



EMPLOYEE BENEFITS *Guide*



20
26



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Core Benefits

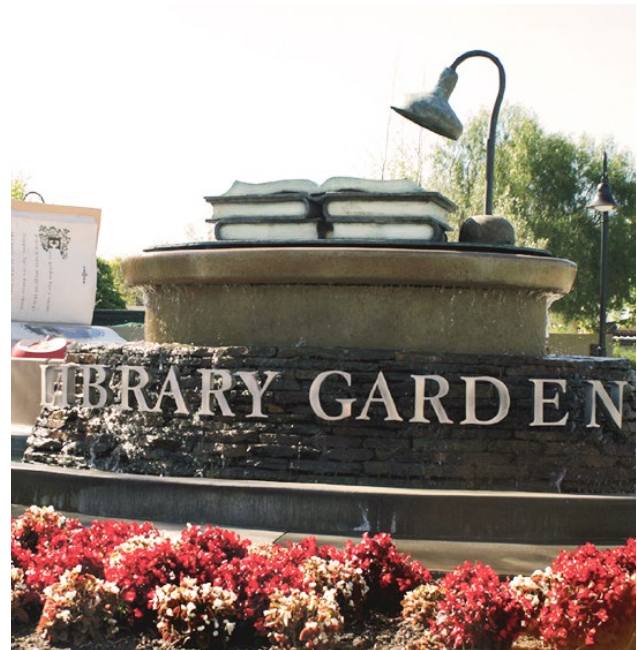
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If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 41 for more details.

The information in this brochure is a general outline of the benefits offered under the City of Bellflower'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.

Dear City of Bellflower Employee:

At the City of Bellflower, we recognize that our employees are our most valuable asset, and your health and wellbeing are of paramount importance. It is with this in mind that we are pleased to offer you a comprehensive benefit plan designed to support your physical and emotional wellbeing. Our goal is to assist you and your family in achieving optimal health by providing you with a range of options to choose from.

Enclosed you will find an overview of the benefits available to you as a valued member of our team. We encourage you to review this information carefully, discuss it with your family, and make selections that best suit your individual needs.

Please note that this benefits overview is intended to provide a general overview of the offerings provided by the City of Bellflower. Complete Medical Plan Documents are available at <https://mycalpers.ca.gov>.

Thank you for your dedication to the City of Bellflower. Please contact Human Resources if you have any questions.

Sincerely,

Dana Hang
Human Resources and Risk Manager

The benefits in this summary are effective:
January 1, 2026 – December 31, 2026



Contact Information



Human Resources	Contact	Phone Number	Contact Information
Human Resources & Risk Manager	Dana Hang	562-804-1424 ext. 2016	dhang@bellflower.ca.gov
Management Analyst	Veronica Yates	562-804-1424 Ext. 2240	vyates@bellflower.ca.gov

Benefit Information and Forms

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

Employee Benefits Program	Group Number	Phone Number	Web Site/Email
Medical			
• CalPERS		888-225-7377	https://my.calpers.ca.gov
– Anthem HMO Select		855-839-4524	www.anthem.com/ca/calpers
– Anthem HMO Traditional		855-839-4524	www.anthem.com/ca/calpers
– Blue Shield Access +		800-334-5847	www.blueshieldca.com/calpers
– Blue Shield Trio		800-334-5847	www.blueshieldca.com/calpers
– HealthNet Salud y Mas		888-926-4921	www.healthnet.com/calpers
– Kaiser Permanente		800-464-4000	www.kp.org/calpers
– United Health Care – Alliance		877-359-3714	www.uhc.com/calpers
– United Health Care – Harmony		877-359-3715	www.uhc.com/calpers
– PERS Gold		855-633-4436	includedhealth.com/calpers
– PERS Platinum		855-633-4436	includedhealth.com/calpers
Dental			
• Delta Dental - PPO	71732	888-335-8227	www.deltadentalins.com
• Delta Care - HMO	19294	800-442-4234	deltadentalins.com/contact
Vision			
• EyeMed	1041108	866-939-3633	www.EyeMed.com
Life and AD&D			
• The Standard	874935	800-628-8600	www.standard.com
Disability (STD & LTD) Claims			
• The Standard LTD & STD	359010		www.standard.com
Supplemental Insurance			
• Aflac		Lisa Arens 714-609-1638	www.aflacenrollment.com/CITYOFBELLFLOWER/C3X732454553
Employee Assistance Program			
• The Standard	359010	877-851-1631	www.workhealthlife.com/Standard6
FSA Section 125			
• Health Equity		855-692-2959	www.healthequity.com/wageworks
Deferred Compensation			
• VOYA		Greg Gower 714-889-9208 or 855-663-8692	www.voya.com
Credit Union			
• F&A Federal Credit Union		Melinda Robles 323-268-1226 ext. 5276	www.fafcu.org

Who Can You Cover?



Who is Eligible?

Permanent, full-time City employees working 80 or more hours per pay period are eligible for the benefits outlined in this overview.

Permanent Part-time employees working 30 hours are eligible for health, dental and vision only.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your registered same or opposite sex domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partner. Any premiums for your domestic partner paid for by City of Bellflower are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children (including natural children, stepchildren, domestic partner's children, adopted children, children fostered under legal custody, and children covered under legal guardianship):
 - Under the age of 26 are eligible to enroll in coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
 - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
 - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Who is Not Eligible?

