

2026



Employee Benefits Overview

For Every Member of the Family



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.

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GETTING STARTED

2026 BENEFITS

January 1, 2026
through
December 31, 2026

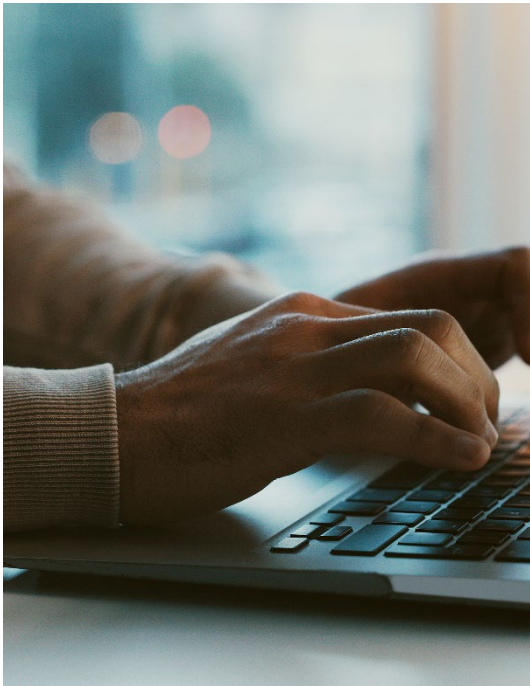
Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, The City of Mountain View supports you and your family with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits 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.

If you have questions about your benefits, please contact the Human Resources Department at (650) 903-6309.

THE EASY WAY TO GET EMPLOYEE INFO



City's Intranet

Current forms, policies, procedures, and notices are posted on the City's Intranet.

Employee Online (EO)

Employee Online (EO) is a web-based system designed to give you the capability to view, modify or update your employee records. This website is accessible from any computer, within the City as well as outside of the City network, with internet access.

Three ways to access EO

- 1) On a computer that is on the City's network, open an internet browser and type **EO** on the URL line,
- 2) On a computer that is on the City's network, navigate to the City's Intranet and use the link to EO, *or*
- 3) If you are not using a City computer, type this link directly into your internet browser

<https://eo.mountainview.gov>

Setup

Log in

Username: 6-digit employee ID

Password: Your last saved password or, if this is your first-time logging in, use your social security number. You will be prompted to create a unique password for future log ins.

Paystubs

- Available to view and print (pay stubs are not distributed to employees signed up for direct deposit).
- For employees without access to a computer or internet, computers are set up in various City facilities to access EO and print pay stubs if needed.
- EO holds over one year's worth of paystubs.

Fine Print

- The benefit information listed in EO is not always accurate and employees should not rely on EO to verify enrollment and/or eligibility status for benefits. Also, benefit changes cannot be made through EO.
- Three login failures will lock your account and require a reset to your password. On the home screen click "Forgot Login" to reset your password. If you don't receive an email to reset your password within 15 minutes, contact HR at humanresources@mountainview.gov for assistance.

WHO'S ELIGIBLE FOR BENEFITS?¹



¹Sworn Police and Fire employees: Please refer to the appropriate CalPERS publications linked on page 11 for information regarding eligibility, open enrollment, medical plan options, and related details.

Employees

You are eligible if you are a regular, probationary, limited-period, or provisional employee working 20 or more hours per week.

Eligible dependents¹

- Legally married spouse.
- Registered Domestic Partner
- 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 benefit booklets for each benefit.

Who is not eligible

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

- Parents, grandparents, and siblings.
- Hourly employees limited to 29 hours per week, seasonable employees, employees who work less than 20 hours per week, temporary employees not on the City of Mountain View payroll, contract employees, or employees residing outside the United States.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following date of hire. You must enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

When benefits terminate

Medical, dental, and vision benefits end on the last day of the month in which an employee separates employment or loses eligibility. Coverage ends on the date of separation for Group Life/AD&D, Short Term Disability (STD), Long Term Disability (LTD) and Employee Assistance Program (EAP). Employees and dependents may be eligible to continue benefits under federal and state COBRA rights.

OPEN ENROLLMENT: Plan Year 2026¹



For 2026 plan premiums, please refer to page 13.

¹Sworn Police and Fire employees: Please refer to the appropriate CalPERS publications linked on page 11 for information regarding eligibility, open enrollment, medical plan options, and related details.

Open Enrollment is a once-a-year opportunity to review your benefit choices, change plans, add or drop dependents, and enroll or re-enroll in Flexible Spending Accounts. After open enrollment ends, you cannot change your benefit elections until the next open enrollment in 2026, unless you experience an eligible life event.

Open enrollment occurs in late October/early November.

Any changes made during OE will be effective on January 1, 2026.

What's new or changing!

At the City of Mountain View, we are committed to offering you and your family comprehensive and affordable options. Our current benefit program will continue into 2026 with minor changes. You may have had some major life changes. Do your current choices still meet your needs? Review this benefits guide to understand your coverage options. Include your spouse or partner in the review if they have input into your family's benefits decisions.

These changes will be effective on January 1, 2026.

HSA IRS Limits

- Employees electing the Kaiser HDHP/HSA Plan for 2026 will have increased HSA contributions limits of \$4,400 for individual coverage or \$8,750 for two-party or family coverage.
- The 2026 deductibles on the Kaiser HDHP will increase to \$1,700 for Individual and \$3,400 for Family.

New Infertility Benefits

- Per Senate Bill 729, our medical plans will cover diagnosis and treatment of infertility and fertility services, including three completed oocyte (egg) retrievals with unlimited embryo transfers. Please refer to the Evidence of Coverage (EOC) document for more detailed information.

New OurRelationship Program from Concern EAP

- Access to free, confidential online program designed to help couples strengthen communication and reduce conflict.

New MetLife Pet Insurance

- Introducing Pet Insurance to help cover unexpected vet costs for your pet.

OPEN ENROLLMENT: Plan Year 2026¹



¹Sworn Police and Fire employees:
Please refer to the appropriate CalPERS publications linked on page 11 for information regarding eligibility, open enrollment, medical plan options, and related details.

What's new or changing!

CALPERS – FOR SAFETY EMPLOYEES ONLY

HMO Plans

- The Blue Shield Access+ HMO will replace the Blue Shield Trio plan in Monterey County

PPO Plans

- PERS Gold – Value Based Insurance Design (VBID) will continue with deductible in-patient credits of up to \$500 for completing preventive care activities, while adding the following activities: participation in the Diabetes Prevention Program, if eligible, as well as depression or anxiety screening

All Plans

- CVS Caremark is replacing OptumRx as CalPERS' Pharmacy Benefits Manager

Visit calpers.ca.gov for more information on ALL upcoming CalPERS plan changes.

FOR ALL EMPLOYEES

New Infertility Benefits

CA Senate Bill 729

Per SB729, our medical plans will cover diagnosis and treatment of infertility and fertility services, including Assisted Reproductive Technology (ART), limited to 3 completed oocyte (egg) retrievals per lifetime. Non-safety members, please refer to the **HealthNet** Summary of Benefits and Coverages (SBCs) and the **Kaiser** Evidence of Coverage (EOC) documents at [InsideMV](#) for more detailed information. For CalPERS members, please refer to your plan documents at calpers.ca.gov. You can also contact carriers directly if you have more specific questions. See the [Plan Contacts](#) page within this Guide for contact information.

Pet Insurance

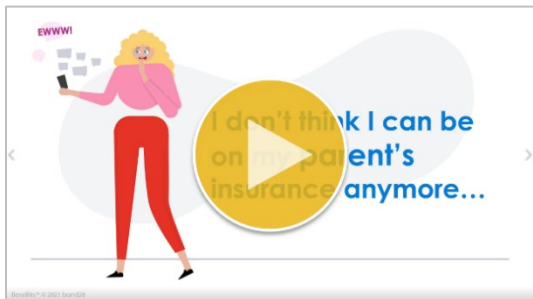
City employees will have the option to purchase pet insurance through MetLife Pet. Please refer to [page 42](#) for more information.

New Flexible Spending Account vendor

All Flexible Spending Accounts and Health Savings Accounts will be administered through Benefit Coordinators Corporation (BCC). If enrolling in either of these plans, you will receive a new card from BCC for 2026, prior to the start of the plan year. You can review more details on [page 24](#).

CHANGING YOUR BENEFITS¹

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 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

¹Sworn Police and Fire employees: Please refer to the appropriate CalPERS publications linked on page 11 for information regarding eligibility, open enrollment, medical plan options, and related details.

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a qualifying 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 have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility verification to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Marriage Certification or License
- Domestic Partners Affidavit
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until the next open enrollment period.

BENEFITS WHILE ON LEAVE



NOTIFY HUMAN RESOURCES

All employees must notify Human Resources as soon as possible to request leave for an employee's own serious health condition or to care for a family member with a serious health condition.

Benefits during The Federal Medical Leave Act (FMLA) & California Family Rights Act (CFRA)

An employee taking leave designated as FMLA and/or CFRA will continue participating in any health and welfare benefit plan in which they were enrolled before the first day of leave (up to the maximum stated by law) at the level and under the same conditions of coverage as if the employee had continued in employment for the duration of such leave. The City will continue to make the same premium contributions as if the employee had continued actively working. The continued participation in health benefits begins on the date leave first begins under FMLA and/or CFRA. In some instances, the City may recover premiums it paid to maintain health coverage if the employee fails to return to work following leave. An employee's use of family/medical leave will not result in the loss of any employment benefit that the employee earned before using family/medical leave.

Benefits During The Pregnancy Disability Leave (PDL)

An employee taking pregnancy disability leave will continue participating in any health and welfare benefit plan in which they were enrolled before the first day of leave at the level and under the same conditions of coverage as if the employee had continued in employment for the duration of such leave (up to the maximum stated by law). The City will continue to make the same premium contributions as if the employee had continued actively working. The continued participation in health benefits begins on the date leave first begins under PDL. In some instances, the City may recover premiums it paid to maintain health coverage if the employee fails to return to work following PDL. An employee's use of pregnancy disability leave will not result in the loss of any employment benefit that the employee earned before using pregnancy disability leave.

Paid Parental Leave Program

An employee whose child was born, placed in foster care with the employee, or began residence with the employee (and the employee had commenced adoption proceedings with full intent to adopt), may be eligible for up to 8 work weeks of paid parental leave. Please review Section III of the City's Administrative Instruction 3-16 Family Care and Medical Leave Policy for the full details and parameters of the program.

