birth, change of custody, adoption, or placement for adoption, you may enroll yourself and all eligible dependents within 30 days of that event.

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

Late Enrollment

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

Considering Your Health Plan Choices



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

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

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

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

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

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

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

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



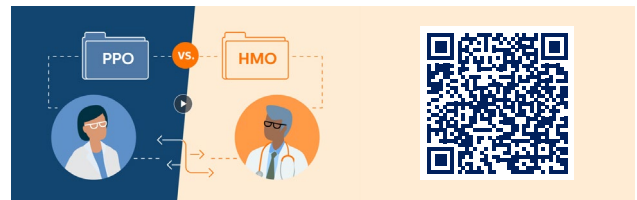
Understanding How CalPERS Health Plans Work



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

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

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



2026 Rates: Full-Time Employees



Group Insurance Plan – Health, Dental and Vision

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

Cafeteria Contributions

The City offers a cafeteria like plan:

- Employee may select any medical Health, Dental and Vision Plan
- Any remaining balance due will be deducted from the employee's paycheck on a bi-weekly basis.



CITY OF INDIO BENEFIT RATES 2026

Cafeteria Contributions	Representation	Monthly	Semi-Monthly
	IPOA/PCU	\$2,200.00	\$1,100.00
	Exec/City Council/Mgmt/	\$2,100.00	\$1,050.00
	Conf/Unrep/SEIU/ICEA/IWAEA	\$2,100.00	\$1,050.00

Insurance Plan	Coverage	Monthly	Semi-Monthly
Medical Rates			
Anthem Select HMO	Single	\$962.68	\$481.34
	2 Party	\$1,925.36	\$962.68
	Family	\$2,502.97	\$1,251.49
Anthem Traditional HMO	Single	\$1,128.53	\$564.27
	2 Party	\$2,257.06	\$1,128.53
	Family	\$2,934.18	\$1,467.09
Blue Shield Access + HMO	Single	\$917.91	\$458.96
	2 Party	\$1,835.82	\$917.91
	Family	\$2,386.57	\$1,193.29
Blue Shield Trio HMO	Single	\$852.56	\$426.28
	2 Party	\$1,705.12	\$852.56
	Family	\$2,216.66	\$1,108.33
Kaiser HMO	Single	\$969.05	\$484.53
	2 Party	\$1,938.10	\$969.05
	Family	\$2,519.53	\$1,259.77
PERS Platinum PPO	Single	\$1,431.81	\$715.91
	2 Party	\$2,863.62	\$1,431.81
	Family	\$3,722.71	\$1,861.36
PERS Gold PPO	Single	\$960.03	\$480.02
	2 Party	\$1,920.06	\$960.03
	Family	\$2,496.08	\$1,248.04
PORAC (IPOA & PCU ONLY) PPO	Single	\$1,057.00	\$528.50
	2 Party	\$2,127.00	\$1,063.50
	Family	\$2,708.00	\$1,354.00
United HealthCare Alliance	Single	\$870.76	\$435.38
	2 Party	\$1,741.52	\$870.76
	Family	\$2,263.98	\$1,131.99
United HealthCare Harmony	Single	\$765.51	\$382.76
	2 Party	\$1,531.02	\$765.51
	Family	\$1,990.33	\$995.17

If you live outside of LA, Riverside or San Bernardino, your rates may be slightly different. Please contact HR for rates.

2026 Rates: Full-Time Employees (continued)



Dental Rates			
Guardian DHMO	Single	\$16.55	\$8.28
	2 Party	\$28.60	\$14.30
	Family	\$47.75	\$23.88
Principal EPO Low	Single	\$22.25	\$11.13
	2 Party	\$44.58	\$22.29
	Family	\$81.24	\$40.62
Principal POS High	Single	\$43.10	\$21.55
	2 Party	\$84.32	\$42.16
	Family	\$131.50	\$65.75
Vision Rate			
VSP- Principal	Single	\$10.14	\$5.07
	2 Party	\$14.57	\$7.29
	EE + Children	\$14.57	\$7.29
	Family	\$26.16	\$13.08



If you live outside of LA, Riverside or San Bernardino, your rates may be slightly different.
Please contact HR for rates.

2026 CalPERS – EPO & HMO Basic Plans



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

Benefits	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	United-Healthcare Signature-Value	Western Health Advantage HMO
	Select HMO Traditional HMO	Access+ HMO EPO Trio HMO				Alliance & Harmony	
Calendar Year Deductible							
• Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Copay or Coinsurance (excluding pharmacy)							
• Individual	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)
• Family	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)
Hospital (including Mental Health and Substance Abuse)							
• Deductible (per admission)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Facility/Surgery Services	No Charge	No Charge	No Charge	\$15	No Charge	No Charge	No Charge
Emergency Services							
• Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Emergency (copay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50	\$50	\$50
• Non-Emergency (copay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Physician Services (including Mental Health and Substance Abuse)							
• Office Visits (copay for each service provided)	\$15	\$15	\$15	\$15	\$15	\$15	\$15
• Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15
• Urgent Care Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15

****Health Net Salud Y Mas Plan is not offered for City of Indio employees****

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2026 CalPERS – EPO & HMO Basic Plans (continued)



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

Benefits	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	United-Healthcare Signature-Value	Western Health Advantage HMO
	Select HMO Traditional HMO	Access+ HMO EPO Trio HMO				Alliance & Harmony	
• Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Surgery/ Anesthesia	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-ray/Lab	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Prescription Drugs							
• Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Retail Pharmacy (30-day supply)	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50 Tier 4: \$30	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Generic: \$5 Brand: \$20	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50	Tier 1: \$5 Tier 2: \$20 Tier 3: \$50
• Retail Pharmacy (90-day supply)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100 Tier 4: \$60 (Retail Preferred Pharmacy Maintenance Medications)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100
• Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100 Tier 4: \$60	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Generic: \$10 Brand: \$40 (31-100 day supply)	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100	Tier 1: \$10 Tier 2: \$40 Tier 3: \$100
• Mail order maximum copayment per person per calendar year	\$1,000	\$1,000	\$1,000	N/A	\$1,000	\$1,000	\$1,000
Durable Medical Equipment	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Infertility Testing/ Treatment	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges

****Health Net Salud Y Mas Plan is not offered for City of Indio employees****

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2026 CalPERS – EPO & HMO Basic Plans (continued)



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

Benefits	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	United-Healthcare Signature-Value	Western Health Advantage HMO
	Select HMO Traditional HMO	Access+ HMO EPO Trio HMO				Alliance & Harmony	
Occupational /Physical /Speech Therapy							
• Inpatient (hospital or skilled nursing facility)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient (office and home visits)	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Diabetes Services							
• Glucose monitors	Coverage varies	No Charge	Coverage varies	No Charge	Coverage varies	Coverage varies	Coverage varies
• Self-management training	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Acupuncture	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
Chiropractic	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
Pregnancy & Maternity Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

****Health Net Salud Y Mas Plan is not offered for City of Indio employees****

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2026 CalPERS – PPO Basic Plans



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

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

- Incentives available to reduce individual inpatient deductible (max. \$500) or family deductible (max. \$1,000). Refer to EOC for details.
- Coinsurance waived for deliveries if enrolled in Included Health’s Maternity Program by the 24th week of pregnancy. For deliveries after April 2026, member must be enrolled by January 1, 2026.
- Deductible is not transferable between PERS Gold and PERS Platinum.
- Of the allowable amount as defined in the EOC.

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

2026 CalPERS – PPO Basic Plans (continued)



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

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Physician Services (including Mental Health and Substance Abuse)						
• Office Visits (copay for each service provided)	\$35 ^{1,2}	40% ³	\$20 ²	40% ³	\$10/\$35 ²	20% ³
• Inpatient Visits	20%	40% ³	10%	40% ³	20%	20% ³
• Outpatient Visits	\$35	40% ³	\$20	40% ³	20%	20% ³
• Urgent Care Visits	\$35	40% ³	\$35	40% ³	\$35	20% ³
• Preventive Services	No Charge	40% ³	No Charge	40% ³	No Charge	
• Surgery/Anesthesia	20%	40% ³	10%	40% ³	20%	20% ³
Diagnostic X-Ray/Lab	20% ⁴	40% ³	10% ⁴	40% ³	20%	20% ³

- 1 Reduced to \$10 when seen by matched primary physician.
- 2 \$35 for specialist visit.
- 3 Of the allowable amount as defined in the EOC.
- 4 For lab services only — no charge when using Quest Diagnostic or Labcorp.

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2026 CalPERS – PPO Basic Plans (continued)



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

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

¹ Of the allowable amount as defined in the EOC.

