CITY OF MISSION VIEJO

Employee Benefit Orientation

Topics Discussed	Items Provided
ESS Access & Submission Dates	1. Voya Beneficiary Form
Benefit Commencement Date	2. Medical Plan Waiver Form
Eligible Benefit Tier	3. 2024 Monthly Benefit Rates
Eligible Fixed Monthly Contribution	4. City of Mission Viejo Summary of Benefit Plans
Medical Plan Options	5. CalPERS Health Program Guide & SBC Instructions
Dental Plan Options	6. Delta Dental – DPPO & DHMO Options
Vision Plan Option	7. Delta DPPO Summary of Benefits
Flexible Spending Account Options	8. 1-page DHMO Reference Sheet
City Provided Life & Disability	9. DHMO Detailed Benefits
Voluntary Supplemental Life Insurance	10. VSP – Vision Benefit Summary Sheet
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CalPERS Eligibility & Enrollment	12. Voya Life Insurance & Disability at a Glance
CalPERS Benefit Formula	13. Voya Life Insurance Booklet
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RHS Contribution & Effective Date	16. Nationwide 457 & Roth Overview
	17. Employee Assistance Program Overview
	18. Welcome to CalPERS
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	21. Retiree Health Savings Plan Overview
	22. Retiree Health Savings Plan Administration
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LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) AND DISABILITY INCOME INSURANCE ENROLLMENT

ReliaStar Life Insurance Company, Minneapolis, MN
Telephone: 800-955-7736
A member of the Voya® family of companies

PLAN INFORMATION section to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. **All** new Life or Disability Income coverage or **any** increases in Life or Disability Income coverage will require evidence of insurability if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

PLAN INFORMATION

Employer/Plan Sponsor Name Public Risk Innovation, Solutions and Management (PRISM) Effective Date of Coverage or Change _____
Group/Plan Number 316407 Account Number/Location 109 - City of Mission Viejo
Class/Occupation _____
Date of Hire _____ Annual Salary $_____ Employment Status: ☐ Active Full-Time ☐ Active Part-Time ☐ Retired
This change is due to *(Check all that apply.)*:
☐ Initial Eligibility Following Hire ☐ Change in Coverage Amount ☐ Late Entrant [1] ☐ Other _____
[1] *A late entrant is an individual who is first enrolling after the initial available opportunity.*

EMPLOYEE INFORMATION

Employee Name *(First, Middle Initial, Last)* _____
Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female
Employee ID Number _____ Work Phone (_____)_____ Home Phone (_____)_____
Address _____ City _____ State _____ ZIP _____

DISABILITY INCOME INSURANCE

Weekly Income Benefits (STD)
☑ Elect Coverage (Note: STD coverage is employer provided.)

Monthly Income Benefits (LTD)
☑ Elect Coverage (Note: LTD coverage is employer provided.)

EMPLOYEE LIFE / AD&D INSURANCE

Basic Life / AD&D Insurance Election
☑ Employee Only—Elect Coverage *(Note: Basic Life and Basic AD&D insurance is employer provided.)*

Supplemental Life Insurance
Guaranteed Issue (GI) Limit = $100,000 or 3 times annual salary, whichever is less. When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability. Total supplemental life coverage up to $350,000 is available if you complete an Evidence of Insurability form subject to approval by the insurance company.

Supplemental Life Insurance Election
☐ I currently have supplemental life coverage of: $_____.
☐ I am applying for additional supplemental life coverage of: $_____. *($10,000 increments, not to exceed 5 TIMES MY ANNUAL SALARY)*
☐ Total supplemental life coverage (current plus additional): $_____.
☐ Waive coverage.

BENEFICIARY INFORMATION

(Designate your beneficiary(ies) below. Percentages must total 100%, using whole percentages only. If additional space is required please attach a separate signed and dated document with the same information for each beneficiary.)

	Name *(First, MI, Last)*	DOB	Gender	SSN / TIN	Relationship	%	Beneficiary Type
1			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ( )			
2			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ( )			
3			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ( )			

.

SPOUSE LIFE INSURANCE *(The use of "spouse" in this form means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the plan. Please contact the Employer for more information.)*

When you are initially eligible for Spouse coverage, you can elect up to $25,000 in coverage without evidence of insurability. Total Spouse coverage up to $50,000 is available if Spouse completes an Evidence of Insurability form subject to approval by the insurance company. Spouse coverage is limited to 50% of the employee's life coverage amount.

Spouse Name *(First, Middle Initial, Last)* _____ Birth Date _____

Spouse Life Insurance Election

☐ I currently have Spouse Life coverage of: $_____.
☐ I am applying for additional Spouse Life coverage of: $_____. *($5,000 increments)*
☐ Total Spouse Life coverage (current plus additional): $_____.
☐ Waive coverage.

Note: The employee is the beneficiary for any Spouse insurance coverage.

CHILDREN LIFE INSURANCE

Coverage is limited to 50% of the employee's life coverage amount. Children from birth to 6 months of age are covered for $1,000.

Children Life Insurance Election

☐ $10,000 for each eligible child
☐ Waive coverage.

Note: The employee is the beneficiary for any Children insurance coverage.

SPOUSE AND CHILDREN INFORMATION

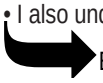
Enter information below. If additional space is required please attach a separate document.

	Spouse Name *(First, MI, Last)*	DOB	Gender	SSN
			☐M ☐F	
	Address			Phone ( )

	Child Name *(First, MI, Last)*	DOB	Gender	SSN
1			☐M ☐F	
	Address			Phone ( )
2			☐M ☐F	
	Address			Phone ( )
3			☐M ☐F	
	Address			Phone ( )

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.



Employee Signature _____ Date _____

FRAUD WARNINGS

Arkansas, Maine, Ohio, Oklahoma, Rhode Island, Tennessee, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

CITY OF MISSION VIEJO

Waiver of Benefits and Release Agreement Form Calendar Year 2024

Employee's Printed Name:_____ Employee ID #:_____

Instructions: An employee wishing to waive City-provided medical coverage in Calendar Year 2024 in exchange for opt-out payments from the City must read this form, sign and date below, and then forward the form via email to the Human Resources Division at hr@cityofmissionviejo.org. Please do not route paper forms.

Capitalized terms used below are defined on the last page of this form. This Waiver Agreement is intended to constitute an Eligible Opt-Out Arrangement within the meaning of IRS Proposed Regulations section 1.36B-2(c)(7) (81 FR 44557).

If you have any questions about this form, please contact Human Resources via email at hr@cityofmissionviejo.org. Thank you.

The City of Mission Viejo provides its benefit-eligible employees with the opportunity to enroll in various health and welfare benefit plans, including the City's group medical insurance plan ("Plan"). I wish to waive coverage under the Plan for calendar year 2024 in exchange for monthly cash "opt-out payments" from the City. By signing below, I hereby agree to the following:

- I am waiving medical coverage under the Plan for myself and my Expected Tax Family.
- I attest that in calendar year 2024, the following will apply: My Expected Tax Family and I will have Minimum Essential Coverage through another **Group Medical Plan**. My Expected Tax Family and I will not be enrolled in an Individual Plan, or in a medical plan offered under or in coordination with a Federal Insurance Marketplace or a State Exchange.

  The name of my Group Medical Plan is (i.e. United Healthcare or Blue Cross):

  _____

  The name of the employer I receive my Group Medical Plan is (i.e. Pepsi Co., Smith Construction; usually your spouse's current or former employer, or your previous employer if you are a retiree):

  _____
- I understand that I will not be able to revoke this waiver and elect medical coverage until the next Open Enrollment Period, unless certain unexpected mid-year changes occur. Such changes generally include the following (among others): a substantial change in cost of alternative coverage, I experience a family-status change, or I lose alternative coverage

for reasons other than failure to pay premiums. I understand that if any such mid-year changes occur, I am solely responsible for notifying the City of the change and my desire to enroll in the Plan. (The rules governing mid-year changes in coverage elections are complicated. For detailed information about these rules, please contact Human Resources.)

- I understand that the City will automatically enroll me in the "Employee Only" category of the lowest-cost coverage option under the Plan (other than Health Net Salud Y Mas) AND that I will not be eligible for any further opt-out payments, if either of the following occurs:

  - I fail to sign and submit this Waiver Agreement to the City by the above-noted deadline and fail to otherwise enroll in any Plan coverage option by the applicable deadline, or

  - I sign and submit this Waiver Agreement to the City, but the City knows, or has reason to know, that I or any member of my Expected Tax Family is not enrolled in alternative coverage as described above.

- I understand that this Waiver Agreement will remain in effect throughout 2024, except as described above. If I wish to receive an opt-out payment for 2025 (if then offered), I will have to sign a new Waiver Agreement for that year.

- I agree to indemnify and hold harmless the City from any responsibility, damages, losses, causes of action or other claims arising under or related to my request to waive coverage under the Plan and any corresponding cancellation of coverage under the Plan for me (or any member of my Expected Tax Family) effected by the City in response to my execution and submission of this Waiver Agreement.

Employee's Signature:_____ Date:_____

HUMAN RESOURCES DIVISION USE ONLY		
DATE RECEIVED:_____	**EFFECTIVE DATE:**_____	**FTE:**_____
HIRE DATE:_____	**ELIGIBLE OPT-OUT TIER #:**_____	
ELIGIBLE OPT-OUT AMOUNT:_____		

DEFINITIONS

ACA
The Affordable Care Act, the federal healthcare reform law enacted in March 2010.

Expected Tax Family
All persons for whom the employee reasonably expects to claim a personal exemption deduction for the calendar year to which the Waiver Agreement applies.

Federal Insurance Marketplace
A service that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace, available at HealthCare.gov, for most states. Some states run their own Marketplaces. The Health Insurance Marketplace (also known as the "Marketplace" or "exchange") provides health plan shopping and enrollment services through websites, call centers, and in-person help.

Group Medical Plan
In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Individual Plan
A type of health insurance purchased by an individual or family, independent of any employer group or organization.

Minimum Essential Coverage
Coverage under another group health plan that satisfies the ACA requirements to be minimum essential coverage. Individual policies, whether obtained through Covered California or elsewhere, don't constitute minimum essential coverage.

Open Enrollment Period
A time period during which eligible employees may make changes to their coverage under the Plan. Open enrollment for the City typically takes place from September to October and changes become effective the following January 1.

Plan
The City's group medical insurance plan. The City provides this plan through PEMHCA (also known as "CalPERS Health"), the health system maintained by the California Public Employees' Retirement System.

State Exchange
Another term for the Health Insurance Marketplace, a service available in every state that helps individuals, families, and small businesses shop for and enroll in affordable medical insurance.

Active Employee Premium Schedule –Effective January 1, 2024

MEDICAL REGION 2 – Orange and San Diego County Residents *(Verify service area of each provider)*			
(Munis Carrier Code) CARRIER NAME	**EMP ONLY**	**EMP & 1**	**EMP & 2 or More**
(AS) Anthem Blue Cross Select	$807.71	$1,615.42	$2,100.05
(AT) Anthem Blue Cross Traditional	$1,034.38	$2,068.76	$2,689.39
(BSA) Blue Shield Access+	$869.14	$1,738.28	$2,259.76
(BST) Blue Shield Trio	$810.24	$1,620.48	$2,106.62
(HNSM) Health Net Salud y Mas	$684.77	$1,369.54	$1,780.40
(KS) Kaiser Permanente	$904.95	$1,809.90	$2,352.87
(PGB) PERS Gold PPO	$799.44	$1,598.88	$2,078.54
(PPB) PERS Platinum PPO	$1,151.50	$2,303.00	$2,993.90
(SHRP) Sharp *(San Diego County Only)*	$833.24	$1,666.48	$2,166.42
(UH) UnitedHealthcare Signature Alliance	$837.88	$1,675.76	$2,178.49
(UHH) UnitedHealthcare Signature Harmony	$792.65	$1,585.30	$2,060.89
MEDICAL REGION 3 – Los Angeles, Riverside, and San Bernardino County Residents *(Verify service area of each provider)*			
(Munis Carrier Code) CARRIER NAME	**EMP ONLY**	**EMP & 1**	**EMP & 2 or More**
(AS) Anthem Blue Cross Select	$841.13	$1,682.26	$2,186.94
(AT) Anthem Blue Cross Traditional	$1,012.67	$2,025.34	$2,632.94
(BSA) Blue Shield Access+	$756.65	$1,513.30	$1,967.29
(BST) Blue Shield Trio	$704.69	$1,409.38	$1,832.19
(HNSM) Health Net Salud y Mas	$630.13	$1,260.26	$1,638.34
(KS) Kaiser Permanente	$865.41	$1,730.82	$2,250.07
(PGB) PERS Gold PPO	$785.28	$1,570.56	$2,041.73
(PPB) PERS Platinum PPO	$1,131.47	$2,262.94	$2,941.82
(UH) UnitedHealthcare Signature Alliance	$826.44	$1,652.88	$2,148.74
(UHH) UnitedHealthcare Signature Harmony	$734.76	$1,469.52	$1,910.38
DENTAL & VISION – All Counties			
(Munis Carrier Code) CARRIER NAME	**EMP ONLY**	**EMP & 1**	**EMP & 2 or More**
(DHMO) Delta Care	$19.40	$34.60	$51.00
(DPPO) Delta Preferred	$64.30	$114.00	$187.50
(VIS) Vision	$26.14	$41.03	$69.78
FLEXIBLE SPENDING ACCOUNTS		**ANNUAL MINIMUM**	**ANNUAL MAXIMUM**
Dependent Care Reimbursement		$300	$5,000
Medical Reimbursement		$180	$3,050
DEFERRED COMPENSATION		**ANNUAL MINIMUM**	**ANNUAL MAXIMUM**
Basic Annual Employee Contribution Levels		$120	$23,000
Age 50 or Older Catch-Up Contribution Levels		$0	Up to additional $7,500
Pre-Retirement Catch-Up Contribution Levels		$0	Up to additional $23,000

Fixed Monthly Employer Contribution Towards Employee Benefits – Non-SEIU

TIER 1 MONTHLY CITY CONTRIBUTION	
FULL-TIME EQUIVALENCY (FTE)	**OPT OUT**
1.000 (40 hrs/wk)	$975.00
.750 to .999 (30 – 39 hrs/wk)	$731.25
.500 to .749 (20 – 29 hrs/wk)	$487.50

TIER 2 MONTHLY CITY CONTRIBUTION TO EMPLOYEE HEALTH BENEFITS				
FULL-TIME EQUIVALENCY (FTE)	**MEDICAL PLAN ENROLLMENT LEVEL**			
	OPT OUT	**Employee Only**	**Employee + 1**	**Employee + Family**
1.000 (40 hrs/wk)	$750.00	$975.00	$1,062.00	$1,264.00
.750 to .999 (30 – 39 hrs/wk)	$512.50	$731.25	$796.50	$948.00
.500 to .749 (20 – 29 hrs/wk)	$275.00	$487.50	$531.00	$632.00

TIER 4 MONTHLY CITY CONTRIBUTION TO EMPLOYEE HEALTH BENEFITS				
FULL-TIME EQUIVALENCY (FTE)	**MEDICAL PLAN ENROLLMENT LEVEL**			
	OPT OUT	**Employee Only**	**Employee + 1**	**Employee + Family**
1.000 (40 hrs/wk)	$450.00	$1,269.00	$2,141.00	$2,437.00
.750 to .999 (30 – 39 hrs/wk)	$312.50	$951.75	$1,605.75	$1,827.75
.500 to .749 (20 – 29 hrs/wk)	$175.00	$951.75	$1,605.75	$1,827.75

Fixed Monthly Employer Contribution Towards Employee Benefits – SEIU

TIER 4 MONTHLY CITY CONTRIBUTION TO EMPLOYEE HEALTH BENEFITS				
FULL-TIME EQUIVALENCY (FTE)	**MEDICAL PLAN ENROLLMENT LEVEL**			
	OPT OUT	**Employee Only**	**Employee + 1**	**Employee + Family**
1.000 (40 hrs/wk)	$450.00	$1,269.00	$2,141.00	$2,437.00
.750 to .999 (30 – 39 hrs/wk)	$312.50	$951.75	$1,605.75	$1,827.75
.500 to .749 (20 – 29 hrs/wk)	$175.00	$951.75	$1,605.75	$1,827.75

CITY OF MISSION VIEJO

MISSION VIEJO

Make Living Your Mission

Summary of Benefit Plans - 2024

Table of Contents

Introduction

The City of Mission Viejo (City) takes pride in offering a benefits program, which provides flexibility for the diverse and changing needs of its employees.

This benefits summary briefly describes the highlights of the City's benefit plans. The official plan documents, when finally executed and as amended from time to time, govern the plans and should be consulted for additional detail on coverages and exclusions. If there is a conflict between this summary and the official plan documents, the official plan documents will prevail. At any time and for any reason, the City may exercise its legal right to modify, replace, or terminate any of the benefit plans it provides.

Carrier Information At-A-Glance

Plan Name	Administrator	Plan Information
Anthem Blue Cross (HMO) • Select HMO • Traditional HMO	Anthem Blue Cross (855) 839-4524	OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.
Blue Shield of California (HMO) • Blue Shield Access+ HMO • Blue Shield Trio HMO	Blue Shield of California (800) 334-5847	Blue Shield of California administers their own prescriptions.
Health Net of California (HMO) • Salud y Más HMO • SmartCare HMO	Health Net of California (888) 926-4921	OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.
Kaiser (HMO)	Kaiser Permanente (800) 305-1220	Kaiser administers their own prescriptions.
PERS Platinum (PPO)	Anthem Blue Cross (877) 737-7776	This plan has no geographical restrictions. It provides coverage anywhere in the world. OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.
PERS Gold (PPO)	Anthem Blue Cross (877) 737-7776	OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.
Sharp Health Plan (HMO) • Sharp Performance Plus	Sharp Health Plan (855) 995-5004	OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.
UnitedHealthcare (HMO) • UnitedHealthcare SignatureValue Alliance • UnitedHealthcare SignatureValue Harmony	UnitedHealthcare (877) 359-3714	OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.

Plan Name	Administrator	Plan Information
Aflac • Cancer Protection Assurance • Accident Advantage • Critical Care Protection • Hospital Confinement	Aflac (800) 992-3522 *CLOSED TO NEW ENROLLEES	Our Aflac representative is Jim Boada. He can be reached at (949) 872-1401 or via email at james_boada@us.aflac.com. *CLOSED TO NEW ENROLLEES
CalPERS • Retirement	CalPERS (888) 225-7377	• Service credit is the time you accrue while on the job under a CalPERS-covered employer. • Your retirement benefits are based on a formula - not what you contribute into the system. • Member Informational Videos
Delta • Delta Dental PPO • DeltaCare USA	Dental PPO (888) 335-8227 DeltaCare USA (800) 422-4234	Dental PPO Group Number • 10535-0001 DeltaCare Plan • CA10 A
Concern • Employee Assistance Program	MHN (800) 344-4222	• Cope with grief, anxiety, stress, depression and other emotional health issues • The online access code is cityofmissionviejo
Voya Financial • Group Term Life Insurance • Short-term Disability • Long-term Disability • 457(b) • 401(a) • Roth IRA	(800) 955-7736 To file a Disability Claim	Life Insurance Policy • 31640-7GAT • Public Risk Innovation, Solutions and Management (“PRISM”) Disability Policy • 31640-7DISABILITY • Public Risk Innovation, Solutions and Management (“PRISM”) 457/401/Roth • A deferred comp plan can help bridge the gap between what you have in your pension and how much you’ll need in retirement. • The City will match your monthly 457(b) or Roth contribution up to $150.00 per month.
Vision Service Plan (VSP)	VSP (800) 877-7195	VSP Signature Provider Network
Wex • Medical FSA • Dependent Care FSA	Wex (866) 451-3399	Live Chat customerservice@wexhealth.com

Fixed Monthly Employer Contribution

Employees are eligible to receive a Fixed Monthly Flex Contribution based upon their hire date, enrollment level in a medical plan (i.e. employee only, plus one, or family), and their full-time equivalency (FTE). Please see the back page titled Premium Schedule for a complete list of the current Fixed Monthly Employer Contributions by tier. You can also reference the Employer Contribution Schedule Personnel Policy listed on the City's website.

Who Is and Is Not Eligible

Individuals are eligible to participate in employee benefits if they fall into any of the following categories:

- A full-time employee
- An at-will executive employee
- A part-time employee in a budgeted position listed on the Authorized Position Schedule and is scheduled to regularly work twenty (20) or more hours per week
- A member of the City Council
- An Hourly/Seasonal/Temporary employee determined to have worked thirty (30) or more hours per week during an initial or standard measurement period.

An eligible employee may also enroll their eligible dependents for benefit coverage. Eligible dependents include:

- Spouse (copy of marriage license and the person's social security number is required)
- Domestic Partner (You are required to complete an Affidavit for Domestic Partnership with the State of California, and your contribution for their coverage is made on an after-tax basis.)
- Eligible children are defined as natural, adopted, step, or domestic partner's children up to age 26 (a copy of the birth certificate and the child's social security number is required)
- An Economically Dependent Child is eligible for medical insurance enrollment only. Another person's child may be eligible for coverage as an Economically Dependent child if the employee has been granted legal custody or joint legal custody of the child; or the child resides with the employee **and** is economically dependent upon the employee (You are required to complete the Affidavit of Eligibility form which is a legally binding document and to report any changes pertaining to the child's dependency).

Who Is Not Eligible: The following is a list of individuals that are not allowed to participate in the City's group benefit plans:

- Former spouses
- Dependent Children over age 26
- Dependent Children's spouses
- Parents or Parent-in-laws
- Grandparents
- Stepchildren of former spouses*
- An hourly/seasonal/temporary employee working less than thirty (30) hours per week
- Any individual in any other classification not directly approved by City Council

*Stepchildren of former spouses are eligible when the employee retains custody. They must certify as "economically dependent". The dissolution of marriage dissolves the relationship as "step". Similarly, a domestic partner's child must be certified as "economically dependent" if the partnership dissolves, but the employee retains custody of the child.

The City of Mission Viejo and its benefit carriers may audit an employee's documentation to determine whether an enrolled dependent is eligible according to the plan requirements. This audit may occur either randomly or in response to uncertainty concerning dependent eligibility.

Dual Coverage

Employees cannot be enrolled in a CalPERS health plan in their own right ("self") and as a dependent of another member enrolled in a CalPERS health plan. Upon discovery, dual enrollments are cancelled on a retroactive basis, and the health plans will bill the employee for services provided on behalf of ineligible family members. However, employees can be enrolled as a dependent in another family member's health plan as long as it is: 1) a non-CalPERS administered plan; and 2) that plan allows dual coverage in their contract.

New Employees Effective Date of Coverage

As a benefit eligible employee, you have 60 calendar days from the date of your initial eligibility to enroll, or decline to enroll, yourself or yourself and all eligible family members in a benefit plan. The effective date is the first day of the month following the date Human Resources receives your enrollment elections via Munis Employee Self-Service (ESS). If you do not submit your benefit elections within 60 calendar days of your initial eligibility, you will be automatically enrolled in the "Employee Only" category of the lowest cost health plan, excluding the Health Net Salud y Mas plan, the cost of which will be offset by your applicable Fixed Monthly Flex Contribution. You will not be able to make any changes to your benefits until the next Open Enrollment period unless you experience a "qualified status change".

Annual Open Enrollment

Each year during open enrollment, you have the opportunity to make changes to your benefit choices. The open enrollment period occurs in the fall, with your new elections taking effect on January 1st of the following year. These elections remain effective through December 31st of that following year and can only be changed in the case of a qualified status change. During open enrollment you may:

- Choose a different option where choices are available
- Add or drop dependents from your coverage
- Elect to participate in the Flexible Spending Accounts for the upcoming year

Employees who do not submit the required benefit election forms during Open Enrollment will be enrolled in the same elections as the prior year, with the exception of Medical and/or Dependent Care Reimbursement Accounts. Any eligible remaining balance from the Fixed Monthly City Contribution will be placed in the taxable Cash Option.

Waiving of Medical Insurance

Employees may conditionally waive medical insurance for themselves if they can provide adequate documentation to prove they have minimum essential group medical coverage elsewhere. In addition, the employee must annually submit a completed "Waiver of Benefits and Release Agreement Form" attesting they have alternative minimum essential coverage from another group plan provider. If an employee does not provide adequate documentation, as determined by the City, then the employee may not waive medical insurance. If you waive the City's group medical plan, you are required to notify the City if you experience a mid-year status change which results in loss of minimum essential group medical coverage. Notice must be made to the Human Resources Division within 30-calendar days of such status change. Please see the Human Resources Division for further conditions that may apply.

Section 125 Plan

The City administers the benefit plans as allowed under Section 125 of the Internal Revenue Code (IRC) that lets employees pay for eligible benefit premiums on a pre-tax basis. The advantage to you is that the premiums are taken out of your paycheck before taxes are deducted. This lowers your taxable income, increasing your take home pay. The amount you save will depend on how much premium is paid with before-tax dollars, your tax bracket, and your earnings when you enroll.

The written plan document and the summary plan description specifically describe all benefits and establish rules for eligibility and elections.

Qualified Status Changes

Once you make your benefit choices, you cannot make changes until the next open enrollment period unless you experience a qualified status change. If such an event occurs, you must email the Human Resources Division within 30-days of the event in order to make changes to your current plans. Examples of qualified status changes include:

- Marriage or Domestic Partner Registration
- Birth, Adoption or placement for adoption
- Divorce or annulment of an employee's marriage or Dissolution of Domestic Partnership
- Death of a spouse, domestic partner or dependent

- ❖ Change in employee's, spouse's, domestic partner's or dependent's employment status that affects eligibility under their plan
- ❖ Dependent no longer meets eligibility criteria or becomes ineligible for other coverage
- ❖ Court order results in the employee gaining or losing custody of a dependent
- ❖ Coordination of spouse's or domestic partner's annual election period

Divorce or Termination of Domestic Partnership

If you divorce or terminate a domestic partnership, your former spouse/domestic partner is no longer eligible to be enrolled in the City's benefit plans, even if the court orders you to provide health coverage for them. The coverage terminates on the first day of the month in which the final decree of divorce or termination is granted. You must submit a copy of your final divorce decree or Notice of Termination of Domestic Partnership form to Human Resources (if active) or CalPERS (if retired).

Employees email the Human Resources Division of the change and attach a copy of the divorce decree. You may also want to review and/or update your beneficiary designations and residence address on file with CalPERS for your retirement account, with Voya for your life insurance, and either ICMA or Nationwide for your deferred compensation account(s).

Medical Plans

Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. The City of Mission Viejo's medical plans are administered through the California Public Employee's Retirement System (CalPERS) and are subject to the rules of the Public Employees' Medical and Hospital Care Act (PEMHCA).

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

The Health Benefit Summary publication on the CalPERS website provides valuable information to help you make an informed choice about your health care providers. It compares covered services, co-payments, and benefits for each CalPERS health plan. It provides information about plan availability by county and a chart summarizing the key differences between a Health Maintenance Organization (HMO) and a Preferred Provider Organization (PPO).

In addition, the Health Program Guide on the CalPERS website describes CalPERS Basic health plan eligibility, enrollment, and choices. It provides an overview of CalPERS health plan types and tells you how and when you can make changes to your plan (including what forms and documentation you will need).

Since these publications only provide a general overview of benefits. Please refer to each health plan's Evidence of Coverage (EOC) booklet for the exact terms and conditions of coverage. Health plans mail EOC's to new members at the beginning of the year, and to existing members upon request. You can also access the EOC's online by visiting the CalPERS website.

SERVICE AREAS: Please ensure you have correctly evaluated the service area of each health plan. Not all plans service all areas of Orange and San Diego Counties.

SPECIFIC PROVIDER NEEDS: If a specific doctor, medical group, or hospital is preferred, a plan must be selected which allows access to the specific provider. Each enrollee needs to contact the carrier(s) and/or provider directly to inquire about the availability of the specific provider BEFORE enrolling.

When employees enroll into a health plan, services are provided through the health plan's delivery system and the continued participation of any one doctor, hospital, or provider network **is not guaranteed**. The provider network may change during the plan year and often does. Employees may be permitted to select another provider, but not another plan.

DUAL COVERAGE: The CalPERS Health Benefits Program **does not permit dual coverage**. Employees who are already covered as a dependent of another PEMHCA enrollee may not be enrolled as "self" with the City of Mission Viejo. Therefore, an employee must cancel their prior dependent enrollment in the other

PEMHCA plan in order to enroll in the City of Mission Viejo plan. Upon discovery, dual enrollments are cancelled on a retroactive basis, and the carriers will bill the employee for services provided on their behalf of ineligible family members.

Dental Plans

Next to medical insurance, dental coverage is the single most requested benefit among employees and an important part of your overall health and well-being. You may choose from two different plans offered by Delta Dental. When choosing between a prepaid/DHMO plan an indemnity/PPO plan, you should consider you and your dependents dental history, level of dental care required, costs/budget, and provider in the network.

DeltaCare Program

DeltaCare is a DHMO plan and provides you and your family with quality dental benefits at an affordable cost. The DeltaCare program is designed to encourage you and your family to visit the dentist regularly to maintain your dental health. When you enroll, you select a contract dentist to provide services. The DeltaCare network consists of private practice dental facilities that have been carefully screened for quality. Your selected contract dentist will take care of your dental care needs. If you require treatment from a specialist, your contract dentist will handle the referral for you. Under the DeltaCare program, many services are covered at no cost, while others have co-payments for certain benefits. See the summary plan document or provider directory for further details and list of required co-payments.

Delta DPO Program

The Delta Dental DPO plan is Delta's preferred provider program. It allows you the freedom to visit any licensed dentist from the Delta Dental Premier indemnity network. However, there are advantages to visiting a Delta Dental DPO network dentist instead of a Premier or non-Delta Dental dentist. Please refer to the Benefit Highlights Sheet for further details.

Vision Plan

Enrolling in VSP Vision Care can save you money and helps keep your family happy and healthy. Keep your comprehensive vision care benefit and continue to get access to quality eye care and eyewear from an in-network doctor you'll love, all at low out-of-pocket costs.

- Value and savings you love. VSP members save on eyewear and eye care with a VSP network doctor. You'll also receive access to Exclusive Member Extras that can save you more than $3,000. Calculate your savings and check out the Exclusive Member Extras you'll get.

- Provider choices you want. Most members have access to five VSP network doctors within six miles of where they live or work. It's easy to find a nearby in-network doctor to maximize your vision coverage.

- See better. Look your best. VSP members have access to a huge selection of designer brand frames. From classic styles to the latest designer frames, you'll find a great selection of eyewear for you and your family at an eye care provider near you.

Flexible Spending Accounts (FSA)

You can make your paycheck go further by taking advantage of the tax savings associated with participating in a Flexible Spending Account (FSA). You can set up one FSA for health care expenses and another to pay for the cost of caring for your dependents while you are at work. You can access your accounts anytime, anywhere, by using the mobile app. Both types of accounts are administered through Wex. An enrollment form is required to enroll in either one or both of these plans. An enrollment form is **required** each year during Open Enrollment for the next calendar plan year.

Health Care Spending Account

The Health Care Spending Account is a tax-free way to pay any qualified out-of-pocket expenses associated with medical, dental, and vision care for yourself and any family members who are legal dependents. You may contribute between $180 and $3,050, pre-tax, annually to this account. You can also receive and use a benefit debit card. There are thousands of eligible procedures, items and expenses based on your plan. View the interactive list of eligible expenses.

Dependent Care Spending Account

The Dependent Care Spending Account allows you to pay for child or elder care expenses on a tax-free basis. You may contribute between $300 and $5,000 annually towards this account. Examples of eligible expenses include:

- Care of a child under age 13 or dependents of any age not capable of caring for themselves because of a mental or physical handicap, when the purpose of that care is to allow you and/or your spouse to work. (See your tax advisor for further details).
- Day care centers, preschool and nursery schools
- Before and after school care

Important IRS Rules

Plan carefully. Once you enroll, your FSA contributions must remain in effect for the entire plan year unless you experience a qualified status change. Your contributions can only be used to pay eligible expenses you incur during the plan year. You can roll over up to $500 of unused Healthcare FSA funds to the following calendar year. After March 31st, the deadline for filing all claims for the previous plan year, any additional money left in your account(s) must be forfeited.

Military Reservists Exception: In accordance with the Heroes Earnings Assistance and Relief Tax Act of 2008, qualified military reservists who participate in a flexible spending account program may withdraw FSA funds (and avoid the use-it-or-lose-it rules) when they are called to active duty for 180 days or more or for an indefinite period. The withdrawal must be made during a period beginning on the day the reservist is called to active duty and ending on the last day of the coverage period of the FSA plan that occurs during the period of active duty.

Employee Assistance Program (EAP)

Life is unpredictable and things happen. To help you through the times when personal problems get in the way, the City provides the Concern Employee Assistance Program (EAP). This free and confidential service is offered to employees and their dependents.

Your EAP provides:

- Easy Access to Services – Services are available 24-hours a day, 7-days per week, via a toll-free telephone number of 800-344-4222.
- Face-to-Face Evaluations – Up to 5 visits per person, per issue, per 12-month period.
- Online – Visit www.employees.concernhealth.com for online assistance with your personal, family, and work-related problems. The access code is cityofmissionviejo.
- Confidentiality – All calls and counseling are confidential, except as required by law (e.g. when a person's emotional condition is a threat to themselves or others, or there is suspected abuse of a minor child, and in some states, spousal or elder abuse).
- Use this QR Code to view an employee orientation video. The access code is cityofmisssionviejo:

Life Insurance

Life Insurance offers peace of mind and important financial protection for your family in the event of your death. The City pays 100% of the monthly premiums associated with your Basic Life, and Accidental Death & Dismemberment (AD&D) coverage. Your Basic Life benefit is equal to two times your basic annual earnings (BAE) to a maximum benefit of $300,000. This coverage is offered to you on a guaranteed issue basis, which means you do not need to provide any medical information to be enrolled into the plan. All you have to do is complete the enrollment form.

Your policy also contains an "Accelerated Death Benefit" option. The Accelerated Death Benefit proceeds are paid in one lump sum and are paid only once. This lump sum payout is the only Settlement Option available to you prior to your death. Life insurance amounts decrease starting on and after your 65th birthday. Refer to your Life Insurance Certificate for more detailed information and requirements.

Supplemental Life Insurance

In addition to any basic life insurance City of Mission Viejo provides, eligible employees may elect more coverage by enrolling in a Supplemental Term Life Insurance program. This Supplemental Life insurance is portable. If you change jobs or retire before the age specified in your certificate, you can keep your coverage until age 70. Basic and Supplemental Life Insurance is underwritten by ReliaStar Life Insurance Company.

For more information, such as rates, please review the Supplemental Term Life (STL) and AD&D Coverage and Rate Information sheet.

For Yourself

Within 30 days of hire, you may apply for supplemental term life (STL) coverage from in increments of $10,000, not to exceed five (5) times your BAE or $350,000, whichever is lesser. If you elect coverage that exceeds the guaranteed issue amount of $100,000, you will need to provide evidence of insurability that is satisfactory to Voya Financial before the excess can become effective. After 30 days of your hire date, you are subject to medical underwriting.

For Your Spouse

If you elect the STL plan for yourself, you may elect STL coverage for your spouse. Your election may be made in increments of $5,000 to a maximum of $50,000 but you may not exceed 50% of your approved election. If you elect an amount that exceeds the guaranteed issue amount of $25,000, your spouse will need to provide evidence of insurability that is satisfactory to Voya Financial before the excess can become effective. Spouse STL rates and premiums are based on the employee's age, not the spouse's age. Spouse coverage terminates at age 70. Domestic partners are eligible for this coverage.

For Your Children

If you elect the STL plan for yourself, you may elect Life coverage for your dependent child(ren) between the ages of 6 months and 19 years (23 years if a full-time student) in the amount of $10,000. This benefit is limited to 10% of elected amount for child(ren) age birth to 6 months.

Short- and Long-Term Disability Plans

The City-paid disability benefits connect you to a source of income should you become sick or injured off the job and unable to work. The City pays the full cost of this important coverage through Voya Financial.

Short-Term Disability

You may be eligible for short-term disability (STD) benefits beginning on the fifteenth (15th) day of your sickness or disability. (There is a 14-day waiting period once your disability begins.) STD benefits replace 66 2/3% of your weekly earnings to a maximum benefit of $1,500 per week up to 90 consecutive days. Proof of disability is required. If you continue to be disabled after 90 consecutive days, you may be eligible for long-term disability benefits. Refer to your Short-term Disability Plan Certificate for more detailed information.

Long-Term Disability

Long-term disability (LTD) benefits replace 66 2/3% of your base monthly salary after your short-term disability coverage ends and your disability continues for more than 90 consecutive days. The maximum plan benefit is $8,000 per month up to 48 months or normal retirement age. Proof of disability is required. Refer to your Long-term Disability Plan Certificate for more detailed information.

California Public Employees' Retirement System

The City contracts with the California Public Employees' Retirement System (CalPERS) for retirement plan administration. CalPERS administers defined benefit retirement plans for State employees, classified school employees, and employees of contracting local public agencies. These plans provide service retirement, disability, survivor, and death benefits to eligible employees and their beneficiaries and survivors. Most members become vested in the CalPERS retirement plan after five years of service.

In a defined benefit retirement plan, a retiree will receive a benefit determined by a set formula. The CalPERS defined benefit plans use the member's years of service, age at retirement, and highest three-year compensation while employed. Three sources fund a defined benefit retirement plan. First, employees make contributions based on a percentage of their earnings. The second source of funding is earnings from the investment of CalPERS assets in stocks, bonds, real estate, and other investment vehicles. The balance of the funding is provided by employer contributions.

The service retirement formula for City employees hired before July 9, 2011, is the 2.7% at 55 formula and employees contribute 9.5% towards this benefit. The service retirement formula for City employees hired after July 9, 2011, and a participant in a California public retirement system prior to January 1, 2013, is the 2% at 60 formula and employees contribute 8.5% towards this benefit. Employees who are hired and first enter a public retirement system on or after January 1, 2013, are eligible for the 2% at 62 formula and contribute 9% towards this benefit effective July 1, 2023. Refer to the CalPERS Your Benefits Your Future publication for more detailed information and requirements.

Supplemental Health Account for Retired Employees (SHARE)

The Supplemental Health Account for Retired Employees (SHARE) became effective January 1, 2007. All employees that first became eligible for benefits on or after January 1, 2007, are required to participate in this program. SHARE is a defined contribution program for retiree health benefits that is intended to help retirees offset post-retirement health care costs by allowing them to contribute pre-tax dollars from their current wages with an additional contribution by the City. This program requires the employee to contribute 1.5% of their salary into an individual employee funded account. In addition, the City will contribute $100 per month for a full-time employee (pro-rated based upon the employee's actual full-time equivalency) into a City funded account. An employee must complete one year of service with the City prior to making their pre-tax contributions. This one year of service will be credited toward the 15 years of service requirement, but no employee or City contributions will be made during this first year.

A retiree shall become eligible for benefit disbursement on the first day of the month following retirement from the City, provided the employee is at least 55 years of age and had at least 15 years of service with the City. An employee who separates from City service prior to becoming an eligible retiree is entitled to the benefit disbursement from the employee funded account, but not the City funded account. Effective July 1, 2017, the plan is administered by MissionSquare through their Retiree Health Savings (RHS) Plan.

Deferred Compensation

You may voluntary elect to establish and contribute to a 457(b) deferred compensation account. Voya Financial offers both a 457(b) traditional pre-tax account as well as a 457(b) ROTH account. The 457(b) plan is a retirement plan offered by the City, created to allow public employees like you to put aside money from each paycheck toward retirement. A 457(b) plan can help bridge the gap between what you have in your pension and how much you'll need in retirement.

For the pre-tax 457 account, federal and state income taxes are deferred until your assets are withdrawn, usually during retirement when you may be in a lower tax bracket. When you choose to make Roth 457(b) contributions, you'll pay taxes upfront when your money goes into the plan. Then you'll enjoy tax-free withdrawals — as long as you're at least 59½, and do not take withdrawals from your Roth account for at least five years after your first Roth contribution is made to the plan.

You can choose to allocate part or all of your salary deferral to the Roth or all or part of your salary deferral to your traditional 457(b) pre-tax account.

The City will match your monthly 457(b) contribution up to $150.00 per month regardless of your full-time equivalency (FTE). In order to receive the City's contribution, you must complete a 401(a) enrollment form. The City's matching contributions will go into the 401(a) account and not the 457(b) account.

What are the benefits of participating in a 457 plan?

- You participate in convenient payroll deductions.
- There are two "Catch-Up" provisions that allow you to contribute over-and- above the normal annual contribution amount.
- If you change jobs, you have the flexibility to move your account into your new Employer's retirement plan.
- Supplemental investments are helpful since no contribution is made to Social Security while working for the City of Mission Viejo.

Keep in Mind:

- There are strict Internal Revenue Code limits on the amount you may contribute each year.
- You are required under IRS rules to begin withdrawing from the plan in the year you reach age 70½ or, if still working for the employer, in the year you retire, whichever occurs later.

Qualified retirement plans, deferred compensation plans, and individual retirement accounts are all different, including fees and when you can access funds. Assets rolled over from your account(s) may be subject to surrender charges, other fees and/or a 10% tax penalty if withdrawn before age 59½.