ENROLLING FOR BENEFITS¹



MID-YEAR CHANGES

- You have year-round access to a summary of your benefits through Flock.
- Mid-year changes should be initiated through Flock. HR may reach out for additional verification.

¹Sworn Police and Fire employees will utilize BeneTrac for vision and life insurance only. Medical elections will be via my.CaLPERS.ca.gov

Flock from Paychex

Flock is an online system that enables you to make all your benefit decisions in one place. If you don't have access to a computer, you can access the enrollment portal from a tablet or smartphone.

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 **FLOCK**

<https://api.helloflock.com/login>

Username & Password: Your email address. This is the email address provided to HR so it may be your work or personal email. For your first login, you can expect an email inviting you to Flock with a link to set your password.

- VERIFY your personal and dependent information.
- ADD your beneficiary information for your life insurance coverage.
- SELECT or WAIVE coverage for each of your benefit plans for the coming year.

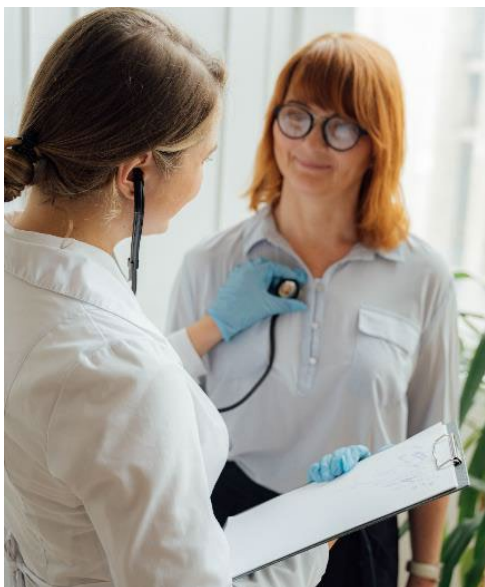
(Safety Employees: use Flock for vision, dental and life insurance plan changes and login to your MyCalPERS account for Medical benefit elections; see next page for more information.)

- ADD your beneficiaries.
- REVIEW your choices and costs before finalizing.
- FINALIZE by clicking "Submit Enrollment" to send your benefit elections to HR for approval.

Find the Flock Employee Login Guide on InsideMV

<https://www.insidemv.city/departments/human-resources/benefits>

CALPERS MEDICAL COVERAGE FOR SAFETY EMPLOYEES



Explore your benefits with myCalPERS

Access your health information year-round, including available health plans and open enrollment updates, by logging in at my.calpers.ca.gov.

Select 'Active Members and Retirees'

Username: Your last saved username and password or, if this is your first-time logging in, follow the steps to 'Register Now'

Password: Your last saved password or, if this is your first-time logging in, follow the steps to 'Register Now'

It is the 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 CalPERS Medical for safety employees and their families.

For a summary of the different plans, and additional information please review the CalPERS open enrollment site: calpers.ca.gov/page/active-members/health-benefits/open-enrollment. On this site you will find the Health Benefits Summary, Health Program Guide, additional resources and information regarding your CalPERS Health Plan options.

Note: There are three CalPERS Regions within California, each offering different health plans at different rates. Your health plan availability depends on zip code AND county. Active employees may establish eligibility with either their residential zip code or the City's zip code (94041). To determine health plan availability and assigned region, please visit www.calpers.ca.gov.

Why would I choose a PPO plan?

- You have a doctor you like, and you would like to keep this doctor.
- You want to see specialists and other providers without having to first get a referral and/or pre-approval.
- You want the freedom to see providers who are not in the network.
- You are confident that you can manage your own care.
- You do not want a primary care doctor.

Why would I choose an HMO plan?

- You do not want the extra responsibility of managing your own care.
- You do not want to get bills from providers.

Making elections

- To find CalPERS health plans available in your area, search by zip code at calpers.ca.gov
- View health plan documents to learn about your plan options
- Enroll yourself and your eligible dependents in a medical plan
- Upload required documentation
- Add Primary Care Physicians for you and/or your dependents
- Submit your elections to Human Resources electronically



MEDICAL¹

OUR PLANS

HEALTH NET HMO

HEALTH NET PPO

KAISER PERMANENTE HMO

KAISER PERMANENTE HDHP

We offer 4 medical plans. Review the network provider information and out-of-pocket costs such as deductible, coinsurance and prescription drugs so you can choose the best fit for your health concerns and budget.

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Consider an HMO (Health Maintenance Organization) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You have access to a National PPO Network
- You are willing to pay more to see out-of-network providers
- When traveling, you have access to out-of-network care for non-emergency services

Consider a HDHP (High Deductible Health Plan) if:

- You want tax-free savings on your healthcare costs
- You want to build a savings account for future healthcare costs for you and your eligible family members
- You want an extra way to add to your retirement savings

¹Sworn Police and Fire employees: Please refer to the appropriate CalPERS publications linked on page 11 for information regarding eligibility, open enrollment, medical plan options, and related details.

YOUR MEDICAL BENEFIT COSTS – Non-Safety Employees

EFFECTIVE JANUARY 1, 2026

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. The City contributes to your HSA for your first two years of enrollment (the City's contribution counts towards the IRS maximum).

HSA contribution limits are determined on a calendar/tax year basis. A mid-year enrollment in an HSA may be subject to a prorated HSA contribution limit including a prorated City HSA contribution. Contributions in excess of the IRS limit are subject to tax penalties.

| HEALTH NET HMO | Full-Time Employee Cost | City Cost | Part-Time Employee Cost | City Cost | Monthly Premium |
|-------------------|-------------------------|------------|-------------------------|------------|-----------------|
| Employee Only | \$28.41 | \$1,802.32 | \$28.41 | \$1,802.32 | \$1,830.73 |
| Employee + 1 | \$219.65 | \$3,441.53 | \$1,858.86 | \$1,802.32 | \$3,661.18 |
| Employee + Family | \$351.46 | \$4,408.13 | \$2,957.27 | \$1,802.32 | \$4,759.59 |

| HEALTH NET PPO | Full-Time Employee Cost | City Cost | Part-Time Employee Cost | City Cost | Monthly Premium |
|-------------------|-------------------------|------------|-------------------------|------------|-----------------|
| Employee Only | \$255.20 | \$1,803.18 | \$255.20 | \$1,803.13 | \$2,058.38 |
| Employee + 1 | \$716.27 | \$3,400.45 | \$2,313.54 | \$1,803.13 | \$4,116.72 |
| Employee + Family | \$948.26 | \$4,407.15 | \$3,552.23 | \$1,803.13 | \$5,355.41 |

| KAISER HMO | Full-Time Employee Cost | City Cost | Part-Time Employee Cost | City Cost | Monthly Premium |
|-------------------|-------------------------|------------|-------------------------|-----------|-----------------|
| Employee Only | \$28.41 | \$981.63 | \$28.41 | \$981.63 | \$1,010.04 |
| Employee + 1 | \$121.20 | \$1,898.88 | \$1,038.45 | \$981.63 | \$2,020.08 |
| Employee + Family | \$221.81 | \$2,636.61 | \$1,876.79 | \$981.63 | \$2,858.42 |

| KAISER HDHP \$1,700 | Full-Time Employee Cost | City Cost | Part-Time Employee Cost | City Cost | Monthly Premium |
|---------------------|-------------------------|------------|-------------------------|-----------|-----------------|
| Employee Only | \$0.00 | \$741.56 | \$0.00 | \$741.56 | \$741.56 |
| Employee + 1 | \$74.16 | \$1,408.96 | \$741.56 | \$741.56 | \$1,483.12 |
| Employee + Family | \$135.71 | \$1,962.90 | \$1,357.05 | \$741.56 | \$2,098.61 |

YOUR MEDICAL BENEFIT COSTS – Full Time Safety Employees

CALPERS MEDICAL PLANS EFFECTIVE JANUARY 1, 2026

There are three CalPERS Regions within California, each offering different health plans and at different rates. Your health plan availability depends on zip code AND county. Active employees may establish eligibility with either their residential zip code or the City’s zip code (94041). To determine health plan availability and assigned region, please visit www.calpers.ca.gov.

| REGION 1 | | | |
|----------------------------|----------|-----------|------------|
| Provider | Single | Two-Party | Family |
| Anthem HMO Select | \$0.00 | \$213.81 | \$277.95 |
| Anthem HMO Traditional | \$275.79 | \$765.39 | \$995.01 |
| Blue Shield Access+ HMO | \$0.00 | \$208.31 | \$270.81 |
| Blue Shield Access+ EPO | \$0.00 | \$208.31 | \$270.81 |
| Blue Shield Trio | \$0.00 | \$186.65 | \$242.65 |
| Kaiser Permanente | \$0.00 | \$187.02 | \$243.12 |
| PERS Gold | \$0.00 | \$179.29 | \$233.08 |
| PERS Platinum | \$333.85 | \$881.51 | \$1,145.96 |
| PORAC | \$0.00 | \$193.44 | \$242.16 |
| United Healthcare Alliance | \$0.00 | \$206.41 | \$268.33 |
| United Healthcare Harmony | \$0.00 | \$181.29 | \$235.68 |
| Western Health Advantage | \$0.00 | \$155.13 | \$201.67 |
| REGION 2 | | | |
| Provider | Single | Two-Party | Family |
| Anthem HMO Select | \$0.00 | \$162.61 | \$211.39 |
| Anthem HMO Traditional | \$0.00 | \$185.32 | \$240.92 |
| Blue Shield Access+ HMO | \$0.00 | \$168.46 | \$219.00 |
| Blue Shield Access+ EPO | \$0.00 | \$168.46 | \$219.00 |
| Blue Shield Trio | \$0.00 | \$149.85 | \$194.81 |
| Health Net Salud y Más | \$0.00 | \$140.73 | \$182.95 |
| Kaiser Permanente | \$0.00 | \$158.03 | \$205.44 |
| PERS Gold | \$0.00 | \$153.00 | \$198.91 |
| PERS Platinum | \$89.95 | \$393.71 | \$511.82 |
| PORAC | \$0.00 | \$170.16 | \$216.64 |
| Sharp | \$0.00 | \$146.59 | \$190.57 |
| United Healthcare Alliance | \$0.00 | \$152.16 | \$179.81 |
| United Healthcare Harmony | \$0.00 | \$137.14 | \$178.28 |