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2026 CalPERS – PPO Basic Plans (continued)



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

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Infertility Testing/ Treatment	50%		50%		50%	50% ²
Occupational / Physical / Speech Therapy						
• Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		20%	20% ²
• Outpatient (office and home visits)	20%	40% (Occupational therapy: 20%)	10%	40% (Occupational therapy: 10%)	20%	20% ²
	(pre-certification required for more than 24 visits)		(Pre-certification required for more than 24 visits)			
Diabetes Services						
• Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies	
• Self-management training	\$20 ¹	40% ²	\$20 ¹	40% ²	\$20	60% ²
Acupuncture	\$15/Visit	40% ²	\$15/Visit	40% ²	20%	20% ²
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)	
Chiropractic	\$15/Visit	40% ²	\$15/Visit	40% ²	20%	20% ²
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)	
Pregnancy & Maternity Care	20% ³	40%	10%	40%	80%	80%

1 \$35 for specialist visit.

2 Of the allowable amount as defined in the EOC.

3 Coinsurance waived for deliveries if enrolled in Included Health's Maternity Program by the 24th week of pregnancy. For deliveries after April 2026, member must be enrolled by January 1, 2026.

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

Obtaining Health Care Quality Information



Following is a list of resources you can use to evaluate and select a doctor and hospital.

Hospitals

CalQualityCare
www.CalQualityCare.org

From hospitals to home care, [CalQualityCare.org](http://www.CalQualityCare.org) makes it easy to find providers and compare the quality of health care in California.

U.S. Department of Health and Human Services
www.medicare.gov/hospitalcompare

Hospital Compare has information about the quality of care at over 4,000 Medicare-certified hospitals across the country.

The Leapfrog Group
www.leapfroggroup.org

This is a coalition of health purchasers who have found that hospitals meeting certain standards have better care results.

Doctors and Medical Groups

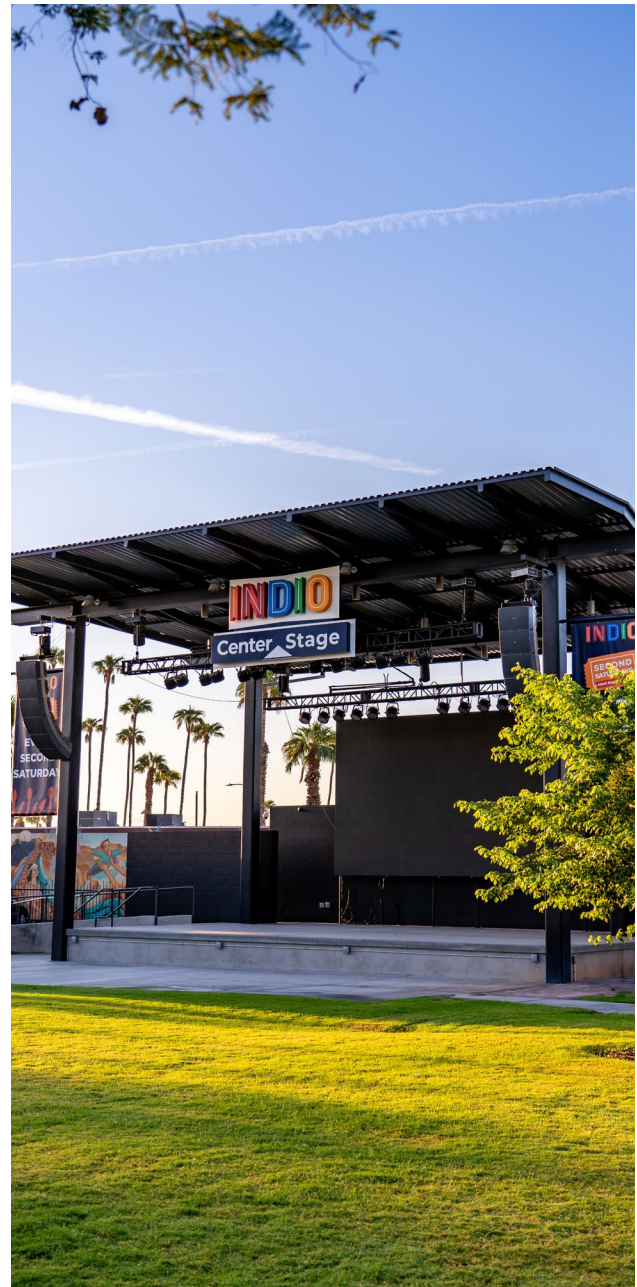
Medical Board of California
www.mbc.ca.gov

This is the California State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.

Have you done a checkup on your doctor's license? The Medical Board of California encourages consumers to check up on their doctor's license. Such a checkup is simple and helps you make an informed choice when choosing a doctor. To determine a doctor's status, go to the Medical Board's website at www.mbc.ca.gov or if you do not have a computer, call [800-633-2322](tel:800-633-2322) and Medical Board staff will look up the doctor for you.

Office of the Patient Advocate
www.opa.ca.gov

This website includes a State of California-sponsored "Report Card" that contains additional clinical and member experience data on HMOs, PPOs and medical groups in California.



Benefit Comparison Charts

The benefit comparison charts on pages 14 - 20 summarize the benefit information for each health plan.

For more details, see each plan's Evidence of Coverage (EOC) booklet.



Principal

Dental PPO/EPO Plans

- **Principal POS is different from other PPO plans because of their unique cost protection safety net:** Principal EPO dentists, who provide an additional network in addition to Principal PPO dentists.
- This translates to up to 50% off of covered services which extends your plan maximum!

	Low EPO Option	High POS Option		
	In-Network	EPO Network	In-Network	Out-of-Network
Annual Deductible <i>(Individual/Family)</i>	\$50/\$150	\$50/\$150	\$50/\$150	\$100/\$300
Waived for Preventive	Yes	Yes	Yes	No
Annual Plan Maximum	\$1,000	\$1,500	\$1,500	\$1,500
Waiting Period	None	None	None	None
Reimbursement Schedule	Based on EPO contracted fees	Based on EPO contracted fees	Based on PPO contracted fees	90th UCR
Diagnostic & Preventive	100%	100%	100%	80%
Basic Services	80%	90%	90%	80%
Major Services	50%	50%	50%	50%
Orthodontia Services				
• Lifetime Plan Maximum	\$1,000	\$1,500	\$1,500	\$1,500
• Eligibility	Adults and dependent children to age 26			



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Guardian Dental HMO Plan

The No Problem Plan

- No Deductibles
- No Claim Forms
- No Annual Maximums
- No Limitations on Most Pre-Existing Conditions
- No Waiting Periods to See a Dentist

See Your Savings

Compare your costs with Guardian Managed Dental Care Plan N600IM to average dental fees:

Sample Treatment Plan	Avg. Fee	with Managed Dental Care	Your Savings
Exams	\$83	No Charge	\$83
Cleanings	\$138	No Charge	\$138
Full Mouth x-rays	\$193	No Charge	\$193
Filling, 1 surface	\$216	No Charge	\$216
Root Canal, single	\$1,535	\$50	\$1,485
Crown, PFM	\$1,658	\$95	\$1,583
TOTAL	\$3,823	\$145	\$3,698

	Managed Dental Care - Plan N600IM All Employees
Diagnostic & Preventive	Various co-pays apply
Basic Services	Various co-pays apply
Major Services	Various co-pays apply
Orthodontia Services	
• Dependent Children	Various co-pays apply
• Adults	Various co-pays apply
• Lifetime Plan Maximum	Unlimited

Note: Dental Implants are covered. Please refer to your fee schedule for specific covered benefits!

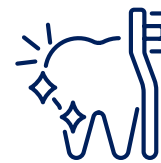
Choose from Hundreds of Dentists

Guardian Dental Network offers comprehensive dental benefits through hundreds of independently owned and operated dental offices conveniently located throughout California.

Specialty Coverage

All general dentists may not be capable of performing each of the services listed herein and, based upon a Member's condition, certain procedures may not be within the scope of practice or ability of a general dentist. In such a case, the general dentist will refer the Member to a Guardian Managed Dental Care Network participating dental specialist. Your costs for the services of a dental specialist may vary, based upon the coverage option selected by your group.

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Managed Dental Care (continued)

Plan N600IM

The following is a partial list of dental services that are covered benefits, at the specified copayment, when provided by a participating Guardian Managed Dental Care Network general dentist. Participating dentists may be found online at www.guardianlife.com.