- Temporary, part-time, or contract employees

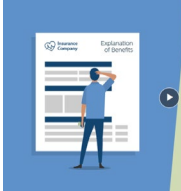
Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, siblings, aunts/uncles, nieces/nephews, and grandchildren
- Divorced spouses
- Family members residing outside the United States
- Former stepchildren as a result of divorce

Dependent Verification

Adding dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You may be required to provide proof of one or more of the following:

- Marriage Certificate or License
- Domestic Partner Affidavit
- Birth Certificate (hospital certificates are not official birth records and will not be accepted as proof of birth)
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children, and children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)
- Additional documentation such as tax returns or utility bills to demonstrate dependent eligibility may be requested



CLICK HERE to watch a video on How to Read an EOB

Who Can You Cover? (continued)



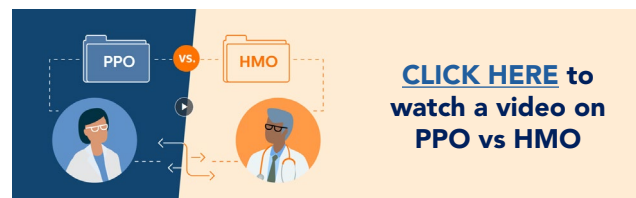
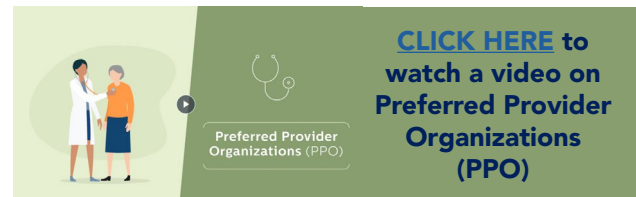
When Can I Enroll?

The initial enrollment period for new employees who are eligible for benefits is the first day of the month following date of hire. Eligible employee coverage begins first of the month following the month in which a full month's premium have been paid by the City and the employee. This can be anywhere from 28 to 45 days following the date of hire, depending on the first day worked by employee. New employees must complete the benefits selection form and return it within 30 days of their hire date. **If you do not return your completed forms by this deadline, your benefits may be delayed by CalPERS.**

Your benefits will remain unchanged until the next open enrollment period, unless a qualifying event occurs. Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child (60 days)
- Marriage (60 days)
- Loss of other healthcare coverage (30 days)
- Loss of Medicaid or Children's Health Insurance Program (CHIP) (60 days)
- Eligibility for new healthcare coverage (30 days)
- Divorce (30 days)

As you can see, depending on the type of event, you have 30 to 60 days to make your change.



Medical Rates



Health Insurance: Region 2 - Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura

Insurance Plan	Monthly		
	Single	2-Party	Family
Medical Rates			
Region 2 - Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura			
Anthem Blue Cross Select HMO	\$1,016.32	\$2,032.64	\$2,642.43
Anthem Blue Cross Traditional HMO	\$1,158.26	\$2,316.52	\$3,011.48
Blue Shield Access+ HMO	\$1,052.89	\$2,105.78	\$2,737.51
Blue Shield Trio HMO	\$936.58	\$1,873.16	\$2,435.11
Health Net Salud y Más	\$879.57	\$1,759.14	\$2,286.88
Kaiser Permanente	\$987.69	\$1,975.38	\$2,567.99
Sharp Performance Plus	\$916.20	\$1,832.40	\$2,382.12
UnitedHealthcare SignatureValue Alliance	\$950.99	\$1,901.98	\$2,472.57
UnitedHealthcare SignatureValue Harmony	\$857.14	\$1,714.28	\$2,228.56
PERS Platinum	\$1,426.24	\$2,852.48	\$3,708.22
PERS Gold	\$956.28	\$1,912.56	\$2,486.33
PORAC	\$1,057.00	\$2,127.00	\$2,708.00

Health Insurance: Region 3 – Los Angeles, Riverside and San Bernardino

Insurance Plan	Monthly		
	Single	2-Party	Family
Medical Rates			
Region 3 - Los Angeles, Riverside, and San Bernardino			
Anthem Blue Cross Select HMO	\$962.68	\$1,925.36	\$2,502.97
Anthem Blue Cross Traditional HMO	\$1,128.53	\$2,257.06	\$2,934.18
Blue Shield Access+ HMO	\$917.91	\$1,835.82	\$2,386.57
Blue Shield Trio HMO	\$852.56	\$1,705.12	\$2,216.66
Health Net Salud y Más	\$740.11	\$1,480.22	\$1,924.29
Kaiser Permanente	\$969.05	\$1,938.10	\$2,519.53
UnitedHealthcare SignatureValue Alliance	\$870.76	\$1,741.52	\$2,263.98
UnitedHealthcare SignatureValue Harmony	\$765.51	\$1,531.02	\$1,990.33
PERS Platinum	\$1,431.81	\$2,863.62	\$3,722.71
PERS Gold	\$960.03	\$1,920.06	\$2,496.08
PORAC	\$1,057.00	\$2,127.00	\$2,708.00

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 – 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
• 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

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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	
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
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

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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	
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

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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.

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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
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%

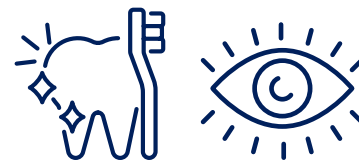
¹ \$35 for specialist visit.

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.

Dental and Vision Rates



At the City of Bellflower, we believe that dental and vision care are an important part of a comprehensive health plan for you and your family. As a result, the City pays 100% of the benefits costs for full-time employees and their families. Permanent Part-time employees working 30 or more hours a week are also eligible to participate in our group plans at competitive rates.

Dental Rates

	Delta Dental PPO	Delta Dental HMO
Employee only	\$55.78	\$27.31
Employee + 1	\$98.00	\$45.07
Employee + Family	\$166.65	\$66.17

Vision Rates

	EyeMed
Employee only	\$10.54
Employee + 1	\$18.97
Employee + Family	\$27.19



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Dental



The City of Bellflower offers Dental PPO Coverage through Delta Dental of California. Below is a summary of benefits, please refer to the plan Evidence of Coverage for complete details.

