EMPLOYEE BENEFITS *Guide*

2026

Employee Benefits Guide 2026

General Information

Core Benefits

Other Benefits

Miscellaneous

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

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

Please see page 30 for more details.

Please note that this guide provides highlights of the benefits available to you. You may find a complete description of each plan, including policy provisions, limitations, exclusions, and insurance contracts, in the summary plan descriptions and official plan documents. If a conflict arises between this guide and the official plan documents, the plan documents will govern. The City of Ceres reserves the right to modify or terminate any of the described benefits at any time and for any reason. The descriptions of these benefits are not guarantees of current or future employment or benefits.

Welcome to Your Employee Benefits

The City of Ceres takes pride in offering a benefit program that provides flexibility for the diverse and changing needs of employees. We offer employees and their family members a full range of benefits. You choose the options that best meet the needs of you and your family. This brochure provides a summary of your benefit options and is designed to help you make choices and enroll in coverage. More information about any of the benefits described can be obtained by contacting Human Resources at 209-538-5747.

Enrollment Information

Who May Enroll

If you are a regular full time or part time benefited employee, you and your eligible dependents may participate in the City of Ceres benefits program. Your eligible dependents include:

- Legally married spouse
- Children under the age of 26, regardless of student or marital status
- Registered domestic partner

When You Can Enroll

As an eligible employee, you may enroll at the following times:

- As a new hire, you may participate in the City's benefits program on the first day of the month following your date of hire; you must enroll within 30 days from your date of hire
- Each year, during open enrollment
- Within 30 days of a qualifying event as defined by the IRS (see Making Changes To Enrollment below)
- You may enroll in Voluntary Life Insurance at any time, subject to proof of good health and carrier approval

Making Changes to Enrollment

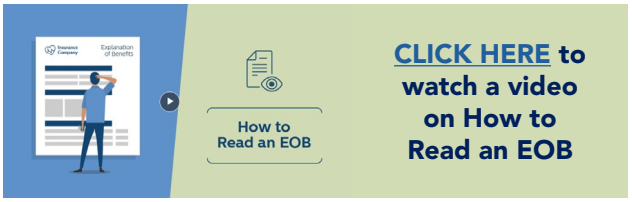
Our benefit plans are effective January 1st through December 31st of each year. There is an annual open enrollment period during which you can make new benefit elections for the following January 1st effective date. Once you make your benefit elections, you cannot change them during the year unless you experience a qualifying event as defined by the IRS. Examples include, but are not limited to the following:

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child
- A qualified medical child support order
- Death of a spouse or child
- A change in your dependent's eligibility status
- Loss of coverage from another health plan
- Change in your residence or workplace (if your benefit options change)
- Loss of coverage through Medicaid or Children's Health Insurance Program (CHIP)
- Becoming eligible for a state's premium assistance program under Medicaid or CHIP

Coverage for a new dependent is not automatic. If you experience a qualifying event, you have 30 days to update your coverage. Please contact the HR Office immediately following a qualifying event to complete the appropriate election forms. If you do not update your coverage within 30 days from the qualifying event, you must wait until the next annual open enrollment period to update your coverage.

Paying For Your Coverage

- You and the City share in the cost of your Medical, Dental, and Vision benefits. Your contributions are deducted before taxes are withheld, which saves you tax dollars. Paying for benefits before-tax means your share of the costs are deducted before taxes are determined, resulting in more take-home pay for you.
- Basic Life and AD&D benefits are provided at no cost to you and are paid entirely by the City for employees who qualify per MOU.
- Any additional Voluntary Benefit options you elect will be paid by you at discounted group rates.



Medical Benefits

City of Ceres Medical Plans

Medical coverage offers health care protection for you and your family. The City of Ceres is pleased to provide you with five medical plans to choose from. Be sure to read about each plan so you can select the plan that best meets the needs of you and your family.

Two Kaiser Health Maintenance Organization (HMO) Plans

These plans are designed for you to select a Primary Care Physician (PCP) who will coordinate your care and help manage your overall health. Plan choices include Basic and Premium HMO:

- **Kaiser Permanente HMO:**
  800-464-4000 - www.kp.org

For all HMOs, specialist care is coordinated through your PCP. Please note that services received outside the network are not covered except for emergency services.

Three Sutter Health Plan - Health Maintenance Organization (HMO) Plans

These plans are designed for you to select a Primary Care Physician (PCP) who will coordinate your care and help manage your overall health.

- **Sutter Health Plan HMO:**
  855-315-5800 - www.sutterhealthplan.org
  Find a provider: Sutter Health Plan Provider Search

Telemedicine and Nurseline Benefits

Phone and/or video visits are an excellent option for convenient, accessible care when you don't need a doctor to see you in person. They are also a good choice when away from home or if you need short term prescription drug refills. The City of Ceres provides telemedicine coverage with all medical plans. Nurseline phone numbers are shown on 36.

Kaiser Permanente Members:

- Log in to your Kaiser account at www.kp.org to make a free phone or video appointment with your doctor or call 866-454-8855.
- For phone visits, the doctor will call you at the time of the appointment
- For video visits, you will be provided with a link; click Join your visit and log in
- There is no copay for phone or video visits

Sutter Health Members:

- **Nurse Advice Line:** 855-836-3500

Medical Benefits (continued)

How the Health Savings Account (HSA) Works

When you elect the Sutter Health Plan Vista HL10 HDHP HMO Plan, you have the opportunity to establish and contribute to a Health Savings Account (HSA) - a tax-free savings account for healthcare expenses that earns interest. You can withdraw funds from an HSA to pay for eligible medical expenses such as deductibles, coinsurance and copays. Your account balance earns interest and the unused balance rolls over from year to year.

