EMPLOYEE 2025 BENEFITS GUIDE

NOVEMBER 24, 1987
CITY OF HIGHLAND

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Contact Information

Employee Benefits Program	Contact Information
Human Resources Benefits Team	909-864-6861 ext. 227 hr@cityofhighland.com
Medical Plans	
Anthem Blue Cross	877-737-7776 anthem.com/ca/calpers
Blue Shield of California	800-334-5847 blueshieldca.com/calpers
Kaiser Permanente	800-464-4000 kp.org/calpers
UnitedHealthcare	877-359-3741 uhc.com/calpers
Health Net of California	888-926-4921 healthnet.com/calpers
PERS Platinum and PERS Gold	800-405-2127 Included Health: 855-633-4436 blueshieldca.com/calpers
Dental Plans	
Ameritas Dental (DPPO)	800-487-5553 ameritas.com
Liberty Dental Plan (DHMO)	888-703-6999 libertydentalplan.com
Vision Plans	
Ameritas – EyeMed Insight Network	866-289-0614 eyemedvisioncare.com
Ameritas – Vision Service Plan (VSP) Network	800-877-7195 www.vsp.com/
Life and Disability Insurance Plans	
Lincoln Financial Group – Basic Life Insurance and AD&D, Additional Life Insurance and AD&D	800-423-2765 LincolnFinancial.com
Lincoln Financial Group – Short Term Disability Insurance	800-423-2765 LincolnFinancial.com
Lincoln Financial Group – Voluntary Long Term Disability Insurance	800-423-2765 LincolnFinancial.com
Employee Assistance Programs	
LifeKeys and EmployeeConnect Services	GuidanceResources.com username: LifeKeys or username: LFGSupport Password: LFGSupport1

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TravelConnect Services	866-525-1955 (U.S. or Canada) 603-328-1955 (Call collect from anywhere in the world) MyOnCallPortal.com Group ID: LFGTravel123 mail@OnCallInternational.com
The Counseling Team International (TCTI)	800-222-9691 thecounselingteam.com
Voluntary and Supplemental Benefit Plans	
Colonial Life – Supplemental Benefit Plans (Accident, Cancer, Critical Illness, STD, Dental, Hospital)	ColonialLife.com/individuals Book an Appointment: Enrollment Support
AmeriFlex – Healthcare and Dependent Care Flexible Spending Accounts (FSA)	888-868-3539 myameriflex.com service@myameriflex.com
Retirement	
CalPERS	1-888 CalPERS (or 888-225-7377) calpers.ca.gov/page/home
Misson Square – 457(b) Deferred Compensation Plan	800-669-7400 msqplanservices.org/myplan/303034

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INTRODUCTION

At the City of Highland we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each and every employee makes to our accomplishments and so our goal is to provide a comprehensive program of benefits to attract and retain the best employees available. Through our benefit programs we strive to support the needs of our employees and their families by providing a benefit package that is easy to understand, easy to access and affordable for all of our employees.

The information herein is intended to be a summary of benefits and does not include all benefit provisions, limitations, exclusions and qualifications. For plan eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with Human Resources). If the information contained herein conflicts in any way with the plan contract, the contract will govern rates and benefits.

The City of Highland provides flat contribution amount of $1,600 per eligible full-time employee, per month to offset the cost of your benefits. Employees are responsible for paying for any insurance costs that exceed the monthly contribution amount. The City of Highland pays 100% of the cost of basic group life insurance and short-term disability insurance for all eligible employees.

Summary of Your Benefits

You can choose between different insurance plans to meet your individual and family needs. Since you have some choices to make, it is important to understand the various programs. This guide will provide summary information on the benefit options available to you. You can access more information, carrier specific websites and resources by using the contact information and hyperlinks included within the guide.

You have 60 days from your date of hire or the date you become eligible for benefits to enroll or decline coverage for yourself and eligible family members. You must complete your enrollment paperwork online using the EASE portal and provide proof of dependent eligibility to Human Resources to initiate coverage for a dependent. If you miss the initial enrollment period, you will not be able to enroll in benefits until the next Open Enrollment Period.

One time each year you will have the option to enroll/cancel and/or make changes to your benefit plans (referred to an Open Enrollment Period) without experiencing a change in family status (also referred to as a Qualifying Event (QE)). Benefit changes you make during the Open Enrollment Period (generally the third week of September through the second week of October) will become effective the following January 1st and will remain in effect through December 31st.

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For enrollment assistance schedule a time to speak with an Enrollment Specialist regarding your enrollment by visiting: Schedule an Enrollment Appointment

The Human Resources team is also available for any questions or concerns.

ELIGIBILITY AND ENROLLMENT

Who is Eligible for Benefits?

Eligible Employee: Employees hired or promoted into a full-time regular benefited position.

Spouse: A spouse (as defined or recognized under State law), or registered domestic partner[1] (as defined or recognized under State law for purposes of marriage).

Child: A biological, adopted[2], step-child, or a legal ward for whom the employee has legal court-appointed guardianship up to age 26. Certified disabled dependent children age 26 and older.

Proof of marriage, Domestic Partnership and/or dependent eligibility must be provided in order to initiate and/or maintain coverage for dependents.

Do Not Enroll Ineligible Family Members

It is against the law to enroll ineligible family members.

If you do so, any ineligible enrollments will be retroactively cancelled and you may have to pay all costs incurred by the ineligible person from the date the coverage began.

Qualifying Events

In most cases the benefits you select as a newly hired employee/benefit eligible employee, or during the Open Enrollment Period, remain in effect for the entire plan year (January 1st – December 31st). However, you can change your benefits during the year if you have a qualifying change in your family or work situation. This may include:

- Change in legal marital status (e.g., marriage, divorce/legal separation, start or end of a domestic partnership, death).

[1] Domestic partner coverage requires a "Declaration of Domestic Partnership" which can be provided by the Office of Secretary of State

[2] A child that is in the process of being adopted is eligible to be covered from and after the moment the child is placed in the physical custody of the insured for adoption (Section 10119 of the California Insurance Code). Adoption documentation must be submitted as proof.

- Change in number or status of dependents (e.g., birth, adoption, marriage, death).
- Change in employee/spouse/domestic partner/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
- Entitlement or loss of entitlement to Medicare or Medicaid.
- Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee/spouse/domestic partner's plan.
- Changes consistent with Special Enrollment rights and FMLA leaves.

It is your responsibility to notify the Human Resources Department of the need to make any changes and in most cases changes must be made within 60 days of the qualifying event; i.e. marriage, birth of child, adoption, etc. It is your responsibility to notify the Human Resources Department immediately if a dependent is no longer eligible for coverage; i.e. divorce, overage dependent, etc. Coverage will end the 1st of the following month from the qualifying event date.

Any changes to your benefit selections must be consistent with your change in status. Documentation must be provided to Human Resources before any changes will be approved.

Health Opt-Out

Eligible employees who can show proof of health insurance coverage with a health care provider elsewhere and waive their rights to City provided health insurance are eligible to receive the monthly employer contribution as taxable compensation. The amount will be prorated to offset any other employee benefit costs to include dental, vision, voluntary life, voluntary long-term disability and supplemental insurance enrollment.

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Medical Insurance

CalPERS | Health Plans

Plan Explanation

Benefit eligible employees have a choice when selecting a medical plan and can choose between any of the CalPERS Health Plan options. Before selecting a plan be sure to review how each plan works, the benefits provided and the out-of-pocket costs you may incur under each plan.

For more information about the CalPERS Health Benefits to include plan options and rates visit the CalPERS website

Visit your health plan's website to learn how benefits, claims and payment of claims are covered, as well as the service limitations and exclusions that may apply. You can also log in to myCalPERS to use the **Search Health Plans** tool to research the health plan coverage and benefits most important to you and your family.

Some health plans are available only in certain counties and/or ZIP codes. Contact the health plan before enrolling to make sure they cover your ZIP codes 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.

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Dental Insurance

Ameritas | Dental PPO

Plan Explanation

The Ameritas Dental PPO plan allows you to elect care from an in-network or out-of-network dental provider. Whether you choose an in-network or out-of-network provider, your coverage includes a wide range of covered services.

In-network and out-of-network costs will vary. To find out what your cost will be in advance, your dentist may request a predetermination of benefits from Ameritas, or you may contact Ameritas customer service to find out the percentage of coverage offered to you, based on your available annual maximum.

Coinsurance

Coinsurance varies by procedure. However, most preventive services will be provided at no cost to you from in-network providers (within maximum allowance limitations).

Claim Forms

Under the Ameritas DPPO, in-network dentists will submit a claim form directly to Ameritas. If your dentist is not contracted (out-of-network) with Ameritas, you may have to file your own claims. It is your responsibility to pay your dentist for services rendered and to submit all necessary claim forms.

Register for an Ameritas online account to verify your coverage details and find outher information such as eligibility, your enrolled family members, claim status and benefit specifics.

Ameritas

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Dental Highlight Sheet

Ameritas

Dental Plan Summary **Effective Date: 7/1/2025**

Plan Benefit	In Network	Out of Network
Type 1	100%	100%
Type 2	100%	80%
Type 3	70%	50%
Deductible	$50 Lifetime Type 2,3 Waived Type 1	$50 Lifetime Type 2,3 Waived Type 1
Maximum *(per person)*	$2,500 per calendar year	$1,500 per calendar year
Allowance	Discounted Fee	90th U&C
Dental Rewards®	Included	Included
Waiting Period	None	None
DHMO	See DHMO page for details	See DHMO page for details
Annual Open Enrollment	Included	Included

Orthodontia Summary - Child Only Coverage

	In Network	Out of Network
Allowance	Discounted Fee	U&C
Plan Benefit	50%	50%
Lifetime Maximum *(per person)*	$1,500	$1,500
Waiting Period	None	None

***Maximum is lifetime for both in network and out of network.*

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

In Network

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period)	• Fillings for Cavities	• Onlays
• Bitewing X-rays (2 per benefit period)	• Restorative Composites (anterior and posterior teeth)	• Crowns (1 in 5 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 3 years)	• Endodontics (nonsurgical)	• Crown Repair
• Periapical X-rays	• Endodontics (surgical)	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
• Cleaning (2 per benefit period)	• Periodontics (nonsurgical)	
• Fluoride for Children 18 and under (1 per benefit period)	• Periodontics (surgical)	
• Sealants (age 16 and under)	• Denture Repair	
• Space Maintainers	• Simple Extractions	
	• Complex Extractions	
	• Anesthesia	

Out of Network

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period)	• Fillings for Cavities	• Onlays
• Bitewing X-rays (2 per benefit period)	• Restorative Composites (anterior and posterior teeth)	• Crowns (1 in 5 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 3 years)	• Endodontics (nonsurgical)	• Crown Repair
• Periapical X-rays	• Endodontics (surgical)	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
• Cleaning (2 per benefit period)	• Periodontics (nonsurgical)	
• Fluoride for Children 18 and under (1 per benefit period)	• Periodontics (surgical)	
• Sealants (age 16 and under)	• Denture Repair	
• Space Maintainers	• Simple Extractions	
	• Complex Extractions	
	• Anesthesia	

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Dental Highlight Sheet

Ameritas

Ameritas Information

We're Here to Help

This plan was designed specifically for the associates of CITY OF HIGHLAND. At Ameritas Group, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: 800-487-5553. For plan information any time, access our automated voice response system or go online to ameritas.com.