COBRA Coverage

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

The Plan Administrator is City of Mission Viejo, Human Resources Division, 200 Civic Center, Mission Viejo, California 92691, (949) 470-3060. The Plan Administrator is responsible for administering COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health Plan coverage when coverage would otherwise end because of a life event known as 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 or domestic partner 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.

1. If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because of either of the following qualifying events:
    a. Voluntary or involuntary termination of your City of Mission Viejo employment (for any reason other than gross misconduct); or
    b. Reduction in hours of employment (including leave without pay).

2. If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because of any one of the following qualifying events:
    a. Voluntary or involuntary termination of the employee's employment (for any reason other than gross misconduct);
    b. Reduction of hours worked by the employee (including leave without pay);
    c. Divorce, legal separation, annulment, or termination of domestic partnership of the employee; or
    d. Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
    e. Death of the employee.

3. Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because of any one of the following qualifying events:
    a. Voluntary or involuntary termination of the employee's employment (for any reason other than gross misconduct);
    b. Reduction of hours worked by the employee (including leave without pay);
    c. Divorce, legal separation, annulment, or termination of domestic partnership of the employee; or
    d. Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
    e. Death of the employee.
    f. Loss of dependent child status under the City's Group Insurance Regulations

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the City of Mission Viejo, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. For each qualified beneficiary who elects COBRA continuation coverage, COBRA coverage will begin on the date that Plan coverage would otherwise terminate.

Notification Requirements

When the qualifying event is due to a divorce, legal separation, annulment, termination of domestic partnership or loss of dependent status, you (or the qualified beneficiary) must notify the Human Resources Division in writing within 30-calendar days of the qualifying event or the date coverage is lost, whichever is later. The following information must be included: name of the qualified beneficiary, the qualifying event, and the date of the qualifying event. Failure to provide written notice within the time limits can result in COBRA continuation coverage being forfeited. You must provide this notice to: City of Mission Viejo, Human Resources Division, 200 Civic Center, Mission Viejo, California 92691.

If your City employment ends or your work hours are reduced, the Human Resources Division will notify you of your right to elect COBRA continuation coverage. In the event of your death, the Human Resources Division will notify your qualified beneficiaries of their right to elect COBRA continuation coverage.

How is COBRA 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. You, your spouse or domestic partner may elect COBRA continuation coverage on behalf of any other qualified beneficiary. In addition, each qualified

beneficiary will have an independent right to elect COBRA continuation coverage. This means each qualified beneficiary can elect independently to continue City-sponsored health coverage, even if you choose not to continue coverage under COBRA.

Length of COBRA Continuation Coverage

18-Month Period
The maximum COBRA continuation coverage period is 18-months for the following qualifying events:

- Voluntary or involuntary termination of your City of Mission Viejo employment (for any reason other than gross misconduct); or
- Reduction in hours (includes leave without pay)

Note: If the covered employee becomes entitled to Medicare (due to age) within 18-months before a termination of employment or reduction in hours, family members who are qualified beneficiaries may continue COBRA continuation coverage for up to 36-months. This period is counted from the date of the employee's Medicare entitlement.

36-Month Period
The maximum COBRA continuation coverage period is 36-months for the following qualifying events:

- Death of the employee;
- Divorce, legal separation, annulment or termination of domestic partnership; or
- Loss of dependent child status under the City's Group Insurance Regulations

Maximum Coverage Period under USERRA

The maximum COBRA continuation coverage period is 24-months for employees on military leave who are covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Extension of 18-Month COBRA Continuation Coverage

Disability
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11-months of COBRA continuation coverage, for a total maximum of 29-months. You are obligated to inform the Plan Administrator of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice must be sent to : **City of Mission Viejo, Human Resources Division, 200 Civic Center, Mission Viejo, California 92691.**

Second Qualifying Event
If your family experiences another qualifying event while receiving 18-months of COBRA continuation coverage, your spouse or domestic partner and dependent children may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36-months, provided the notice of the second qualifying event is properly given to the Plan. This extension may be available to your spouse or domestic partner and any dependent children receiving continuation coverage if you (the employee or former employee) die, become divorced or legally separated, get an annulment, terminate a domestic partnership, or if your child loses dependent child status – but only if the event would have caused these individuals to lose coverage under the Plan had the first qualifying event not occurred. In all cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. The notice must be sent to : **City of Mission Viejo, Human Resources Division, 200 Civic Center, Mission Viejo, California 92691.**

CalCOBRA (AB 1401)

You and your qualified beneficiaries may be eligible to extend your medical plan coverage under CalCOBRA for up to a maximum of 36-months from the date of the beginning of your COBRA continuation coverage period if you have exhausted the 18-month or 29-month federal COBRA coverage period. This does not apply to City-sponsored dental and vision plans.

In order to exercise the continuation rights afforded under CalCOBRA, an election to purchase the extended coverage must be made in writing to the medical carrier no later than 30 calendar days prior to the end of the federal 18-month COBRA continuation period.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

City of Mission Viejo
Human Resources Division
200 Civic Center
Mission Viejo, CA 92691
(949) 470-3060
(949) 770-9926 FAX
hrnotifications@cityofmissionviejo.org

Notice of Privacy Practices

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

This notice is provided to you in accordance with federal and state privacy laws enacted to protect your medical information. This notice describes the privacy practices of our health care carriers, third party administrators, and our plan as listed below, our legal duties, and your rights concerning your medical information.

Health care carriers, third party administrators, and our plan are required to follow the privacy practices that are described in this notice while it is in effect. However, health care carriers, third party administrators, and our plan reserve the right to change privacy practices and the terms of this notice at any time, provided that applicable law permits such changes.

If health care carriers and/or third-party administrators make any substantive changes to their privacy practices, they will send you a new privacy notice within 60 days of the change in their practices.

If the City of Mission Viejo (City) makes any substantive changes to its privacy practices, the City will modify this notice and send you a new notice within 60 days of the change in the City's practices. You may request a copy of this notice at any time. For more information about the City's privacy practices, or for additional copies of this notice, please contact the City of Mission Viejo Human Resources Division.

This notice applies to the privacy practices of the health care carriers, third party administrators, and our plan as listed below:

HEALTH CARE CARRIERS	TYPE OF COVERAGE
Anthem Blue Cross	Medical
Blue Shield of California	Medical
Delta	Dental
Health Net	Medical
Kaiser	Medical
Optum RX	Pharmacy
Sharp	Medical
United Healthcare	Medical
Vision Service Plan	Vision
THIRD PARTY ADMINISTRATORS	**TYPE OF COVERAGE**
CalPERS	Medical Plan Administration
BCC	Dental Plan Administration
Wex	Flexible Spending Account Administration

Uses and Disclosures of Your Medical Information

Health care carriers, third party administrators, and our plan are permitted to use or disclose your protected health information (PHI) for the following purposes:

Treatment: Health care carriers, third party administrators, and our plan may use and disclose your protected health information in order to assist your health care provider (doctors, hospitals, pharmacies, and others) in your diagnosis and treatment.

Payment: Health care carriers, third party administrators, and our plan use and disclose your protected health information to pay claims from doctors, hospitals and other providers for services delivered to you that are covered by your plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, or to be reimbursed by another entity that may be responsible for payment.

Health Care Operations: Health care carriers, third party administrators, and our plan use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service. In some cases, we may use or disclose your information for underwriting purposes, determining premiums, and the detection and investigation of fraud.

Other Permitted or Required Disclosures

Health care carriers, third party administrators, and our plan may also use or disclose your protected health information in support of:

As Required By Law: Health care carriers, third party administrators, and our plan must disclose protected health information about you when required to do so by law.

Plan Administration: To the plan sponsor, employer or other organization that sponsors your group health plan, to permit the plan sponsor to perform plan administration functions, as described in your plan documents.

Public Health Activities: Health care carriers, third party administrators, and our plan may disclose protected health information to public health agencies for reasons such as prevention or controlling disease, injury or disability.

Business Associates: To persons who provide services to us and assure health care carriers, third party administrators, and our plan that they will comply with privacy regulations and our procedures on the use of protected health information.

Law Enforcement: Health care carriers, third party administrators, and our plan may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Research: Under certain circumstances, health care carriers, third party administrators, and our plan may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

Special Government Functions: Health care carriers, third party administrators and our plan may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

Judicial and Administrative Proceedings: Health care carriers, third party administrators, and our plan may disclose protected health information in response to a court or administrative order. Health care carriers, third party administrators, and our plan may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.

Industry Regulation: Health care carriers, third party administrators, and our plan may disclose you protected health information to state insurance departments, the U.S. Department of Labor and other government agencies, for activities authorized by law.

Workers' Compensation: Health care carriers, third party administrators, and our plan may disclose protected health information to the extent necessary to comply with state laws for workers' compensation programs.

Coroners, Funeral Directors, Organ Donation: Health care carriers, third party administrators, and our plan may disclose the protected health information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Other Uses or Disclosures With An Authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the plan.

Your Rights Regarding Your Protected Health Information

Right To Access Your Protected Health Information: You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. Health care carriers, third party administrators, and/or our plan may charge a fee for the costs of producing, copying and mailing your requested information, but we will inform you of the cost in advance.

Right To Amend Your Protected Health Information: If you feel that protected health information maintained by the health care carriers, third party administrators, and/or our plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. Health care carriers, third party administrators, and our plan may deny your request if, for example, you ask to amend information that was not created by the health care carriers, third party administrators, or our plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

If health care carriers, third party administrators, and/or our plan deny your request to amend, you will be notified in writing. You then have the right to submit to the health care carriers, third party administrators, and/or our plan a written statement of disagreement with our decision and the health care carriers, third party administrators, and/or our plan have the right to rebut that statement.

Right to an Accounting of Disclosures by the Plan: You have the right to request an accounting of disclosures health care carriers, third party administrators, and our plan have made of your protected health information. The list will not include disclosures related to your treatment, or payment, or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). Health care carriers, third party administrators, and our plan, may charge for providing the accounting disclosures, but we will inform you of the cost in advance.

Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information: You have the right to request that health care carriers, third party administrators, and our plan restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

Right To Receive Confidential Communications: You have the right to request that health care carriers, third party administrators, and our plan use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

Contact Information for Exercising Your Rights: You may exercise any of the rights described above by contacting the City of Mission Viejo Human Resources Division.

Health Information Security

Health care carriers, third party administrators, and our plan require our employees and business associates to follow the Company's security policies and procedures that limit access to health information about members to those employees and or entities that need it to perform their job responsibilities. In addition, we maintain physical, administrative and technical security measures to safeguard your protected health information.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the health care carriers, third party administrators, and/or our plan and/or with the Secretary of the Department of Health and Human Services. All complaints to the health care carriers, third party administrators, and our plan, must be made in writing and sent to the address listed below:

CARRIER/TPA/PLAN	REQUEST FOR ACCOUNTING	RECORD OF DISCLOSURES	FILING A COMPLAINT	QUESTIONS
Anthem Blue Cross	**Call** Member Services at the toll-free number on the back of your ID card. **Write** to the Privacy Office at: CO0109-0903, 700 Broadway, Denver, CO 80273. **Email** the Privacy Office at Privacy.Office@anthem.com.			
Blue Shield of California	Call the Blue Shield Privacy Office at (888) 266-8080 (toll free). Write to the Blue Shield Privacy Office at: P.O. Box 272540, Chico, CA 95927-2540. Email the Privacy Office at privacy@blueshieldca.com.			
City of Mission Viejo	Call the Privacy Officer at (949) 470-8416. Write to the Privacy Officer at 200 Civic Center, Mission Viejo, CA 92691.			
Delta Dental	You may contact Delta Dental at 866-530-9675, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice. Delta Dental P.O. Box 997330 Sacramento, CA 95899-7330			

HealthNet	**Health Net Privacy Office** Attn: Privacy Official P.O. Box 9103 Van Nuys, CA 9140 **Telephone: 1-800-522-0088** Fax: 1-818-676-8314 Email: Privacy@healthnet.com
Kaiser	**By phone:** Call member services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays). **By mail:** Call us at **1-800-464-4000** (TTY **711**) and ask to have a form sent to you. **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses) **Online:** Use the online form on our website at **kp.org**
Sharp	Please call or write at: Privacy Officer, Sharp Health Plan, 8520 Tech Way, Ste. 200, San Diego, CA 92123-1450 (1-800-359-2002).
United Healthcare	**Please call the toll-free member phone number on your health plan ID card or you may contact a UnitedHealth Group Customer Call Center Representative at 1-866-633-2446.** **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address: UnitedHealthcare Customer Service -Privacy Unit PO Box 740815 Atlanta, GA 30374-0815
VSP	Submit your requests to: VSP Attn: Regulatory Compliance 3333 Quality Drive MS-163 Rancho Cordova, CA 95670 HIPAA@vsp.com
Wex	Email: privacy@wexinc.com Mail: WEX, Inc. c/o Privacy 97 Darling Avenue South Portland, ME USA 04106

2024 | **Health Benefit Summary**

Helping you make an informed decision about your health plan

CalPERS

About CalPERS

CalPERS is the largest purchaser of public employee health benefits in California, and the second largest public purchaser in the nation after the federal government. Our program provides benefits for 1.5 million public employees, retirees, and their families.

Depending on where you reside or work, CalPERS offers active employees and retirees one or more types of health plans, which may include:

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Exclusive Provider Organization (EPO) (for members in certain California counties)

The CalPERS Board of Administration annually determines health plan availability, covered benefits, health premiums, and copayments.

Whether you are working or retired, your employer or former employer makes monthly contributions toward your health premiums. The amount of this contribution varies. Your cost may depend on your employer or former employer's contribution to your premium, the length of your employment, and the health plan you choose. For monthly contribution amounts, active employees should contact their employer, State retirees should contact CalPERS, and contracting agency retirees should contact their former employer.

About This Publication

The ***2024 Health Benefit Summary*** provides only a general overview of certain benefits. It does not include details of all covered expenses or exclusions and limitations. Please refer to each health plan's *Evidence of Coverage* (EOC) booklet for the exact terms and conditions of coverage. Health plans mail EOCs to new members at the beginning of the year, and to existing members upon request. In case of a conflict between this summary and your health plan's EOC, the EOC establishes the benefits that will be provided.

The ***2024 Health Benefit Summary*** provides valuable information to help you make an informed choice about your health plan and health care providers. This publication compares covered services, copayments, and benefits for each CalPERS health plan. It also provides information about plan availability by county and a chart summarizing important differences among health plan types.

You can use this information to determine which health plan offers the services you need at the cost that works for you. The 2024 health plan premiums are available at the CalPERS website at **www.calpers.ca.gov**. Check with your employer to find out how much they contribute toward your premium.

We recommend that you only use this publication in conjunction with the current year's health premium rate schedule and EOCs. To obtain a copy of the health premium schedule for any health plan, please go to the CalPERS website at **www.calpers.ca.gov** or contact CalPERS at **888 CalPERS** (or **888**-225-7377).

Other Health Publications

This publication is one of many resources CalPERS offers to help you choose and use your health plan. Others include:

- ***Health Program Guide:*** Describes Basic and Medicare health plan eligibility, enrollment, and choices
- ***Medicare Enrollment Guide:*** Provides information about how Medicare works with your CalPERS health benefits

You can obtain the above publications and other information about your CalPERS health benefits through myCalPERS at **my.calpers.ca.gov** or by calling CalPERS at **888 CalPERS** (or **888**-225-7377).

Contents

Considering Your Health Plan Choices

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

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

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

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

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

- Do you prefer to receive your health care from an HMO or PPO? Your preference will impact the plans available to you, your access to health care providers, and how much you pay for certain services. See the chart on the next page for a summary of the differences among plan types.[1]
- What are the costs (premiums, copayments, deductibles, and coinsurance)? Beginning on page 16 of this publication, you will find information about benefits, copayments, and covered services. Visit the CalPERS website at **www.calpers.ca.gov** to find out what the premiums are for the various plans.
- Does the plan provide access to the doctors and hospitals you want? Contact health plans directly for this information. See the "Health Plan Directory" on page 14 of this publication for health plan contact information.

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

Understanding How CalPERS Health Plans Work

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

Features	HMO	PPO	EPO
Accessing health care providers	Contracts with providers (doctors, medical groups, hospitals, labs, pharmacies, etc.) to provide you services at a fixed price	Gives you access to a network of health care providers (doctors, hospitals, labs, pharmacies, etc.) known as preferred providers	Gives you access to the EPO network of health care providers (doctors, hospitals, labs, pharmacies, etc.)
Selecting a primary care physician (PCP)	Most HMOs require you to select a PCP who will work with you to manage your health care needs [1]	All PPO plan members will have an assigned PCP; however you can choose not to go through your PCP[2]	All EPO plan members will have an assigned PCP; however you can choose not to go through your PCP
Seeing a specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Allows you access to many types of services without receiving a referral or advance approval	Allows you access to many types of services without receiving a referral or advance approval
Obtaining care	Generally requires you to obtain care from providers who are a part of the plan network Requires you to pay the total cost of services if you obtain care outside the HMO's provider network without a referral from the health plan (except for emergency and urgent care services)	Encourages you to seek services from preferred providers to ensure your coinsurance and copayments are counted toward your calendar year out-of-pocket maximums [3] Allows you the option of seeing non-preferred providers, but requires you to pay a higher percentage of the bill [4]	Requires you to obtain care from providers who are a part of the plan network Requires you to pay the total cost of services if you obtain care outside the EPO's provider network without a referral from the health plan (except for emergency and urgent care services)
Paying for services	Requires you to make a small copayment for most services	Limits the amount preferred providers can charge you for services Considers the PPO plan payment plus any deductibles and copayments you make as payment in full for services rendered by a preferred provider	Requires you to make a small copayment for most services

[1] Your PCP may be part of a medical group that has contracted with the health plan to perform some functions, including treatment authorization, referrals to specialists, and initial grievance processing.

[2] Members enrolled in the PERS Gold plan may access a lower copayment if they select a personal doctor.

[3] Once you meet your annual deductible and maximum coinsurance, the plan pays 100% of medical services/claims from Preferred Providers for the remainder of the calendar year; however, you will continue to be responsible for copayments for physician office visits, pharmacy, and other services, up to the annual out-of-pocket maximum.

[4] Non-preferred providers have not contracted with the health plan; therefore, you will be responsible for paying any applicable member deductibles or coinsurance, plus any amount in excess of the allowed amount.

CalPERS Health Plan Choices

Depending on where you reside or work, your Basic and Medicare health plan options may include the following:

Basic EPO & HMO Health Plans	Basic PPO Health Plans	Supplement to Medicare PPO & HMO Health Plans	Medicare Managed Care Plans (Medicare Advantage)	Out-of-State Plan Choices
Anthem Blue Cross EPO	California Association of Highway Patrolmen (CAHP) Health Plan[1]	CAHP Health Plan[1]	Anthem Medicare Preferred (PPO)	Blue Shield Medicare (PPO)
Anthem Blue Cross Select HMO	PERS Gold	PERS Gold	Blue Shield Medicare (PPO)	Kaiser Permanente (HMO)[2]
Anthem Blue Cross Traditional HMO	PERS Platinum	PERS Platinum	CCPOA Medical Plan Medicare (PPO)	Kasier Permanente Senior Advantage[2]
Blue Shield Access+ HMO	Peace Officers Research Association of California (PORAC) Police and Fire Health Plan[1]	PORAC Police and Fire Health Plan[1]	Kaiser Permanente Senior Advantage	PERS Platinum (PPO)
Blue Shield Access+ EPO			Kaiser Permanente Senior Advantage Summit	PORAC Police and Fire Health Plan (PPO)[1]
Blue Shield Trio HMO			Sharp Direct Advantage (HMO)	UnitedHealthcare Group Medicare Advantage (PPO)
California Correctional Peace Officers Association (CCPOA) Medical Plan[1]			UnitedHealthcare Group Medicare Advantage (PPO)	UnitedHealthcare Group Medicare Advantage Edge (PPO)
Health Net Salud y Más			UnitedHealthcare Group Medicare Advantage Edge (PPO)	
Kaiser Permanente			Western Health Advantage MyCare Select (HMO)	
Sharp Performance Plus				
UnitedHealthcare SignatureValue Alliance				
UnitedHealthcare SignatureValue Harmony				
Western Health Advantage				

Contacting a Health Plan

If you have a specific question about a plan's coverage, benefits, or participating providers, please contact the plan directly. See the "Health Plan Directory" on page 14 for health plan contact information.

[1] You must belong to the specific employee association and pay applicable dues to enroll in an Association Plan (CCPOA, CAHP or PORAC)

[2] Plan only available in certain states. Benefits out-of-state may differ from those in California.

Choosing Your Doctor and Hospital

Once you choose a health plan, you should select a primary care physician. Except in the case of an emergency, the doctors you can use — and the medical groups and hospitals you will have access to — will depend on your choice of health plan.

Many people find their doctor by asking neighbors or co-workers for a doctor's name. Others receive referrals from doctors they already know. Still others simply select a physician from their health plan who happens to be nearby. You can also use the **Search Health Plans** tool (described on page 11), which is available by logging into your myCalPERS account at **my.calpers.ca.gov**. Before you choose a health plan, you should call the health plan's member services to inquire about physician availability. When choosing an HMO plan, you should confirm that the doctor is taking new patients in the plan you select.

If you need to be hospitalized, your health plan or medical group will have certain hospitals that you are able to use. If you prefer a particular hospital, you should make sure the health plan you select contracts with that hospital. See page 15 for a list of resources that can help you evaluate and select a doctor and hospital.

Enrolling in a Health Plan Using Your Residential or Work ZIP Code

Some of our health plans are available only in certain counties and/or ZIP Codes. As you consider your health plan choices, you should determine which health plans are available in the ZIP Code in which you are enrolling.

In general, if you are an active employee or a working CalPERS retiree, you may enroll in a health plan using either your residential or work ZIP Code.

If you are a retired CalPERS member, you may select any health plan in your residential ZIP Code area. You cannot use the address of the CalPERS-covered employer from which you retired to establish ZIP Code eligibility.

To enroll in a Medicare Advantage plan, you must use your residential address. In addition, Medicare Part D Employer Group Waiver plans require you to provide a physical address.

If you have a combination of Basic and Medicare members on your health plan, you must choose a health plan that has both Basic and Medicare plan options available within your residential ZIP Code area.

If you use your residential ZIP Code, all enrolled dependents must reside in the health plan's service area. When you use your work ZIP Code, all enrolled dependents must receive all covered services (except emergency and urgent care) within the health plan's service area, even if they do not reside in that area.

To determine if the health plan you are considering provides services where you reside or work, see the "Health Plan Availability by County" chart on the following page. You can also use the **Health Plan search by ZIP Code**, which is available on the CalPERS website at **www.calpers.ca.gov**, to find out which plans are available in your area. If you have questions about plan availability or coverage, or wish to obtain a copy of the ***Evidence of Coverage***, contact the health plans using the "Health Plan Directory" on page 14.

Health Plan Availability by County: **Basic Plans**

Some health plans are available only in certain counties and/or ZIP Codes. Use the chart below to determine if the health plan you are considering provides services where you reside or work. Contact the plan before enrolling to make sure they cover your ZIP Code and that their provider network is accepting new patients in your area. You may also use our online service, the **Health Plan Search by ZIP Code**, available at **www.calpers.ca.gov**.

All counties subject to regulatory approval.

- ● Health plan covers all or part of county.
- ▲ Only PERS Platinum is available out-of-state.

County	Anthem Blue Cross EPO	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+ HMO	Blue Shield Access+ EPO	Blue Shield Trio HMO	CAHP	CCPOA Medical Plan	Health Net Salud y Más	Kaiser Permanente	PERS Gold & PERS Platinum	PORAC	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	UnitedHealthcare SignatureValue Harmony	Western Health Advantage HMO
Alameda		●	●	●			●	●		●	●	●		●		
Alpine					●		●				●	●				
Amador							●			●	●	●				
Butte			●	●		●	●	●			●	●				
Calaveras					●		●				●	●				
Colusa					●		●				●	●				●
Contra Costa		●	●	●			●	●		●	●	●		●		
Del Norte	●				●		●				●	●				
El Dorado		●	●	●		●	●	●		●	●	●				●
Fresno		●	●	●			●	●		●	●	●		●		
Glenn				●			●				●	●				
Humboldt			●	●			●				●	●				●
Imperial		●	●	●			●	●			●	●				
Inyo					●		●				●	●				
Kern		●	●	●		●	●	●	●	●	●	●		●		
Kings			●	●		●	●	●		●	●	●		●		
Lake					●		●				●	●				
Lassen					●		●				●	●				
Los Angeles		●	●	●		●	●	●	●	●	●	●		●	●	
Madera			●	●			●	●		●	●	●		●		
Marin			●	●			●	●		●	●	●		●		●
Mariposa				●			●	●		●	●	●				
Mendocino			●		●		●				●	●				
Merced		●	●	●			●	●			●	●		●		
Modoc					●		●				●	●				
Mono					●		●				●	●				
Monterey		●				●[1]	●				●	●				
Napa			●				●			●	●	●				●
Nevada		●	●	●		●	●	●			●	●				
Orange		●	●	●		●	●	●	●	●	●	●		●	●	

County	Anthem Blue Cross EPO	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+ HMO	Blue Shield Access+ EPO	Blue Shield Trio HMO	CAHP	CCPOA Medical Plan	Health Net Salud y Más	Kaiser Permanente	PERS Gold & PERS Platinum	PORAC	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	UnitedHealthcare SignatureValue Harmony	Western Health Advantage HMO
Placer		●	●	●		●	●	●		●	●	●		●		●
Plumas					●		●				●	●				
Riverside		●	●	●		●	●	●	●	●	●	●		●	●	
Sacramento		●	●	●		●	●	●		●	●	●		●		●
San Benito			●		●		●				●	●				
San Bernardino		●	●	●		●	●	●	●	●	●	●		●	●	
San Diego		●		●			●	●	●	●	●	●	●	●	●	
San Francisco		●	●	●			●	●		●	●	●		●		
San Joaquin		●	●	●			●	●		●	●	●		●		
San Luis Obispo			●	●		●	●	●			●	●		●		
San Mateo			●	●			●	●		●	●	●		●		
Santa Barbara			●	●		●	●	●			●	●				
Santa Clara		●	●	●			●	●		●	●	●		●	●	
Santa Cruz		●	●	●		●	●	●		●	●	●		●	●	
Shasta					●		●				●	●				
Sierra					●		●				●	●				
Siskiyou					●		●				●	●				
Solano			●	●			●	●		●	●	●		●		●
Sonoma			●	●			●	●		●	●	●		●		●
Stanislaus		●	●	●		●	●	●		●	●	●		●		
Sutter							●			●	●	●				
Tehama					●		●				●	●				
Trinity					●		●				●	●				
Tulare		●	●	●		●	●	●		●	●	●				
Tuolumne					●		●				●	●				
Ventura		●	●	●		●	●	●		●	●	●		●		
Yolo		●	●	●		●	●	●		●	●	●		●		●
Yuba							●			●	●	●				
Out-of-State										●	▲	●				

Health Plan Availability by County: **Medicare Plans**

Some health plans are available only in certain counties and/or ZIP Codes. Use the chart below to determine if the health plan you are considering provides services where you reside or work. Contact the plan before enrolling to make sure they cover your ZIP Code and that their provider network is accepting new patients in your area. You may also use our online service, the **Health Plan Search by ZIP Code**, available at **www.calpers.ca.gov**. All counties subject to regulatory approval.

● Health plan covers all or part of county.
▲ Only PERS Platinum is available out-of-state.

County	Anthem Medicare Preferred PPO	Blue Shield Medicare PPO	CAHP Medicare Supplement	CCPOA Medical Plan Medicare (PPO)	Kaiser Permanente Senior Advantage	Kaiser Permanente Senior Advantage Summit	PERS Gold Medicare Supplement	PERS Platinum Medicare Supplement	PORAC Medicare Supplement	Sharp Direct Advantage HMO	UnitedHealthcare Group Medicare Advantage PPO	UnitedHealthcare Group Medicare Advantage Edge PPO	Western Health Advantage MyCare Select HMO
Alameda	●	●	●	●	●	●	●	●	●		●	●	
Alpine	●	●	●	●			●	●	●		●	●	
Amador	●	●	●	●	●	●	●	●	●		●	●	
Butte	●	●	●	●			●	●	●		●	●	
Calaveras	●	●	●	●			●	●	●		●	●	
Colusa	●	●	●	●			●	●	●		●	●	●
Contra Costa	●	●	●	●	●	●	●	●	●		●	●	
Del Norte	●	●	●	●			●	●	●		●	●	
El Dorado	●	●	●	●	●	●	●	●	●		●	●	●
Fresno	●	●	●	●	●	●	●	●	●		●	●	
Glenn	●	●	●	●			●	●	●		●	●	
Humboldt	●	●	●	●			●	●	●		●	●	●
Imperial	●	●	●	●			●	●	●		●	●	
Inyo	●	●	●	●			●	●	●		●	●	
Kern	●	●	●	●	●	●	●	●	●		●	●	
Kings	●	●	●	●	●	●	●	●	●		●	●	
Lake	●	●	●	●			●	●	●		●	●	
Lassen	●	●	●	●			●	●	●		●	●	
Los Angeles	●	●	●	●	●	●	●	●	●		●	●	
Madera	●	●	●	●	●	●	●	●	●		●	●	
Marin	●	●	●	●	●	●	●	●	●		●	●	●
Mariposa	●	●	●	●	●	●	●	●	●		●	●	
Mendocino	●	●	●	●			●	●	●		●	●	
Merced	●	●	●	●			●	●	●		●	●	
Modoc	●	●	●	●			●	●	●		●	●	
Mono	●	●	●	●			●	●	●		●	●	
Monterey	●	●	●	●			●	●	●		●	●	
Napa	●	●	●	●	●	●	●	●	●		●	●	●
Nevada	●	●	●	●			●	●	●		●	●	
Orange	●	●	●	●	●	●	●	●	●		●	●	

County	Anthem Medicare Preferred PPO	Blue Shield Medicare PPO	CAHP Medicare Supplement	CCPOA Medical Plan Medicare (PPO)	Kaiser Permanente Senior Advantage	Kaiser Permanente Senior Advantage Summit	PERS Gold Medicare Supplement	PERS Platinum Medicare Supplement	PORAC Medicare Supplement	Sharp Direct Advantage HMO	UnitedHealthcare Group Medicare Advantage PPO	UnitedHealthcare Group Medicare Advantage Edge PPO	Western Health Advantage MyCare Select HMO
Placer	●	●	●	●	●	●	●	●	●		●	●	●
Plumas	●	●	●	●			●	●	●		●	●	
Riverside	●	●	●	●	●	●	●	●	●		●	●	
Sacramento	●	●	●	●	●	●	●	●	●		●	●	●
San Benito	●	●	●	●			●	●	●		●	●	
San Bernardino	●	●	●	●	●	●	●	●	●		●	●	
San Diego	●	●	●	●	●	●	●	●	●	●	●	●	
San Francisco	●	●	●	●	●	●	●	●	●		●	●	
San Joaquin	●	●	●	●	●	●	●	●	●		●	●	
San Luis Obispo	●	●	●	●			●	●	●		●	●	
San Mateo	●	●	●	●	●	●	●	●	●		●	●	
Santa Barbara	●	●	●	●			●	●	●		●	●	
Santa Clara	●	●	●	●	●	●	●	●	●		●	●	
Santa Cruz	●	●	●	●	●	●	●	●	●		●	●	
Shasta	●	●	●	●			●	●	●		●	●	
Sierra	●	●	●	●			●	●	●		●	●	
Siskiyou	●	●	●	●			●	●	●		●	●	
Solano	●	●	●	●	●	●	●	●	●		●	●	●
Sonoma	●	●	●	●	●	●	●	●	●		●	●	●
Stanislaus	●	●	●	●	●	●	●	●	●		●	●	
Sutter	●	●	●	●	●	●	●	●	●		●	●	
Tehama	●	●	●	●			●	●	●		●	●	
Trinity	●	●	●	●			●	●	●		●	●	
Tulare	●	●	●	●	●	●	●	●	●		●	●	
Tuolumne	●	●	●	●			●	●	●		●	●	
Ventura	●	●	●	●	●	●	●	●	●		●	●	
Yolo	●	●	●	●	●	●	●	●	●		●	●	●
Yuba	●	●	●	●	●	●	●	●	●		●	●	
Out-of-State		●	●	●	●	●		●	●		●	●	

Tools to Help You Choose Your Health Plan

This section provides a variety of information that can help you evaluate your health plan choices. Included here are details about using your myCalPERS account, the **Search Health Plans** tool, and the **Health Plan Choice Worksheet**.

Accessing Health Plan Information with myCalPERS

You can use myCalPERS at **my.calpers.ca.gov**, our secure, personalized website, to get one-stop access to all of your current health plan information, including details about which family members are enrolled. You can also use it to shop for other health plans that are available in your area, compare health plans, access CalPERS Health Program forms, and find additional information about CalPERS health plans. If you are a **retiree,** CalPERS is your Health Benefits Officer. Retirees may change their health plan during Open Enrollment by calling CalPERS toll free at **888 CalPERS** (or **888**-225-7377) or by using your myCalPERS account.

myCalPERS Health Plan Comparison Feature

Health Plan Resources

Choosing a health plan that's right for you is unique for every person or family. myCalPERS includes additional resources to help you choose a health plan. These resources provide access to more detailed health benefit information that can help you when selecting what is most important to you in determining the plan that best fits your needs.

Evaluate Plan Features

Available health plans for you will be displayed based on the physical or mailing health eligibility ZIP Code in our system.

Create a customized plan search where you'll be able to review:

- Monthly premiums for each plan available to you
- Side-by-side comparisons of covered benefits, deductibles, and copayments for up to three plans at one time.
- Search for your doctor, specialist, behavioral health providers, medical groups, and Medicare doctors and see which health plans they are available in
- Member satisfaction ratings for each health plan

Your myCalPERS Account

Log in to your myCalPERS account at **my.calpers.ca.gov** and select the **Health** tab and then select **Search Health Plans** to see what's available to you. To speak with someone at CalPERS about your health plan choices, call **888 CalPERS** (or **888**-225-7377).

Comparing Your Options: Search Health Plans

Access your myCalPERS account for a convenient way to evaluate your health plan options and make a decision about which plan is best for you and your family. With this easy-to-use health plan comparison tool, you can weigh plan benefits and costs, and view how the plans compare.

You can access your account 24/7 to help you make health plan decisions at any time. You can use it to:

- Review health plan options during Open Enrollment.
- Evaluate your health plan options and estimate costs.
- Review a health plan option when your employer first begins offering the CalPERS Health Benefits Program.
- Search doctors, specialists, behavioral health providers, medical groups, and Medicare doctors to see which plans they participate in.
- Review health plan options due to changes in your marital status or enrollment area.
- Explore health plan options because you are planning for retirement or have become Medicare eligible.

Be sure to tell us what you think about your myCalPERS plan search experience by completing a survey at the end of your research.

Get customized assistance selecting the health plan that is right for you and your family by logging into your myCalPERS account at **my.calpers.ca.gov**, selecting the **Health** tab and then selecting **Search Health Plans**.

Comparing Your Options: Health Plan Choice Worksheet

An alternative tool we provide to help you choose the best plan for yourself and your family is the *Health Plan Choice Worksheet,* which you can find on page 12 of this publication. This worksheet can be used to compare factors such as cost, availability, benefits, and quality of care measures. Simply follow the steps listed in the left column of the Worksheet. Several questions can be answered with a simple "yes" or "no," while others will require you to insert information or call the health plan. Some of the information can be found on the CalPERS website at **www.calpers.ca.gov**.

Health Plan Choice Worksheet

Plan name and phone numbers:								
Select the type of plan: *(circle choice)*	HMO	PPO	EPO	Assoc. Plan[1]	HMO	PPO	EPO	Assoc. Plan[1]
Step 1 — Cost								
Calculate your monthly cost. Enter the monthly premium (see current year's rate schedule). Premium amounts will vary based on 1-party/2-party/family and Basic/Medicare.								
Enter your employer's contribution. For contribution amounts, active members should contact their employer; retired members should contact CalPERS.								
Calculate your cost. Subtract your employer's contribution from the monthly premium. If the total is $0 or less, your cost is $0.								
Step 2 — Availability								
Search available plans online. Use the Health Plan Search by Zip Code, at **www.calpers.ca.gov** to find out if the plan is available in your residential or work ZIP Code. You may also call the plan's customer service center.								
Call the doctor's office. Confirm that they contract with the plan and are accepting new patients. Ask what specialists are available and the hospitals with which they are affiliated.								
Step 3 — Comparisons								
How does the plan rate in quality of care measures? See page 15 to find out.								
Compare the benefits. See pages 16–31. CalPERS plans offer a standard package of benefits, but there are some differences.								
Step 4 — Other								
Other considerations: Does the plan offer health education? Do you or your family have special medical needs? What services are available when you travel? Are the provider locations convenient?								
What changes are you planning in the upcoming year (e.g., retirement, transfer, move, etc.)?								
Other information								
Compare and select a plan.								

[1] You must belong to the specific employee association and pay applicable dues to enroll in the Association Plans.

CalPERS Health Plan Member Survey Results

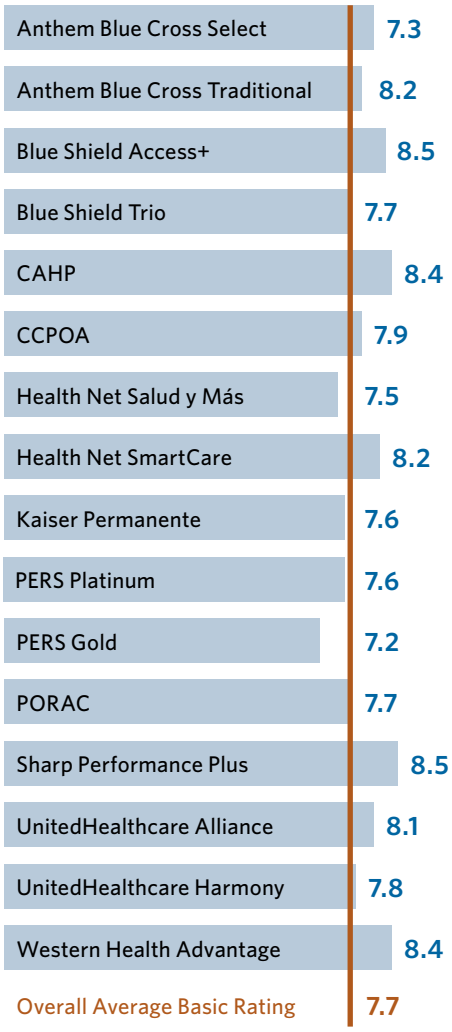
CalPERS conducts an annual Health Plan Member Survey to assess members' satisfaction with their health plans during the previous 12-month period. We use a modified version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, a standard tool for measuring health plans. CalPERS evaluates the survey results to compare satisfaction ratings across health plans and over time. The results below reflect health plan satisfaction during the 2022 plan year.

Member ratings offer another tool to help you choose a plan that is right for you. Please note that your experience may differ. The health plan ratings are based on the experience of the individuals who participated in the survey.

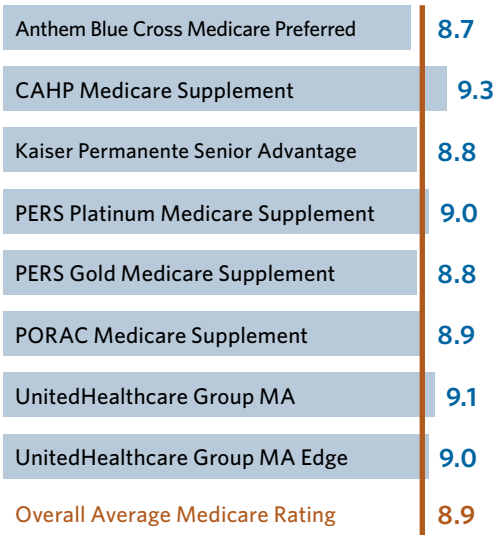
Member Rating of Health Plans

Members were asked to rate their health plan on a 10-point scale with 10 being the best health plan possible. The following charts show the average rating by plan respondents in eligible Basic and Medicare health plans.

Basic Plan Ratings



Medicare Plan Ratings



The CalPERS Health Benefits Program Annual Report displays other valuable information about the Health Program. To view the report, visit CalPERS online at **www.calpers.ca.gov**.

Association Plans (CCPOA, CAHP, and PORAC) are available only to members who belong to the applicable association.
In 2022, PERS Choice and PERSCare transitioned to PERS Platinum and PERS Select transitioned to PERS Gold.

Additional Resources

As a health care consumer, you have access to many resources, services, and tools that can help you find the right health plan, doctor, medical group, and hospital for yourself and your family.

Health Plan Directory

Following is contact information for the health plans. Contact your health plan with questions about: ID cards; verification of provider participation; service area boundaries (covered ZIP Codes); benefits, deductibles, limitations, exclusions; and *Evidence of Coverage* booklets.