The IRS limits the amount you can contribute to an HSA for 2026 to:

- **Employee:** $4,400
- **Family:** $8,750
- **Catch-up contribution (if you are 55 years of age or older):** $1,000

Your HSA contributions are taken out of your paycheck before you pay federal income taxes, Social Security taxes and most state taxes (excluding state taxes in AL, CA and NJ). You can change your contribution amount at any time during the course of the year.

Please note that you cannot participate in the Healthcare Flexible Spending Account (FSA) while participating in an HSA.

You're eligible to open a HSA if:

- You enroll in the high-deductible health plan.
- Your only coverage is a high-deductible health plan. If you are covered under your spouse's plan and that plan is not a high-deductible plan, you are not eligible to contribute to a HSA.
- You are not covered by a traditional Healthcare Flexible Spending Account (FSA) through your spouse.
- You have not signed up for Medicare coverage.

For more information or to set up an account, contact Voya at 833-232-4673.

Examples of Eligible HSA Expenses

Medical

Providers (Doctors, Specialists, Nurses)

Prescription Drugs

Inpatient Hospital Services

Laboratory & X-Ray

Emergency Services

Acupuncture / Chiropractic

Dental

Providers (Dentists, Specialists, Orthodontists)

Teeth Cleaning

Dental Treatment

Orthodontia

Vision

Providers (Optometrists, Ophthalmologists)

Exams

Glasses

Contact Lenses

Lasik Surgery

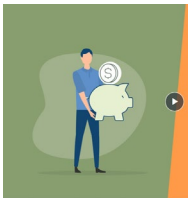
Premiums

COBRA

Long-Term Care

Medicare

Ineligible HSA expenses include expenses that are not medical or health related, such as cosmetic surgery.



CLICK HERE to watch a video on Health Savings Accounts (HSA)

CLICK HERE to watch a video on How to Optimize Your HSA

Medical Benefits (continued)

	Kaiser Premium HMO	Kaiser Basic HMO
Contracted Network		
Calendar Year Deductible		
• Individual	N/A	$500
• Family	N/A	$1,000
Calendar Year Out-of-Pocket Maximum		
• Individual	$1,500	$3,000
• Family	$3,000	$6,000
Lifetime Maximum Benefit	Unlimited	Unlimited
Health Benefits	**You Pay**	**You Pay**
Office Visit *(Includes Specialists)*	PCP $15/Specialist: $15	PCP $20/Specialist: $40
Coinsurance *(Plan Pays)*	100%	100%
Hospital Coinsurance / Copay	No charge	10% after deductible
Lab and X-Ray	No charge	$10
Urgent Care Copay	$15	$20
Emergency Room	$100	10% after deductible
Emergency Medical Ambulance	$100	10% after deductible
Inpatient Hospital & Surgery	No charge	10% after deductible
Outpatient Surgery *(In Ambulatory Surgery Center)*	$15/occurrence	10% after deductible
Chiropractic	$10 (20 visits/calendar year)	$10 (20 visits/calendar year)
Acupuncture	$15*	$15*
Mental Health/Substance Abuse		
• Outpatient Visit	$15	$20
• Inpatient Care	No charge	10% after deductible
Pharmacy Benefits	**You Pay**	**You Pay**
Retail Pharmacy *(Up to 30 Day Supply)*		
• Tier 1 - Preferred Generic	$10	$10
• Tier 2 - Non-preferred Generic/Preferred Brand	$30	$30
• Tier 3 - Non-preferred Brand	N/A	N/A
• Tier 4 - Non-formulary	N/A	N/A
Mail Order Pharmacy *(Up to 90 Day Supply)*		
• Tier 1 - Preferred Generic	$20	$20
• Tier 2 - Non-preferred Generic/Preferred Brand	$60	$60
• Tier 3 - Non-preferred Brand	N/A	N/A
• Tier 4 - Non-formulary *(Excluding Specialty Drugs)*	N/A	N/A

* Subject to medical necessary

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Medical Benefits (continued)

	Sutter Health Plan Summit HMO LG20	Sutter Health Plan Summit HMO LG 18
Contracted Network		
Calendar Year Deductible		
• Individual	N/A	N/A
• Family	N/A	N/A
Calendar Year Out-of-Pocket Maximum		
• Individual	$1,000	$1,500
• Family	$2,000	$3,000
Lifetime Maximum Benefit	Unlimited	Unlimited
Health Benefits	**You Pay**	**You Pay**
Office Visit *(Includes Specialists)*	PCP $10 / Specialist $20	PCP $20 / Specialist $40
Coinsurance *(Plan Pays)*	100%	100%
Lab and X-Ray	$10 copay	$10 copay
Urgent Care Copay	$20	$40
Emergency Room	$100	$200
Emergency Medical Ambulance	$50	$100
Inpatient Hospital & Surgery	$100 copay per day-max 5 days	$250 copay per day-max 5 days
Outpatient Surgery	$25/surgery	$50
Chiropractic	$10 (30 visits/calendar year)	$20 (30 visits per calendar year)
Acupuncture	$10 Copay	$20 Copay
Mental Health/Chiropractic/Substance Abuse		
• Outpatient Visit	$10	$20
• Inpatient Care	$100 copay per day-max 5 days	$250 copay per day - max 5 days
Pharmacy Benefits	**You Pay**	**You Pay**
RX Deductible	N/A	N/A
Retail Pharmacy *(Up to 30 Day Supply)*		
• Tier 1 - Most generic drugs and low-cost preferred brand name drugs	$5	$10
• Tier 2 - Preferred brand name drugs and non-preferred generic drugs	$20	$30
• Tier 3 - Non-preferred brand name drugs	$40	$75
• Tier 4 - Specialty drugs, drugs that require special handling, or drugs that cost SHP more than $600 net of rebates	10% coinsurance up to $250	10% coinsurance up to $250
Mail Order Pharmacy *(Up to 100 Day Supply)*		
• Tier 1 - Most generic drugs and low-cost preferred brand name drugs	$10	$20
• Tier 2 - Preferred brand name drugs and non-preferred generic drugs	$40	$60
• Tier 3 - Non-preferred brand name drugs	$80	$150