Dental Rewards®

This dental plan includes a valuable feature that allows qualifying plan members to carryover part of their unused annual maximum. A member earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Benefit Threshold	$750	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Dental Rewards amount is added to the following year's maximum
Maximum Carryover	$1,000	Maximum possible accumulation for Dental Rewards

Dental Network Information

To find a provider, visit ameritas.com and select **FIND A PROVIDER,** then **DENTAL**. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose the Ameritas Network found on your ID Card or contact Customer Connections at 800-487-5553.

Your provider network is Ameritas Classic and Plus Network.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Dental Cost Estimator

Members can use our dental cost estimator at any time to find average procedure charges in their area. The estimates do not include network discounts or plan benefits. Find the dental cost estimator at ameritas.com/applications/group/estimator.

After coverage begins, members can view average in-network charges in their secure member account. Members also may ask their dentist's office to submit a pretreatment estimate so they can see exactly how a proposed service would be covered and avoid any surprises. The pretreatment estimate is based on their plan benefits.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

Easily Manage Your Dental Benefits

Here's what you can do now to get the most from your plan.

Create your secure online member account today

1 Go online

Visit ameritas.com/sign-in and select 'Member Sign In' under 'Dental, Vision & Hearing.'

2 Register

Under first-time users, select 'Register Now' and complete the form. Log into your new account and complete the verification process.

3 Authenticate

Provide the personal information used at enrollment including name, date of birth and ZIP Code. Mark if you are the insured member and enter your member ID.

Due to HIPAA regulations, only the primary member/policyholder has full account access. Learn more about access levels.

Go paperless. Sign up to receive your explanation of benefits (EOB) statements online. To receive electronic EOBs instead of paper statements, select the go paperless option once you are logged in or when setting up your member account.

Member account to-do list:

Print out or save your **ID card** to your smartphone

Review your **plan details** including maximum benefit, deductible amounts and your remaining benefits

Check if your current provider is part of the **Ameritas Dental Network**

Locate your **claims status** page so you can see how benefits are calculated and payments are processed

Additional plan benefits found in your secure member account

Additional savings

Ameritas offers money-saving discounts to help with hearing, prescription and eyewear expenses. These savings arrangements are not insurance and are available to Ameritas plan members at no additional cost to the plan premium. Access savings cards using the QR code or through your secure account at ameritas.com.

Worldwide support

AXA Assistance helps find a provider and schedule an appointment if you have a dental or vision emergency while traveling outside the U.S.

Save these numbers:
866-662-2731 (toll free)
and 312-935-3727 (collect).

Watch this short video to learn more about navigating your secure member account.

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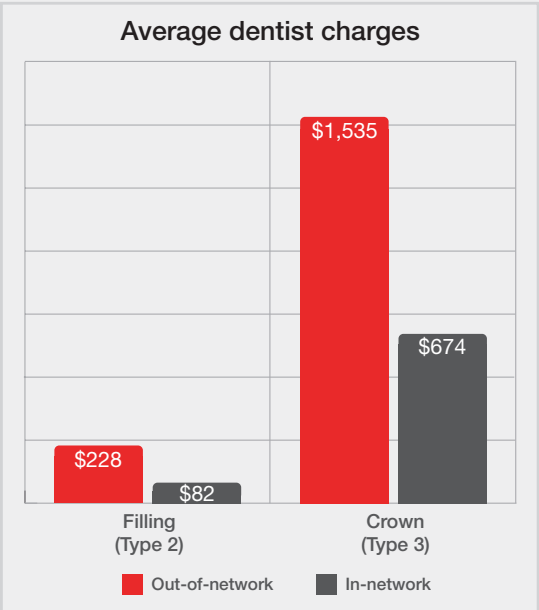
Evaluate your potential out-of-pocket costs

- Located in your secure member account, the dental cost estimator lets you compare estimated procedure charges based on ZIP Code. You can search estimates for both in-network and out-of-network providers.
- Ask your dentist to submit a pretreatment estimate for any dental work you consider expensive. Then Ameritas will let you know the amount insurance will cover so you can budget for the remainder. The pretreatment estimate is based on your plan benefits and submitted claims.



For illustrative purposes only. Allowance and cost estimates are specific to ZIP Code 605XXX. The initial cost without insurance has been estimated. Actual charges may vary.

Save money

You can use your dental benefits with any provider. The thing to consider is out-of-network dentists will charge you their regular rates, whereas Ameritas network providers have agreed to charge you 25-50% less. After your plan benefits are applied, you pay the remaining balance.

Find out if your dentist is in the network

Visit ameritas.com, Find a Health Provider, to find a new dentist or see if your current provider is in the Ameritas Dental Network. For a list of providers that allow you to use your in-network benefits in Mexico, select Find a Contracted Provider in Mexico.

Nominate your dentist

If your dentist is not in the network already, just go to ameritas.com, search for “nominate a provider” and complete the online form.

Here to help

For plan information any time, visit ameritas.com and sign in to your secure member account. Or download the Ameritas Benefits app available for iOS and Android. Log in with the same user ID and password you use for your secure member account. If you have questions about your plan benefits, use the chat feature located in your secure member account or call the Ameritas customer connections team.

GET IT ON Google Play

Download on the App Store

Claims, benefit and provider network questions:
group@ameritas.com I 800-487-5553
Monday - Thursday, 7 a.m. - Midnight (CST)
Friday, 7 a.m. - 6:30 p.m. (CST)

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Dental Insurance

Liberty Dental | Dental DHMO

Plan Explanation

The Liberty Dental plan offers comprehensive, budget-friendly coverage from a large network of Liberty Dental Network dentists. You must visit a Liberty Dental Plan network general dentist to use your plan and you may select an in-network general dentist at the time you choose to enroll. If you do not select a general dentist, one will be assigned to you. You can select or change dentists at any time. You must utilize the selected primary care dentist for all of your dental services. If services are not obtained through the primary care dental office, or if Liberty Dental Plan has not authorized the services, those services will not be covered. If you require specialty care, your primary care dentist will refer you to a network specialist.

Copayments

Unlike a dental PPO plan, your payment for covered services are predefined, all-inclusive co-payments, with no deductibles, maximums or waiting periods for covered services. The Evidence/Certificate of Coverage (plan booklet) provides a list of covered services, copayments and any limitations and exclusions. A summary of some covered services and the associated co-pays has is listed below. For most basic and preventative services, you pay no copays.

Orthodontia Coverage

You and your covered dependents may obtain comprehensive and/or limited orthodontic care from the Liberty Dental Plan network orthodontist of your choice.

You should request a treatment plan, which outlines your out-of-pocket costs, from your dentist before proceeding with any recommended services.

Create an online account by going to Liberty Dental Plan's website and creat an account to select or change your dentist, review plan benefits and access your ID card if you want one (an ID card is not needed to receive services).

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Southern California DHMO Dental Rates: LDP-200

Company Name: CITY OF HIGHLAND
Effective Date: 7/1/2025

Group Size: 2 -300; groups over 300 employees contact your representative	**Rate Assumption:** Based on Group Situs
Contribution: Valid for Voluntary and Employer Paid Groups	**Billing:** Ameritas Co-packaged Billing
Network: CA DHMO Select	**Coverage Areas:** Southern California Regions

DHMO Benefit Plan Summary: LDP-200		
Code	**Description**	**Member Copayment**
Diagnostic Services		
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation	$0
D0150	Comprehensive oral evaluation	$0
D0210	Intraoral, complete series of radiographic images	$0
D0220	Intraoral, periapical, first radiographic image	$0
D0230	Intraoral, periapical, each additional radiographic image	$0
D0272	Bitewings, 2 radiographic images	$0
D0274	Bitewings, 4 radiographic images	$0
D0330	Panoramic radiographic image	$0
Preventive Services		
D1110	Prophylaxis, adult	$0
D1120	Prophylaxis, child	$0
Restorative Services		
D2140	Amalgam, 1 surface, primary or permanent	$0
D2150	Amalgam, 2 surfaces, primary or permanent	$0
D2160	Amalgam, 3 surfaces, primary or permanent	$0
D2391	Resin-based composite, 1 surface, posterior	$35
D2751	Crown, porcelain fused to predominantly base metal*	$55
*The total maximum amount chargeable to the member for elective upgraded procedures is $250.00 per tooth.		
Endodontic Services		
D3330	Root canal, Molar (excluding final restoration)	$0
Periodontal Services		
D4341	Periodontal scaling & root planing, 4 or more teeth per quadrant	$0
D4910	Periodontal maintenance	$0
Removable Prosthodontic Services		
D5110	Complete denture, maxillary	$0
Oral and Max Surgery		
D7140	Extraction, erupted tooth or exposed root	$0
D7210	Surgical removal of erupted tooth	$0
Orthodontia		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,775
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,950

This is only a summary of the Plans. The Dental Plan Contract, complete Benefit Schedule and Evidence of Coverage must be consulted to determine the exact terms, limitations and exclusions of coverage. Groups must meet the terms and conditions. Please see LIBERY's Underwriting Guidelines for more details. Custom rate combinations are available upon request.

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Vision Insurance

Ameritas | Choice of EyeMed or VSP

Plan Explanation

Benefit eligible employees have a choice when selecting vision coverage. There are two vision plan options to choose from offered through Ameritas: EyeMed or Vision Service Plan (VSP). Each plan differs and offers a range of benefits. Both plan options allow you the choice to visit a participating network or non-network provider.

The EyeMed vision plan allows enrolled members the option to visit **EyeMed Insight Network** optometrists or utilize a non-network provider of choice.

The VSP vision plan allows enrolled members the option to visit **VSP Choice Network** optometrists or utilize a non-network provider of choice.

When considering your options and enrolling some key differences that you may want to consider when selecting a plan include your preference in Retail Partners. EyeMed's in-network with Retail Partners include LensCrafters, Target Optical, America's Best and others that may provide you more retail convience and access. VSP's in-network Retail Partners include Visionworks, Pearle Vision, MyEyeDr and others that may provide you more opportunity to have access to private-practice options and personlized care. EyeMed may allow more flexibility with upgrades with more variability in out-of-pocket costs as upgrades are used while VSP may provide more predictable co-pays and consistent costs with a slighty higher monthly premium.