YOUR MEDICAL BENEFIT COSTS – Full Time Safety Employees

| REGION 3 | | | |
|----------------------------|---------|-----------|----------|
| Provider | Single | Two-Party | Family |
| Anthem HMO Select | \$0.00 | \$153.03 | \$200.24 |
| Anthem HMO Traditional | \$0.00 | \$180.56 | \$234.73 |
| Blue Shield Access+ | \$0.00 | \$146.87 | \$190.93 |
| Blue Shield Trio | \$0.00 | \$136.41 | \$177.33 |
| Health Net Salud y Más | \$0.00 | \$118.42 | \$153.94 |
| Kaiser Permanente | \$0.00 | \$155.05 | \$201.56 |
| PERS Gold | \$0.00 | \$153.60 | \$199.69 |
| PERS Platinum | \$95.52 | \$404.85 | \$526.31 |
| PORAC | \$0.00 | \$170.16 | \$216.64 |
| United Healthcare Alliance | \$0.00 | \$139.32 | \$181.12 |
| United Healthcare Harmony | \$0.00 | \$122.48 | \$159.23 |

| OUT-OF-STATE | | | |
|--------------------|---------|-----------|----------|
| Provider | Single | Two-Party | Family |
| Kaiser Colorado | \$62.67 | \$339.15 | \$440.90 |
| Kaiser Georgia | \$62.67 | \$339.15 | \$440.90 |
| Kaiser Hawaii | \$62.67 | \$339.15 | \$440.90 |
| Kaiser MidAtlantic | \$62.67 | \$339.15 | \$440.90 |
| Kaiser Northwest | \$62.67 | \$339.15 | \$440.90 |
| Kaiser Washington | \$62.67 | \$339.15 | \$440.90 |
| PERS Platinum | \$74.00 | \$361.81 | \$470.35 |
| PORAC | \$0.00 | \$195.84 | \$232.00 |

MEDICAL PLANS – Non-Safety Employees

HEALTH MAINTENANCE ORGANIZATION (HMO)

| | KAISER PERMANENTE HMO | HEALTH NET HMO |
|--|--------------------------|--------------------------|
| | In-Network | In-Network |
| Calendar Year Deductible Individual Family | None None | None None |
| Calendar Year Out-of-Pocket Maximum¹ Individual Family | \$1,500 \$3,000 | \$1,500 \$4,500 |
| Office Visit Primary Care Specialist | \$10 Copay \$10 Copay | \$10 Copay \$10 Copay |
| Preventive Services | No Charge | No Charge |
| Chiropractic/Acupuncture (up to 20 combined visits/year) | \$5 copay | \$5 copay |
| Lab and X-ray | No Charge | No Charge |
| Urgent Care | \$10 copay | \$10 copay |
| Emergency Room | \$50 copay | \$50 copay |
| Ambulance | No Charge | \$50 per transport |
| Inpatient Hospitalization | No Charge | No Charge |
| Inpatient Surgery | No Charge | No Charge |
| Outpatient Surgery | \$10 Copay | No Charge |
| Physical Therapy | \$10 copay | \$10 copay |
| Mental Health Inpatient Outpatient | No Charge \$10 copay | No Charge \$10 copay |
| Substance Abuse Inpatient Outpatient | No Charge \$10 copay | No Charge \$10 copay |

¹Deductibles and out-of-pocket maximums accumulate on a plan year/calendar year from January 2026 through December 2026.

This summary is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

MEDICAL PLANS – Non-Safety Employees

HEALTH MAINTENANCE ORGANIZATION (HMO)

Family Planning & Prescription Benefits

| | KAISER PERMANENTE HMO | HEALTH NET HMO |
|--|---|---|
| | In-Network | In-Network |
| Infertility & Family Planning | | |
| Diagnosis and Treatment | Included | Included |
| Cost Share | Based on service type and where it is performed | Based on service type and where it is performed |
| Assisted Reproductive Technology (ART) <i>(per lifetime)</i> | 3 egg retrievals | 3 egg retrievals |
| Cryopreservation | One-time storage up to 6 months | One-time storage up to 1 year |
| Vasectomy & Tubal Ligation | \$0 | \$0 |
| PRESCRIPTION DRUGS | | |
| Out-of-Pocket Maximum | | \$2,000/\$4,000 |
| Retail | | |
| Generic | \$10 Copay | \$10 Copay |
| Brand | \$25 Copay | \$25 Copay |
| Non-Formulary | \$25 Copay | \$40 Copay |

This summary is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

MEDICAL PLANS – Non-Safety Employees

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP) & PREFERRED PROVIDER ORGANIZATION (PPO)

Family Planning & Prescription Benefits

| | KAISER HDHP | HEALTH NET PPO | |
|--|----------------------|-----------------------------------|-----------------------------------|
| | In-Network | In-Network | Out-of-Network |
| Calendar Year Deductible¹ | | | |
| Individual | \$1,700 | | \$250 |
| Family | \$3,400 | | \$750 |
| Embedded | \$3,400 | | |
| Calendar Year Out-of-Pocket Maximum¹ | | | |
| Individual | \$3,400 | | \$6,000 |
| Family | \$6,800 | \$3,000 | \$18,000 |
| Embedded | \$3,400 | \$9,000 | |
| Office Visit | | | |
| Primary Care | 10% after Deductible | \$20 Copay | 30% |
| Specialist | 10% after Deductible | \$20 Copay | 30% |
| Preventive Services | No Charge | No Charge | No Charge |
| Chiropractic/Acupuncture (up to 20 combined visits/year) | \$5 Copay | \$20 Copay | 30% |
| Lab and X-ray | 10% after Deductible | 10% | 30% |
| Urgent Care | 10% after Deductible | \$20 Copay | 30% |
| Emergency Room | 10% after Deductible | \$100 Copay + 10% | |
| Ambulance | 10% after Deductible | \$100 +10% per transport | |
| Inpatient Hospitalization | 10% after Deductible | 10% ³ | 30% ³ |
| Inpatient Surgery | 10% after Deductible | 10% ³ | 30% ³ |
| Outpatient Surgery | 10% after Deductible | 10% | 30% |
| Mental Health | | | |
| Inpatient | 10% after Deductible | 10% ³ after Deductible | 30% ³ after Deductible |
| Outpatient | 10% after Deductible | 10% ³ after Deductible | 30% ³ after Deductible |
| Substance Abuse | | | |
| Inpatient | 10% after Deductible | 10% ³ after Deductible | 30% ³ after Deductible |
| Outpatient | 10% after Deductible | 10% ³ after Deductible | 30% ³ after Deductible |

¹Deductibles and out-of-pocket maximums accumulate on a plan year/calendar year from January 2026 through December 2026.

An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.

An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

³Pre-certification required, otherwise benefit will be reduced to 50%

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MEDICAL PLANS – Non-Safety Employees

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP) & PREFERRED PROVIDER ORGANIZATION (PPO)

Family Planning & Prescription Benefits

| | KAISER HDHP | HEALTH NET PPO | |
|--|---|---|---|
| | In-Network | In-Network | Out-of-Network |
| Infertility & Family Planning | | | |
| Diagnosis and Treatment | Included | Included | Included |
| Cost Share | Based on service type and where it is performed | Based on service type and where it is performed | Based on service type and where it is performed |
| Assisted Reproductive Technology (ART) <i>(per lifetime)</i> | 3 egg retrievals | 3 egg retrievals | 3 egg retrievals |
| Cryopreservation | One-time storage up to 6 months | One-time storage up to 1 year | One-time storage up to 1 year |
| Vasectomy & Tubal Ligation | Covered at 100% | Covered at 100% | Covered at 100% |
| PRESCRIPTION DRUGS* | | | |
| Retail- 30 Day Supply | | | |
| Generic | \$10 Copay | \$15 Copay | \$15 Copay + 50%* |
| Brand | \$30 Copay | \$35 Copay | \$35 Copay + 50%* |
| Non-Formulary | \$30 Copay | \$55 Copay | \$55 Copay + 50%* |
| | | | <i>*\$250 Max Average Wholesale Price</i> |

*All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

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HEALTH NET RESOURCES



HealthNet's Website

You can also go to [HealthNet.com](https://www.healthnet.com) to view more helpful resources and educational tools.

Did you know our plans through HealthNet offer several programs to help you manage your healthcare? Learn more about them here.

Teladoc

Teladoc's U.S. board-certified doctors are available 24/7/365 to resolve many non-emergency medical issues through phone or video consults. Contact Teladoc online at [teladoc.com](https://www.teladoc.com), on the phone at 800-teladoc (835-2362).

Teladoc Health Features:

- 24/7 on-demand and scheduled general medicine visits for all ages
- Scheduled appointments for behavioral health services are available 7 days a week from 7 AM to 9 PM (PST)
- Psychiatry visits (18 years and older)
- Web-based visit option and Smartphone/tablet app

Active&Fit Direct

The Active&Fit Direct program gives you access to 12,200+ participating gyms, 9,700+ On-Demand Videos, and 1:1 Well-Being Coaching for \$28/month, with no annual fees or long-term contracts (only an enrollment fee and applicable taxes). You can also enroll your spouse (for additional fee). Register or log in at: www.healthnet.com (group members) or www.myhealthnetca.com (individual & family plan members) to access the Active&Fit Direct™ website located under the Wellness Center tab.

Online Wellness

Improve your health and wellness on your own terms. We have a wide range of online content that features topics such as: Healthy weight, Eating better, How to manage stress, How to quit smoking for good, and more. Online wellness resources include articles, videos, health trackers, health challenges, and many more.

HEALTH NET RESOURCES, Cont.



GET STARTED TODAY

To access these value-added services, visit www.healthnet.com and click on **Wellness Center**.

HMO Members Call: 800-522-0088

PPO/POS Members Call: 800-676-6976

OOS PPO Members Call: 800-861-7214

Eat Right Now Program

Eat Right Now is a new evidence-based program that combines neuroscience and mindfulness tools to help members identify eating triggers and ride out cravings to change their eating patterns for good. With help from videos and exercises, members will learn to listen to their body's hunger signals so they can differentiate between real hunger and emotional cravings. This progressive 28-day program lets members reshape how they eat in about 10 minutes a day.

Through video, audio, and animated lessons, clinically validated exercises and on-demand tools, members learn how to identify, work with, and eliminate their eating triggers.

Start Smart for Your Baby® program

A program for pregnant people and new parents. Get custom support and care to help you have good outcomes for your baby and you. Plus, sign up to get health information, such as Mother's Guide to Pregnancy and Guide to Life After Delivery. You also get guidance from a care manager along the way.