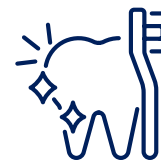
Eligibility	PPO Plan Option	
	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Deductibles	None	\$75/\$225
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Not Applicable	Yes
Maximums	\$2,000 per person each calendar year	\$1500
Waiting Period(s)		
Basic Services	None	
Major Services	None	
Prosthodontics	None	
Orthodontics	None	

Benefits and Covered Services*	PPO Plan Option	
	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) - Exams, cleanings, x-rays and sealants	100%	100%
Basic Services - Fillings	90%	80%
Endodontics - Root Canals <i>(Covered Under Basic Services)</i>	90%	80%
Periodontics - Gum Treatment <i>(Covered Under Basic Services)</i>	90%	80%
Oral Surgery <i>(Covered Under Basic Services)</i>	90%	80%
Major Services - Crowns, inlays, onlays and cast restorations	80%	60%
Prosthodontics - Bridges and dentures	80%	60%
Orthodontic Benefits	50%	50%
Orthodontic Maximums	\$1,000	
Eligibility	Adults and dependent children to age 19	

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

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Delta Care USA DHMO Plan

- No Deductible
- No Annual Dollar Amount Maximum
- No Waiting Periods
- Adult & Child Orthodontia
- Copay based plan

This is only a summary of the Plan. The Dental Plan Contract, complete Benefit Schedule and Evidence of Coverage must be consulted to determine the exact terms, limitations and exclusions of coverage.

Delta Care USA DHMO		
Code	Description	Member Copayment
Diagnostic and Preventive Services		
• D0150	Comprehensive Oral Evaluation	No Charge
• D1510	Space Maintainers	\$10
Restorative Services		
• D2392	Composite Filling (two surfaces, posterior)	\$55
Endodontics		
• D3220	Therapeutic Pulpotomy	\$0
• D3310	Root Canal Therapy - Anterior	\$45
• D3320	Root Canal Therapy - Premolar	\$90
• D3330	Root Canal Therapy - Molar	\$205
Periodontics		
• D4210	Gingivectomy (per quadrant)	\$80
• D4260	Osseous Surgery	\$175
• D4341	Scaling and Root Planing (per quadrant)	No Cost
Prosthodontics		
• D5110	Complete (Upper)	\$100
• D5130	Immediate (Upper)	\$120
Crown and Bridge		
• D6740	Crown - Porcelain/Ceramic	\$195
• D6750	Crown - Porcelain Fused to High Noble Metal	\$195
• D6790	Crown - Full Cast High Noble Metal	\$170
Oral Surgery		
• D7220	Extractions (impacted tooth; soft tissue)	\$25
• D7230	Extractions (impacted tooth; partial bony)	\$50
• D7240	Extractions (impacted tooth; full bony)	\$70
Orthodontics - Comprehensive		
• D8070	Children (to age 18)	\$1,700
• D8090	Adults	\$1,900

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Save even more
with PLUS Providers

\$50
Additional frame
allowance from
PLUS Providers*

*Compared to \$130 frame
allowance at other EyeMed
in-network providers

Find an eye doctor
(Insight
Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call
1.800.988.4221

City of Bellflower

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam at PLUS Provider	\$0 copay	Up to \$40
Exam	\$10 copay	Up to \$40
Retinal Imaging	Up to \$39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit & Follow-up - Standard	Up to \$40; contact lens fit and two follow-up visits	Not covered
Fit & Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame at PLUS Provider	\$0 copay; 20% off balance over \$180 allowance	Up to \$91
Frame - Retail	\$0 copay; 20% off balance over \$130 allowance	Up to \$91
Frame - Wholesale*	\$0 copay; balance over \$91 allowance	Up to \$91
STANDARD PLASTIC LENSES		
Single Vision	\$10 copay	Up to \$30
Bifocal	\$10 copay	Up to \$50
Trifocal	\$10 copay	Up to \$70
Lenticular	\$10 copay	Up to \$70
Progressive - Standard	\$10 copay	Up to \$50
Progressive - Premium Tier 1 - 4	\$95 - 185 copay	Up to \$50
LENS OPTIONS		
Anti Reflective Coating - Standard	\$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	\$57 - 68 copay	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	\$75	Not covered
Polycarbonate - Standard	\$40	Not covered
Polycarbonate - Standard < 19 years of age	\$0 copay	Up to \$20
Scratch Coating - Standard Plastic	\$15	Not covered
Tint - Solid and Gradient	\$15	Not covered
UV Treatment	\$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	\$0 copay; 15% off balance over \$130 allowance	Up to \$91
Contacts - Disposable	\$0 copay; 100% of balance over \$130 allowance	Up to \$91
Contacts - Medically Necessary	\$0 copay; paid-in-full	Up to \$300
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY		
	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contacts Lenses	Once every 12 months	Once every 12 months
(Plan allows member to receive either contacts and frame, or frame and lens services)		

QL-0000075764

*Available at wholesale providers, such as Costco Optical; discounts do not apply. View the provider locator to find wholesale providers. EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate.



INNOVATIVE ANSWERS FOR SMART SHOPPERS

Smarter tools for smarter shoppers

KNOW BEFORE YOU GO

At EyeMed, we want to help you get the most from your vision benefit. That's why we've enhanced our Know Before You Go tool. Now, it's easier to estimate your out-of-pocket costs, so you can be a savvy shopper.

- **New look and feel**—Navigate with ease.
- **Designed for all devices**—Use your phone, tablet or PC. The tool's responsive design adjusts to any screen size.
- **More flexibility**—Easily edit your selections or start over.
- **Spotlight on special offers**—Find more ways to save with your vision benefit.
- **Provider search**—Quickly find an eye doctor near you.

Along with these new features, the tool still offers simple definitions and interactive examples of common products and add-ons. Plus, you get a range of costs with each selection you make.

TRY IT OUT FOR YOURSELF

- 1 **Register or log into your account at member.eyemedvisioncare.com and click the Estimate Costs tab.**
- 2 **Select the service you want an estimate for: "Eye Exam" or "Vision Products" for glasses or contacts.**
- 3 **Choose your frame type – are you more fashion or function? Basic or premium?**
- 4 **Explore a variety of lens types, options and add-ons. Get details for each product.**
- 5 **Get a clear summary of your estimated out-of-pocket costs based on your selections.**

INDEPENDENT
PROVIDER
NETWORK



LENSCRAFTERS

PEARLE
VISION

OPTICAL

PDF-XXXX-X-XXX



Life Insurance and AD&D



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

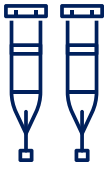
Life Insurance	Standard Insurance
All full-time employees of the City of Bellflower are eligible for Life coverage through Standard Insurance. The amount of Life Insurance is as follows:	
City Council	\$60,000
Non Representative Employee	\$232,000
Mid-Management Employee	\$160,000
Executive Assistants	\$87,000
Maintenance Employee	\$92,000
City Manager	\$271,000

Accidental Death and Dismemberment (AD&D)	Standard Insurance
For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage.	