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Eye Care Highlight Sheet

Ameritas

Vision Plan Summary **Effective Date: 7/1/2025**

	EyeMed Insight Network	Out of Network
Deductibles	$0 Exam $0 Eye Glass Lenses	No deductible
Annual Eye Exam	Covered in full	Up to $35
Lenses (per pair)		
Single Vision	Covered in full	Up to $25
Bifocal	Covered in full	Up to $40
Trifocal	Covered in full	Up to $55
Lenticular	20% discount	No benefit
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams		
Standard	Standard: Member cost up to $40	No benefit
Premium (Allowance)	Premium: 10% off of retail	No benefit
Elective	Up to $150	Up to $120
Medically Necessary	Covered in full	Up to $200
Frame Allowance	$150	Up to $75
Frequencies (months)		
Exam/Lens/Frame	12/12/12 Based on date of service	12/12/12 Based on date of service

Lens Options (member cost)

	EyeMed Insight Network	Out of Network
Progressive Lenses		
Standard	$65 + lens deductible	No benefit
Premium		
Tier 1	$85 + lens deductible	No benefit
Tier 2	$95 + lens deductible	No benefit
Tier 3	$110 + lens deductible	No benefit
Tier 4	$65 plus 80% of charge less $120 allowance	No benefit
Std. Polycarbonate	$40	No benefit
Tint (solid and gradient)	$15	No benefit
Scratch Resistant Coating	$15	No benefit
Anti-Reflective Coating		
Standard	$45	No benefit
Premium		
Tier 1	$57	No benefit
Tier 2	$68	No benefit
Tier 3	80% of the charge	No benefit
Ultraviolet Coating	$15	No benefit
Lasik or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers.	No benefit

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Eye Care Highlight Sheet

Ameritas

Additional ViewPointe® H Features

EyeMed In-Network Discounts	15% discount off the remaining balance in excess of the conventional contact lens allowance. 20% discount off the remaining balance in excess of the frame allowance. 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers. This discount does not apply to EyeMed Provider's professional services, or contact lenses.
EyeMed In-Network Secondary Purchase Plan	Members receive a 40% discount on a complete pair of glasses once the funded benefit has been exhausted. Members receive a 15% discount off the retail price on conventional contact lenses once the funded benefit has been exhausted. Discount applies to materials only.
Contact Lens Replacement by Mail Program	After exhausting the contact lens benefit, replacement lenses may be obtained at significant discounts on-line. Visit **www.eyemedvisioncare.com** for details.

Based on applicable laws, reduced costs may vary by doctor location.

Eye Care Plan Member Service

ViewPointe eye care from Ameritas Group features the money-saving eye care network of EyeMed Vision Care. Customer service is available to plan members through EyeMed's well-trained and helpful service representatives. Call or go online to locate the nearest EyeMed network provider, view plan benefit information and more.

EyeMed Customer Care Center: 1-866-289-0614

- Service representative hours: 8 a.m. to 11 p.m. ET Monday through Saturday, 11 a.m. to 8 p.m. ET Sunday
- Interactive Voice Response available 24/7

Locate an EyeMed provider at: ameritas.com
View plan benefit information at: eyemedvisioncare.com

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

Start Using Your Vision Benefits

Featuring the EyeMed vision network

Maintaining good vision and eye health is a priority. Now that you've enrolled, here's what you can do to make the most of your vision benefits.

1 Create an EyeMed account

Register at EyeMed.com. Complete all required fields and enter your Member ID or last 4 digits of the primary member's SSN number. Select 'Create An Account.' Once you are registered, you'll receive an email with a link to set up your password.

2 Review your plan details and print or save your ID card

Once logged in, locate the My Benefits page to verify your coverage and eligibility. If you lose your ID card or need extras, you can access a digital version to print or save to your smartphone.

3 Verify your network and find a provider

You are free to see the vision provider of your choice, and you save more when seeing an EyeMed network provider. Log into your member account to verify your network. Search for a network provider by selecting 'Find an Eye Doctor.'

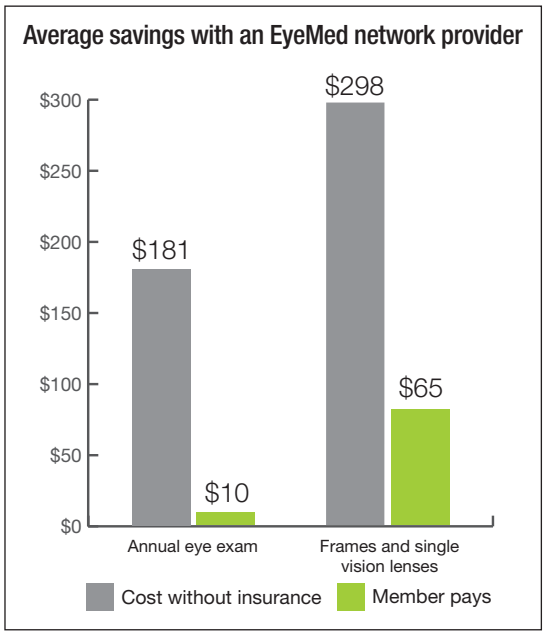
EyeMed Network

EyeMed's network includes some of the most recognized names, including:

LensCrafters, Pearle Vision, Target Optical

Browse and buy eyewear online. Glasses.com, ContactsDirect.com, LensCrafters, Ray-Ban, and Target Optical are in the EyeMed network, and your vision benefits are applied directly to your online order.

Find ways to save more with EyeMed Perks.



This example reflects average savings for EyeMed members. For illustrative purposes, the initial cost without insurance has been estimated. Actual charges may vary.

4 Schedule an appointment

Appointments can be scheduled online with participating network providers. When you arrive, just give them your name and date of birth, no ID card is necessary. When you stay in-network, your provider can look you up instantly.

5 Check your claims in your member account

To access the out-of-network form or to check the status of a claim, log in to your member account and navigate to the Claims tab.

Manage your eye care needs anytime and anywhere by downloading the EyeMed Members App. Search for the app on the App Store (iOS) or Google Play (Android).

Ameritas fulfilling life.

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Frequently Asked Questions

Can I use my benefits if I visit a provider outside the network?

Yes. If you visit an out-of-network provider, you pay your provider the full balance and submit a claim with your itemized receipt for reimbursement based on your out-of-network benefits. Greater benefits are available with network providers, and they submit the claim for you.

Can I use my benefits at Walmart and Sam's Club?

Yes. These locations are out-of-network for EyeMed plans, so your out-of-network benefits would apply. But these benefits still go a long way due to the lower overall price points of these retailers.

Can I get glasses and contacts in the same year?

Yes. With EyeMed network plans, benefits for frames and contact/eyeglass lenses are separated. If you use your lens benefits to purchase contacts, you are still able to use your frame allowance towards new glasses during the same benefit year. In this case, the eyeglass lenses to go in your new frames would be an out-of-pocket expense.

Who do I contact if I have questions?

Contact EyeMed for benefit, claims or network questions.

866-289-0614
Monday – Saturday 6:30 a.m. - 10 p.m.
Sunday 10 a.m. - 7 p.m. (CST)

Contact Ameritas for billing, administration, ID card or network questions.

group@ameritas.com
If you enrolled through an employer: 800-487-5553
If you purchased online: 800-300-9566
Monday – Thursday 7 a.m. - 7 p.m.
Friday 7 a.m. - 5:30 p.m. (CST)

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CITY OF HIGHLAND

Eye Care Highlight Sheet

Ameritas

Vision Plan Summary **Effective Date: 7/1/2025**

	VSP Choice Network + Affiliates	Out of Network
Deductibles		
	$0 Exam	$0 Exam
	$0 Eye Glass Lenses or Frames*	$0 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Member cost up to $60	No benefit
Elective	Up to $150	Up to $120
Medically Necessary	Covered in full	Up to $210
Frame Allowance	$150**	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/12 Based on date of service	12/12/12 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco and Walmart allowance will be the wholesale equivalent.*

Lens Options (member cost)*

	VSP Choice Network + Affiliates (Other than Costco)	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	No benefit
Solid Plastic Dye	$15 (except Pink I & II)	No benefit
Plastic Gradient Dye	$17	No benefit
Photochromatic Lenses (Glass & Plastic)	$31-$82	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

**Lens Option member costs vary by prescription, option chosen and retail locations.*

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CITY OF HIGHLAND

Eye Care Highlight Sheet

Ameritas

Additional Focus® Choice Network Features

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for members is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

Eye Care Plan Member Service

Focus eye care from Ameritas Group features the money-saving eye care network of VSP. Customer service is available to plan members through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 1-800-877-7195

- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: ameritas.com
View plan benefit information at: vsp.com

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

Start Using Your Vision Benefits

Featuring the VSP vision network

vsp vision care

Maintaining good vision and eye health is a priority. Now that you've enrolled, here's what you can do to make the most of your vision benefits.

1 Create a VSP account

Register at VSP.com. Enter the last 4 digits of the primary member's SSN or Member ID number and complete all required fields. Select 'Create an Account' to complete your registration.

2 Review your plan details and print or save your ID card

Log in and locate your benefit plan to verify your coverage and eligibility. If you lose your ID card or need extras, you can access a digital version to print or save to your smartphone.

3 Verify your network and find a provider

You are free to see the vision provider of your choice, and you save more when seeing a VSP network provider. Log into your member account to verify your network and use the 'Find a Doctor' tool to locate a network provider.

VSP Network

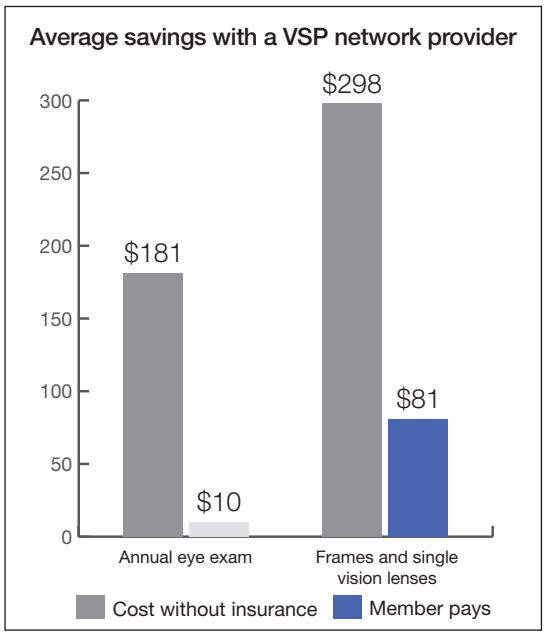
VSP offers the nation's largest network of independent doctors. Retail locations include:

COSTCO OPTICAL Walmart sam's club Visionworks

Online options

Browse and buy online at eyeconic.com and get the most current deals on eyewear. Eyeconic.com is in the VSP network, and your vision benefits are applied directly to your online order.

Find more ways to save with VSP Exclusive Member Extras.



This example reflects average savings for VSP members. For illustrative purposes, the initial cost without insurance has been estimated. Actual charges may vary.

4 Schedule an appointment

Select a provider and schedule your appointment. When you arrive, tell them you have VSP. No ID card is necessary. Your provider will be able to look up your benefits by providing your social security number or unique ID.

5 Check your claims in your member account

You can check your claim status on the benefits history page on your account dashboard.

Manage your eye care needs anytime and anywhere by downloading the VSP Vision Care App. Search for the app on the App Store (iOS) or Google Play (Android).

Ameritas fulfilling life.

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Frequently Asked Questions

Can I use my benefits if I visit a provider outside the network?

Yes, if you visit an out-of-network provider, you pay your provider the full balance and submit a claim with your itemized receipt for reimbursement based on out-of-network plan benefits. Greater benefits are available with network providers, and they submit the claim for you.

Can I get glasses and contacts in the same year?