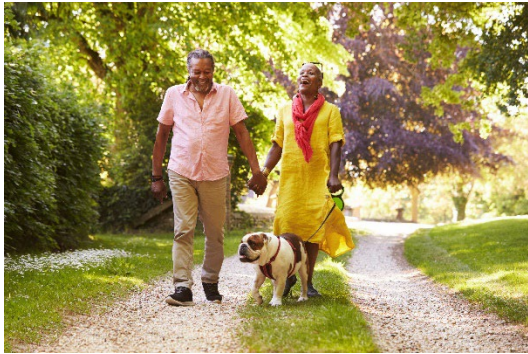
Craving to Quit program

The Craving to Quit program covers most types of tobacco, lets you talk with a personal coach for encouragement and support and offers a tailored plan to quit. The 21-day program teaches awareness of cravings and habits to help you stop, whether you smoke, vape or dip.

Health Coaching

Health coaching is confidential and is provided by highly trained and qualified experts who have been in your shoes and faced their own health challenges. Together, you'll create a plan to help you meet the goals you want to achieve or maintain to live a healthy, happy life. A coach will be your accountability partner to help you stay on track and celebrate your success. Get started today and sign up! You can call 855-430-5272 or register at healthnet.sharecare.com – go to **Achieve** and then **Coaching**.

KAISER RESOURCES



FINDING A KAISER PROVIDER

To find a Kaiser Permanente provider near you, please visit www.kp.org or call (800) 464-4000.

MY HEALTH MANAGER

Stay engaged with your health and simplify your busy life by using the [Kaiser Website](http://www.kp.org) or download the Kaiser Permanente app from the App StoreSM or Google Play[®].

KP On-Call/24 Hour Advice Nurse

After hours nurse advice is available. Speak with a licensed health care professional by phone for health questions, and advice about seeking medical care. To get advice or schedule an appointment, call 1-866-454-8855.

“Get Care Now” on kp.org

Get Care Now guides you to timely, convenient care options, whether at home or while traveling across the US. First, select your concern from our list of common symptoms and conditions. Then choose from the care options our doctors recommend to help you feel better, faster. Get Care Now offers self-care information, and telephone and video appointment options. Many conditions include an option to complete an E-visit questionnaire. For an E-visit, you answer a few questions about your symptoms, and a provider will get back to you with a care plan and prescriptions (if appropriate) — usually within 2 hours between 7 a.m. to 7 p.m., 7 days a week. From the member’s home page on kp.org, the member selects “get care now” button to start a virtual visit.

Headspace Care App

The Headspace Care app offers immediate 1-on-1 support for coping with many common challenges — from stress and low mood to issues with work and relationships, and more. Headspace Care’s highly trained emotional support coaches are ready to help 24/7, and adult Kaiser Permanente members can use Headspace Care for 90 consecutive days at no cost. Download the app from the App StoreSM or Google Play[®].

Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps.

Online wellness tools

Visit kp.org/healthyliving for wellness information, health calculators, fitness videos, podcasts, and recipes from world class chefs. Connect to better health with programs to help you lose weight, quit smoking, and more — all at no cost.

KAISER RESOURCES, Cont.



FINDING A KAISER PROVIDER

To find a Kaiser Permanente provider near you, please visit www.kp.org or call 800-464-4000.

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Whether you're traveling in the United States or a foreign country, Kaiser's travel [website](#) will explain what to do if you need emergency or urgent care during your trip.

Health classes

Sign up for health classes and support groups at many of our facilities. See what's available near you at kp.org/classes – some may require a fee.

Personal wellness coaching

Get help reaching your health goals. Work one on one with a wellness coach by phone at no cost. Find out more at kp.org/wellnesscoach.

One Pass Select Affinity™ from Optum

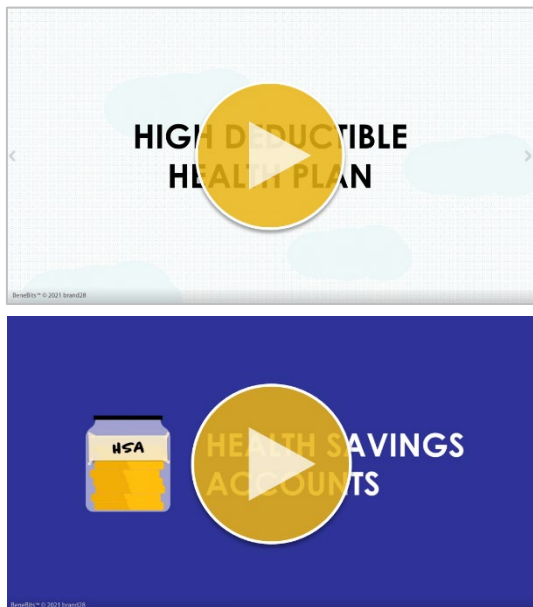
Choose a fitness plan that fits your lifestyle and get unlimited access to all locations available within that plan, plus extensive digital resources:

- 5 membership tiers with different monthly fees
- 19,000 gym locations and boutique studios
- 23,000+ on-demand and livestreamed classes
- Digital tools to track progress and an AI workout builder
- 10% off memberships for family and friends
- No contracts — change tiers monthly or cancel within 30 days
- Groceries and household essentials delivered with Walmart+ and Shipt
- Access to Optum's affinity musculoskeletal program.
- Get 20% off chiropractors, acupuncturists, and massage therapists when you visit a participating provider.

For more information, visit kp.org/exercise.

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video



ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the HDHP.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

FIND OUT MORE

- [Eligible Expenses](#)
- [Ineligible Expenses](#)

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future. You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Five reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.
5. **Investment Options.** You can invest your HSA funds in an interest-bearing account or our standard mutual fund line-up.

How the HSA works

- Your HSA account is set up automatically after you enroll.
 - When you enroll in a HDHP for the **FIRST TIME**, the City will contribute 100% of the plan deductible:
Individual: \$1,700
Family: \$3,400
 - When you enroll in a HDHP for the **SECOND, SUBSEQUENT YEAR**, the City will contribute 50% of the plan deductible:
Individual: \$850
Family: \$1,700
 - You can contribute up to the 2026 annual limit set by the IRS (less City contributions, if any):
Individual: \$4,400 per year
Family: \$8,750 per year
Are you age 55 or over? You can contribute an additional \$1,000 per year

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

- [BCC My SmartCare Website](#)
- [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 Benefit Coordinators Corporation (BCC).

How the 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, even eligible drugstore items.
- For 2026, employees can contribute up to \$3,200*. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on 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're for eligible healthcare expenses.
- Expenses must be incurred between 1/1/2026 and 3/15/2027 (2 ½ month "grace period" after the end of the plan year) and claims must be submitted for reimbursement no later than 3/31/2027. If you don't spend all the money in your account, you forfeit the leftover balance.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year to participate.

**IRS limits subject to change*

HSA & FSA – BCC RESOURCES



SAVE YOUR RECEIPTS

We recommend saving itemized receipts and EOBs for tax purposes. At the end of the year, BCC will provide you with the tax forms required to file your taxes. You are responsible for reporting your HSA contributions and distributions at tax time.

BCC MySmartCare MOBILE APP

Download SmartCare from the app store to:

- Check your balance and view account activity
- File a claim and upload documentation in seconds
- Report a card lost or stolen

Log in using the same information you set up on the website. For first time users, click Register.

NEED HELP?

Contact BCC's Customer Call Center at 800-685-6100 or email customersupport@benxcel.com.

How to set up and manage your account online

BCC makes it easy for you to manage your FSA with an online account through [My SmartCare](#), a free benefits mobile app, as well as text and email alerts.

Features of My SmartCare:

- Check your account balance
- File a claim for reimbursement
- Check the status of a claim
- View, activate, and report lost/stolen debit cards

How to set up your online account:

1. Visit [My SmartCare](#) online and click **Register**
2. Enter your name and zip code. If you have received an FSA debit card, check the box to enter the card number and expedite the registration process
3. Enter the verification code you received via email or text
4. Create a username and password
5. Select four security questions and answers
6. Confirm your email address
7. Review your answers and submit your registration

Your FSA Debit Card

You will receive two free Debit Cards when you enroll in the FSA; mailed directly to your home address. You can activate your card on the My SmartCare app or online portal, or by calling the toll-free number on the activation sticker on the front of your card.

You can use the debit card to pay for eligible services and products. When you use the debit card, payments are automatically withdrawn from your FSA, resulting in fewer out-of-pocket costs for you.

You can also request a debit card for your dependents and/or spouse. A dependent must be 18 years of age or older to receive a debit card in their own name.






How to file a claim if you pay out-of-pocket

If you choose to pay for your FSA eligible expenses out-of-pocket, you can file for a reimbursement.

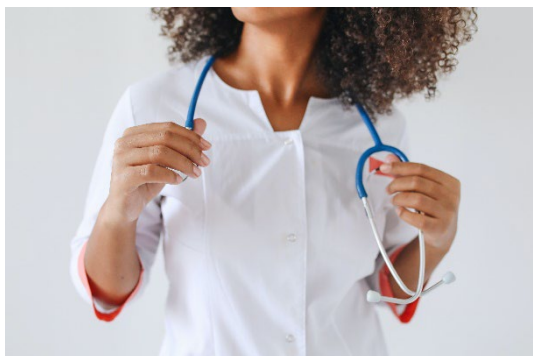
- Login to My SmartCare portal online or use the My SmartCare app to request a payment be sent directly to you, or your provider.
- Don't forget about direct deposit! You can set up direct deposit online and allow BCC to deposit reimbursements directly into your bank account.

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 |
|---|---|--|-----------------------------|------------|
| Nurse line  | Quick answers from a trained nurse | <ul style="list-style-type: none"> Identifying symptoms Decide if immediate care is needed Home treatment options and advice | 24/7 | \$0 |
| Online visit  | Many non-emergency health conditions | <ul style="list-style-type: none"> Cold, flu, allergies Headache, migraine Skin conditions, rashes Minor injuries Mental health concerns | 24/7 | \$ |
| Office visit  | Routine medical care and overall health management | <ul style="list-style-type: none"> Preventive care Illnesses, injuries Managing existing conditions | Office Hours | \$\$ |
| Urgent care, walk-in clinic  | Non-life-threatening conditions requiring prompt attention | <ul style="list-style-type: none"> Stitches Sprains Animal bites Ear-nose-throat infections | Office Hours, or up to 24/7 | \$\$\$ |
| Emergency room  | Life-threatening conditions requiring immediate medical expertise | <ul style="list-style-type: none"> 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 yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit [cdc.gov](https://www.cdc.gov) 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.