Services	Your Copayment
Preventive	
• Office visit	No Charge
• Oral examination	No Charge
• Intraoral X-rays, complete series	No Charge
• Bitewing X-rays, single film	No Charge
• Panoramic X-ray	No Charge
• Prophylaxis (teeth cleaning)	No Charge
• Topical fluoride (child)	No Charge
• Oral Hygiene	No charge
Routine Services	
• Amalgam, One surface	No Charge
• Amalgam, Two surfaces	No Charge
• Amalgam, Three surfaces	No Charge
Restorations	
• Resin, one surface anterior	No Charge
• Resin, two surface anterior	No Charge
• Extraction, single tooth	No Charge
Oral Surgery	
• Surgical removal of erupted tooth	\$30
• Removal of impacted tooth, soft tissue	\$50
• Removal of impacted tooth, partially bony	\$50
• Surgical incision with drainage of abscess, intraoral soft tissue	\$25
Endodontics	
• Pulp cap, direct	No Charge
• Pulp cap, indirect	No Charge
• Therapeutic pulpotomy	\$10
• Root canal, anterior	\$70
• Root canal, bicuspid	\$80
• Root canal, molar	\$140
Periodontics	
• Gingivectomy or gingivoplasty, 4 or more contiguous teeth, per quadrant	\$62
• Scaling & root planing, per quadrant	\$30

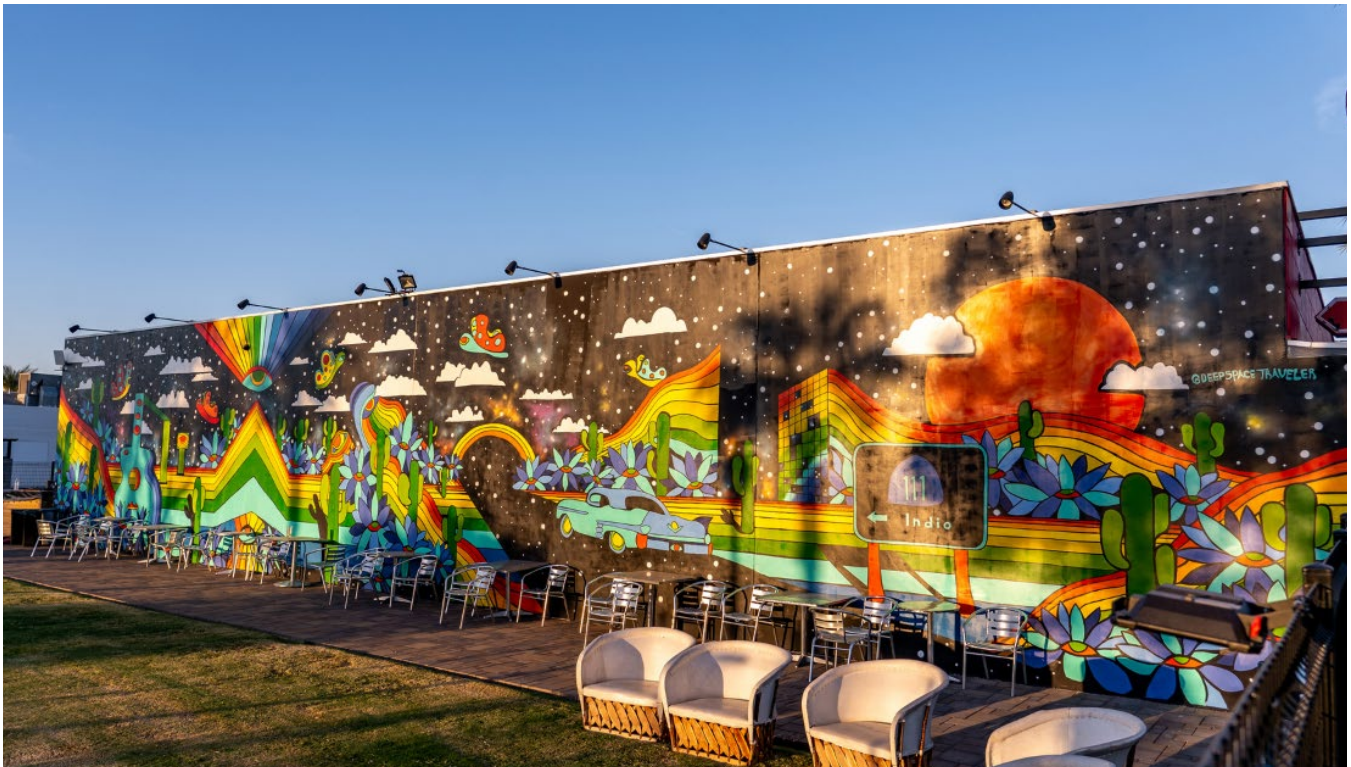
Services	Your Copayment
Major*	
• Crowns	
– Porcelain fused to high noble metal	\$95
– Porcelain fused topredominantly base metal	\$95
• Full cast base metal	\$95
• 3/4 cast noble metal	\$90
Dentures & Prosthodontics	
• Complete upper or lower denture	\$110
• Upper or lower partial denture, resin base	\$90
• Upper or lower partial denture, cast metal base with resin saddles	\$137
• Replace missing or broken teeth, complete denture, each tooth	\$0
Implants	
• Surgical placement of implant body (endosteal)	\$1,050
• Prefab. abutment (includes placement)	\$575
• Abutment supported porcelain/ceramic crown	\$725
• Abutment supported retainer, porcelain/ceramic fixed partial denture	\$725
Cosmetic Benefits	
• Tooth colored fillings, one surface, back tooth	Not covered
• Bleaching, per arch	\$165
• Labial veneer (porcelain laminate), laboratory	\$100
• Night guards, soft, includes lab fee	Not covered

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Principal (VSP)

Plan Benefits	Principal (VSP)	
	In-Network	Out-of-Network
Co-pay		
• Examination	\$10 co-pay	Up to \$45
• Materials	\$10 co-pay	Varies by Lens
Benefit Frequency		
• Examination	12 months	12 months
• Lenses	12 months	12 months
• Frames	12 months	12 months
• Contacts	12 months	12 months
Lenses		
• Single Vision Lens	\$0 co-pay	Up to \$30
• Bifocal Lens	\$0 co-pay	Up to \$50
• Trifocal Lens	\$0 co-pay	Up to \$65
• Lenticular	\$0 co-pay	Up to \$100
Contact Lenses		
• Medically Necessary	\$10 copay (covered in full for specific conditions)	Up to \$210
• Elective	\$150 allowance	Up to \$105
• Frames	Up to \$60 copay (\$150 allowance)	Up to \$70



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Basic Life & AD&D

Basic Life

The City of Indio provides Group Life and Accidental Death and Dismemberment Insurance for full-time employees. The City also includes the option to cover your spouse / domestic partner for \$1,000 and children for up to \$1,000 at no cost to you.

Life and Accident Insurance

Life insurance can provide your dependents with a lifetime of financial security, and upon your death, can be used to pay off your debts- like credit cards and your mortgage - or other expenses that could burden your family. The City of Indio provides Basic Life Insurance at no cost to you.

What is Accidental Death & Dismemberment Insurance?

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

Don't Forget to Name a Beneficiary

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



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Term Life and AD&D Insurance



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

All Full-time Non-Safety Employees

Term Life and AD&D Insurance

Safeguard the most important people in your life.

Think about what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like covering everyday expenses, paying off debt, and protecting savings. AD&D provides even more coverage if you die or suffer a covered loss in an accident.

AT A GLANCE:

- A cash benefit of \$50,000 to your loved ones in the event of your death, plus a matching cash benefit if you die in an accident
- A cash benefit to you if you suffer a covered loss in an accident, such as losing a limb or your eyesight
- The option to cover your spouse / domestic partner for \$1,000 and children for up to \$1,000
- *Accident Plus* - If you suffer an AD&D loss in an accident, you may also receive benefits for the following on top of your core AD&D benefits: coma, plegia, education, child care, spouse training, and more.
- *LifeKeys*[®] services, which provide access to counseling, financial, and legal support
- *TravelConnect*SM services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

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

ADDITIONAL DETAILS

Conversion: You can convert your group term life coverage to an individual life insurance policy without providing evidence of insurability if you lose coverage due to leaving your job or for another reason outlined in the plan contract. AD&D benefits cannot be converted.

Benefit Reduction: Coverage amounts begin to reduce at age 80 and benefits terminate at retirement. See the plan certificate for details.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

LifeKeys[®] services are provided by ComPsych[®] Corporation, Chicago, IL. ComPsych[®], EstateGuidance[®] and GuidanceResources[®] are registered trademarks of ComPsych[®] Corporation. *TravelConnect*SM services are provided by On Call International, Salem, NH. ComPsych[®] and On Call International are not Lincoln Financial Group[®] companies. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations.

Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations. Limitations and exclusions apply.

Benefits Overview | The Lincoln National Life Insurance Company

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Term Life and AD&D Insurance (continued)



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

All Full-time Safety Employees

Term Life and AD&D Insurance

Safeguard the most important people in your life.

Think about what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like covering everyday expenses, paying off debt, and protecting savings. AD&D provides even more coverage if you die or suffer a covered loss in an accident.