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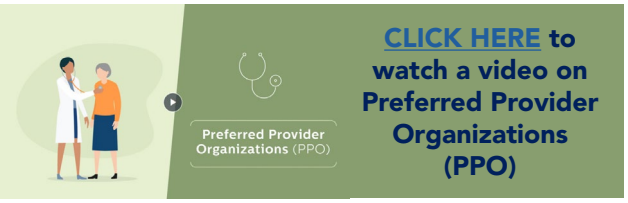
Medical Benefits (continued)

	Sutter Health Plan Vista HL10 HDHP HMO
	In-Network
Calendar Year Deductible	
• Individual	$1,700
• Family	$3,400
Calendar Year Out-of-Pocket Maximum	
• Individual	$3,400
• Family	$6,800
Lifetime Maximum Benefit	Unlimited
Health Benefits	**You Pay**
Office Visit *(Includes Specialists)*	$20 copay/$40 copay*
Lab and X-Ray	$20 copay*/$10 copay*
Imaging *(CT/PET scans, MRIs)*	$50 copay per procedure*
Urgent Care Copay	$40 copay*
Emergency Room	$200 copay/visit*
Emergency Medical Ambulance	$200 copay/trip*
Inpatient Hospital & Surgery	$250 copay/day (5 days/admit)*
Outpatient Surgery	$100 copay/visit*
Acupuncture	$20* (limited EHB benefit)
Mental Health/Substance Abuse	
• Outpatient Visit	$20 copay*
• Inpatient Care	$250 copay/day (5 days/admit)*
Pharmacy Benefits	**You Pay**
Rx Deductible *(Medical ded applies)*	$1,700/ $3,400
Retail Pharmacy *(Up to 30 Day Supply)*	
• Tier 1 - Most generic drugs and low-cost preferred brand name drugs	$10*
• Tier 2 - Preferred brand name drugs and non-preferred generic drugs	$30*
• Tier 3 - Non-preferred brand name drugs	$75*
• Tier 4 - Specialty drugs, drugs that require special handling, or drugs that cost SHP more than $600 net of rebates	20% ($250 max)*
Mail Order Pharmacy *(Up to 100 Day Supply)*	
• Tier 1 - Most generic drugs and low-cost preferred brand name drugs	$20*
• Tier 2 - Preferred brand name drugs and non-preferred generic drugs	$60*
• Tier 3 - Preferred brand name drugs and non-preferred generic drugs	$150*

* Copays after deductible is satisfied



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Dental Benefits

Delta Dental Plan

The City of Ceres provides employees with dental coverage through Delta Dental Plan.

- You can choose any dentist you wish for your dental care. You may visit an in-network dentist and benefit from the negotiated rate or visit an out-of-network dentist.
- When you utilize an in-network dentist, your out-of-pocket expenses will be less.
- When you obtain covered services from an out-of-network dentist, you are responsible for paying the difference between the covered amount and the actual charges, and you may be responsible for filing claims.

To find in-network providers, visit www.deltadental.com or call 888-335-8227.

Benefits	Delta Dental PPO Dentists	Delta Dental Premier Dentists	Non-Delta Dental Dentists
Deductibles			
• per member / per family each calendar year	$25/ $75	$25/ $75	$25/ $75
• Deductibles waived for Diagnostic & Preventive?		Yes, for all Dentists	
• Deductibles waived for Orthodontics?		Yes, for all Dentists	
Maximums			
• Per member each calendar year	$2,000	$2,000	$2,000
• D&P counts toward maximum?		Yes, for all Dentists	
Covered Services	**Delta Dental PPO Dentists**	**Delta Dental Premier Dentists**	**Non-Delta Dental Dentists**
Diagnostic & Preventive Services (D&P)			
• Exams, Cleanings, X-Rays, Sealants and Space Maintainers	100%	100%	100%
Basic Services			
• Fillings, Simple Extractions, Posterior Composites and Denture Repair/Reline/Rebase	80%	80%	80%
Endodontics			
• Root Canals	80%	80%	80%
Periodontics			
• Surgical and Non-Surgical Periodontics	80%	80%	80%
Oral Surgery	80%	80%	80%
Major Services			
• Crowns, Inlays, Onlays and Cast Restorations	50%	50%	50%
Prosthodontics			
• Bridges and Dentures	50%	50%	50%
Implants			
• Implant Services	50%	50%	50%
Orthodontic Services			
• Dependent Children	50%	50%	50%
Orthodontic Maximums *(up to age 26)*	$1,000 Lifetime	$1,000 Lifetime	$1,000 Lifetime

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Dental Benefits (continued)

Remember...

Use Contracted Network Providers When Possible

Contracted network providers have rate agreements with insurance companies for services rendered. If you use an out-of-network provider, your out-of-pocket expenses will be higher and you may be subject to balance billing.

Ask for a Predetermination of Benefits

It's recommended you ask your dentist for a predetermination if charges are expected to exceed $500. Predetermination enables you and your dentist to know in advance what the payment will be for any service that may be in question.