No, your benefit can be applied to contacts OR glasses during the benefit year. In other words, you will not receive an allowance for contacts if you already chose to apply your vision benefits to a new pair of lenses and/or frames during the same benefit year.

Are prescription safety glasses covered?

Yes. You can use your benefits towards prescription safety glasses in lieu of regular eyeglasses or contacts.

Who do I contact if I have questions?

Contact VSP for benefit, claims or network questions.

800-877-7195
Monday – Saturday, 8 a.m. - 7 p.m. (CST)

Contact Ameritas for billing, administration, ID card or network questions.

group@ameritas.com
If you enrolled through an employer: 800-487-5553
If you purchased online: 800-300-9566
Monday - Thursday, 7 a.m. - Midnight
Friday, 7 a.m. - 6:30 p.m. (CST)

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*Not all providers at Costco locations are VSP network providers. Please verify that your provider is in the VSP network before seeking services. The frame allowance at some retailers may be less due to lower wholesale pricing.

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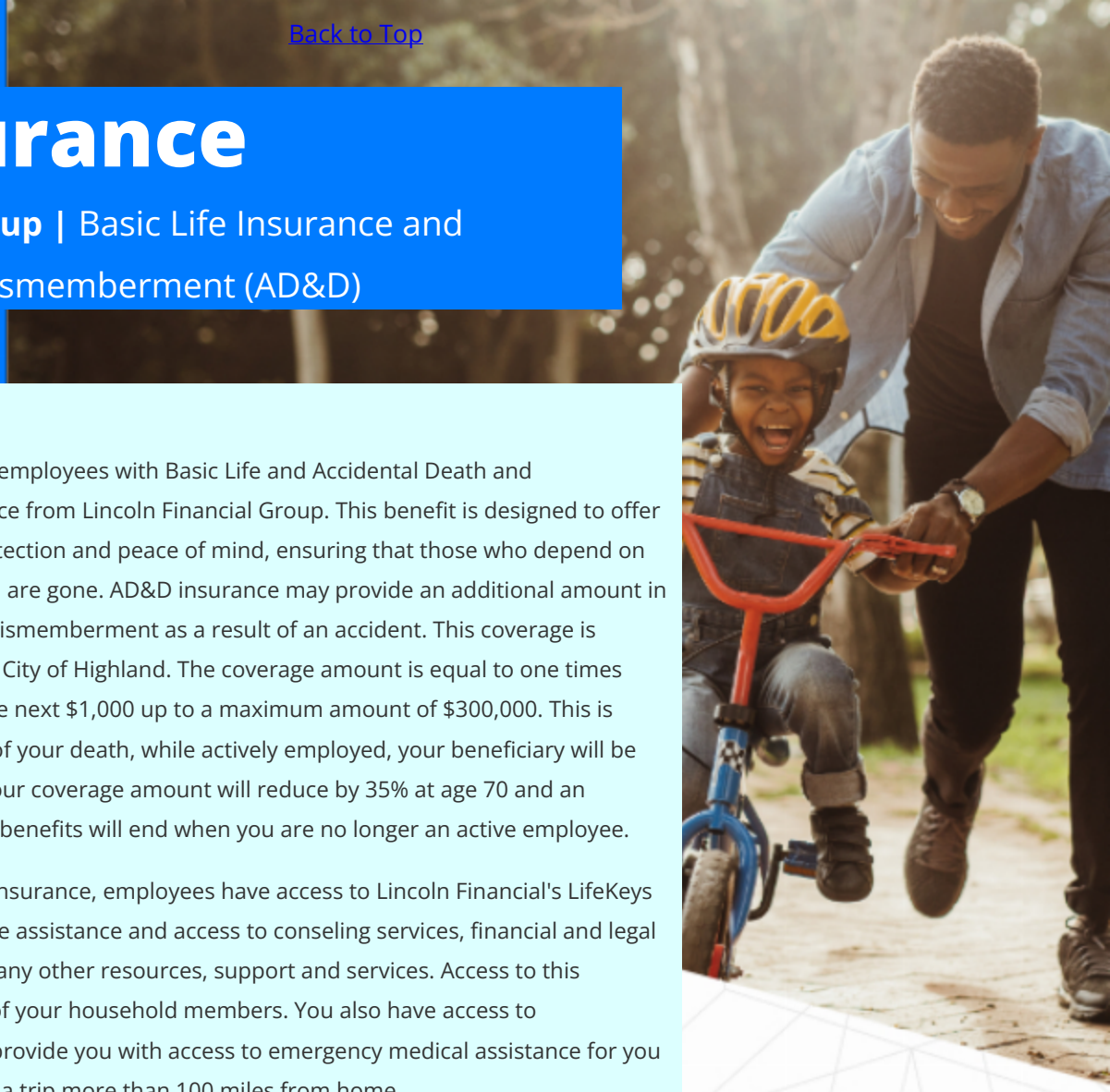
Life Insurance

Lincoln Financial Group | Basic Life Insurance and Accidental Death & Dismemberment (AD&D)



Plan Explanation

The City provides benefit eligible employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance from Lincoln Financial Group. This benefit is designed to offer you and your family financial protection and peace of mind, ensuring that those who depend on you are supported even after you are gone. AD&D insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident. This coverage is provided to you at no cost by the City of Highland. The coverage amount is equal to one times your annual salary rounded to the next $1,000 up to a maximum amount of $300,000. This is term life insurance. In the event of your death, while actively employed, your beneficiary will be paid the full coverage amount. Your coverage amount will reduce by 35% at age 70 and an additional 20% at age 75 and the benefits will end when you are no longer an active employee.

In addition to the life and AD&D insurance, employees have access to Lincoln Financial's LifeKeys Services. LifeKeys offers employee assistance and access to conseling services, financial and legal support services in addition to many other resources, support and services. Access to this program is free for you and any of your household members. You also have access to TravelConnect Services that can provide you with access to emergency medical assistance for you and your family when you are on a trip more than 100 miles from home.

ADDITIONAL PLAN SERVICES, SUPPORT AND RESOURCES	
LifeKeys Services	GuidanceResources.com username: LifeKeys or username: LFGSupport Password: LFGSupport1
TravelConnect Services	866-525-1955 (U.S. or Canada) 603-328-1955 (Call collect from anywhere in the world) https://www.MyOnCallPortal.com Group ID: LFGTravel123 mail@OnCallInternational.com
Lincoln Financial Customer Service Phone Number	800-423-2765

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What is it?

Life and accidental death and dismemberment (AD&D) insurance provide cash benefits in the unfortunate event that you or a covered family member passes away or suffers a traumatic injury.

Why is this coverage valuable?

Life and AD&D insurance can offer reassurance that you, or the people you love, will have access to money to help cover expenses during a challenging time.

Your life insurance and AD&D coverage

Eligibility description	All Full-Time Employees
Contribution	Your employer pays the cost of your coverage.
Employee life coverage amount	One times your annual earnings rounded to the next higher $1,000
Employee life coverage maximum	This amount may not exceed the lesser of one times annual earnings next higher $1,000, or $300,000.
AD&D Plus coverage amount	Your enhanced AD&D coverage is equal to the life benefit amount.
Benefit reductions	Employee: 35% reduction at age 70, and an additional 20% reduction of the original amount at age 75. Benefits end when you retire.
Conversion: Allows you to continue coverage after your group plan has terminated.	Yes, with restrictions. See certificate of benefits.
***LifeKeys*® services:** Access to counseling, financial, and legal support services.	Included
***TravelConnect*® services:** Access to emergency medical assistance for you and your family when you're on a trip 100 or more miles from home.	Included

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Benefit exclusions

Like any insurance, this life and AD&D insurance policy does have exclusions.
For life insurance, a suicide exclusion may apply.
For AD&D, benefits won't be paid if death/dismemberment occurs as the result of:

- War, declared or undeclared, or any act of war
- Intentionally self-inflicted injuries, while sane or insane
- Suicide, or suicide attempt, while sane or insane
- Active participation in a riot
- Committing or attempting to commit a felony
- Disease, bodily or mental illness, or medical or surgical treatment thereof
- Infections
- Controlled substances voluntarily taken, ingested, or injected, unless prescribed or administered by a physician
- Serving on full-time active duty in the armed forces of any country or international authority
- The presence of alcohol in the covered person's blood, which raises the presumption that the covered person was under the influence of alcohol and contributed to the cause of the accident

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

Reminder: Please review your beneficiary(ies) to ensure they're up to date. It's good practice to review, and if necessary, update your beneficiary(ies) annually.

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

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. ComPsych® is not a Lincoln Financial® company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations (except in Vermont).

State limitations apply. Beneficiary grief counseling is the only benefit available to a beneficiary(ies) of policies issued in the state of New York. Online will prep is the only benefit available to insured employees and dependents of policies issued in the state of Washington.

TravelConnect® services are provided by On Call International, Salem, NH. On Call International is not a Lincoln Financial® company and Lincoln Financial® does not administer these services. Each independent company is solely responsible for its own obligations.

On Call International must coordinate and provide all arrangements in order for eligible services to be covered. Coverage is subject to contract language that contains specific terms, conditions, and limitations, which can be found in the program description.

The *TravelConnect*® program is not available to insured employees and dependents of policies issued in the state of New York and Washington. Access only program available to insured employees and dependents of policies issued in the state of Missouri and Texas. Benefits provided under the Access only program exclude payment for paid services. **Not available in New York and Washington.**

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

LincolnFinancial.com

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

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

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Order code: GP-LADEP-FLI001

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Additional Life Insurance

Lincoln Financial Group | Voluntary Life Insurance and Accidental Death & Dismemberment (AD&D)

Plan Explanation

As an eligible employee you will be covered under the Basic Life insurance provided to you by Lincoln Financial Group and paid for by the City of Highland. In addition to that coverage, you have the option to purchase voluntary addtional life insurance for yourself and purchase life insurance for your eligible spouse and children. The opportunity to purchase voluntary life insurance provides you with competitive group rates, which may be more affordable than those available through individual insurance, an opportunity to apply for a guaranteed coverage amount without a requirement to answer health questions and the convenience of paying the premium directly from your paycheck.

To be eligible to buy ife insurance for your eligible spouse and/or child(ren) you must purchase additional life insurance for yourself. If you elect to purchase spouse or child coverage, that coverage amount may not be greater than 50% of additional life insurance amount you purchase for yourself. For example, if you purchase $60,000 of additional life insurance for yourself, your spouse may be eligble for a maxium of $30,000 in coverage and your child(ren) will be eligible for $10,000 in coverage. Dependent child(ren) are covered from birth through age twenty-five.

Coverage amounts may be limited to the Guaranteed Insurability (GI) amount(s). To purchase coverage in amounts over the GI you must complete Evidence of Insurability (EOI) and be approved for coverage by Lincoln Financial Group. EOI instructions are included in the following pages. EOI information is confidential and not shared with the City of Highland. If you are approved or denied coverage, the City will be notified of the status of the request and amount of coverage approved or denied.

Lincoln Financial Group®

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Lincoln Financial℠

City of Highland
Voluntary life/AD&D insurance

What is it?

