2027

Culver CITY

Active Employee Benefits Overview

Live Well. Benefit More.

CONTENTS

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

GETTING STARTED

MEDICAL, DENTAL, VISION, AND FLEXIBLE SPENDING ACCOUNTS

January 1, 2027
through
December 31, 2027

VOLUNTARY PLANS

March 1, 2027
through
February 28, 2028

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, the City of Culver City supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, voluntary coverages, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

WHEN CAN YOU ENROLL

You can enroll in benefits as a new hire, when you experience a change in status event, and/or during the annual Open Enrollment period. New hire coverage or status changes begin on the first day of the month following the date a completed and signed "Benefits Enrollment/Change Selection" form is received by Human Resources.

Employees

You are eligible if you are a full-time employee working 40 or more hours per pay week.

Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

Eligible dependents

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the plan documents for each benefit.

Who is not eligible

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

- Parents, grandparents, and siblings.
- Employees who work less than 20 hours per week, temporary employees not on the City of Culver City payroll, or contract employees

Additional Information

New Hires must complete the "Benefits Enrollment/Change Selection" form within 60 days of becoming eligible, whether you choose to enroll in or decline coverage. If you miss the enrollment deadline, there is a 90-day waiting period to enroll in a CalPERS health plan.

You'll need to wait until the next Open Enrollment for dental and/or vision, or a change in status event.

Open Enrollment for Medical, Dental, Vision, and Flexible Spending Accounts (FSAs) is held in September - October annually for a January 1 effective date.

The annual Open Enrollment for Voluntary Plans is typically held in February for a March 1 effective date.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 60 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Outside of Open Enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act

You must submit your change within 60 days of the event.

Dependent Verification

Adding or making changes to your dependent coverage is subject to verification to ensure that only eligible individuals are participating in our plans. You will be required to provide the following:

- Copy of government issued marriage certificate for spouse
- Copy of Declaration of Domestic Partnership issued by California Secretary of State for Registered Domestic Partnership
- Copy of birth or adoption certificate for children
- Social security numbers for all dependents listed on your enrollment forms.

If you do not supply the proper documentation to make dependent changes within the 60-day event window, you will not be able to add the dependent(s) until the next Open Enrollment period.

ENROLLING FOR MEDICAL, DENTAL, VISION, AND FLEXIBLE SPENDING ACCOUNTS

MID YEAR CHANGES

- You have year-round access to a summary of your benefits through Employee Self-Service (ESS).
- Mid-year changes should be initiated through HR.

Employee Self-Service (ESS)

You will enroll in Medical, Dental, Vision, and Flexible Spending Accounts via our Employee Self-Service (ESS) portal. If you don't have access to a computer, you can access ESS from a tablet or smartphone.

Open Enrollment for Medical, Dental, Vision, and Flexible Spending Accounts (FSAs) is generally held in September/October every year for a January 1 effective date.

If you do not act during Open Enrollment, your current benefit elections will carry over into next year, except for UnitedHealthcare enrollments and Flexible Spending Account elections.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- LOG IN to Employee Self-Service (ESS). culvercityselfservice.org to make Open Enrollment changes.

  Username: Your first name, a period, and your last name. Example: John.Doe

  Password: Your last saved password or click "forgot your password" for it to be reset.

- ADD your personal and dependent information in the *Personal Information* tab.
- SELECT your benefit plans for the coming year in the *Benefits* tab.
  - First, you will select the number of dependents you would like to cover under the Cafeteria Allowance section. **Note**: If you choose Employee + 1 or Employee + 2, you will be required to confirm or add your eligible dependents for each plan. ***For existing dependents, click "Save", and do not enter the SSN – we already have it on file. Only add the SSN if you are adding a new dependent.***
  - Then, you will select the plans you would like to enroll in.
- REVIEW your choices and costs then click "Submit" to save your selections.

Note: If you need help accessing or navigating ESS Open Enrollment changes, a link to detailed instructions is included on the ESS Benefits Open Enrollment page.

MEDICAL

Click to play video

WORDS TO KNOW

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **OUT-OF-POCKET MAXIMUM:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

UNDERSTANDING PLAN TYPES

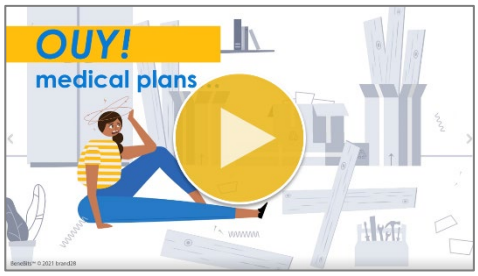
Culver City offers two medical plan types so that you can pick the plan that best fits your budget and healthcare needs.

Some plans (like HMOs) restrict you to in-network doctors. Other plans (like PPOs) allow you to see any doctor, but you will pay a higher coinsurance percentage if the doctor is out-of-network.

	HMO Health Maintenance Organization	**PPO** Preferred Provider Organization
Deductible	N/A	✓
Out-of-Network Care Covered	N/A	✓
Referral Needed to see Specialist	✓	N/A
Must select Primary Care Physician	✓	Optional – Not Required
Pros	• More predictable costs • You don't have the extra responsibility of managing your own care • You won't receive bills from providers	• You can go anywhere, whether in-network or out-of-network • If you have a doctor that you like, you can keep them
Cons	• Less flexibility • No out-of-network coverage • May have to select Primary Care Physician	• You pay more for out-of-network providers

Important Note: Review your plan documents for the specific plan details.

Click to play video



All About Medical Plans

Medical plans can seem hard to understand, but once you understand the building blocks you will be able to choose the best plan for you and your dependents.

CALPERS MEDICAL BENEFITS

It is Culver City's goal to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. The City offers a choice of medical plans through the California Public Employees' Retirement System (CalPERS).

For a summary of the different plans and additional information, please review the CalPERS Health Benefits site: CalPERS.CA.gov/Page/Active-Members/Health-Benefits. On this site, you will find the Health Benefits Summary, Health Program Guide, additional resources, and information regarding your CalPERS Health Plan options.

2027 HEALTH BENEFIT SUMMARY

Click the image above to view the 2027 CalPERS Health Benefit Summary.

Important CalPERS Plan Information

- To assist with the process of choosing a health plan, CalPERS has produced a Summary of Benefits and Coverage (SBC).
- In addition, the federal government has compiled a glossary of common health terms to help you better understand our health benefit coverage.
- All HMO and PPO Plans offer a pharmacy mail-order program with opt-out option for home delivery for non-specialty maintenance medications.

Explore your benefits with myCalPERS

Access your health information year-round, including available health plan documents and Open Enrollment updates, by logging in to myCalPERS at CalPERS.CA.gov.

To find CalPERS health plans available in your area, search by zip code at CalPERS.CA.gov.

Enrolling In CalPERS Plans

Please make sure to review the enrollment instructions provided by HR. All enrollments must be processed through **Human Resources (ESS) and not the CalPERS website**. A completed and signed Benefits Enrollment/Change Selection form is also required if you are changing plans and/or adding, deleting dependents.

2027 CALPERS MONTHLY HEALTH CARE PREMIUMS – SWORN EMPLOYEES

Effective January 1 – December 31, 2027

The City contributes a Cafeteria Allowance for all eligible employees. To calculate your Cafeteria Allowance credit or debit*, subtract the premium amount for your plan and level of coverage from the Cafeteria Allowance listed in the table.

EXAMPLE: If you live in Los Angeles Area Region 3 and are enrolled in Employee + 1 coverage for the Anthem Blue Cross Select HMO plan, your monthly premium would be **$2,118.12** with a Cafeteria Allowance of **$2,122.56**. This results in a **$4.44** Cafeteria Allowance debit.