Have Dental Checkups Regularly

Routine dental visits not only help keep your teeth and mouth healthy; they can also provide an opportunity for early detection of serious diseases such as diabetes.

DELTA DENTAL®

Go PPO!

Make the most of your dental plan by choosing a network dentist

Your Delta Dental PPO™ plan lets you visit any licensed dentist, but you'll maximize your savings by taking advantage of the nationwide PPO network.[1]

Why should I choose a PPO dentist?

1. Greater savings

PPO dentists have agreed to reduced fees, which leaves more money in your pocket.

2. Quality assurance

Make sure your smile gets the care it deserves. We monitor PPO dentists to ensure proper licensing, cleanliness and safety procedures.

3. No balance billing

PPO dentists can't charge you more than their set fees. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's contracted rate — a process known as "balance billing."

4. No unbundling

PPO dentists agree not to "unbundle" services that are part of a treatment, like tooth preparation or local anesthesia. Out-of-network dentists may charge for these services separately, making overall costs higher.

5. Less paperwork

PPO dentists handle all claim forms and other paperwork for you. If you choose an out-of-network dentist, you may need to submit claims yourself.

6. No prepayment required

When you choose a PPO dentist, you'll pay only your portion of the bill.[2] We'll pay our share directly to your dentist. Out-of-network dentists may require you to pay the full cost of treatment up front and request reimbursement from Delta Dental.

Save with a PPO dentist

PPO

PREMIER

NON-DELTA DENTAL

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

[2] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services.

deltadentalins.com/members

Dental Benefits (continued)

How do I find a PPO dentist?

1. Visit deltadentalins.com.

You can find a network dentist near you by using the **Find a dentist** tool. Using the network dropdown menu, be sure and select Delta Dental PPO.

2. Talk to your dentist.

Once you've chosen a dental provider, call that dentist's office and verify that they're part of the Delta Dental PPO network.

3. If you can't go PPO, go Premier.

You'll save the most by visiting a Delta Dental PPO dentist but your next best bet is the Delta Dental Premier® network, the largest dental network nationwide.[3] PPO and Premier dentists cannot charge you more than their agreed PPO or Premier fees. This helps lower your out-of-pocket costs.

4. Coordinate your benefits.

Are you covered under a second dental plan? Ask your dentist to include information about both plans with your claim. We'll handle the rest.[4]

Seek diagnostic and preventive care

Your overall health can affect your dental health, from hypertension to pregnancy. Your plan covers regular exams and cleanings at low or no cost to help catch problems before they require costly, extensive treatment.

What you need to know about out-of-network claims

Since Delta Dental's networks are some of the largest in the country, your dentist is probably already in-network. If they're not, we've still got you covered.

When you visit a non-Delta Dental dentist, you'll still receive coverage but your out-of-pocket costs will be higher. That's because dentists who aren't contracted with Delta Dental can charge higher rates. You'll be responsible for paying the difference between what your plan pays and the rate your dentist charges. You may even be asked to pay the full cost of treatment upfront and will need to file a claim for reimbursement.

Claim forms are available on our website. Visit **deltadentalins.com/members**, click **After your visit** and scroll to **How to file a claim**.

[3] Delta Dental Premier is the largest dentist network nationwide based on total unique dentists, as of September 2022, according to Zelis Network360.

[4] Group- and state-specific exceptions may apply. Please review your plan booklet for details about coordination of benefits, including rules for determining primary and secondary coverage.

Delta Dental PPO and Delta Dental Premier are underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV, TX and UT and by not-for-profit dental service companies in these states: CA – Delta Dental of California; PA, MD – Delta Dental of Pennsylvania; NY – Delta Dental of New York, Inc.; DE – Delta Dental of Delaware, Inc.; WV – Delta Dental of West Virginia, Inc. In TX, Delta Dental PPO provides a dental provider organization (DPO) plan.

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

Vision Benefits

VSP - Vision Service Plan

The City of Ceres provides employees with vision coverage through VSP.

- VSP provides professional vision care and high quality lenses and frames through a large network of optical specialists
- You will receive greater benefits if you utilize a network provider.
- If you utilize an out-of-network provider, you will be responsible for paying all charges at the time of your appointment and will be required to file an itemized claim with VSP.

To find in-network providers, visit www.vsp.com or call 800-877-7195

	VSP
	In-Network
Vision Care Services	**You Pay**
Exam	No charge
Glasses (In Lieu of Contact Lenses)	**You Pay**
Frames	Amount over $150 allowance
Lenses	
• Single Vision	No charge
• Bifocal	No charge
• Trifocal	No charge
• Lenticular	No charge
Contact Lenses (In Lieu of Glasses)	**You Pay**
Contact Lenses	
• Medically Necessary	No charge
• Cosmetic	Amount over $120 allowance
Frequency	
• Exam	Once every 12 months
• Frames	Once every 12 months
• Lenses	Once every 12 months
• Contact Lenses	Once every 12 months

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Tax Savings Benefits

Voya - Flexible Spending Accounts

These accounts allow you to pay for eligible healthcare and dependent care expenses with tax-free dollars.