AT A GLANCE:

- A cash benefit of \$50,000 to your loved ones in the event of your death, plus a matching cash benefit if you die in an accident
- A cash benefit to you if you suffer a covered loss in an accident, such as losing a limb or your eyesight
- The option to cover your spouse / domestic partner for \$1,000 and children for up to \$1,000
- *LifeKeys*[®] services, which provide access to counseling, financial, and legal support
- *TravelConnect*SM services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

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

ADDITIONAL DETAILS

Conversion: You can convert your group term life coverage to an individual life insurance policy without providing evidence of insurability if you lose coverage due to leaving your job or for another reason outlined in the plan contract. AD&D benefits cannot be converted.

Benefit Reduction: Coverage amounts begin to reduce at age 80 and benefits terminate at retirement. See the plan certificate for details.

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Benefits Overview | The Lincoln National Life Insurance Company

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Voluntary Term Life and AD&D Insurance



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

Voluntary Life Insurance

Plan Benefits	Lincoln Insurance
Coverage Amount	Employee must elect coverage for Spouse/Domestic Partner or dependents to be eligible.
<ul style="list-style-type: none"> Employee 	Increments of \$5,000, limited to 5x's annual salary to a maximum of \$200,000
<ul style="list-style-type: none"> Spouse 	Increments of \$5,000, limited to 100% of the employee amount
<ul style="list-style-type: none"> Child(ren) 	
– Day 1 to age 26	\$10,000
Minimum/Maximum Benefit	
<ul style="list-style-type: none"> Employee 	\$5,000 minimum. 5 x's annual salary to a maximum of \$200,000
<ul style="list-style-type: none"> Spouse 	\$5,000 minimum. 100% of the employee coverage amount, to a maximum of \$100,000
<ul style="list-style-type: none"> Child(ren) 	\$10,000/\$10,000
Guaranteed Issue	
<ul style="list-style-type: none"> Employee 	\$150,000
<ul style="list-style-type: none"> Spouse 	\$30,000
<ul style="list-style-type: none"> Child(ren) 	\$10,000

Voluntary Accidental Death and Dismemberment (AD&D)

All full-time employees of the City are eligible for AD&D coverage through Lincoln Insurance.

The coverage amount is the same as the life insurance coverage listed above.

The guarantee issue amount is only applicable when you are first eligible for the benefit.

If you wish to elect/enroll additional coverage, you will need to complete an Evidence of Insurability (EOI) form and go through the underwriting process. However, during open enrollment (only), you can increase you and your dependents coverage amount by two increments without needing to complete an Evidence of Insurability (EOI) form. Note: If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability (EOI).

Please refer to your voluntary life enrollment kit for rates.

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Voluntary Term Life and AD&D Insurance (continued)



City of Indio

Benefits At-A-Glance

Voluntary Term Life and AD&D Insurance

The Lincoln Term Life and AD&D Insurance Plan:

- Provides a cash benefit to your loved ones in the event of your death
- Provides an additional cash benefit to your loved ones if you die — or to you if you lose a limb or your eyesight — in a covered accident when you add optional AD&D insurance
- Features group rates for City of Indio employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services
- Also includes *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Employee	
Guaranteed coverage amount during initial offering or approved special enrollment period	\$150,000
Newly hired employee guaranteed coverage amount	\$150,000
Continuing employee guaranteed coverage annual increase amount	Choice of \$5,000 or \$10,000
Maximum coverage amount	5 times your annual salary (\$200,000 maximum in increments of \$5,000)
Minimum coverage amount	\$5,000
Optional AD&D coverage amount	Equal to the life insurance amount chosen
Spouse / Domestic Partner	
Guaranteed coverage amount during initial offering or approved special enrollment period	\$30,000
Newly hired employee guaranteed coverage amount	\$30,000
Continuing employee guaranteed coverage annual increase amount	Choice of \$5,000 or \$10,000
Maximum coverage amount	100% of the employee coverage amount (\$100,000 maximum in increments of \$5,000)
Minimum coverage amount	\$5,000
Optional AD&D coverage amount	Equal to the life insurance amount chosen
Dependent Children	
Day 1 to age 26 guaranteed coverage amount	\$10,000

The Lincoln National Life Insurance Company



What your benefits cover

Employee Coverage

Guaranteed Life and Optional AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to \$150,000 without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase your coverage amount by \$5,000 or \$10,000 without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to \$10,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 5 times your annual salary (\$200,000 maximum) with evidence of insurability. See the Evidence of Insurability page for details.
- Your coverage amount will reduce by 35% when you reach age 65 and an additional 15% of the original amount when you reach age 80.

Spouse / Domestic Partner Coverage - You can secure term life and AD&D insurance for your spouse / domestic partner if you select coverage for yourself.

Guaranteed Life and Optional AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to 100% of your coverage amount (\$30,000 maximum) for your spouse / domestic partner without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase the coverage amount for your spouse / domestic partner by \$5,000 or \$10,000 without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to \$10,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 100% of your coverage amount (\$100,000 maximum) for your spouse / domestic partner with evidence of insurability.
- Coverage amounts are reduced by 35% when an employee reaches age 65 and an additional 15% when an employee reaches age 80.

Dependent Children Coverage - You can secure term life insurance for your dependent children when you choose coverage for yourself.

Guaranteed Life Insurance Coverage Options: \$2,500, \$5,000, \$7,500, and \$10,000.

Voluntary Life and AD&D Insurance Benefits At-A-Glance

Voluntary Term Life and AD&D Insurance (continued)



Additional Plan Benefits

Accelerated Death Benefit	Included
Premium Waiver	Included
Conversion	Included
Portability	Included
Seat Belt & Airbag	Included with AD&D
Common Carrier	Included with AD&D

Benefit Exclusions

Like any insurance, this term life and AD&D insurance policy does have exclusions.

For life insurance, a suicide exclusion may apply.

For AD&D, benefits will not be paid if death results from suicide, or death/dismemberment occurs while:

- Inflicting or attempting to inflict injury to one's self
- Participating in a riot or as a result of war or act of war
- Serving as a member of the military, including the Reserves and National Guard
- Committing or attempting to commit a felony
- Deliberately inhaling gas (such as carbon monoxide) or using drugs other than those prescribed by a physician and administered as prescribed
- Flying in a non-commercial airplane or aircraft, such as a balloon or glider
- Driving while intoxicated (with a blood alcohol level of .08 grams or more per 100 milliliters of blood)

In addition, the AD&D insurance policy does not cover sickness or disease, including the medical and surgical treatment of a disease.

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

Questions? Call 800-423-2765 and mention Group ID: CITYINDIO.

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Voluntary Life and AD&D Insurance Benefits At-A-Glance

LFE-ENRO-BRC001-CA

457 Deferred Compensation Plan



The City of Indio's 457 Plan offers you the opportunity to defer a specific amount of your paycheck on a pretax basis through a payroll deduction. It's a great way to save for your retirement years! Taxes are deferred until withdrawal. Like a 401(k), your money grows tax deferred until retirement when it is taxed as ordinary income when withdrawn.

Nationwide Retirement Solutions

Janice D. Nichols | [760-567-5007](tel:760-567-5007) | Nicho7@nationwide.com | www.NRSforu.com

CalPERS Retirement System

Service Retirement

Your retirement formula is determined by your employer's contract with CalPERS. Your benefit factor is the percentage of pay to which you are entitled for each year of service. It is determined by your age at retirement and the retirement formula that was contracted by the City of Indio with CalPERS. Contact your Human Resources or CalPERS to determine your retirement formula.

Retirement Formulas

	Tier I*	Tier II**	Tier III**
Local Miscellaneous	2.7% @ 55	2% @ 62	N/A
Local Safety	3% @ 50	3% @ 55	2.7% @ 57

* Annuity based on employee's highest paid year

** Annuity based on average of employee's three (3) highest paid consecutive years

California Public Employees' Retirement System

[888-225-7377](tel:888-225-7377)

www.calpers.ca.gov

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Flexible Spending Accounts

American Fidelity Assurance Company

Flexible Spending Accounts are great cost savings tools to help with common medical expenses not covered by your major medical insurance and/or dependent care expenses. You can elect a portion of your pay to be deducted, on a pre-tax basis, from each paycheck to use for reimbursement of qualified out-of-pocket expenses throughout the plan year.

Flexible Spending Account Savings Example

With FSA		Without FSA
\$30,000	Annual Gross Income	\$30,000
- \$2,400	Healthcare FSA Election	\$0
- \$2,500	Dependent Care Account Election	\$0
\$25,100	Taxable Gross Income	\$30,000
- \$5,020	Estimated Federal Tax (20%)*	- 6,000
- \$1,920.15	Estimated FICA (7.65%)	- 2,295
\$18,159.85	Annual Net Income	\$21,705
\$0	Cost of Medical Expenses	- \$2,400
\$0	Cost of Dependent Care Expenses	- \$2,500
\$18,159.85	Spendable Income	\$16,805
With an FSA, potential annual savings in this example is: \$1,354.85		
By using an FSA to pay for eligible expenses, you can reduce your taxable income.		