Opt-Out/Cash Out Option: Effective 1/1/2027, the "Opt-Out" shall be a maximum of $600 as follows: Upon proof of other coverage that meets ACA requirements, unit employees may elect to not participate in the City's medical insurance program and choose from one of the following options on the right:

Medical Plan Cafeteria Allowance	
Employee Only	$1,111.28
Employee + 1	$2,122.56
Employee + Family	$2,729.33

_____ - _____ = _____

Premium *Allowance* *Credit/Debit*

Cash Out Option (Taxable)	**Taxable Income:**
	Paid in first two (2) pay checks per month ($300 each)
457 Plan Contribution	Pre-Tax Retirement Savings
	Contributions made in first two (2) pay checks per month ($300 each); Reduces annual IRS 457 Limit

LOS ANGELES AREA REGION 3: Los Angeles, Riverside, San Bernardino			
Medical Plan	**Employee Only**	**Employee + 1**	**Employee + Family**
Anthem Blue Cross Select HMO	$1,059.06	$2,118.12	$2,753.56
Anthem Blue Cross Traditional HMO	$1,239.02	$2,478.04	$3,221.45
Blue Shield Access+ HMO	$975.19	$1,950.38	$2,535.49
Blue Shield EPO	$975.19	$1,950.38	$2,535.49
Blue Shield Trio HMO	$908.01	$1,816.02	$2,360.83
Health Net Salud y Mas	$801.75	$1,603.50	$2,084.55
Kaiser Permanente	$1,011.28	$2,022.56	$2,629.33
Peace Officers Research Association of CA	$1,020.00	$2,040.00	$2,650.00
PERS Gold	$1,014.50	$2,029.00	$2,637.70
PERS Platinum	$1,549.00	$3,098.00	$4,027.40
OTHER SOUTHERN CALIFORNIA REGION 2: Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, Ventura			
Medical Plan	**Employee Only**	**Employee + 1**	**Employee + Family**
Anthem Blue Cross Select HMO	$1,140.20	$2,280.40	$2,964.52
Anthem Blue Cross Traditional HMO	$1,263.81	$2,527.62	$3,285.91
Blue Shield Access+ HMO	$1,177.77	$2,355.54	$3,062.20
Blue Shield EPO	$1,177.77	$2,355.54	$3,062.20
Blue Shield Trio HMO	$971.24	$1,942.48	$2,525.22
Health Net Salud y Mas	$953.15	$1,906.30	$2,478.19
Kaiser Permanente	$1,030.94	$2,061.88	$2,680.44
Peace Officers Research Association of CA	$1,020.00	$2,040.00	$2,650.00
PERS Gold	$1,010.12	$2,020.24	$2,626.31
PERS Platinum	$1,538.57	$3,077.14	$4,000.28
Sharp Performance Plus (OS Region only)	$975.21	$1,950.42	$2,535.55

*The health plan costs that exceed the cafeteria allowance are referred to as debit. Any remaining cafeteria balance amounts (credit) will be applied to life (mandatory enrollment), dental, and vision (if enrolled). Any excess cafeteria allowance will be paid to the employee as taxable income on a bi-weekly basis.

2027 CALPERS MONTHLY HEALTH CARE PREMIUMS – MISCELLANEOUS EMPLOYEES

Effective January 1 – December 31, 2027

The City contributes a Cafeteria Allowance for all eligible employees. To calculate your Cafeteria Allowance credit or debit*, subtract the premium amount for your plan and level of coverage from the Cafeteria Allowance listed in the table.

EXAMPLE: If you live in Los Angeles Area Region 3 and are enrolled in Employee + 1 coverage for the Anthem Blue Cross Select HMO plan, your monthly premium would be **$2,118.12** with a Cafeteria Allowance of **$1,775.00**. This results in a **$343.50** Cafeteria Allowance debit.

Medical Plan Cafeteria Allowance	
Employee Only	$1,011.66
Employee + 1	$1,774.62
Employee + Family	$2,218.24

_____ - _____ = _____

Premium *Allowance* *Credit/Debit*

LOS ANGELES AREA REGION 3: Los Angeles, Riverside, San Bernardino			
Medical Plan	**Employee Only**	**Employee + 1**	**Employee + Family**
Anthem Blue Cross Select HMO	$1,059.06	$2,118.12	$2,753.56
Anthem Blue Cross Traditional HMO	$1,239.02	$2,478.04	$3,221.45
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Peace Officers Research Association of CA	$1,020.00	$2,040.00	$2,650.00
PERS Gold	$1,014.50	$2,029.00	$2,637.70
PERS Platinum	$1,549.00	$3,098.00	$4,027.40
OTHER SOUTHERN CALIFORNIA REGION 2: Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, Ventura			
Medical Plan	**Employee Only**	**Employee + 1**	**Employee + Family**
Anthem Blue Cross Select HMO	$1,140.20	$2,280.40	$2,964.52
Anthem Blue Cross Traditional HMO	$1,263.81	$2,527.62	$3,285.91
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Blue Shield Trio HMO	$971.24	$1,942.48	$2,525.22
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Sharp Performance Plus (OS Region only)	$975.21	$1,950.42	$2,535.55

*The health plan costs that exceed the cafeteria allowance are referred to as debit. Any remaining cafeteria balance amounts (credit) will be applied to life (mandatory enrollment), dental, and vision (if enrolled). Any excess cafeteria allowance will be paid to the employee as taxable income on a bi-weekly basis.

CALPERS DEPENDENT ELIGIBILITY VERIFICATION

All employees adding/removing dependents must submit documentation to verify their dependent's eligibility and/or Qualifying Life Event. The following chart is an easy guide to what documents must be submitted along with the Health Enrollment/Change form.

	Enrollment Form	Marriage Certificate	State of California Domestic Partner (DP) Registration	Birth Certificate or Certificate of Adoption	Social Security Number
Employee Only	●				●
Employee & Spouse	●	●			●
Employee & Domestic Partner (DP)	●		●		●
Employee & Children	●			●	●
Employee, Spouse/DP & Children	●	●	●	●	●

You are responsible for ensuring that the health enrollment information about you and your family members is accurate and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or health care services incurred during the entire ineligibility period.

For example, if your divorce or dissolution occurred in 2018, yet you did not report it until 2021, your former spouse or domestic partner will be retroactively canceled from coverage effective the first of the month following the divorce or dissolution.

On page 5, you will find a detailed list of Qualifying Life Events, which must be reported to the HR Department so we can make the appropriate change to your health coverage. All Qualifying Life Event changes must be made within 60 days from the date of the event. Proper documentation is required, such as a copy of the marriage/domestic partnership certificate, birth/adoption certificate, or divorce/dissolution of domestic partnership decree.

For further clarification, please contact Human Resources.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- MyAmeriflex.com
- Eligible Expenses
- Ineligible Expenses

Set aside healthcare dollars for the coming year

A Healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through AmeriFlex.

How the AmeriFlex Healthcare FSA works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, or even eligible drugstore items.
- You can contribute up to $3,400 for the 2027 plan year. Annual limits are set by the IRS. The minimum annual election amount is $100. Contributions are deducted from your pay on a pre-tax basis, meaning no federal or state tax is applied to that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they are for eligible healthcare expenses.
- If you don't spend all the money in your account, you can rollover up to $680 to use the following year. Any additional remaining balance will be forfeited.
- Expenses must be incurred between 01/01/2027 and 12/31/2027 and claims must be submitted for reimbursement no later than 03/31/2028. Elections cannot be changed during the plan year, unless you experience a Qualifying Life Event (QLE).
- You must re-enroll in this program each year.

FSA TAX SAVINGS EXAMPLE (SINGLE FILERS)

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,850 FSA Contribution

$684 24% Federal income tax	**$219** 7.65% FICA tax	**$903** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $5,000 per year tax-free

A Dependent Care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by AmeriFlex.