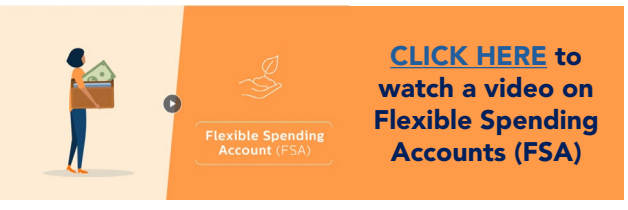
	Flexible Spending Accounts (FSAs)
For Both Flexible Spending Accounts	
• Carrier	Voya
• Plan Year	January 1 – December 31
• Primary Benefit	Using pre-tax money to pay for eligible healthcare and/or dependent care expenses reduces your taxable income and can help you save money on taxes
• Employee Contributions	Employees fund the FSAs; the City of Ceres pays for administration costs
Healthcare Spending Account	
• Plan Benefits	Pre-tax contributions can be used to pay for qualified out-of-pocket medical, dental, vision and prescription drug expenses plan for you and your dependents; eligible expenses can include deductibles, copays, coinsurance and qualified health expenses not covered by your health plan
• Eligible Expenses	For a complete list of eligible healthcare expenses, go to Voya's website at https://presents.accp.voya.com/Content/Delivers/harvard/pdf/HU-FSA-Eligible-Expenses.pdf
• Maximum Plan Year Contribution	$3,400
• Paying for Eligible Expenses:	You can pay for eligible healthcare expenses directly from the Healthcare FSA using the Voya Debit Card *(keep receipts, as documentation to verify expense eligibility may be required)* You can also choose to be reimbursed via direct deposit or by check
Dependent Care Spending Account	
• Plan Benefits	Pre-tax contributions can be used to pay for qualified dependent care expenses incurred while you are working, including child care, elder care and other eligible dependent care
• Eligible Expenses	For a complete list of eligible dependent care expenses, go to the American Fidelity website at http://voya.benstrat.com/
• Maximum Plan Year Contribution	$7,500
• Paying for Eligible Expenses:	You pay your care provider directly, and then submit a claim to Voya; you can choose to be reimbursed via direct deposit or by check

Flexible Spending Account Rules

- You must designate how much money you wish to contribute annually to each account at the beginning of the Plan Year. Money set aside for one account cannot be moved to another account.
- You may change your annual contributions only if you experience a qualifying "change in family status," such as marriage, divorce, addition or loss of a dependent or a change in your spouse's employment.
- It is important to carefully review your estimated expenses before enrolling. Unspent funds remaining in the FSAs after December 31 will be forfeited – referred to as the "Use It or Lose It Rule."
- There is a 90 day run-out period in the new plan year that allows participants to file claims for expenses incurred during the previous plan year.

Important!

Your FSA elections expire at the end of the plan year, on December 31st, and do not automatically roll over into the next plan year. You must re-enroll in the FSA every year you wish to participate.



CLICK HERE to watch a video on Flexible Spending Accounts (FSA)

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

Financial Protection Benefits

The Standard - Life and Accident Insurance - City Paid Basic Plan

The City of Ceres gives you the ability to help financially protect your family/beneficiaries with Life and Accidental Death & Dismemberment (AD&D) Insurance. Only employees who qualify per MOU are eligible for the Life and AD&D benefit. You have the option to supplement the company-provided plan with life insurance for family members and additional coverage for yourself through Voluntary Life Insurance.

	Basic Life and Accidental Death & Dismemberment (AD&D) Insurance
Carrier	The Standard
Plan Benefits	**Life Insurance:** City Manager - $150,000 and All Others - $50,000 **AD&D Insurance:** The Death benefit equals your Life Insurance benefit; partial benefits paid for accidents that result in serious injuries *(e.g., loss of limbs or eyesight)*
Employee Contribution	None; the City pays the full cost for this coverage for those who qualify

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The Standard - Voluntary Life Insurance

As an employee of City of Ceres, you have the option of purchasing additional life and AD&D coverage through The Standard. This voluntary policy enables you to purchase coverage for yourself and qualified dependents. When you enroll yourself and your dependents in this benefit, you pay the full cost through post-tax payroll deductions.

New Hires: If you apply for coverage that is above the Guaranteed Issue Amount of $150,000, or if you are applying for coverage after 31 days after you become eligible, you must fill out a Medical Evidence of Insurability (EOI) form.

Current Employees: If you previously waived coverage, all benefit amounts are subject to full medical underwriting/EOI.

	Voluntary Life Insurance
Carrier	The Standard
Plan Benefits	**Employee:** You may purchase coverage in increments of $10,000 to a maximum of $300,000 for City Managers and a maximum of $300,000 for All Others **Spouse/Domestic Partner:** You may purchase coverage for your spouse/ domestic partner in increments of $5,000 to a maximum of $150,000 or 50% of the employee's approved Voluntary Life coverage, whichever is less. **Children:** $10,000 per child ages live birth through age 25.
Guarantee Issue	**Employee:** For new hires, amounts over $150,000 require proof of good health and approval by The Standard. **Spouse/Domestic Partner:** For new hires, amounts over $30,000 require proof of good health and approval by The Standard. **Child(ren):** For new hires, a flat amount of $10,000. Proof of good health is not required when purchasing coverage for your child(ren)
Portability	You can convert your coverage to an individual policy if you leave the City of Ceres
Employee Contribution	You pay the full cost for this coverage

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The Standard - Voluntary Life Insurance (continued)

	Voluntary Life Insurance Rates
Age of Employee or Spouse/Domestic Partner	**Monthly Cost per $10,000 of Employee or Spouse/ Domestic Partner Coverage**
15 – 29	$0.50
30 – 34	$0.60
35 – 39	$0.70
40 – 44	$1.00
45 – 49	$1.50
50 – 54	$2.30
55 – 59	$4.30
60 – 64	$5.10
65 – 69	$7.40
70 – 74*	$12.10
75 – 79*	$38.80
80 – 84	$38.80
85 – 89	$38.80
90 – 94	$38.80
95 and Older	$38.80
Age of Child(ren)	**Monthly Cost for $10,000 of Child(ren) Coverage**
Birth to 26 Years	$2.00

* At age 70, coverage decreases to 65% of benefit amount; at age 75 it decreases to 50% of benefit amount

* Coverage for your spouse/domestic partner ends at age 70; you have the option to convert this coverage to a permanent life insurance policy.