Life and accidental death and dismemberment (AD&D) insurance provides cash benefits in the unfortunate event that you or a covered family member passes away or suffers a traumatic injury from certain covered accidents.

Why is this coverage valuable?

Life and AD&D insurance can offer reassurance that you or the people you love will have access to money to help cover expenses during a challenging time.

Your life/AD&D coverage

Eligibility description	All Full-Time Employees
Contribution	You pay the cost of your coverage.
Employee life coverage amount	Increments of $10,000
Employee life coverage maximum	This amount may not exceed the lesser of five times annual earnings to the next higher $10,000, or $500,000.
Spouse/domestic partner life coverage	Increments of $5,000 The amount of dependent life insurance coverage cannot be greater than 50% of the employee benefit or 2.5 times employee annual earnings rounded to the next higher $5,000.
Spouse/domestic partner life coverage maximum	This amount may not exceed $250,000
Dependent child(ren) life coverage	Live birth but under six months: $1,000 At least six months but under 26 years: $10,000
AD&D Plus coverage	Your enhanced AD&D coverage is equal to the life benefit amount
Guarantee issue: You're not required to answer health questions to qualify for coverage up to and including the specified amount when you sign up for coverage during the initial enrollment period.	Employee: $80,000 Spouse: $30,000
Evidence of insurability (EOI): A health statement requiring you to answer a few medical history questions.	Health statement may be required.
Benefit reductions	Employee: 35% reduction at age 70, and an additional 20% reduction of the original amount at age 75. Benefits end when you retire.
Portability: Allows you to continue maintaining coverage if you terminate your employment.	Yes
Conversion: Allows you to continue coverage after your group plan has been terminated.	Yes, with restrictions. See certificate of benefits.
Accelerated life benefit: A lump-sum benefit is paid to you if you're diagnosed with a terminal condition as defined by the plan.	Yes. See certificate of benefits.

Waiver of premium: Relieves you from paying premiums during a period of disability that's lasted for a specific length of time.	Included
***LifeKeys*® services:** Access to counseling, financial, and legal support services.	Included
***TravelConnect*® services:** Access to emergency medical assistance for you and your family when you're on a trip 100 or more miles from home.	Included

Life/AD&D rate information

Option	Monthly rate
Employee and spouse life and AD&D insurance	See rate tables below
Employee and Spouse AD&D	$0.016 per $1,000 in covered benefit
Dependent Child coverage	$.250 per $1,000

Employee & Spouse life and AD&D insurance monthly rate:

Age range	Premium monthly rate
under20	$0.069
20-24	$0.069
25-29	$0.078
30-34	$0.100
35-39	$0.109
40-44	$0.120
45-49	$0.172
50-54	$0.256
55-59	$0.464
60-64	$0.704
65-69	$1.339
70-74	$2.162
75-79	$2.162
80-84	$2.162
85-89	$2.162
90-94	$2.162
95-99	$2.162
100Plus	$2.162

Benefit exclusions

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

For life insurance, a suicide exclusion may apply.

For AD&D, benefits won't be paid if death/dismemberment occurs as the result of:

- War, declared or undeclared, or any act of war
- Intentionally self-inflicted injuries, while sane or insane
- Suicide, or suicide attempt, while sane or insane
- Active participation in a riot
- Committing or attempting to commit a felony
- Disease, bodily or mental illness, or medical or surgical treatment thereof
- Infections
- Controlled substances voluntarily taken, ingested, or injected unless prescribed or administered by a physician
- Serving on full-time active duty in the armed forces of any country or international authority
- The presence of alcohol in the covered person's blood, which raises the presumption that the covered person was under the influence of alcohol and contributed to the cause of the accident

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

Reminder: Please review your beneficiary(ies) to ensure that they're up to date. It's good practice to review, and if necessary, update your beneficiary(ies) annually.

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

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. ComPsych® is not a Lincoln Financial® company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations (except in Vermont).

State limitations apply. Beneficiary Grief counseling is the only benefit available to a beneficiary(ies) of policies issued in the state of New York. Online will prep is the only benefit available to insured employee and dependents of policies issued in the state of Washington.

TravelConnect® services are provided by On Call International, Salem, NH. On Call International is not a Lincoln Financial® company and Lincoln Financial® does not administer these services. Each independent company is solely responsible for its own obligations.

On Call International must coordinate and provide all arrangements in order for eligible services to be covered. Coverage is subject to contract language that contains specific terms, conditions, and limitations, which can be found in the program description.

The *TravelConnect*® program is not available to insured employees and dependents of policies issued in the state of New York and Washington. Access only program available to insured employees and dependents of policies issued in the state of Missouri and Texas. Benefits provided under the Access only program exclude payment for paid services. **Not for use in New York and Washington.**

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

LincolnFinancial.com

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

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

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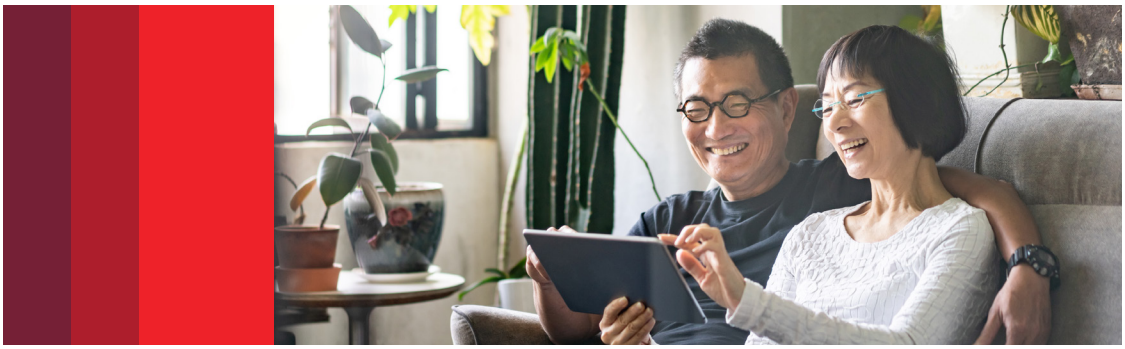

Evidence of insurability

Instructions for online submission

What is EOI and when is it needed?

EOI is the information we use to verify your good health when you're purchasing life, disability, or critical illness insurance. We require EOI if you are:

- Buying an insurance amount higher than the guaranteed amount for your plan
- Already enrolled and want to increase coverage

Get started now

1. Log in to my MyLincolnPortal.com. First time user? Register using Company Code **1257484**
2. Click "Complete Evidence of Insurability."
3. Answer the questions about you and other applicants. You'll be asked:
   - General applicant information, such as date of birth, height, and weight
   - Qualifying questions, including if you or other applicants have been diagnosed with a disease or are prescribed medications for a condition
   - Medical questions—if you or other applicants have a condition, we may need to know a little more about it, such as the name, diagnosis date, and treatments
4. Review your responses, then electronically sign and submit your application.
5. Save your confirmation report.

Submitting EOI made easy

Minimal questions
The online questionnaire adjusts to your responses, so you only answer questions that are relevant to you.

Guided support
Quick tips and search-as-you-type features help you provide quick and appropriate responses.

Instant confirmation
You'll receive email acknowledgment that we've received your application. In some cases, you may be automatically approved.

What happens next?

In some cases, you may be auto-approved for coverage. If not, we'll review your application and contact you if more information is required. In all cases, we'll notify you of your application outcome.

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Disability Insurance

Lincoln Financial Group | Short-Term Disability

Plan Explanation

Disability insurance provides financial assistance to you if you are unable to work due to a non-work-related injury or illness. It covers a portion of your earnings while you are unable to work. The City of Highland does not participate in California State Disability Insurance (CA SDI) and therefore provides all full time employees with Short-Term Disability (STD) insurance via Lincoln Financial Group. The City of Highland is providing this coverage to you at no cost. You are automatically enrolled in the plan once you become a benefit eligible employee. The plan will cover 60% of your weekly earnings up to a maximum of $2,300 per week for a maximum of 13 weeks (90 days).

Lincoln Financial Group®

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Lincoln Financial

City of Highland
Short-term disability coverage

What is it?

Short-term disability coverage pays you a portion of your salary while you're away from work or recovering from a covered illness or injury.

Why is this coverage valuable?

When you're unable to collect your normal paycheck due to injury or illness, your disability plan provides money that can help you pay your bills.

Your short-term disability coverage

Eligibility description	All Full-Time Employees
Contribution	Your employer pays the cost of your coverage.
Coverage amount	60% of your weekly earnings up to a maximum of $2,300
Maximum benefit	13 weeks
Accident elimination period	7 days
Illness elimination period	7 days
Recurrent disability benefits	If you become disabled for the same condition within 14 days following your prior disability, your benefits will continue under the same claim
Evidence of insurability (EOI): A health statement requiring you to answer a few medical history questions.	Not applicable
Preexisting condition(s): Any condition or symptom for which you, in the specified time period before coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	Not applicable
Premium waived if disabled: Premium won't need to be paid when you're receiving benefits.	Not applicable

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Exclusions and limitations

Like any insurance, this short-term disability insurance policy does have exclusions. You won't receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- Your disability occurs while you're committing a felony or misdemeanor, or participating in a riot

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

Your benefits may be reduced if you're eligible to receive income or benefits from:

- State disability or no-fault insurance
- A retirement plan
- Social Security
- Any form of employment
- Workers' compensation
- Salary continuance plan
- Sick leave
- State paid family leave benefits
- Any other group insurance plan
- Unemployment
- Recovery from third party

State variations apply.

LincolnFinancial.com

LCN-6447206-030124
PDF 4/24 **Z01**
Order code: GP-STDEP-FLI001

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Disability Insurance

Lincoln Financial | Voluntary Long-Term Disability Plan

Plan Explanation

Long-term disability (LTD) insurance is designed to replace a portion of your income if you become unable to work for an extended period due to a non-work-related injury or illness. This is a voluntary benefit paid for by you via a deduction from your paycheck. If you become disabled and can't work, you file a claim. After the waiting period of 90 days, you begin recieving monthly payments. The payments will be 60% of your monthly salary at the time of your disability injury or illness and benefits can last until Social Security Normal Retirement Age (SSNRA). The cost of this coverage is based on your monthly earnings and your current age.

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Lincoln Financial

City of Highland
Long-term disability insurance

What is it?

Long-term disability insurance pays you a portion of your salary while you're away from work or recovering from a covered illness or injury.

Why is this coverage valuable?

When you're unable to collect your normal paycheck due to injury or illness, your disability policy provides money that can help you pay your bills.