* Estimated state 5% and federal 15%.

Healthcare Flexible Spending Account (Healthcare FSA)

A Healthcare FSA allows you to allocate money on a pre-tax basis to reimburse yourself for qualified medical expenses for you and your family. Qualified expenses include anything from co-payments, medical deductibles, prescriptions and much more.

Minimum Annual Election: Determined by your employer
Maximum Annual Election: Internal Revenue Code allows up to \$2,750 per plan year, but your employer will determine amount.

Examples of Eligible Expenses for Healthcare FSA

- Copays/coinsurance
- Deductibles
- Dental treatments
- Diabetic supplies
- Prescription drugs and medicines
- Eye exams, eyeglasses, contact lenses, contact lens solution and enzyme
- Flu shots
- Immunizations
- Lab fees
- Laser/Lasik/RK surgery
- Medical exams
- Orthodontia
- Psychiatric care
- Wheelchair
- X-rays

For a more complete list of eligible expenses, please visit www.americanfidelity.com

SB-23290-0419



HRA, FSA, HSA numbers are reflected for the 2025 calendar year. 2026 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2026 year should keep this in mind.

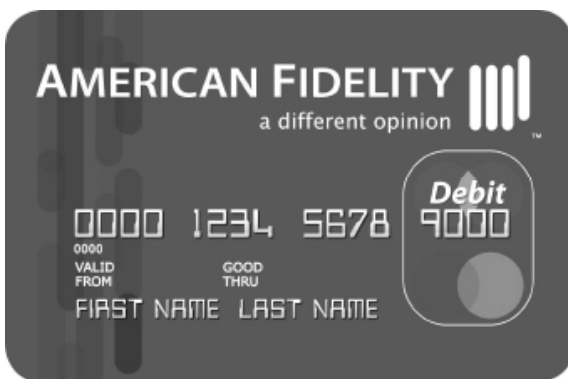


Flexible Spending Accounts

Benefits Debit Card

Benefits Debit Card

American Fidelity will provide a Benefits Debit Card to all employees who elect to participate in a Healthcare FSA (where offered by your employer.) The debit card gives immediate, convenient access to Healthcare FSA funds at the point of sale for prescriptions, copays, and other common qualified medical expenses. The card can only be used for the Healthcare FSA and is not available for the DCA.



Using Your Benefits Debit Card

Simply swipe your card like you would with any other credit card. Whether at the doctor's office or the dentist, the amount of your eligible expenses will be automatically deducted from your Healthcare FSA. Save ALL receipts!

Cards for Healthcare FSAs can be used at:

- Health care related facilities which include: hospitals, physician offices, dental offices, vision offices; and,
- Merchants participating in the Inventory Information Approval System (IIAS).
- The card is for medical expenses only; dependent day care expenses are not eligible.
- The card cannot be used for over-the-counter drugs filled with a prescription. You will need to file a manual claim for these types of expenses.

Snap. Submit. And Go!

When using your Benefits Debit Card to pay for an eligible expense, you may need to retain documentation to verify the expense. The AFmobile® app makes this easy.

- **Snap** a photo of the itemized receipt* with your phone.
- **Submit** the photo of the itemized receipts within the app when you receive notification that a receipt is needed to verify your expense.
- **Go!** After submitting your verification and its review, you will be able to view the status of your reimbursement within the app.

*The Internal Revenue Code (IRC) requires proof of the eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.

Activating Your Card

You will receive your card at your home address and may begin using your card on the first day of your plan year. Your card will be automatically activated when you use it for the first time for an eligible expense.



Flexible Spending Accounts

American Fidelity Assurance Company

Dependent Care Account (DCA)

A Dependent Care Account allows you to allocate money on a pre-tax basis to reimburse yourself for dependent care expenses that allow you (and your spouse) to work. Reimbursement is permitted only after the services have been provided and the expense has been paid. As dependent care contributions are withheld from your paycheck and placed into the account, these funds become available for reimbursement requests. Submit the entire amount of your dependent care expense after the care is provided, even if it exceeds your monthly contribution amount, to maximize reimbursement opportunities. This allows you to build up a "pool" of submitted expenses, with pending amounts ready for reimbursement as soon as your next contribution is received and deposited into your account.

Minimum Annual Election: Determined by your employer.

Maximum Annual Election: While the IRC allows a maximum of \$5,000 per year, the employer may set the maximum equal to or lower than this amount.

Examples of Eligible Dependent Care Expenses

After-school care or extended day programs

Nanny expenses

Baby-sitter inside or outside participant's household

Custodial or elder care expenses if the qualifying individual still spends at least 8 hours each day in the employee's household

Dependent Day Care center* expenses/pre-kindergarten/nursery school expense

Expenses paid to a non-dependent relative of participant to care for the child

Summer day camp if the primary purpose of the expense is custodial in nature and not educational

For a more complete list of eligible expenses, please visit www.americanfidelity.com.

**A Dependent Care Center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, regardless of whether the center is run for profit.*

Regardless of whether you participate in the Dependent Care Account under the Section 125 Plan or claim the Dependent Care credit on your income tax return, you must provide the Internal Revenue Service with the name, address and taxpayer identification number (TIN) or Social Security number of your dependent care provider(s) by completing either Schedule 2 of Form 1040A or Form 2441 and attaching it to your annual income tax return. Be sure that you follow

the current instructions given by the IRS for preparing your annual income tax return. Failure to provide this information to the IRS could result in loss of the pre-tax treatment of your Dependent Day Care FSA contributions or loss of the Dependent Care Tax Credit.

FSA Fund Availability

Healthcare FSA

Your full annual election is available to you on the first day of the plan year.

Dependent Care Account

Unlike the Healthcare FSA, the entire elected amount is not available on the first day of the plan year, but rather as contributions are received.

Important FSA Notes:

- Participants are generally allowed a 90-day run-off period after the plan year ends to submit claims for expenses that occurred during the plan year but were not yet submitted.
- If you are a new employee entering the FSA during a plan year, reimbursement is only available for expenses and services provided after you begin your participation in the FSA.
- If you are enrolled in the Healthcare FSA and take a leave of absence during the plan year, you may (subject to your employer's plan):
 1. Prepay the contributions on a pre-tax basis, or
 2. Continue the contributions by remitting them to your employer. Pre-tax contributions may continue if you continue to receive enough pay, or
 3. Prorate the unpaid contributions over the remaining pay periods when you return to work.
- Failure to make all elected contributions will result in termination of your account as of the date contributions ceased.
- Healthcare FSAs must comply with COBRA and generally must offer COBRA continuation rights to qualified beneficiaries who lose Healthcare FSA coverage due to certain qualifying events. For most Healthcare FSAs, COBRA may be offered upon a qualifying event only if you have a balance remaining in your Healthcare FSA. The balance is generally calculated by subtracting the reimbursements made prior to the qualifying event from the annual election. If eligible, you may choose to continue your contributions by either sending your contributions to your employer on an after-tax basis each pay period, or, you may choose to make a pre-tax contribution for your remaining elections for the plan year from your final pay or severance pay. Expenses incurred while contributions are being made are eligible for reimbursement. Coverage generally may not continue beyond the current plan year. If you do not elect COBRA, only expenses incurred during the period of employment are reimbursable. Coverage under the Healthcare FSA ceases when the contributions cease.

SB-23290-0419



Flexible Spending Accounts

Managing Your Account

File a Claim

Three Easy Ways

1. On your mobile device using AFmobile®

Use AFmobile to manage your reimbursement accounts and insurance benefits.

2. Online at americanfidelity.com

3. By mail or fax

Insurance Claim

American Fidelity Assurance Company, Attn: Benefits Department
P.O. Box 268898, Oklahoma City, OK 73125
Fax: 800-818-3453

FSA and HRA Claim

American Fidelity Assurance Company
Attn: Flex Account Administration
P.O. Box 161968, Altamonte Springs, FL 32716
Fax # 844-319-3668

*Obtain a claim form for your insurance claim at www.americanfidelity.com/fileclaim.

Manage Your Reimbursement Account With AFmobile®

AFmobile® allows FSA and HRA participants to submit reimbursement account claims while on the go.

- Access accounts - check balances, view transaction history, and more.
- Manage claims - submit new claims, upload receipts, and check claims status.
- Receive account alerts - choose to receive account updates by text and push notifications.
- Submit documentation - tie receipts and other documentation to a pending card swipe to expedite adjudication.

Getting Started:

Download AFmobile. To register, you will need:

- Your email address - this should be the same email address provided at time of enrollment.
- Your Social Security Number.