How the AmeriFlex Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $2,500 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully! You can't change your FSA election amount mid-year unless you experience a Qualifying Life Event. Money contributed to a Dependent Care FSA must be used for expenses incurred between 01/01/2027 and 12/31/2027 and claims must be submitted for reimbursement no later than 03/31/2028. Unspent funds will be forfeited.

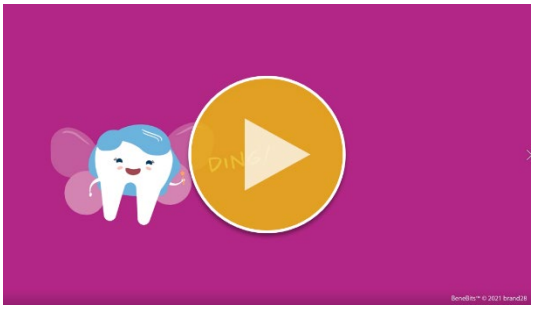
DENTAL

OUR PLANS

DeltaCare USA DHMO

Delta Dental of California DPPO

Click to play video



We offer two dental plans through Delta Dental.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early, before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

Delta Dental Toothpic App

Toothpic is a photo-based teledentistry app where members can set up a virtual dental screening or even send in photos for dental issues. A Delta Dental dentist can review the photos to identify potential issues such as cavities, gum disease, or other oral health concerns and provide guidance on next steps, including treatment options or a recommended home care routine.

Dental Plans

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible is met, if applicable. Dependents are eligible up to age 26.

	DELTACARE USA DHMO	DELTA DENTAL OF CALIFORNIA DPPO[1]	
	In-Network	In-Network	Out-of-Network
Annual Deductible	None	$40 per individual $80 per family	$50 per individual $100 per family
Annual Plan Maximum	N/A	$2,000 per individual	
Diagnostic & Preventive	$0-$25 copay[2]	No Charge[3]	No Charge
Basic Services Restorative Endodontics Periodontics	$0-$250 copay[2]	Member pays 20%	Member pays 20%
Major Services (includes prosthodontics)	$0-$175 copay[2]	Member pays 50%	Member pays 50%
Orthodontia Adults Children (up to age 19)	$350 start up fee $1,800[4] $1,600[4]	Member pays 50%[5]	Member pays 50%[5]
Ortho Lifetime Max	N/A	$2,000	$2,000
COST OF COVERAGE			
Monthly Cost	$27.90	$107.88	

[1]Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers and Program Allowance for Non-Delta Dental Providers.
[2]Varies by service, refer to the plan's fee schedule.
[3]Diagnostic and Preventive (D&P) Waiver Program - when diagnostic or preventive services are obtained through a Delta Dental DPPO provider, the annual maximum is waived for you and your dependents.
[4]Beyond 24 months of active treatment, an additional monthly fee of $75 applies.
[5]Deductible does not apply.

What you need to know about this plan

	DHMO	DPPO
Features:	More predicable costs	See any provider, but you'll pay more out of network
Am I restricted to in-network providers?	Yes	No
Do I have to select a primary dentist?	Yes	No
Can I use my HSA or FSA?	If you participate in a healthcare FSA, you can use your account to pay for dental expenses.	
Where can I get more details?	Visit deltadentalins.com to find a provider and view plan details.	

VISION

OUR PLANS

VSP Signature

Click to play video

We offer vision coverage for eligible employees and their dependents through VSP.

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. Even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like Laser Vision Correction, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

Shop at Eyeconic

Prefer to shop online? Your favorite eyewear brands are also available at Eyeconic. Check out all of the latest styles available at the VSP online eyewear store. Visit Eyeconic.com today!

Vision Plan

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below. Dependents are eligible up to age 26.

	VSP SIGNATURE	
	In-Network	Out-of-Network
Exams WellVision Exam Retinal Screening Frequency	$0 copay Up to $39 Once every 12 months	Up to $50 reimbursement
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	$0 copay $0 copay $0 copay Once every 12 months	Up to $50 reimbursement Up to $75 reimbursement Up to $100 reimbursement Once every 12 months
Frames Benefit Frequency	$160 frame allowance + 20% off remaining balance $180 featured frame allowance + 20% off remaining balance Once every 12 months	Up to $70 reimbursement Once every 12 months
Contacts (in lieu of glasses) Exam (fitting & evaluation) Materials Frequency	Up to $60 copay $150 allowance Once every 12 months	Up to $105 reimbursement (combined professional fees and materials) Once every 12 months
COST OF COVERAGE		
Monthly Cost	$20.63	

What you need to know about this plan

Plan Considerations
Confirm your provider's in-network status on VSP.com.

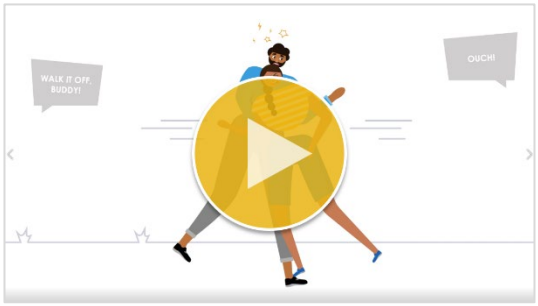
What other services are covered?
The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?
Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

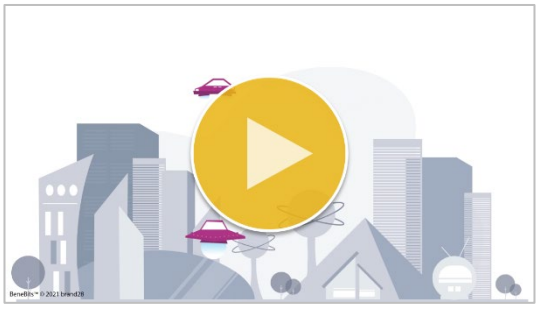
Where can I get more details?
Visit VSP.com or download the VSP app.

ENGAGE

Click to play video



Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

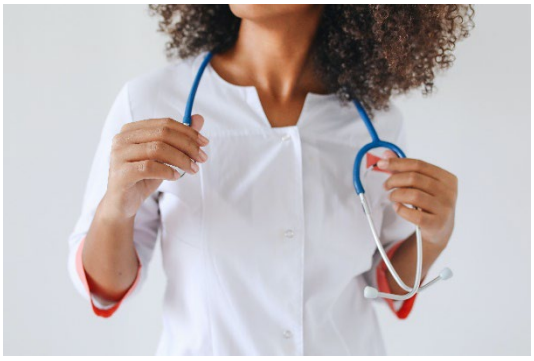
- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$**

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your annual deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit Healthcare.gov/Coverage/Preventive-Care-Benefits for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

Please review your CalPERS plan documents for information regarding prescription drug copays and information.

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit and change your beneficiary as needed if your situation changes.

Please review and update your beneficiary(ies) annually and upon each change in status event you experience. (i.e., marriage, new child, etc.).

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

Depending on your MOU, we provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

Please note that not all MOUs offer disability coverage.

BASIC LIFE AND AD&D INSURANCE

CLASS DEFINITION

Class 1 - Any classification in the Executive Compensation Plan

Class 2 - All other active Members

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Lincoln Financial and employee premiums are paid in full by Culver City. If you elect Dependent Supplemental Basic Life, the monthly cost will be deducted from your paycheck.

Lincoln Basic Employee Life and AD&D

Class 1 - $250,000

Class 2 - $50,000

Lincoln Dependent Supplemental Basic Life

Eligible Spouse/Domestic Partner - $1,000
Eligible Child(ren)* - $1,000

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

*Benefit amount for dependent child is from birth to age 26.

DEPENDENT BASIC LIFE AND AD&D – Monthly Cost	
Spouse/Domestic Partner	$0.24
Single Child or Multiple Children	$0.24

CALIFORNIA STATE DISABILITY INSURANCE (SDI)

EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. CA State Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

SUBMITTING A CLAIM

Use SDI Online to securely file for benefits or request a paper claim form online.