Anthem Blue Cross[2] HMO & EPO
(855) 839-4524
www.anthem.com/ca/calpers

Anthem Medicare Preferred[2] PPO
(855) 251-8825
www.anthem.com/ca/calpers

Blue Shield of California
Active Member Services
(800) 334-5847
Medicare Member Services
(888) 802-4599
www.blueshieldca.com/calpers

California Association of Highway Patrolmen (CAHP)
(800) 734-2247
www.thecahp.org

California Correctional Peace Officers Association (CCPOA)
Active Member Services
(800) 257-6213
Medicare Member Services
(800) 776-4466
www.ccpoabtf.org

Health Net of California[1]
(888) 926-4921
www.healthnet.com/calpers

Kaiser Permanente
(800) 464-4000
www.kp.org/calpers

OptumRx
Pharmacy Benefit Manager
Active Member Services
(855) 505-8110
Medicare Member Services
(855) 505-8106
www.optumrx.com/calpers

PERS Gold[2] and PERS Platinum[2]
Administered by Anthem Blue Cross
(877) 737-7776
www.anthem.com/ca/calpers
Supplement to Medicare
(877) 737-7776

Peace Officers Research Association of California (PORAC)
(800) 655-6397
http://ibtofporac.org

Sharp Health Plan[1]
Active Member Services
(855) 955-5004
Retiree Member Services
(833) 346-4322
sharphealthplan.com/CalPERS

UnitedHealthcare
Active Member Services
(877) 359-3714
www.uhc.com/calpers
Retiree Member Services
(888) 867-5581
www.UHCRetiree.com/calpers

Western Health Advantage[2]
Active Member Services
(888) 942-7377
Medicare Member Services
(888) 942-7377
www.westernhealth.com/calpers

[1] Pharmacy benefits administered by OptumRx for the Basic plan only.

[2] Pharmacy benefits administered by OptumRx for both Basic and Medicare plans.

Obtaining Health Care Quality Information

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

Hospitals

Cal Hospital Compare

www.calhospitalcompare.org

Cal Hospital Compare makes it easy to find and compare the quality of hospitals in California.

U.S. Department of Health and Human Services

www.medicare.gov/hospitalcompare

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

The Leapfrog Group

www.leapfroggroup.org

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

Doctors and Medical Groups

Medical Board of California

www.mbc.ca.gov

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

Have you done a checkup on your doctor's license?

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

Office of the Patient Advocate

www.opa.ca.gov

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

Benefit Comparison Charts

The benefit comparison charts on pages 16–31 summarize the benefit information for each health plan. For more details, see each plan's ***Evidence of Coverage*** (EOC) booklet.

CalPERS Health Plan Benefit Comparison—**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	EPO & HMO Basic Plans						
	Anthem Blue Cross EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	UnitedHealthcare SignatureValue 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

Continued on next page

Western Health Advantage HMO	CCPOA *(Association Plan)*	BENEFITS	PPO Basic Plans							
			PERS Gold		PERS Platinum		CAHP *(Association Plan)*		PORAC *(Association Plan)*	
			PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
		Calendar Year Deductible								
N/A	N/A	Individual	$1,000 [1,3]	$2,500 [3]	$500 [3]	$2,000 [3]	N/A		$300	$600
N/A	N/A	Family	$2,000 [1,3]	$5,000 [3]	$1,000 [3]	$4,000 [3]	N/A		$900	$1,800
		Maximum Calendar Year Copay or Coinsurance *(excluding pharmacy)*								
$1,500 (copay)	$1,500 (copay)	Individual	$3,000 (coinsurance)	Unlimited	$2,000 (coinsurance)	Unlimited	$3,000 (coinsurance)	Unlimited	$2,000	$2,000
$3,000 (copay)	$4,500 (copay)	Family	$6,000 (coinsurance)	Unlimited	$4,000 (coinsurance)	Unlimited	$6,000 (coinsurance)	Unlimited	$4,000	$4,000
		Hospital *(including Mental Health and Substance Abuse)*								
N/A	N/A	Deductible (per admission)	N/A		$250		N/A		N/A	
No Charge	$100/ admission	Inpatient	20% [2]	40% [4]	10%	40% [4]	10%	Varies	20%	20% [4]
No Charge	$50	Outpatient Facility/ Surgery Services	20%	40% [4]	10%	40% [4]	10%	40% [4]	20%	20% [4]

[1] Incentives available to reduce individual deductible (max. $500) or family deductible (max. $1,000) include: getting a biometric screening ($100 credit); receiving a flu shot ($100 credit); getting a non-smoking certification ($100 credit); getting a virtual second opinion ($100 credit); and getting a condition care certification ($100 credit).

[2] Coinsurance waived for deliveries if enrolled in Future Moms Program.

[3] Deductible is transferable between PERS Gold and PERS Platinum.

[4] Of the allowable amount as defined in the EOC.

CalPERS Health Plan Benefit Comparison—**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.

	EPO & HMO Basic Plans						
BENEFITS	**Anthem Blue Cross EPO Select HMO Traditional HMO**	**Blue Shield Access+ HMO & Access+ EPO Trio HMO**	**Health Net**	**Kaiser Permanente**	**Sharp Performance Plus**	**UnitedHealthcare SignatureValue Alliance**	**UnitedHealthcare SignatureValue Harmony**
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
Diagnostic X-Ray/Lab							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

Continued on next page

Western Health Advantage HMO	CCPOA *(Association Plan)*	BENEFITS	PPO Basic Plans							
			PERS Gold		PERS Platinum		CAHP *(Association Plan)*		PORAC *(Association Plan)*	
			PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
		Emergency Services								
N/A	N/A	Emergency Room Deductible	$50 (applies to hospital emergency room facility charge only)		$50 (applies to hospital emergency room charges only)		$50 (copay reduced to $25 if admitted on an inpatient basis)		N/A	
$50	$75	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.)		10% (applies to other services such as physician, x-ray, lab, etc.)		20%	
$50	$75	Non-Emergency	20% (payment for physician charges only; emergency room facility charge is not covered)	40%	10% (payment for physician charges only; emergency room facility charge is not covered)	40%	$50+10% (copay reduced to $25 if admitted on an inpatient basis)	$50+40%	50% (for non-emergency services provided by hospital emergency room)	
		Physician Services *(including Mental Health and Substance Abuse)*								
$15	$15	Office Visits (copay for each service provided)	$35 [1]	40% [3]	$20 [2]	40% [3]	$20	40% [3]	$10/$35 [2]	20% [3]
No Charge	No Charge	Inpatient Visits	20%	40% [3]	10%	40% [3]	10%	40% [3]	20%	20% [3]
$15	$15	Outpatient Visits	$35	40% [3]	$20	40% [3]	10%	40% [3]	20%	20% [3]
$15	$15	Urgent Care Visits	$35	40% [3]	$35	40% [3]	$20	40% [3]	$35	20% [3]
No Charge	No Charge	Preventive Services	No Charge	40% [3]	No Charge	40% [3]	No Charge	40% [3]	No Charge	
No Charge	No Charge	Surgery/Anesthesia	20%	40% [3]	10%	40% [3]	10%	40% [3]	20%	20% [3]
		Diagnostic X-Ray/Lab								
No Charge	No Charge		20% [4]	40% [3]	10% [4]	40% [3]	10%	40% [3]	20%	20% [3]

[1] Reduced to $10 when seen by 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.

CalPERS Health Plan Benefit Comparison—**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	EPO & HMO Basic Plans						
	Anthem Blue Cross EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	UnitedHealthcare SignatureValue Harmony
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	Generic/Tier 1[1]: $5 Preferred Brand/ Tier 2[1]: $20 Non-Preferred/ Tier 3[1]: $50 Tier 4[1]: $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 Preferred Pharmacy Maintenance Medications (90-day supply)	N/A	Generic/Tier 1[1]: $10 Preferred Brand/ Tier 2[1]: $40 Non-Preferred/ Tier 3[1]: $100 Tier 4[1]: $60	N/A	N/A	N/A	N/A	N/A
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Tier 1: $10 Tier 2: $40 Tier 3: $100	Generic/Tier 1[1]: $10 Preferred Brand/ Tier 2[1]: $40 Non-Preferred/ Tier 3[1]: $100 Tier 4[1]: $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

[1] Tier Formulary is for BSC Trio HMO only. Tier 1 refers to medications classified as 'Generic'; Tier 2 refers to medications classified as "Preferred Brand"; and Tier 3 refers to medications classified as "Non-Preferred Brand".

Continued on next page

Western Health Advantage HMO	CCPOA *(Association Plan)*	BENEFITS	PPO Basic Plans							
			PERS Gold		PERS Platinum		CAHP *(Association Plan)*		PORAC *(Association Plan)*	
			PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
		Prescription Drugs								
N/A	Tier 2, 3, and 4: $50 (not to exceed $150/family)	Deductible	N/A		N/A		N/A		N/A	
Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $10 Tier 2: $25 Tier 3 and 4: $50	Retail Pharmacy (30-day supply)	Tier 1: $5 Tier 2: $20 Tier 3: $50		Tier 1: $5 Tier 2: $20 Tier 3: $50		Generic: $5 Formulary: $20 Non-Formulary: $50		Generic: $10 Brand Formulary: $25 Non-Formulary: $45 Compound: $45	
N/A	Tier 1: $30 Tier 2: $75 Tier 3 and 4: $150	Retail Preferred Pharmacy Maintenance Medications (90-day supply)	N/A		N/A		Generic: $10 Formulary: $40 Non-Formulary: $100		N/A	
Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $20 Tier 2: $50 Tier 3 and 4: $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		Generic: $10 Formulary: $40 Non-Formulary: $100		Generic: $20 Brand Formulary: $40 Non-Formulary: $75	N/A
$1,000	N/A	Mail order maximum copayment per person per calendar year	$1,000		$1,000		N/A		N/A	
		Durable Medical Equipment								
No Charge	No Charge		20% (pre-certification required for specific equipment)	40%[1] (pre-certification required for specific equipment)	10% (pre-certification required for the purchase of equipment priced at $1,000 or more)	40%[1] (pre-certification required for the purchase of equipment priced at $1,000 or more)	10%	40%[1]	20%	20%[1]
		Infertility Testing/Treatment								
50% of Covered Charges	50% of Allowed Charges		50%		50%		Not Covered		50%	50%[2]

[1] Of the allowable amount as defined in the EOC

CalPERS Health Plan Benefit Comparison—**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	EPO & HMO Basic Plans						
	Anthem Blue Cross EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	UnitedHealthcare SignatureValue Harmony
Occupational / Physical / Speech Therapy							
Inpatient (hospital or skilled nursing facility)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient (office and home visits)	**$15**	$15	$15	$15	$15	$15	$15
Diabetes Services							
Glucose monitors	Coverage varies	No Charge	Coverage varies	No Charge	Coverage varies	Coverage varies	Coverage varies
Self-management training	$15	$15	$15	$15	$15	$15	$15
Acupuncture	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
Chiropractic	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)

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Western Health Advantage HMO	CCPOA *(Association Plan)*	BENEFITS	PPO Basic Plans							
			PERS Gold		PERS Platinum		CAHP *(Association Plan)*		PORAC *(Association Plan)*	
			PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Occupational / Physical / Speech Therapy										
No Charge	No Charge	Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		10%	40%	20% (no copy for in-patient PT/OT by a PAR provider)	20% [2]
$15	No Charge	Outpatient (office and home visits)	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20%	10% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 10%	10% (pre-certification required for more than 24 visits)	40%	$15 / Office Visit (all other services 20%) [3]	20% [2]
Diabetes Services										
Coverage varies	No Charge	Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
$15	$15	Self-management training	$20 [1]	40% [2]	$20 [1]	40% [2]	$20	60% [2]	$20	60% [2]
Acupuncture										
$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	N/A		$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% [2]	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% [2]	10% (acupuncture/chiropractic; combined 20 visits per calendar year)	40% [2]	$15 / Office Visit (all other services 20%) [3]	20% [2]
Chiropractic										
$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15 exam (up to 20 visits per calendar year) chiropractic appliances benefit: $50		$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% [2]	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% [2]	10% (acupuncture/chiropractic; combined 20 visits per calendar year)	40% [2]	$15 / Office Visit (all other services 20%) [3]	20% [2]

[1] $35 for specialist visit
[2] Of the allowable amount as defined in the EOC
[3] Combined 20 visits per calendar year. (Occupational/Physical/Chiropractor) Combined 20 visits per calendar year

CalPERS Health Plan Benefit Comparison—**Medicare 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	Medicare Plans						
	Kaiser Permanente Senior Advantage (HMO)	**Kaiser Permanente Senior Advantage Summit (HMO)**	**Anthem Medicare Preferred (PPO)**	**Blue Shield Medicare (PPO)**	**Sharp Direct Advantage (HMO)**	**UnitedHealthcare Group Medicare Advantage (PPO)**	**UnitedHealthcare Group Medicare Advantage Edge (PPO)**
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/coinsurance)	$1,500 (copay)	$1,500 (copay/coinsurance)	$1,500 (copay)	$0 (copay)
Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hospital *(including Mental Health and Substance Abuse)*							
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Facility/ Surgery Services	$10	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Skilled Nursing Facility *(up to 100 days/benefit period)*							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Home Health Services							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Hospice							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Emergency Services *(waived if admitted or hospitalized as an outpatient)*							
	$50	$50	$50	$50	$50	$50	$50
Ambulance Services							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

Continued on next page

Western Health Advantage MyCare Select (HMO)	CCPOA Medical Plan Medicare (PPO)	BENEFITS	Medicare Plans					
			PERS Gold		PERS Platinum		CAHP Medicare Supplement *(Association Plan)*	PORAC *(Association Plan)*
			PPO	Non-PPO	PPO	Non-PPO		
		Calendar Year Deductible						
N/A	N/A	Individual	N/A		N/A		N/A	N/A
N/A	N/A	Family	N/A		N/A		N/A	N/A
		Maximum Calendar Year Copay or Coinsurance *(excluding pharmacy)*						
$1,500 (copay/coinsurance)	$1,500 (copay)	Individual	N/A		$3,000[1,2] (co-insurance)	N/A	N/A	N/A
N/A	N/A	Family	N/A		N/A		N/A	N/A
		Hospital *(including Mental Health and Substance Abuse)*						
No Charge	$100/ admission	Inpatient	No Charge		No Charge		No Charge	No Charge
No Charge	No Charge	Outpatient Facility/ Surgery Services	No Charge		No Charge		No Charge	No Charge
		Skilled Nursing Facility *(up to 100 days/benefit period)*						
No Charge	No Charge		No Charge		No Charge		No Charge	No Charge
		Home Health Services						
No Charge	$15/visit		No Charge		No Charge		No Charge	No Charge
		Hospice						
No Charge	No Charge		No Charge		No Charge		No Charge	No Charge
		Emergency Services *(waived if admitted or hospitalized as an outpatient)*						
$50	No Charge		No Charge		No Charge		No Charge	No Charge
		Ambulance Services						
No Charge	No Charge		No Charge		No Charge		No Charge	No Charge

[1] See EOC for additional details
[2] For Benefits Beyond Medicare
[3] Of the allowed amount

CalPERS Health Plan Benefit Comparison—**Medicare 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	Medicare Plans						
	Kaiser Permanente Senior Advantage (HMO)	**Kaiser Permanente Senior Advantage Summit (HMO)**	**Anthem Medicare Preferred (PPO)**	**Blue Shield Medicare (PPO)**	**Sharp Direct Advantage (HMO)**	**UnitedHealthcare Group Medicare Advantage (PPO)**	**UnitedHealthcare Group Medicare Advantage Edge (PPO)**
Surgery/Anesthesia							
	No Charge inpatient; $10 outpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Physician Services *(including Mental Health and Substance Abuse)*							
Office Visits	$10	No Charge	$10	No Charge	No Charge	$10	No Charge
Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Visits	$10	No Charge	$10	No Charge	No Charge	$10	No Charge
Urgent Care Visits	$10	No Charge	$25	No Charge	No Charge	$25	No Charge
Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Durable Medical Equipment							
	No Charge	No Charge	10% (coinsurance)	No Charge	No Charge	No Charge	No Charge

Continued on next page

Western Health Advantage MyCare Select (HMO)	CCPOA Medical Plan Medicare (PPO)	BENEFITS	Medicare Plans					
			PERS Gold		PERS Platinum		CAHP Medicare Supplement *(Association Plan)*	PORAC *(Association Plan)*
			PPO	Non-PPO	PPO	Non-PPO		
		Surgery/Anesthesia						
No Charge	No Charge		No Charge		No Charge		No Charge	No Charge
		Physician Services *(including Mental Health and Substance Abuse)*						
No Charge	$10	Office Visits	No Charge		No Charge		$10	No Charge
No Charge	No Charge	Inpatient Visits	No Charge		No Charge		No Charge	No Charge
No Charge	$10	Outpatient Visits	No Charge		No Charge		No Charge	No Charge
No Charge	No Charge	Urgent Care Visits	No Charge		No Charge		No Charge	No Charge
No Charge	No Charge	Preventive Services	No Charge		No Charge		No Charge	No Charge
		Diagnostic X-Ray/Lab						
No Charge	No Charge		No Charge		No Charge		No Charge	No Charge
		Durable Medical Equipment						
No Charge	No Charge		No Charge		No Charge		No Charge	No Charge

CalPERS Health Plan Benefit Comparison—**Medicare 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	Medicare Plans						
	Kaiser Permanente Senior Advantage (HMO)	**Kaiser Permanente Senior Advantage Summit (HMO)**	**Anthem Medicare Preferred (PPO)**	**Blue Shield Medicare (PPO)**	**Sharp Direct Advantage (HMO)**	**UnitedHealthcare Group Medicare Advantage (PPO)**	**UnitedHealthcare Group Medicare Advantage Edge (PPO)**
Prescription Drugs							
Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Retail Pharmacy (30-day supply)	Generic: $5 Preferred: $20	Generic: $5 Preferred: $20	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50 Tier 4: $20	Preferred Generic: $5 Generic: $5 Preferred Brand: $20 Non-Preferred: $50 Specialty: $20 Select Care: $0	Generic: $5 Preferred: $20 Specialty: $20 Non-Preferred: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50
Retail Preferred Pharmacy Long-Term Prescription Medications	N/A	N/A	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100 Tier 4: N/A	Preferred Generic: $15 Generic: $15 Preferred Brand: $60 Non-Preferred: $150 Specialty: N/A Select Care: $0	Generic: $10 Preferred: $40 Specialty: $40 Non-Preferred: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100
Mail Order Pharmacy Program (not to exceed 90-day supply)	Generic: $10 Preferred: $40 (31-100 day supply)	Generic: $10 Preferred: $40 (31-100 day supply)	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100 Tier 4: N/A	Preferred Generic: $10 Generic: $10 Preferred Brand: $40 Non-Preferred: $100 Specialty: N/A Select Care: $0	Generic: $10 Preferred: $40 Specialty: $40 Non-Preferred: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100
Mail order maximum copayment per person per calendar year	N/A	N/A	$1,000	$1,000	N/A	$1,000	$1,000
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)	$10	No Charge	$10	No Charge	No Charge	$10	No Charge

Continued on next page

Western Health Advantage MyCare Select (HMO)	CCPOA Medical Plan Medicare (PPO)	BENEFITS	Medicare Plans					
			PERS Gold		PERS Platinum		CAHP Medicare Supplement *(Association Plan)*	PORAC *(Association Plan)*
			PPO	Non-PPO	PPO	Non-PPO		
		Prescription Drugs						
N/A	N/A	Deductible	N/A		N/A		N/A	$100
Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $35 Tier 4: $50	Retail Pharmacy (30-day supply)	Tier 1: $5 Tier 2: $20 Tier 3: $50		Tier 1: $5 Tier 2: $20 Tier 3: $50		Generic: $5 Formulary: $20 Non-Formulary: $50	Generic: $10 Preferred: $25 Non-Preferred: $45
Generic: $10 Preferred: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $70 Tier 4: N/A	Retail Preferred Pharmacy Long-Term Prescription Medications	Tier 1: $10 Tier 2: $40 Tier 3: $100		Tier 1: $10 Tier 2: $40 Tier 3: $100		Generic: $5 Formulary: $20 Non-Formulary: $50	N/A
Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $70 Tier 4: N/A	Mail Order Pharmacy Program (not to exceed 90-day supply)	Tier 1: $10 Tier 2: $40 Tier 3: $100		Tier 1: $10 Tier 2: $40 Tier 3: $100		Generic: $10 Formulary: $40 Non-Formulary: $100	Generic: $20 Preferred: $40 Non-Preferred: $75
$1,000	N/A	Mail order maximum copayment per person per calendar year	$1,000		$1,000		N/A	N/A
		Occupational / Physical / Speech Therapy						
No Charge	No Charge	Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		No Charge	No Charge
No Charge	No Charge	Outpatient (office and home visits)	No Charge		No Charge		No Charge	No Charge

[1] Of the allowed amount
[2] See EOC for additional details

CalPERS Health Plan Benefit Comparison—**Medicare 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	Medicare Plans						
	Kaiser Permanente Senior Advantage (HMO)	Kaiser Permanente Senior Advantage Summit (HMO)	Anthem Medicare Preferred (PPO)	Blue Shield Medicare (PPO)	Sharp Direct Advantage (HMO)	UnitedHealthcare Group Medicare Advantage (PPO)	UnitedHealthcare Group Medicare Advantage Edge (PPO)
Diabetes Services							
Glucose monitors	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Hearing Services							
Routine Hearing Exam	$10	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Physician Services	$10	No Charge	$10	$10	$10	$10	No Charge
Hearing Aids	$1,000 max/ 36 months	$1,000 max/ 36 months	$1,000 max/ 36 months	$1,000 max/ 36 months	$1,000 max/ 36 months	$1,000 max/ 36 months	$2,000 allowance every 24 months
Vision Care							
Vision Exam	$10	No Charge	$10	$10	$10	$10	No Charge
Eyeglasses (following cataract surgery)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Contact Lenses (following cataract surgery)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Benefits Beyond Medicare *(Services covered beyond Medicare coverage)*							
Acupuncture	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$10/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)	$10/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)

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Western Health Advantage MyCare Select (HMO)	CCPOA Medical Plan Medicare (PPO)	BENEFITS	Medicare Plans					
			PERS Gold		PERS Platinum		CAHP Medicare Supplement *(Association Plan)*	PORAC *(Association Plan)*
			PPO	Non-PPO	PPO	Non-PPO		
		Diabetes Services						
No Charge	No Charge	Glucose monitors	No Charge		No Charge		No Charge	$25
		Hearing Services						
No Charge	No Charge	Routine Hearing Exam	No Charge		No Charge		No Charge	20%
No Charge	$10	Physician Services	No Charge		No Charge		No Charge	20%
$1,000 max/ 36 months	$500 max/ 12 months	Hearing Aids	20% ($1,000 max/36 months)		20% ($2,000 max/24 months)		10% ($1,000 max/36 months)	20% ($900 max/36 months)
		Vision Care						
No Charge	$10	Vision Exam	One exam per calendar year		One exam per calendar year		N/A	20%
No Charge	No Charge	Eyeglasses	One set of frames during a 24-month period; $30 maximum allowance		One set of frames during a 24-month period; $30 maximum allowance		N/A	20% ($40 maximum allowance)
No Charge	No Charge	Contact Lenses	$100 maximum allowance		$100 maximum allowance		No Charge	20% ($40 maximum allowance)
		Benefits Beyond Medicare *(Services covered beyond Medicare coverage)*						
$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	Acupuncture	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)		$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)		20%	20%
$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)		20%	20%

CalPERS Health Benefits Program
P.O. Box 942715
Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377)
www.calpers.ca.gov

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DELTA DENTAL

Keep Smiling

Delta Dental PPO™

Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **deltadentalins.com**.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.[4] Log in to our online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist

PPO

NON-PPO

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

[5] Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

West Virginia: Learn about our commitment to providing access to a quality dentist network at **deltadentalins.com/about/legal/index-enrollee.html**.

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HL_PPO #133904.21 (rev. 3/22)

Plan Benefit Highlights for: City of Mission Viejo
Group No: 10535

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	$50 per person / $150 per family each calendar year Yes			
Maximums	$1,500 per person each calendar year			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists** In-PPO Network	Non-PPO dentists** Out-of-PPO Network
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	100 %
Basic Services Fillings, simple tooth extractions and sealants	90%	80 %
Endodontics (root canals)	90 %	80 %
Periodontics (gum treatment)	90 %	80 %
Oral Surgery	90 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	60 %	50 %
Prosthodontics Bridges, dentures and implants	60 %	50 %
Orthodontic Benefits Adults and dependent children	50 %	50 %
Orthodontic Maximums	$1,000 Lifetime	$1,000 Lifetime
Cosmetic Benefits	50 %	50 %
Cosmetic Maximums	$500 Lifetime	$500 Lifetime

* 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.

Delta Dental of California
560 Mission St., Suite 1300
San Francisco, CA 94105

Customer Service
888-335-8227

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Dental Benefits	ADA code	Delta Dental DHMO (PRISM) 10A Current
DIAGNOSTIC & PREVENTIVE		
Office Visit	999	$0
Prophylaxis Cleaning	1110	$0
X-Rays	210	$0
Sealants - per tooth	1351	$5
RESTORATIVE		
Amalgam Filling 1-4 Surfaces	2140-61	$0
PERIODONTICS		
Gingivectomy (Per Quadrant)	4210	$80
Osseus Surgery	4260	$175
Scaling and Root Planning - per quad	4341	$0
ENDODONTICS		
Pulp Cap	3110	$0
Therapeutic Pulpotomy	3220	$0
Root Canal Therapy - anterior	3310	$45
Root Canal Therapy - bicuspid	3320	$90
Root Canal Therapy - molar	3330	$205
PROSTHODONDICS		
Complete - Upper or Lower	5110-20	$100
Immediate - Upper or Lower	5130-40	$120
Partial Denture - Upper or Lower	5213 - 14	$120
CROWNS & BRIDGES		
Inlay / Onlay 1-3 Surfaces	2510-2530	$0
Crown - Porcelain/Ceramic Substrate	2740	$190
Crown - Porcelain Fused to Metals	2750-52	$95 - $195
Crown - Full Cast High Metals	2790-92	$70- $170
ORAL SURGERY		
Extractions - Impacted tooth: soft tissue	7220	$25
Extractions - Impacted tooth: partial bony	7230	$50
Extractions - Impacted tooth: full bony	7240	$70
ORTHODONTICS		
Child to age 19	8070 - 80	$1,700
Member over age 19	8090	$1,900

Note: This summary is for informational purpose only. It does not amend, extend, or alter the current policy in any way. In the event information in this summary differs from the Plan Document, the Plan Document will prevail.

DELTA DENTAL

Keep smiling

DeltaCare® USA

Dental benefits made easy!

When you enroll in a DeltaCare USA[1] plan, you'll choose a primary care dentist from our network of carefully screened, private-practice dentists. You must visit your primary care dentist to receive benefits.[2]

- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency care

A partner in oral health

Your DeltaCare USA plan encourages regular dental care with an extensive list of covered services to help you stay healthy.

- Low or no copayments for services like cleanings and exams

Budget-friendly costs

With your DeltaCare USA plan, there are no surprises. You'll know your copayments, and your out-of-pocket costs are clearly defined before treatment begins.

- No deductibles or maximums[3] for covered services
- Pay only your copayment (if any) at the time of treatment

Convenient services

We make it easy for you — there are no claim forms to complete, and no plan ID card is required to receive treatment.

- Access plan information online
- Change your primary care dentist by phone or online

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

[1] DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. Delta Dental is a registered trademark of Delta Dental Plans Association.

[2] Verify your selected DeltaCare USA primary care dentist before each appointment.

[3] Plans with an Accidental Injury Rider have a $1,600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.

deltadentalins.com/enrollees

Frequently asked questions

What you need to know about your DeltaCare® USA plan

Getting started

1. **How do I enroll in a DeltaCare USA plan?**
   Simply complete the enrollment process as directed by your benefits administrator. Be sure to select a primary care network dentist for yourself or your dependents, and indicate this dentist and the name of your group when you enroll.

2. **How do I get started using my DeltaCare USA plan?**
   Once we process your enrollment, we'll mail you welcome materials that will include:

   - **The name, address and phone number of your selected primary care dentist.** Simply call the dental facility to make an appointment. **Important note:** In order to receive benefits under your plan, you must visit your primary care network dentist for all services. If you require treatment from a specialist, your primary care dentist will coordinate a referral for you. You can change your primary care dentist by contacting us.
   - **Your Evidence/Certificate of Coverage (plan booklet).** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
   - **An ID card.** This card is for your records only — you do not need to present it in order to receive treatment.

3. **How long will it take to get an appointment with my primary care dentist?**
   Two to four weeks[1] is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time slot, you may need to wait longer. Most DeltaCare USA dentists are in private group practices, which generally offer greater appointment availability and extended office hours.

4. **How much will my dental treatments cost? How do I pay?**
   With your DeltaCare USA plan, some services are covered at no cost, while others have a copayment (amount you pay) for certain services. To find out how much a treatment will cost, refer to the "Description of Benefits and Copayments" in this brochure for a list of covered services and copayments. It's a good idea to bring your Evidence/Certificate of Coverage to your appointment in case you need to discuss your copayment for a service with your dentist. If you have any questions about the charges for a service, please contact Customer Service. If you receive treatment that requires a copayment, simply pay the dental facility at the time of service.

Choosing a dentist

5. **How do I select my primary care dentist?**
   When you enroll, you must select a primary care dentist from the DeltaCare USA network[2]. To search for a dentist, use the **Find a dentist** tool at **deltadentalins.com** and select the DeltaCare USA network. You must visit your selected primary care dentist to use plan benefits. Important: Dental services provided by a dentist other than your selected primary care dentist will be denied. Your primary care dentist will refer you to a specialist if any specialty care is required.

6. **Does everyone in my family have to choose the same primary care dentist?**
   No. Each family member can select his or her own primary care network dentist.[3]

7. **Can I change my primary care dentist?**
   Yes. You can request to change your primary care dentist at any time. Simply visit our website and log on to your online account or contact Customer Service. Selections made by the 15th of the month are effective immediately. Selections made on or after the 16th of the month will be effective on the first day of the following month.

[1] In TX, three weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. In TX, there is no limit on the number of miles or on the dollar amount per emergency.
[2] In AZ, MD, and TX, if you do not select a dentist when you enroll, we will choose one for you.
[3] In MA, you cannot select more than three primary care dentist facilities per family.

8. **My dentist says she is a Delta Dental dentist, but she isn't listed in the DeltaCare USA directory. Can I still visit her for services?**
No. Delta Dental has many networks, and participation may vary — not all Delta Dental dentists are DeltaCare USA dentists. You must visit your selected primary care network dentist to receive benefits under this plan.

9. **What should I do if I need to see a specialist?**
If you require specialty dental care — such as oral surgery, endodontics, periodontics or pediatric dentistry — contact your primary care dentist to request a referral. Specialty dental services not performed by your selected primary care dentist must be authorized by us. You are responsible for any applicable copayments.

General plan information

10. **If I'm traveling, is emergency treatment covered under my plan?**
You and your eligible dependents have out-of-area coverage for dental emergencies.[3] Your out-of-area emergency benefit (typically limited to $100 per person) is for services to relieve pain until you can return to your primary care network dentist.[4] Standard plan limitations, exclusions and copayments may apply.

11. **Can I access my plan online?**
Yes. Visit **deltadentalins.com** to create a free, secure online account. You can access your plan benefits and ID card, select (or change) your primary care dentist and more.

12. **Does my plan cover pre-existing conditions? What about treatments that are in progress?**
Treatment for pre-existing conditions (except work in progress[5]), including missing or extracted teeth, is covered under your plan. Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.

13. **Does my plan cover teeth whitening?**
Yes. External bleaching is a benefit under your DeltaCare USA plan. Review your plan booklet for more information and talk to your dentist about your options.

14. **Does my plan cover tooth-colored fillings and crowns?**
Yes. Porcelain and other tooth-colored materials are included in this plan.

15. **What if I have additional questions about my plan?**
Please contact us for additional support. Our Customer Service representatives can answer benefits questions as well as help you change your primary care dentist or arrange for urgent care referrals. See the back page of this brochure for our contact information.

[3] State-specific minimum distance requirements may apply.
[4] In TX, there is no limit on the number of miles or on the dollar amount per emergency.
[5] In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

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SCHEDULE A

The Benefits shown below are performed as needed and deemed necessary by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2023 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - *1 every 12 months*	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *1 every 12 months*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *1 every 12 months*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *1 every 12 months*	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost
D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost

D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis *cleaning* - adult - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$5.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$5.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$5.00
D1354	Application of caries arresting medicament - per tooth - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	$10.00
D1516	Space maintainer - fixed - bilateral, maxillary	$10.00
D1517	Space maintainer - fixed - bilateral, mandibular	$10.00
D1520	Space maintainer - removable - unilateral - per quadrant	$10.00
D1526	Space maintainer - removable - bilateral, maxillary	$10.00
D1527	Space maintainer - removable - bilateral, mandibular	$10.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Cost
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Cost
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - *child to age 9*	$10.00

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

- When there are more than six crowns in the same treatment plan, You may be charged an additional $100.00 per crown, beyond the 6th unit.

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior	$45.00
D2392	Resin-based composite - two surfaces, posterior	$55.00
D2393	Resin-based composite - three surfaces, posterior	$65.00
D2394	Resin-based composite - four or more surfaces, posterior	$75.00
D2510	Inlay - metallic - one surface	No Cost
D2520	Inlay - metallic - two surfaces	No Cost
D2530	Inlay - metallic - three or more surfaces	No Cost
D2542	Onlay - metallic - two surfaces	No Cost
D2543	Onlay - metallic - three surfaces	No Cost
D2544	Onlay - metallic - four or more surfaces	No Cost
D2610	Inlay - porcelain/ceramic - one surface	$135.00

D2620	Inlay - porcelain/ceramic - two surfaces	$150.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$160.00
D2642	Onlay - porcelain/ceramic - two surfaces	$150.00
D2643	Onlay - porcelain/ceramic - three surfaces	$165.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$175.00
D2650	Inlay - resin-based composite - one surface	$85.00
D2651	Inlay - resin-based composite - two surfaces	$95.00
D2652	Inlay - resin-based composite - three or more surfaces	$115.00
D2662	Onlay - resin-based composite - two surfaces	$110.00
D2663	Onlay - resin-based composite - three surfaces	$120.00
D2664	Onlay - resin-based composite - four or more surfaces	$145.00
D2710	Crown - resin-based composite (indirect)	$35.00
D2712	Crown - 3/4 resin-based composite (indirect)	$35.00
D2720	Crown - resin with high noble metal	$155.00
D2721	Crown - resin with predominantly base metal	$55.00
D2722	Crown - resin with noble metal	$95.00
D2740	Crown - porcelain/ceramic	$195.00
D2750	Crown - porcelain fused to high noble metal	$195.00
D2751	Crown - porcelain fused to predominantly base metal	$95.00
D2752	Crown - porcelain fused to noble metal	$135.00
D2753	Crown - porcelain fused to titanium and titanium alloys	$195.00
D2780	Crown - 3/4 cast high noble metal	$170.00
D2781	Crown - 3/4 cast predominantly base metal	$70.00
D2782	Crown - 3/4 cast noble metal	$110.00
D2783	Crown - 3/4 porcelain/ceramic	$195.00
D2790	Crown - full cast high noble metal	$170.00
D2791	Crown - full cast predominantly base metal	$70.00
D2792	Crown - full cast noble metal	$110.00
D2794	Crown - titanium and titanium alloys	$195.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$10.00
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - *anterior primary tooth*	$15.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$10.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	No Cost
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	No Cost
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	No Cost
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	No Cost
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	$19.00
D2980	Crown repair necessitated by restorative material failure	$10.00
D2981	Inlay repair necessitated by restorative material failure	$10.00
D2982	Onlay repair necessitated by restorative material failure	$10.00
D2983	Veneer repair necessitated by restorative material failure	$10.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15* .	$5.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	$5.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$5.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$5.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$45.00
D3320	*Root canal* - endodontic therapy, premolar tooth (excluding final restoration)	$90.00
D3330	*Root canal* - endodontic therapy, molar tooth (excluding final restoration)	$205.00
D3331	Treatment of root canal obstruction; non-surgical access	$45.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$45.00
D3333	Internal root repair of perforation defects	$45.00
D3346	Retreatment of previous root canal therapy - anterior	$60.00
D3347	Retreatment of previous root canal therapy - premolar	$105.00
D3348	Retreatment of previous root canal therapy - molar	$220.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	No Cost
D3421	Apicoectomy - premolar (first root)	No Cost
D3425	Apicoectomy - molar (first root)	No Cost
D3426	Apicoectomy (each additional root)	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation - per root	No Cost
D3471	Surgical repair of root resorption - anterior	No Cost
D3472	Surgical repair of root resorption - premolar	No Cost
D3473	Surgical repair of root resorption - molar	No Cost
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	No Cost
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	No Cost
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	No Cost
D3921	Decoronation or submergence of an erupted tooth	No Cost

D4000-D4999 V. PERIODONTICS

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$50.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$80.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$50.00
D4245	Apically positioned flap	$75.00
D4249	Clinical crown lengthening - hard tissue	$75.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$175.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$140.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$195.00

D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$60.00
D4270	Pedicle soft tissue graft procedure	$195.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$45.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$195.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$195.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - *1 D1110, D1120 or D4346 per 6 month period*	No Cost
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - *limited to 1 treatment in any 12 consecutive months*	No Cost
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	No Cost
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first 6 months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$100.00
D5120	Complete denture - mandibular	$100.00
D5130	Immediate denture - maxillary	$120.00
D5140	Immediate denture - mandibular	$120.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$80.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$120.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$120.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$80.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$80.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$120.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$120.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery .	$170.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) .	$170.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$80.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$80.00
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5511	Repair broken complete denture base, mandibular	$15.00
D5512	Repair broken complete denture base, maxillary	$15.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$5.00
D5611	Repair resin partial denture base, mandibular	$15.00
D5612	Repair resin partial denture base, maxillary	$15.00
D5621	Repair cast partial framework, mandibular	$15.00

D5622	Repair cast partial framework, maxillary	$15.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	$15.00
D5640	Replace broken teeth - per tooth	$5.00
D5650	Add tooth to existing partial denture	$5.00
D5660	Add clasp to existing partial denture - per tooth	$5.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$75.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$75.00
D5710	Rebase complete maxillary denture	$35.00
D5711	Rebase complete mandibular denture	$35.00
D5720	Rebase maxillary partial denture	$35.00
D5721	Rebase mandibular partial denture	$35.00
D5725	Rebase hybrid prosthesis	$35.00
D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside)	No Cost
D5750	Reline complete maxillary denture (laboratory)	$35.00
D5751	Reline complete mandibular denture (laboratory)	$35.00
D5760	Reline maxillary partial denture (laboratory)	$35.00
D5761	Reline mandibular partial denture (laboratory)	$35.00
D5765	Soft liner for complete or partial removable denture - indirect	$35.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - *limited to 1 in any 12 consecutive months*	$45.00
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - *limited to 1 in any 12 consecutive months*	$45.00
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- When a crown and/or pontic exceeds six units in the same treatment plan, You may be charged an additional $100.00 per unit, beyond the 6th unit.

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$170.00
D6211	Pontic - cast predominantly base metal	$70.00
D6212	Pontic - cast noble metal	$110.00
D6240	Pontic - porcelain fused to high noble metal	$195.00
D6241	Pontic - porcelain fused to predominantly base metal	$95.00
D6242	Pontic - porcelain fused to noble metal	$135.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	$135.00
D6245	Pontic - porcelain/ceramic	$195.00
D6250	Pontic - resin with high noble metal	$155.00
D6251	Pontic - resin with predominantly base metal	$55.00
D6252	Pontic - resin with noble metal	$95.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$150.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$160.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$100.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$100.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces	$40.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$40.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$150.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$165.00

D6610	Retainer onlay - cast high noble metal, two surfaces	$100.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$100.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces	$40.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$40.00
D6720	Retainer crown - resin with high noble metal	$155.00
D6721	Retainer crown - resin with predominantly base metal	$55.00
D6722	Retainer crown - resin with noble metal	$95.00
D6740	Retainer crown - porcelain/ceramic	$195.00
D6750	Retainer crown - porcelain fused to high noble metal	$195.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$95.00
D6752	Retainer crown - porcelain fused to noble metal	$135.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$195.00
D6780	Retainer crown - 3/4 cast high noble metal	$170.00
D6781	Retainer crown - 3/4 cast predominantly base metal	$70.00
D6782	Retainer crown - 3/4 cast noble metal	$110.00
D6783	Retainer crown - 3/4 porcelain/ceramic	$195.00
D6784	Retainer crown - titanium and titanium alloys	$170.00
D6790	Retainer crown - full cast high noble metal	$170.00
D6791	Retainer crown - full cast predominantly base metal	$70.00
D6792	Retainer crown - full cast noble metal	$110.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	$10.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$15.00
D7220	Removal of impacted tooth - soft tissue	$25.00
D7230	Removal of impacted tooth - partially bony	$50.00
D7240	Removal of impacted tooth - completely bony	$70.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$90.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	$90.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$50.00
D7280	Exposure of an unerupted tooth	$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7509	Marsupialization of odontogenic cyst	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost

D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	No Cost
D7970	Excision of hyperplastic tissue - per arch	$50.00
D7971	Excision of pericoronal gingiva	$50.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

	The benefit for pre-treatment records and diagnostic services includes:	$200.00
D0210	Intraoral - comprehensive series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0470	Diagnostic casts	
D0801	3D dental surface scan - direct	
D0802	3D dental surface scan - indirect	
D0803	3D facial surface scan - direct	
D0804	3D facial surface scan - indirect	
	The benefit for post-treatment records includes:	$70.00
D0210	Intraoral - comprehensive series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	$950.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$950.00
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$950.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	$5.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$80.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	$0.00
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost

D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	$10.00
D9944	Occlusal guard - hard appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9945	Occlusal guard - soft appliance, full arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9946	Occlusal guard - hard appliance, partial arch - *limited to 1 D9944, D9945 or D9946 in 3 years*	$95.00
D9951	Occlusal adjustment, limited	$20.00
D9952	Occlusal adjustment, complete	$40.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review .	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

Procedures with age restrictions will be subject to exceptions based on medical necessity.