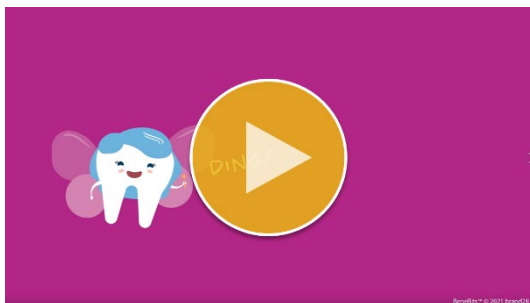


DENTAL

OUR PLAN

STANDARD DENTAL PPO PLAN

Click to play video



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.

YOUR DENTAL BENEFIT COSTS

ALL EMPLOYEES

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn.

| POA | | | |
|------------------------------------|---------------|-----------|-----------------|
| STANDARD DENTAL \$1,500/\$2,000 | Employee Cost | City Cost | Monthly Premium |
| Employee Only | \$0.00 | \$92.44 | \$92.44 |
| Employee + 1 | \$9.68 | \$163.44 | \$173.12 |
| Employee + Family | \$18.04 | \$224.76 | \$242.80 |

| NPOA, MVFF, Public Safety Department Heads, Police Managers, Fire Managers, SEIU, EAGLES, Confidential, Council Appointees, Miscellaneous Department Heads & City Council. | | | |
|--|---------------|-----------|-----------------|
| STANDARD DENTAL \$2,000/\$2,500 | Employee Cost | City Cost | Monthly Premium |
| Employee Only | \$0.00 | \$102.89 | \$102.89 |
| Employee + 1 | \$10.77 | \$181.91 | \$192.68 |
| Employee + Family | \$20.08 | \$250.16 | \$270.24 |

DENTAL

WITH MAX BUILDER

| | DENTAL PPO PLAN | | DENTAL PPO PLAN | |
|--|-----------------|----------------|--|----------------|
| | POA | | NPOA, MVFF, Public Safety Dept. Heads, Police Managers, Fire Managers, SEIU, EAGLES, Non-Safety Dept. Heads, City Council Appointees, Confidential Council Members | |
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Calendar Year Deductible | None | | None | |
| Calendar Year Plan Maximum (Non-Ortho)¹ Per Insured Person | \$1,500 | | \$2,000 | |
| Lifetime Maximum (Ortho) | \$2,000 | | \$2,500 | |
| Diagnostic & Preventive | 100% | | | |
| Basic Services² | 80% | | | |
| Major Services² | 80% | | | |
| Orthodontia Adults Children (up to age 26) | 50% | | | |

¹ May increase with the Max Builder In-Network option.

² Incentive Plan Provision - Percentage of coverage can increase or decrease by 10% based on the regular usage of your dental benefits. The benefit percentage will never be less than 80% or more than 100%. Please review the dental plan certificate for details.

- Limitations may apply for some benefits; some services may be excluded. Please refer to your plan certificate for a more detailed review of benefits and contract limitations.
- Fees are based on PPO fees for in-network dentists and the maximum plan allowance (MPA) for out-of-network dentists.
- Reimbursement is paid on contract allowances and not necessarily each dentist’s actual fees.
- Dental coverage ends the last day of the month in which the dependent turns 26 years of age. If a dependent’s birthday falls on the 1st of the month coverage will end on the last calendar day of the month before they turn 26.



Important Tip

When seeing a dental provider, make sure you request a “pre-authorization” from your provider for your treatments to ensure you know what is covered and what out-of-pocket costs you can expect.

DENTAL

Max Builder

The Max Builder option gives you and your dependents the opportunity to build your annual benefits maximums from year to year – if you see a dentist at least once a year and do not exceed your annual benefit maximum. Plus, you can also earn a bigger increase on your calendar year maximums by receiving an In- Network Bonus by visiting a dentist in the Ameritas network. The key to remember is that eligibility is based on paid claims for the current year, and if the amount paid stays under the plan threshold, then the following year will show the amount accumulated. The most accurate date reflecting the annual claims paid for the current year will be December 31st. On January 1st, any rollover amount will reflect for the new calendar year. Members have access to their maximum information on the member portal and their Explanation of Benefits (EOB) will also indicate the amount left of their maximum for the calendar year. To find a dentist within your network visit: standard.com/dental, select Find a Dentist, in your Search, choose your network, which is noted on your ID card. On the same portal you can access your maximum information and your EOB will also indicate the amount left of your maximum calendar year.

Building Annual Benefit Maximums is simple

- 1. Visit the dentist annually:** You must file at least one claim per year.
- 2. Stay below the annual threshold:** During some years, you may only need preventive care, which makes it easy to stay below the threshold (typically half or less of the annual maximum benefit).
- 3. Build annual maximums:** If you meet these first two criteria, you can carry over a specified amount and build your benefit for the following year, subject to plan limits.
- 4. Stretch benefit dollars:** You may use carried-over benefits to help reduce your out-of-pocket costs for covered dental services, subject to applicable deductible, coinsurance, and plan provisions.
- 5. Start over:** If you do not submit a dental claim during a benefit year, all carried-over benefits will be lost, but you can start building your maximum again the next year.

Max Builder with In-Network Bonus builds dental benefits

| PLAN | ANNUAL MAXIMUM | ANNUAL THRESHOLD | ANNUAL CARRY-OVER | IN-NETWORK BONUS | MAXIMUM CARRY-OVER (LIFETIME) |
|--|----------------|------------------|-------------------|------------------|-------------------------------|
| POA | \$1,500 | \$750 | \$250 | \$150 | \$1,000 |
| NPOA, MVFF, Public Safety Dept. Heads, Police Managers, Fire Managers, SEIU, EAGLES, Non-Safety Dept. Heads, City Council Appointees, Confidential Council Members | \$2,000 | \$750 | \$400 | \$200 | \$1,200 |

Example

- A POA employee only needed cleanings in 2026. The Standard Insurance paid an In-Network provider \$700 in 2026.
- Starting January 1, 2026, the employee's dental benefit would be:
 - Beginning Annual Maximum \$1,500
 - Carry-Over (for costs below \$750) \$250
 - In-Network Bonus \$150
 - Annual Maximum for 2026 **\$1,900**
- If the same thing happens in 2027, another \$400 will be added to the annual maximum for 2027. If the same happens in 2028, member will again qualify for Max Builder but the carryover will be limited to an additional \$200 for 2028 since the maximum carry-over is \$1,000.



VISION¹

OUR PLANS

VSP VISION PLAN

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But 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.

Click to play video



¹VSP Vision is available to HealthNet members and CalPERS health plan enrollees only.

Non-Safety employees enrolled in Kaiser medical plans receive vision services through Kaiser.

VISION

Your vision checkup is fully covered after your exam copay. After any materials copay, the plan covers frames, lenses, and contacts as described below.

| | VSP VISION PLAN | |
|--|---|--|
| | In-Network | Out-of-Network |
| Exams Benefit Frequency | \$0 copay Once every 12 months | Up to \$45 Once every 12 months |
| Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency | \$0 Copay \$0 Copay \$0 Copay Once every 12 months | Up to \$30 Up to \$50 Up to \$65 Once every 12 months |
| Frames Retail Frequency | Up to \$135 (extra \$50 on Featured Frame Brands) Once every 12 months | Up to \$70 Once every 12 months |
| Contacts* (Elective) Conventional Frequency | Up to \$150 Once every 12 months | Up to \$105 Once every 12 months |

*Contact lenses are available once every 12 months in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

What you need to know about this plan



Features:

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?

Where can I get more details?

Find a provider

See any provider, but you'll pay more out of network

Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA or HSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

www.vsp.com
(800) 877-7195
Claims Address
Box 495918 Cincinnati, OH 45249-5918

Go to <https://www.vsp.com/>
Click on "Find a Doctor" and search by location, office or doctor

VSP SAVINGS AND RESOURCES



ACCESS TO OVER \$3,000 IN EXCLUSIVE MEMBER SAVINGS

Visit vsp.com/offers to learn more about these resources and other VSP exclusive member extras.

Extra Savings on Glasses and Sunglasses

Get an extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. You can also save 30% on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.

Eyeconic

To shop online, go to eyeconic.com, the preferred VSP online retailer where you can shop in-network with your VSP benefits. Select from a wide selection of ready-made sunglasses and blue light filtering glasses for everyone.

Retinal Screening

You won't pay more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam.

LASIK - Laser Vision Correction

Save up to an average of 15% off the regular price of LASIK or 5% off the promotional price. Discounts are only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

TruHearing® Hearing Aid Discount

VSP® Vision Care members can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too. TruHearing also provides members with:

- 3 provider visits for fitting, adjustments, and cleanings
- A 45-day trial
- 3-year manufacturer's warranty for repairs and one-time loss and damage
- 48 free batteries per hearing aid

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call (877)396-7194.

Essential Medical Eye Care

With your vision benefits from VSP, you have access to supplemental coverage for urgent and medical eye care. Essential Medical Eye Care includes:

- Fully covered retinal screening for members with diabetes
- Exams and services to treat immediate issues like pink eye and sudden changes in vision
- Treatment options to monitor ongoing health conditions such as dry eye, diabetic eye disease, glaucoma, and more

If you need treatment, contact your VSP network doctor to schedule an appointment or visit vsp.com to find a doctor.



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.

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.

We provide short and/or long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

CITY PROVIDED LIFE AND AD&D INSURANCE

Basic Life Insurance pays your beneficiary a lump sum if you die. Coverage is provided by The Hartford and premiums are paid in full by the City.

The Hartford Basic Life

Regular full time and regular part time employees, working minimum of 20 hours per week.

| | |
|-----------------|--|
| Option 1 | Up to 5x base annual earnings up to a maximum of \$600,000 |
| Option 2 | \$50,000 |

The benefit amounts above will be reduced by 65% at age 70 and by 50% at age 75 or over. Refer to the plan document for details. (Terminates at retirement)



A NOTE ABOUT TAXES

Employer-provided life insurance coverage over \$50,000 for employee or over \$2,000 for dependents is considered a taxable benefit. The value of the benefit over \$50,000 for employees or over \$2,000 for dependents will be reported as taxable income on your annual W-2 form.