Using Our Online Portal

Our online portal provides all the same great features as mobile, plus powerful self-service account access and education resources to help put you in the driver's seat.

Getting started:

- Register at americanfidelity.com
- Register using your email address and Social Security Number
- Once completed, access your reimbursement accounts and insurance benefits.

Direct Deposit

By enrolling in direct deposit, you can ensure a timely reimbursement! You will no longer need to worry about having to wait on checks or make any more trips to the bank.

Three ways to sign up for direct deposit:

1. Through your mobile app.
2. Online through your account at americanfidelity.com
3. By downloading a direct deposit request form



Voluntary Benefits

The city provides all eligible employees the opportunity to purchase the voluntary insurance benefits shown below directly from the providers.

The city will continue to maintain current payroll deductions. Please notify HR if any policy changes are made directly with American Fidelity.

	American Fidelity	Lincoln Financial
Critical Illness	✓*	
Disability (STD)	✓	
Accident	✓*	
Cancer	✓*	
Hospital Confinement (see important note below)	✓	
Voluntary Life & AD&D	✓	✓

* Review your plan information, as you may be eligible for a Wellness benefits each year based on level of plan. To receive your benefit, contact your carrier for a form, complete it and return it to them for processing.



Limitations, exclusions, and waiting periods apply. Refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage.**



Hospital Indemnity Insurance

Are you financially prepared for a medical emergency?

If an unexpected medical event were to happen, could you cover the out-of-pocket medical costs on top of bills, groceries and housing?

Major medical insurance plans are designed to pay a large portion of your medical costs. But with a high deductible plan, you must pay out of your pocket until you meet your deductible and plan maximum.

Limited Benefit Hospital Indemnity Insurance is designed to help pay for out-of-pocket expenses, like an inpatient stay, while also providing tax benefits and potential savings from a Health Savings Account (HSA).



Routine Screening Benefit
Take care of yourself and get rewarded



Critical Illness Benefit
Financial protection for high-dollar illnesses



Hospital Benefit
Help pay for your stay



Accident Benefit
Prepare for the unexpected



Hospital Indemnity Insurance

Features

- Benefits paid directly to you
- No health questions
- A policy you own—take the policy with you if you leave your employer or retire
- Coverage for you, your spouse and children

*This product may contain limitations, exclusions, and waiting periods.
This product is not intended for people who are eligible for Medicaid coverage.*

*Hospital shall not include an institution used by you as a place for rehabilitation; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatric ward; or an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.
The definition of a hospital may vary by state.*

Want to know more about hospital indemnity insurance?

Learn more at americanfidelity.com/hospital-indemnity

AMERICAN FIDELITY 
a different opinion



Short-Term Disability Income Insurance

American Fidelity Assurance Company

How do you pay for your mortgage, bills, food and other monthly expenses? If your paycheck stopped today, could you maintain your current lifestyle?

American Fidelity Assurance Company's AF™ **Short-Term Disability Income Insurance** is designed to help protect you if you become disabled and cannot work due to a covered Accidental Injury or Sickness.

How the Plan Works

If you become disabled due to a covered accident or sickness, Short-Term Disability Income Insurance will pay the disability benefit once you have satisfied the elimination period. Your benefit amount is dependent on your salary and the amount you select at the time of application. Disability benefits will be payable up to the benefit period stated in your policy.

Benefits Begin (Elimination Period)

For the Short-Term Disability Income plan, benefits can begin on the eighth day - 181st day, depending on the plan selected at the time of application. Benefits are payable for a covered Injury or Sickness up to 90 days or 180 days, based on the plan your employer has selected. Refer to your employer's plan and your Certificate for details regarding benefit amounts and more.

Eligibility

All full-time employees and employees of members on active service working 25 hours or more per week. Applicant's eligibility for this program may be subject to insurability. It is your responsibility to see the American Fidelity representative once you have satisfied your employer's waiting period.

Coverage Feature	What It Means To You
Benefit Paid Directly to You, Regardless of Other Coverage	Use the money however best fits your financial needs, regardless of other insurance.
Age at Entry	Your premiums will be based on the date your policy becomes effective.
Accidental Death Benefit	Receive a benefit if you die as the direct result of an Accidental Injury and death occurs within 90 days after the date of the Accidental Injury.
Competitive Premiums	Your monthly premiums could be paid with only one hour of a week's paycheck.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.
Physician Benefit	Receive a benefit if you receive treatment by a Physician due to a covered Injury.
Accidental Death Benefit	Receive a benefit if death occurs as a direct result of an Injury within 90 days after the Injury.
Guaranteed Issue	First-time eligible employees may be able to receive coverage without being subject to insurability.
Age at Entry Premiums	Premiums will be based on the date your policy becomes effective.

Limitations, exclusions, and waiting periods apply. Refer to your policy for complete details.



Accident Only Insurance

Limited Benefit Accident Only Insurance

Whether a weekend warrior with an active lifestyle or just a busy family, accidents can happen anytime, anywhere, without warning. Being prepared for the unexpected can make all the difference.

American Fidelity Assurance Company's AF™ **Limited Benefit Accident Only Insurance** policy can provide you with a solution for those unforeseen accidents that life sometimes delivers. Our Limited Benefit Accident Only Insurance is designed to help pay for the unexpected medical expenses an individual may incur for the treatment of covered injuries received in an accident.

How the Plan Works

Our Accident Only Insurance policy pays according to a wide-ranging schedule of benefits. In addition, the policy provides 24-hour coverage for accidents that occur both on and off the job.

All benefits are only paid as a result of Injuries received in an Accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. All benefits are paid once per Covered Person per Covered Accident unless otherwise specified in the Limitations and Exclusions section.

Optional Rider

Enhance your base plan with the following rider:

- **Accident Benefit Enhancement Rider**

American Fidelity Assurance Company

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

Limitations, exclusions and waiting periods apply. Refer to your policy for complete details, AO-03 series with AMDI258 rider. **This product is inappropriate for people who are eligible for Medicaid coverage.** The premium and amount of benefits provided vary dependent upon the plan selected. The company has the right to change premiums by class. Availability of riders may vary by state.



Cancer Insurance

Limited Benefit Cancer Insurance Policy

American Fidelity Assurance Company

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

American Fidelity Assurance Company's AF™ **Limited Benefit Individual Cancer Insurance** offers a solution to help you focus your attention on fighting cancer. We offer plans that can help assist with out-of-pocket costs often associated with a cancer diagnosis.

How the Plans Work

Our plans are designed to help cover expenses if you are diagnosed with a covered Cancer. With over 20 benefits available to you, these plans can provide benefits for the treatment of cancer, transportation, hospitalization and more. We provide the benefit directly to you, to be used however you see fit.

Optional Riders

Enhance your base plan with the following riders:

- **Critical Illness Rider**
Includes a cancer benefit and a heart attack/stroke benefit
- **Hospital Intensive Care Unit Rider**

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

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



Group Critical Illness Insurance

Limited Benefit Group Critical Illness Insurance Policy

American Fidelity Assurance Company

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

American Fidelity Assurance Company's AF™ **Limited Benefit Critical Illness Insurance** can be the solution that helps you and your family focus on recovery, and may help you with paying bills. Our plan can assist with the expenses that may not be covered by major medical insurance.

How the Plan Works

If you are diagnosed with a covered Critical Illness, such as a heart attack or stroke, this plan is designed to pay a lump sum benefit amount to help cover expenses. Also, this plan offers a Recurrent Diagnosis Benefit for certain specified Critical Illnesses that provides an additional 50% of the Critical Illness benefit amount after the second occurrence date. Covered Critical Illness events include Heart Attack, Permanent Damage Due to a Stroke, and Major Organ Failure.

Guaranteed Renewable

You are guaranteed the right to renew your base policy until age 75 as long as you pay premiums when due or within the premium grace period. The insurer has the right to increase premium rates if the policy so provides.

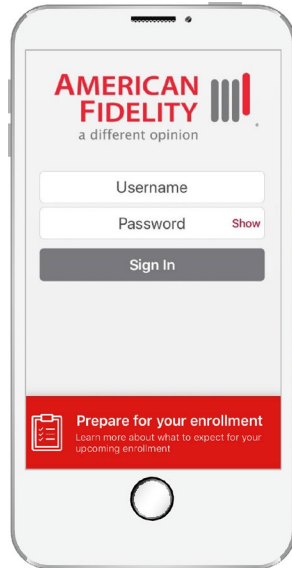
Coverage Feature	What It Means For You
Plan Options	Choose from three lump sum benefit amounts: \$10,000, \$20,000 or \$30,000.
Coverage Option	Children are automatically covered under the Employee base plan. If elected, Spousal Benefit Amounts will be 50% of the Employee Benefit Amount.
Wellness Benefit	Receive a benefit for your annual health screening test.
Benefit Paid Directly to You	Use the benefit however best fits your financial needs.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by adding an optional rider.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage.** Group Critical Illness is only offered on an after-tax basis.