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Disability - The Standard



Short Term Disability – (Paid for by the City)

	Class 1 - City Manager, Assistant City Manager and Public Works Director	Class 2 - All other Employees
Benefit Percentage	60%	60%
Weekly Benefit Maximum	\$3,500	\$3,000
Minimum Weekly Benefit	\$10	\$10
Elimination Period	30 days	30 days

Long Term Disability – (Paid for by the City)

	Class 1 - City Manager, Assistant City Manager and Public Works Director	Class 2 - All other Employees
Benefit Percentage	60%	60%
Monthly Benefit Maximum	\$15,000	\$12,000
Minimum Monthly Benefit	\$100	\$100
Elimination Period	180 days	180 days
Definition of Disability	You are prevented from performing at least one of the material duties of your regular occupation during the first 2 years of disability and after 2 years are unable to perform all of the material duties of any gainful occupation; and during the first 2 years of disability are unable to generate current earnings which exceed 80% of your monthly earnings from your regular occupation, and after 2 years are unable to generate current earnings which exceed 60% of your monthly earnings from any gainful occupation.	You are prevented from performing at least one of the material duties of your regular occupation during the first 2 years of disability and after 2 years are unable to perform all of the material duties of any gainful occupation; and during the first 2 years of disability are unable to generate current earnings which exceed 80% of your monthly earnings from your regular occupation, and after 2 years are unable to generate current earnings which exceed 60% of your monthly earnings from any gainful occupation.



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Supplemental Insurance: Aflac



Open enrollment planning isn't complete until you have Aflac

Aflac for City of Bellflower

Who hasn't been blindsided by an unexpected medical bill? That's why there's Aflac. We can help take care of the expenses health insurance doesn't cover, so you can take care of everything else.

Aflac supplemental benefits

Our product portfolio is as broad as your needs, with individual insurance policies that help cover the expected – and unexpected – that's sure to come life's way.

Cancer/Specified-Disease: Aflac's cancer/specified-disease insurance policy can help you and your family better cope financially if a positive diagnosis of cancer occurs.

Accident: Accidents happen. When a covered accident happens to you, our accident insurance policy pays you cash benefits, unless assigned otherwise, to help with the unexpected medical and everyday expenses that begin to add up almost immediately.

Critical Illness (Specified Health Event): An Aflac specified health event insurance policy is designed to help with the costs of treatment if you experience a covered health event.

Whole or Term Life: With Aflac's whole life or term life insurance, you can rest easy knowing that your family can have financial security when they need it most.



Short-Term Disability: How would you pay your bills if you're disabled and can't work? An Aflac short-term disability insurance policy can help provide you with a source of income while you concentrate on getting better.

Hospital Confinement Indemnity: Hospital stays are expensive. An Aflac hospital confinement indemnity insurance policy can help ease the financial burden of hospital stays by providing cash benefits.

Short-Term Disability: How would you pay your bills if you're disabled and can't work? An Aflac short-term disability insurance policy can help provide you with a source of income while you concentrate on getting better.

To learn more, contact your Aflac agent, **Lisa Arens**, 0K29297 at lisa_arens@us.aflac.com or 714-609-1638.



This is a brief product overview only. Coverage may not be available in all states, including but not limited to ID, NJ, NM, NY or VA. Benefits/premium rates may vary based on plan selected. Optional riders may be available at an additional cost. Policies/riders have limitations and exclusions that may affect benefits payable. Refer to the specified policy/riders form(s) for complete details, benefits, limitations and exclusions. For availability and costs, please contact your local Aflac agent. Coverage is underwritten by Aflac. In New York, coverage is underwritten by Aflac New York. WWHQ | 1932 Wynnton Road | Columbus, GA 31999

Z2200359R1

EXP 4/24



Scan the QR Code below to see the Aflac Insurance Plans

Aflac helps with expenses
health insurance doesn't cover,
so you can care about
everything else.



Or, visit your benefits page at:
www.aflacenrollment.com/CITYOFBELLFLOWER/C3X732454553



Aflac's family of insurers American Family Life Assurance Company of Columbus and/or American Family Life Assurance Company of New York, and/or Continental American Insurance Company (CAIC) and/or Continental American Life Insurance Company.

Aflac | WWWHQ | 1932 Wynnton Road | Columbus, GA 31999

Continental American Insurance Company | Columbia, SC

Z2300116QR

EXP 3/24

Employee Assistance Program



EAP Services Overview

HealthAdvocateSM



Employee Assistance Program Services for Standard Insurance Company

Service Feature	Service Overview
Eligibility	The EAP is made available through The Standard's group insurance products and services. Covered employees, their spouse and/or domestic partner, married or unmarried dependent children to age 26 and all other household members are eligible for services. The services are available for up to 30 days after termination of coverage and/or employment.* If the covered employee dies, the services are available for up to 90 days to their dependents and beneficiaries.
Sessions: face-to-face, phone or video	Up to three sessions (or six sessions if buy-up is elected) per presenting problem, per individual, per year.
Call center and more	24/7/365 support from master's level counselors who provide immediate assessment using motivational interviewing techniques.
Program access	• Dedicated toll-free number • Web • Mobile device application
Referral service standards	• Life-threatening emergencies will have appropriate care coordinated upon initial contact. • Urgent appointments are offered and available within 8-24 hours. • Routine appointments are offered and available within five business days.
Case management	Coordinated telephone intake, case management and follow up by a master's level counselor ensures continuity of care.
Qualified provider network	• National network of more than 62,000 providers. • Network has more than 30 years of experience. • Open panel policy (no closed networks).
EAP clinical provider credentialing standards	• Minimum of a master's degree • State licensure
Legal services	• Nationwide panel of attorneys • Up to 30-minute free face-to-face or telephonic consultation for each separate legal matter • 25% discount if network attorney is retained • Coverage for most legal issues, including civil, personal/family, credit, elder law, tax law, real estate and estate planning • Online will preparation and other legal documents
Financial services	• Up to 30-minute free financial counseling session per issue from Certified Consumer Credit Counselors, Certified Credit Report Reviewers and financial planners. • Help with issues such as spending habits, budgeting strategies, managing credit, debt-management, debt consolidation, financial planning information, goal setting and other personal finance issues. • Up to 60-minute free identity theft consultation when identity theft occurs, and an identity theft kit and other resources are available online.