BENEFICIARY INFORMATION

Make sure that you have a beneficiary named on your life insurance benefit and that the information is up to date. Please note that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

AD&D Benefits

| | |
|---|----------|
| Loss of Life | 100% |
| Loss of one hand, or one foot, or sight of one eye | 50% |
| Loss of two or more of the losses listed above | 100% |
| Seatbelt Benefit | \$50,000 |

Family Benefits under AD&D

| | |
|--|---------------------------------------|
| Childcare | Up to \$10,000 over 36 months |
| Spouse Career Adjustment & Training | Up to \$10,000 over 36 months |
| Child Higher Education | Up to \$20,000 per child over 4 years |

Plan Details

| | |
|--|--|
| Accelerated Death Benefit Maximum (if life expectancy is 12 months or less) | 75% to \$150,000 of Benefit (Minimum \$5,000; Maximum \$500,000) |
| Waiver of Premium | Included |
| Conversion | Yes |
| Portability | Yes |

This summary is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

VOLUNTARY LIFE AND AD&D INSURANCE



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 Standard to approve the amount of coverage. Visit myeoi.standard.com/763702 to complete and submit a medical history statement online.

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 The Standard.

The Standard Voluntary Life

| | |
|-------------------|--|
| Employee | Increments of \$10,000 up to \$500,000 Guaranteed Issue: \$150,000 |
| Spouse | Increments of \$5,000 up to \$250,000 (not to exceed 100% of the employee's Voluntary Life coverage) Guaranteed Issue: \$20,000 |
| Child(ren) | \$10,000 |

Note: Benefit amount reduces by 35% at age 65, 50% at age 70, and by 65% at age 75 or over (terminates at retirement).

In the event of a serious or fatal accident

Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you. Coverage is provided by The Standard.

The Standard Voluntary AD&D

| | |
|-------------------|---|
| Employee | Matches the amount of your Voluntary Life benefit. |
| Spouse | Matches the amount of your Spouse Voluntary Life benefit. |
| Child(ren) | Matches the amount of your Child(ren) Voluntary Life benefit. |

VOLUNTARY LIFE & AD&D INSURANCE COSTS

EMPLOYEE OPTIONAL LIFE AND AD&D OPTIONS

If you are a new employee, you may elect up to a maximum of \$500,000 of life insurance, in increments of \$10,000, with \$150,000 guaranteed with no medical underwriting. If you are a current employee, you may apply for coverage and will be subject to medical underwriting for any amount elected. If you elect Voluntary Life insurance, your monthly premium rate for this plan is indicated in the table below.

SPOUSE & DEPENDENT CHILD(REN) OPTIONS

If you are a new employee, you may elect up to 100% of your Voluntary Life to a maximum of \$250,000 of life insurance for your spouse, in increments of \$5,000 with \$20,000 guaranteed with no medical underwriting. You may also elect a flat rate of \$10,000 for each eligible child. If you are a current employee, you may apply for coverage and will be subject to medical underwriting for any amount elected. If you elect Voluntary Life insurance for your spouse or child(ren), your monthly premium rate for this coverage is indicated in the tables below.

VOLUNTARY LIFE & AD&D

| Age | Employee Rate* Per \$1,000 | Spouse Rate** Per \$1,000 |
|------------|----------------------------|---------------------------|
| Under 25 | \$0.070 | \$0.070 |
| 25-29 | \$0.070 | \$0.070 |
| 30-34 | \$0.080 | \$0.080 |
| 35-39 | \$0.100 | \$0.100 |
| 40-44 | \$0.120 | \$0.120 |
| 45-49 | \$0.150 | \$0.150 |
| 50-54 | \$0.230 | \$0.230 |
| 55-59 | \$0.380 | \$0.380 |
| 60-64 | \$0.540 | \$0.540 |
| 65-69 | \$0.910 | \$0.910 |
| 70 or over | \$1.510 | \$1.510 |

To calculate your monthly premium:

1. Amount Elected: Write the amount of units you want (1 unit = \$1,000)

Line 1: _____

2. Write your age-based rate from the table on the left

Line 2: _____

3. Multiply line 1 by line 2. This is your monthly premium amount.

Line 3: _____

Example: 40 year old employee requesting Life and AD&D insurance: \$200,000
 = 200 x \$.150 = \$30.00

*Includes a monthly rate of \$0.02 per \$1,000 of AD&D benefit

**Includes a monthly rate of \$0.02 per \$1,000 of AD&D benefit for your spouse

CHILD(REN)* VOLUNTARY LIFE & AD&D

| Coverage Amount | |
|-----------------|----------------------|
| \$10,000 | |
| Child(ren) | \$0.23** per \$1,000 |

*If you elect Life with AD&D for your child(ren), your monthly rate is \$0.23 per \$1,000, no matter how many children you're covering

**Includes a monthly rate of \$.03 per \$1,000 of AD&D benefit for your child(ren)

CITY PROVIDED SHORT-TERM DISABILITY INSURANCE (STD)



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. The Hartford determines the eligibility and approves the benefit payment. 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.

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

- Pregnancy disability leave 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. The City pays the cost of this coverage. Coverage is provided by The Hartford.

| | | | | | |
|---|--|----------|-----------------------|----------|-----------------------|
| Eligibility | Regular full time and regular part-time employees working a minimum of 20 hours per week (excluding POA/NPOA & MVFF employees) | | | | |
| Weekly Benefit Amount | Plan pays 66 ² / ₃ % of weekly earnings | | | | |
| Maximum Weekly Benefit | \$1,750 | | | | |
| Benefits Begin After | <table border="0"> <tr> <td>Accident</td> <td>30 days of disability</td> </tr> <tr> <td>Sickness</td> <td>30 days of disability</td> </tr> </table> | Accident | 30 days of disability | Sickness | 30 days of disability |
| Accident | 30 days of disability | | | | |
| Sickness | 30 days of disability | | | | |
| Definition of Disability | You are unable to perform the essential duties of your occupation, or you are able to perform some, but not all, of the essential duties of your occupation, due to accidental bodily injury, sickness, mental illness, substance abuse or pregnancy | | | | |
| Maximum Payment Period¹ | 22 nd week of disability | | | | |

¹Maximum payment period is based on the first day benefits begin, not the first day you are disabled.

CITY PROVIDED LONG-TERM DISABILITY INSURANCE (LTD)



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 however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

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, stroke
- Mental disorders.

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

The Hartford LTD

| | |
|--|--|
| Eligibility | Regular full time and regular part-time employees working a minimum of 20 hours per week (excluding POA/NPOA & MVFF employees) |
| Monthly benefit amount | 66 ² / ₃ % up to a maximum of \$7,500 |
| Benefits begin | After 180 days of disability |
| Maximum payment period | If you become disabled prior to age 63, benefits may continue for as long as you remain disabled or until you reach your Social Security normal retirement age. If your disability occurs at age 63 or above, the number of payments may reduce. |
| Survivor Income Benefit | Lump sum payment of three months benefit to surviving spouse (or your children in equal shares if there is no surviving spouse) if you die while receiving LTD benefits. |
| Mental Illness, Alcoholism, & Substance Abuse | You can receive benefit payments for long-term disabilities resulting from mental illness, alcoholism and substance abuse for a total of 24 months for all disability periods during your lifetime |

This summary is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

TRAVEL ASSISTANCE & ID THEFT PROTECTION

Extra protection while traveling

With The Hartford’s Travel Assistance program, you’ll have the help you need if you’re covered under one of the group policies. Toll-free emergency assistance is available to you, your spouse and your dependents 24 hours a day, seven days a week when traveling 100 miles or more from your primary home (national or international travel) for 90 days or less. The Hartford’s Travel Assistance program is provided by International Medical Group (IMG).

International Medical Group (IMG) also helps to protect you and your family from consequences of identity theft 24/7 at home and when you travel. In addition to prevention education, this service provides advice and help with administrative tasks resulting from identity theft.

Travel Assistance begins even before you embark, with pre-trip information, and continues throughout your trip. List of services are as follows:

CALL FOR ASSISTANCE

US or Canada: (800) 243-6108
Outside U.S.: (202) 828-5885
Or email: assist@imglobal.com
Travel Assistance ID: GLD-09012

| EMERGENCY MEDICAL ASSISTANCE | PRE-TRIP INFORMATION | EMERGENCY PERSONAL SERVICES | IDENTITY THEFT SUPPORT SERVICES |
|--|---|---|---|
| <ul style="list-style-type: none"> • Medical referrals • Medical monitoring • Medical evacuation • Repatriation • Traveling companion assistance • Dependent children assistance • Visit by a family member or friend • Emergency medical payments • Return of mortal remains | <ul style="list-style-type: none"> • Visa and passport requirements • Inoculation and immunization requirements • Foreign exchange rates • Embassy and consular referrals | <ul style="list-style-type: none"> • Medication and eyeglass prescription assistance • Emergency travel arrangements⁸ • Emergency cash⁸ • Locating lost items • Bail advancement | <ul style="list-style-type: none"> • Prevention Services <ul style="list-style-type: none"> - Education - Identity Theft Resolution Kit • Detection Services <ul style="list-style-type: none"> - Fraud alert to three credit bureaus • Resolution Guidance and Assistance <ul style="list-style-type: none"> - Credit information review - ID Theft Affidavit Assistance - Card replacement • Personal Services <ul style="list-style-type: none"> - Translation - Emergency cash advance* |

* Cash advance available when theft occurs 100 miles or more from your primary residence. Must be secured by a valid credit card

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company, under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford’s legal notice at www.TheHartford.com. © 2022 The Hartford

¹ Travel Assistance and Identity Theft Support services are offered through a vendor which is not affiliated with The Hartford. These services are not insurance. The Hartford is not responsible and assumes no liability for the goods and services described in this material and reserves the right to discontinue any of these services at any time. Services may vary and may not be available in all states.

² Coverage includes spouse (or domestic partner) and dependent children under age 26.

THE HARTFORD ADDED SERVICES



HOW TO ACCESS CARE

MEMBERS

Register online at:

join.empathy.com/hartfordcare

Once registered, access these services by calling 1-229-544-2332.

BENEFICIARIES

- Visit: empathy.com/partner/Hartford
- Register online at: join.empathy.com/Hartford
- Download the digital app and use access code: **EMP-HART**
- Contact: Hartford@empathy.com, or call 1-270-681-1364.

Ability Assist® Counseling Services

Access to Master's- and PhD degreed clinicians for 24/7 assistance if you're enrolled in our long-term disability plan. This includes 3 face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal, and work-life concerns.

For more information on Ability Assist® Counseling Services call 1-800-964-3577 or visit www.guidanceresource.com, use company name: ABILI and company ID: HLF902.