If services for a listed procedure are performed by the Contract Dentist, You pay the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the Contract Dentist, must be authorized by Us. You pay the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, which are supported either by a natural tooth or dental implant, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Us, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist s submitted fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. We are financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments.*
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. The replacement of lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, and crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Procedures that may include:
   a. precious metal for removable appliances;
   b. metallic or permanent soft bases for complete dentures;
   c. porcelain denture teeth;

d. precision abutments for removable partials or fixed partial dentures including but not limited to overlays and related specialized appliances; and/or

e. personalization and characterization of complete and partial dentures.

8. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

9. Consultations for non-covered Benefits.

10. Dental services received from any Dentist other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

12. Prescription drugs.

13. Dental expenses incurred in connection with any dental or orthodontic procedure started before Your eligibility with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

14. Lost, stolen or broken orthodontic appliances.

15. Changes in orthodontic treatment necessitated by accident of any kind.

16. Myofunctional and parafunctional appliances and/or therapies with the exception of procedures D9944 (Occlusal guard, hard appliance, full arch), D9945 (Occlusal guard - soft appliance, full arch), and D9946 (Occlusal guard-hard appliance, partial arch).

17. Composite or ceramic brackets, lingual adaption of orthodontic bands.

18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

19. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

Useful information at your fingertips

Boost your wellness IQ

Find oral health resources, including articles, quizzes, videos and a subscription to *Grin!*, our free dental wellness e-magazine at **deltadentalins.com/wellness**.

Find a network dentist near you

Use our convenient **Find a dentist** tool and select DeltaCare USA as your network.

- Find a dentist near your home or office
- Narrow your search by location, specialty, languages spoken — and more

Sign up for an online account

Sign up for a free, secure online account.

- Review your plan benefits
- Access your ID card

Contact us

Need help? Let us know.

Online: Visit **deltadentalins.com/contact**

Write to:
Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Call toll-free: 800-422-4234
Customer Service agents are available Monday through Friday, 8 am to 9 pm, Eastern time. Or, use our automated phone system, available 24/7.

Underwritten by:
Delta Dental of California
18000 Studebaker Road, Suite 530
Cerritos, CA 90703

Administered by:
Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

NOTE: This is only a brief summary of your plan.
This brochure is not intended to replace your legally required plan booklet. The Group Dental Service Contract determines the exact terms and conditions of your coverage. Please refer to the "Description of Benefits and Copayments" and "Limitations and Exclusions of Benefits" in this brochure for a complete list of covered procedures, copayments, plan limitations and exclusions. You may also consult your Evidence/Certificate of Coverage, which will be mailed to you upon enrollment. If you wish to review an Evidence/Certificate of Coverage prior to enrollment, you may request a copy by calling Customer Service at **800-422-4234**.

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A LOOK AT YOUR VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM MISSION VIEJO CITY OF AND VSP.

vsp Vision care for life

As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

It's easy to find a nearby in-network doctor. Maximize your coverage with bonus offers and savings that are exclusive to Premier Program locations—including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

PREMIER PROGRAM

Visionworks

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

GET YOUR PERFECT PAIR

EXTRA $20 TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST EYEWEAR

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

\+

UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

Contact us: **800.877.7195** or **vsp.com**

YOUR VSP VISION BENEFITS SUMMARY
MISSION VIEJO CITY OF and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature
EFFECTIVE DATE:
01/01/2022

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10 for exam and glasses	Every calendar year
PRESCRIPTION GLASSES			
FRAME	• $180 featured frame brands allowance • $160 frame allowance • 20% savings on the amount over your allowance • $160 Walmart®/Sam's Club® frame allowance • $160 Costco® frame allowance	Combined with exam	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with exam	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Tints/Light reactive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $0 $80 - $90 $120 - $160	Every calendar year
COVERED CONTACT LENSES (IN ADDITION TO GLASSES)	• Annual supply of contacts • Contact lens exam (fitting and evaluation)	$50	Every calendar year
PRIMARY EYECARE℠	• Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. • Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 per exam	As needed
LIGHTCARE™	• $160 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts	Combined with exam	Every calendar year
ADDITIONAL COVERAGE	• Additional Pairs of Eyewear $20 Copay		
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Log in to **vsp.com** to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Log in to **vsp.com** to find an in-network provider based on your plan type.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Classification: Restricted

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Medical FSA

Why should I choose a medical flexible spending account?

A medical FSA is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses. This saves you money by reducing your taxable income.

Funds on Day 1
Schedule that surgery, buy those eyeglasses or finally get those braces. All of your FSA funds are available to spend right away. Use your benefits debit card at the point of purchase.

Discount
Think of it like a discount on healthcare expenses at stores such as Amazon, Target, CVS, Walmart, Walgreens and more. Dollars you contribute are taken out of your paycheck before tax which means a $100 purchase would actually cost you over $130 without a medical FSA.*

Plan ahead
Think about the money you spent on healthcare expenses last year. Plan ahead and set those funds aside in a medical FSA and save 30%.*

*Based on a 30% tax bracket.

What does it cover?

There are thousands of eligible items, including:

- Copays and coinsurance
- Doctor visits and surgeries
- Over-the-counter medications (first aid, allergy, asthma, cold/flu, heartburn, etc.)
- Prescription drugs
- Birthing and lamaze classes
- Dental and orthodontia
- Frames, contacts, prescription sunglasses, etc.

View our interactive eligible expense list at
www.wexinc.com/insights/benefits-toolkit/eligible-expenses/

Can I enroll?

Yes, as long as you or your spouse aren't actively enrolled and contributing to a health savings account (HSA).

Fast fact

Don't know how much to elect? Determine how much you spent on healthcare expenses last year and estimate the amount you'll spend this year using our eligible expense list. Any funds you contribute to the medical FSA must be spent by the end of the plan year.

WEX Benefits Card

Our benefits debit card is the fastest and most convenient way to access your funds and pay for eligible expenses. Just one debit card is all you need for your card-eligible benefits with us.

While the IRS requires documentation for certain spending and reimbursement benefits, we automate some of that substantiation through:

IIAS approval: If a merchant uses the Inventory Information Approval System (IIAS), the debit card will automatically approve eligible expenses. You can view a list of IIAS merchants at www.sig-is.org/card-holders/store-locator.

Copayments: If your employer provides us copayment amounts for your insurance plans, we can auto-approve expenses that match these copayment amounts.

Recurring claims: If you use your debit card for a purchase that requires substantiation, once the claim has been approved and you make that same purchase for the same dollar amount at that merchant, the recurring claim will be automatically approved.

How do I get a card?

We'll automatically mail you two debit cards to the address listed in your account the first time you enroll. If you're already enrolled, continue using the debit card you have.

Additional cards

You can request additional debit cards for your spouse or dependents from your online account. Log in, under Accounts select "Banking/Cards.

Expiring debit card

We will automatically mail you a new debit card 30 or more days prior.

Lost or stolen cards

If your debit card is lost or stolen, you can report it in your online account or mobile app and request a new card.

Dependent Care FSA

Why should I choose a dependent care FSA?

A dependent care FSA allows you to put aside a portion of your paycheck before taxes for eligible dependent care expenses each year.

Save money

The dependent care FSA lets you pay for eligible dependent care expenses while you reap the benefits of additional tax savings. You're spending the money either way. This way, eligible childcare and other dependent care costs are a little less.

Save strategically

Submit all of your dependent care expenses at the end of the plan year for one lump sum reimbursement to give yourself a hard-earned "bonus".

What does it cover?

The list includes, but is not limited to, eligible:

- Childcare center, babysitter, nanny (birth through age 12)
- Summer day camp
- Before- or after-school care
- Disabled dependent and/or spouse care
- Elder care

Fast Fact

For recurring costs, submit our Recurring Dependent Care Form. It makes claim filing simple because you only need to submit one form once in order to get reimbursed each pay period. You can find the form on the back of this handout.

View our interactive eligible expense list at **www.wexinc.com/insights/benefits-toolkit/eligible-expenses/**

Can I enroll?

You are eligible if you and/or your spouse (if applicable) are gainfully employed, looking for work, or are attending school on a full-time basis.

www.wexinc.com
866-451-3399 866-451-3245
PO Box 2926 Fargo, ND 58108-2926
forms@wexhealth.com

Recurring Dependent Care Request Form

This form is to be completed each plan year and as changes occur when you want to receive recurring reimbursement of dependent care expenses. Documentation must be retained for your records and provided to WEX when requested to do so (if a receipt is unavailable, a signature from the provider is sufficient). If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

* = Required Fields

Step 1: Participant information

*Participant Name (First, MI, Last)

*Social Security Number

*Employer Name (Do not abbreviate)

Employee ID

Updates or changes to your information can be made by logging into your account at **www.wexinc.com**.

Step 2: Recurring dependent care FSA information

*Please select only one:

☐ Start Recurring Dependent Care FSA: Please start my recurring reimbursement with the information provided in Step 3.

☐ Change Recurring Dependent Care FSA Information: Please update my recurring reimbursement with the information provided in Step 3 as of the Effective Date listed on the right.

Effective Date (mm/dd/yyyy)

☐ Stop Recurring Dependent Care FSA: Please stop my recurring reimbursement for the information provided in Step 3 as of the Effective Date listed on the right.

Effective Date (mm/dd/yyyy)

Step 3: Dependent care provider information and signature (to be completed by the provider)

I certify the information provided below is accurate. I understand the purpose of my signature on this form is to substantiate the name of the dependent care provider, the dates of service care is being provided and the dollar amount of the services. I agree to provide the necessary receipts for documenting the participant's incurred dependent care expenses.

*Dependent(s) Name	*Start Date of Service Must be within current plan year (mm/dd/yyyy)	*End Date of Service Must be within current plan year (mm/dd/yyyy)	*Provider's Signature	*Cost Per Week	*Total Cost

Step 4: Participant certification

To the best of my knowledge, the provided information is complete and accurate. By submitting this, I acknowledge my child is under the age of 13, the services are eligible dependent care expenses as defined by the IRS, that I have not been previously reimbursed for these expenses and that I will not seek reimbursement from any other source. I understand that WEX, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify WEX. I understand that WEX may require me to submit any additional documentation, receipts and an updated request form at any time. I should retain a copy of all submitted documentation in the event of an IRS audit. I confirm my payroll deductions are less than my daycare costs per week so recurring reimbursements will occur when payroll deductions post to my Dependent Care FSA. By submitting this form I certify the above.

Group Term Life Insurance

Enrollment at a Glance

Convenient, affordable life insurance, offering financial protection for your loved ones.

For the employees of:
Public Risk Innovation, Solutions and Management (PRISM)
City of Mission Viejo, Account #109

What is Group Term Life Insurance?

Group Term Life Insurance is offered through your employer and pays a benefit to your beneficiary if you pass away during a specific period of time (known as a "term"). The term of this coverage is generally one year, renewing on an annual basis with your other employer-offered benefits. Your employer offers Basic Life Insurance and Accidental Death and Dismemberment Insurance, which is the amount they provide at no cost to you. You also have the option to elect additional coverage called Supplemental Life Insurance.

What is Accidental Death and Dismemberment (AD&D) Insurance?

AD&D Insurance pays a benefit to you or your beneficiary, separate from the life insurance benefit, if you are severely injured or die as the result of a covered accident. This coverage is part of the Group Term Life Insurance offered through your employer.

How can life insurance help?

Below are a few examples of how your life insurance benefit could be used (coverage amounts may vary):

- Pay off any remaining medical bills, funeral costs and debts
- Provide ongoing financial support to your family
- Keep your family in your home by paying off the mortgage
- Fund your children's education

Who is eligible for life insurance?

- You—all active employees working 20+ hours per week.
- Your spouse*—If your spouse is covered under the policy as an employee, then your spouse is not eligible for coverage under the spouse rider/benefit. Coverage is available only if Employee Supplemental Life Insurance is elected.
- Your children—Birth to age 26. Coverage is available only if Employee Supplemental Life Insurance is elected. If both you and your spouse are covered under the policy as employees, then only one, but not both, may cover the same children under the children's rider/benefit. If the parent who is covering the children stops being insured as an employee, then the other parent may apply for children's coverage.

**The use of "spouse" in this document means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the group policy. Please contact your employer for more information.*

What amount of coverage am I eligible for?

- For you
  - Your employer provides you with Basic Life Insurance and Basic AD&D Insurance of 2 times your annual salary up to a maximum of $300,000, but not less than $10,000. There is no cost to you for this insurance.
  - Eligible employees may elect Supplemental Life Insurance of $10,000 to $350,000 in $10,000 increments not to exceed 5 times your annual salary.

- For your spouse*
  - Eligible employees may elect Spouse Supplemental Life Insurance of $5,000 to $50,000 in $5,000 increments not to exceed 50% of your approved employee Life Insurance amount.

- For your children
  - Eligible employees may elect Children Supplemental Life Insurance of $10,000. Coverage is limited to 50% of your employee Life insurance coverage amount. Children from birth to six months of age are covered for $1,000.

**The use of "spouse" in this document means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the group policy. Please contact your employer for more information.*

Meet the Wilsons

Mark and Jodi Wilson had a busy life filled with work, sports and their three children. Mark was the breadwinner of the family and worked as a construction manager. Jodi had quit her job to stay home with the children when their second child was born. Mark had been suffering from recurring headaches and, after seeing many doctors, was diagnosed with an inoperable brain tumor. Fortunately for the Wilson family, Mark had elected Group Term Life Insurance coverage through his employer. When Mark passed away, Jodi was able to use the life insurance proceeds to pay off the remaining home mortgage and cover Mark's funeral. There was even enough money to support the family while she transitioned from being a stay-at-home mother to a working single parent.

Expenses covered by Mark's Life Insurance Proceeds:

$180,000	**Total Life Insurance Proceeds**
-$8,000	Funeral Costs
-$75,000	Remaining Mortgage
$97,000	Everyday Expenses (utilities, car, groceries, etc.)

The amounts shown are an example only. Actual costs/results may vary.

What does my life insurance include?

The benefits listed below are included with your life insurance coverage.

- **Accelerated Death Benefit:** If are diagnosed with a terminal illness with a limited life expectancy, you may receive a portion of your death benefit while still living.
- **Accidental Death and Dismemberment (AD&D) Insurance**: Pays a benefit to you or your beneficiary, separate from the life insurance benefit, if you are severely injured or die as the result of a covered accident. The proceeds can be used however you or your beneficiary would like.
- **Continuation**: If on an approved absence from work, you may continue your life insurance coverage under the employer's group policy for a set amount of time. Premiums must be paid during this time.
- **Conversion**: You, your spouse and/or your children may convert life insurance coverage to an individual whole life insurance policy when you leave your employer or due to loss of eligibility under the employer's group policy.
- **Portability**: You may apply to continue your Supplemental coverage when you leave your current employer, and pay premiums to the insurance company directly.
- **Waiver of Premium**: If you become unable to work due to total disability, your Basic and Supplemental Life Insurance can be continued without premium payment.
- **Convenient Payroll Deductions**: Premium deductions for Supplemental coverages are taken directly from your paycheck, so you never have to worry about late payments or lapse notices.

How much does my life insurance cost?

Basic Life Insurance and Basic AD&D Insurance are provided by your employer at no cost to you.

The cost for Supplemental Life is calculated based on the age of the employee at the start of the plan's current policy year.

Rates shown are guaranteed until June 30, 2023.

Employee Supplemental Life Insurance Rates

Age	Monthly Rate per $1,000 of Coverage
Under 30	$0.09
30-34	$0.12
35-39	$0.17
40-44	$0.26
45-49	$0.41
50-54	$0.68
55-59	$1.08
60-64	$1.42
65-69	$2.29
70-74	$4.06
75 +	$7.01

Spouse Supplemental Life Insurance Rates

Age	Monthly Rate per $1,000 of Coverage
Under 30	$0.045
30-34	$0.06
35-39	$0.095
40-44	$0.13
45-49	$0.205
50-54	$0.34
55-59	$0.54
60-64	$0.71
65-69	$1.145
70-74	$2.03
75 +	$3.505

The rates are per individual.

Children Life Insurance Rate

Coverage Level	Monthly Cost
$10,000	$0.90

Monthly cost for all eligible children.

Use the steps below to calculate your premium for you and your spouse based on the amount of insurance you elected:

Step 1: Enter the rate per $1,000 based on age: _____

Step 2: Take the amount of insurance and divide it by 1,000: _____
(Example: For $150,000 of coverage, enter "150")

Step 3: Multiply lines 1 and 2 (this is your monthly cost): _____

Monthly cost for your children: (covers all eligible children)
Enter the monthly cost for the amount of coverage from the table above: _____

Do I need to provide evidence of insurability (answer health questions) to be covered?

New Hires

- For you—You may elect up to $75,000 or 3 times your annual salary, whichever is less, of Supplemental Life Insurance without providing evidence of insurability.
- For your spouse*—You may elect up to $25,000 of Supplemental Life Insurance on your spouse without providing evidence of insurability.
- For your children—You may elect $10,000 of Supplemental Life Insurance on your children without providing evidence of insurability.
- If you elect higher amount(s), you will need to submit evidence of insurability to the insurance company for approval before coverage becomes effective.

**The use of "spouse" in this document means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the group policy. Please contact your employer for more information.*

Will my benefits decrease as I get older?

- For you - Benefit amount(s) reduce to 65% of original coverage at age 65, to 50% of original coverage at age 70, and to 30% of original coverage at age 75 and after.
- For your spouse* - Benefit amount(s) reduce to 65% of original coverage at spouse age 65, to 50% of original coverage at age 70, and to 30% of original coverage at age 75 and after.
- Your payroll deductions will be adjusted to pay premium based on the new benefit amount(s).

**The use of "spouse" in this document means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the group policy. Please contact your employer for more information.*

Exclusions and Limitations

Supplemental Life Insurance coverages have a two year suicide exclusion from the effective date of coverage or an increase in coverage.

AD&D Insurance has exclusions that are described in the certificate of insurance or rider.

Are there additional non-insurance services available?

- Funeral Planning and Concierge Services: You have the support of a team of independent professionals ready to assist with funeral planning for you and eligible family members.

  Funeral Planning and Concierge Services are provided by Everest Funeral Package, LLC, Houston, TX.

- Employee Assistance Program: You have access to ComPsych GuidanceResources®, which provides support, resources and information for personal and work-life issues.

  Employee Assistance Program (EAP) services are provided by ComPsych® Corporation, Chicago, IL.

- Travel Assistance: When traveling more than 100 miles from home, Voya Travel Assistance offers enhanced security for your leisure and business trips. You and your dependents can take advantage of four types of services: pre-trip information, emergency personal services, medical assistance services and emergency transportation services.

  Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD.

Who do I contact with questions?

For more information, contact your human resource representative.

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. To keep coverage in force, premiums are payable up to the date of coverage termination. Group Term Life Insurance is underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Policy form ICC LP14GP or LP00GP (may vary by state).

CN0203-21788-0217

Public Risk Innovation, Solutions and Management (PRISM), Group #31640-7, Acct #109 Date Prepared: 06/30/2020

172501-02/10/2016

Group Disability Income Insurance

Enrollment at a Glance

Protection that provides benefits and access to expert resources during a difficult time.

For the employees of:
Public Risk Innovation, Solutions and Management (PRISM)
City of Mission Viejo, Account #109

What is Group Short Term Disability Income Insurance?

Group Short Term Disability Income Insurance provides you with benefits to replace part of your paycheck when you can't work because of a sickness or injury. Your Short Term Disability benefits are paid for up to 13 weeks.

When you become disabled, you must complete a waiting period before benefits are payable.

- If the disability was caused by an accidental injury*, the waiting period is 14 days.
- If the disability was caused by sickness, the waiting period is 14 days.
- There is no waiting period if you are confined in a hospital.

*You must see a doctor within 48 hours of the accident. If you do not, the benefit waiting period for sickness will apply.

How can Short Term Disability benefits be used?

When your claim is approved, you will receive weekly benefits to replace part of your income based on your coverage level. You may use this money however you would like. Below are a few examples of how your Short Term Disability benefits could be used, depending on how much coverage you have:

- Everyday expenses, such as groceries, utilities, house payments and car payments
- Medical bills and recovery expenses
- Support services during your recovery

Who is eligible?

All active employees working 20+ hours per week.

What amount of coverage am I eligible for?

- Your employer provides you with Short Term Disability coverage of 66.67% of weekly earnings for up to 13 weeks with a maximum weekly benefit of $1,500. This coverage is provided at no cost to you.

What is Group Long Term Disability Income Insurance?

Group Long Term Disability Income Insurance provides you with benefits to replace a part of your paycheck when you can't work because of a sickness or injury.

How can Long Term Disability benefits be used?

When your claim is approved, you will receive monthly benefits to replace part of your income based on your coverage level. You may use this money however you would like. Below are a few examples of how your Long Term Disability benefits could be used, depending on how much coverage you have:

- Rent or mortgage payment
- Car payments
- Groceries and utilities
- Medical bills and recovery expenses

Who is eligible?

All active employees working 20+ hours per week.

What amount of coverage am I eligible for?

Your employer provides you with Long Term Disability Income Insurance of 66.67% of monthly earnings with a maximum monthly benefit of $8,000. This insurance is provided at no cost to you. The minimum monthly benefit is $100.

What is the elimination period?

When you become disabled, you must complete an elimination period meaning that you are absent from work due to the same disability for three consecutive months before benefits are payable. Any days that you are able to work after the start of your disability will not count towards your elimination period. You may be eligible for Short Term Disability payments during this time.

How long will I receive benefits?

Long Term Disability Income benefits are paid for the duration of your disability or to the maximum period of payment shown below.

Age When Disability Begins	Maximum Period of Payment
Less than 61	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

What does my Long Term Disability Income Insurance include?

The benefits listed below are included with your Long Term Disability coverage. For a complete description of your available benefits, along with applicable provisions, exclusions and limitations, see your certificate of insurance and any riders.

- **Vocational rehabilitation:** We have vocational rehabilitation services available to assist you in returning to work when possible. If applicable, we will provide you with a written plan developed specifically for you.
- **Conversion:** If you leave your job, you may be eligible to convert long term disability coverage and pay premiums to the insurer directly.
- **Survivor Benefit:** If you pass away while receiving disability benefits, we may pay your eligible survivor a lump-sum benefit equal to three times your monthly payment.

Who do I contact with questions?

For more information, contact your human resource representative.

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. To keep coverage in force, premiums are payable up to the date of coverage termination. Disability Income Insurance is underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Policy form HP08GP and/or HP13GP (may vary by state).

CN0205-21867-0217

Public Risk Innovation, Solutions and Management (PRISM), Group #31640-7, Acct #109 Date Prepared: 06/30/2020

172504-03/01/2016

ReliaStar Life Insurance Company, a member of the Voya® family of companies.

PLAN | INVEST | PROTECT

VOYA FINANCIAL

YOUR GROUP **LIFE INSURANCE** PLAN

For Employees of

CITY OF MISSION VIEJO

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IF YOU HAVE A QUESTION ABOUT YOUR POLICY, IF YOU NEED ASSISTANCE WITH A PROBLEM, OR IF YOU HAVE QUESTIONS ABOUT A CLAIM, YOU MAY WRITE OR CALL US AT:

ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota 55440
Telephone Number: (800) 955-7736

YOU WILL NEED TO PROVIDE YOUR POLICY NUMBER WITH ANY COMMUNICATION.

IF YOU DO NOT REACH A SATISFACTORY RESOLUTION AFTER HAVING DISCUSSIONS WITH US, OR OUR AGENT OR REPRESENTATIVE, OR BOTH, YOU MAY CONTACT THE FOLLOWING UNIT WITHIN THE DEPARTMENT OF INSURANCE THAT DEALS WITH CONSUMER AFFAIRS:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013
Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota 55440

ReliaStar Life Insurance Company (ReliaStar Life) certifies that it has issued the Group Policy listed below to the Policyholder. All benefits are controlled by the terms and conditions of the Group Policy.

The Group Policy is on file in the Policyholder's office. You may look at the Group Policy there.

ReliaStar Life also certifies that the person named below is insured under the Group Policy.*

31640-7GAT
CSAC Excess Insurance Authority

*If you are actively at work on the effective date. If you are not, your insurance is effective on the date you return to active work.

The insurance included in this certificate applies to you only if you have elected and are insured for it.

The Dependent's Insurance part of this certificate applies to you only if you are insured for it.

Your beneficiary is the last beneficiary you named, according to the records on file in ReliaStar Life's Home Office or on file with the Plan Administrator, if applicable. You may change your beneficiary any time, according to the terms of the Group Policy.

The certificate summarizes and explains the parts of the Group Policy which apply to you. This certificate is not an insurance policy. In any case of differences or errors, the Group Policy rules.

This certificate replaces any other certificates ReliaStar Life may have given you under the Group Policy.

Registrar

SCHEDULE OF BENEFITS

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

Class	Amount of Life Insurance*	Full Amount of AD&D Insurance*
All Eligible Employees	Two times your Basic Yearly Earnings up to a maximum of $300,000, but not less than $10,000	Two times your Basic Yearly Earnings up to a maximum of $300,000, but not less than $10,000

Supplemental Life Insurance

Class	Amount of Life Insurance*
All Eligible Employees	$10,000 to $350,000 in $10,000 increments, not to exceed 5 times Basic Yearly Earnings

*Beginning on and after your 65th birthday, ReliaStar Life decreases the amount of your insurance. ReliaStar Life pays a percentage of the amount otherwise payable as follows:

- From your 65th birthday to age 70, ReliaStar Life pays 65%,
- From your 70th birthday to age 75, ReliaStar Life pays 50%,
- From your 75th birthday and after, ReliaStar Life pays 30%.

Basic Yearly Earnings – the yearly salary or wage you receive for work done for the Participating Employer. It does not include bonuses, commissions or overtime pay. To determine benefits, your amount of insurance is rounded to the next higher $1,000 multiple unless the amount equals a multiple of $1,000.

Accelerated Death Benefit

This benefit is equal to 80% of your amount of Life Insurance in force, or $500,000, whichever is less. Employees must have at least $6,000 in Life Insurance coverage in force to qualify for this benefit.

Supplemental Life Insurance Continued under the Portability Option

The amount of your Supplemental Life Insurance that can be continued is limited to the lesser of the amount of your Supplemental Life Insurance on the date you elect portability or $350,000. You may elect to continue a lesser amount based on the amounts available to active employees.

Any reductions in coverage due to age will apply to all coverage continued under the portability option.

SCHEDULE OF BENEFITS

Supplemental Dependent Life Insurance

Class	Amount of Life Insurance**
Spouse or Domestic Partner	$5,000 to $50,000 in $5,000 increments
Child (each)	
· from birth to 6 months of age	$1,000
· 6 months but less than 21 years, student dependent less than age 23	$10,000

The amount of insurance for a dependent can be no more than 50% of your Life Insurance amount.

**Beginning on and after your spouse's or domestic partner's 65th birthday, ReliaStar Life decreases the amount of your spouse's or domestic partner's insurance. ReliaStar Life pays a percentage of the amount otherwise payable as follows:

- From your spouse's or domestic partner's 65th birthday to age 70, ReliaStar Life pays 65%,
- From your spouse's or domestic partner's 70th birthday to age 75, ReliaStar Life pays 50%,
- From your spouse's or domestic partner's 75th birthday and after, ReliaStar Life pays 30%.

Dependent Spouse or Domestic Partner Accelerated Death Benefit

This benefit is equal to 80% of your amount of Dependent Spouse or Domestic Partner Life Insurance in force, or $40,000, whichever is less. You must have at least $10,000 of Dependent Spouse or Domestic Partner Life Insurance in force to qualify for this benefit.

Dependent Life Insurance Continued under the Portability Option

The amount of Dependent Life Insurance that may be continued for each dependent is limited to the lesser of the amount of your Dependent Life Insurance on the date you elect portability, or the amount of your Life Insurance that is continued. You must elect portability of your Supplemental Life Insurance in order to continue your Dependent Life Insurance.

Any reductions in coverage due to age will apply to all coverage continued under the portability option.

SCHEDULE OF BENEFITS

Proof of Good Health

Proof of good health is required for amounts in excess of the limits described below. Coverage is subject to the Group Policy's proof of good health requirements that are in force on the effective date of coverage. Any increase to coverage is subject to the Group Policy's proof of good health requirements that are in force on the effective date of the increase. For proof of good health, a completed Evidence of Insurability form must be submitted to ReliaStar Life for approval.

Employee-Basic Life Insurance	**Limit without Proof**
· Initial eligibility...	$300,000
· Increases due to salary, job or class changes, that combined with existing coverage do not exceed $300,000...	Amount of the increase

Employee-Supplemental Life Insurance	**Limit without Proof**
· Application for new coverage within 31 days after the date you become eligible for insurance...	$75,000 or 3 times Basic Yearly Earnings, whichever is less.
· Application for new coverage more than 31 days after the date you become eligible for insurance...	None. Proof of good health is required.
· Application for an increase to existing supplemental coverage...	None. Proof of good health is required.

Dependent Life Insurance	**Limit without Proof**
· Application for new dependent coverage within 31 days after the date you become eligible for dependent's insurance...	$25,000 on your spouse or domestic partner and $10,000 on your child(ren).

SCHEDULE OF BENEFITS

• Application for new dependent coverage more than 31 days after the date you become eligible for dependent's insurance...	None. Proof of good health is required.
• Application for an increase to existing dependent coverage...	None. Proof of good health is required.

EMPLOYEE'S INSURANCE

Eligibility
You are eligible on the first day of the month on or after the date you complete 30 days of continuous service with the Participating Employer.

You must meet the following conditions to become insured:
- Be eligible for the insurance.
- Be actively at work.
- Apply for the insurance, if you have to pay any part of the premium.
- Give to ReliaStar Life proof of good health, which it approves, as required on the Schedule of Benefits.

Effective Date of Employee's Insurance
Your insurance starts on the latest of the following dates:
- The date you become eligible.
- The date you return to active work if you are not actively at work on the date insurance would otherwise start. **Exception:** Your insurance starts on a nonworking day if you were actively at work on your last scheduled working day before the nonworking day.
- The date you apply for insurance, if you have to pay any part of the premium.
- The date ReliaStar Life approves your proof of good health, if proof is required.

Effective Date of Change in Amount of Insurance
If there is an increase in the amount of your insurance, the increase will take effect on –
- The first day of the month on or after the date of the increase, if you are actively at work on the date of the increase.
- The date you return to active work if you are not actively at work on the first day of the month on or after the date of the increase.
- The first day of the month on or after the date of the increase, if the first day of the month is a nonworking day and you were actively at work on your last scheduled working day before the nonworking day.

If proof of good health is required, the increase will take effect on the later of the dates indicated above or the date ReliaStar Life approves your proof of good health.

A decrease in the amount of your insurance will take effect on the date of the decrease.

EMPLOYEE'S INSURANCE

Termination of Insurance
Your insurance stops on the earliest of the following dates:

- For coverage not continued under the portability option, the last day of the month during which you were last actively at work for the Participating Employer.
- For coverage not continued under the portability option, the last day of the month during which you are no longer eligible for insurance under the Group Policy.
- For coverage not continued under the portability option, the last day of the month during which you retire.
- For coverage continued under the portability option, the date you attain age 70.
- The date the Policyholder replaces the Supplemental Life Insurance under this plan with a similar life insurance plan through another insurance carrier, if you are actively at work for the Participating Employer on that date.
- The date the Group Policy stops.
- The date the Participating Employer stops subscribing to the agreement establishing the CSAC Excess Insurance Authority.
- The end of the period for which you paid premiums, if you do not make the next required premium contribution when due.
- For Accelerated Death Benefit, the date your Life Insurance stops.
- For AD&D Insurance, the date your Life Insurance stops or the date Life Insurance premiums are waived under the Waiver of Life Insurance Premium Disability Benefit.

ReliaStar Life stops providing a specific benefit to you on the date that benefit is no longer provided under the Group Policy.

Family and Medical Leave Act of 1993
Certain employers are subject to the FMLA. If you have a leave from active work certified by your employer, then for purposes of eligibility and termination of coverage you will be considered to be actively at work. Your coverage will remain in force so long as you continue to meet the requirements as set forth in the FMLA.

Extension of Life Insurance
If you are no longer eligible for Life Insurance because you stop active work, the Policyholder may continue your Life Insurance. Premiums must be paid. Your Life Insurance is continued subject to all other terms of the Group Policy.

If you stop active work because of a medical or non-medical leave of absence, temporary layoff, or the Participating Employer suspending operations, the Policyholder may continue your Life Insurance in accordance with the employer's documented personnel practices and precluding individual selection among employees.

EMPLOYEE'S INSURANCE

Portability
Portability means you have the option to continue your Supplemental Life Insurance if certain conditions are met. You must elect portability before you reach age 70.

To continue your insurance, you must elect portability within 31 days of the date your Supplemental Life Insurance terminates due to the following:

- You retire or terminate employment with the Participating Employer, if coverage is in effect for active employees under the Group Policy; or
- The Policyholder terminates coverage for active employees under the Group Policy and does not replace it with a similar life insurance plan; or
- You are no longer eligible for insurance under the Group Policy; or
- All other continuation under the Group Policy ends.

In all cases, you must pay premiums directly to ReliaStar Life beginning on the first day of the month following the date you elect portability.

If your Supplemental Life Insurance reduces due to age or a change in employment status, this is not considered a termination of insurance. Please refer to the **Conversion Rights** section for more information about conversion following reductions in coverage.

If you continued coverage under the portability option and then later become eligible for Supplemental/Optional/Voluntary Life Insurance as an active employee under a Group Policy issued by ReliaStar Life, then your amount of coverage continued under the portability option will be reduced by your amount of Supplemental/Optional/Voluntary insurance as an active employee.

Reinstatement
ReliaStar Life will reinstate your insurance not eligible for portability if you stop work and then return to work within 12 months. You will be eligible for insurance on the date you return to active work with the Participating Employer.

DEPENDENT'S INSURANCE

NOTE: YOUR DOMESTIC PARTNER AND YOUR DOMESTIC PARTNER'S CHILDREN MAY BE ELIGIBLE FOR INSURANCE UNDER THIS PLAN, AS DEFINED UNDER DEFINITIONS OF DEPENDENT AND DOMESTIC PARTNER AND CHILD. YOU SHOULD CONSULT WITH YOUR PERSONAL TAX ADVISER TO ASSESS POSSIBLE TAX IMPLICATIONS.

Eligibility
You are eligible for Dependent's Insurance on the later of the following dates:
- The date you are eligible for Employee's Supplemental Life Insurance.
- The date you first acquire a dependent as defined.

You must meet all of the following conditions to become insured for Dependent's Insurance:
- Be insured for Employee's Supplemental Life Insurance.
- Apply for Dependent's Insurance. You must apply for all dependents you have within 31 days of the date you are eligible for Dependent's Insurance.
- Give to ReliaStar Life proof of good health for your dependent, which it approves, as required on the Schedule of Benefits.

If you and your spouse or domestic partner are insured as employees under the Group Policy, either you or your spouse or domestic partner, but not both, can apply for Dependent's Insurance. If the spouse or domestic partner carrying the Dependent's Insurance stops being insured as an employee, the other spouse or domestic partner may become insured for Dependent's Insurance by applying within 31 days.

Any person eligible for insurance as an employee under the Group Policy is not considered an eligible dependent for Dependent's Insurance.

Effective Date of Dependent's Insurance
Your dependent's insurance starts on the latest of the following dates:
- The date you become eligible for Dependent's Insurance.
- The date of your dependent's final discharge from any facility for care and treatment of sickness or accidental injury, for any dependent, other than a newborn, who is confined in such facility on the date your dependent's insurance starts.
- The date ReliaStar Life approves your dependent's proof of good health, if ReliaStar Life requires proof.
- The date you apply for Dependent's Insurance.

A newborn child will be covered from the date of eligibility. A foster or adopted child will be covered from the date of placement in the home.

DEPENDENT'S INSURANCE

Effective Date of Change in Amount of Insurance
If there is an increase in the amount of your dependent's insurance, the increase will take effect on:

- The first day of the month on or after the date of the increase unless your dependent is confined in a facility for care and treatment of sickness or accidental injury on that date.
- The date of your insured dependent's final discharge from such facility, if your insured dependent is confined to such facility on the first day of the month on or after the date of the increase.

If proof of good health is required, the increase will take effect on the later of the dates indicated above or the date ReliaStar Life approves your dependent's proof of good health.

If you elect to decrease your insured dependent's insurance, the decrease will take effect on the first day of the month on or after the date of the elected decrease. All other decreases will take effect on the date of the decrease.

Termination of Insurance
Your dependent's insurance stops on the earliest of the following dates:

- The date the Dependent's Insurance part of the Group Policy stops.
- The date the Group Policy terminates.
- The end of the period for which you made your last premium contribution for Dependent's Insurance if you do not make the next required contribution when due.
- The date your insurance stops.
- The date you retire.
- The date your dependent's insurance is converted under the Conversion Right.
- The last day of the month during which your insured dependent is no longer a dependent or a student dependent as defined.
- The date your Life Insurance premiums are waived under the Waiver of Life Insurance Premium Disability Benefit provision of the Group Policy.

ReliaStar Life stops providing a specific benefit under your dependent's insurance on the date that benefit is no longer provided under the Group Policy.

DEPENDENT'S INSURANCE

Termination of Eligibility as a Student Dependent
Your student dependent is no longer an eligible student on the earliest of the following dates:

- The date of graduation.
- The date he or she voluntarily stops attending school full-time.
- Thirty-one days following the date he or she involuntarily stops attending school full-time and does not return to school full-time within that 31 days.
- At the end of any 12 month period during which the student dependent did not complete at least 8 months of full-time attendance, unless he or she is attending school full-time on that date.

Insurance does not stop solely due to school vacations. If your insured student dependent is unable to attend school full-time because of sickness or accidental injury, ReliaStar Life will continue the insurance until the first day of the next regular semester or quarter following your student dependent's recovery from sickness or accidental injury, or until your student dependent does not meet the definition of dependent.

Family and Medical Leave Act of 1993
If your coverage remains in force due to a certified leave under the FMLA, then your dependents' coverage will also remain in force so long as you continue to meet the requirements as set forth in the FMLA.

Continuation of Insurance

Your insured dependent's insurance may be continued. Premiums must be paid. Your insured dependent's insurance stops at the end of the period for which the last premium was paid if the next premium is not paid on time. Your insured dependent's continuation is subject to all other terms of the Group Policy.

You Stop Active Work
If you stop active work and your insurance is being continued, your dependent's insurance will also be continued as shown in the Employee's Insurance part of this certificate.

DEPENDENT'S INSURANCE

Incapacitated Dependent Child
If your insured dependent child has an intellectual disability or physical handicap and reaches the maximum age for Dependent's Insurance, you may continue this child's insurance as long as all required premiums are paid. You must give ReliaStar Life proof that:

- The child is incapable of self-sustaining employment due to an intellectual disability or physical handicap.
- The child became incapacitated before reaching the maximum age for Dependent's Insurance.
- The child is chiefly dependent on you for support and maintenance.

Proof must be given within 31 days after the date the child reaches the maximum age for insurance. Before granting a continuation of this child's insurance, ReliaStar Life may require that a doctor examine the child. ReliaStar Life will specify the doctor and pay the fee for all exams ReliaStar Life requires. During the 2 years after the child reaches the maximum age, ReliaStar Life may ask for regular proof of the child's continued incapacity. After the 2 year period, ReliaStar Life will not ask for proof, including doctor's exams, more often than once a year.

This incapacitated child's continuation stops on the **earliest** of the following dates:

- The date the child becomes covered under any other group plan.
- The date the child is no longer incapacitated.
- The date you do not give ReliaStar Life proof of the child's incapacity when requested.
- The end of the period for which you paid premiums for this continuation, if you do not make the next required premium contribution when due.
- The date your Dependent's Insurance would otherwise stop under the Group Policy.

The Conversion Right will be available to your insured dependent child when all continuation is exhausted.

Portability
You may continue your Dependent Life Insurance if you elected portability of your Supplemental Life Insurance.

If you elected portability of Dependent's Insurance and then later become eligible as an active employee for Dependent's Insurance under a Group Policy issued by ReliaStar Life, then your amount of Dependent's Insurance continued under the portability option will be reduced by your amount of Dependent's Insurance as an active employee.

LIFE INSURANCE

Employee's Life Insurance
ReliaStar Life pays a death benefit to your beneficiary if written proof is received that you have died while this insurance is in force. The death benefit is the amount of Life Insurance for your class shown on the Schedule of Benefits in effect on the date of your death.