- Online: State Disability Insurance (EDD.CA.gov/Disability)
- By mail: EDD, Disability Insurance PO Box 989777, West Sacramento, CA 95798-9777
- If you have any questions, please call 1-800-480-3287

California State Disability Insurance (SDI) is available to CCEA members who are paying into the tax. The tax collected is contributed to the California State Disability Insurance Plan (CA SDI Plan), which pays disability benefits if you can't work due to an injury or illness (including pregnancy).

Disability is an illness or injury, either physical or mental, which prevents customary work. Disability includes elective surgery, pregnancy, childbirth, or related medical conditions.

Disability Insurance (DI) is a component of the State Disability Insurance (SDI) program, designed to partially replace wages lost due to a non-work-related disability.

It also pays for the Paid Family Leave (PFL) benefit if you need to take time away from work to care for a family member, bond with a new child, or participate in a qualifying event related to a family member's military deployment. Whether you use these benefits or not, you will be subject to the state tax.

For additional information about California State Disability Insurance (SDI) or to apply for coverage contact:

- EDD DI customer service at 1-800-480-3287 or
- Visit the State Disability Insurance website (EDD.CA.gov/Disability).

Cost To Employees*	1.2% of earnings
Deduction Type	State Tax via Payroll Deduction
Weekly Benefit Amount*	70-90% of earnings up to $1,681 weekly
Filing a Claim	2-step process: 1. File claim online or by mail 2. Provide certification receipt to Human Resources

*Contribution rates and benefits may vary from year to year. For current rates and benefits, visit State Disability Insurance (EDD.CA.gov/Disability).

SHORT-TERM DISABILITY INSURANCE (STD)

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. Culver City pays the cost of this coverage. Coverage is provided by Lincoln Financial.

This benefit is available to Class 1 - Definition:
Any classification in the Executive Compensation Plan

EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

SUBMITTING A CLAIM

If you are disabled due to an illness or accidental injury, unable to work, and under the care of a licensed physician, you are eligible to submit a claim for benefits under this plan. As long as you remain disabled and meet the plan's disability requirements, you will continue to receive a percentage of your earnings until benefits are no longer payable.

Weekly Benefit Amount	66.67% percent of weekly predisability earnings
Maximum Weekly Benefit	$3,500
Minimum Weekly Benefit	$15
Benefits Begin After Accident Sickness	 0 days of disability 14 days of disability
Maximum Benefit Period	26 weeks

LONG-TERM DISABILITY INSURANCE (LTD)

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack or stroke
- Mental disorders

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Culver City pays the cost of this coverage. Coverage is provided by Lincoln Financial.

This benefit is available to Class 1 - Definition:
Any classification in the Executive Compensation Plan

3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits for whatever you need: housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

Monthly Benefit Amount	66.67% percent of monthly predisability earnings
Maximum Monthly Benefit	$15,000
Benefits Begin	After 180 days of disability
Maximum Payment Period	Until age 65 or to the Social Security Normal Retirement Age (SSNRA)

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

Voluntary Life and AD&D Insurance

Pet Insurance

Accident Insurance

Critical Illness Insurance

Hospital Indemnity Insurance

Legal Plan

Identity Theft and Fraud Protection Plan

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

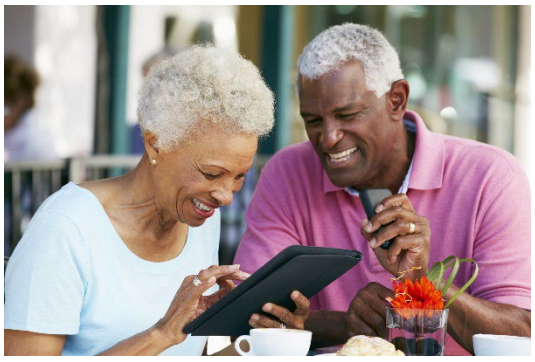
Culver City offers plans to help:

- replace income if you're injured or ill
- bridge the gap for special healthcare needs

You pay the entire cost for these plans, but rates may be more affordable than individual coverage.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

ENROLLING FOR VOLUNTARY PLANS



Voluntary Benefit Enrollment Portal

You will enroll in our Lincoln Financial and MetLife Voluntary Benefits (except for Pet Insurance) via our Voluntary Benefit Enrollment Portal. If you don't have access to a computer, you can access the portal from a tablet or smartphone.

Open Enrollment for Voluntary Plans is typically held in February for a March 1 effective date.

Before you enroll

- Review your enrollment materials to understand your benefit options and costs for the coming year.

Enrolling in Voluntary Life, Supplemental Health, Legal, and ID Theft Protection Plans

- Visit GoToBenefits.Info/Culver26.
- Click the "Enroll Online 24/7" button from the main page and enter the Company Identifier "CulverCity" to register and make your elections.
- Make sure to review your selected plans and click submit. If you log in and view the plans, but decide to opt out, please ensure you update/cancel your enrollment.

Enrolling in Pet Insurance

- To enroll in Pet Insurance, visit MetLife.com/GetPetQuote or call 1-800-GET-MET8. Here you can get a quote for your pet at your preferred coverage level and enroll all in one place.

Key Enrollment Information

- Voluntary Life and AD&D, Supplemental Health, Legal, and ID Theft and Fraud Protection - You are able to enroll in these plans during your initial New Hire onboarding, during the annual Open Enrollment period, or as the result of a Qualifying Life Event (QLE). You are only able to drop these coverages during the annual Open Enrollment period or if you experience a QLE.
- Pet Insurance – You are eligible to enroll in MetLife Pet Insurance at any time of the year. Coverage may be added, modified, or dropped at any time via the MetLife Pet Insurance webpage at MetLifePetInsurance.com.

VOLUNTARY LIFE AND AD&D INSURANCE

Monthly Voluntary Life Rates	Employee & Spouse/DP Rate per $1,000
<25	$0.070
25 - 29	$0.070
30 - 34	$0.080
35 - 39	$0.110
40 - 44	$0.170
45 - 49	$0.280
50 - 54	$0.470
55 - 59	$0.750
60 - 64	$1.000
65 - 69	$1.570
70 - 74	$2.770
75+	$2.770

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Lincoln Financial and available for your spouse and/or child(ren).

Lincoln Financial Voluntary Life and AD&D

Employee[1]	Increments of $20,000 up to $500,000 Guaranteed Issue: $200,000
Spouse or Domestic Partner[2,3]	Increments of $10,000 up to $250,000 Guaranteed Issue: $30,000
Child(ren)[4]	Increments of $5,000 up to $25,000

[1]Employee benefit amount reduces to 65% at age 70 and to 50% at age 75. Guaranteed issue is up to $40K for employees who are age 70 or above.
[2]Spouse/Domestic Partner benefit amount reduces to 65% at age 65.
[3]Spouse/Domestic Partner benefit cannot exceed 2.5 times employee's annual salary or 50% of the employee's benefit amount.
[4]Child(ren) benefit is for child(ren) at least 15 days old but under 26 years old. Child(ren) from live birth to 14 days old receive no benefit.

Guaranteed Issue

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Evidence of Insurability (EOI)

If you choose Voluntary Life coverage above the guaranteed issue amount (as noted on this page), previously declined coverage and now wish to enroll, or are increasing your current coverage, you must complete and submit Evidence of Insurability (EOI). This can be completed by logging into your account on LincolnFinancial.com and selecting "Complete Evidence of Insurability".

Monthly Voluntary Life Rate	Dependent Child(ren) Rate per $1,000
	$0.184

Monthly Voluntary AD&D Rate	Employee & Spouse/DP Rate per $1,000
	$0.020

METLIFE PET INSURANCE

METLIFE APP

Visit the App Store or Google Play Store to download the MetLife app and have access to view your policy, edit your pet's profile, submit and track claims.