continued on next page

Employee Assistance Program (continued)



EAP Services Overview

Service Feature	Service Overview
WorkLife services	• Access to expert multi-lingual telephonic consultations and referral to resources • Supplemental information in multiple media options • Online support — articles, self-search locators, financial calculators, health assessments and web links to many government and nonprofit services • Child care services • Elder care services • Health and wellness • Emotional and well-being • Daily living resources
EAP website	• EAP and WorkLife services • Comprehensive library, videos, articles, self-assessments, links, archived webinars.
Management consultation services	• Toll-free, 24/7 • Unlimited management consultations • Mandatory/voluntary management referrals, with follow-up • Unlimited policy development consultations and regulation consultations (for example, Drug Free Workplace)
Utilization reports	Electronic reports available on request.
Coordination with health plan(s) and other resources	The EAP counselor will make every effort to coordinate with in-network providers should the member's need surpass the designated EAP session model (EAP is a short term problem resolution program). They will also empower the member by educating them about available resources and referral options.
Communication materials	Brochures, flyers, monthly webinars and newsletters, posters and manager materials.
Supervisor orientation and training	Two webinars per year are included and provided at predetermined dates and times



*Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

Employee Assistance Program (continued)



EAP Services Overview

Service Feature	Service Overview
Critical incident stress management/disruptive event management services	Ten hours per incident free on-site crisis support in the event of a catastrophic incident at the workplace affecting a group of employees (e.g., robbery, assault, employee injury or death in the workplace). • Terrorism and natural disasters are excluded but will be provided at \$275 per hour, per EAP counselor for a minimum of two hours per event, per counselor, plus \$75 flat travel fee per counselor. • On-site crisis services exceeding 10 hours per event is available at \$275 per hour, per EAP counselor (minimum of two hours per event), plus \$75 flat travel fee per counselor. • Cancellations made within 24 hours before scheduled service will be charged a \$275 per on-site hour, per EAP counselor administrative fee. • Unlimited telephonic CISM consultation included at no additional charge. • On-site services for catastrophic events that occur outside the workplace are available at \$275 an hour per counselor, for a minimum two hours per event, plus \$75 flat travel fee per counselor.
On-site services	On-site services include: • Reduction-in-force • Grief counseling • EAP orientations • Health/benefits fairs representation • Wellness seminars • Compliance trainings • Other workshops On-site group or individual sessions are provided fee-for-service at \$275 per hour (minimum of two hours per event), plus \$75 flat travel fee per EAP counselor. Cancellations within 24 hours of service will be charged a \$275 per hour administrative fee.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | standard.com

The EAP service is provided through an arrangement with Health AdvocateSM, which is not affiliated with The Standard. Health AdvocateSM is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10-2,499 lives. This service is only available while insured under The Standard's group policy.

[†]The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

SI 17207

EAP Services Overview
(3/23)

3

Employee Assistance Program (continued)



A helping hand when you need it.

Rely on the support, guidance and resources of your Employee Assistance Program.



There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program,¹ which includes WorkLife Services and is available to you and your family in connection with your group insurance from Standard Insurance Company (The Standard). It's confidential — information will be released only with your permission or as required by law.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)² and all household members can contact the program's master's-level counselors 24/7. Reach out through the mobile EAP app or by phone, online, live chat, and email. You can get referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to six counseling sessions per issue. Sessions can be done in person, on the phone or through video.

EAP services can help with:



Depression, grief, loss and emotional well-being



Family, marital and other relationship issues



Life improvement and goal-setting



Addictions such as alcohol and drug abuse



Stress or anxiety with work or family



Financial and legal concerns



Identity theft and fraud resolution



Online will preparation and other legal documents



Contact EAP

877.851.1631
(TTY Services: 711)
24 hours a day,
seven days a week

healthadvocate.com/standard6

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

With EAP, personal assistance is immediate, confidential and available when you need it.

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, daily living and care for your pet, child or elderly loved one.

Online Resources

Visit healthadvocate.com/standard6 to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

¹ The EAP service is provided through an arrangement with Health AdvocateSM, which is not affiliated with The Standard. Health AdvocateSM is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10–2,499 lives. This service is only available while insured under The Standard's group policy.

² Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older, and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | standard.com

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SI 17200

Employee Assistance Program-6 EE
(3/23)

Section 125 (Flexible Spending Accounts)



HealthEquity® | WageWorks

P.O. Box 60010 Phoenix, AZ 85082-0010

QUICKSTART GUIDE

Your Flexible Spending Account



At-a-Glance

Your FSA:
The Essentials

Managing Your Account

Using Your FSA Dollars

Register online now!

If you haven't registered online yet, please do so today. To register, just visit www.healthequity.com/wageworks, select "LOG IN/REGISTER" and then "Employee Registration." You'll need to answer a few simple questions and create a username and password.

Questions?

HealthEquity makes it easy for you to get the help you need now. Please call us at 855.692.2959 or visit the Support Center at www.healthequity.com/wageworks where you will find answers to frequently asked questions, important forms, videos and other useful resources.

Download the EZ Receipts® mobile app!

Use your mobile device to file claims and take care of your account paperwork from anywhere. Go to www.healthequity.com/wageworks to learn more.

Welcome to HealthEquity. Start Saving. Here's How.

Welcome to your healthcare and/or dependent care flexible spending account (FSA) sponsored by your employer and brought to you by HealthEquity.

Your FSA is a great way to save on hundreds of eligible expenses like prescriptions, copayments, over-the-counter (OTC) items, and child and elder care.