Beneficiary Assist® Counseling Services

Offers compassionate expertise to help you or your will beneficiaries (those you name in your policy) cope with emotional, financial and legal issues that arise after a loss. Includes unlimited phone contact with a counselor, attorney or financial planner for up to a year, and 5 face-to-face sessions. For more information on Beneficiary Assist® Counseling Services, call 1-800-411-7239.

Empathy Life Services

Whether you're preparing your loved ones, or grieving a loss, Empathy provides a suite of online tools to guide you through key decisions.

Member Support

- **Will Preparation:** Step-by-step guidance and support for preparing a will.
- **Funeral Planning:** Detailed instructions and on-demand assistance to help plan a funeral, burial, and/or cremation.

Beneficiary Support

- **Easy-to-use App:** Access resources and services in one place to help you navigate the challenges of loss.
- **Grief Counseling:** Licensed social workers are available to listen and give support.
- **Funeral Planning:** Detailed instructions and on-demand assistance to manage the logistics of funeral planning, burial, cremation, and other related services.
- **Estate Administration:** Guidance for navigating estate and probate processes.
- **Account Deactivation:** Get help closing unneeded financial accounts, memberships, and subscriptions.
- **Identity Theft Protection:** Step-by-step instructions to freeze credit and protect the identity of your loved one.

PET INSURANCE



CONNECT WITH METLIFE

Call 1-800-GET-MET8

MetLife Pet Insurance

No matter what unpredictable antics furry family members get into, a family isn't complete without them. MetLife Pet Insurance can help pet parents protect their wallet and their pet when faced with an unexpected trip to the vet. Pet Insurance can help reimburse you for covered vet visits, accidents, illness and more!

Why choose MetLife Pet Insurance?

- Flexible coverage with up to 90% reimbursement
- The freedom to visit any U.S. licensed vet
- Optional Preventive Care coverage
- 24/7 access to Vet Chat via the MetLife Pet mobile app
- MetLife Pet mobile app to manage pet's health and wellness, submit & track claims and find nearby pet services

How to Get a Quote

Get a free quote by following these steps:

1. Visit [metlife.com/getpetquote](https://www.metlife.com/getpetquote)
2. Provide some basic information about your pet – type, gender, age, zip code, and **Employer Code: City of Mountain View**
3. Choose the plan that's right for you and your pet – you can select your annual benefit, deductible, reimbursement rate and wellness option

Additional discounts available for multiple pets!

Things to Consider

Rates are determined by the age of the pet, breed or size, state of residence, species, and plan choice.

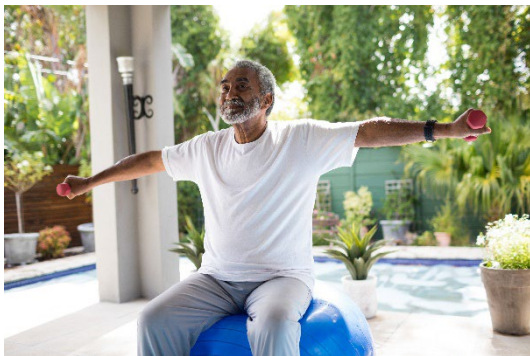
Note that pre-existing conditions are not typically covered in pet insurance; however, MetLife will cover pre-existing conditions that were previously covered for those switching from another pet insurance provider.

Download the MetLife Pet App

With the MetLife Pet mobile app, pet parents can manage their furry family member's health and wellness all in one location.

- Access your pet insurance policy: submit and track claims.
- Manage your pet's health records: Upload and view health records and documents all in one location.
- Receive reminders and notifications about upcoming appointments
- Find nearby pet services: emergency rooms or groomers
- Live 24/7 Telehealth Concierge Services: Get answers and tips by licensed vets from your own home.
- Access personalized articles on topics recommended for you.

WELLNESS PROGRAM



GET STARTED TODAY

Log on to the City's Intranet to learn more about the Wellness Incentive Program and Event Calendar

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. With this in mind, the City offers an integrated wellness program to help you create healthy habits, reach your highest level of well-being and champion wellness!

The program consists of opportunities and support for managing stress, choosing nutritious foods, staying active, maintaining or reaching a healthy weight, avoiding unhealthy habits, and more. **Regularly benefited employees are eligible to participate to receive up to \$400 for participation in designated components of the City's wellness program.**

How does it work

This program is voluntary. Use the Wellness Incentive Request Form (available on the City's Intranet) to identify eligible wellness activities and track your participation and points. Some activities can be repeated more than once to earn additional points. For example, if you complete two preventative cancer screenings as recommended by your doctor, you can earn up to 60 points (30 points per screening).

Documentation

Documentation must be submitted with your incentive form in order to verify participation. However, do not return any medical information to the City, Wellness Committee or Human Resources. We only need confirmation of your participation in the various activities listed. For example, if you want to lead a stretch break/meeting recess during a work meeting, please include it in the printed agenda for the meeting and, along with your signature, have at least two co-workers sign the agenda confirming the activity. Another example is if you receive a flu shot or health screening through the City sponsored events then HR will have proof of your participation. If you receive a flu shot, physical, and/or cancer screenings from your doctor you can provide a note from the doctor confirming the services were performed.

Get the family involved

We want these healthy activities to become habits in both your professional and personal lives. Encourage your family members to take advantage of the valuable and often free resources provided by our medical carriers.

EMPLOYEE ASSISTANCE PROGRAM (EAP)



CONTACT CONCERN: EAP

Phone

800-344-4222

Website

[EMPLOYEES.CONCERNHEALTH.COM](http://employees.concernhealth.com)

Company Code

MTNVIEW

Help for you and your household members

The EAP administered by Concern can help you handle a wide variety of short-term 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 counseling for short-term issues
- Live chat and text therapy options
- Unlimited web access to a suite of evidence-based live and on-demand mindfulness solutions through **eM Life**. Visit <http://employees.concernhealth.com>, enter company code **MTNVIEW**, and click “Get Services” in the main menu. Click on Self-Help and choose any link in the Guided Mindfulness Programs panel.

COUNSELING BENEFITS

- Difficulty with relationship
- 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

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT CONCERN: EAP

Phone
800-344-4222

Website
[EMPLOYEES.CONCERNHEALTH.COM](https://employees.concernhealth.com)

Company Code
MTNVIEW



ALL ELIGIBLE EMPLOYEES

Full-time and part-time employees, spouses/domestic partners and dependent children up to age 26 have access to up to eight (8) in-person or video counseling visits per issue, per year.

FIRST RESPONDERS

(POA, MVFF, Police Managers, Fire Managers, and Safety Department Heads)

First Responders often face extreme stressors in the course of their duties. Those traumatic events can result to profound, long-lasting effects.

The City's Police, firefighters, and other first responders often suffer from emotional distress due to job stress, repeated exposure to trauma, lack of sleep, and the physical demands of their jobs. That is why it is essential that they meet with a counselor who understands and who can provide them with the support they need.

Full-time and part-time First Responders, spouses/domestic partners and dependent children up to age 26 have access to up to ten (10) in-person or video counseling visits per issue, per year.

First Responder Specialty Program

In addition to access to Concern's digital platform, emLife, Counseling Benefits and Life Balance Solutions, First Responders have access to a specialty panel of trauma-trained counselors – many of whom are former first responders themselves. Concern's First Responder Specialty Panel is comprised of:

- Trauma trained specialist
- Years of experience working with First Responders
- Many are vetted by First Responder peer review panels
- Located throughout central and Northern California
- All are passionate about supporting First Responders and will quickly, make themselves available to scheduled appointments

The EAP offers short-term support and counseling. If you need ongoing counseling, mental health support or have a medical diagnosis, please visit your medical provider or Better Help.

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 \$7,500 per year tax-free

A dependent care Flexible Spending Account (DFSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by Benefit Coordinators Corporation (BCC).

Here's how the 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 \$7,500 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to \$3,750 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.

Expenses must be incurred between 1/1/2026 and 3/15/2027 and claims must be submitted for reimbursement no later than 3/31/2027. If you don't spend all the money in your account by 3/15/2027, you forfeit the leftover balance.

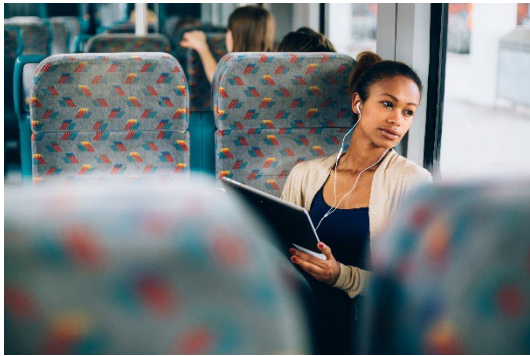


Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

AbilityPath Child Care Center

The City's Child Care Center, operated by AbilityPath, is a qualified childcare provider for children ages 6 weeks to 5 years. To learn more about enrollment priority, curriculum, programs, and tuition rates, contact AbilityPath at (650) 938-2252, or enroll@learninglinks.org.

SAVE ON COMMUTE EXPENSES



HOW TO SET UP YOUR ONLINE ACCOUNT:

1. Visit [BCC My SmartCare Website](#)
2. Click 'REGISTER' at the top right corner of the screen to begin

Transportation Savings Account—up to \$340* per month tax-free

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by BCC.

The account lets you set aside money—before it's taxed—through payroll deduction. You may enroll in or stop this program at any time. Money in the account can be used in future months or plan years.

The pre-tax dollars can be used to pay for expenses related to commuting to and from work for mass transit, vanpooling and work-related parking costs. This includes transit passes, tokens, fare cards, vouchers, parking passes and more. Conveniently purchase transit products with the Benefits debit card; the same card used for FSA.

The City will contribute up to \$150 per month (prorated for part-time employees) for mass transit expenses when the employee contributes at least \$10 per month.

2026 IRS maximum monthly contributions for mass transit and parking is \$340* (combined employer and employee contributions).

**IRS limits subject to change*

Bike Commute Benefit

Eligible employees who use their bike a minimum of 12 days per month, as part of or all of their commute to work, can earn a taxable \$20 stipend each month. An additional \$10 bonus per month can be earned when an employee's daily bike commute is 10 or more miles for at least the 12 qualifying days in the month. This benefit of up to \$360 per year is taxable and is paid out in the first quarter of the subsequent calendar year.

Bike Locker Room

Located in the City Hall garage, space is limited. Employees interested in using this room to park their bikes during the workday. Please contact the Human Resources Department at (650) 903-6309 for more information.