CONTACT INFORMATION

Website

MetLifePetInsurance.com

Phone

1-800-Get-Met8

Employer Key

City of Culver City

Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. MetLife provides coverage for this program. You can enroll or unenroll in this program at any time.

MetLife Pet Insurance offers:

- Flexible insurance plans
- Freedom to visit any U.S. veterinarian and be reimbursed up to 90% of the cost of services
- Optional Preventive Care coverage
- 24/7 access to Telehealth Concierge Services for immediate assistance
- Discounts up to 30% and additional offers on pet care, where available
- Coverage of previously covered pre-existing conditions when switching providers

The enrollment and claim process is simple, with only three steps:

1. Select and enroll in the coverage that's right for you and your pet and download the MetLife mobile app. Make sure to enter your employer as "City of Culver City" when enrolling.
2. Take your pet to the vet and pay the bill; manage your pet's health and wellness using the app.
3. Send the bill and your claim to MetLife and receive reimbursement by check or direct deposit if the claim expense is covered under the policy.

Important Notes:

- Rates for pet insurance may vary based on your pet and other factors.
- Payment is made directly to MetLife and will not be deducted from your paycheck.

To get a quote, visit the MetLife.com/GetPetQuote or call 1-800-Get-Met8.

VOLUNTARY HEALTH-RELATED PLANS

THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Accident Insurance

Accident Insurance from MetLife helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

Monthly Rates	MetLife Accident
Employee Only	$16.47
Employee + Spouse	$32.45
Employee + Child(ren)	$38.87
Employee + Family	$45.96

Hospital Indemnity Insurance

Hospital indemnity insurance from MetLife can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide.

Monthly Rates	MetLife Hospital Indemnity Low Plan	MetLife Hospital Indemnity High Plan
Employee Only	$9.39	$15.90
Employee + Spouse	$21.37	$36.87
Employee + Child(ren)	$16.88	$28.06
Employee + Family	$28.86	$49.02

Critical Illness Insurance

Critical illness insurance from MetLife can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

VOLUNTARY HEALTH-RELATED PLANS

Critical Illness Monthly Rates – $10k In Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Age <25	$4.70	$9.50	$8.10	$12.80
Age 25 – 29	$5.30	$10.70	$8.70	$14.00
Age 30 – 34	$6.20	$12.60	$9.60	$16.00
Age 35 – 39	$8.20	$16.90	$11.60	$20.30
Age 40 – 44	$10.90	$22.60	$14.30	$25.90
Age 45 – 49	$15.00	$30.60	$18.30	$34.00
Age 50 – 54	$21.30	$41.70	$24.60	$45.10
Age 55 – 59	$30.10	$57.50	$33.40	$60.90
Age 60–64	$40.10	$75.40	$43.50	$78.80
Age 65–69	$50.70	$95.20	$54.10	$98.60
Age 70 – 74	$66.00	$124.30	$69.40	$127.60
Age 75+	$88.90	$170.20	$92.30	$173.60

Critical Illness Monthly Rates – $20k In Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Age <25	$9.40	$19.00	$16.20	$25.60
Age 25 – 29	$10.60	$21.40	$17.40	$28.00
Age 30 – 34	$12.40	$25.20	$19.20	$32.00
Age 35 – 39	$16.40	$33.80	$23.20	$40.60
Age 40 – 44	$21.80	$45.20	$28.60	$51.80
Age 45 – 49	$30.00	$61.20	$36.60	$68.00
Age 50 – 54	$42.60	$83.40	$49.20	$90.20
Age 55 – 59	$60.20	$115.00	$66.80	$121.80
Age 60–64	$80.20	$150.80	$87.00	$157.60
Age 65–69	$101.40	$190.40	$108.20	$197.20
Age 70 – 74	$132.00	$248.60	$138.80	$255.20
Age 75+	$177.80	$340.40	$184.60	$347.20

Critical Illness Monthly Rates – $30k In Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Age <25	$14.10	$28.50	$24.30	$38.40
Age 25 – 29	$15.90	$32.10	$26.10	$42.00
Age 30 – 34	$18.60	$37.80	$28.80	$48.00
Age 35 – 39	$24.60	$50.70	$34.80	$60.90
Age 40 – 44	$32.70	$67.80	$42.90	$77.70
Age 45 – 49	$45.00	$91.80	$54.90	$102.00
Age 50 – 54	$63.90	$125.10	$73.80	$135.30
Age 55 – 59	$90.30	$172.50	$100.20	$182.70
Age 60–64	$120.30	$226.20	$130.50	$236.40
Age 65–69	$152.10	$285.60	$162.30	$295.80
Age 70 – 74	$198.00	$372.90	$208.20	$382.80
Age 75+	$266.70	$510.60	$276.90	$520.80

VOLUNTARY LEGAL & ID THEFT PROTECTION

Monthly Rate	MetLife Legal Plan
Employee (Dependent Included)	$19.50

Monthly Rates	Aura Identity & Fraud Protection Plan powered by MetLife
Employee Only	$10.95
Employee + Family	$16.95

Legal Plan

Do you have an attorney on retainer? Most people don't, so our legal program through MetLife offers you access to legal advice and even representation for an affordable monthly premium. Whether you need assistance reviewing a rental agreement, fighting a traffic ticket, creating a will, buying a house or navigating an IRS audit, the MetLife Legal allows you to tap into a network of 18,000 reputable attorneys to assist you and your family.

Below are some of the many issues that the MetLife Legal Plan can assist with:

- Money Matters
  - Debt collection defense
  - Financial wellness programs
  - Identity theft defense
  - Identity restoration
- Home & Real Estate
  - Boundary & title disputes
  - Deeds
  - Eviction defense
  - Mortgages
  - Sale or purchase of home
  - Security deposit assistance
- Estate Planning
  - Wills
  - Living wills
  - Powers of attorney
  - Trusts
- Family & Personal
  - Adoption
  - Affidavits
  - Guardianship
  - Name Change
- Civil Lawsuits
- Elder-Care Issues
- Traffic

Identity Theft and Fraud Protection Plan

The Aura ID Theft Protection Plan, powered by MetLife, allows you to securely safeguard your personal information in our increasingly digital world. The plan offers:

- **$5 million ID theft insurance for each enrolled adult** - Each adult member on the plan is backed by a $5 million insurance policy to cover eligible losses and expenses due to identity theft.
- **Digital Vault** - Securely store and share sensitive data, digital files and passwords with military-grade encryption all in one place. We'll automatically enable monitoring and alerts for all financial and personal information stored in the Digital Vault to help keep accounts and assets secure.
- **Fully Automated Privacy Assistant** - We automatically and continuously scan websites that collect, sell and publish personal info online and request the removal of your data on your behalf. This helps protect your personal info and helps reduce robocalls/texts and other unwanted spam.

Under Family Coverage, you are able to add up to 10 adults to the plan. Each adult member will get their own full-feature Aura account. You are also able to add unlimited children under the age of 18 to the plan. Alerts for children are sent to the parent account.

FINANCIAL WELLNESS & RETIREMENT

OUR PLANS

Retirement Health Savings (RHS) Account

457 Retirement Savings Plan

What Is CalPERS?

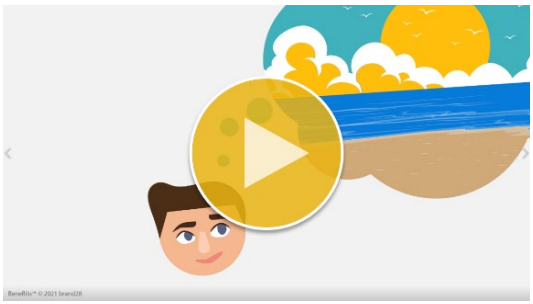
10 Steps To Retirement

Wherever you may be in life, it's never too early or too late to begin planning for retirement.

You have access to a Retirement Health Savings Account, 457 Retirement Savings Plan, and CalPERS to help you and your loved ones assess your current situation and determine future needs.