ReliaStar Life pays the death benefit for all causes of death. However, for Supplemental Life Insurance, if you commit suicide, while sane or insane, within 2 years of the date your insurance starts, ReliaStar Life will refund the amount of premiums paid for your Supplemental Life Insurance under the Group Policy instead of paying a death benefit.

Waiver of Life Insurance Premium Disability Benefit

ReliaStar Life waives your Life Insurance premium that becomes due while you are totally disabled. The premium will be waived if you satisfy certain conditions. When ReliaStar Life waives a premium, the amount of Life Insurance equals the amount that would have been provided if you had not become totally disabled. That amount will reduce or stop according to the Schedule of Benefits in effect on the date total disability begins.

When ReliaStar Life waives a premium it includes Life Insurance, Accelerated Death Benefit, and Waiver of Premium. It does not include AD&D Insurance, Dependent's Insurance, or any other benefits as elected under this certificate which were effective at the time of disability.

Conditions, Notice and Proof of Total Disability
ReliaStar Life requires written notice of claim and proof of total disability to waive your premium. All of the following conditions must also be met:

- Total disability must begin before your 60th birthday.
- You are insured for the Waiver of Life Insurance Premium Disability Benefit on the date you become totally disabled.
- You continue to be totally disabled.
- Your insurance is in force when you suffer the sickness or accidental injury causing the total disability.
- All premiums are paid up to the date total disability begins.

ReliaStar Life needs written notice of claim before it waives any premium. This notice must be received –

- while you are living,
- while you are totally disabled, and
- within one year from the date the last premium payment was made. If you cannot give ReliaStar Life notice within one year, your claim is still valid if you show you gave ReliaStar Life notice as soon as reasonably possible.

LIFE INSURANCE

ReliaStar Life needs proof of your total disability before any premiums can be waived. ReliaStar Life may require you to have a physical exam by a doctor it chooses. ReliaStar Life pays for that exam. ReliaStar Life can only require one exam a year after premiums have been waived for 2 full years.

When ReliaStar Life approves your proof of total disability, premiums are waived as of the date you became totally disabled. ReliaStar Life refunds, to the Policyholder, any premium paid for a period during which you were totally disabled. It is the Policyholder's responsibility to refund to you any part of the premium you paid.

Termination of Waiver of Premium
ReliaStar Life stops waiving premiums on the earliest of the following dates:
- The date you are no longer totally disabled.
- The date you do not give ReliaStar Life proof of total disability when asked.
- The date you attain age 70.

If ReliaStar Life stops waiving your premiums, your Life Insurance will stay in force only if all of the following conditions are met:
- The Life Insurance under the Group Policy is still in force.
- You are eligible for Employee's Insurance under the Group Policy.
- Your premium payments are resumed.

The amount of Life Insurance that stays in force will be the amount shown on the Schedule of Benefits in effect on the date your premium payments are resumed.

You will not be eligible to continue insurance under the portability option when ReliaStar Life stops waiving your premiums.

If you buy an individual policy under the Conversion Right of the Group Policy during the first year of your disability, your Life Insurance may be restored. ReliaStar Life will cancel the individual policy as of its issue date:
- If within 12 months of the date you become totally disabled you –
  – file a claim under this provision and ReliaStar Life approves it, and
  – surrender the individual policy without claim, except for refund of premium.

When ReliaStar Life cancels your individual policy, ReliaStar Life –
- refunds all premiums paid for the individual policy.
- restores your Life Insurance under the Group Policy.
- retains the beneficiary named under the individual policy as beneficiary under the Group Policy, unless you ask ReliaStar Life to change the beneficiary in writing.

LIFE INSURANCE

Beneficiary
The beneficiary is named to receive the proceeds to be paid at your death. You may name more than one beneficiary. The Policyholder or the Participating Employer cannot be the beneficiary.

You may name, add or change beneficiaries by written request as described below. You may also choose to name a beneficiary that you cannot change without his or her consent. This is an irrevocable beneficiary.

You may name, add or change beneficiaries by written request if all of the following conditions are met:
- Your coverage is in force.
- ReliaStar Life has written consent of all irrevocable beneficiaries.
- You have not assigned the ownership of your insurance. The rights of an assignee are described in the Assignment section.

All requests are subject to the approval of ReliaStar Life. A change will take effect as of the date it is signed but will not affect any payment ReliaStar Life makes or action it takes before receiving your notice.

Payment of Proceeds
ReliaStar Life pays proceeds to the beneficiary. If there is more than one beneficiary, each receives an equal share, unless you have requested otherwise, in writing. To receive proceeds, a beneficiary must be living on the earlier of the following dates:
- The date ReliaStar Life receives proof of your death.
- The tenth day after your death.

If there is no eligible beneficiary or if you did not name one, ReliaStar Life pays the proceeds in the following order:
1. Your spouse or domestic partner.
2. Your natural and adopted children.
3. Your parents.
4. Your estate.

The person must be living on the tenth day after your death.

Settlement Options
Settlement options are alternative ways of paying the proceeds under the Group Policy. Proceeds is the amount of each benefit ReliaStar Life pays when you die or when you receive a lump sum amount under the Accelerated Death Benefit. To find out more about settlement options, please contact the Policyholder.

LIFE INSURANCE

Accelerated Death Benefit

NOTE: AT THIS TIME IT IS UNCLEAR WHETHER YOU WILL BE REQUIRED TO PAY TAX ON ACCELERATED DEATH BENEFIT PROCEEDS. YOU SHOULD CONSULT WITH YOUR PERSONAL TAX ADVISER TO ASSESS POSSIBLE TAX IMPLICATIONS.

ReliaStar Life pays this benefit if it has been determined that you have a terminal condition. Accelerated Death Benefit proceeds is the amount ReliaStar Life pays to you or your legal representative while you are living when it has been determined that you have a terminal condition. The Accelerated Death Benefit proceeds are paid in one lump sum and are paid only once. This lump sum payout is the only Settlement Option available to you prior to your death.

The Accelerated Death Benefit is the amount of the Accelerated Death Benefit shown on the Schedule of Benefits in effect on the date you apply for Accelerated Death Benefit proceeds. You will not be able to increase your contributory Life Insurance benefit after the time you apply for the Accelerated Death Benefit, unless you are determined to be ineligible to receive Accelerated Death Benefit proceeds.

To receive the Accelerated Death Benefit, **all** of the following conditions must be met. You must:

- request this benefit in writing while you are living. If you are unable to request this benefit yourself, your legal representative may request it for you.
- be insured as an employee for Life Insurance benefits.
- have Life Insurance benefits of at least $6,000 as shown on the Schedule of Benefits.
- provide to ReliaStar Life a doctor's statement which gives the diagnosis of your medical condition; and states that because of the nature and severity of such condition, your life expectancy is no more than 6 months. ReliaStar Life may require that you be examined by a doctor of its choosing. If ReliaStar Life requires this, ReliaStar Life pays for the exam.
- provide to ReliaStar Life written consent from any irrevocable beneficiary, assignee, and, in community property states, from your spouse.

Benefit Payment

ReliaStar Life pays the Accelerated Death Benefit proceeds to you unless both of the following are true:

- It is shown, to the satisfaction of ReliaStar Life, that you are physically and mentally incapable of receiving and cashing the lump sum payment.
- A representative appointed by the courts to act on your behalf does not make a claim for the payment.

If ReliaStar Life does not pay you because the two above conditions apply, payments instead will be made to one of the following:

- A person who takes care of you.
- An institution that takes care of you.
- Any other person ReliaStar Life considers entitled to receive the payments as your trustee.

Accelerated Death Benefit Exclusions

ReliaStar Life does not pay benefits for a terminal condition if either of the following apply:

- the required Accelerated Death Benefit premium or Life Insurance premium is due and unpaid.
- the terminal condition is directly or indirectly caused by attempted suicide or intentionally self-inflicted injury, whether sane or insane.

Effects on Coverage

When ReliaStar Life pays out this benefit, your coverage is affected in the following ways:

- Your total available Life Insurance benefit equals your amount of Life Insurance shown on the Schedule of Benefits at the time you apply for the Accelerated Death Benefit.
- Your Life Insurance benefit is reduced by the Accelerated Death Benefit proceeds paid out under this provision.
- Your Life Insurance benefit amount which you may convert is reduced by the Accelerated Death Benefit proceeds paid out under this provision.
- You will not be able to increase your Life Insurance benefit after ReliaStar Life approves you to receive the Accelerated Death Benefit.
- Your premium is based upon the Life Insurance benefit amount in force prior to any proceeds paid under this Accelerated Death Benefit provision. Such premium must be paid, unless waived, to keep the Life Insurance coverage in force.
- Your remaining Life Insurance benefit is subject to future age reductions, if any, as shown on the Schedule of Benefits.
- You will not be able to reinstate your coverage to its full amount in the event of a recovery from a terminal condition.
- Your dependents' Life Insurance coverage will be unaffected by Accelerated Death Benefit proceeds paid to you, provided all required premiums are paid.
- Your receipt of Accelerated Death Benefit proceeds does not affect your Accidental Death and Dismemberment Insurance. Thus, if you should die in an accident after receiving Accelerated Death Benefit Proceeds, your Accidental Death and Dismemberment Insurance will be based on your Life Insurance in force prior to the Accelerated Death Benefit payout, provided your premium is not being waived.

LIFE INSURANCE

Accidental Death & Dismemberment (AD&D) Insurance

ReliaStar Life pays this benefit if you suffer a covered loss due to a covered accident. All of the following conditions must be met:

- You are covered for AD&D Insurance on the date of the accident.
- Loss occurs within 180 days of the date of the accident.
- The cause of the loss is not excluded.

ReliaStar Life pays the benefit shown below if you suffer any of the losses listed. The Full Amount is shown on the Schedule of Benefits. ReliaStar Life pays only one Full Amount while the Group Policy is in effect. If you have a loss for which ReliaStar Life paid 1/2 of the Full Amount, ReliaStar Life pays no more than 1/2 of the Full Amount for the next loss.

For:	The benefit is:
Loss of life	Full Amount
Loss of both hands, both feet or sight of both eyes	Full Amount
Loss of one hand and one foot	Full Amount
Loss of speech and hearing in both ears	Full Amount
Loss of one hand or one foot and sight of one eye	Full Amount
Loss of one hand or one foot or sight of one eye	1/2 Full Amount
Loss of speech	1/4 Full Amount
Loss of hearing in both ears	1/4 Full Amount
Loss of thumb and index finger of same hand	1/4 Full Amount
Quadriplegia	Full Amount
Paraplegia	1/2 Full Amount
Hemiplegia	1/2 Full Amount

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed.

Quadriplegia means total paralysis of all four limbs. **Paraplegia** means total paralysis of both lower limbs. **Hemiplegia** means paralysis of one arm and one leg on the same side of the body.

Paralysis must be the result of a spinal cord injury which is due to an accident. ReliaStar Life does not pay an AD&D benefit for any paralysis caused by a stroke. Paralysis must be determined by competent medical authority to be permanent, complete and irreversible.

ReliaStar Life does not pay a benefit for loss of use of the hand or foot or thumb and index finger.

LIFE INSURANCE

Death benefits are paid to your beneficiary. All other benefits are paid to you.

Exposure and Disappearance Benefit
ReliaStar Life pays an **Exposure** benefit if:
- the loss is from injury caused by exposure to the elements, and
- is the result of a covered accident.

ReliaStar Life pays a **Disappearance** benefit if:
- you are in a conveyance, including but not limited to an automobile, airplane, ship or train, that disappears, sinks or wrecks; and
- you disappear and your body is not found, and the disappearance is the result of a covered accident; and
- a reasonable period of time, but no more than one year, has lapsed since the accident, and
- ReliaStar Life has reviewed all evidence and there is no reason to believe that you are living.

The amount payable for the Exposure benefit is contained in the table above. The amount payable for the Disappearance benefit is the AD&D benefit for loss of life. If benefits are paid for Exposure or Disappearance, no other AD&D benefits will be payable under the Group Policy.

Exposure benefits are paid to you if living, otherwise to your beneficiary. Disappearance benefits are paid to your beneficiary.

If ReliaStar Life pays the Disappearance benefit and it is later found you are alive, the amount of benefits paid must be refunded to ReliaStar Life.

Safe Driver Benefit
ReliaStar Life pays a **Safe Driver** benefit in addition to the AD&D benefit and subject to the exclusions listed below if you were:
- killed due to an automobile accident, and
- wearing a properly fastened safety belt at the time of the accident.

An additional amount will be paid if you were also driving in or riding in an automobile equipped with a factory installed airbag that operated properly upon impact.

For loss of:	**The benefit is:**
Life (with safety belt only)	An additional 10% of Full Amount of AD&D Insurance up to a maximum of $25,000
Life (with safety belt and airbag)	An additional 15% of Full Amount of AD&D Insurance up to a maximum of $40,000

LIFE INSURANCE

Automobile means any self-propelled private passenger vehicle which has four or more tires and which is not being used for commercial purposes. **Safety belt** means a passenger restraint system properly installed in the vehicle in which you were riding. **Airbag** means an additional restraint system which inflates for added protection to the head and chest areas.

ReliaStar Life will not pay the Safe Driver benefit if the loss of life was in consequence of your being intoxicated or under the influence of any controlled substance unless administered on the advice of a doctor.

Safe Driver benefits are paid to your beneficiary.

Coma Benefit
ReliaStar Life pays a **Coma** benefit if, due to an accident, you are in a coma. Coma benefit payments will stop when you are no longer in a coma or when maximum benefits have been paid, whichever comes first.

In the event of:	**The benefit is:**
Coma	An additional 2% of Full Amount of AD&D Insurance per month for up to 12 months to a total maximum of $24,000

Coma means that you remain unresponsive to any stimuli and speechless for a period of time not less than 30 days, as determined by a competent medical authority.

If you are physically and mentally incapable of receiving and cashing Coma benefit payments, then the payments instead will be made to a person legally authorized to receive the payments on your behalf.

Education Benefit
ReliaStar Life pays an **Education** benefit in addition to the AD&D benefit and subject to the conditions below if you die due to an accident. This benefit will be paid at the end of each annual period following your death to your dependent who is enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond grade 12 within 365 days following the date of your death. Benefit payments will stop if either of the following is true during the preceding annual period –

- the student's full-time school attendance is less than 6 months; or
- the student would no longer be considered your eligible dependent under the definition of dependent in the policy.

For:	**The benefit is:**

LIFE INSURANCE

Education ..... An additional 5% of Full Amount of AD&D Insurance per year for up to 4 years to a maximum of $3,000 per year

Education benefits are paid to each eligible dependent student, or to the dependent's legal guardian.

Transportation Benefit
ReliaStar Life pays a **Transportation** benefit in addition to the AD&D benefit if you die due to an accident that occurs at least 75 miles from your primary residence.

For: **The benefit is:**

Transportation ..... An additional 2% of Full Amount of AD&D Insurance up to a maximum of $2,000

Transportation benefits are paid to your beneficiary.

Child Care Benefit
ReliaStar Life pays a **Child Care** benefit in addition to the AD&D benefit if you die due to an accident, and your dependent child under age 13 years is enrolled in a licensed day care center within 90 days of your death. This benefit is paid on behalf of each eligible dependent child at the end of each annual period following your death. Benefit payments will stop if either of the following is true during the preceding annual period –

- your dependent child does not attend a licensed day care center for at least 1000 hours; or
- your dependent child is not under age 13 years for any part of that year.

For: **The benefit is:**

Child Care ..... An additional 3% of Full Amount of AD&D Insurance per year for up to 6 years to a maximum of $2,000 per year

Child Care benefits are paid to the person who has incurred the cost of day care expenses for your eligible dependent child.

LIFE INSURANCE

Common Carrier Benefit
ReliaStar Life pays a **Common Carrier** benefit in addition to the AD&D benefit if you suffer a covered loss due to an accident, and the loss occurs while traveling:
- as a fare paying passenger,
- in or on or entering into or alighting from a public conveyance, and
- the public conveyance is operated by a licensed common carrier for passenger service.

For:	**The benefit is:**
Common Carrier	An additional AD&D Amount equal to 50% of the AD&D amount otherwise payable for this loss up to a maximum of $50,000

Common Carrier benefits are paid to you if living, otherwise to your beneficiary.

Occupational Assault Benefit
ReliaStar Life pays an **Occupational Assault** benefit in addition to the AD&D benefit if you suffer a covered loss due to an accident, **and:**
- the loss is due to an intentional and unlawful act of physical violence directed at you by another person,
- you are actively at work, performing assigned duties on behalf of the Participating Employer at the time of the assault, and
- a report of criminal activity has been filed on your behalf with the appropriate law enforcement authority within 48 hours of the assault.

For loss due to:	**The benefit is:**
Occupational Assault	An additional AD&D Amount equal to the AD&D amount otherwise payable for this loss up to a maximum of $10,000

Occupational Assault benefits are paid to you if living, otherwise to your beneficiary.

Brain Damage Benefit
ReliaStar Life pays a **Brain Damage** benefit if, due to an accident, you sustain an injury which, independently of all other causes, directly results in traumatic brain injury causing brain damage.

The benefit will be payable if:
- the brain damage begins within 365 days of the accident; and
- the brain damage continues for 12 consecutive months; and

- you are hospitalized for at least 7 days within the first 365 days following the accident for treatment related to the accident; and
- a qualified doctor certifies that the brain damage is permanent and irreversible at the end of the 12 consecutive months, and the certification is deemed satisfactory to ReliaStar Life.

In the event of:	**The benefit is:**
Brain Damage	An additional 2% of Full Amount of AD&D Insurance per month for up to 50 months

Brain Damage means physical assault to the brain tissue to the extent that you are considered to be in a vegetative state, as determined by a competent medical authority.

Payment of this benefit, plus any other benefits payable as a result of the same accident, will not exceed the full AD&D benefit you are eligible to receive under the Group Policy.

If you are physically and mentally incapable of receiving and cashing Brain Damage benefit payments, then the payments instead will be made to a person legally authorized to receive the payments on your behalf.

Line of Duty Benefit
ReliaStar Life pays a **Line of Duty** benefit in addition to the AD&D benefit if you die or suffer a covered loss as the result of a covered accident that occurred while you were performing in your own occupation and while in the line of duty.

Line of Duty means any action that you are authorized or obligated to perform by law, rule, regulation or condition of employment or service.

For:	**The benefit is:**
Line of Duty	An additional 50% of the amount of AD&D Insurance otherwise payable for this loss up to a maximum of $50,000

Accidental Death and Dismemberment Exclusions
ReliaStar Life does not pay benefits for loss directly or indirectly caused by any of the following:
- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning. **Exception:** Infection from a cut or wound caused by an accident.
- Riding in or descending from an aircraft as a pilot or crew member.

- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury suffered while in the military service for any country or government.
- Injury which occurs when you commit or attempt to commit a felony.
- Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

ReliaStar Life does not pay benefits for loss sustained or contracted in consequence of your being under the influence of any controlled substance unless administered on the advice of a doctor.

Dependent's Life Insurance

ReliaStar Life pays a death benefit in the amount of the Dependent's Life Insurance shown on the Schedule of Benefits. ReliaStar Life pays according to the Schedule of Benefits in effect on the date your insured dependent dies.

ReliaStar Life pays the death benefit for all causes of death. However, if your insured dependent, while sane or insane, commits suicide within 2 years from the date his or her coverage starts, ReliaStar Life will refund the amount of premiums already paid for Dependent Life Insurance instead of paying a death benefit.

ReliaStar Life requires that proof of your insured dependent's death be mailed to ReliaStar Life at its Home Office.

ReliaStar Life pays benefits for your insured dependent's death to you, if you are living on the earlier of the following:

- The date ReliaStar Life receives proof of your insured dependent's death at its Home Office.
- The tenth day after your insured dependent's death.

If you are not living on either of these dates, ReliaStar Life pays the proceeds to the following in the order listed:

1. Your spouse or domestic partner if living.
2. Your estate.

Dependent Spouse or Domestic Partner Accelerated Death Benefit

NOTE: AT THIS TIME IT IS UNCLEAR WHETHER YOU WILL BE REQUIRED TO PAY TAX ON ACCELERATED DEATH BENEFIT PROCEEDS. YOU SHOULD CONSULT WITH YOUR PERSONAL TAX ADVISER TO ASSESS POSSIBLE TAX IMPLICATIONS.

ReliaStar Life pays this benefit if it has been determined that your insured dependent spouse or domestic partner has a terminal condition.

LIFE INSURANCE

Dependent Spouse or Domestic Partner Accelerated Death Benefit proceeds is the amount ReliaStar Life pays to you or your legal representative when it has been determined that your insured dependent spouse or domestic partner has a terminal condition. The Dependent Spouse or Domestic Partner Accelerated Death Benefit proceeds are paid in one lump sum and are paid only once. This lump sum payout is the only Settlement Option available to you prior to your insured dependent spouse's or domestic partner's death.

LIFE INSURANCE

The Dependent Spouse or Domestic Partner Accelerated Death Benefit is the amount of the Dependent Spouse or Domestic Partner Accelerated Death Benefit shown on the Schedule of Benefits in effect on the date you apply for Dependent Spouse or Domestic Partner Accelerated Death Benefit proceeds. You will not be able to increase your contributory Dependent Spouse or Domestic Partner Life Insurance benefit after the time you apply for the Dependent Spouse or Domestic Partner Accelerated Death Benefit, unless you are determined to be ineligible to receive Dependent Spouse or Domestic Partner Accelerated Death Benefit proceeds.

To receive the Dependent Spouse or Domestic Partner Accelerated Death Benefit, **all** of the following conditions must be met. You must:

- request this benefit in writing while your insured dependent spouse or domestic partner is living. If you are unable to request this benefit yourself, your legal representative may request it for you.
- be insured for Dependent Spouse or Domestic Partner Life Insurance benefits.
- have Dependent Spouse or Domestic Partner Life Insurance benefits of at least $10,000 as shown on the Schedule of Benefits.
- provide to ReliaStar Life a doctor's statement which gives the diagnosis of your insured dependent spouse's or domestic partner's medical condition; and states that because of the nature and severity of such condition, life expectancy is no more than 6 months. ReliaStar Life may require that your insured dependent spouse or domestic partner be examined by a doctor of its choosing. If ReliaStar Life requires this, ReliaStar Life pays for the exam.

Benefit Payment

ReliaStar Life pays the Dependent Spouse or Domestic Partner Accelerated Death Benefit proceeds to you unless both of the following are true:

- It is shown, to the satisfaction of ReliaStar Life, that you are physically and mentally incapable of receiving and cashing the lump sum payment.
- A representative appointed by the courts to act on your behalf does not make a claim for the payment.

If ReliaStar Life does not pay you because the two above conditions apply, payments instead will be made to one of the following:

- A person who takes care of you.
- An institution that takes care of you.
- Any other person ReliaStar Life considers entitled to receive the payments as your trustee.

LIFE INSURANCE

Dependent Spouse or Domestic Partner Accelerated Death Benefit Exclusions

ReliaStar Life does not pay benefits for a terminal condition if either of the following apply:

- the required Dependent Spouse or Domestic Partner Accelerated Death Benefit premium or Life Insurance premium is due and unpaid.
- the terminal condition is directly or indirectly caused by attempted suicide or intentionally self-inflicted injury, whether sane or insane.

Effects on Coverage

When ReliaStar Life pays out this benefit, your dependent spouse or domestic partner coverage is affected in the following ways:

- Your total available benefit equals your amount of Dependent Spouse or Domestic Partner Life Insurance shown on the Schedule of Benefits at the time you apply for the Dependent Spouse or Domestic Partner Accelerated Death Benefit.
- Your Dependent Spouse or Domestic Partner Life Insurance benefit is reduced by the Dependent Spouse or Domestic Partner Accelerated Death Benefit proceeds paid out under this provision.
- Your Dependent Spouse or Domestic Partner Life Insurance benefit amount which you may convert is reduced by the Dependent Spouse or Domestic Partner Accelerated Death Benefit proceeds paid out under this provision.
- You will not be able to increase your contributory Dependent Spouse or Domestic Partner Life Insurance benefit after ReliaStar Life approves the Dependent Spouse or Domestic Partner Accelerated Death Benefit.
- Your premium is based upon the amount of your Dependent Spouse or Domestic Partner Life Insurance benefit in force prior to any proceeds paid under this Accelerated Death Benefit provision. Such premium must be paid to keep the Dependent Spouse or Domestic Partner Life Insurance coverage in force.
- Your remaining Dependent Spouse or Domestic Partner Life Insurance benefit is subject to future age reductions.
- You will not be able to reinstate your Dependent Spouse or Domestic Partner Life Insurance coverage to its full amount in the event of your spouse's or domestic partner's recovery from a terminal condition.

CONVERSION RIGHTS

Life Insurance
You or your insured dependent may convert this insurance to an individual life insurance policy if any part of your or your insured dependent's Life Insurance under the Group Policy stops. Proof of good health is not required.

Conditions for Conversion
You or your insured dependent may convert this Life Insurance if it stops for any of the following reasons:

- For coverage not continued under the portability option, you are no longer actively at work.
- For coverage not continued under the portability option, you are no longer eligible for Employee's Insurance under the Group Policy.
- For coverage continued under the portability option, you have reached the maximum age limit under the Group Policy.
- The Group Policy is changed or cancelled, and your Life Insurance under the Group Policy has been in effect for at least 5 years in a row.
- For your Life Insurance –
  - the amount of Life Insurance is reduced.
  - the premium is no longer being waived under the Waiver of Life Insurance Premium Disability Benefit, and your group Life Insurance stops.
- For your dependent's Life Insurance –
  - your dependent's Life Insurance stops.
  - your dependent is no longer a dependent as defined.
  - your dependent's Life Insurance shown on the Schedule of Benefits is reduced.
  - your Life Insurance premiums are waived because of total disability.
  - if you divorce, your insured spouse may convert.
  - if you terminate your domestic partnership, your insured domestic partner may convert.
  - you die.

You or your insured dependent may convert this insurance by applying and paying the first premium for an individual policy within 31 days after any part of your or your insured dependent's insurance stops.

If you or your insured dependent are not given notice of this conversion right within 16 days after any part of this insurance stops, you or your insured dependent will have more time to apply and pay the first premium for the individual policy. This additional time period will end 25 days after you or your insured dependent is given notice of this conversion right. In no event will the additional time period extend for more than 91 days after any part of your Life Insurance or Dependent's Life Insurance stops.

CONVERSION RIGHTS

ReliaStar Life or the Policyholder must be notified if you or your insured dependent wishes to convert. ReliaStar Life will supply you or your insured dependent with a conversion form to complete and return.

If your insured dependent is too young to contract for life insurance, the following people may apply in this order:
1. You, while living.
2. Your spouse or domestic partner, while living.
3. The court-appointed guardian of your insured dependent.

Type of Converted Policy
You or your insured dependent may purchase any individual nonparticipating policy offered by ReliaStar Life, except term insurance. The new policy must provide for a level amount of insurance and have premiums at least equal to those of ReliaStar Life's whole life plan with the lowest premium.

If your previous coverage included additional benefits such as disability, Accidental Death and Dismemberment Insurance or the Accelerated Death Benefit, the new insurance will not include these benefits.

Amount of Conversion Coverage
If your or your insured dependent's Life Insurance is changed or cancelled because the Group Policy is changed or cancelled, and your Life Insurance under the Group Policy has been in effect for at least 5 years in a row, the amount of the individual policy is limited to the lesser of –
- $5,000 or
- the amount of your or your insured dependent's Life Insurance which stops, minus the amount of other group insurance for which you or your insured dependent becomes eligible, within 31 days of the date your or your insured dependent's insurance stops.

If your or your insured dependent's Life Insurance stops for any reason other than the above, the amount of your or your insured dependent's individual policy may be any amount up to the amount of your or your insured dependent's Life Insurance that stopped.

Effective Date
The new policy takes effect 31 days after the part of your or your insured dependent's Life Insurance being converted stops.

If you or your insured dependent dies within the 31-day period allowed for making application to convert, ReliaStar Life will pay a death benefit to your or your insured dependent's beneficiary in the amount you or your insured dependent were entitled to convert. ReliaStar Life will pay the amount whether or not application was made. ReliaStar Life will return any premium paid for the individual policy to your or your insured dependent's beneficiary named under the Group Policy.

CONVERSION RIGHTS

Premiums
Premiums for the new policy are based on your or your insured dependent's age on the date of conversion.

CLAIM PROCEDURES

Submitting a Claim
You, your insured dependent or someone on your behalf must send ReliaStar Life written notice of the loss on which your claim will be based. The notice must –

- include information to identify you or your insured dependent, like your name, address and Group Policy number.
- be sent to ReliaStar Life or to the authorized administrator.
- be sent within 91 days after the loss for which claim is based has occurred or as soon as reasonably possible.

Claim Forms
ReliaStar Life or its authorized administrator will send proof of loss claim forms within 15 days after ReliaStar Life receives notice of claim.

Completed proof of loss claim forms or other written proof of loss detailing how the loss occurred must be sent to ReliaStar Life within 91 days after the loss or as soon as reasonably possible.

GENERAL PROVISIONS

Life Insurance Assignment
You can change the owner of your Life Insurance under the Group Policy by sending ReliaStar Life written notice. This change is an absolute assignment. You cannot make an absolute assignment to the Policyholder or the Participating Employer. You transfer all your rights and duties as owner to the new owner. The new owner can then make any change the Group Policy allows. A request for an absolute assignment –

- does not change the insurance or the beneficiary.
- applies only if ReliaStar Life receives your notice.
- takes effect from the date signed.
- does not affect any payment ReliaStar Life makes or action ReliaStar Life takes before receiving your notice.

A collateral assignment is not allowed.

ReliaStar Life assumes no responsibility for the validity of any assignment. You are responsible to see that the assignment is legal in your state and that it accomplishes the goals that you intend.

Legal Action
Legal action may not be taken to receive benefits until 60 days after the date proof of loss is submitted according to the requirements of the Group Policy. Legal action must be taken within 3 years after the date proof of loss must be submitted.

If the Policyholder's state requires longer time limits, ReliaStar Life will comply with the state's time limits.

Exam and Autopsy
For AD&D Insurance, when reasonably necessary, ReliaStar Life may have you examined while a claim is pending under the Group Policy. ReliaStar Life pays for the initial exam. ReliaStar Life may have an autopsy made if you die, if not forbidden by state law.

Incontestability
Your and your dependent's insurance has a contestable period starting with the effective date of your insurance and continuing for 2 years while you are living. During that 2 years, ReliaStar Life can contest the validity of your and your dependent's insurance because of inaccurate or false information received relating to your and your insured dependent's insurability. Only statements that are in writing and signed by you or your insured dependent can be used to contest the insurance.

DEFINITIONS

Accident – an unexpected, external, violent and sudden event.

Active Work, Actively at Work – the employee is physically present at his or her customary place of employment with the intent and ability of working the scheduled hours and doing the normal duties of his or her job on that day.

Child –
- your natural or adopted child, who is dependent on you for support and maintenance.
- a child who is placed in your physical custody for purposes of adoption.
- a child who is your stepchild, your domestic partner's child, your foster child, or a child for whom you are legal guardian, who is primarily dependent on you for support and lives with you in a permanent parent-child relationship.

Dependent –
- your lawful spouse.
- your domestic partner, as defined.
- your unmarried child until 21 years of age.
- your unmarried child 21 years of age but less than 23 years of age, who is a student dependent.

The term "dependent" does not include –
- a spouse, domestic partner, or child living outside the United States.
- a spouse, domestic partner, or child eligible for Employee's Insurance under the Group Policy.
- a spouse, domestic partner, or child on active military duty.
- a parent of you or your spouse or domestic partner.
- a spouse, domestic partner, or child who does not give proof of good health when asked, or whose proof is not accepted.

Domestic Partner – another adult with whom you have a Declaration of Domestic Partnership registered with the California Secretary of State. A copy of the certified registration may be required as proof.

Employee – an active employee residing in the United States who is employed by the City of Mission Viejo (a Participating Employer) and is regularly scheduled to work on at least a 20-hour-per-week basis. Temporary and seasonal employees are excluded.

Group Policy – the written group insurance contract between ReliaStar Life and the Policyholder.

DEFINITIONS

Nonworking Day – a day on which the employee is not regularly scheduled to work, including time off for the following:
- Vacations.
- Personal holidays.
- Weekends and holidays.
- Approved nonmedical leave of absence.
- Paid Time Off for nonmedical-related absences.

Nonworking day does not include time off for any of the following:
- Medical leave of absence. Time off for a medical leave of absence will be considered a scheduled working day.
- Temporary layoff.
- The Policyholder suspending its operations, in part or total.
- Strike.

Policyholder – CSAC Excess Insurance Authority. A Participating Employer is defined as a unit of government who has subscribed to the agreement establishing the CSAC Excess Insurance Authority.

ReliaStar Life – ReliaStar Life Insurance Company, at its Home Office in Minneapolis, Minnesota.

Spouse – your lawful husband or wife.

Student Dependent – a dependent who has his or her chief place of residence with you, does not have a regular full-time job and is a full-time student physically attending classes at a school with a regular teaching staff, curriculum and student body.

ReliaStar Life considers full-time to be the number of credits or courses required for full-time students by the school your dependent is attending.

Terminal Condition – an injury or sickness which is expected to result in your or your insured dependent spouse's or domestic partner's death within 6 months and from which there is no reasonable chance of recovery. ReliaStar Life, or a qualified party chosen by ReliaStar Life, will make this determination.

Total Disability, Totally Disabled – your inability, due to sickness or accidental injury, to work at or perform the material and substantial duties of any job suited to your education, training or experience.

Written, In Writing – signed, dated and received at ReliaStar Life's Home Office in a form ReliaStar Life accepts.

You, Your – an employee insured for Employee's Insurance under the Group Policy.

Plan for the future with confidence

By taking the time to understand your personal situation, our Retirement Specialists can provide the guidance you need to:

- Identify your retirement goals
- Develop a personalized retirement plan
- Keep track of your plan over time

We are committed to putting you first — because what matters is where you want to go and how you're going to get there.

This material is not a recommendation to buy or sell a financial product or to adopt an investment strategy. Investors should discuss their specific situation with their financial professional.

Have questions? Your Nationwide Retirement Specialist is here to help.

Douglas Rhyu
(714) 504-8312
rhyud@nationwide.com

Retirement Resource Group
(888) 401-5272
nrsforu@nationwide.com

To schedule an individual appointment, scan this code.

NRM-10100AO.6 (11/22)

Nationwide®

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Concern
Real help, real experts, real fast.

City of Mission Viejo

Your all-in-one mental health, employee wellbeing solution at no cost to you or your family.

GETTING STARTED IS EASY

Just call 800-344-4222 24/7 or visit employees.concernhealth.com* and log in with your company code **Cityofmissionviejo.** Then click on "Get Services" to create your confidential digital dashboard. Check out this video* for a brief introduction to Concern.

HELP WHEN YOU NEED IT*

Confidential Counseling*

In-person, Telephone, Video, Text, Chat

Experienced, licensed counselors help with:

- Stress, anxiety
- Major life changes
- Communication
- Grief and loss
- Relationships
- Substance abuse
- Emotional wellbeing
- Job stress

Parent Coaching

Experienced parent coaches can help you understand the issues, guide you in making decisions and provide you with the tools to help you create healthier, more fulfilling relationships with your children.

In-the-Moment Support

In distress or just want to talk? Maybe you're worried about kids, anxious about work, or had a fight with a family member. A Concern counselor is here to listen and help you plan a positive next step.

Work-Life Resources

Receive expert guidance for life's expected and unexpected events, helping you find a happier balance at home and less distraction at work. Help with financial* issues, legal* concerns, adult care* resources, parenting and childcare* referrals.

Guided Mindfulness

Full suite of live and on-demand mindfulness solutions designed for daily use. Discover resources to help you build and sustain healthy habits. Access through your digital dashboard.

YOUR BENEFITS

Available to all budgeted position employees working 20 or more hours per week, all hourly/seasonal employees working 30 or more hours per week, City Council Members, your spouse/domestic partner, and dependent children up to age 26.

- Counseling. Up to **5** visits per person, per issue, per 12-month period.
- Parent Coaching. Three free telephonic sessions per year with an experienced certified coach.
- Financial. Free one to two 30-minute phone consultations with a financial specialist.
- Legal. Free 30-minute consultations with a qualified attorney. 25% discount off normal hourly rates if you retain their services.

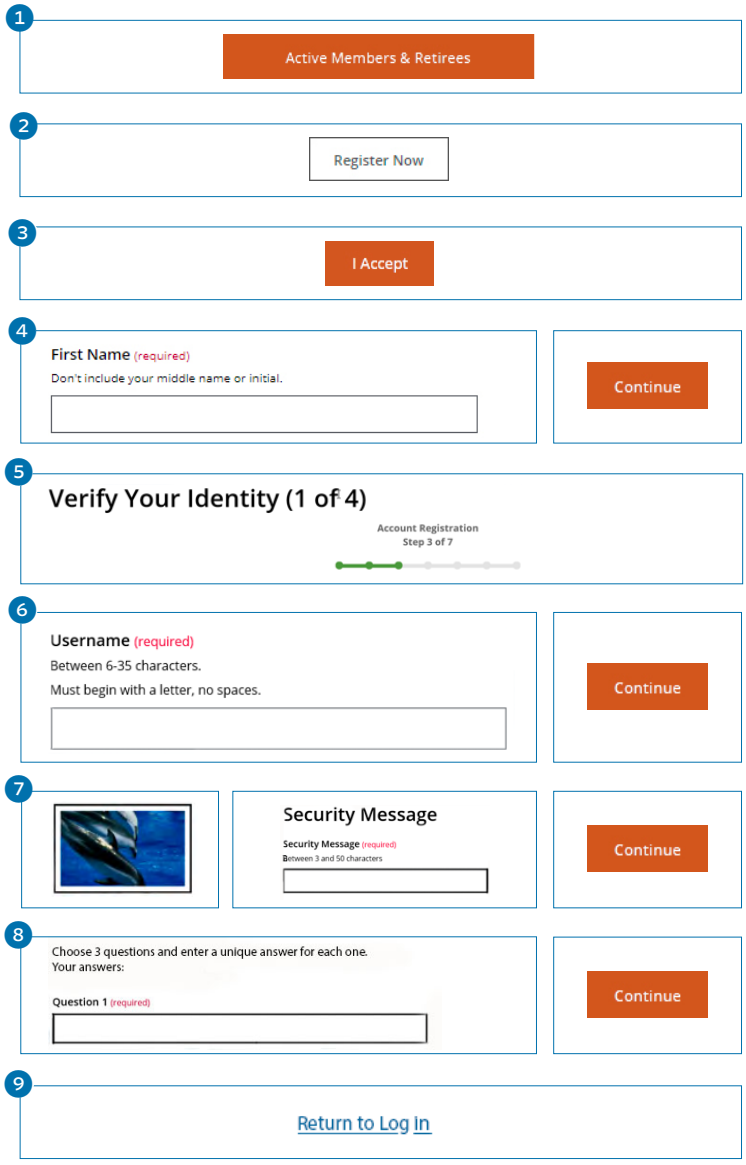
**Open links for more detail*

How to Register for myCalPERS

Not registered yet?

Go to **my.calpers.ca.gov** and follow these steps:

1. Select **Active Members & Retirees**.
2. Select **Register Now**.
3. Accept the terms and conditions under the Security Agreement.
4. Identify yourself. Then, select **Continue.**
5. Verify your identity by answering a set of questions.
6. Create a Username and Password. Enter your email address. Then, select **Continue**.
7. Choose a security image. Enter a **Security Message.** Then, select **Continue.**
8. Choose your security questions and answers. Then, select **Continue**.
9. When your registration is complete, select **Return to Log In**.