Important Facts About Beneficiaries

Beneficiaries are individuals or entities that you select to receive benefits from your policy. If you do not have a beneficiary, benefits are paid to your estate. Here's what you need to know about beneficiaries:

- You can change your beneficiary designation at any time
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percentage(s) allocated
- To select or change your Life Insurance beneficiary, contact HR to complete a new beneficiary form.

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The Standard - Long Term Disability (LTD)

	Voluntary LTD
Benefit Schedule	60%
Maximum Monthly Benefit	$8,000
Minimum Monthly Benefit	$100
Benefit Waiting Period	90 Days
Maximum Benefit Period	To SSNRA
Guarantee Issue Benefit Amount	Full Benefit
Employer Contribution	0%
Taxability of Benefits	Non-Taxable
Own Occupation Period	24 Months
Partial/Residual Disability	Included
Preexisting Condition Period	3/12
Mental & Nervous Limitation	24 months
Drug & Alcohol Limitation	24 months
Musculoskeletal/Connective Tissue Limitation	24 months
Chronic Fatigue Limitation	24 months
Environmental Sensitivities Limitation	24 months
Return to Work Incentive	12 months
Employee Assistance Program	Included: 3 face-to-face

Additional Plan Design Details

- The own occupation definition of disability requires an earnings loss OR an inability to perform the substantial and material acts of the own occupation.
- The Standard pays the employer's matching FICA and Medicare taxes and prepares W-2s for members receiving LTD benefits.
- The plan includes the Workplace Possibilities(SM) program, an innovative approach to addressing and reducing the causes of absence and disability - with innovative tools and resources designed to help keep your employees productive and on the job.
- This coverage includes a $25,000 Reasonable Accommodation Expense Benefit, which reimburses employers for workplace modifications that enable employees to return to or remain at work. The Reasonable Accommodation Expense Benefit is separate from the LTD claim payment.
- A Rehabilitation Plan Benefit is included, which increases the LTD benefit amount by 10% of predisability earnings, not to exceed the maximum benefit, when member is participating in an approved rehabilitation plan. This benefit will also assist in paying for approved expenses incurred by a disabled member a part of an approved rehabilitation plan.
- Survivors Benefit pays a lump sum equal to 3 times the non-integrated LTD benefit.
- Continuity of Coverage.
- Each limitation in the policy is a separate lifetime limitation, not combined.
- Domestic partner language is included.

Use this formula to calculate your premium payment:

_____	x	0.29	÷ 100 =	_____
Enter your monthly earnings (cannot be more than $13,333		Rate Percentage		This amount is an estimate of how much you'd pay each month

Voluntary Benefits

Voya - Accident Insurance

Accident Insurance can complement existing medical coverage and pays a lump sum for a variety of life's accidents. Listed below are some examples of the types of covered incidents and the associated cost of the plans. A full list of covered occurrences is available from HR.

Category	
Accident Care	
• Initial Doctor Visit	$100
• Urgent Care Facility Treatment	$250
• Emergency Room Treatment	$250
• Ground Ambulance	$400
• Air Ambulance	$2,000
• Follow up Treatment	$100
• Chiropractic Treatment	$60
• Medical Equipment	$275
• Physical Therapy*(per treatment up to 6)*	$60
• Occupational & Speech Therapy	$60
• Prosthetic Device (one)	$1,250
• Prosthetic Device *(two or more)*	$2,000
• Major Diagnostic exams	$300
• Outpatient Surgery *(once per accident)*	$250
• X-ray	$90
Fracture	$300 - $10,000 depending on open or closed reduction
Dislocation	$300 – $8,000

Sample Claim Payment Amounts

Accident Related Treatment	Benefit
Emergency Room Treatment	$250
X-ray	$90
Stiches *(for lacerations up to 2")*	$90
Follow-up Doctor Treatment	$100

Annual Wellness Benefit of $50 when an eligible health screening test is completed.

Monthly			
Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$10.15	$20.31	$21.84	$32.00

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Voluntary Benefits (continued)

Voya - Critical Illness Insurance

Critical Illness Insurance can not only help you fill gaps in medical coverage; it can also help fill the gaps during a stressful time to help you pay your mortgage payments, college tuition, hire household help, or pay for treatment not covered by a medical plan. Benefits are payable directly to you to be used for whatever needs may arise.

- You can choose to be covered for $10,000 or $20,000.
- Spouses can be enrolled for up to 50% of the amount of your benefit. Coverage for dependent children, if elected, will 50% of the employee coverage at no additional cost.

Annual Wellness Benefit of $50 when an eligible health screening test is completed.

Category	Initial Benefit	Recurrence Benefit
Heart Attack Benefit	100% of benefit	100%
Coronary Artery Bypass Surgery	25%	25%
Stroke Benefit	100% of benefit	100%
Paralysis Benefit *(Permanent Paralysis)*	100% of benefit	None
Major Organ Failure Benefit	100% of benefit	100%
Kidney Failure *(End State Renal)* **Benefit**	100% of benefit	100%
Early Stage Cancer *(Carcinoma In Situ)* **Benefit**	25%	25%
Invasive Cancer Benefit	100% of benefit	100%
Benign Brain Tumor	100%	100%
Bone Marrow Transplant	25%	25%
Stem Cell Transplant	25%	25%
Skin Cancer	10%	10%

Voya	$10,000 Benefit
Age Bracket	Employee & Spouse Monthly Premium
Under 25	$2.50
25-29	$4.70
30-34	$5.50
35-39	$6.40
40-44	$9.90
45-49	$15.50
50-54	$20.70
55-59	$29.30
60-64	$35.40
65-69	$38.80
70+	$58.00

Voya	$20,000 Benefit
Age Bracket	Employee & Spouse Monthly Premium
Under 25	$5.00
25-29	$9.40
30-34	$11.00
35-39	$12.80
40-44	$19.80
45-49	$31.00
50-54	$41.40
55-59	$58.60
60-64	$70.80
65-69	$77.60
70+	$116.00

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Voluntary Benefits (continued)

Voya - Hospital Confinement Insurance

Out-of-pocket costs from a stay in a hospital or other medical facility can be overwhelming. As expenses add up, Hospital Indemnity Insurance can help.