SAVE NOW, ENJOY LATER

Click to play video



CalPERS

CalPERS is a “defined benefit” plan which provides retirement benefits that are calculated using a “defined formula,” rather than contributions and earnings to a savings plan. Retirement benefits are calculated using a member’s years of service credit, age at retirement, and highest compensation for one year or three years averaged. The retirement formula varies based on occupation (miscellaneous versus safety) and time of hire. You are fully vested after five years of CalPERS full-time credited service.

For more information on CalPERS, go to CalPERS.CA.gov.

457 Retirement Savings Plan

Available to all benefit eligible employees.

Our 457 Deferred Compensation plan helps you save for retirement. The plan offers tax savings NOW through pre-tax contributions or tax savings AFTER you retire through a Roth after-tax option.

Visit the MissionSquare website at MissionSquare.com to manage your account, investments and contributions.

Visit MissionSquare.com to set up your account online. Use plan #300166 and plan name: City of Culver City. Then complete a 457 Deferred Compensation Plan Employee Enrollment Form and submit it electronically to Human Resources for processing.

Maximum annual contribution limit

Up to $24,500. Additional “catch-up” contributions apply for those age 50 and older:

- Ages 50 through 59 or 64+ - an additional $8,000 (or $32,500 total)
- Ages 60 through 63 - an additional $11,250 (or $35,750 total)

IRS limits are evaluated annually and may change. For individuals with prior-year FICA taxable earnings of $150K or over and participating in a catch-up allowance (i.e., age 50 or age 60-63), the IRS requires that catch-up allowance contributions be deposited in an after-tax ROTH IRA.

Retirement Health Savings (RHS) Account

The MissionSquare Retirement Health Savings (RHS) Account is designed to help you and your loved ones meet a critical expense, retiree health care, through a tax-advantaged savings vehicle.

Your RHS Account is sponsored by Culver City and administered by MissionSquare Retirement. The contributions and amounts are mandated by your prospective bargaining group. All contributions to your account are set aside exclusively for qualifying medical expenses.

Use the Retiree Health Cost Estimator to estimate your health care costs at and through retirement, factoring in your current health status and savings options. Calculate how much you will need to cover these costs.

Make an appointment with **Retirement Plans Specialist, Marcus Marshall by calling (202) 759-7203** or emailing MMarshall@missionsquare.com.

MissionSquare Financial Planning

Take advantage of **no-cost** financial planning with **Certified Senior Financial Planning Professional Katherine Espinosa, CFP,** by calling **(202) 759-7229** or emailing KEspinosa@missionsquare.com.

WHAT IS CALPERS?

MEMBER EDUCATION

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

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

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

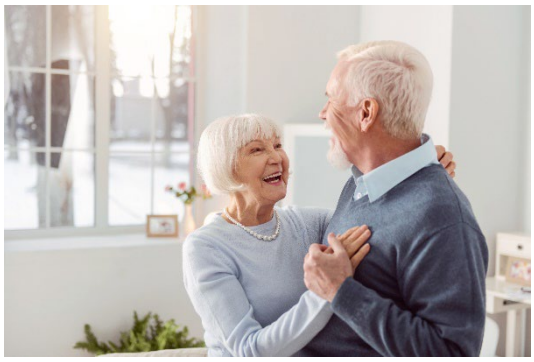
The following summary is subject to change and if there are any discrepancies, CalPERS is the sole determiner of CalPERS pension benefits, reciprocity, membership, retirement formula(s), etc. For the most current and detailed information, employees can visit the CalPERS website or call CalPERS at (888)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

CalPERS Membership Eligibility

- Employees hired to either work full-time for six months or longer, or regular part-time for at least 20 hours or more per week for one year or longer, are automatically placed in CalPERS as a member.
- Employees who do not fall in either category will have their hours monitored until the criteria is met for membership (1,000+ hours).
- Once eligible for CalPERS membership, the employee is considered either a Classic or PEPRA* member, depending on when the employee first became a CalPERS member.
- Being a Classic or PEPRA member also determines the contribution amount, the retirement formula and compensation limits that are applicable to the employee.

*PEPRA - Public Employees' Pension Reform Act, which became effective January 1, 2013.

WHAT IS CALPERS?



SERVICE CREDIT

A full year of CalPERS Service Credit is equivalent to:

- 1,720 hours (Hourly Pay Employees)

Service credit is calculated annually based on CalPERS' July 1 – June 30 fiscal year. Members have opportunities throughout their career to purchase service credit for: Service Prior to Membership, Leaves of Absence, Military Service, etc.

Retirement Benefits Calculation

Retirement benefits are calculated using a formula with three factors:

Service Credit (Years)	X	Benefit Factor (% per year)	X	Final Compensation (Monthly $)	=	Unmodified Allowance ($)

- **Service Credit** - Total years of employment with a CalPERS employer. This could include other types of service credit such as sick leave and service credit purchase. Employees can view their Annual Member Statement by logging in to myCalPERS.CA.gov to view service credit.
- **Benefit Factor** - Percentage of final compensation for each year of service credit, based on an employee's age at retirement and retirement formula(s).
- **Final Compensation** – Employee's highest average full-time monthly pay rate for 12 or 36 consecutive months of employment, depending upon the employee's benefit formula.
- **Unmodified Allowance** - Highest benefit payable.

Final Compensation Caps – Amounts May Change Annually

- Employees who became members of CalPERS on or after 7/1/1996, are subject to the IRC 401(a) (17) limit, which restricts the amount of compensation that can be used to calculate the CalPERS retirement benefit. For 2026, the limit is $360,000*.
- Employees who become new members of CalPERS on or after 1/1/2013, and deemed PEPRA members, are subject to a compensation cap of $159,733* if subject to Social Security, and $191,679* for employees who are not subject to Social Security (i.e., Public Safety). These amounts represent the maximum salary that can count toward final compensation and calculation of retirement benefits for employees that are placed in the PEPRA retirement formula(s).

*As of release of this booklet, 2027 limits and/or amounts have not been announced.

10 STEPS TO RETIREMENT

Retirement Planning Made Simple

Preparing To Complete Your Retirement Application

Step 1: Call CalPERS or attend a CalPERS Retirement webinar (on-demand or live) to familiarize yourself with the process.

Step 2: Choose your retirement date.

Step 3: Request a retirement estimate from CalPERS.

Step 4: Apply for retirement through CalPERS (documents can be submitted via mail or via myCalPERS online). Some documents may require a notary.

Once Your Application is Filed

Step 5: Update your supervisor of your pending retirement to ensure that there is ample time to transition your duties.

Step 6: Review the CalPERS "Understanding *Retirement Benefits Options*" *video* to learn more about the retirement process, payment options and more.

Step 7: Schedule a retirement counseling appointment with the HR-Benefits team timely so that you have an idea as to what your accrual cash-out amounts will be and what your retiree health enrollment and reimbursement options are.

Step 8: Once you receive confirmation of your service retirement date from CalPERS, please update your department and the HR-Benefits team.

Step 9: Return the required forms to the HR-Employee Benefits team timely – completed and signed. Return forms by email to CC_Benefits@culvercity.org or in-person.

Step 10: Participate in the City's offboarding process.

Please note: If you are not separated from City service timely due to lack of notification, your CalPERS retirement check may be delayed or hours paid to you after your retirement date may be reversed, requiring you to reimburse the City.