Your long-term disability coverage

	Long-term disability
Eligibility description	All Full-Time Employees
Contributions	You pay the cost of your coverage.
Coverage amount	60% of your monthly earnings up to a maximum of $10,000 per month.
Maximum benefit	Social Security Normal Retirement Age (SSNRA) or maximum benefit period outlined below, whichever is later: **Age at disability** / **Maximum benefit period** Under 60 — To age 65 60 — 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
Elimination period	90 Days
Evidence of insurability (EOI): A health statement requiring you to answer a few medical history questions.	Not applicable.
Preexisting condition(s): Any condition or symptom for which you, in the specified time period before coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months lookback; 12 months after effective date of coverage
Premium waived if disabled: Premium won't need to be paid when you're receiving benefits.	Yes
EmployeeConnect℠ **services:** Gives you and your family confidential access to counselors, along with personal, legal, and financial assistance.	Included

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Long-term disability rate information

	Per $100 of covered payroll	
	Age	**Rate**
Monthly rate	0-29	$0.080
	30-34	$0.156
	35-39	$0.259
	40-44	$0.395
	45-49	$0.551
	50-54	$0.712
	55-59	$0.908
	60-64	$0.761
	65-69	$0.598
	70-74	$0.519
	75+	$0.519

Exclusions, limitations, and reductions

Like any insurance, this long-term disability insurance policy does have some exclusions. You won't receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- Your disability occurs while you're committing a felony or misdemeanor, or participating in a riot
- Your disability occurs while you're imprisoned for committing a felony
- Your disability occurs while you're residing outside of the United States or Canada for more than 12 consecutive months for a purpose other than work

Your benefits may be reduced if you're eligible to receive benefits from:

- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers' compensation
- Salary continuance
- Sick leave

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

LCN-6459796-030624

PDF 5/24 **Z01**

Order code: GP-LTDEP-FLI001

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Flexible Savings Account

WHAT IS A FLEXIBLE SAVINGS ACCOUNT (FSA)?

An FSA is an employer-sponsored spending account that allows employees to set aside pretax earnings to pay for eligible health care or dependent care expenses. Every dollary you contribute to an FSA lowers your taxable income. That means if you earn $40,000 a year and contribute $3,300 to an FSA, only $36,700 of your income is subject to tax. The account is funded through payroll deductions over the course of the year, but your entire annual contribution is immediately available for use at the beginning of the plan year. Ameriflex is the City of Highland's FSA administrator and you can learn more about the benefits of an FSA on their website at myameriflex.com/fsa.

ARE THERE ANY CONTRIBUTION LIMITS?

Yes, contributions must conform to the IRS regulations on FSA annual contribution limits and plan rules. Employees may contribution up to the maximum amount as determined by the IRS.

WHAT ARE FSA ELIGIBLE EXPENSES?

Eligible Expenses under the FSA are called Qualified Medical Expenses (QME). These are defined in IRS Publication 502. There are thousands of eligible medical expenses. Examples of qualified medical expenses are Deductibles, Office Visits, Prescription Drugs, Hospital bills, Dental charges, Lenses & Frames, etc…

HOW DO I USE IT?

AmeriFlex will provide you with a debit card that you can swipe, or you may submit claim forms or receipts along with itemized bills from your provider to obtain reimbursement.

WHO IS ELIGIBLE FOR AN FSA?

Full time employees are eligible to participate and contribute to FSA's.

WHEN CAN I ENROLL FOR AN FSA?

Since the contributions are made via pre-tax payroll deductions you may only enroll at open enrollment or when you have a mid year qualifying event.

DO I HAVE TO USE ALL FUNDS BEFORE THE END OF THE YEAR?

You must use all or the bulk of your funds before the end of the year. Any remaining funds, up to $660, may rollover from year to year.

WHEN CAN I ACCESS THE FUNDS?

You have access to all funds from the 1st day of the plan year.

IS THE FSA PORTABLE?

No - this is an employer owned account and it is not portable.

MEMBER WEBSITE

https://www.myameriflex.com

CUSTOMER SERVICE PHONE NUMBER

888-868-3539

MissionSquare RETIREMENT

CITY OF HIGHLAND CA
457 Deferred Compensation Plan

Join your plan using your computer, tablet, or mobile device. To enroll, or view your plan's features and investment options, scan the QR code or visit:

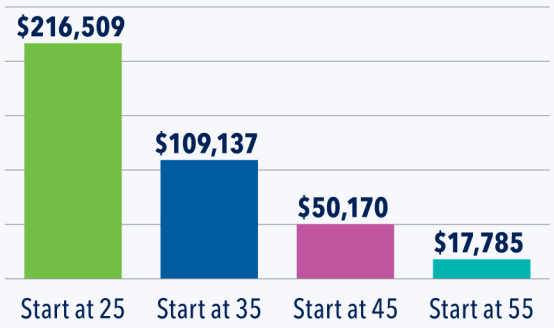
www.missionsq.org/enroll

All you need to get started is your Employer, Plan Name, or Plan State to visit your plan resource site.

How much could my account be worth at age 65?*

Saving now can help alleviate the pressure to catch up later. Starting early can give you an advantage due to compounding, in which your investments produce earnings from previous earnings.

** For illustrative purposes only. Assumes $50 bi-weekly contributions and an effective annual return of 6%, compounded bi-weekly.*



Questions? Get personalized help from your MissionSquare Retirement Plans Specialist. See next page for contact information.

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While a pension and/or Social Security may go a long way, they may not to be enough. Saving to a 457 plan will supplement your retirement income and help you build a secure financial future.

- Set your own savings goals
- Control your investments
- Choose your beneficiaries
- Get tax benefits
- Access to your MissionSquare representative for personalized help

By joining your 457 Plan, you've taken an important first step on your retirement journey. For more information, visit: **www.missionsq.org/457**

For assistance with your Plan and your overall retirement goals, contact your MissionSquare representative.

Isaiah Carter
Retirement Plans Specialist
202-962-4836
icarter@missionsq.org

Start your journey.

Visit **www.missionsq.org/enroll** to join your plan today.

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Supplemental Benefits

Colonial Life | Accident 1.0 Plan

Plan Explanation

Accidents can happen anytime, anywhere. Accidents are usually followed by a series of bills. Even if you have good insurance you may still have to cover out-of-pocket costs, such as: Doctor bills, Ambulance fees, Hospital expenses. Accident insurance can help protect you, your spouse and your dependent children from the unexpected expenses of an accident. Schedule an appointment with Colonial Life to enroll HERE.

INJURY	SCHEDULED BENEFIT
Burn - 2nd Degree	$1,000 - $2,000
Burn - 3rd degree	$1,000 - $2,000
Coma	$7,500 (duration of at least 7 days)
Concussion	$60
Dislocation - Hip	$90 - $4,800
Dislocation - Knee	$90 - $4,800
Dislocation - Shoulder	$90 - $4,800
Fracture - Hip	$90 - $6,000 (based on bone and if repaired by open or closed reduction)
Fracture - Skull	$90 - $6,000 (based on bone and if repaired by open or closed reduction)
Fracture - Arm	$90 - $6,000 (based on bone and if repaired by open or closed reduction)
Fracture - Hand	$90 - $6,000 (based on bone and if repaired by open or closed reduction)
Loss of Speech	$10,000 EE & SP / $5,000 CH
Loss of Hearing	$10,000 EE & SP / $5,000 CH
Accidental Death & Dismemberment	$20,000 EE & SP / $4,000 CH(ren)
PLAN INFORMATION	
Member Website	coloniallife.com/individuals/

Colonial Life

Disclaimer

This is a medical indemnity plan that provides employees and their families with hospital, doctor, accidental death and catastrophic accident benefits in the event of a covered accident. This is a partial listing of your covered benefits. For a complete listing of covered benefits, limitations and exclusions, refer to certificate of coverage

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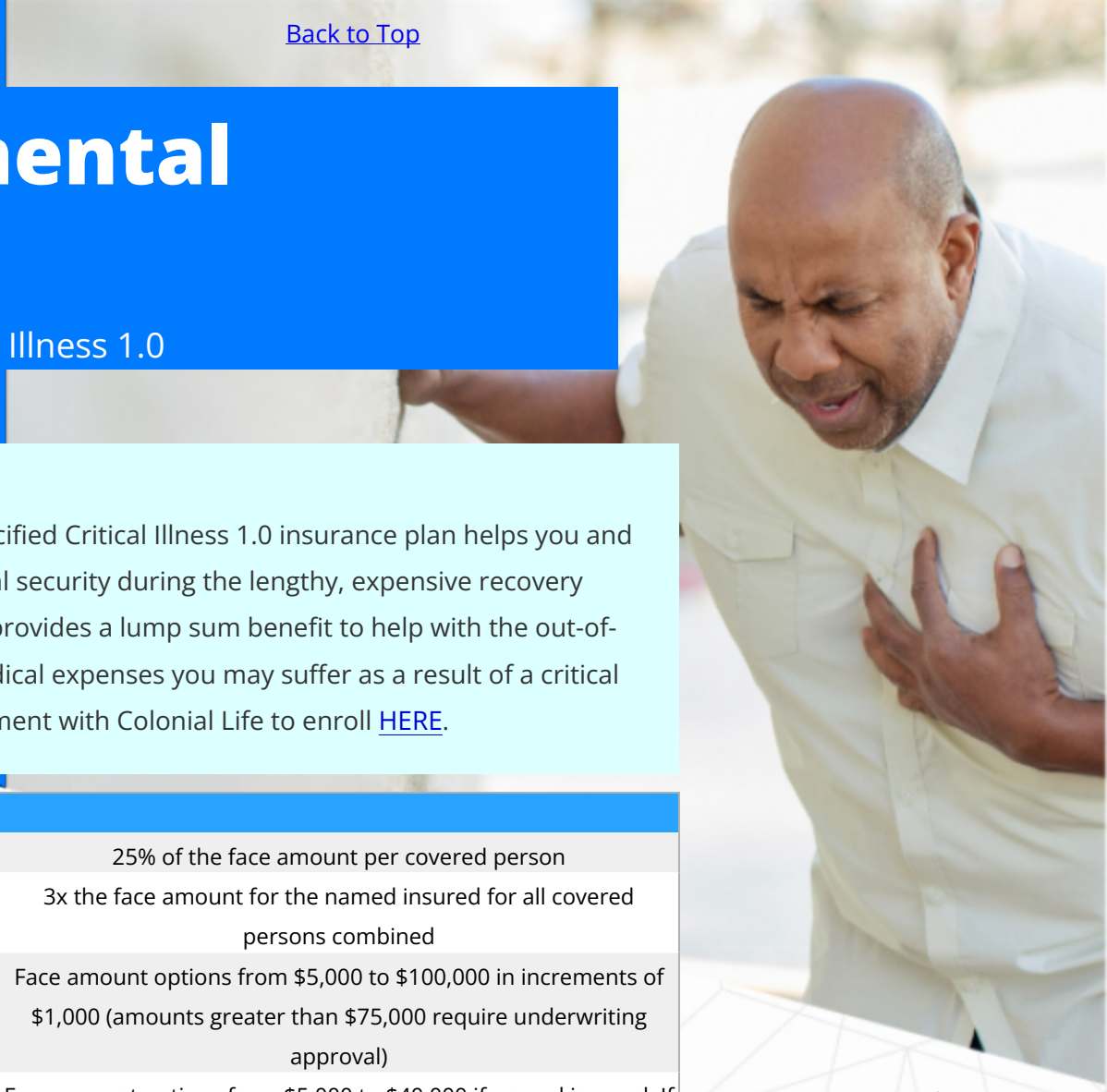
Supplemental Benefits

Colonial Life | Critical Illness 1.0



Plan Explanation

Colonial Life's individual Specified Critical Illness 1.0 insurance plan helps you and your family maintain financial security during the lengthy, expensive recovery period of a critical illness. It provides a lump sum benefit to help with the out-of-pocket medical and non-medical expenses you may suffer as a result of a critical illness. Schedule an appointment with Colonial Life to enroll HERE.