CalPERS

Can't remember your username or password? See reverse side »

How to Access myCalPERS

Recover Your Username

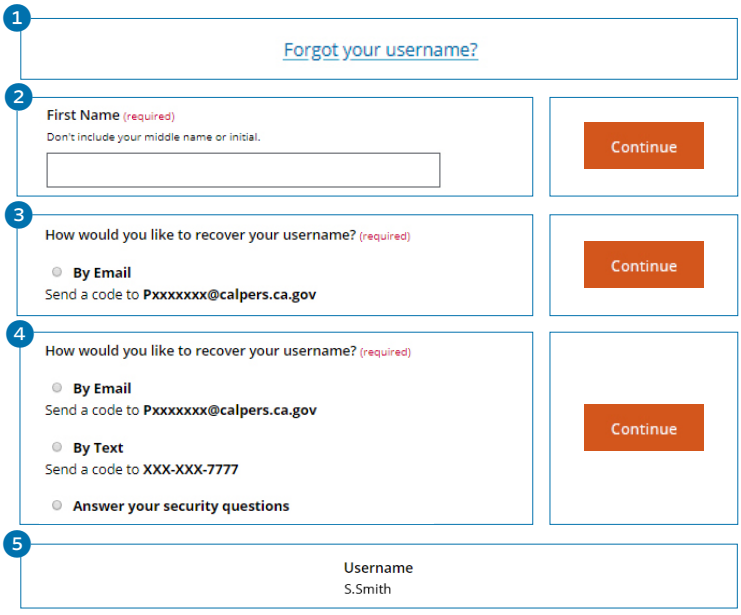
Reset Your Password

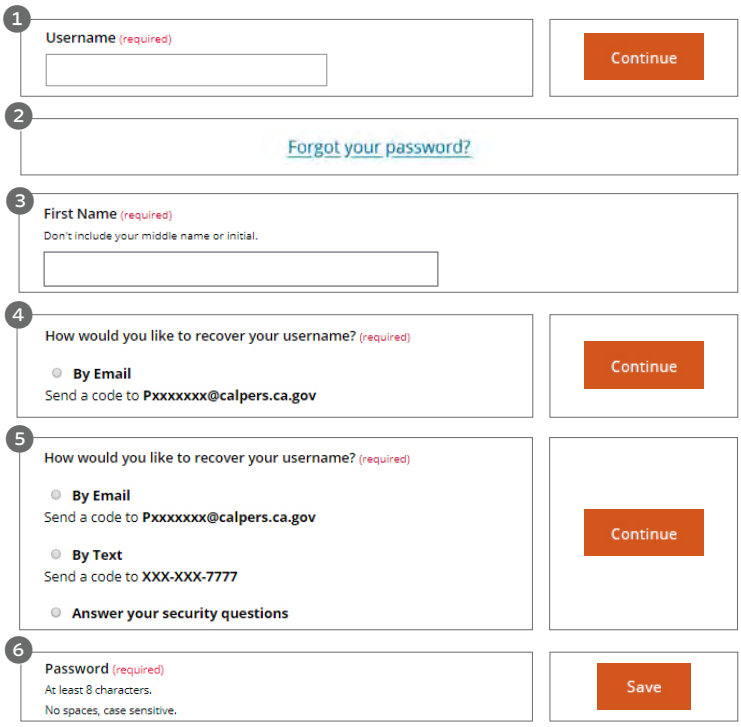
Recover Your Username

1. Select **Forgot Your Username?**
2. Identify yourself. Then, select **Continue**.
3. Select how you'd like to recover your username, then select **Continue**.
4. If you selected
   - **By Email:** enter the code you received, then select **Continue**.
   - **By Text:** enter the code you received, then select **Continue**.
   - **Answer your security questions:** enter your answers, then select **Continue**.
5. Your username displays on the following page.

Reset Your Password

1. Enter your username, then select **Continue.**
2. Select **Forgot your password?**
3. Identify yourself.
4. Select how you'd like to reset your password, then select **Continue**.
5. If you selected
   - **By Email:** enter the code you received, then select **Continue**.
   - **By Text:** enter the code you received, then select **Continue**.
   - **Answer your security questions:** enter your answers, then select **Continue**.
6. Create a new password, then select **Save.**





Printed at CalPERS – January 2020

Not registered yet? See reverse side »

Welcome to CalPERS

A Benefits Guide for
Public Agency Members

explore

plan

Explore and plan for your secure retirement

CalPERS

Welcome to CalPERS

We're here to make sure you enjoy financial security when you retire from your public service career.

This publication answers some of the questions you may have as a public agency CalPERS member. We'll describe how your pension is funded, the basics of your retirement benefits, and frequently asked questions from members like you.

Explore and plan for your secure retirement.

Contents

Get Familiar With CalPERS

CalPERS at a Glance

The California Public Employees' Retirement System (CalPERS) is the nation's largest public pension system, with more than 2 million members from California's state, school, and public agency employers. The 13-member Board of Administration governs CalPERS and administers benefits under the California Public Employees' Retirement Law.

CalPERS administers retirement benefits for three groups of public employees:

- **State of California employees**
  includes California State University
- **School employees**
  classified employees in non-certificated positions
- **Public agency employees**
  employed by local agencies that contract with CalPERS

CalPERS Public Agency Members

Public agency employees are grouped into two categories of CalPERS membership:

Local miscellaneous
Members employed by a public agency or special district that has contracted with CalPERS, and who are **not** involved in law enforcement, fire suppression, the protection of public safety, or employed in a position designated by law as local safety

Local safety
Members employed by a public agency or special district that has contracted with CalPERS, and who are involved in law enforcement, fire suppression, the protection of public safety, or employed in a position designated by law as local safety

If you have questions about your CalPERS membership, please contact your employer.

Pension and Retirement Benefits

CalPERS Defined Benefit Plan

In a defined benefit retirement plan, pension payments are determined by a set formula and are payable for life. This contrasts with a defined contribution plan (like a 401(k) or 457 plan), in which benefits are determined not by a formula, but solely by the amount of contributions in an account, plus earnings.

How Your Pension Is Funded

Three sources fund a defined benefit retirement plan like CalPERS:

- **CalPERS members** – Employees generally make contributions from their paycheck into the CalPERS fund. The percentage you contribute is defined by law and your bargaining unit.
- **CalPERS employers** – Additional funding is provided by employer contributions.
- **CalPERS investment earnings** – This funding source makes up the largest contribution to the fund with earnings from CalPERS investments in stocks, bonds, real estate, and other investment types.

What companies does CalPERS invest in?

Our investment portfolio is diversified into several asset classes. To learn more, go to **www.calpers.ca.gov/investments**.

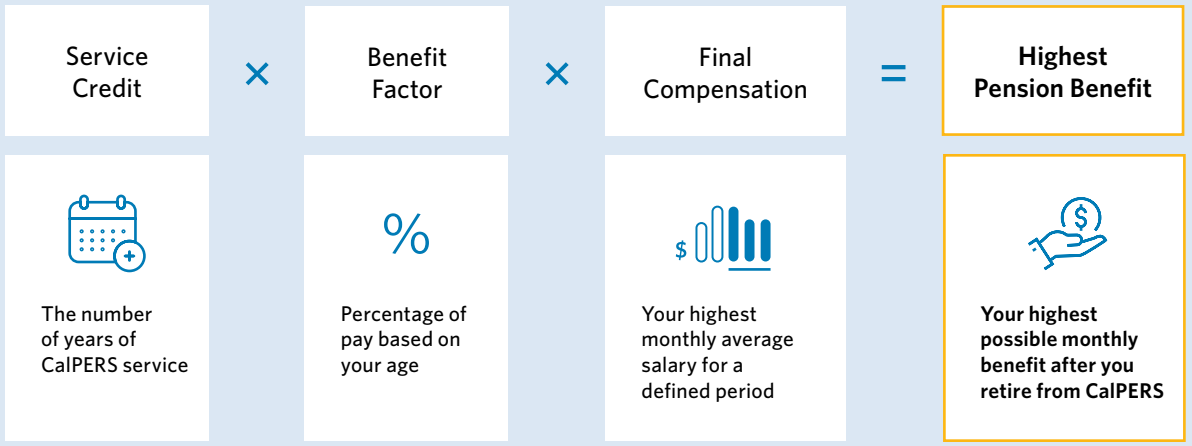
How Your Pension Is Calculated

We use three factors to calculate your service retirement pension:

- **Service credit** – This is your total years of CalPERS service, including partial years. Your service credit accumulates on a fiscal year basis, which is July 1 through June 30.
- **Benefit factor** – This is the percentage of pay to which you are entitled for each year of service, based on your age at retirement.
- **Final compensation** – This is your highest average annual compensation earnable during any consecutive 12-month or 36-month period of employment.

The basic retirement calculation is shown on the next page.

Basic Retirement Calculation



Service Credit

Service credit is the number of years, including partial years, you have worked and contributed to CalPERS.

To earn a full year of service credit during a fiscal year, you must work at least:

- 1,720 hours (hourly pay employees)
- 215 days (daily pay employees)
- 10 months (full-time monthly employees)

You cannot earn more than one year of service credit in one fiscal year. If you work part time or less than eight hours per day, it will take you longer to earn one year.

You can view your current service credit at any time by logging in to myCalPERS at **my.calpers.ca.gov** or by referring to your CalPERS Annual Member Statement to verify your service credit total.

Service Credit Purchase

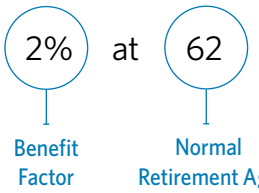
In some cases, you may be eligible to purchase other types of service credit to help maximize your retirement benefits. Some of these types of service include redeposit of contributions previously withdrawn from CalPERS, prior service with a CalPERS employer, certain types of leaves of absence, and more.

For information about types of service credit available to purchase, see our publications ***Service Credit Purchase Options*** (PUB 12) and ***Military Service Credit Options*** (PUB 15).

Benefit Factor

Your benefit factor, sometimes called "age factor," is the percentage of pay you are entitled to for each year of CalPERS-covered service. It's determined by your age at retirement and your retirement formula. The benefit factor changes for every quarter year of age based on the retirement formula.

If your retirement formula is 2% at 62, for example, this means you get 2% of your pay if you retire at age 62. Age 62 is referred to as your "normal retirement age."



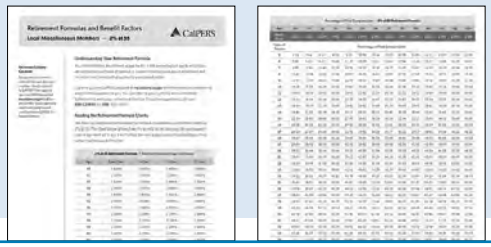
Local miscellaneous members receive one of six retirement formulas, with varying retirement ages and final compensation percentages. Most miscellaneous members hired after January 1, 2013, receive the 2% at 62 formula.

Local safety members receive one of eight retirement formulas, with varying retirement ages and final compensation percentages. The percentage of pay is limited for all the local safety benefit formulas **except** for 2% at 57, 2.5% at 57, and 2.7% at 57. If you have safety service with multiple employers and under different safety formulas, there could be more than one maximum benefit cap applied to your retirement allowance.

You can verify your retirement formula by logging in to myCalPERS at **my.calpers.ca.gov** or by referring to your CalPERS Annual Member Statement. You could have more than one formula depending on your membership date and number of employers.

View Benefit Factor Charts Online

Get a head start on your retirement planning. Go to **www.calpers.ca.gov/benefitcharts** to find the retirement formula charts for your benefit factor and final compensation.



Final Compensation

Your final compensation is your highest average annual compensation earnable during any consecutive 12-month or 36-month period of employment, depending on your membership date and employer's contract. Which compensation period we use depends on your retirement formula(s).

If you are an elected official or were appointed to a city council or county board of supervisors on or after July 1, 1994, your final compensation is based on the highest annual average compensation earnable during each period of state service you elected CalPERS optional membership.

We use your full-time pay rate, not your earnings. If you work part time, we will use your full-time equivalent pay rate to determine your final compensation. Your employer reports your payroll information to CalPERS, so if you have questions about the accuracy of your final compensation amount, or what can be reported to CalPERS under the law, please contact your employer.

Compensation Limits

The final compensation amount we can use to calculate your retirement benefit may be limited by Retirement Law, Internal Revenue Code (IRC) section 401(a)(17), or both. If your service is subject to the California Public Employees' Pension Reform Act (PEPRA), the annual compensation limit amounts are lower than the IRC compensation limits. These limits do not limit the salary your employer can pay, but rather limit the amount of compensation we can consider under your retirement plan. For more information about your retirement compensation limits, talk to your employer or go to **www.calpers.ca.gov**.

Special Compensation

Certain items such as special compensation earned during your final compensation period may be included in your final compensation. Contact CalPERS if you are not sure which items of special compensation can be included.

Retirement Eligibility

To be eligible for service retirement, you must have at least five years of CalPERS-credited service and be at least age 50 or 52, depending on your retirement formula. If you have a combination of classic and PEPRA service, you may be eligible to retire at age 50. (See page 12 for more about PEPRA.) There is no mandatory retirement age for local public agency members.

There are some exceptions to the five-year requirement. If you are employed on a permanent part-time basis and worked at least five calendar years, or you're a member with another California public retirement system, contact CalPERS to find out if an exception may apply to you.

If you are considering retiring, you will need to submit an application to CalPERS. To learn about the retirement options and application process, review our publications ***Planning Your Service Retirement*** (PUB 1) and ***Service Retirement Election Application*** (PUB 43).

Estimate Your Retirement

Do you want a retirement estimate that uses data your employer already reported to CalPERS? Log in to your myCalPERS account at **my.calpers.ca.gov** to get an estimate. You can generate a variety of scenarios and save them in myCalPERS for future reference.

Death Benefits

Before Retirement

If you pass away before you retire, CalPERS provides several benefits for your family or a beneficiary. The benefits range from a simple return of your contributions plus interest to a monthly allowance equal to half of what you would have received at retirement paid to a spouse or domestic partner.

To be eligible for a monthly pre-retirement death benefit, your spouse or domestic partner must have been either married to you or legally registered before the occurrence of the injury or the onset of the illness that resulted in your death, or for at least one year prior to your death.

Use the appropriate chart below to determine which pre-retirement death benefits your family and/or beneficiary **may** be eligible to receive.

Local Miscellaneous Members

Are You Eligible to Retire?

- Age 50 if you became a member on or before December 31, 2012 **or**
- Age 52 if you became a member on or after January 1, 2013

And have at least 5 years of CalPERS service or have worked part time for at least 5 years

No

Not eligible to retire,
but your beneficiary could receive:

1) Special Death Benefit*
If your death is the direct result of a violent act while performing your official duties, a monthly allowance equal to 50% of your highest final compensation with this employer for spouse's lifetime or to eligible children until age 22

Or

2) Basic Death Benefit
Your beneficiary will receive a lump-sum payment of:

- A refund of your contributions, plus interest; and
- Up to six months' pay

Yes

Eligible to retire,
and your beneficiary could receive:

1) Special Death Benefit*
If your death is the direct result of a violent act while performing your official duties, a monthly allowance equal to 50% of your highest final compensation with this employer for spouse's lifetime or to eligible children until age 22

Or

2) Pre-Retirement Option 2W Death Benefit*
For eligible spouses and registered domestic partners, a monthly allowance equal to the amount you would have received if you had retired at your date of death and elected the 100% of the option portion of your ongoing monthly benefit

Graphic continued on next page...

* Talk to your employer to find out if they have contracted for this benefit.

Local Miscellaneous Members, *continued*

Are You Eligible to Retire?

No

And

3) 1959 Survivor Benefit*

If applicable, a monthly allowance for eligible survivors for members not covered by Social Security and not receiving the Special Death Benefit

Or

4) Limited Death Benefit

If you separate from employment for over 120 days, and your separation was not due to illness or injury, your beneficiary will receive a lump-sum payment of:

- A refund of your contributions, plus interest

Yes

Or

3) 1957 Survivor Benefit

For eligible children if there is no spouse, monthly allowance equal to half of what your unmodified allowance would have been at your date of death

Or

4) Basic Death Benefit

Your beneficiary will receive a lump-sum payment of:

- A refund of your contributions, plus interest; and
- Up to six months' pay (one month's salary for each year of current service, to a maximum of six months)

And

5) 1959 Survivor Benefit*

If applicable, a monthly allowance for eligible survivors for members not covered by Social Security and not receiving the Special Death Benefit

Or

6) Limited Death Benefit

If you separate from employment for over 120 days, and your separation was not due to illness or injury, your beneficiary will receive a lump-sum payment of:

- A refund of your contributions, plus interest

* Talk to your employer to find out if they have contracted for this benefit.

Local Safety Members

Are You Eligible to Retire?

- Age 50 **and**
- Have at least 5 years of CalPERS service or have worked part time for at least 5 years

No

Not eligible to retire,
but your beneficiary could receive:

1) **Alternate Death Benefit for Qualified Firefighters***
   For members with 20 or more years of CalPERS service, eligible spouses and registered domestic partners receive a monthly allowance equal to the amount you would have received if you had retired at age 50 or later and elected the 100% of the option portion of your ongoing monthly benefit. If no spouse or registered domestic partner, for eligible children, equal to half of what your unmodified retirement allowance would have been at your date of death until age 18.

Or

2) **Special Death Benefit**
   If your death is job-related, a monthly allowance equal to 50%–75% of your highest final compensation with this employer for spouse's lifetime or to eligible children until age 22

Or

Yes

Eligible to retire,
and your beneficiary could receive:

1) **Special Death Benefit**
   If your death is job-related, a monthly allowance equal to 50%–75% of your highest final compensation with this employer for spouse's lifetime or to eligible children until age 22

Or

2) **Pre-Retirement Option 2W Death Benefit***
   For eligible spouses and registered domestic partners, a monthly allowance equal to the amount you would have received if you had retired at your date of death and elected the 100% of the option portion of your ongoing monthly benefit

Or

3) **1957 Survivor Benefit**
   For eligible children if there is no spouse, monthly allowance equal to half of what your unmodified allowance would have been at your date of death

Or

Graphic continued on next page...

* Talk to your employer to find out if they have contracted for this benefit.

Local Safety Members, *continued*

Are You Eligible to Retire?

No

3) Basic Death Benefit

Your beneficiary will receive a lump-sum payment of:

- A refund of your contributions, plus interest; and
- Up to six months' pay

And

4) 1959 Survivor Benefit*

If applicable, a monthly allowance for eligible survivors for members not covered by Social Security and not receiving the Special Death Benefit

Or

5) Limited Death Benefit

If you separate from employment for over 120 days, and your separation was not due to illness or injury, your beneficiary will receive a lump-sum payment of:

- A refund of your contributions, plus interest

Yes

4) Basic Death Benefit

Your beneficiary will receive a lump-sum payment of:

- A refund of your contributions, plus interest; and
- Up to six months' pay

And

5) 1959 Survivor Benefit*

If applicable, a monthly allowance for eligible survivors for members not covered by Social Security and not receiving the Special Death Benefit

Or

6) Limited Death Benefit

If you separate from employment for over 120 days, and your separation was not due to illness or injury, your beneficiary will receive a lump-sum payment of:

- A refund of your contributions, plus interest

* Talk to your employer to find out if they have contracted for this benefit.

For more information on survivor benefits, go to **www.calpers.ca.gov/deathbenefits** and select Benefits Payable. And don't forget to log in to myCalPERS at **my.calpers.ca.gov** to make sure you've named a beneficiary for your lump-sum benefits. If there is no beneficiary designation on file at the time of your death, we'll determine your beneficiary by statutory order.

After Retirement

When you pass away after retirement, CalPERS provides benefits for your family or beneficiary based on choices you make when you retire. For more information on the different retirement payment options and the benefits they provide, see our publication ***Planning Your Service Retirement*** (PUB 1).

Special Power of Attorney

A CalPERS special power of attorney allows you to designate a representative, known as your attorney-in-fact, to conduct your retirement affairs. You may already have a power of attorney set up through another resource; however, it may not address your CalPERS retirement benefits. Learn more and download the designation form at **www.calpers.ca.gov/powerofattorney**.

Health Program Benefits

To be eligible for CalPERS health benefits while you are working, you must meet these three requirements:

- Work for an employer who has contracted with CalPERS for their health benefits.
- Be appointed to a job that will last at least six months and one day.
- Work at least half time.

The Affordable Care Act has provisions that expand the eligibility criteria for certain variable hour employees. While you are still working, contact your employer for information regarding your health eligibility, enrollment, and health premiums.

Health Benefits in Retirement

If you have CalPERS health coverage, the date of your retirement must be less than 120 days after your separation date (last day of employment), or you will not be eligible to be enrolled in a CalPERS health plan at retirement or at any future date.

For more information on CalPERS health benefits, go to **www.calpers.ca.gov** to read our three health publications:

- ***Health Program Guide*** (HBD 120)
- ***Health Benefit Summary*** (HBD 110)
- ***Medicare Enrollment Guide*** (HBD 65)

Frequently Asked Questions

Can I take a loan out against my retirement account?

No, you can't borrow from your CalPERS retirement account or receive any loans or hardship withdrawals of your member contributions. If you're leaving CalPERS-covered employment, you can elect to take a refund of your contributions plus interest. However, taking a refund ends your CalPERS membership, and you will no longer be eligible to receive a lifetime monthly pension payment, health benefits into retirement, or any death benefits.

I'm a PEPRA member. How is that different from other members?

The California Public Employees' Pension Reform Act (PEPRA) changed the way CalPERS retirement and health benefits were applied, and placed compensation limits on new members who joined CalPERS for the first time on or after January 1, 2013. Members who don't fall under the definitions of PEPRA are considered classic members. Classic members will retain the existing benefit enrollment levels for future service with the same employer. For more details about PEPRA, go to **www.calpers.ca.gov/PEPRA**.

What if I can't work because of injury or illness?

If you become disabled and can no longer perform the duties of your job, you may qualify for disability retirement or industrial disability retirement. Learn about the eligibility requirements in our publication ***Disability Retirement Election Application*** (PUB 35).

What happens if I leave my job before I retire?

If you permanently leave your job and do not take a position with another agency covered by CalPERS, you can keep your money with CalPERS, or you can request a refund of your member contributions and interest by submitting a ***Refund Election Application*** or by applying for a refund through your myCalPERS account. If you choose not to take a refund, your money will continue to earn 6% interest and you can withdraw it at a later date, or you may apply for a retirement benefit as soon as you meet the minimum retirement eligibility requirements.

What happens if I work for another CalPERS-covered employer in the future?

If you return to your old job or take a new job covered by CalPERS, and you already withdrew your contributions, you will again become a member. You would then have the option of putting back, with interest, any money you withdrew. If you do this, you will again get credit for those years of service. For more information on how to redeposit your withdrawn contributions, read our publication ***Service Credit Purchase Options*** (PUB 12).

If you left your money with CalPERS and return to a job covered by CalPERS, your new service credit and contributions get added to your existing account balances.

I have "reciprocity" with another California retirement system. What does this mean?

CalPERS has an agreement with many public retirement systems in California that allows movement from one public employer to another without losing valuable retirement rights and related benefits. This is called "reciprocity."

CalPERS and the California State Teachers' Retirement System (CalSTRS) have a similar agreement. For more information on reciprocity, read our publication ***When You Change Retirement Systems*** (PUB 16).

If I get a divorce, is my pension considered community property?

In California, all types of retirement benefits are considered community property. If you have a community property claim on your retirement account, a hold is placed on your account and benefits are held until the claim is resolved. We recommend that you resolve the claim before you retire to avoid possible delays in processing your retirement benefits. For more information, read ***Facts About Community Property*** and our publication ***CalPERS Community Property*** (PUB 38A).

How does Social Security affect my pension?

If you worked for a federal, state, or local government where you did not pay Social Security taxes, the pension you receive from that agency could reduce your Social Security benefits. Visit **www.calpers.ca.gov/socialsecurity** to see the relationship between the two benefits. You can also call the Social Security Administration at (800) 772-1213 or visit **www.ssa.gov** for more information.

Will I receive a cost-of-living increase in retirement?

A contract provision is built into your retirement plan to allow for a cost-of-living adjustment (COLA). The COLA is provided by law and is based on the Consumer Price Index for All Urban Consumers (CPI, 1967). You are eligible to receive your first COLA in the second calendar year after your retirement date. The adjustment is paid on the May 1 retirement check and then every year thereafter. Public agency employers can contract for a maximum 2%, 3%, 4%, or 5% COLA. For more information, read our publication ***Planning Your Retirement*** (PUB 1) or visit **www.calpers.ca.gov/cola**.

Where can I learn more about my benefits?

Do you have specific questions about your death benefits, health coverage, retirement options, or other considerations? Talk to your employer or get in touch with CalPERS—see page 15 for ways to contact us.

New Member Checklist

It's never too early to plan for your future. Use this checklist as a guide to learn about your benefits and prepare for a secure retirement.

☐ **Sign up for myCalPERS at my.calpers.ca.gov.**
Review your account summary and personal information. Be sure to verify your retirement formula, membership date, and contact information.

With myCalPERS you can...

- Ask us specific questions via secure messaging.
- Schedule an appointment.
- View your current and past Annual Member Statements.
- Estimate your future retirement benefits.
- Change your beneficiary designation.
- Search for health plans and rates (if applicable).
- Sign up for classes to learn about your benefits.
- Follow the steps at **my.calpers.ca.gov** to set up your account.

☐ **Add or change your beneficiary.**
While you're logged in to myCalPERS, make sure you've named the correct beneficiary for your lump-sum and pre-retirement benefits.

☐ **Read CalPERS publications to learn more about your benefits.**
Find details on retirement planning, service credit purchase, community property, and more. Go to **Forms & Publications** at **www.calpers.ca.gov** to download member publications. Here are some of our most popular:

- ***Planning Your Service Retirement*** (PUB 1)
- ***Service Credit Purchase Options*** (PUB 12)
- ***Military Service Credit Options*** (PUB 15)
- ***When You Change Retirement Systems*** (PUB 16)
- ***CalPERS Community Property*** (PUB 38A)
- ***Health Program Guide*** (HBD 120)

☐ **Complete a CalPERS Special Power of Attorney form.**
A CalPERS special power of attorney allows you to designate an attorney-in-fact to conduct your retirement affairs should you become unable to act on your own behalf. To learn more and download the designation form, go to **www.calpers.ca.gov/powerofattorney**.

☐ **Check your Annual Member Statement in September.**
Log in at **my.calpers.ca.gov** to view current and past statements to keep track of your member contributions and service credit. Set a reminder in your calendar to check your statement each year to ensure your service credit is accurate.

☐ **Consider signing up for a deferred compensation plan to earn additional money for retirement.**
The CalPERS 457 Plan, which includes pre-tax and after-tax options, is for participating public agency and school employees. Visit **www.calpers457.com** to learn more.

☐ **Connect with CalPERS and stay informed.**

- Subscribe to Member Education Bulletin emails at **www.calpers.ca.gov**.
- Read PERSpective for the latest news and updates at **news.calpers.ca.gov**.
- Watch member education videos at **www.youtube.com/calpers**.
- Sign up for our instructor-led and online classes at **my.calpers.ca.gov**.
- Attend our annual CalPERS Benefits Education Events at a location near you.
- Follow us on social media and share our posts.

How to Contact Us

Find Us Online

www.calpers.ca.gov
Learn about your benefits and subscribe to email alerts. You'll also find all our publications and forms.

my.calpers.ca.gov
Log in to access your account information or send us a secure message.

news.calpers.ca.gov
Stay up to date on CalPERS news that matters to you.

Call Us

Our offices are open Monday through Friday, 8:00 a.m. to 5:00 p.m. We're closed on state holidays.

Toll free: **888 CalPERS** (or **888**-225-7377)
TTY: (877) 249-7442
Fax: (800) 959-6545
International Calls: +1 916-795-3000

¿Hablas Español?
Para servicio en español marque:
888 CalPERS (o **888**-225-7377)

Write to Us

California Public Employees' Retirement System
Retirement Benefit Services Division
P.O. Box 942711
Sacramento, California 94229-2711

Experience CalPERS Through Social Media

Connect with us to get the latest CalPERS news.

Visit Your Nearest CalPERS Regional Office

Go to **www.calpers.ca.gov/regionaloffices** to learn how to make an appointment and prepare for your visit.

Sacramento Regional Office
Lincoln Plaza East
400 Q Street
Lincoln Plaza East, Suite 1820
Sacramento, CA 95811

Walnut Creek Regional Office
Pacific Plaza
1340 Treat Blvd., Suite 200
Walnut Creek, CA 94597

San Jose Regional Office
181 Metro Drive, Suite 520
San Jose, CA 95110

Fresno Regional Office
10 River Park Place East, Suite 230
Fresno, CA 93720

San Bernardino Regional Office
650 East Hospitality Lane, Suite 330
San Bernardino, CA 92408

Orange Regional Office
500 North State College Blvd., Suite 750
Orange, CA 92868

San Diego Regional Office
7676 Hazard Center Drive, Suite 350
San Diego, CA 92108

Glendale Regional Office
Glendale Plaza
655 North Central Ave., Suite 1400
Glendale, CA 91203

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status. Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number. Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at **888 CalPERS** (or **888**-225-7377).

CalPERS is governed by the Public Employees' Retirement Law and the Alternate Retirement Program provisions in the Government Code, together referred to as the Retirement Law. The statements in this publication are general. The Retirement Law is complex and subject to change. If there is a conflict between the law and this publication, any decisions will be based on the law and not this publication. If you have a question that is not answered by this general description, you may make a written request for advice regarding your specific situation directly to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811.

California Public Employees'
Retirement System
400 Q Street
P.O. Box 942701
Sacramento, California 94229-2701
888 CalPERS (or **888**-225-7377)

www.calpers.ca.gov

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CalPERS

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Retirement Formulas and Benefit Factors

Local Miscellaneous Members — 2% at 60

Retirement Estimate Calculator

Do you want a retirement estimate that uses data your employer already reported to CalPERS? Then log in to your myCalPERS account at **my.calpers.ca.gov** to obtain an estimate. You can generate a variety of scenarios and save them in myCalPERS for future reference.

Understanding Your Retirement Formula

Your benefit factor, also known as age factor, is the percentage of pay to which you are entitled for each year of service. It is determined by your age at retirement and the retirement formula that applies to your classification.

Log in to your myCalPERS account at **my.calpers.ca.gov** for information on determining which formula applies to you. You can refer to your CalPERS Annual Member Statement to verify your retirement formula. If you have questions, call us at **888 CalPERS** (or **888**-225-7377).

Reading the Retirement Formula Charts

We have included two charts related to the local miscellaneous retirement formula 2% at 60. The chart below shows how the benefit factor increases for each quarter year of age from 50 to 63. The chart on the next page shows the percentage of final compensation you will receive.

2% at 60 Retirement Formula — Minimum retirement age is 50 years

Age	Exact Year	¼ Year	½ Year	¾ Year
50	1.092%	1.108%	1.124%	1.140%
51	1.156%	1.172%	1.190%	1.206%
52	1.224%	1.242%	1.260%	1.278%
53	1.296%	1.316%	1.336%	1.356%
54	1.376%	1.396%	1.418%	1.438%
55	1.460%	1.482%	1.506%	1.528%
56	1.552%	1.576%	1.600%	1.626%
57	1.650%	1.678%	1.704%	1.730%
58	1.758%	1.786%	1.816%	1.846%
59	1.874%	1.906%	1.938%	1.970%
60	2.000%	2.034%	2.068%	2.100%
61	2.134%	2.168%	2.202%	2.238%
62	2.272%	2.308%	2.346%	2.382%
63 or older	2.418%	2.418%	2.418%	2.418%

Percentage of Final Compensation — **2% at 60 Retirement Formula**														
Age	50	51	52	53	54	55	56	57	58	59	60	61	62	63+
Benefit Factor	1.092	1.156	1.224	1.296	1.376	1.460	1.552	1.650	1.758	1.874	2.000	2.134	2.272	2.418
Years of Service	Percentage of Final Compensation													
5	5.46	5.78	6.12	6.48	6.88	7.30	7.76	8.25	8.79	9.37	10.00	10.67	11.36	12.09
6	6.55	6.94	7.34	7.78	8.26	8.76	9.31	9.90	10.55	11.24	12.00	12.80	13.63	14.51
7	7.64	8.09	8.57	9.07	9.63	10.22	10.86	11.55	12.31	13.12	14.00	14.94	15.90	16.93
8	8.74	9.25	9.79	10.37	11.01	11.68	12.42	13.20	14.06	14.99	16.00	17.07	18.18	19.34
9	9.83	10.40	11.02	11.66	12.38	13.14	13.97	14.85	15.82	16.87	18.00	19.21	20.45	21.76
10	10.92	11.56	12.24	12.96	13.76	14.60	15.52	16.50	17.58	18.74	20.00	21.34	22.72	24.18
11	12.01	12.72	13.46	14.26	15.14	16.06	17.07	18.15	19.34	20.61	22.00	23.47	24.99	26.60
12	13.10	13.87	14.69	15.55	16.51	17.52	18.62	19.80	21.10	22.49	24.00	25.61	27.26	29.02
13	14.20	15.03	15.91	16.85	17.89	18.98	20.18	21.45	22.85	24.36	26.00	27.74	29.54	31.43
14	15.29	16.18	17.14	18.14	19.26	20.44	21.73	23.10	24.61	26.24	28.00	29.88	31.81	33.85
15	16.38	17.34	18.36	19.44	20.64	21.90	23.28	24.75	26.37	28.11	30.00	32.01	34.08	36.27
16	17.47	18.50	19.58	20.74	22.02	23.36	24.83	26.40	28.13	29.98	32.00	34.14	36.35	38.69
17	18.56	19.65	20.81	22.03	23.39	24.82	26.38	28.05	29.89	31.85	34.00	36.28	38.62	41.11
18	19.66	20.81	22.03	23.33	24.77	26.28	27.94	29.70	31.64	33.73	36.00	38.41	40.90	43.52
19	20.75	21.96	23.26	24.62	26.14	27.74	29.49	31.35	33.40	35.61	38.00	40.55	43.17	45.94
20	21.84	23.12	24.48	25.92	27.52	29.20	31.04	33.00	35.16	37.48	40.00	42.68	45.44	48.36
21	22.93	24.28	25.70	27.22	28.90	30.66	32.59	34.65	36.92	39.35	42.00	44.81	47.71	50.78
22	24.02	25.43	26.93	28.51	30.27	32.12	34.14	36.30	38.68	41.23	44.00	46.95	49.98	53.20
23	25.12	26.59	28.15	29.81	31.65	33.58	35.70	37.95	40.43	43.10	46.00	49.08	52.26	55.61
24	26.21	27.74	29.38	31.10	33.02	35.04	37.25	39.60	42.19	44.98	48.00	51.22	54.53	58.03
25	27.30	28.90	30.60	32.40	34.40	36.50	38.80	41.25	43.95	46.85	50.00	53.35	56.80	60.45
26	28.39	30.06	31.82	33.70	35.78	37.96	40.35	42.90	45.71	48.72	52.00	55.48	59.07	62.87
27	29.48	31.21	33.05	34.99	37.15	39.42	41.90	44.55	47.47	50.60	54.00	57.62	61.34	65.29
28	30.58	32.37	34.27	36.29	38.53	40.88	43.46	46.20	49.22	52.47	56.00	59.75	63.62	67.70
29	31.67	33.52	35.50	37.58	39.90	42.34	45.01	47.85	50.98	54.35	58.00	61.89	65.89	70.12
30	32.76	34.68	36.72	38.88	41.28	43.80	46.56	49.50	52.74	56.22	60.00	64.02	68.16	72.54
31	33.85	35.84	37.94	40.18	42.66	45.26	48.11	51.15	54.50	58.09	62.00	66.15	70.43	74.96
32	34.94	36.99	39.17	41.47	44.03	46.72	49.66	52.80	56.26	59.97	64.00	68.29	72.70	77.38
33	36.04	38.15	40.39	42.77	45.41	48.18	51.22	54.45	58.01	61.84	66.00	70.42	74.98	79.79
34	—	39.30	41.62	44.06	46.78	49.64	52.77	56.10	59.77	63.72	68.00	72.56	77.25	82.21
35	—	—	42.84	45.36	48.16	51.10	54.32	57.75	61.53	65.59	70.00	74.69	79.52	84.63
36	—	—	—	46.66	49.54	52.56	55.87	59.40	63.29	67.46	72.00	76.82	81.79	87.05
37	—	—	—	—	50.91	54.02	57.42	61.05	65.05	69.34	74.00	78.96	84.06	89.47
38	—	—	—	—	—	55.48	58.98	62.70	66.80	71.21	76.00	81.09	86.34	91.88
39	—	—	—	—	—	—	60.53	64.35	68.56	73.09	78.00	83.23	88.61	94.30
40	—	—	—	—	—	—	—	66.00	70.32	74.96	80.00	85.36	90.88	96.72

Retirement Formulas and Benefit Factors

Local Miscellaneous Members — 2% at 62

Retirement Estimate Calculator

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Reading the Retirement Formula Charts

We have included two charts related to the local miscellaneous retirement formula 2% at 62. The chart below shows how the benefit factor increases for each quarter year of age from 50 to 67. The chart on the next page shows the percentage of final compensation you will receive.

2% at 62 Retirement Formula — Minimum retirement age is 52 years*

Age	Exact Year	¼ Year	½ Year	¾ Year
50*	0.842%	0.861%	0.880%	0.898%
51*	0.917%	0.938%	0.959%	0.979%
52	1.000%	1.025%	1.050%	1.075%
53	1.100%	1.125%	1.150%	1.175%
54	1.200%	1.225%	1.250%	1.275%
55	1.300%	1.325%	1.350%	1.375%
56	1.400%	1.425%	1.450%	1.475%
57	1.500%	1.525%	1.550%	1.575%
58	1.600%	1.625%	1.650%	1.675%
59	1.700%	1.725%	1.750%	1.775%
60	1.800%	1.825%	1.850%	1.875%
61	1.900%	1.925%	1.950%	1.975%
62	2.000%	2.025%	2.050%	2.075%
63	2.100%	2.125%	2.150%	2.175%
64	2.200%	2.225%	2.250%	2.275%
65	2.300%	2.325%	2.350%	2.375%
66	2.400%	2.425%	2.450%	2.475%
67 or older	2.500%	2.500%	2.500%	2.500%

* Minimum retirement age is 50 years when you have combined classic and PEPRA service.

Percentage of Final Compensation — **2% at 62 Retirement Formula**																
Age	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67+
Benefit Factor	1.000	1.100	1.200	1.300	1.400	1.500	1.600	1.700	1.800	1.900	2.000	2.100	2.200	2.300	2.400	2.500
Years of Service	Percentage of Final Compensation															
5	5.00	5.50	6.00	6.50	7.00	7.50	8.00	8.50	9.00	9.50	10.00	10.50	11.00	11.50	12.00	12.50
6	6.00	6.60	7.20	7.80	8.40	9.00	9.60	10.20	10.80	11.40	12.00	12.60	13.20	13.80	14.40	15.00
7	7.00	7.70	8.40	9.10	9.80	10.50	11.20	11.90	12.60	13.30	14.00	14.70	15.40	16.10	16.80	17.50
8	8.00	8.80	9.60	10.40	11.20	12.00	12.80	13.60	14.40	15.20	16.00	16.80	17.60	18.40	19.20	20.00
9	9.00	9.90	10.80	11.70	12.60	13.50	14.40	15.30	16.20	17.10	18.00	18.90	19.80	20.70	21.60	22.50
10	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00	24.00	25.00
11	11.00	12.10	13.20	14.30	15.40	16.50	17.60	18.70	19.80	20.90	22.00	23.10	24.20	25.30	26.40	27.50
12	12.00	13.20	14.40	15.60	16.80	18.00	19.20	20.40	21.60	22.80	24.00	25.20	26.40	27.60	28.80	30.00
13	13.00	14.30	15.60	16.90	18.20	19.50	20.80	22.10	23.40	24.70	26.00	27.30	28.60	29.90	31.20	32.50
14	14.00	15.40	16.80	18.20	19.60	21.00	22.40	23.80	25.20	26.60	28.00	29.40	30.80	32.20	33.60	35.00
15	15.00	16.50	18.00	19.50	21.00	22.50	24.00	25.50	27.00	28.50	30.00	31.50	33.00	34.50	36.00	37.50
16	16.00	17.60	19.20	20.80	22.40	24.00	25.60	27.20	28.80	30.40	32.00	33.60	35.20	36.80	38.40	40.00
17	17.00	18.70	20.40	22.10	23.80	25.50	27.20	28.90	30.60	32.30	34.00	35.70	37.40	39.10	40.80	42.50
18	18.00	19.80	21.60	23.40	25.20	27.00	28.80	30.60	32.40	34.20	36.00	37.80	39.60	41.40	43.20	45.00
19	19.00	20.90	22.80	24.70	26.60	28.50	30.40	32.30	34.20	36.10	38.00	39.90	41.80	43.70	45.60	47.50
20	20.00	22.00	24.00	26.00	28.00	30.00	32.00	34.00	36.00	38.00	40.00	42.00	44.00	46.00	48.00	50.00
21	21.00	23.10	25.20	27.30	29.40	31.50	33.60	35.70	37.80	39.90	42.00	44.10	46.20	48.30	50.40	52.50
22	22.00	24.20	26.40	28.60	30.80	33.00	35.20	37.40	39.60	41.80	44.00	46.20	48.40	50.60	52.80	55.00
23	23.00	25.30	27.60	29.90	32.20	34.50	36.80	39.10	41.40	43.70	46.00	48.30	50.60	52.90	55.20	57.50
24	24.00	26.40	28.80	31.20	33.60	36.00	38.40	40.80	43.20	45.60	48.00	50.40	52.80	55.20	57.60	60.00
25	25.00	27.50	30.00	32.50	35.00	37.50	40.00	42.50	45.00	47.50	50.00	52.50	55.00	57.50	60.00	62.50
26	26.00	28.60	31.20	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00	54.60	57.20	59.80	62.40	65.00
27	27.00	29.70	32.40	35.10	37.80	40.50	43.20	45.90	48.60	51.30	54.00	56.70	59.40	62.10	64.80	67.50
28	28.00	30.80	33.60	36.40	39.20	42.00	44.80	47.60	50.40	53.20	56.00	58.80	61.60	64.40	67.20	70.00
29	29.00	31.90	34.80	37.70	40.60	43.50	46.40	49.30	52.20	55.10	58.00	60.90	63.80	66.70	69.60	72.50
30	30.00	33.00	36.00	39.00	42.00	45.00	48.00	51.00	54.00	57.00	60.00	63.00	66.00	69.00	72.00	75.00
31	31.00	34.10	37.20	40.30	43.40	46.50	49.60	52.70	55.80	58.90	62.00	65.10	68.20	71.30	74.40	77.50
32	32.00	35.20	38.40	41.60	44.80	48.00	51.20	54.40	57.60	60.80	64.00	67.20	70.40	73.60	76.80	80.00
33	33.00	36.30	39.60	42.90	46.20	49.50	52.80	56.10	59.40	62.70	66.00	69.30	72.60	75.90	79.20	82.50
34	34.00	37.40	40.80	44.20	47.60	51.00	54.40	57.80	61.20	64.60	68.00	71.40	74.80	78.20	81.60	85.00
35	35.00	38.50	42.00	45.50	49.00	52.50	56.00	59.50	63.00	66.50	70.00	73.50	77.00	80.50	84.00	87.50
36	36.00	39.60	43.20	46.80	50.40	54.00	57.60	61.20	64.80	68.40	72.00	75.60	79.20	82.80	86.40	90.00
37	37.00	40.70	44.40	48.10	51.80	55.50	59.20	62.90	66.60	70.30	74.00	77.70	81.40	85.10	88.80	92.50
38	38.00	41.80	45.60	49.40	53.20	57.00	60.80	64.60	68.40	72.20	76.00	79.80	83.60	87.40	91.20	95.00
39	39.00	42.90	46.80	50.70	54.60	58.50	62.40	66.30	70.20	74.10	78.00	81.90	85.80	89.70	93.60	97.50
40	40.00	44.00	48.00	52.00	56.00	60.00	64.00	68.00	72.00	76.00	80.00	84.00	88.00	92.00	96.00	100.00

City Of Mission Viejo

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City of Mission Viejo
Personnel Policy

Subject: **FIXED MONTHLY EMPLOYER CONTRIBUTION SCHEDULE (ECS)**

Statement of Intent:
This City of Mission Viejo Fixed Monthly Employer Contribution Schedule ("ECS") summarizes the City's health and welfare benefit structure. The ECS applies for calendar year 2018 and for subsequent years unless and until modified by the City of Mission Viejo.