2027 RETIREMENT BENEFIT PLAN RATES*

LOS ANGELES AREA REGION 3: Los Angeles, Riverside, San Bernardino – Up to Age 65			
Medical Plan	**Employee Only**	**Employee + 1**	**Employee + Family**
Anthem Blue Cross Select HMO	$1,059.06	$2,118.12	$2,753.56
Anthem Blue Cross Traditional HMO	$1,239.02	$2,478.04	$3,221.45
Blue Shield Access+ HMO	$975.19	$1,950.38	$2,535.49
Blue Shield EPO	$975.19	$1,950.38	$2,535.49
Blue Shield Trio HMO	$908.01	$1,816.02	$2,360.83
Health Net Salud y Mas	$801.75	$1,603.50	$2,084.55
Kaiser Permanente	$1,011.28	$2,022.56	$2,629.33
Peace Officers Research Association of CA	$1,020.00	$2,040.00	$2,650.00
PERS Gold	$1,014.50	$2,029.00	$2,637.70
PERS Platinum	$1,549.00	$3,098.00	$4,027.40
OTHER SOUTHERN CALIFORNIA REGION 2: Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, Ventura – Up to Age 65			
Medical Plan	**Employee Only**	**Employee + 1**	**Employee + Family**
Anthem Blue Cross Select HMO	$1,140.20	$2,280.40	$2,964.52
Anthem Blue Cross Traditional HMO	$1,263.81	$2,527.62	$3,285.91
Blue Shield Access+ HMO	$1,177.77	$2,355.54	$3,062.20
Blue Shield EPO	$1,177.77	$2,355.54	$3,062.20
Blue Shield Trio HMO	$971.24	$1,942.48	$2,525.22
Health Net Salud y Mas	$953.15	$1,906.30	$2,478.19
Kaiser Permanente	$1,030.94	$2,061.88	$2,680.44
Peace Officers Research Association of CA	$1,020.00	$2,040.00	$2,650.00
PERS Gold	$1,010.12	$2,020.24	$2,626.31
PERS Platinum	$1,538.57	$3,077.14	$4,000.28
Sharp Performance Plus (OS Region only)	$975.21	$1,950.42	$2,535.55
Medicare Plan Rates – Must Be Medicare Eligible (Typically Age 65+)**			
Medicare Advantage Plans	**Retiree Only**	**Retiree + 1**	**Retiree + Family**
Anthem Medicare Preferred PPO	$619.25	$1,238.50	$1,857.75
Blue Shield Medicare PPO (Nationwide)	$619.36	$1,238.72	$1,858.08
Kaiser Permanente Senior Advantage	$333.93	$667.86	$1,001.79
Kaiser Permanente Senior Advantage Summit	$391.74	$783.48	$1,175.22 6
Sharp Direct Advantage HMO	$320.22	$640.44	$960.66
UnitedHealthcare Group Medicare Advantage PPO - Nationwide	$534.00	$1,068.00	$1,602.00
Medicare Supplement Plans	**Retiree Only**	**Retiree + 1**	**Retiree + Family**
PERS Gold Medicare Supplement	$597.57	$1,195.14	$1,792.71
PERS Platinum Medicare Supplement	$665.50	$1,331.00	$1,996.50
Retiree Dental, Vision and Life Insurance Rates (Up to Age 65)			
DeltaCare HMO Plan	$27.90		
Delta Dental PPO Plan	$107.88		
VSP (Vision Coverage)	$20.63		
Lincoln Life Insurance – 50K	$7.25		

*The Cafeteria Allowance amounts highlighted in this booklet are not applicable to retirees.
**All options for Medicare plans are not listed here, as options vary due to retiree's residence, and/or Medicare status of the spouse/RDP, etc..

WELLBEING & BALANCE

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your physical well-being

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT INFORMATION

Phone
(800) 344-4222

Website
Employees.ConcernHealth.com

Company Code
CulverCity

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The Concern EAP can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video confidential counseling for short-term issues; up to 6 visits per issue per 12-month period
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

LIFEBALANCE DISCOUNT PROGRAM

LifeBalance

CONTACT INFORMATION

Phone
(888) 754-5433

Email
Info@LifeBalanceProgram.com

Get discounts at thousands of businesses focused on your well-being

The LifeBalance Program works like an online coupon book, offering discounts at thousands of participating businesses nationwide. Discounts are available at health clubs, fitness studios, online retailers, sporting goods stores, amusement parks, movie theaters, hotels, ski resorts, and more.

Create an account to access discounts

1. Navigate to LifeBalanceProgram.com.
2. Enter your preferred email address, then click "Let's Get Started"
3. Enter all required info, create a password for your account, answer the prompts, and then click "Sign In."

Once you've set up your account, you can browse the discounts by clicking the "Find Savings By Interest" tile on the home page. You can also use the search box to look for businesses by name or location.

For household members too!

This benefit is also available to family members in your household, so encourage them to create their free accounts at LifeBalanceProgram.com.

NEVER GET SO BUSY MAKING A LIVING THAT YOU NEVER MAKE A LIFE!

ALLIANT MEDICARE SOLUTIONS

Alliant
MEDICARE SOLUTIONS
A Non-Government Entity

CONTACT AMS

Phone

(877) 888-0165

Website

AlliantMedicareSolutions.com

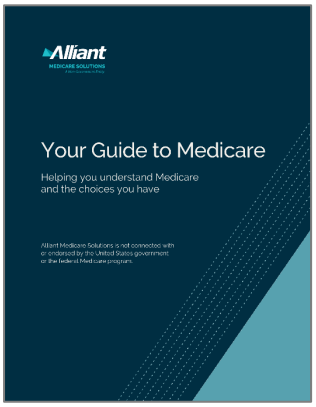
Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Medicare can be complicated. Figuring out the rules, not to mention how Medicare works with or compares to your employer-provided medical coverage, can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

- Call Alliant Medicare Solutions at (877) 888-0165 to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
- Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
- If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Learn more



Your Guide to Medicare

Medicare 101

Social Security Planning

WELLNESS RESOURCES

Enhance your well-being

Being well involves more than just using your healthcare plans. Wellness is a daily commitment to eating healthy, staying active, managing stress and maintaining balance. The City offers wellness resources to help you create healthy habits and reach your highest level of well-being including:

- **LifeBalance – Tap in for discounts that make life fun!**
- **MS Teams Wellness Page –** Access information about healthy lunch spots, hiking trails, and upcoming challenges. Interact with your team by posting wellness related pictures, helpful tips and encouragement. Click HERE to access the Wellness page.
- **Educational webinars and resources –** Keep an eye on your email for wellness newsletters and educational webinar invitations.
- **Seasonal challenges –** Throughout the year HR will be offering wellness related challenges to help you meet your goals and have fun!
- **CalPERS Health Plans –** Your CalPERS health plan enrollment features health, wellness and physical fitness programs. Refer to your plan's website for information.

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website
Plan Coverage Questions & Enrollment Changes	Culver City HR	Last Name A-L: Julius Rhaburn; Ext. 5645 Last Name M-Z: Ronnie Lee; Ext. 5644	CC_Benefits@CulverCity.org
CalPERS	CalPERS	(888) 225-7377	CalPERS 2027 Health Benefit Summary
Dental	Delta Dental Plan of California	DPPO: (888) 335-8227 DHMO: (800) 422-4234	DeltaDentalins.com
Vision	Vision Service Plan (VSP)	(800) 877-7195	VSP.com
Flexible Spending Accounts	AmeriFlex	(888) 868-3539	MyAmeriFlex.com
Life and Disability	Lincoln Financial	(800) 423-2765	LincolnFinancial.com
Pet Insurance	MetLife	(800) 438-6388	MetLife.com/GetPetQuote
Accident, Hospital Indemnity, and Critical Illness	MetLife	(800) 438-6388	MetLife.com/MyBenefits
Legal Plan	MetLife	(800) 821-6400	Members.LegalPlans.com
Identity Theft and Fraud Protection Plan	Aura powered by MetLife	(844) 931-2872	My.Aura.com/Start
Retirement Savings	MissionSquare	Marcus Marshall (202) 759-7203 Participant Services (800) 669-7400	MMarshall@missionsquare.com MissionSquare.com
Wellness Discounts	LifeBalance	(888) 754-5433	LifeBalanceProgram.com
Employee Assistance Program (EAP)	Concern	(800) 344-4222	Employees.ConcernHealth.com
Alliant Medicare Solutions	Alliant	(877) 888-0165	AlliantMedicareSolutions.com

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

DETERMINING ELIGIBILITY

LOOK-BACK MEASUREMENT METHOD

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee whose works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. City of Culver City uses the look-back measurement method to determine group health plan eligibility.