CRITICAL ILLNESS BENEFIT	
Minimum Benefit	25% of the face amount per covered person
Maximum Benefit	3x the face amount for the named insured for all covered persons combined
Employee Scheduled Benefit	Face amount options from $5,000 to $100,000 in increments of $1,000 (amounts greater than $75,000 require underwriting approval)
Spouse Scheduled Benefit	Face amount options from $5,000 to $40,000 if named insured. If enrolled as a spouse on an employee plan, face amount may not exceed 50% of the employee's face amount.
Child Scheduled Benefit	25% of named insured coverage face amount
Wellness Benefit	$50 payable 1x per year per covered person upon completion of 1 health screening test (1 of 21 options)
ILLNESS	**BENEFITS ARE PAID AS A LUMP SUM PAYMENT FOR A SPECIFIED CRITICAL ILLNESSES WHEN THE COVERED PERSON IS DIAGONSED.**
PLAN INFORMATION	
Member Website	coloniallife.com/individuals/

Colonial Life

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

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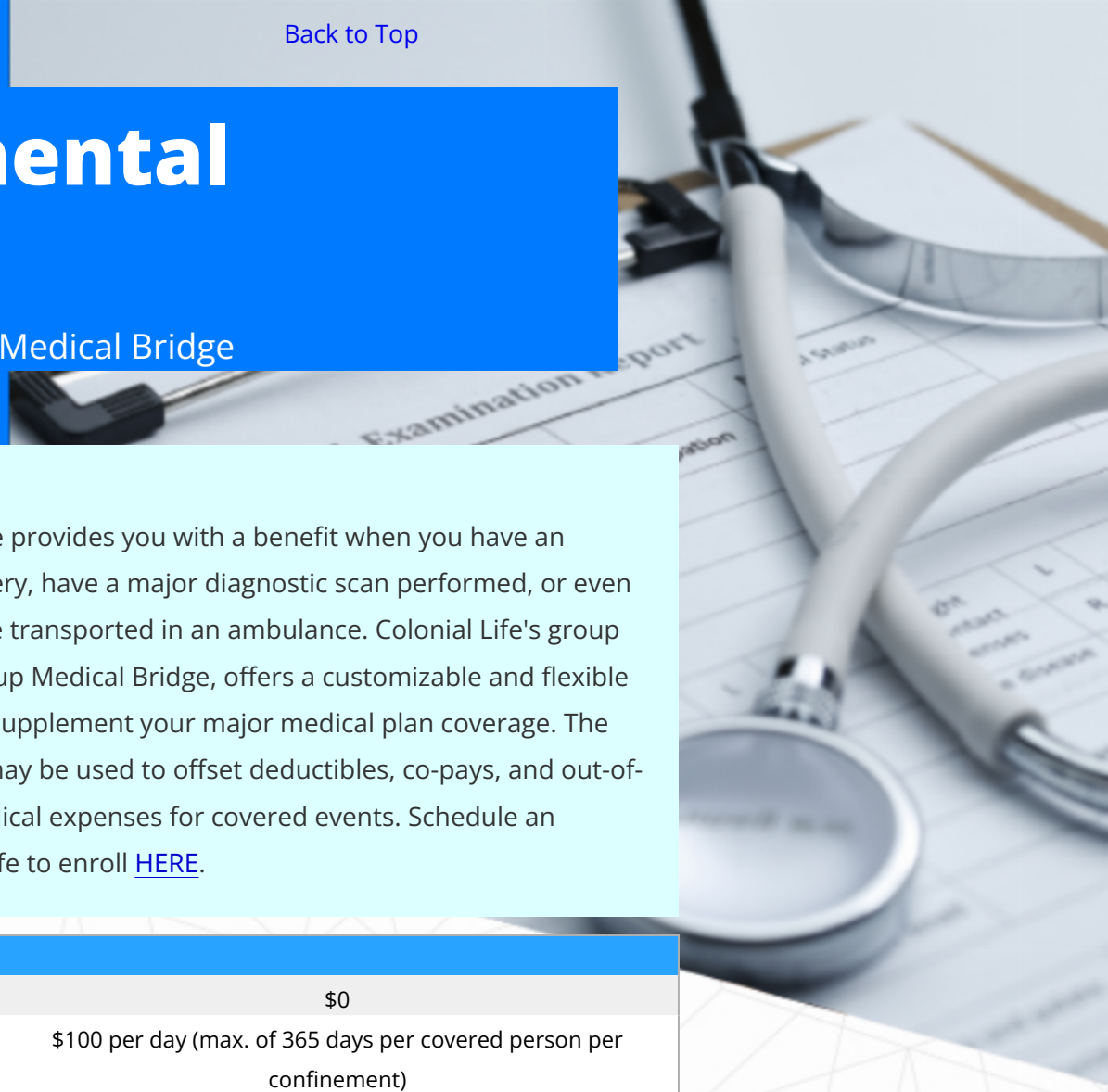
Supplemental Benefits

Colonial Life | Group Medical Bridge



Plan Explanation

Hospital Indemnity insurance provides you with a benefit when you have an Inpatient or Outpatient surgery, have a major diagnostic scan performed, or even when you need to need to be transported in an ambulance. Colonial Life's group hospital indemnity plan, Group Medical Bridge, offers a customizable and flexible plan design that will help to supplement your major medical plan coverage. The plan provides benefits that may be used to offset deductibles, co-pays, and out-of-pocket medical and non-medical expenses for covered events. Schedule an appointment with Colonial Life to enroll HERE.

HOSPITAL INDEMNITY BENEFIT	
Hospital Admission	$0
Hospital Confinement	$100 per day (max. of 365 days per covered person per confinement)
ICU Confinement	$0
Inpatient Surgery	$500 per day (max. 1 day per covered person per calendar year and subject to a lifetime benefit maximum of $2,000)
Outpatient Surgery	$0
Anesthesia	$25
ER visit	$100 per day (max. of 2 days per covered person per calendar year)
Air Ambulance	$1,000 per day (max. of 1 day per covered person per calendar year)
Ground or Water Ambulance	$100 per day (max. of 1 day per covered person per calendar year)
MRI, CT Scan, PT Scan	$250
Labs	$250
X-Rays	$25 per day (max. of 2 days per covered person per calendar year)
PLAN INFORMATION	
Member Website	coloniallife.com/individuals/

Colonial Life

Disclaimer

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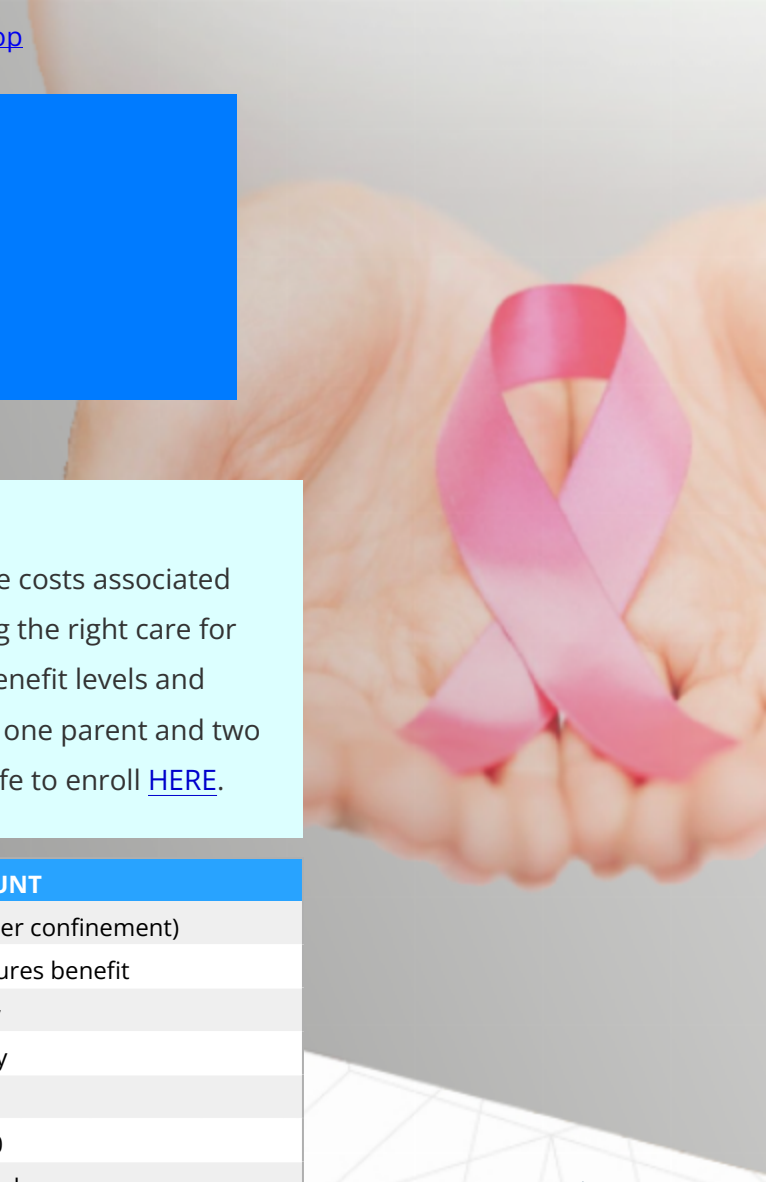
Supplemental Benefits

Colonial Life | Cancer Assist



Plan Explanation

Cancer Insurance helps protect you financially from a lot of the costs associated with cancer treatment and the travel associated with accessing the right care for you or a loved one. Employees can choose from one of four benefit levels and coverage types include employee only, employee and spouse, one parent and two parent family plans. Schedule an appointment with Colonial Life to enroll HERE.

CANCER BENEFIT	BENEFIT AMOUNT
Ambulance	$250 per trip (max. 2 trips per confinement)
Anesthesia	25% of Surgical Procedures benefit
Anti-Nausea Medication	$25 per day
Blood Transfusions	$150 per day
Cancer Vaccine	$50
Chemotherapy	$75 - $1,000
Experimental Treatment	$200 - $300 per day
Home Health Care Services	$50 - $100
Hospice	$1,000 / $50 daily
Hospital Confinement	$100 - $350
Lodging	$50 - $80 per day
Radiation	$250 - $1,000 (max. 1x per week)
Reconstructive Surgery	$40 - $60 per surgical unit
Skilled Nursing Facility	$75 - $150
Skin Cancer Initial Diagnosis	$300 - $600
Wellness Rider	$25 - $100
PLAN INFORMATION	
Member website	coloniallife.com/individuals/

Colonial Life

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

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Insurance Terms and Definitions

PPO (PREFERRED PROVIDER ORGANIZATION)

A PPO is a type of insurance network. In this type of network, you may choose to obtain care in or out of your network. If you choose to visit a "Preferred", or "In-Network", provider, your out of pocket expense will be significantly less than if you visit a provider outside your network. The reason for this is the In-Network provider agrees to accept set, contracted rates as payment in full for their services in return for being part of the insurance carrier's Preferred Provider network.