Your FSA: The Essentials

Your FSA is governed by IRS regulations that detail who is eligible to use the account and where and how the money in it is to be used. Your FSA was designed to be simple. To keep it that way, it's important to comply with the IRS regulations that govern the program. The following guidelines will help you avoid any inconvenience.

- **Make sure account funds are only spent on expenses for those who are eligible.** Typically, those eligible are you, your spouse and your eligible dependents.
- **Know what expenses are eligible.** Log in to your account at www.healthequity.com/wageworks for a complete list of eligible healthcare expenses. Generally, eligible healthcare expenses include services and products that are medically necessary to treat a specific condition. Dependent care expenses typically include care provided for your qualifying child (under age 13) or other qualifying dependent so you can work.
- **Keep your receipts.** Save receipts that describe exactly what you paid for. Make sure the amount and service date—not the payment date—are included.
- **Over-the-counter (OTC) medications, drugs and menstrual care products.** You can use your HealthEquity® Visa® Healthcare Card (Card) for OTC medications and drugs, including menstrual care products. Alternatively, you can pay for the item out of pocket and use Pay Me Back to submit your claim to HealthEquity for reimbursement. Pay Me Back claims can be submitted online, or with your smartphone or mobile device. (FSA plans vary by employer, and these changes do not necessarily change the benefits under your employer's plan.)
- **Watch where you shop.** If using a HealthEquity Healthcare Card, shop only at general merchandise stores or pharmacies that have an IRS-approved inventory system in place. Visit www.sigis.com for the most updated list of approved merchants. The healthcare Card will not work at a non-certified merchant.
- **Verify all healthcare Card transactions.** If a transaction is not automatically verified at checkout or by a third-party system, you will be notified by email or upon login to your account. Failure to verify an outstanding transaction may result in healthcare Card suspension.
- **Register for an online account at www.healthequity.com/wageworks.** When you register online and provide a current email, you ensure that you will have 24/7 access to your account and will be automatically signed up to receive important updates and alerts. You also must have an account to use the mobile app and take advantage of features like Submit Receipt or Claim and healthcare Card usage requests.
- **Keep track of your FSA balance.** Plan ahead to make sure you spend the full amount of your balance.

PE-301-FSA-QS-CSAM

Section 125 (Flexible Spending Accounts) (continued)



QUICKSTART GUIDE

Managing Your Account

You can manage and check up on your account through HealthEquity online or over the phone. The "Claims and Activity" page online details all your account activity and will even alert you if any healthcare Card transactions are in need of verification.

For the latest information, visit www.healthequity.com/wageworks and log in to your account 24/7. In addition to reviewing your most recent FSA activity, you can:

- Update your account preferences and personal information.
- View your transactions and account history.
- Schedule payments to healthcare and dependent care providers.
- Check the complete list of eligible expenses for your FSA program.
- Order additional HealthEquity Healthcare Cards for your family.
- Download the EZ Receipts app to file claims and healthcare Card use paperwork.

Using Your FSA Dollars

When you pay for an eligible healthcare and dependent care expense, you want to put your FSA to work right away. HealthEquity gives you several options to use your money the way you choose.

Using your HealthEquity Healthcare Card

Use your HealthEquity Healthcare Card (Card) instead of cash or credit at healthcare providers and pharmacies for eligible services, goods and prescriptions. You can also use the healthcare Card at general merchants and drug stores that have an industry standard (IAS) checkout system that can automatically verify if the item is eligible for purchase with your account.

- Go to www.sigis.com to review a list of eligible merchants, like drug stores, supermarkets and warehouse stores, that accept the healthcare Card.
- When you swipe your healthcare Card at the checkout, choose "credit" (even though it isn't a credit card).
- Consider paying for items or services on the day you receive them. If your health plan covers a portion of the cost, make sure you know what amount you need to pay before using the healthcare Card, by presenting your health plan member ID card first, so the merchant can identify your copay or coinsurance amount and ensure the service is claimed to your healthcare, dental, or vision insurance plan.
- Save your receipts or digital copies. You will need them for tax purposes. Plus, even when your healthcare Card is approved, a detailed receipt may still be requested.
- If you've lost or can't produce a receipt for an expense, your options may range from submitting a substitute receipt to paying back the plan for the amount of the transaction.
- If you use your healthcare Card at an eye doctor's or dentist's office, we will most likely ask you to submit an Explanation of Benefits (EOB) or other documentation for verification. Failure to do so may result in your healthcare Card being suspended.
- If you lose your healthcare Card, please call HealthEquity immediately and order a new one. You will be responsible for any charges until you report the lost healthcare Card.



Using your Mobile Device

With the EZ Receipts mobile app, you can file and manage your reimbursement claims and healthcare Card usage paperwork on the spot, with a click of your mobile device camera, from anywhere.

To use EZ Receipts:

- Download at www.healthequity.com/wageworks/aboutmobile.
- Log in to your account.
- Choose the type of receipt from the simple menu.
- Enter some basic information about the claim or healthcare Card transaction.
- Use your mobile device camera to capture the documentation.
- Submit the image and details to HealthEquity.

Paying online

You can pay many of your eligible healthcare and dependent care expenses directly from your FSA with no need to fill out paper forms.* It's quick, easy, secure and available online at any time.

To pay a provider:

- Log in to your FSA at www.healthequity.com/wageworks.
- Select "Submit Receipt or Claim."
- Request "Pay My Provider" from the menu and follow the instructions.
- Make sure to provide an invoice or appropriate documentation. When you're done, HealthEquity will schedule the checks to be sent in accordance with the payment guidelines. If you pay for eligible, recurring expenses, follow the online instructions to set up automatic payments.

* You must, however, provide documentation. For more information about the documentation requirements and payment guidelines, visit www.healthequity.com/wageworks.

Filing a claim

You also can file a claim online to request reimbursement for your eligible healthcare and dependent care expenses.

- Go to www.healthequity.com/wageworks, log in to your account and select "Submit Receipt or Claim."
- Select "Pay Me Back."
- Fill in all the information requested on the form and submit.
- Scan or take a photo of your receipts, EOBs and other supporting documentation.
- Attach supporting documentation to your claim by using the upload utility.
- Make sure your documentation includes the five following pieces of information required by the IRS:
 - Date of service or purchase
 - Detailed description
 - Provider or merchant name
 - Patient name
 - Patient portion or amount owed

Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

If you prefer to submit a paper claim by fax or mail, download a Pay Me Back claim form at www.healthequity.com/wageworks and follow the instructions for submission.