The City provides health and welfare benefits described below to its eligible employees (collectively, "Welfare Benefits"). To assist employees with the cost of their selected Welfare Benefits, the City provides fixed monthly contributions up to certain dollar amounts specified below. In addition, subject to certain limitations, eligible employees who elect medical-insurance coverage may receive part of these contributions as cash; and eligible employees may receive cash in exchange for opting out of medical-insurance coverage. All elections among Welfare Benefits and cash as described in this ECS are provided through the City's cafeteria plan, which is qualified under Section 125 of the Internal Revenue Code (the "Cafeteria Plan").

Employees' benefit elections (and changes thereto) may be made only at the time and in the manner determined by the City in its sole discretion. Such election procedures will be in accordance with the Cafeteria Plan and with any Welfare Benefit plan provisions governing the time and manner of such elections.

Policy:
PART A. GENERAL REQUIREMENTS

I. ELIGIBLE EMPLOYEE
To receive Welfare Benefits, a City employee must fall into one of the following categories (each an "Eligible Employee"):

1. An employee hired into a budgeted position (as described in the Authorized Position Schedule) for an indefinite period of time and scheduled to regularly work twenty (20) or more hours per week;
2. A member of the City Council; or
3. An Hourly/Seasonal/Temporary (HST) employee who is either:
    i. Determined to have worked at least thirty (30) hours per week after the City has analyzed the total hours of work during either the employee's Initial Measurement Period or Standard Measurement Period; or
    ii. Reasonably expected to work thirty (30) or more hours per week.

II. INELIGIBLE PERSONS

The following persons are ineligible to receive Welfare Benefits:

1. A variable hour employee who works less than thirty (30) hours per week;
2. Any other person who does not satisfy the requirements set out in Part A.I. above to be an Eligible Employee.

III. ENROLLMENT

Current Eligible Employees: An employee who does not submit the required benefit election forms during Open Enrollment for a calendar year will be enrolled in the same elections as the prior year, with one exception: The employee will be deemed to elect *not* to participate in the Flexible Spending Account (FSA) programs regardless of the employee's election for the prior year. The amount of any City contribution (i.e., Monthly Flex Contribution or Monthly Opt Out Contribution) that would have been allocated to the FSA programs had the employee's prior-year FSA elections remained in effect will be paid to the employee in taxable cash (subject to 50% reduction if the employee is in Tier 4).

New Eligible Employees: A newly Eligible Employee (e.g., new hire or employee changing from an ineligible to an eligible position) will become eligible to receive Welfare Benefits effective the first (1st) of the month following the date the employee submits their elections in the Munis Employee Self-Service module. If the employee does not submit electronic benefit elections within thirty (30) calendar days after becoming an Eligible Employee, then (i) the employee will be automatically enrolled in the "Employee Only" category of the lowest cost health plan, excluding the Health Net Salud y Mas plan, the cost of which will be offset by the applicable Fixed Monthly Flex Contribution specified below for Tier 4 employees, and (ii) 50% of the remaining balance (if any) of the Fixed Monthly Flex Contribution will be paid to the employee in taxable cash.

PART B. PLAN REQUIREMENTS

I. TIER 4 MONTHLY EMPLOYER CONTRIBUTION

The fixed monthly contribution amounts listed below apply to non-represented employees. The fixed monthly contribution amounts for represented employees will be guided by the applicable collective bargaining agreement.

A City employee who becomes an Eligible Employee on or after December 3, 2007, shall be enrolled in Tier 4. Each Tier 4 employee will receive the following benefits:

<u>Employees Who Elect CalPERS Health Coverage</u>

A. The employee will receive a Monthly Flex Contribution upon the employee's enrollment (i.e., employee only, employee plus one, employee plus family) in a coverage option offered under the California Public Employees' Retirement System medical plan ("CalPERS Health"). Effective January 1, 2024, the contribution amount is based on the employee's FTE status and coverage election, as follows:

FULL-TIME EQUIVALENCY (FTE)	MEDICAL PLAN ENROLLMENT LEVEL		
	Employee Only	Employee + 1	Employee + 2 or More
1.000 (40 hrs/wk)	$1,269.00	$2,141.00	$2,437.00
. 500 to .999 (30 – 39 hrs/wk)	$951.75	$1,605.75	$1,827.75

B. Each employee's Monthly Flex Contribution encompasses the amount that the City is required to contribute to CalPERS Health for the employee. To the extent that the Monthly Flex Contribution exceeds the cost of the employee's elected CalPERS Health option, the employee may allocate the balance among the following in any combination:

1. Dental Insurance
2. Vision Insurance
3. Flexible Spending Account Programs
4. Additional Life Insurance
5. Catastrophic Care Programs
6. Taxable Cash Back (subject to 50% reduction). Per Government Code Section 36516, City Councilmembers are not eligible for taxable cash back options.

C. To the extent that the cost of the employee's elections (other than cash back) under paragraph B above exceed the allocable Monthly Flex Contribution, the balance will be deducted from the employee's City compensation through the Cafeteria Plan on a pre-tax basis.

D. An Hourly/Seasonal/Temporary (HST) employee is not eligible to enroll into any benefit plan other than medical insurance. Therefore, the Monthly Flex Contribution that exceeds the cost of the employee's elected CalPERS Health option will be provided as taxable cash back subject to the 50% reduction.

<u>Employees Who Opt Out of CalPERS Health Coverage</u>

E. Employees may elect to waive—i.e., "Opt Out"—of CalPERS Health coverage in exchange for a Monthly Opt Out Contribution. To Opt Out of CalPERS Health and receive this contribution, the employee must first sign and comply with the requirements set out in the City's Waiver Agreement. This waiver form will satisfy the requirements of an Eligible Opt-Out Arrangement ("EOA") as defined in Internal Revenue Service (IRS) Proposed Regulation REG-109086, or as subsequently amended by the IRS. In accordance with the EOA rules, the waiver form requires that the employee attest to minimum essential coverage ("MEC") through another source and satisfy several other requirements. Employees who wish to waive CalPERS Health coverage should carefully review the waiver form.

F. An employee who elects to Opt Out of CalPERS Health will receive a Monthly Opt Out Contribution as follows:

FULL-TIME EQUIVALENCY (FTE)	MONTHLY CONTRIBUTION
1.000 (40 hrs/wk)	$450.00
.750 to .999 (30 – 39 hrs/wk)	$312.50
.500 to .749 (20 – 29 hrs/wk)	$175.00

G. The employee may allocate their Monthly Opt Out Contribution among the following in any combination:
   1. Dental Insurance
   2. Vision Insurance
   3. Flexible Spending Account Programs
   4. Additional Life Insurance
   5. Catastrophic Care Programs
   6. Taxable 100% Cash Back. Per Government Code Section 36516, City Councilmembers are not eligible for taxable cash back options.

H. To the extent that the cost of the employee's elections (other than cash back) under paragraph F above exceed the allocable Monthly Opt Out Contribution, the balance will be deducted from the employee's City compensation through the Cafeteria Plan on a pre-tax basis.

I. An Hourly/Seasonal/Temporary (HST) employee is not eligible to receive the above referenced Monthly Opt Out Contribution.

II. TIER 3 MONTHLY EMPLOYER CONTRIBUTION – *CANCELLED*

The City eliminated Tier 3 effective December 31, 2007.

III. TIER 2 MONTHLY EMPLOYER CONTRIBUTION

A City employee who became an Eligible Employee before December 3, 2007, is eligible to participate in Tier 2. Each Tier 2 employee will receive the following benefits:

<u>Employees Who Elect CalPERS Health Coverage</u>

A. The employee will receive a Monthly Flex Contribution upon the employee's enrollment (i.e., employee only, employee plus one, employee plus family) in a coverage option offered under the California Public Employees' Retirement System medical plan ("CalPERS Health"). The contribution amount is based on the employee's FTE status and coverage election, as follows:

FULL-TIME EQUIVALENCY (FTE)	MEDICAL PLAN ENROLLMENT LEVEL		
	Employee Only	Employee + 1	Employee + 2 or More
1.000 (40 hrs/wk)	$975.00	$1,062.00	$1,264.00
.750 to .999 (30 – 39 hrs/wk)	$731.25	$796.50	$948.00
.500 to .749 (20 – 29 hrs/wk)	$487.50	$531.00	$632.00

B. Each employee's Monthly Flex Contribution encompasses the amount that the City is required to contribute to CalPERS Health for the employee. To the extent that the Monthly Flex Contribution exceeds the cost of the employee's elected CalPERS Health option, the employee may allocate the balance among the following in any combination:

1. Dental Insurance
2. Vision Insurance
3. Flexible Spending Account Programs
4. Additional Life Insurance
5. Catastrophic Care Programs
6. Taxable 100% Cash Back. Per Government Code Section 36516, City Councilmembers are not eligible for taxable cash back options.

C. An Hourly/Seasonal/Temporary (HST) employee is not eligible to enroll into any benefit plan other than medical insurance. Therefore, the Monthly Flex Contribution that exceeds the cost of the employee's elected CalPERS Health option will be provided as taxable cash back.

D. To the extent that the cost of the employee's elections (other than cash back) under paragraph B above exceed the allocable Monthly Flex Contribution, the balance will be deducted from the employee's City compensation through the Cafeteria Plan on a pre-tax basis.

<u>Employees Who Opt Out of CalPERS Health Coverage</u>

E. Employees may elect to waive—i.e., "Opt Out"—of CalPERS Health coverage in exchange for a Monthly Opt Out Contribution. To Opt Out of CalPERS Health and receive this contribution, the employee must first sign and comply with the requirements set out in the City's Waiver Agreement. This waiver form will satisfy the requirements of an Eligible Opt-Out Arrangement ("EOA") as defined in Internal Revenue Service (IRS) Proposed Regulation REG-109086, or as subsequently amended by the IRS. In accordance with the EOA rules, the waiver form requires that the employee attest to minimum essential coverage ("MEC") through another source and satisfy several other requirements. Employees who wish to waive CalPERS Health coverage should carefully review the waiver form.

F. An employee who elects to Opt Out of CalPERS Health will receive a Monthly Opt Out Contribution as follows:

FULL-TIME EQUIVALENCY (FTE)	MONTHLY CONTRIBUTION
1.000 (40 hrs/wk)	$750.00
.750 to .999 (30 – 39 hrs/wk)	$512.50
.500 to .749 (20 – 29 hrs/wk)	$275.00

G. The employee may allocate their Monthly Opt Out Contribution among the following in any combination:
   1. Dental Insurance
   2. Vision Insurance
   3. Flexible Spending Account Programs
   4. Additional Life Insurance
   5. Catastrophic Care Programs
   6. Taxable 100% Cash Back. Per Government Code Section 36516, City Councilmembers are not eligible for taxable cash back options.

H. To the extent that the cost of the employee's elections (other than cash back) under paragraph F above exceed the allocable Monthly Opt Out Contribution, the balance will be deducted from the employee's City compensation through the Cafeteria Plan on a pre-tax basis.

I. An Hourly/Seasonal/Temporary (HST) employee is not eligible to receive the above referenced Monthly Opt Out Contribution.

IV. TIER 1 MONTHLY EMPLOYER CONTRIBUTION

Tier 1 consists of Eligible Employees who have waived CalPERS Health coverage every calendar year since January 1, 2006. No other City employee may become a member of Tier 1.

Employees Who Opt Out of CalPERS Health Coverage

A. Employees may elect to waive—i.e., "Opt Out"—of CalPERS Health coverage in exchange for a Monthly Opt Out Contribution. To Opt Out of CalPERS Health and receive this contribution, the employee must first sign and comply with the requirements set out in the City's Waiver Agreement. This waiver form will satisfy the requirements of an Eligible Opt-Out Arrangement ("EOA") as defined in Internal Revenue Service (IRS) Proposed Regulation REG-109086, or as subsequently amended by the IRS. In accordance with the EOA rules, the waiver form requires that the employee attest to minimum essential coverage ("MEC") through another source and satisfy several other requirements. Employees who wish to waive CalPERS Health coverage should carefully review the waiver form.

B. An employee who elects to Opt Out of CalPERS Health will receive a Monthly Opt Out Contribution as follows:

FULL-TIME EQUIVALENCY (FTE)	MONTHLY CONTRIBUTION
1.000 (40 hrs/wk)	$975.00
.750 to .999 (30 – 39 hrs/wk)	$731.25
.500 to .749 (20 – 29 hrs/wk)	$487.50

C. The employee may allocate their Monthly Opt Out Contribution among the following in any combination:
   1. Dental Insurance
   2. Vision Insurance
   3. Flexible Spending Account Programs
   4. Additional Life Insurance
   5. Catastrophic Care Programs
   6. Taxable 100% Cash Back. Per Government Code Section 36516, City Councilmembers are not eligible for taxable cash back options

D. To the extent that the cost of the employee's elections (other than cash back) under paragraph C above exceed the allocable Monthly Opt Out Contribution, the balance will be deducted from the employee's City compensation through the Cafeteria Plan on a pre-tax basis.

Employees Who Elect CalPERS Health Coverage

E. A Tier 1 employee may elect to enroll in a CalPERS Health plan during an annual Open Enrollment period preceding the calendar year of coverage or during the coverage year if the employee experiences an IRS approved qualified status change.

F. Tier 1 employees who elect to enroll in a CalPERS Health plan are eligible to participate in either the Tier 4 or the Tier 2 Monthly Flex Contribution.

PART C. LIMITATIONS OF FIXED MONTHLY EMPLOYER CONTRIBUTIONS

Notwithstanding this ECS, the City reserves the right to at any time and on any basis deemed necessary and appropriate by the City do the following: modify or eliminate any provisions of its Cafeteria Plan or Welfare Benefits plans; increase, decrease, or eliminate the City contribution amounts (i.e., Monthly Flex Contribution or Monthly Opt Out Contribution); or otherwise modify any component of the City's health-and-welfare benefits structure.

Further, this ECS is not intended to in any way modify the provisions of the Cafeteria Plan or the underlying Welfare Benefits plans themselves. Employees should refer to the actual plan documents for specific provisions and/or answers to specific questions.

If there is any conflict between this ECS and the Cafeteria Plan or any Welfare Benefits plan, the relevant plan controls.

Administration:

In accordance with City of Mission Viejo Municipal Code chapter 2.60 “Personnel System”, this Personnel Policy is deemed to have a direct financial impact on the City. City Council approval is required prior to initial implementation and for any subsequent amendments.

Adopted: City Council November 8, 2016 – Resolution 16-51

Reference: City Council August 24, 1992 – Resolution 92-152
City Council June 28, 1993 – Resolution 93-114
City Council June 19, 2000 – Resolution 00-110
City Council July 1, 2002 – Resolution 02-113
City Council November 3, 2003 – Resolution 03-150
City Council October 4, 2004 – Resolution 04-130
City Council October 3, 2005 – Resolution 05-115
City Council December 4, 2006 – Resolution 06-85
City Council November 5, 2007 – Resolution 07-66
City Council March 13, 2013 – Resolution 13-21
City Council November 4, 2013 – Resolution 13-63
City Council June 28, 2016 – Resolution 16-31

Revised: City Council on October 24, 2017 – Resolution 17-51.
City Council on May 14, 2019 – Resolution No. 19-10
City Council on June 22, 2021, to be effective July 1, 2021 – Resolution No. 21-19
City Council on June 27, 2023, to be effective July 1, 2023 – Resolution No. 23-28
City Council on October 24, 2023, to be effective January 1, 2024 – Resolution No. 23-41

EMPLOYER VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN ADOPTION AGREEMENT

Plan Number: 8 03691

Select as applicable: ☑ Standalone RHS ☐ Integrated RHS ☐ Amendment to Existing Plan ☑ New Plan (see NOTE below)

NOTE: (For existing employers only): **Check here** ☐ if you want ICMA-RC to use existing plan contact information for this new plan setup. Otherwise, if contact information has changed, please complete and return the Implementation Data Form found on pg. II:31 along with the adoption materials.

Employer Retirement Health Savings Plan Name:

I. Employer Name: City of Mission Viejo State: CA

II. The Employer hereby attests that it is a unit of a state or local government or an agency or instrumentality of one or more units of a state or local government.

III. Effective Date of the Plan: 07/01/2017

IV. The Employer intends to utilize the Trust to fund only welfare benefits pursuant to the following welfare benefit plan(s) established by the Employer: Supplemental Health Account for Retired Employees

V. Eligible Groups, Participation and Participant Eligibility Requirements

A. Eligible Groups

The following group or groups of Employees are eligible to participate in the VantageCare Retirement Health Savings Plan (check all applicable boxes):

- ☐ All Employees
- ☐ All Full-Time Employees
- ☐ Non-Union Employees
- ☐ Public Safety Employees – Police
- ☐ Public Safety Employees – Firefighters
- ☐ General Employees
- ☐ Collectively-Bargained Employees (Specify unit(s)) _____
- ☑ Other (specify group(s)) See attached Exhibit A

The Employee group(s) specified must correspond to a group(s) of the same designation that is defined in the statutes, ordinances, rules, regulations, personnel manuals or other documents or provisions in effect in the state or locality of the Employer.

B. Participation

Mandatory Participation: All Employees in the covered group(s) are required to participate in the Plan and shall receive contributions pursuant to Section VI.

If the Employer's underlying welfare benefit plan or funding under this VantageCare Retirement Health Savings Plan is in whole or part a non-collectively bargained, self-insured plan, the nondiscrimination requirements of Internal Revenue Code (IRC) Section 105(h) will apply. These rules may impose taxation on the benefits received by highly compensated individuals if the Plan discriminates in favor of highly compensated individuals in terms of eligibility or benefits. The Employer should discuss these rules with appropriate counsel.

C. Participant Eligibility Requirements

1. Minimum service: The minimum period of service required for participation is 12 months (write N/A if no minimum service is required).
2. Minimum age: The minimum age required for eligibility to participate is N/A (write N/A if no minimum age is required).

VI. Contribution Sources and Amounts

A. Definition of Earnings

The definition of Earnings will apply to all RHS Contribution Features that reference "Earnings", including Direct Employer Contributions (Section VI.B.1.) and Mandatory Employee Compensation Contributions (Section VI.B.2.).

Definition of earnings: Regular hourly rate of pay including any retroactive earnings, but excluding any overtime pay

B. Direct Employer Contributions and Mandatory Contributions

1. Direct Employer Contributions

The Employer shall contribute on behalf of each Participant

- ☐ _____ % of Earnings
- ☐ $ _____ each Plan Year
- ☐ A discretionary amount to be determined each Plan Year
- ☑ Other (describe): See attached Exhibit B

2. Mandatory Employee Compensation Contributions

The Employer will make mandatory contributions of Employee compensation as follows:

☑ Reduction in Salary - 1.5 % of Earnings or $ _____ will be contributed for the Plan Year.

☐ Decreased Merit or Pay Plan Adjustment - All or a portion of the Employees' annual merit or pay plan adjustment will be contributed as follows:

An Employee shall not have the right to discontinue or vary the rate of Mandatory Contributions of Employee Compensation.

3. Mandatory Employee Leave Contributions

The Employer will make mandatory contributions of accrued leave as follows (provide formula for determining Mandatory Employee Leave contributions):

- ☐ Accrued Sick Leave N/A
- ☐ Accrued Vacation Leave N/A
- ☐ Other (specify type of leave) Accrued N/A Leave

An Employee shall not have the right to discontinue or vary the rate of mandatory leave contributions.

C. Limits on Total Contributions (check one box)

The total contribution by the Employer on behalf of each Participant (including Direct Employer and Mandatory Employee Contributions) for each Plan Year shall not exceed the following limit(s) below. Limits on individual contribution types are defined within the appropriate section above.

☑ There is no Plan-defined limit on the percentage or dollar amount of earnings that may be contributed.

☐ _____ % of earnings*

*Definition of earnings: ☐ Same as Section VI.A.. ☐ Other

☐ $ _____ for the Plan year.

See Section V.B. for a discussion of nondiscrimination rules that may apply to non-collectively bargained self-insured Plans.

VII. Vesting for Direct Employer Contributions

A. Vesting Schedule (check one box)

☐ The account is 100% vested at all times.

☑ The following vesting schedule shall apply to Direct Employer Contributions as outlined in Section VI.B.1.:

Years of Service Completed	Vesting Percentage
15	100 %
	%
	%
	%
	%
	%
	%
	%
	%
	%

B. The account will become 100% vested upon the death, disability, retirement*, or attainment of benefit eligibility (as outlined in Section IX) by a Participant.

*Definition of retirement includes a separation from service component and is further defined by (check one):

☐ The primary retirement plan of the Employer

☐ Separation from service

☑ Other No vesting until completing 15 years of service measured from most recent date of hire

C. Any period of service by a Participant prior to a rehire of the Participant by the Employer shall not count toward the vesting schedule outlined in A above.

VIII. Forfeiture Provisions

Upon separation from the service of the Employer prior to attainment of benefit eligibility (as outlined in Section IX), or upon reversion to the Trust of a Participant's account assets remaining upon the participant's death (as outlined in Section XI), a Participant's non-vested funds shall (check one box):

☐ Remain in the Trust to be reallocated among all Plan Participants with a balance as Direct Employer Contributions for the next and succeeding contribution cycle(s).*

☐ Remain in the Trust to be reallocated on an equal dollar basis among all Plan Participants with a balance.*

☐ Remain in the Trust to be reallocated among all Plan Participants based upon Participant account balances.*

☑ Revert to the Employer via check.

** If the forfeited balance is small whereby the reallocation amount to each Plan Participant with a balance is minimal, the assets will revert to employer's forfeiture account for further direction from the employer. If there are participants without a balance who should receive forfeiture assets, please provide alternative instructions to ICMA-RC on the forfeiture reallocation notice.*

IX. Eligibility Requirements to Receive Medical Benefit Payments from the VantageCare Retirement Health Savings Plan

A. A Participant is eligible to receive benefits:

☐ At retirement only (also complete Section B.)
Definition of retirement:

☐ Same as Section VII.B.

☐ Other _____

_____

☑ At separation from service with the following restrictions

☐ No restrictions

☑ Other Complete at least 15 years of service to receive reimbursements from the Employer Contributions. Reimbursements from the Employee Contributions account can occur upon separation.

B. Termination prior to general benefit eligibility: In case where the general benefit eligibility as outlined in Section IX.A includes a retirement component, a Participant who separates from service of the Employer prior to retirement will be eligible to receive benefits:

☐ Immediately upon separation from service

☑ Other Complete at least 15 years of service to receive reimbursements from the Employer Contributions. Reimbursements from the Employee Contributions account can occur upon separation.

C. A Participant that becomes totally and permanently disabled

☐ **as defined by the Social Security Administration**

☐ **as defined by the Employer's primary retirement plan**

☑ **other** Reimbursements from the Employee Contributions account can occur upon separation. Complete at least 15 years of service to receive reimbursements from the Employer Contributions.

will become immediately eligible to receive medical benefit payments from his/her VantageCare Retirement Health Savings Plan account.

D. Upon the death of the Participant, benefits shall become payable as outlined in Section XI.

X. Permissible Medical Benefit Payments

Benefits eligible for reimbursement consist of:

☑ All Medical Expenses eligible under IRC Section 213* other than (i) direct long-term care expenses, and (ii) expenses for medicines or drugs which are not prescribed drugs (other than insulin).

☐ The following Medical Expenses eligible under IRC Section 213* other than (i) direct long-term care expenses, and (ii) expenses for medicines or drugs which are not prescribed drugs (other than insulin). Select only the expenses you wish to cover under the VantageCare Retirement Health Savings Plan:

☐ Medical Insurance Premiums

☐ Medical Out-of-Pocket Expenses*

☐ Medicare Part B Insurance Premiums

☐ Medicare Part D Insurance Premiums

- ☐ Medicare Supplemental Insurance Premiums
- ☐ Prescription Drug Insurance Premiums
- ☐ COBRA Insurance Premiums
- ☐ Dental Insurance Premiums
- ☐ Dental Out-of-Pocket Expenses*
- ☐ Vision Insurance Premiums
- ☐ Vision Out-of-Pocket Expenses*
- ☐ Qualified Long-Term Care Insurance Premiums
- ☐ Non-Prescription medications allowed under IRS guidance*
- ☐ Other qualifying medical expenses (describe)*

** See Section V.A. for a discussion of nondiscrimination rules which may apply to non-collectively bargained, self-insured Plans.*

XI. Benefits After the Death of the Participant

In the event of a Participant's death, the following shall apply:

A. Surviving Spouse and/or Surviving Dependents

The surviving spouse and/or surviving eligible dependents (as defined in Section XII.D.) of the deceased Participant are immediately eligible to maintain the account and utilize it to fund eligible medical benefits specified in Section X above.

Upon notification of a Participant's death, the Participant's account balance will be transferred into Dreyfus Cash Management fund* (or another fund selected by the Employer). The account balance may be reallocated by the surviving spouse or dependents.

**An investment in the Dreyfus Cash Management money market fund is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency. Although the fund seeks to preserve the value of your investment at $1.00 per share, it is possible to lose money by investing in the fund. Investors should consider the investment objectives, risks, charges, and expenses of the fund carefully before investing. You may visit us at www.icmarc.org or call 800-669-7400 to obtain a prospectus that contains this and other information about the fund. Read the prospectus carefully before investing.*

If a Participant's account balance has not been fully utilized upon the death of the eligible spouse, the account balance may continue to be utilized to pay benefits of eligible dependents. Upon the death of all eligible dependents, the account will revert to the Plan to be applied as specified in Section VIII.

B. No Surviving Spouse or Surviving Dependents

If there are no living spouse or dependents at the time of death of the Participant, the account will revert to the Plan to be applied as specified in Section VIII.

XII. The Plan will operate according to the following provisions:

A. Employer Responsibilities

1. The Employer will submit all VantageCare Retirement Health Savings Plan contribution data via electronic submission.
2. The Employer will submit all VantageCare Retirement Health Savings Plan Participant status updates or personal information updates via electronic submission. This includes but is not limited to termination notification and benefit eligibility notification.

B. Participant account administration and asset-based fees will be paid through the redemption of Participant account shares, unless agreed upon otherwise in the Administrative Services Agreement.

C. Assignment of benefits is not permitted. Benefits will be paid only to the Participant, his/her Survivors, the Employer, or an insurance provider (as allowed by the claims administrator). Payments to an third-party payee (e.g., medical service provider) are not permitted with the exception of reimbursement to the Employer or insurance provider (as allowed by the claims administrator).

D. An eligible dependent is (a) the Participant's lawful spouse, (b) the Participant's child under the age of 27, as defined by IRC Section 152(f)(1) and Internal Revenue Service Notice 2010-38, or (c) any other individual who is a person described in IRC Section 152(a), as clarified by Internal Revenue Service Notice 2004-79.

E. The Employer will be responsible for withholding, reporting and remitting any applicable taxes for payments which are deemed to be discriminatory under IRC Section 105(h), as outlined in the VantageCare Retirement Health Savings Plan Employer Manual.

XIII. Employer Acknowledgements

A. The Employer hereby acknowledges it understands that failure to properly fill out this Employer VantageCare Retirement Health Savings Plan Adoption Agreement may result in the loss of tax exemption of the Trust and/or loss of tax-deferred status for Employer contributions.

B. ☑ Check this box if you are including supporting documents that include plan provisions.

EMPLOYER SIGNATURE

By: _____ **Date:** 4/28/17

Title: City Manager

Attest: _____ **Date:** 4/27/17

Title: Director of Administrative Services

City of Mission Viejo VantageCare Retirement Health Savings Plan

Adoption Agreement

Exhibit A

1) The following group or groups of Employees are eligible to participate in the VantageCare Retirement Health Savings Plan:
   a) An individual employed by the City of Mission Viejo, and/or elected to the City Council, and first eligible for health insurance benefits on or after January 1, 2007, as follows:
      i) A full-time employee;
      ii) An at-will employee, including an employee in any of the following positions: city manager, assistant city manager, city clerk, department head, deputy city manager and/or assistant to the city manager;
      iii) A part-time employee scheduled to regularly work twenty (20) or more hours per week in a classification designated on an Authorized Position Schedule adopted by the City Council;
      iv) A member of the City Council first elected or appointed to a term on or after January 1, 2007.
   b) A former City employee re-hired by the City into any of the positions listed above in Section 1 (a) (i), (ii), or (iii) and eligible to receive health insurance benefits on or after January 1, 2007.
   c) A member of the City Council who returns to office on or after January 1, 2007, following a break in service on the City Council

2) The following group or groups of Employees are not eligible to participate in the VantageCare Retirement Health Savings Plan:
   a) Any individual in any other employment classification not set out in Section 1 above.

City of Mission Viejo VantageCare Retirement Health Savings Plan

Adoption Agreement

Exhibit B

1) Direct Employer Contributions
   a) After the completion of the 12 month minimum period of service, the City of Mission Viejo shall contribute on behalf of each Participant:
      i) $100 per month ($50 per pay period for 24 pay periods) for full-time employees
      ii) $75 per month ($37.50 per pay period for 24 pay periods) for full-time equivalents of .750 to .999
      iii) $50 per month ($25 per pay period for 24 pay periods) for full-time equivalents of .500 to .749.

   b) Contributions shall commence the first pay period following completion of the 12 month minimum period of service.

ICMA RC

City of Mission Viejo

NAME OF EMPLOYER

RETIREE WELFARE BENEFITS PLAN

RETIREE WELFARE BENEFITS PLAN

Table of Contents

City of Mission Viejo

Name of Employer

RETIREE WELFARE BENEFITS PLAN

ARTICLE I

Preamble

THIS INSTRUMENT made and published by City of Mission Viejo (hereinafter called "Employer") on the 28 day of March, 20 17, creates the Supplemental Health Account for Retired Employees Retiree Welfare Benefits Plan ("Plan"), as follows:

1.01 Establishment of Plan

The Employer named above hereby establishes a Retiree Welfare Benefits Plan as of the 1 day of July, 20 17.

1.02 Purpose of Plan

This Plan has been established to reimburse the eligible Retirees of the Employer for medical and dental expenses incurred by them, their Spouses and Dependents through the Employer's VantageCare Retirement Health Savings (RHS) Program.

ARTICLE II

Definitions

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context:

2.01 "Benefits" means any amounts paid to a Participant, Spouse or Dependents in the Plan as reimbursement for Eligible Medical and Dental Expenses incurred by the Participant during a Plan Year by him, his Spouse or his Dependents.

2.02 "Code" means the Internal Revenue Code of 1986, as amended.

2.03 "Dependent" means any individual who is a dependent of the Participant within the meaning of Code Sec. 152, as amplified by Internal Revenue Service Notice 2004-79, 2004-49 I.R.B.898 and Internal Revenue Service Notice 2010-38.

2.04 "Eligible Medical Expenses or Dental Expenses" means those expenses designated by the Employer as eligible for reimbursement in the VantageCare Retirement Health Savings Adoption Agreement.

2.05 "Employer" means the unit of state or local government creating this Plan, or any affiliate or successor thereof that likewise adopts this Plan.

2.06 "Entry Date" means the first day the Participant meets the eligibility requirements of Article III as of such Date.

2.07 "Participant" means any Retiree who has met the eligibility requirements set forth in Article III.

2.08 "Plan Administrator" means the Employer or other person appointed by the Employer who has the authority and responsibility to manage and direct the operation and administration of the Plan.

2.09 "Plan Year" means the annual accounting period of the Plan, which begins on the 1 day of July, 20 17, and ends on the 31 day of December, 20 17, with respect to the first Plan Year, and thereafter as long as this Plan remains in effect, the period that begins on January 1st, and ends on month/day December 31st.

2.10 "Retiree" means any individual who, while in the service of the Employer, was considered to be in a legal employer-employee relationship with the Employer for federal withholding tax purposes, and who was part of the classification of employees designated as covered by the Employer's VantageCare Retirement Health Savings Program.

2.11 "Spouse" means the Participant's lawful spouse as determined under the laws of the jurisdiction in which the Participant was married. All other defined terms in this Plan shall have the meanings specified in the various Articles of the Plan in which they appear.

ARTICLE III

Eligibility

Each Retiree who meets the eligibility requirements outlined in the Employer's VantageCare Retirement Health Savings Adoption Agreement shall be eligible to participate in this Plan.

ARTICLE IV

Amount of Benefits

4.01 Annual Benefits Provided by the Plan

Each Participant shall be entitled to reimbursement for his documented, Eligible Medical Expenses incurred during the Plan Year in an annual amount not to exceed the participant's account balance under the Plan.

4.02 Cost of Coverage

The expense of providing the benefits set out in Section 4.01 shall be contributed as outlined in the Employer's VantageCare Retirement Health Savings Adoption Agreement.

ARTICLE V

Payment of Benefits

5.01 Eligibility for Benefits

a) Each Participant in the Plan shall be entitled to a benefit hereunder for all Eligible Medical Expenses incurred by the Participant on or after the Entry Date of his or her participation (and after the effective date of the Plan), subject to the limitations contained in this Article V, regardless whether the mental or physical condition for which the Participant makes application for benefits under this Plan was detected, diagnosed, or treated before the Participant became covered by the Plan.

b) In order to be eligible for benefits, the Participant must separate from service or separate from service and meet the benefit eligibility criteria outlined in the Employer's VantageCare Retirement Health Savings Plan Adoption Agreement.

c) A Participant who becomes totally and permanently disabled (as defined by the Social Security Administration, by the Employer's primary retirement plan, or otherwise by the Employer) will become immediately eligible to receive medical benefit payments from the Plan. Pursuant to Section 9.02 of this Plan and Section XI of the Employer's VantageCare Retirement Health Savings Adoption Agreement, the surviving Spouse and Dependents shall become immediately eligible to receive or to continue receiving medical benefit payments from the Plan upon the death of the Participant.

5.02 Claims for Benefits

No benefit shall be paid hereunder unless a Participant, his Spouse or Dependent has first submitted a written claim for benefits to the Plan Administrator on a form specified by the Plan Administrator, and pursuant to the procedures set out in Article VI, below. Upon receipt of a properly documented claim, the Plan Administrator shall pay the Participant, his Spouse or Dependent the benefits provided under this Plan as soon as is administratively feasible.

ARTICLE VI

Plan Administration

6.01 Allocation of Authority

The Employer shall control and manage the operation and Administration of the Plan. The Employer shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Employer with respect to any matter hereunder shall be conclusive and binding on all persons.

Without limiting the generality of the foregoing, the Employer shall have the following powers and duties:

a) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan;

b) To determine the amount of benefits that shall be payable to any person in accordance with the provisions of the Plan; to inform the Plan Administrator, as appropriate, of the amount of such Benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part; and

c) To designate other persons to carry out any duty or power which would otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan.

d) To require any person to furnish such reasonable information as it may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

e) To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan.

6.02 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with operation of the Plan. The Plan Administrator, the Employer (and any person to whom it may delegate any duty or power in connection with the administration of the Plan), and all persons connected therewith may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant, (including Employees who are actuaries or accountants), consultant, third party administration service provider, legal counsel, or other specialist, and they shall be fully protected in respect to any action taken or permitted in good faith in reliance thereon. All actions so taken or permitted shall be conclusive and binding as to all persons.

6.03 Several Fiduciary Liability

To the extent permitted by law, neither the Plan Administrator nor any other person shall incur any liability for any acts or for failure to act except for his own willful misconduct or willful breach of this Plan.

6.04 Compensation of Plan Administrator

Unless otherwise agreed to by the Employer, the Plan Administrator shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of his duties shall be paid by the Employer.

6.05 Bonding

Unless otherwise determined by the Employer, or unless required by any Federal or State law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

6.06 Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third party administrative service provider, actuary, consultant, accountant, attorney, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, shall be paid by the Employer, provided, however that each Participant shall bear the monthly cost (if any) charged by a third party administrator for maintenance of his Benefit Account unless otherwise paid by the Employer.

6.07 Timeliness of Payment for Benefits

Payment for Benefits shall be made as soon as administratively feasible after the required forms and documentation have been received by the Plan Administrator.

6.08 Annual Statements

The Plan Administrator shall furnish each Participant with an annual statement of his medical expense reimbursement account within ninety (90) days after the close of each Plan Year.

ARTICLE VII

Claims Procedure

7.01 Procedure if Benefits are Denied Under the Plan

Any Participant, Spouse, Dependent, or his duly authorized representative may file a claim for a plan benefit to which the claimant believes that he is entitled. Such a claim must be in writing on a form provided by the Plan Administrator and delivered to the Plan Administrator, in person or by mail, postage paid. Within thirty (30) days after receipt of such claim, the Plan Administrator shall send to the claimant, by mail, postage prepaid, notice of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed forty-five (45) days from the end of the initial period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial 30-day period. If such extension is necessary due to a failure of the Participant, Spouse or Dependent to submit the information necessary to decide the claim, the notice of extension shall describe the required information and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide such information. The Plan Administrator shall have full discretion to deny or grant a claim in whole or in part. If notice of the denial of a claim is not furnished in accordance with this Section, the claim shall be deemed denied and the claimant shall be permitted to exercise his right to review pursuant to Sections 7.03 and 7.04.

7.02 Requirement for Written Notice of Claim Denial

The Plan Administrator shall provide, to every claimant who is denied a claim for benefits, written notice setting forth in a manner calculated to be understood by the claimant:

a) The specific reason or reasons for the denial;

b) Specific reference to pertinent Plan provisions, including references to the VantageCare Retirement Health Savings Adoption Agreement, on which the denial is based;

c) A description of any additional material of information necessary for the claimant to perfect the claim and an explanation of why such material is necessary, and

d) An explanation of the Plan's claim review procedure.

7.03 Right to Request Hearing on Benefit Denial

Within one-hundred eighty (180) days after the receipt by the claimant of written notification of the denial (in whole or in part) of his claim, the claimant or his duly authorized representative, upon written application to the Plan Administrator, in person or by certified mail, postage prepaid, may request a review of such denial, may review pertinent documents, and may submit issues and comments in writing.

7.04 Disposition of Disputed Claims

Upon its receipt of notice of a request for review, the Plan Administrator shall make a prompt decision on the review. The decision on review shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent plan provisions on which the decision is based. The decision on review shall be made not later than sixty (60) days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than one hundred-twenty (120) days after receipt of a request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial sixty (60) day period. If notice of the decision on the review is not furnished in accordance with this Section, the claim shall be deemed denied and the claimant shall be permitted to exercise his right to legal remedy pursuant to Section 7.05.

7.05 Preservation of Other Remedies

After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available.

ARTICLE VIII

Amendment or Termination of Plan

8.01 Permanency

While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 8.02 and 8.03, below.

8.02 Employer's Right to Amend

The Employer reserves the right to amend the Plan at any time and from time-to-time, and retroactively if deemed necessary or appropriate to meet the requirements of the Code, or any similar provisions of subsequent revenue or other laws, or the rules and regulations in effect under any of such laws or to conform with governmental regulations or other policies, to modify or amend in whole or in part any or all of the provisions of the Plan.

8.03 Employer's Right to Terminate

The Employer reserves the right to discontinue or terminate the Plan at any time without prejudice.

ARTICLE IX

General Provisions

9.01 No Employment Rights Conferred

Neither this Plan nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

9.02 Payments After Death of Participant

Any benefits otherwise payable to a Participant following the date of death of such Participant shall be paid as outlined in Section XI of the Employer's VantageCare Retirement Health Savings Plan Adoption Agreement.