Mobile Convenience

For ultimate convenience, get 24/7 access, direct from your tablet or mobile device with AFmobile®. Our mobile application allows you to manage your reimbursement accounts and insurance benefits, all from the palm of your hand.



AFmobile Features

- Manage claims
- Receive account alerts
- Maintain personal information
- View account balance
- Prepare for enrollment
- Submit receipt documentation

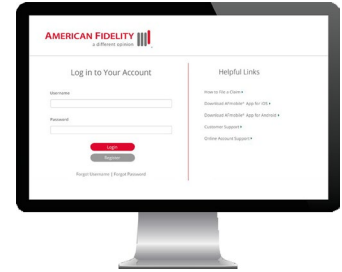
Getting started:

- Download AFmobile on your smart device.
- Register using your last name, Social Security Number, and email address.
- Your email address should be the same email address provided at time of enrollment.

If you already have an online account, your username and password will be the same for AFmobile.

Online Control

From your laptop or desktop, access all of your American Fidelity accounts - reimbursement accounts and insurance benefits - from one portal.



Getting started:

- Visit americanfidelity.com and click on the Login button.
- Register using your last name, Social Security Number, and email address.
- Your email address should be the same email address provided at time of enrollment.

File a Claim. Three Easy Ways.

1. Mobile

- Use AFmobile to manage your reimbursement accounts and insurance benefits.

2. Online

- Log in to your account by visiting americanfidelity.com and clicking on the Login button.

3. Mail or fax

- Download a claim form at americanfidelity.com/forms. Follow the instructions on the form to mail or fax to us.

Please allow one business day after you enroll before registering for your account.

Employee Assistance Program



Employee Assistance Program



Your employer offers this service at no additional cost to you! Available to you, your spouse and your dependents.

You get

Unlimited phone access to legal, financial and work-life services

In-person help with short-term issues

Up to six in-person sessions per person, per issue, per year

Help and support for personal and work-life matters

*EmployeeConnect Plus*SM gives you and your loved ones the support, resources and information you need to handle life's demands.

GuidanceConsultantsSM

When going through a difficult time, having someone to talk to can make a big difference in your state of mind. You and your loved ones have access to confidential counseling from trained counselors for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Parenting questions
- Job pressures
- Grief and loss
- Substance abuse

GuidanceResources[®] Online

Whenever you need guidance on important life matters, visit GuidanceResources.com or download the *GuidanceNow*SM mobile app. You'll find help on relationships, work, school, children, legal, financial concerns and more. You have access to:

- Timely articles, *HelpSheets*SM, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches
- Pet insurance discounts and care locator

Financial services

Everyone needs a bit of financial advice now and then. With *EmployeeConnect Plus*, you can speak with a *ComPsych*[®] financial expert to discuss:

- Managing personal financial challenges
- Credit card and debt management
- Budgeting
- Tax questions
- Financing for college
- Estate planning
- Investment options
- Mortgages, loans and refinancing
- Retirement planning

*EmployeeConnect Plus*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

24 hours a day, 7 days a week. Call 855-327-4463, or visit us online at www.GuidanceResources.com (Web ID=Lincoln)

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress



Employee Assistance Program (continued)



Legal services

You can easily feel overwhelmed when faced with legal issues. Fortunately, help is just a phone call away. *EmployeeConnect Plus*SM gives you access to a ComPsych[®] staff attorney. Get valuable legal help with:

- Family law
- Bankruptcy and credit issues
- Landlord/tenant issues
- Civil actions and small claims
- DUI/DWI
- Wills, living wills and trusts
- Name changes
- Contracts
- Probate matters
- Immigration

Along with unlimited phone access to staff attorneys, you can receive one free 30-minute consultation with a local network attorney (per legal issue), and 25% off network attorneys' customary legal fees.

Work-life services

When you need help resolving issues at home or work, *EmployeeConnect Plus* is here for you. Work-life specialists will research your question and will send you information based on your needs. Find help with:

- Childcare and before- and after-school care
- Elder care and assisted living services
- Relocation information
- Event planning and home improvement



To find out more:
Visit GuidanceResources.com (Web ID = Lincoln),
download the *GuidanceNow*SM mobile app, or
call 855-327-4463.

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LCN-2831851-111819

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Order code: EED-ECPT-FLI001



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*EmployeeConnect Plus*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

24 hours a day, 7 days a week. Call 855-327-4463, or visit us online at www.GuidanceResources.com (Web ID = Lincoln)





Handling Life, Handling Loss

LifeKeys® services help you meet life's challenges

Term Life Insurance/Support Services

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

For You And Your Family...

EstateGuidance® Will Preparation

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

You can:

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

GuidanceResources® Online

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

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

Identity Theft

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

Our online resource helps you:

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

You May Also Be Eligible For Beneficiary Services

If you develop a terminal illness and access your Accelerated Death Benefit, you will be able to use beneficiary services listed below.

For Your Beneficiaries...

Services are available for up to one year after a loss, and include:

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

Assistance at a Difficult Time

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

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



Financial Services

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

- Estate planning
- Budgeting
- Debt
- Bankruptcy
- Investments

Legal Support

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

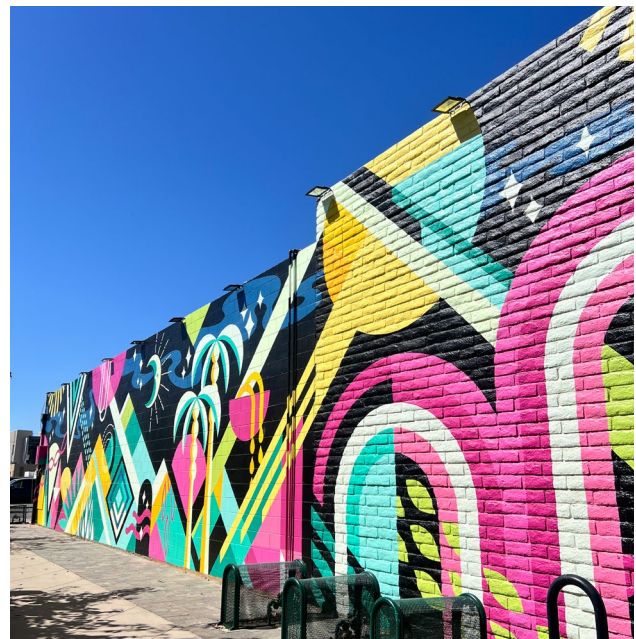
- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents beneficiaries need

Support with Day-to-Day Concerns

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

Topics include:

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



To Access LifeKeys Services:

[855-891-3684](tel:855-891-3684)

[GuidanceResources.com](https://www.GuidanceResources.com) (First-time user: Web ID = LifeKeys)



GROUP BENEFITS

Travel more. Worry less.

Travel assistance services user guide

Travel made easier

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

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

For travel more than 100 miles from home

Business and leisure travel

Staff and resources provide 24/7 travel support



GLOBAL ASSISTANCE

Travel ConnectSM **Life/AD&D**

UHC Global ID #: 322541



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

Cut out this card and keep it with you for quick reference.

Your comprehensive coverage includes...

Medical emergency evacuation and transportation

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

Dependent child transportation

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

Travel treatment monitoring

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



Insurance products issued by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York

Travel Insurance (continued)



...And much more

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

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

Travel assistance services are subject to specific terms, conditions and limitations. A program description is available at www.Lincoln4Benefits.com. To use *TravelConnect*SM services, call UnitedHealthcare Global at 800-527-0218 or 410-453-6330, and provide them with ID number 322541.

UnitedHealthcare Global Emergency Response Center:
 United States +1-410-453-6330 (Reverse Charges Accepted)
 TOLL FREE ACCESS - The numbers below must be dialed from within the country

If your location is not listed or the call will not go through, call the 24-hour
 Emergency Response Center collect (reverse charges accepted)

Australia	1 800 127 907	Japan	00531 11 4065
Brazil	0800 891 2734	Mexico	001 800 101 0061
China (northern)	108888*800 527 0218	Philippines	1 800 1 111 0503
China (southern)	10811*800 527 0218	Singapore	800 1100 452
Dominican Republic	1 888 567 0977	South Africa	0800 9 92379
France	0800 90 8505	Spain	900 98 4467
Germany	0800 1 811401	Switzerland	0800 55 6029
Hong Kong	800 96 4421	Thailand	001 800 11 471 0661
Israel	1 809 41 0172	U.K.	0800 252 074
Italy	800 877 204	U.S. & Canada	1 800 527 0218

* Dial the first portion of phone number, wait for tone, and then dial remaining numbers.
 For a complete list, go to the Global Intelligence Center: <https://members.uhcglobal.com>

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LincolnFinancial.com

LCN-1217118-060415

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Order code: LFE-TRAV-FLI001



You're In Charge®

*TravelConnect*SM travel assistance services are provided by UnitedHealthcare Global, Baltimore, MD. UnitedHealthcare Global is not a Lincoln Financial Group® company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations.