HealthEquity®

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The California Public Employees Retirement System (CalPERS) offers a defined benefit retirement plan. It provides benefits based on members' years of service, age, and final compensation. In addition, benefits are provided for disability, death, and payments to survivors or beneficiaries of eligible members. The City of Bellflower contracts with the California Public Employees' Retirement System (CalPERS) to manage eligible employees' pension benefits. Membership is mandatory for those of the City of Bellflower employees who are eligible.

CalPERS uses contributions of the employer and the employee as well as income from investments to pay for employee retirement benefits. Employee and employer contributions are a percentage of applicable employee compensation and are made on a pre-tax basis; federal and state taxes are deferred until benefits are paid. Any investment return on an employee's account is also tax deferred. The investment of contributions is managed solely by CalPERS and employee pension benefits mature with years of service and final compensation.

Pension Rules Changed in 2013- Are you PEPPRA or Classic?

If you were hired on or after January 1, 2013, it's likely the Public Employees' Pension Reform Act (PEPPRA) is applicable to you.

You may fall under the category of a PEPPRA member if:

- You're a member who joined CalPERS prior to January 1, 2013, who, on or after January 1, 2013, is hired by a different CalPERS employer following a break in service of more than six months.
- You're a new hire who joined CalPERS for the first time on or after January 1, 2013, and you have no prior membership in another California public retirement system.
- You're a new hire who joined CalPERS for the first time on or after January 1, 2013, and you were a member of another California public retirement system prior to that date, but you were not subject to reciprocity upon joining CalPERS.

If none of the above categories apply to you, you're considered a classic member, and the existing benefit enrollment levels for future service with the same employer will be applicable to you.

Your CalPERS Pension is on a Vesting System

To receive a CalPERS pension, most members must be vested by meeting two requirements: age and service credit. That means you must reach a certain age and have enough working years (usually five years) to collect your pension.

1. **Age:** Depending on your retirement formula, your minimum retirement age could be 50, 52, or 55. **(Note:** If you have a combination of classic and PEPPRA service, you may be eligible to retire at age 50.)
2. **Service Credit:** You must have at least five years of CalPERS-credited service, or 10 years if you are a State of California Second Tier member. (There are exceptions to the minimum service requirement: If you are employed on a part-time basis and have worked at least five years, or you are also a member of a reciprocal retirement system, contact us to find out if an exception applies to you.)

The summary is subject to change and if there are any discrepancies, CalPERS is the sole determiner of CalPERS pension benefits, reciprocity, membership, retirement formula(s), etc. For the most current and detailed information, employees can visit the [CalPERS website](#) or call CalPERS at [888-225-7377](tel:888-225-7377). Members may log into myCalPERS to manage their account online 24/7.

Member Education

CalPERS hosts a Member Education page with instructor led and online training on various topics, in addition to a dedicated YouTube page with videos on every aspect of being a CalPERS member, including how to sign up for myCalPERS, CalPERS QuickTips, and how to file an online retirement application.



JOIN TODAY TO ENJOY F&A's EXCLUSIVE MEMBER BENEFITS

- Products and services designed to meet your individual needs
- Personalized service
- Dedicated Loan Officer
- Trusted advice
- Superior rates on loans
- Exceptional dividends on deposits
- Financial Wellness Program
- Banking anytime, anywhere with 24/7 secure access to online and mobile banking



Join today in three easy steps:

1. Take a photo of your driver's license and work ID so you can upload them to our system.
2. Use your phone's camera to capture the QR code, then open the link to get started.
3. Complete your online application. When asked "How did you hear about F&A?", please select **HR Dept.** or **Credit Union Event** from the drop-down menu and we will deposit \$5 in your savings account to establish your new membership.

We're part of the CO-OP Network!

Access your F&A accounts and funds at over 5,600 shared branches and over 30,000 surcharge-free ATMs nationwide.

We help our members reach their financial goals at every life stage by providing access to the highest value products, superior service, and trusted advice.

Start your membership application today!



Call us today
800-222-1226



Visit a branch
2625 Corporate Place
Monterey Park, CA 91754

13303 Hadley Street
Whittier, CA 90601



Scan the QR
code to get
started now!



Federally insured
by **NCUA**



**F&A Federal
Credit Union**



Start the year consolidating your debt with our exceptionally low rates.

Home Equity Loan **6.25%**
fixed rates as low as APR*

Signature Loan **7.90%**
fixed rates as low as APR*

To apply, log in to
F&A Digital Banking
or simply call us
at (800) 222-1226.

Home Equity Loan:
Rates are subject to change without notice. Loan rates are based on the Combined Loan to Value Ratio (CLTV), loan term and credit score of the primary borrower. Available in all U.S. states except where prohibited by law. Additional CLTV restrictions may apply to properties outside of CA, second homes and 2-4 unit properties. Upfront costs are waived or paid by the Credit Union. Other terms and conditions apply. Representative Example: 7-year term. Make 84 monthly payments of \$368.22 at 6.250% APR based on \$25,000. NMLS# 421486

Signature Loan:
Rates and terms are subject to change without notice. All loans subject to approval. Additional terms and conditions may apply. Rate reflects 0.50% reduction for automatic payments. Payment Example: Financing \$25,000.00 at 7.90% for 60 months, payment of \$506.00 per month.

*APR = Annual Percentage Rate.



**F&A Federal
Credit Union**



Earn 4.59% APY* with eChecking!

A great rate with no monthly
fees or paper statements



Earn more with eChecking from F&A

An F&A High Yield eChecking Account has all of the great features as our Regular Checking Account, **plus you earn 4.59% Annual Percentage Yield (APY)* for the first \$9,999 (0.25% APY when the balance reaches \$10,000 and more).** Simply agree to receive your statements electronically instead of by mail. You'll help the environment and earn a lot, too!