With Hospital Indemnity Insurance, you'll receive a fixed daily benefit if you have a covered stay in a hospital, intensive care unit or rehabilitation facility that occurs on or after your coverage effective date.

When you are admitted to a covered medical facility, you become eligible for an admission benefit for the first day of confinement. This benefit is payable once per confinement, up to a maximum of 2 admission(s) per calendar year:

Type of Admission	Benefit Amount
Hospital Admission	$1,000

Beginning on Day 2 of your confinement, for each day that you have a stay in a covered facility, you'll be eligible for a fixed daily benefit payment. The benefit amount and maximum number of days per confinement varies by facility:

Type of Facility	Daily Benefit
Hospital *(10 day maximum per confinement)*	$100
Intensive Care Unit* *(10 day maximum per confinement)*	$200
Rehabilitation Facility *(30 day maximum per confinement)*	$50

* An Intensive Care Unit may be referred to as a "Critical Care Unit" in your certificate of coverage. An ICU Transitional Care Unit may be referred to as a "CCU Step-Down Unit" in your policy documentation. Refer to your policy documentation for complete definitions and descriptions of each facility type.

Hospital Indemnity Insurance benefits apply if you have employee or spouse coverage and are hospitalized for childbirth. In addition, your newborn child(ren) may be covered as well. See below for more details and for a complete description of your available benefits, exclusions and limitations, see your certificate of insurance and riders.

If child coverage <u>is effective</u> before the child is born

- Benefits will apply just as they would for any other child

If child coverage <u>is NOT effective</u> before the child is born

- A one-time benefit os $100 is payable for the newborn child's birth

Annual Wellness Benefit of $50 when an eligible health screening test is completed.

Coverage Type	Monthly Rate
Employee	$13.96
Employee + Spouse	$29.99
Employee + Children	$32.74
Employee + Family	$48.77

* Child(ren) birth to age 26; no limit to the number of children per family

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Life Balance Benefits

Employee Assistance Program - **SimpleTherapy**

The City of Ceres provides employees with support for a wide variety of challenges through the Employee Assistance Program (EAP). If you or a family member need assistance with personal, family or work-life balance issues, you can contact the EAP for free, confidential assistance. Benefits include face to face counseling sessions and unlimited telephone counseling sessions with master's and doctoral-level counselors.

Other benefits you and your family can access from the EAP include:

- Tobacco cessation coaching
- EAP website resources
- College planning resources
- Work life balance resources and counseling
- Child and elder care referral
- Employee discounts
- Unlimited telephone legal support
- Free 30-minute face to face consultation with an attorney and 25% discount on additional services
- Online legal forms and extensive law library
- Unlimited telephone support for financial planning or issues (including tax consultation
- 30 days of free financial coaching
- Will preparation
- Legal document preparation
- Online self service legal documents such as living trusts, wills, power of attorney and deeds

The City provides two EAP options:

- To access your EAP benefits from Simple Therapy, call 888-425-4800 or visit www.simpleeap.com. Username: frms
- To access your EAP benefits from Health Advocate, sponsored by The Standard by calling 888-293-6948 or visit www.healthadvocate.com/standard3

Employee Contributions

The City of Ceres shares the cost of health benefits with you as shown by the chart below. Please note that your contributions are deducted before taxes are withheld which saves you tax dollars. Paying for benefits before-tax means that your share of the costs are deducted before taxes are determined, resulting in more take-home pay for you. The contributions listed below will be pro-rated for benefited part time employees.

	Monthly Contributions for Medical/Dental/Vision		
	Total Premium	City of Ceres Pays	You Pay
Kaiser Basic HMO Dental + Vision			
• Employee	$807.33	$810.00	$0.00
• Employee + Spouse	$1,700.65	$1,600.00	$100.65
• Employee + One Child	$1,688.98	$1,600.00	$88.98
• Employee + Children	$2,376.79	$2,250.00	$126.79
• Family	$2,429.74	$2,250.00	$179.74
Kaiser Premium HMO Dental + Vision			
• Employee	$858.17	$810.00	$48.17
• Employee + Spouse	$1,807.70	$1,600.00	$207.70
• Employee + One Child	$1,795.19	$1,600.00	$195.19
• Employee + Children	$2,525.88	$2,250.00	$275.88
• Family	$2,582.72	$2,250.00	$332.72
Sutter Health Plan Basic HMO Dental + Vision (LG18)			
• Employee	$904.25	$810.00	$94.25
• Employee + Spouse	$1,985.72	$1,600.00	$385.72
• Employee + One Child	$1,976.17	$1,600.00	$376.17
• Employee + Children	$2,533.34	$2,250.00	$283.34
• Family	$2,576.36	$2,250.00	$326.36
Sutter Health Plan Premium HMO Dental + Vision (LG20)			
• Employee	$968.80	$810.00	$158.80
• Employee + Spouse	$2,127.36	$1,600.00	$527.36
• Employee + One Child	$2,116.98	$1,600.00	$516.98
• Employee + Children	$2,713.52	$2,250.00	$463.52
• Family	$2,760.42	$2,250.00	$510.42
Sutter Health Plan HDHP HMO Dental + Vision (HL10)			
• Employee	$814.49	$810.00	$4.49
• Employee + Spouse	$1,784.94	$1,600.00	$184.94
• Employee + One Child	$1,773.06	$1,600.00	$173.06
• Employee + Children	$2,267.18	$2,250.00	$17.18
• Family	$2,320.93	$2,250.00	$70.93
Laborer's Medical Plan *(Dental & Vision included)*			
• Employee	See your representative for rates		
• Employee + Spouse			
• Employee + One Child			
• Employee + Children			
• Family			
Medical Waiver Opt-Out (for any plan)*	**$200**	**Employee must submit a signed waiver form to HR**	