NEW EMPLOYEES HIRED TO WORK FULL-TIME: If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of the first day of the month following the date a completed and signed Health Benefits Enrollment form is submitted to Human Resources.

NEW EMPLOYEES HIRED TO WORK A PART-TIME, VARIABLE HOUR OR SEASONAL SCHEDULE: If you are hired into a part-time position, a position where your hours vary and City of Culver City is unable to determine — as of your date of hire — whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months. Your IMP will begin on the 1st of the month following your start date unless your start date is the first day of the calendar month. If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage effective the first day of the month following your ACA eligibility date. Your full-time status will remain in effect during an associated stability period that will last 12 months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

ONGOING EMPLOYEES: An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12 months period during which City of Culver City counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for 12 months. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

City of Culver City uses the standard measurement period and associated stability period annual cycle set forth below:

MEASUREMENT PERIOD: STARTS: October 1 – September 30 DURATION: 12 Months

Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility.

STABILITY PERIOD: STARTS: January 1 DURATION: 12 Months

Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices section of this booklet.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries. Summary Plan Descriptions are available contacting the carriers listed at the end of this guide or by contacting Human Resources.

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to City of Culver City's Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

2027 SUMMARY OF BENEFITS AND COVERAGE NOTICE

Choosing your health plan is an important decision. To assist you with this process, each health plan available through the California Public Employees' Retirement System has produced a Summary of Benefits and Coverage (SBC). In addition, the federal government has compiled a glossary of common health terms. Together, these documents provide important information to help you better understand our health benefit coverage and more easily compare health plan options.

To access the SBCs and glossary online, visit CalPERS.CA.gov/Forms-Publications.

Medicare Part D Notice

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Culver City 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.

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

1. 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.
2. City of Culver City has determined that the prescription drug coverage offered by CalPERS 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 City of Culver City coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. Since the existing prescription drug coverage under CalPERS is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your City of Culver City prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 City of Culver City 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 City of Culver City changes. You also may request a copy of this notice at any time.

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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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).

Date:	01/01/2027
Name of Entity/Sender:	City of Culver City
Contact-Position/Office:	Human Resources Department
Address:	9770 Culver Boulevard, Culver City, CA 90232-0507
Phone Number:	310-253-5640

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your health plan's Member Services for more information.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in City of Culver City's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in City of Culver City's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 60 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 60-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in City of Culver City's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for City of Culver City describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the insurance carriers directly.

Notice of Choice of Providers

Health Maintenance Organizations (HMOs) generally 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, your plan may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health plan or the Human Resources Department.

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

You do not need prior authorization from your plan or from any other person (including a primary care provider) in order 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, contact your health plan provider.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.96% of your modified adjusted household income in 2026.

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 **1-877-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 **1-866-444-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, 2026**. Contact your State for more information on eligibility—

Alabama – Medicaid

Website: myalhipp.com
Phone: (855) 692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program
Website: myakhipp.com
Phone: (866) 251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid eligibility: health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid

Website: myarhipp.com
Phone: (855) MyARHIPP (692-7447)

California – Medicaid

Health Insurance Premium Payment (HIPP) Program Website: dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance
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 (CHP+)

Health First Colorado website: healthfirstcolorado.com
Health First Colorado Member Contact Center: (800) 221-3943 (TTY: 711)
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: (800) 359-1991 (TTY: 711)
Health Insurance Buy-In Program (HIBI): mycohibi.com
HIBI Customer Service: (855) 692-6442

Florida – Medicaid

Website:
flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp
Phone: (877) 357-3268

Georgia – Medicaid

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

Illinois – Medicaid

Illinois Medicaid Premium Assistance Information
Medicaid application website: abe.illinois.gov
HIPP Hotline Number: (217) 524-8268
HIPP Email: mhfs.boc.hipp@illinois.gov

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: in.gov/medicaid
Website: in.gov/fssa/dfr
Family and Social Services Administration
Phone: (800) 403-0864
Member Services phone: (800) 457-4584

Iowa – Medicaid and CHIP (Hawki)

Medicaid website: hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid phone: (800) 338-8366
Hawki website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: (800) 257-8563
HIPP website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: (888) 346-9562

Kansas – Medicaid

Website: kancare.ks.gov
Phone: (800) 792-4884
HIPP Phone: (800) 967-4660

Kentucky – Medicaid

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

Louisiana – Medicaid

Louisiana Medicaid website: ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: (888) 342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP)
Website: ldh.la.gov/lahipp
LaHIPP phone: (877) 697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: (888) 716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084

Maine – Medicaid

Enrollment website: mymaineconnection.gov/benefits
Phone: (800) 442-6003 (TTY: 711)
Private Health Insurance Premium webpage:
maine.gov/dhhs/ofi/applications-forms
Phone: (800) 977-6740 (TTY: 711)

Massachusetts – Medicaid and CHIP

Website: mass.gov/masshealth/pa
Phone: (800) 862-4840 (TTY: 711)
Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: mn.gov/dhs/health-care-coverage/
Phone: (800) 657-3672

Missouri – Medicaid

Website: mydss.mo.gov/mhd/healthcare
Phone: (573) 751-2005

Montana – Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: (800) 694-3084
Email: HHSHIPPProgram@mt.gov

Nebraska – Medicaid

Website: accessnebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

Nevada – Medicaid

Medicaid website: dhcfp.nv.gov
Medicaid phone: (800) 992-0900

New Hampshire – Medicaid

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

New Jersey – Medicaid and CHIP

Website: nj.gov/humanservices/dmahs/individuals-families/familycare
Phone: (800) 356-1561
CHIP Premium Assistance Phone: (609) 631-2392
CHIP phone: (800) 701-0710 (TTY: 711

New York – Medicaid
Website: health.ny.gov/health_care/medicaid
Phone: (800) 541-2831

North Carolina – Medicaid
Website: medicaid.ncdhhs.gov
Phone: (919) 855-4100

North Dakota – Medicaid
Website: hhs.nd.gov/healthcare
Phone: (866) 614-6005

Oklahoma – Medicaid and CHIP
Website: insureoklahoma.org
Phone: (888) 365-3742

Oregon – Medicaid
Website: healthcare.oregon.gov
Phone: (800) 699-9075

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

Rhode Island – Medicaid and CHIP
Website: eohhs.ri.gov
Phone: (855) 697-4347 or (401) 462-0311 (Direct RIte Share Line)

South Carolina – Medicaid
Website: scdhhs.gov
Phone: (888) 549-0820

South Dakota – Medicaid
Website: dss.sd.gov
Phone: (888) 828-0059

Texas – Medicaid
Website: 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: medicaid.utah.gov/upp
Phone: (888) 222-2542
Email: upp@utah.gov
Adult Expansion website: medicaid.utah.gov/expansion
Utah Medicaid Buyout Program website: medicaid.utah.gov/buyout-program
CHIP website: chip.utah.gov

Vermont – Medicaid
Website: dvha.vermont.gov/members/medicaid/hipp-program
Phone: (800) 250-8427

Virginia – Medicaid and CHIP
Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP phone: (800) 432-5924

Washington – Medicaid
Website: hca.wa.gov
Phone: (800) 562-3022

West Virginia – Medicaid and CHIP
Website: bms.wv.gov
Website: mywvhipp.com
Medicaid phone: (304) 558-1700
CHIP toll-free phone: (855) MyWVHIPP (699-8447)

Wisconsin – Medicaid and CHIP
Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: (800) 362-3002

Wyoming – Medicaid
Website: 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, 2026, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

NOTES

Culver CITY