Here's how to open a High Yield eChecking Account:

1. Log in to F&A Online or Mobile Banking and navigate to Accounts.
2. Click Open Deposit Account.
3. Select Checking (Open Now), then High Yield eChecking and follow the online instructions.
4. To convert an existing Regular Checking Account to a High Yield eChecking Account, select Convert Checking to a High Yield eChecking and follow the online instructions.

Start earning more today! For more information, visit FAFCU.org or call (800) 222-1226.

*APY is accurate as of the last dividend declaration date. Rate is subject to change without notice. No Minimum Daily Balance is required to earn the stated APY. All dividends are compounded daily and credited monthly. Subject to qualifications. Requires paperless eStatements to open and maintain the account. Maximum three (3) High Yield eChecking accounts per member.

Insured by **NCUA**

Deferred Compensation - 457B and 401A Enrollment



Do something
good for
yourself



It's easy to get started

The steps you take today will affect how you spend tomorrow. On your journey to retirement, do something good for yourself by planning ahead for the kind of future you envision. Start by setting a little aside regularly for the kind of retirement you can look forward to by enrolling in your employer's retirement savings plan.

- 1 Scan the QR code or go to enroll.voya.com
- 2 Enter plan number
664278
- 3 Enter verification number
202338



Enroll Me™

5 reasons to enroll now

1. Make changes anytime
2. Save automatically
3. Help lower your taxable income
4. Invest your way
5. Take your money with you

For more info contact:
Greg Gower, CFP® - CA Insurance Lic. # 0H80564
greg.gower@voyafa.com

City of Bellflower 457B



Not FDIC/NCUA/NCUSIF Insured | Not a Deposit of a Bank/Credit Union | May Lose Value | Not Bank/Credit Union Guaranteed | Not Insured by Any Federal Government Agency

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Investment adviser representative and registered representative of, and securities and investment advisory services offered through Voya Financial Advisors, Inc. (member SIPC).

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PLAN
INVEST
PROTECT



Mobile Resources



Did you know that most of our carriers & vendors offer mobile applications allowing you to access your benefits information on the go? Make sure to download these apps on your phone and share with your dependents.

Medical

CalPERS Medical

Download the mobile application for your medical carrier! Anthem, Blue Shield, Health Net, Kaiser and UnitedHealthCare all have mobile applications available for download.

Find a doctor

- Get to an urgent care center fast with maps and driving directions
- Locate a hospital or emergency room
- Access your ID card on your phone
- Search claims information

Dental

Delta Dental

Delta Dental's website and mobile application allows members to:

- Find a dentist
- View your benefits, eligibility, deductibles and maximums
- Check claims and manage billing
- Use a cost estimator

Simply visit deltadentalins.com from your smartphone's browser and select visit mobile site

Vision

EyeMed

EyeMed's mobile website eyemed.com allows members to find a doctor, access your member vision card, view exclusive member extras, and get important information on a variety of topics regarding eye care to maintain optimal eye health.

Flexible Spending Account (FSA)

HealthEquity/WageWorks

With the EZ Receipts mobile app you can file and manage your reimbursement claims and healthcare Card usage paperwork on the spot with a click of your mobile device camera, from anywhere

- Log into your account
- Choose the type of receipt from the simple menu
- Enter some basic information about the claim or healthcare Card transaction
- Use you mobile device camera to capture documentation
- Submit the image and detail to HealthEquity



Important Notices



No Surprises Act Notice

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

Discrimination is Against the Law

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

Newborns' and Mothers' Health Protection Act (NMLHA)

Benefits for 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 562-804-1424

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 CalPERS.

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 CalPER.

Networks/Claims/Appeals

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

COBRA Continuation Coverage

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

Important Notices (continued)



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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

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

Important Notices (continued)



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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

Important Notices (continued)



ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment 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.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

¹ <http://www.socialsecurity.gov/>

Important Notices (continued)



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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Dana Hang
Human Resources & Risk Manager
562-804-1424 ext. 2016

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

City of Bellflower 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 Dana Hang 562-804-1424 ext. 2016.

Important Notices (continued)



Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about City of Bellflower 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 Bellflower	4. Employer Identification Number (EIN) 95-6005896	
5. Employer address 16600 Civic Center Drive	6. Employer phone number 562-804-1424	
7. City Bellflower	8. State CA	9. ZIP code 90706
10. Who can we contact about employee health coverage at this job? Dana Hang		
11. Phone number (if different from above)	12. Email address dhang@bellflower.ca.gov	

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



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

Important Notices (continued)



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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office, 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.flmedicaidtplecovery.com/flmedicaidtplecovery.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/la hipp

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: HHSHIPPPProgram@mt.gov

NEBRASKA - Medicaid

Website: <http://www.accessnebraska.ne.gov/>

Phone: 1-855-632-7633

Lincoln: 1-402-473-7000

Omaha: 1-402-595-1178

NEVADA - Medicaid

Medicaid Website: <https://dhcfp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 1-603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY - Medicaid & CHIP

Medicaid Website:

<https://www.nj.gov/humanservices/dmahs/clients/medicaid/>

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 1-609-631-2392

CHIP Website: <https://njfamilycare.dhs.state.nj.us/>

CHIP Phone: 1-800-701-0710 (TTY 711)

NEW YORK - Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 1-919-855-4100

NORTH DAKOTA - Medicaid

Website: <https://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP

Website: <http://www.insureoklahoma.org/>

Phone: 1-888-365-3742

OREGON - Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid & CHIP

Website: <https://www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp>

Phone: 1-800-692-7462

CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND - Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347, or 1-401-462-0311 (Direct Rlt Share Line)

SOUTH CAROLINA - Medicaid

Website: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

Important Notices (continued)



TEXAS - Medicaid

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

UTAH - Medicaid & CHIP

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

VERMONT - Medicaid

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

VIRGINIA - Medicaid & CHIP

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

WASHINGTON - Medicaid

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

WEST VIRGINIA - Medicaid and CHIP

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

WISCONSIN - Medicaid & CHIP

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

WYOMING - Medicaid

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

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

U.S. Department of Labor

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

U.S. Department of Health and Human Services

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



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.