HMO (HEALTH MAINTENANCE ORGANIZATION)

An HMO is a type of insurance network. In this type of network, you must stay in your network to obtain care under your plan. There are no benefits paid out for services obtained outside the network. In some instances, HMO's may require that you have a referral from your primary care physician to obtain services from a specialist.

DEDUCTIBLE

The amount you pay before the insurance carrier starts sharing the expense of your medical care. Major medical expenses apply to the deductible like inpatient/outpatient surgeries, MRI's, CT Scans, etc…

EMBEDDED DEDUCTIBLE

This only applies to employees who have dependents enrolled on their plans. In an Embedded deductible, no member of the family unit can satisfy more than the single deductible during the deductible period. Even though the family is subject to the family deductible as a whole, no one person can satisfy more than the single deductible.

AGGREGATE DEDUCTIBLE

This only applies to employees who have dependent enrolled on their plans. In an Aggregate deductible, one member of the family can satisfy the entire family deductible during the deductible period.

DEDUCTIBLE PERIOD

This is the 12 month time period in which all medical expenses that would apply to your deductible accumulate. Your deductible will reset after this period ends. This time period is important to note, because it does not always align with your plan year

DEDUCTIBLE CREDIT

If your Deductible Period and Plan Year are not the same with your new health insurance carrier, the new carrier will give you "credit" for the portion of the deductible you've satisfied with the old health insurance carrier during the most recent Deductible period. In order to obtain this credit, please supply your Plan Administrator with your most recent Explanation of Benefits (EOB) from the old carrier.

CO-INSURANCE

After you've reached your deductible for the year, the insurance carrier will split the balance of the major medical expense with you. They pay a percentage and you pay a percentage of your medical expense until you've reached your Out of Pocket Maximum

OUT OF POCKET MAXIMUM

This is the maximum amount you will pay for covered medical expenses during your deductible period

CO-PAYS

This is a set Dollar amount you pay when you receive medical care from a PCP, Specialist, Urgent Care, Emergency Room, or Pharmacy. It's called a CO-pay, because you pay the set dollar amount and your insurance carrier pays the rest of the actual charge from the doctor/facility. Co-pays DO NOT apply to the deductible

NEGOTIATED RATE (CONTRACTED RATE)

When a Provider (doctor, facility, pharmacy or hospital) contracts with an insurance carrier, they are considered In-Network. Part of the contract states that the provider will accept a lower payment (lower than what they normally charge) from the insurance carrier as payment in full. This lower payment is the Negotiated Rate.

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EXPLANATION OF BENEFITS

Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate) It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

This is an account funded by your employer, where you are reimbursed a % of the covered in-network medical expenses you incur. The goal is to help lower your overall out of pocket expense for the year and not leave you with a high deductible

PREMIUM SAVER

Premium Saver, administered through a company called The Morgan White Group, is a secondary insurance plan that will pay a large portion of your deductible, so you are not stuck with high out of pocket costs. You will receive a second ID card to give to all doctors and hospitals at the time of service. Your medical plan will always pay the provider 1st and Premium Saver will always pay them 2nd.

HEALTH SAVINGS ACCOUNT (H S A)

This is an Employee Owned savings account that allows you to pay for Qualified Medical Expenses (IRS Publication 502) through tax free contributions. The maximum contributions for 2025 are $4,300 for single coverage and $8,550 for family coverage. Members ages 55-64 can contribute an additional $1,000. If you are age 65 or older, you are no longer eligible to contribute to the H S A. This is a true savings account plan, so you can rollover all unused funds from year to year. With an H S A, money has to be in the account for you to be able to use it.

FLEXIBLE SPENDING ACCOUNT (F S A)

This is an account funded by the Employee and in part by your employer. The FSA is used to pay for Qualified Medical Expenses (IRS Publication 502) through tax free contributions. The employee chooses the total amount they want in their FSA for the year during open enrollment. That amount is divided up by the number of pays per year and is taken out of each paycheck before taxes. With the FSA, you have access to the Total Amount of funds you Selected during open enrollment at the beginning of your plan year. The maximum amount you can contribute to the FSA is $3,300 in 2025. Typically, you can only rollover $660 from year to year. This is an account funded by the Employee and in part by your employer. The FSA is used to pay for Qualified Medical Expenses (IRS Publication 502) through tax free contributions. The employee chooses the total amount they want in their FSA for the year during open enrollment. That amount is divided up by the number of pays per year and is taken out of each paycheck before taxes. With the FSA, you have access to the Total Amount of funds you Selected during open enrollment at the beginning of your plan year.

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Important Notices

No Surprises Act Notice

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

Discrimination is Against the Law

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

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 909-864-6861.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please visit www.blueshieldca.com, www.kp.org, www.healthnet.com, www.anthem.com, www.uhc.com, www.sharp.com, or www.westernhealth.com.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please visit www.blueshieldca.com, www.kp.org, www.healthnet.com, www.anthem.com, www.uhc.com, www.sharp.com, or www.westernhealth.com.

Networks/Claims/Appeals

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

Notice of Extended Coverage to Children Covered as Students

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

Important Notices

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

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

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

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

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

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

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

COBRA Continuation Coverage

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

Important Notices

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

Important Notices

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

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

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

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

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

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

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

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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Important Notices

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

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Important Notices

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

City of Highland
Human Resources Division
27215 Baseline
Highland, CA 92346
909-864-6861, lnavacruz@cityofhighland.org

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Important Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

Open Enrollment for health insurance coverage through Covered California will begin on November 1, 2024, and end on January 31, 2025. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 8.39% (for 2024) of your household income for the year, then that coverage for you is not Affordable. **Note**: The IRS will update the applicable percentage for 2025. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

STATES WITH INDIVIDUAL MANDATE

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

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PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name City of Highland	**4. Employer Identification Number (EIN)** 33-0270638	
5. Employer address 27215 Baseline	**6. Employer phone number** 909-864-6861	
7. City Highland	**8. State** CA	**9. ZIP code** 92346
10. Who can we contact about employee health coverage at this job? Leticia Nava-Cruz, Director of Administrative Services/City Treasurer		
11. Phone number (if different from above)	**12. Email address** lnavacruz@cityofhighland.org	

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

Important Notices

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

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

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

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

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

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

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

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

INDIANA – Medicaid
Website: https://www.in.gov/medicaid/
Or http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 800-403-0864
Member Services Phone: 800-457-4584

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IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 800-338-8366
Hawki Website: http://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/free-service/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884
HIPPA Phone: 800-967-4660

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

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

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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840 | TTY: Massachusetts relay 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 800-657-3672

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

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

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

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

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

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710 (TTY: 711)

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

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

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 844-854-4825

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

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

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/en/services/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

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

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

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

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 800-440-0493

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

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

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

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

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

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

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

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

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

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Important Notices

Important Notice from City of Highland About Your Prescription Drug Coverage and Medicare

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

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

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- **City of Highland has determined that the prescription drug coverage offered by the CalPERS Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

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

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

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

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

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

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

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Highland changes. You also may request a copy of this notice at any time.

Date:	January 1, 2025
Name of Entity / Sender:	City of Highland
Contact:	Human Resources Division
Address:	27215 Base Line Highland, CA 92346
Phone:	909-864-6861

Important Notices

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

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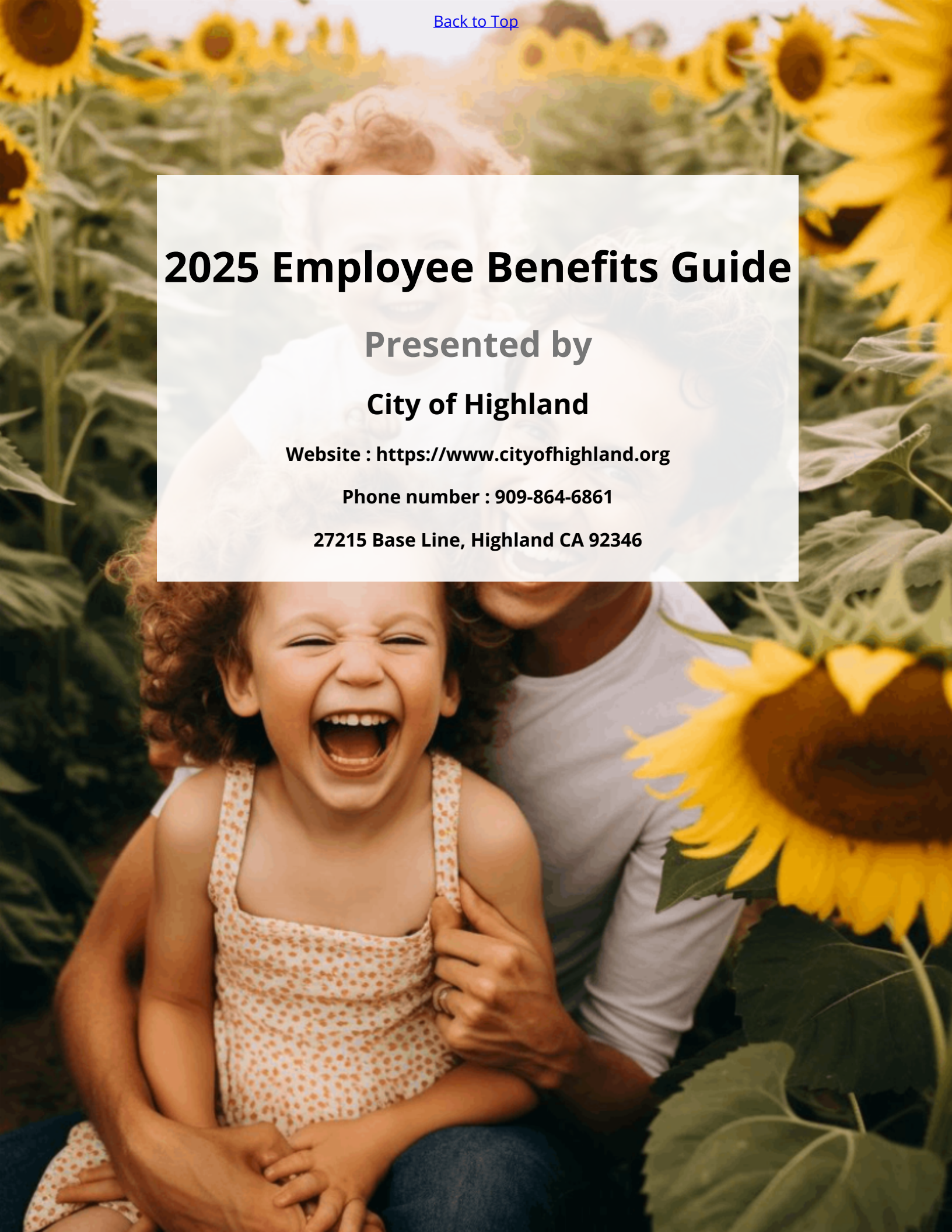

2025 Employee Benefits Guide

Presented by

City of Highland

Website : https://www.cityofhighland.org

Phone number : 909-864-6861

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