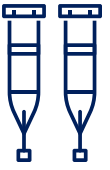
Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. In New York, insurance products (policy series GL1101) are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group® companies. Product availability and/or features may vary by state. Limitations and exclusions apply.

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

Page 2 of 2

Long-Term Disability Insurance



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

All Full-time Non-Safety Employees

Long-term Disability Insurance

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

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

AT A GLANCE:

- A cash benefit of 66.67% of your monthly salary (up to \$14,000) starting 60 days after you are out of work and continuing up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is later
- *EmployeeConnect*SM services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance.
 - Program Services include:
 - Unlimited, 24/7 access to information and referrals
 - In-person help for short-term issues; up to five sessions with a counselor per person, per issue, per year.
 - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
 - Online tools, tutorials, videos and much more

ADDITIONAL DETAILS

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

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

*EmployeeConnect*SM services are provided by ComPsych[®] Corporation, Chicago, IL. ComPsych[®] is a registered trademark of ComPsych[®] Corporation. ComPsych[®] is not a Lincoln Financial Group[®] company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations.

Insurance products (policy series GL3001) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations. Limitations and exclusions apply.

Benefits Overview | The Lincoln National Life Insurance Company

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Long-Term Disability Insurance (continued)



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

All Full-time Safety Employees

Long-term Disability Insurance

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

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

AT A GLANCE:

- A cash benefit of 66.67% of your monthly salary (up to \$10,000) starting 60 days after you are out of work and continuing up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is later
- *EmployeeConnect*SM services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance.
 - Program Services include:
 - Unlimited, 24/7 access to information and referrals
 - In-person help for short-term issues; up to five sessions with a counselor per person, per issue, per year.
 - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
 - Online tools, tutorials, videos and much more

ADDITIONAL DETAILS

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

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

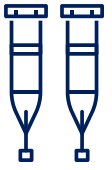
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[Benefits Overview](#) | [The Lincoln National Life Insurance Company](#)

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Disability & Leaves of Absence



Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 and applicable state law (collectively, "FMLA") generally affords eligible employees: (1) the right to leave without pay for up to a maximum of 12 weeks in 12 months for qualifying circumstances; (2) continuation of health coverage during the leave period at the same cost as during active employment; (3) reinstatement of other benefits upon return from the leave; and (4) restoration of individual's position or an equivalent one upon return from leave. FMLA qualifying circumstances include time off: (1) to care for the employee's child, or placement for adoption or foster care; (2) to care for the employee's spouse, child or parent who has serious health condition; or (3) for a serious health condition that renders the employee unable to perform his/her job. The 12-month period used by the City of Indio to determine an employee's allowable FMLA leave is the 12-month period measured backward from the date an employee's FMLA request begins.

Pregnancy Disability Leave (PDL)

All employees, regardless of how long they have been with the City are entitled to Pregnancy Disability Leave for up to four months for each pregnancy. PDL applies when a pregnant woman is disabled by pregnancy, childbirth or related medical conditions according to her health care provider. PDL occurs at the same time as FMLA.



California Family Rights Act (CFRA)

The CFRA allows for 12 weeks of unpaid leave for all of the same reasons as FMLA, except CFRA does not include pregnancy or related medical conditions within the definition of a serious health condition. This is the most significant difference between the FMLA and the CFRA. The result is that if a woman's pregnancy precludes her from performing her job (i.e., her absence from work is medically necessary because she is disabled by pregnancy), she is entitled to FMLA leave and PDL, but no CFRA leave. When the child is born, the woman may choose to remain on Pregnancy Leave until the disability ends and then begin CFRA leave to bond with her newborn.

The distinction between the FMLA and the CFRA does not increase the maximum amount of time a woman may be out of work due to pregnancy. The maximum amount of leave is four months (for PDL/FMLA), plus 12 weeks for CFRA/FMLA leave to care for a newborn.

Military Family Leave (MFL)

On 1/28/08, President Bush signed into law the National Defense Authorization Act for FY 2008 (NDAA), Public Law 110-181. Section 585(a) of the NDAA amended the FMLA to provide eligible employees working for covered employers two important new leave rights related to military service:

1. **New Qualifying Reason for Leave.** Eligible employees are entitled up to 12 weeks of leave for "any qualifying exigency" because a spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. Until "any qualifying exigency" is fully defined, employers are encouraged to provide this type of leave to qualifying employees.
2. **New Leave Entitlement.** An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to a combined total of 26 weeks of FMLA leave in a single 12-month period to care for the service member. This provision became effective immediately upon enactment. Additional FMLA and Military Family Leave information is available on <https://www.dol.gov/whd/fmla>.



No Surprises Act Notice

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

Discrimination is Against the Law

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

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 760-541-4437.

Patient Protections

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

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

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

Networks/Claims/Appeals

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

Notice of Extended Coverage to Children Covered as Students

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

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



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

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

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

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

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

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

COBRA Continuation Coverage

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

Important Notices (continued)



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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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



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

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

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

IF YOU HAVE QUESTIONS

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

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

¹ <http://www.socialsecurity.gov/>



KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

Important Notices (continued)



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

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

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

For information about Special Enrollment Rights, please contact:

Yvette Villaseñor
Human Resources Analyst
760-541-4437 or yvillasenor@indio.org

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

City of Indio Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Yvette Villaseñor, 100 Civic Center Mall, Indio, CA 92201, 760-541-4437.



Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

Open Enrollment for health insurance coverage through Covered California begins on November 1 of each year and ends on January 31 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com, KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not “Affordable,” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.96% (for 2026) of your household income for the year, then that coverage for you is not Affordable. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

STATES WITH INDIVIDUAL MANDATE

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

Important Notices (continued)



PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name City of Indio	4. Employer Identification Number (EIN) 95-6000726	
5. Employer address 100 Civic Center Mall	6. Employer phone number 760-541-4437	
7. City Indio	8. State CA	9. ZIP code 92201
10. Who can we contact about employee health coverage at this job? Yvette Villaseñor, Human Resources Analyst		
11. Phone number (if different from above)	12. Email address yvillasenor@indio.org	

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



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

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

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

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

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

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

If you are Medicare eligible and go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have creditable coverage. For example, if you go 19 months without creditable coverage, your premium may be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) the entire time you have Medicare prescription drug coverage.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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



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

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

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

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

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

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

ALABAMA - Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA - Medicaid

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

ARKANSAS - Medicaid

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

CALIFORNIA - Medicaid

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

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

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

FLORIDA - Medicaid

Website:
<https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA - Medicaid

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

INDIANA - Medicaid

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

IOWA – Medicaid & CHIP (Hawki)

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

Important Notices (continued)



KANSAS - Medicaid

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

KENTUCKY - Medicaid

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

LOUISIANA - Medicaid

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

MAINE - Medicaid

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

MASSACHUSETTS - Medicaid & CHIP

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

MINNESOTA - Medicaid

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

MISSOURI - Medicaid

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

MONTANA - Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084
Email: HSHIPPProgram@mt.gov

NEBRASKA - Medicaid

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

NEVADA - Medicaid

Medicaid Website: <https://dhcftp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid

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

NEW JERSEY - Medicaid & CHIP

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

NEW YORK - Medicaid

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

NORTH CAROLINA - Medicaid

Website: <https://medicaid.ncdhhs.gov/>
Phone: 1-919-855-4100

NORTH DAKOTA - Medicaid

Website: <https://www.hhs.nd.gov/healthcare>
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP

Website: <http://www.insureoklahoma.org/>
Phone: 1-888-365-3742

OREGON - Medicaid

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

PENNSYLVANIA - Medicaid & CHIP

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

RHODE ISLAND - Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RItte Share Line)

SOUTH CAROLINA - Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

Important Notices (continued)



TEXAS - Medicaid

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

UTAH - Medicaid & CHIP

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

VERMONT - Medicaid

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

VIRGINIA - Medicaid & CHIP

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

WASHINGTON - Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid and CHIP

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

WISCONSIN - Medicaid & CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING - Medicaid

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

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

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, ext. 61565



Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer’s version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children’s Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay “out-of-pocket” for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay “out-of-pocket” for certain services, such as a doctor’s office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay “out-of-pocket” before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).



Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

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

Plan Year

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

Preferred Provider

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

Premium

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

Preventive Care

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

Qualifying Life Event

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

Skilled Nursing Care

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

Urgent Care

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