9.03 Nonalienation of Benefits

No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person. If any person entitled to benefits under the Plan becomes bankrupt or attempts to anticipate, alienate, sell, transfer, assign, pledge, encumber or charge any benefit under the Plan, or if any attempt is made to subject any such benefit to the debts, contracts, liabilities, engagements or torts of the person entitled to any such benefit, except as specifically provided in the Plan, then such benefit shall cease and terminate in the discretion of the Plan Administrator, and he may hold or apply the same or any part thereof to the benefit of any dependent of such person, in such manner and proportion as he may deem proper.

9.04 Mental or Physical Incompetency

If the Plan Administrator determines that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, he may cause all payments thereafter becoming due to such person to be made to any other person for his benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Plan Administrator and the Employer.

9.05 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because he cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Participant or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Participant or other person shall be escheated under the laws of the State of the last known address of the Participant or other persons eligible for benefits.

9.06 Requirement of Proper Forms

All communications in connection with the Plan made by a Participant shall become effective only when duly executed on forms provided by and filed with the Plan Administrator.

9.07 Source of Payments

The Employer shall be the sole source of benefits under the Plan. No Employee, Spouse or Dependents shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee, Spouse or Dependents.

9.08 Tax Effects

Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether any payments received by a Participant, his Spouse or Dependents hereunder will be treated as includible in gross income for federal or state income tax purposes.

9.09 Multiple Functions

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

9.10 Gender and Number

Masculine pronouns include the feminine as well as the neuter gender, and the singular shall include the plural, unless indicated otherwise by the context.

9.11 Headings

The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

9.12 Applicable Laws

The provisions of the Plan shall be construed, administered and enforced according to the laws of the State of CA.

9.13 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

IN WITNESS WHEREOF, we have executed this Plan Agreement the date and year first written above.

EMPLOYER

By: _____ Title: City Manager

Signature of Authorized Official

ATTEST (if applicable)

By: _____ Title: Director of Administrative Services

Signature of Attestor

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

This matrix outlines the qualifying events under Section 125 which allow election changes during the Plan Year and the permissible changes allowed for each Plan Class. You will see codes, footnotes, or endnotes showing restrictions or qualifications following each action. The code definitions can be found on page 11. The endnotes (also defined on page 11) contain information that is referred to on more than one page. Information that only refers to one place is placed in footnotes with that information shown at the bottom of that particular page. The P/C column refers to Personal or City events. This matrix does not address changes to individually owned policies. To find allowable changes, look under the Plan Class pertinent to the individual policy.

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1. STATUS CHANGES											
1.1 Change in Employee's Legal Marital Status											
1.1.1 Employee Gains Spouse: Marriage	P	Add sp/dep: H1,C,T Drop dependents: C1 Drop Coverage: C1	Add sp/dep: H2,C,T Drop dependents: C1 Drop Coverage: C1	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Increase coverage: C,H2 Decrease coverage[1]: C	Add Coverage[2]: C2 Increase coverage[2]: C2 Drop Coverage[3]: C2 Decrease coverage[3]: C2	Add sp/dep: C,H2,T Drop Coverage: C1 Drop sp/dep: C1	Add sp/dep: C,H2,T Drop Coverage: C1 Drop sp/dep: C1	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN
1.1.2 Lose Spouse: Divorce, Legal Separation, Annulment, Death of Spouse	P	Add Coverage[4]: C,H1 Add dependents[4]: H1,C Revoke election only for spouse: C	Add Coverage[4]: C,H2 Add dependents[4]: C,H2 Revoke election only for spouse: C	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage:C, H2 [5] Increase Coverage: C, H2[5] Decrease coverage[6]: C,H2	Add Coverage[2]: C2 Increase Coverage[2]: C2 Drop Coverage[7]: C2 Decrease coverage[7]: C2	Add Coverage[4]: C,H2 Add dependents[4]: C,H2 Revoke election only for spouse: C	Add Coverage[4]: C,H2 Add dependents[2]: C,H2 Revoke election only for spouse: C	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN
1.2 Change in Number of Employee's Dependents											
1.2.1 Gain Dependent: Birth, Adoption, Legal Guardianship	P	Add Coverage: H1,T,C Add sp/dep: H1,T,C	Add Coverage: H2 T,C Add sp/dep: C,H2,T	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: C,H2 Increase coverage: C, H2	Add Coverage: C2 Increase coverage C2,	Add Coverage: H2,T,C Add sp/dep: H2,T,C	Add Coverage: H2 T ,C Add sp/dep: H2,T,C	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1.2.2 Lose Dependent: Death, Placement for Adoption	P	Drop affected dependent: C	Drop affected dependent: C	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Decrease coverage[8]: C	Decrease coverage[6]	Drop affected dependent: C	Drop affected dependent: C	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN
1.3 Change in Employment Status of Employee, Spouse, or Dependent that Affects Eligibility*											
1.3.1 Employee Gains Eligibility under Employer's Plan	P	Add Coverage: EY,C,T	Add Coverage: EY,C,T	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EY,C	Add Coverage: EY,C2	Add Coverage: EY,C,T	Add Coverage: EY,C,T	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN
1.3.2 Employee Maintains Prior Eligibility under Employer's Plan after return from termination or unpaid leave within 30 days.	C	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9]:	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9] [10]	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9]:	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9]
1.3.3 Employee Rehired or returns from non-FMLA leave without pay after 30 days[19]	P	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.
1.3.4 Employee Loses Eligibility under Employer's Plan through Change in Employment	C	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]

* Can be such events as starting or ending employment; switching between part time and full time, hourly and salary; starting or ending strike/lockout; or any other event causing gain or loss of eligibility.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1.3.5 Spouse/Dependent Gains Eligibility under their Employer's Plan	P	Drop Coverage[12] Drop sp/dep[12]	Drop Coverage[12] Drop sp/dep[12]	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Decrease coverage[12]: C	Add Coverage[13] Increase coverage[13] Drop Coverage[12]	Drop Coverage[12] Drop sp/dep[12]	Drop Coverage[12] Drop sp/dep[12]	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN
1.3.6 Spouse/Dependent Loses Eligibility under their Employer's Plan	P	Add Coverage[14]: T,H1 Add sp/dep[14]: T, H1,	Add Coverage[14]: T, H2 Add sp/dep[14]: T, H2	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Add Coverage[14]: H2 Increase coverage[14]: H2	Add Coverage[14] Increase coverage[14] Drop Coverage[15]	Add Coverage[14]: T, H2 Add sp/dep[14]: T, H2	Add Coverage[14]: T, H2 Add sp/dep[14]: T, H2	Increase coverage: EN Decrease coverage: EN
1.4 Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirement*											
1.4.1 Dependent Gains Eligibility under Employee's Plan	P	Add dependents: C,T	Add dependents: C,T	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Add Coverage[16]: C Increase coverage[16]: C	Add Coverage[8]: C2 Increase coverage[8]: C2	Add dependents: C,T	Add dependents: C,T	Increase coverage: EN Decrease coverage: EN
1.4.2 Dependent Loses Eligibility under Employee's Plan	P	Drop affected dependent: C	Drop affected dependent: C	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Decrease coverage: [8] C	Decrease coverage[8]: C2	Drop affected dependent: C	Drop affected dependent: C	Increase coverage: EN Decrease coverage: EN
1.5 Change in Place of Residence of Employee, Spouse, or Dependent											
1.5.1 Move by Employee Causes Gain of Eligibility	P	Add Coverage: EY,C	Add Coverage: EY,C	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage[17]: C Decrease coverage[17]: C	Not applicable.	Add Coverage: EY,C	Add Coverage: EY,C	Increase coverage: EN Decrease coverage: EN
1.5.2 Move by Employee causes Loss of Eligibility	P	Drop and elect similar coverage: E,C,DY	Drop and elect similar coverage: E, C,DY	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase Coverage: EN Decrease Coverage: EN	Increase coverage[17]: C Decrease coverage[17]: C	Not applicable.	Drop and elect similar coverage: E, C,DY	Drop and elect similar coverage: E, C,DY	Increase Coverage: EN Decrease Coverage: EN
1.5.3 Employee moves out of HMO Service Area*	P	Drop and elect similar coverage: E,C,DY	Drop and elect similar coverage: E,C,DY	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	No change allowed. [18]	Not applicable	Drop and elect similar coverage: E,C,DY	Drop and elect similar coverage: E,C,DY	Increase coverage: EN Decrease coverage: EN

* Can be such actions as attaining a specified age; switching between single and married, student or non-student, or any other event causing gain or loss of eligibility.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1.5.4 Spouse's or Dependent's move causes gain of eligibility	P	Add sp/dep: EY,C	Add sp/dep: EY,C	Increase Coverage: EN Decrease Coverage: EN	Increase Coverage: EN Decrease Coverage: EN	Increase Coverage: EN Decrease Coverage: EN	Increase coverage[17]: C Decrease coverage[17]: C	Not applicable.	Add sp/dep: EY,C	Add sp/dep: EY,C	Increase Coverage: EN Decrease Coverage: EN
1.5.5 Spouse's or Dependent's move causes loss of eligibility	P	Drop sp/dep: E,C	Drop sp/dep: E,C	Increase Coverage: EN Decrease Coverage: EN	Increase Coverage: EN Decrease Coverage: EN	Increase Coverage: EN Decrease Coverage: EN	Increase coverage[17]: C Decrease coverage[17]: C	Not applicable.	Drop sp/dep: E,C	Drop sp/dep: E,C	Increase Coverage: EN Decrease Coverage: EN
2. SMALL COST CHANGES[19]											
2.1 Small Cost Changes[19]											
2.1.1 Employer- Initiated Automatic Small Cost Changes: Includes Collective Bargaining	C	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	No change allowed.	Not applicable	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost
2.1.2[20] Employer-Submitted Automatic Small Cost Changes for Individuals†	C	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	No change allowed.	Not applicable	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost
2.1.3 Employee-Initiated Small Cost Changes: DCAP Provider or Personal Policy	P	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Increase or Decrease Cost‡ [19]	Not applicable	Not applicable	Not applicable
3. SIGNIFICANT COST CHANGES[19]											
3.1 Significant Cost Increases[19]											
3.1.1a[20] Employer-Submitted Significant Cost Increase	C	Increase Costs	Increase Costs	Increase Costs	Increase Costs	Increase Costs	No change allowed.	Not applicable	Increase Costs	Increase Costs	Increase Costs

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* Notice that the employee has the option of dropping the election even when similar coverage is available.

† Includes pre-established cost change parameters such as increases in life insurance triggered by salary increase or credit provisions, changes resulting from employee satisfying requirement such as stop smoking, or any similar event which changes cost of premium.

‡ No change allowed if day care provider is a relative of the employee.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
3.1.1b Permitted Response by Employee to Employer-Submitted Significant Cost Increase	P	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	No change allowed.	Not applicable	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY
3.2 Significant Cost Decreases[19]											
3.2.1a Employer-Submitted Significant Cost Decrease	C	Decrease Costs	Decrease Costs	Decrease Costs	Decrease Costs	Decrease Costs	No change allowed	Not applicable	Decrease Costs	Decrease Costs	Decrease Costs
3.2.1b Permitted Response by Employee to Significant Cost Decrease	P	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	No change allowed	Not applicable	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage
4. SIGNIFICANT CURTAILMENT OF COVERAGE											
4.1 Significant Coverage Curtailment											
4.1.1a Employer-Initiated Significant Coverage Curtailment	C	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment	No change allowed.	No change allowed.	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment
4.1.1b Permitted Response by Employee to Significant Coverage Curtailment	P	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN	No change allowed.	No change allowed.	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN
4.1.1c Permitted Response by Employee to Curtailment Resulting in Loss of Coverage*	P	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	No change allowed.	No change allowed	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY
5. ADDITION OR IMPROVEMENT OF BENEFIT PACKAGE OPTION											
5.1 Change in Benefits Offered under Cafeteria Plan											
5.1.1a Employer Adds New Benefit or Option	C	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	No change allowed.	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System

* Complete loss of coverage under the benefit package option or other coverage option (such as HMO ceasing to be available where employee reside or employee losing coverage because of overall annual or lifetime limitation). Plan has discretion to treat the following as a loss of coverage: substantial decrease in medical care providers, reduction in benefits for specific type of medical condition that employee or dependents are being treated , and similar fundamental coverage loss (this leaves room for additional reasons).

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
5.1.1b Permitted Response by Employee to Addition of New Benefit or Option	P	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	No change allowed.	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage
5.1.2a Employer Drops Existing Benefit or Option	C	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	No change allowed.	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System
5.1.2b Permitted Response by Employee to Drop of Existing Benefit or Option	P	Elect similar coverage	Elect similar coverage	Elect similar coverage	Elect similar coverage	Elect similar coverage	No change allowed.	Elect similar coverage	Elect similar coverage	Elect similar coverage	Elect similar coverage
5.1.3a Employer Replaces one Benefit or Option with Similar Benefit or Option	C	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	No change allowed.	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System
5.1.3b Permitted Response by Employee to Replacement of Benefit or Option	P	No change allowed unless considered significant cost increase or coverage curtailment.*	No change allowed unless considered significant cost increase or coverage curtailment.‡‡	No change allowed unless considered significant cost increase or coverage curtailment.‡‡	No change allowed unless considered significant cost increase or coverage curtailment.‡‡	No change allowed unless considered significant cost increase or coverage curtailment.‡‡	No change allowed.	No change allowed unless considered significant cost increase or coverage curtailment.‡‡	No change allowed unless considered significant cost increase or coverage curtailment.‡‡	No change allowed unless considered significant cost increase or coverage curtailment.‡‡	No change allowed unless considered significant cost increase or coverage curtailment.‡‡
5.1.4a Significant Improvement of Benefit or Option	C	Enter event in system.	Enter event in system.	Enter event in system.	Enter event in system.	Enter event in system.	No change Allowed	Not Applicable	Enter event in system.	Enter event in system.	Enter event in system.
5.1.4b Permitted Response by Employee to Significant Improvement of Benefit or Option	P	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	No change allowed.	Not applicable.	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage
5.15 Employee changes DCAP providers	P	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Change Deductions to reflect new rates†	Not applicable	Not applicable	Not applicable

* See significant cost change or coverage curtailment section for employee options.

† Deductions can be changed to zero if relative is keeping child for free.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
5.16 DCAP Provider FN changed rates	P	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Change Deductions to reflect new rates*			
6. CHANGE IN COVERAGE UNDER ANOTHER EMPLOYER PLAN†											
6.1 Change in Coverage of Spouse or Dependent under Another Employer Plan†††											
6.1.1 Another Employer Plan Adds or Increases Coverage[20]	P	Drop Coverage[21] Drop sp/dep[21]	Drop Coverage[21] Drop sp/dep[21]	Drop Coverage[21] Decrease coverage[21]	Drop Coverage[21] Decrease coverage[21]	Drop Coverage[21] Decrease coverage[21]	No change allowed.	Drop Coverage[21] Decrease coverage[21]	Drop Coverage[21] Drop sp/dep[21]	Drop Coverage[21] Drop sp/dep[21]	Drop Coverage[21] Decrease coverage[21]
6.1.2 Another Employer Plan Drops or Decreases Coverage[20]	P	Add Coverage[22] Add sp/dep[22]	Add Coverage[22] Add sp/dep[22]	Add Coverage[22] Increase coverage: [22]	Add Coverage[22] Increase coverage: [22]	Add Coverage[22] Increase coverage: [22]	No change allowed.	Add Coverage[22] Increase coverage: [22]	Add Coverage[22] Add sp/dep[22]	Add Coverage[22] Add sp/dep[22]	Add Coverage[22] Increase coverage: [22]
6.1.3 Open Enrollment under Employer Plan of Spouse or dependent'	P	Add Coverage[22] Add sp/dep[22] Drop Coverage[21] Drop sp/dep[21]	Add Coverage[22] Add sp/dep[22] Drop Coverage[21] Drop sp/dep[21]	Add Coverage[22] Increase coverage[22] Drop Coverage[21] Decrease coverage[21]	Add Coverage[22] Increase coverage[22] Drop Coverage[21] Decrease coverage[21]	Add Coverage[22] Increase coverage[22] Drop Coverage[21] Decrease coverage[21]	No change allowed.	Add Coverage[22] Increase coverage[22] Drop Coverage[21] Decrease coverage[21]	Add Coverage[22] Add sp/dep[22] Drop Coverage[21] Drop sp/dep[21]	Add Coverage[22] Add sp/dep[22] Drop Coverage[21] Drop sp/dep[21]	Add Coverage[22] Increase coverage[22] Drop Coverage[21] Decrease coverage[21]
6.1.4 Employee, Spouse, or Dependent loses coverage under group health plan of a governmental or educational institution‡	P	Add Coverage§ Add affected dependent	Add Coverage§§§ Add affected dependent	Not Applicable	Not Applicable	Not Applicable	No change allowed.	Not Applicable	Add Coverage§§§ Add affected dependent	Add Coverage§§§ Add affected dependent	Not Applicable

* DCAP Provider cannot be relative.

* Rates cannot be changed if the Day Care Provider is a relative.

† The employer plan can be a cafeteria plan or qualified benefits plan of the same employer or of another employer,

‡ Includes (a) A State's child health insurance program (SCHIP) under Title XXI of the Social Security Act, (b) a medical care program of an Indian Tribal government (as defined in Section 7701(a)(40)), the Indian Health Service, or a tribal organization, (c) a State health benefits risk pool, or (d) a Foreign government group health plan.

§ Evidently, only the affected person can be added. If so, the only time coverage previously not elected can only be added if the affected individual is the employee.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
7. FMLA LEAVE											
7.1 Commencement of FMLA Leave											
7.1.1 Employee begins FMLA Leave	P	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA
7.2 Return from FMLA Leave											
7.2.1 Employee returns from FMLA Leave	P	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA
8. COBRA EVENTS											
8.1 COBRA (or similar state law continuation) Events											
8.1.1 Employee COBRA Event with Employee remaining eligible for Cafeteria Plan*	P	Increase coverage[23]	Increase coverage[23]	No change allowed	No change allowed	No change allowed	No change allowed	No change allowed	Increase coverage [23]	Increase coverage [23]	No change allowed.
8.1.2 Spouse/Dependent COBRA Event†.	P	Increase coverage [23] [24]	Increase coverage[23] [24]	No change allowed	No change allowed	No change allowed	No change allowed	No change allowed	Increase coverage [23] [24]	Increase coverage [23] [24]	Increase coverage [23] [24]
9. JUDGMENT, DECREE, OR ORDER											
9.1 Judgment, Decree, or Order Requires Coverage of Code § 152 Dependent Child to be Provided by Employee											
9.1.1 Judgment, Decree, or Order Requires Coverage under Employee's Plan	P	Add Coverage: C Add affected dependent	Add Coverage: C Add affected dependent	No change allowed.	No change allowed.	No change allowed.	Add Coverage: C Increase coverage	No change allowed.	Add Coverage: C Add affected dependent	Add Coverage: C Add affected dependent	No change allowed.

* Such as reduction in work hours resulting in employee no longer eligible for employer contribution credit.

† Such as dependent reaching maximum age under group plan and employee continues coverage for dependent under COBRA.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
9.2 Judgment, Decree, or Order Requires Coverage of Code § 152 Dependent to be Provided by Spouse, Former Spouse, or Other Person											
9.2.1 Judgment, Decree, or Order Requires Spouse, Former Spouse, or Other Person to Provide Coverage	P	Drop affected dependent: C3	Drop affected dependent: C3	No change allowed.	No change allowed.	No change allowed.	Decrease coverage: C3	No change allowed.	Drop affected dependent: C3	Drop affected dependent: C3	No change allowed.
10. ENTITLEMENT TO MEDICARE OR MEDICAID*											
10.1 Employee or Employee's Spouse or Dependent Becomes Entitled to Medicare and Medicaid ‡‡‡‡											
10.1.1 Employee Becomes Entitled	P	Drop Coverage	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Decrease coverage: C Increase coverage[25]	No change allowed.	No change allowed.	No change allowed.	No change allowed.
10.1.2 Spouse/Dependent under Employer's Plan Becomes Entitled	P	Drop sp/dep:	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Decrease coverage: C Increase coverage[25]	No change allowed.	No change allowed.	No change allowed.	No change allowed.
10.2 Employee or Employee's Sp/dep Loses Eligibility for Medicare and Medicaid											
10.2.1 Employee Loses Eligibility	P	Add Coverage: C	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Increase coverage: C Decrease[26] coverage	No change allowed.	No change allowed.	No change allowed.	No change allowed.
10.2.2 Spouse/Dependent under Employer's Plan Loses Eligibility	P	Add sp/dep: C	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Increase coverage: C Decrease coverage[26]	No change allowed.	No change allowed.	No change allowed.	No change allowed.
11. ADMINISTRATIVE EVENTS											
11.1 Correcting Obvious Errors†											
11.1.1 Employee mistake in an making election	C	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.

* Other than coverage solely for pediatric vaccines.

† Must have "clear and convincing" evidence.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
11.1.2 Employer mistake in recording election	C	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.
11.2 Employee Fails Medical Underwriting											
11.2.1 Participant fails medical underwriting	C	Not applicable	Revoke coverage as of date it was added.	Revoke coverage as of date it was added.	Revoke coverage as of date it was added.	Revoke coverage as of date it was added.	Not applicable	Not applicable	Not applicable	Not applicable	Revoke coverage as of date it was added.
11.3 Adjustments to Meet Federal Requirements[19]											
11.3.1 Changes needed to maintain plan's status under Code § 125 or to prevent violation of the nondiscrimination rules.	C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C

Notes:

- Change in eligibility for non-employer-sponsored coverage (other than Medicare and Medicaid) will not allow a change.
- Dependent is defined to be a tax dependent under Code § 152 except, for accident or health coverage, any child to whom Code § 152(e) applies is treated as a dependent of both parents.
- Health FSA coverage can never be changed solely on account of a change in cost or coverage under another plan.
- Increase coverage can be increases in volume, dollar, or amount.
- A plan may treat coverage by another employer, such as a spouse’s or dependent’s employer, as similar coverage.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

CODES USED IN MATRIX

C..... Must be consistent with change.

C1..... Only if coverage for individual becomes effective or is increased under the other employer's plan.

C2..... Consistency rule is satisfied if the election change is on account of and corresponds with a change of status that either (1) affects eligibility for coverage under an employer's plan or (2) affects eligibility of DCAP expenses for tax exclusions under Code § 129.

C3 ... Coverage for the affected dependent cannot be dropped unless the coverage is actually picked up by the spouse, former spouse, or other person.

DY .... Can drop altogether if alternative coverage is not available.

DN .... Cannot drop even if alternative coverage is not available.

D..... Can drop even if alternative coverage is available.

E..... Eligibility must be affected.

EN .... Eligibility need not be impacted.

EY..... Eligibility must be gained.

H1..... HIPAA special enrollment rights apply. (Retroactive election changes are only allowed for changes resulting from birth, adoption, or placement for adoption submitted within 30 days of event.)

H2..... HIPAA special enrollment rights likely do not apply.

H3..... HIPAA special enrollment rights do not apply.

PD .... Must be addressed in Plan Document.

T ..... Tag-Along Rule applies (can change for dependents who were previously eligible for coverage).

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[1] If employee or dependents become eligible dependents under new spouse's health plan.

[2] If change creates or increases need for child care.

[3] If spouse is not employed or makes DCAP FSA election on spouse's employer's Plan

[4] If eligibility is lost under spouse's plan as a result of the divorce, legal separation, annulment or death

[5] Only if coverage is lost under spouse's major medical plan.

[6] To take into account expenses of affected spouse.

[7] If change decreases or negates need for day care

[8] To take into account expenses of affected dependent.

[9] Can have Plan Documents prohibit participation until next plan year.

[10] Balances and current annual election remain the same and employee cannot be made to make up missed contributions.

[11] Underlying coverage's ceases in accordance with component plan.

[12] If added to spouse's or dependent's coverage.

[13] If spouse previously did not work.

[14] If dropped from spouse's or dependent's coverage.

[15] If spouse no longer works.

[16] Only if dependent gains eligibility under Health FSA.

[17] If underlying health coverage change occurs.

[18] Not even if underlying health coverage change occurs.

[19] Must be addressed in plan documents.

[20] Includes cost changes resulting from actions taken by employee, such as switching from full-time to part-time or vice-versa.

[21] If employee, spouse, or dependent have received corresponding increased coverage or added coverage under other employer's plan.

[22] If employee, spouse, or dependent have received corresponding decreased coverage or dropped coverage under other employer's plan.

[23] To cover increased amount of employee's contribution.
[24] If individual still qualifies as tax dependent of employee.
[25] Only if prior employer coverage was more comprehensive.
[26] On if the employer plan is more comprehensive.

CITY OF MISSION VIEJO
CAFETERIA PLAN

AND ALL SUPPORTING FORMS HAVE BEEN PRODUCED FOR

City of Mission Viejo

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CITY OF MISSION VIEJO
CAFETERIA PLAN

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CITY OF MISSION VIEJO
CAFETERIA PLAN

INTRODUCTION

The Employer has amended this Plan effective January 1, 2015, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on January 1, 2004. The Plan shall be known as City of Mission Viejo Cafeteria Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I
DEFINITIONS

1.1 **"Administrator"** means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 **"Affiliated Employer"** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.7 **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)).

"Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his/her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

1.8 **"Effective Date"** means January 1, 2004.

1.9 **"Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

Employees whose employment is governed by the terms of a collective bargaining agreement between Employee representatives (within the meaning of Code Section 7701(a)(46)) and the Employer under which benefits were the subject of good faith bargaining between the parties, unless such agreement expressly provides for such coverage in this Plan, will not be eligible to participate in this Plan.

However, Employees who are "leased employees" as defined in Code Section 414(n)(2) shall not be eligible to participate in this Plan.

Also, any Employee or former Employee shall not be eligible to participate in this Plan unless he is eligible to receive medical benefits pursuant to a group medical plan sponsored by the Employer.

However, any Employee who is a "part-time" Employee shall not be eligible to participate in this Plan. A "part-time" Employee is any Employee who works, or is expected to work on a regular basis, less than 20 hours a week and is designated as a part-time Employee on the Employer's personnel records.

However, any Employee who is a nonresident alien and who receives no earned income (within the meaning of Code Section 911(d)(2)) from the Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)), shall not be eligible to participate in this Plan.

1.11 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 **"Employer"** means City of Mission Viejo and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

1.13 **"Employer Contribution"** means the contributions made by the Employer pursuant to Section 3.1 to enable a Participant to purchase Benefits. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V and as set forth in Section 3.1.

1.14 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.15 **"Insurance Premium Payment Plan"** means the plan of benefits contained in Section 4.1 of this Plan, which provides for the payment of Premium Expenses.

1.16 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan.

1.17 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.18 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.19 **"Plan"** means this instrument, including all amendments thereto.

1.20 **"Plan Year"** means the 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.21 **"Premium Expenses"** or **"Premiums"** mean the Participant's cost for the Benefits described in Section 4.1.

1.22 **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

1.23 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.2. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.24 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.25 **"Spouse"** means "spouse" as defined in an Insurance Contract for purposes of coverage under that Contract only or the "spouse," as defined under Federal law, of a Participant, unless legally separated by court decree.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the entry date under the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

(a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.6;

(b) **Change in employment status.** The end of the Plan Year during which the Participant became a limited Participant because of a change in employment status pursuant to Section 2.5;

(c) **Death.** The Participant's death, subject to the provisions of Section 2.7; or

(d) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2.

2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be eligible to participate because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. As a limited Participant, no further Salary Redirection may be made on behalf of the Participant, and, except as otherwise provided herein, all further Benefit elections shall cease, subject to the limited Participant's right to continue coverage under any Insurance Contracts. However, any balances in the limited Participant's Dependent Care Flexible Spending Account may be used during such Plan Year to reimburse the limited Participant for any allowable Employment-Related Dependent Care incurred during the Plan Year. Subject to the provisions of Section 2.6, if the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided he otherwise satisfies the participation requirements set forth in this Article II as if he were a new Employee and made an election in accordance with Section 5.1.

2.6 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

(a) **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

(b) **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred up to the date of termination and submitted within 90 days after termination, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 11.14 of the Plan.

2.7 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 EMPLOYER CONTRIBUTION

The Employer shall make available to each Participant an Employer Contribution to be used for any Benefit under the Plan in an amount to be determined by the Employer prior to the beginning of each Plan Year. Each Participant's Employer Contribution shall be converted to Cafeteria Plan Benefit Dollars and be available to purchase Benefits hereunder. The Employer's Contribution shall be made on a pro rata basis for each pay period of the Participant. If a Participant fails to make any election of Benefit Option, then the Employer Contribution shall be distributed in cash to the Participant.

3.2 SALARY REDIRECTION

If a Participant's Employer Contribution is not sufficient to cover the cost of Benefits or Premium Expenses he elects pursuant to Section 4.1, his Compensation will be reduced in an amount equal to the difference between the cost of Benefits he elected and the amount of Employer Contribution available to him. Such reduction shall be his Salary Redirection, which the Employer will use on his behalf, together with his Employer Contribution, to pay for the Benefits he elected. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.3 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Employer Contribution and Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.4 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

(1) Health Flexible Spending Account

(2) Dependent Care Flexible Spending Account

(3) Insurance Premium Payment Plan

(i) Health Insurance Benefit

(ii) Dental Insurance Benefit

(iii) Vision Insurance Benefit

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

(b) **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

4.6 VISION INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.

(b) **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

4.7 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with the Code and regulations. Any act taken by the Administrator shall be carried out in a uniform and nondiscriminatory manner. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

Any Participant failing to complete an election of benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year.

5.4 CHANGE IN STATUS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and guidance thereunder, shall qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's

employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

(l) **Health FSA amount can only increase.** A Participant may only increase his Benefit elections under the Health Flexible Spending Account in the event of a change in status.

(m) **Changes due to reduction in hours or enrollment in an Exchange Plan.** A Participant may prospectively revoke coverage under the group health plan (that is not a health Flexible Spending Account) which provides minimum essential coverage (as defined in Code § 5000A(f)(1)) provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

(1) The Participant has been reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(2) The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan:

(1) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the Participant and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

6.3 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $2,500.00.

(b) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Flexible Spending Account contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Flexible Spending Account.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not

utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year subject to Section 2.6, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment.

6.8 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.4.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

6.9 QUALIFIED RESERVIST DISTRIBUTIONS

(a) **Qualified Reservist Distribution.** A Participant may request a Qualified Reservist Distribution, provided the following provisions are satisfied. "Qualified Reservist Distribution" means any distribution to a Participant of all or a portion of the balance in the Participant's Health Flexible Spending Account if:

(1) Such Participant was an individual who was (by reason of being a member of a reserve component (as defined in Section 101 of Title 37, United States Code)) ordered or called to active duty for a period of 180 days or more or for an indefinite period.

(2) A Participant may have been called prior to June 18, 2008, provided the individual's active duty continues after June 18, 2008 and the period of duty complies with subsection (a).

(3) The distribution is made during the period beginning on the date of the order or call that applies to the Participant and ending on the last day of the Plan Year which includes the date of such order or call.

(4) The Qualified Reservist Distribution option is offered to all Participants who qualify under this Article.

(5) Qualified Reservist Distributions may only be made if the Participant is ordered or called to active duty, not the Participant's spouse or dependents.

(6) Under Section 101 of the Title 37 of the United States Code, "reserve component" means: (1) the Army National Guard, (2) the Army Reserve, (3) the Navy Reserve, (4) the Marine Corps Reserve, (5) the Air National Guard, (6) the Air Force Reserve, (7) the Coast Guard Reserve, or (8) the Reserve Corps of the Public Health Service.

(b) **Conditions:** The following conditions apply:

(1) The Employer must receive a copy of the order or call to active duty and may rely on the order or call to determine the period that the Participant has been ordered or called to duty.

(2) Eligibility for a Qualified Reservist Distribution is not affected if the order or call is for 180 days or more or is indefinite, but the actual period of active duty is less than 180 days or is changed otherwise from the order or call.

(3) If the original order is less than 180 days, then no Qualified Reservist Distribution is allowed. However, if subsequent calls or orders increase the total days of active duty to 180 or more, then a Qualified Reservist Distribution will be allowed.

(c) **Amount:** The amount a Participant may be reimbursed from the Health Flexible Spending Account is the entire amount elected by the Participant for the Plan Year less any reimbursements received (or in process) as of the date of the distribution request.

(d) **Procedure.** The Employer must specify a process for requesting the distribution. The Employer may limit the number of distributions processed for a Participant to 1 per Plan Year. The distribution request must be made on or after the call or order and before the last day of the Plan Year. The QRD shall be paid within a reasonable time but in no event more than 60 days after the date of the request.

(e) **Claims.** Claims incurred prior to the date of the request of the distribution shall be paid as any other claim. Claims incurred after the date of the distribution shall not be paid and the Participant's right to submit a claim shall be terminated as of the date of the distribution request.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

(a) **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under

this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment.

7.13 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Employment-Related Dependent Care Expenses, subject to the following terms:

(a) **Card only for dependent care expenses.** Each Participant issued a card shall certify that such card shall only be used for Employment-Related Dependent Care Expenses. The Participant shall also certify that any Employment-Related Dependent Care Expense paid with the card has not already been reimbursed by any other plan covering dependent care benefits and that the Participant will not seek reimbursement from any other plan covering dependent care benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Dependent Care Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Dependent Care Flexible Spending Account.

(c) **Only available for use with certain service providers.** The cards shall only be accepted by such service providers as have been approved by the Administrator. The cards shall only be used for Employment-Related Dependent Care Expenses from these providers.

(d) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(e) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as an Employment-Related Dependent Care Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.

(b) **Dependent Care Flexible Spending Account or Health Flexible Spending Account claims.** Any claim for Dependent Care Flexible Spending Account or Health Flexible Spending Account Benefits shall be made to the Administrator. For the Health Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment. For the Dependent Care Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific references to the pertinent Plan provisions on which the denial is based;

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(3) an explanation of the Plan's claim procedure.

(c) **Appeal.** Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

(1) request a review upon written notice to the Administrator;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

(d) **Review of appeal.** A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(e) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account or Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal in writing (or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.5 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.12.

11.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.7 EMPLOYER'S PROTECTIVE CLAUSES

(a) **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

(b) **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

11.8 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

11.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.10 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.11 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of California.

11.12 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.13 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.14 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

11.15 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

11.16 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

11.17 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

11.18 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(d) **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

11.19 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.18.

11.20 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

11.21 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

11.22 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

11.23 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

IN WITNESS WHEREOF, this Plan document is hereby executed this 19th day of October 2016.

City of Mission Viejo

By _____
EMPLOYER

AMENDMENT TO THE
CITY OF MISSION VIEJO
CAFETERIA PLAN

The City of Mission Viejo Cafeteria Plan (the "Plan"), as amended effective January 1, 2015, is hereby amended in the following respects, effective January 1, 2016:

1. Section 3.1, entitled "Employer Contribution," is restated to read as follows:

The Employer may in its sole discretion make available to each Participant an Employer Contribution in an amount to be determined by the Employer before the beginning of each Plan Year. Each Participant's Employer Contribution will be converted to Cafeteria Plan Benefit Dollars and will be available to purchase Benefits hereunder or, subject to any conditions imposed by the Employer in its discretion (which condition may include a benefit waiver), paid in cash to the Participant, or both. The Employer Contribution amount may vary depending on the Participant's elections under the Plan, or any other factor determined by the Employer. The Employer Contribution will be made on a pro rata basis for each pay period of the Participant or over such other period as the Employer may determine. If the Employer Contribution exceeds the cost of Benefit Options elected by the Participant, all or a portion of such excess amounts may, in the discretion of the Employer, be distributed in cash to the Participant.

2. Section 6.4, entitled "Limitation on Allocations," is amended by restating subsection (a) to read as follows:

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary:

(i) the maximum amount that may be allocated to the Health Flexible Spending Account through a Participant's Salary Redirection Agreement in or on account of any Plan Year is the lesser of (A) $2,550, as adjusted for cost of living from time to time under Code Section 125(i), or (B) any lesser amount established by the Employer for the Plan Year; and

(ii) the maximum benefit payable to any Participant from the Health Flexible Spending Account in or on account of any Plan Year is the greater of: (A) two times the Participant's Salary Redirection election allocated to the Health Flexible Spending Account for the Plan Year, or (B) $500 plus the amount of the Participant's Salary Redirection election allocated to the Health Flexible Spending Account for the Plan Year.

CITY OF MISSION VIEJO

By: _____

Title: City Manager

Date: 10-19-16

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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 coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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 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.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Monique Goetz, HR Manager 949-470-8416.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
City of Mission Viejo	932-03107
5. Employer address	**6. Employer phone number**
200 Civic Center	949-470-3060

7. City	8. State	9. ZIP code
Mission Viejo	CA	92691

10. Who can we contact about employee health coverage at this job?
Monique Goetz, Human Resources Manager

11. Phone number (if different from above)	12. Email address
949-470-3060	mgoetz@cityofmissionviejo.org

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

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

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Individuals are eligible to participate in employee benefits if they fall into any of the following categories: A full-time employee, An at-will executive employee, A part-time employee in a budgeted position listed on the Authorized Position Schedule and is scheduled to regularly work twenty (20) or more hours per week, An Hourly/Seasonal/Temporary employee determined to have worked thirty (30) or more hours per week during an initial or standard measurement period.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse; Domestic Partner; Natural, adopted, step, or domestic partner's children up to age 26.

☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? 1st of the month following enrollment form submission (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ See Rate Sheet
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

DELTA DENTAL®

Your Smile, Your Choice

Delta Dental PPO™ & DeltaCare® USA

You can choose between two dental plans from Delta Dental. Either way, you'll get reliable dentist networks and affordable preventive care. Your options are:

Delta Dental PPO[1]

This preferred provider plan offers the convenience and flexibility of visiting any licensed dentist, anywhere. Covered services are paid based on a percentage — if, for example, fillings are covered at 80%, you pay the remaining 20%. Get the most plan value by choosing a Delta Dental PPO dentist. PPO network dentists complete claim forms for you and can help advise you on questions regarding your share of the payment.

DeltaCare USA

Under this HMO-type plan, you'll have your choice of skilled primary care dentists from the DeltaCare USA network. Select a primary care dentist, who will then coordinate any needed referrals to a specialist.[2] Covered services provided by your DeltaCare USA dentist have preset copayments (dollar amounts), which are listed in your plan booklet. There are no maximums or deductibles.[3]

Turn the page for more details to help you choose the best plan for your needs.

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] In WY, you do not need to select a primary care dentist, but you must visit a network dentist to receive benefits. In the following states, you can maximize your savings when you visit a network dentist, although you may visit any licensed dentist and receive out-of-network coverage: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT. Refer to your plan booklet for details about your out-of-network benefits.

[3] Refer to your plan booklet for more information about covered services, deductibles and maximums.

deltadentalins.com/enrollees

Compare Plan Features

	Delta Dental PPO	DeltaCare USA
Can I go to any dentist?	You can visit any licensed dentist to receive coverage, but you'll save the most at an in-network dentist.	You must select a DeltaCare USA primary care dentist and visit this dentist to receive benefits.[2]
What procedures are covered?	Your plan covers a wide range of services, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, is offered at low or no cost.	Your plan covers over 300 procedures, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, has low or no copayments.
Are there deductibles and maximums?	Yes, most plans have an annual deductible and maximum.	No, there are no annual deductibles or maximums.[4]
Am I covered for treatment I began under a different employer-sponsored dental plan?	Coverage is provided only for treatment started and completed after your effective date. Orthodontic treatment may be an exception to this rule.	Coverage is provided only for treatment started and completed after your effective date.[5] Orthodontic treatment may be an exception to this rule.
What if I started orthodontic treatment under my previous dental plan?	Typically, Delta Dental pays the remaining benefit not paid by your prior dental plan.	You are responsible for the copayments and fees subject to the provisions of your prior dental plan.
What happens if I need to see a specialist?	You do not need a referral from your dentist.	Contact your DeltaCare USA primary care dentist to coordinate your referral.[6]
What is my out-of-area coverage?	You can visit any licensed dentist.	You have a limited benefit to go out of network for emergency care.
How do I change my dentist?	You can change your dentist at any time without contacting us.	You can change your selected or assigned primary care dentist online or by telephone.[7]
Do I need to fill out claims?	If you visit a Delta Dental dentist, the dental office will file the claim for you. If you go to a non-Delta Dental dentist, you may have to submit the claim yourself.	There are generally no claim forms under your plan.[8]

[4] In AK, CT, ND and SD, you have an out-of-network calendar year maximum of $500 when you visit an out-of-network dentist.

[5] Except in Texas; please refer to your plan booklet for details.

[6] Most services not performed by your primary care dentist must be authorized by Delta Dental. In some states, specialty care benefits are only available for services performed by an in-network specialist. Refer to your plan booklet for details.

[7] In the following states, you can change your dentist any time without contacting Delta Dental: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT, WY.

[8] You may have to complete a claim form if you visit an out-of-network dentist, such as for limited emergency treatment or in the following states: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Delta Dental PPO is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA - Delta Dental of California; PA, MD - Delta Dental of Pennsylvania; NY - Delta Dental of New York, Inc.; DE - Delta Dental of Delaware, Inc.; WV - Delta Dental of West Virginia, Inc. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

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