* In order to be eligible for the Medical Waiver Opt-Out benefit, you must prove other minimum essential value coverage through any source other than the individual marketplace.

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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

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

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at Plan Administrator at Kaiser Permanente – (800) 464-4000 or Blue Shield – (877) 356-0666.

Patient Protections

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

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

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

Networks/Claims/Appeals

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

COBRA Continuation Coverage

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

Important Notices (continued)

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

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

Important Notices (continued)

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

Important Notices (continued)

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

IF YOU HAVE QUESTIONS

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

[1] http://www.socialsecurity.gov/

Important Notices (continued)

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Human Resources
(209) 538-5746

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

The City of Ceres Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact please contact Human Resources, (209) 538-5746.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

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

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

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

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

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

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

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

STATES WITH INDIVIDUAL MANDATE

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

Important Notices (continued)

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name City of Ceres	**4. Employer Identification Number (EIN)** 94-6000307	
5. Employer address 2220 Magnolia Street	**6. Employer phone number** (209) 538-5746	
7. City Ceres	**8. State** CA	**9. ZIP code** 95307
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	**12. Email address** hr@ci.ceres.ca.us	

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 (continued)

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

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

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

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

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

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

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

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

Important Notices (continued)

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

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

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

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

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

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

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

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

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

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

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

FLORIDA - Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

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

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

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

Important Notices (continued)

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

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

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

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

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

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

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

MONTANA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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

NEVADA - Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

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

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

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

NORTH CAROLINA - Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA - Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP
Website: http://www.insureoklahoma.org/
Phone: 1-888-365-3742

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

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

RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

Important Notices (continued)

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

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

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

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

WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

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

WISCONSIN - Medicaid & CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

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

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, ext. 61565

Glossary

Affordable Care Act and Patient Protection (ACA)

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

Allowed Amount

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

Balance Billing

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

Brand Name Drug

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

COBRA (Consolidated Omnibus Budget Reconciliation Act)

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

Children's Health Insurance Program (CHIP)

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

Claim

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

Coinsurance

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

Copayment (Copay)

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

Comprehensive Coverage

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

Deductible

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

Formulary

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

Generic Drug

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

High-Deductible Health Plan (HDHP)

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

Glossary (continued)

Health Savings Account (HSA)

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

Health Reimbursement Arrangements (HRAs)

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

In-Network

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

Non-Preferred Provider

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

Out-of-Pocket Maximum

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

Out-Of-Network

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

Out-Of-Pocket Limit

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

Plan Year

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

Preferred Provider

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

Premium

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

Preventive Care

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

Qualifying Life Event

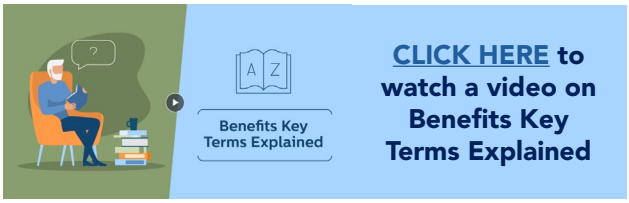
A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

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

Urgent Care

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



Contact Information

Plan	Phone Number	Web Site
City of Ceres		
Human Resources	209-538-5747	hr@ci.ceres.ca.us
Benefit Plans		
Sutter Health Plan	855-315-5800	www.sutterhealthplan.org
Kaiser Permanente HMO Plan		
• Member Services	800-464-4000	www.kp.org
• Advice Nurse and Appointments	866-454-8855	www.kp.org
Delta Dental Plan		
• Member Services	888-335-8227	www.deltadental.com
Vision Service Plan	800-877-7195	www.vsp.com
The Standard		
• Life/AD&D Insurance	800-628-8600	lifepro@standard.com
• Short-Term Disability *(STD)* Insurance	800-368-2859 (STD)	
• Long-Term Disability *(LTD)* Insurance	800-368-1135 (LTD)	
• Health Advocate *(Employee Assistance Program)*	888-293-6948	www.healthadvocate.com/standard3
SimpleTherapy *(Employee Assistance Program)*	888-425-4800	www.simpleeap.com
Voya Health Care and Dependent Care Flexible Spending Accounts, Health Savings Account, Voluntary Benefits		
• Voya HealthCare and Dependent Care Flexible Spending Accounts *(Jessica Carle)*	603-836-3317	Jessica.Carle@voya.com
• Voya Voluntary Benefits *(Kim Schott)*	925-216-6722	kimberly.schott@voya.com
Keenan & Associates *(Employee Benefits Consultant)*		
• Pam Cote	951-715-0190 ext. 1138	pcote@keenan.com
• Sista Duncan	916-859-7160 ext. 4261	sduncan@keenan.com