Guaranteed Ride Home

In the event of an emergency, employees who commute to work by way of mass transit, bicycle, or carpool are eligible for a City-paid ride home.

RETIREMENT PROGRAMS



California Public Employees' Retirement System (CalPERS)

Participation in this retirement plan is mandatory beginning on the first day of employment.

Social Security

In January 1971, following a vote of all affected employees, the City withdrew from participation in Social Security. All new employees are provided with and required to sign the "Statement Concerning Your Employment in a Job Not Covered by Social Security" form provided by the Social Security Administration. A copy of this form can be found on the City's Intranet.

Medicare

Required 1.45% contribution by both the employee and the City.

457(b) Deferred Compensation and Roth Plans

Employees may choose to enhance their retirement savings through voluntary payroll deductions into a 457(b) Deferred Compensation or Roth 457(b) plan, both administered by Empower. Contributions to the traditional 457(b) are made before taxes, reducing current taxable income; taxes are then paid when funds are withdrawn, usually at retirement.

Contributions to the Roth 457(b) are made after taxes, allowing tax-free withdrawals of both contributions and earnings when certain IRS conditions are met.

Retirees Health Program (Defined Benefit)

For regular full-time and regular part-time employees who retire from the City of Mountain View through CalPERS, the City provides and pays for a percentage/portion of health insurance for the life of the employee. Eligibility for the program is determined by vesting requirements, which vary depending on the employee group and the specific number of years of service.

Retirement Health Savings Account (Defined Contribution)

An alternate option to the Defined Benefits Retirees Health Program (for certain employee groups) provides employer-paid contributions to an employee's Retiree Health Savings Account (RHSA) during employment. Upon separation, this account can be used to reimburse qualified after-tax medical expenses for the employee, their spouse, registered domestic partner, and/or dependents. Eligibility for the program is determined by vesting requirements for a specific number of years of service, depending upon the employee group. Contributions are pre-tax and funds used for reimbursement of qualified medical expenses upon separation are not taxed. Accounts are administered by Aviben and funds may be invested within the fund options available under the plan.

For more information, please refer to your MOU.

PLAN CONTACTS

| Plan Type | Provider | Phone Number | Website | Policy No. |
|---------------------------------------|-----------------------------------|---|--|--------------------------------|
| MEDICAL | Health Net | 800-522-0088 | www.healthnet.com | HMO: 64178 PPO: 29610 |
| | Kaiser Permanente | 800-464-4000 | www.kp.org | 804 |
| DENTAL | The Standard | 800-547-9515 | standard.com/dental | 515680 |
| VISION | VSP | 800-877-7195 | www.vsp.com | 30105867-0650 |
| LIFE/AD&D/STD/LTD | The Hartford | 877-778-1383 | thehartford.com/employeebenefits | 402265 |
| VOLUNTARY LIFE/AD&D | The Standard | 800-628-8600 | www.standard.com | 763702 |
| FSA/HSA/COMMUTER | BCC | (800) 685-6100 | benefitcc.wealthcareportal.com | |
| FSA/HSA/COMMUTER for 2025 balances | WEX | 866-451-3399 | www.wexinc.com | |
| EAP | Concern | 800-344-4222 | employees.concernhealth.com | Online code: mtnview |
| GLOBAL ASSISTANCE | International Medical Group (IMG) | 800-243-6108 Outside US: 202-828-5885 | assist@imglobal.com | Identification #: GLD-09012 |
| RETIREMENT HSA (DEFINED CONTRIBUTION) | Aviben | 888-507-6053 | https://www.yourplanaccess.net/ebc/ | |
| RETIREMENT | CalPERS | 888-225-7377 | www.calpers.ca.gov | |
| DEFERRED COMPENSATION | Empower Retirement | 800-701-8255 | www.empowermyretirement.com | |

Human Resources Department

| | |
|--|--|
| Erika Baquero, HR Technician, x6061 | Jameson Knittel, HR Analyst II x6062 |
| Lindsey Bishop, HR Manager, x6056 | Austin Phillips, Administrative Assistant, x6460 |
| Meg Biss, HR Analyst II, x6286 | Maxine Gullo, HR Director, x6057 |
| Kimberly Castaneda, HR Analyst II, x6099 | Tiffany Sison, HR Technician, x6051 |
| Karin Davalos, Senior HR Analyst, x6059 | Alxea Vilkins, HR Technician, x6050 |
| Alijah Diaz, HR Analyst II, x6454 | Nathan Wong, HR Analyst I, x6065 |

HR Main Line - (650) 903-6309

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 under age

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 / Teladoc

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.

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE

Under Federal law, the City of Mountain View is required to offer covered employees and covered family members the opportunity for a temporary extension of group coverage (called “continuation coverage”) at group rates when coverage under the plan would otherwise end due to certain qualifying events. This notice is simply intended to inform you (and your covered dependents, if any), in a summary fashion of your potential future options and obligations under the continuation coverage provisions of the law. Should an actual qualifying event occur in the future, the City of Mountain View will send you the appropriate notification. **Please take special note, however, of your notification obligations which are highlighted in this notice.**

Qualifying Events for Covered Employees—If you are an employee of the City of Mountain View and are covered by one of the City’s group plans, you may have the right to elect this continuation coverage if you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

Qualifying Events for Covered Spouse—If you are the covered spouse of an employee of the City of Mountain View (who is covered by one of the City’s group plans) and lose your coverage because of any of the following reasons:

1. A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction of your spouse’s hours of employment with the City of Mountain View.
2. The death of your spouse.
3. Divorce or, if applicable, legal separation from your spouse.
4. Your spouse becomes enrolled for Medicare benefits (Part A, Part B, or both).

Under Federal law, the term “spouse” includes a person of the opposite sex and applies when the employee and spouse are married according to the state law in which they reside. While the group plan(s) may allow domestic partners and/or same-sex marriage partners to be covered by the plan(s), if they lose group insurance as a result of one of the above-listed events, they may not be offered the opportunity to continue group insurance as an individual qualified beneficiary.

Qualifying Events for Covered Dependent Children—If you are the covered dependent child of an employee who is covered by one of the City’s group plans, you may have the right to elect continuation coverage for yourself if you lose group coverage because of any of the following reasons:

1. A voluntary or involuntary termination of the employee’s employment (for reasons other than gross misconduct) or reduction in the employee’s hours of employment with the City of Mountain View.
2. The death of a parent employed by the City of Mountain View.
3. Parent’s divorce or, if applicable, legally separate. The employee of the City of Mountain View becomes enrolled in Medicare benefits (Part A, Part B, or both).
4. You cease to be a “dependent child” under the terms of your plan.

Employer Notification Responsibilities

If the qualifying event is a termination of employment, reduction in hours, death, or enrollment in Medicare benefits (Part A, Part B, or both), the City must notify you of your continuation rights.

Important Employee, Spouse, and Dependent Notification Responsibilities

Under the law, the employee, spouse, or other family member has the responsibility to inform the City of Mountain View Human Resources Department of a qualifying event (such as divorce, legal separation, or a child losing dependent status) under their group plan. This notification must be made in writing and must be within 60 days from whichever date is later, the date of the event or the date on which coverage would be lost under the terms of the insurance contract because of the event. Carefully read the dependent eligibility rules contained in the summary plan description of your plan(s). **If this notification is not completed in a timely manner, then rights to continuation coverage may be forfeited.** The City of Mountain View has the responsibility to notify

your group plan of any change in an employee's status (i.e., termination of employment, reduction in hours that results in loss of health coverage, death of an employee, Medicare enrollment).

Election Period and Coverage—Once the City of Mountain View Human Resources Department is notified that a qualifying event has occurred, Human Resources will then notify covered individuals (also known as qualified beneficiaries) of their right to elect continuation coverage. Each qualified beneficiary has independent election rights and will have 60 days from the later of either the date coverage is lost under your group plan (usually the end of month following termination of employment) or from the date of notification to elect continuation coverage. This is the maximum period allowed to elect COBRA as the plan does not provide an extension of the election period beyond what is required by law. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue group insurance will end. More specific information regarding the election period will be provided at the time of the qualifying event.

If a qualified beneficiary elects continuation coverage and pays the applicable premium, the City of Mountain View is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated employees and/or covered dependents. Should coverage change or be modified for similarly situated active employees, then the change and/or modification will be made to the qualified beneficiary's coverage as well.

Length of Continuation Coverage—18 or 24 Months. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for a maximum period of 18 months from the date of the actual qualifying event or the date when coverage is lost due to the qualifying event. If you are an active reservist and are called to active duty, each qualified beneficiary will have a maximum period of 24 months. In general, there are three ways in which the 18- or 24- month period can be extended.

- **Social Security Disability**—The 18 months of continuation coverage can be extended to a maximum of 29 months for all qualified beneficiaries if the Social Security Administration determines that a qualified beneficiary was disabled according to Title II or Title XVI of the Social Security Act. The disability would have to have started some time prior to the date of the qualifying event or within the first 60 days of continuation coverage and must last until the end of the 18- or 24-month period of continuation coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the City of Mountain View Human Resources Department within 60 days of the date of determination and before the original 18 or 24 months expire. It is also the qualified beneficiary's responsibility to notify the City of Mountain View Human Resources Department within 30 days that a final determination has been made that they are no longer disabled.
- **Secondary Events**—Another extension of the 18- or above-mentioned 29-month continuation period can occur if, **during the 18 or 29 months** of continuation coverage, a second event takes place (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent). If a second event does take place, then the 18 or 29 months of continuation coverage can be extended to 36 months from the date of the original qualifying event date. If a second event occurs, it is the qualified beneficiary's responsibility to notify the City of Mountain View Human Resources Department in writing within 60 days of the event and within the original COBRA timeline. In no instance, however, will continuation coverage last beyond three years from the date of the original qualifying event.
- **Special Medicare Entitlement Rule for Dependents Only**—If the employee is entitled to Medicare benefits prior to the date of the original 18-month qualifying event, then the dependent qualified beneficiaries are eligible for the 18 months of continuation coverage, or 36 months measured from the date of the Medicare entitlement, whichever is greater. For example, if a covered employee becomes entitled to Medicare eight months prior to the date on which employment terminates, the dependent will be offered 28 months of continuation coverage (36-8=28). The covered employee, however, will only be offered 18 months.

Length of Continuation Coverage—36 Months. If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under the terms of your group plan, then each qualified beneficiary will have the opportunity to continue

coverage for a maximum of 36 months from the date of the qualifying event. Under no circumstances will coverage exceed 36 months.

Eligibility, Premiums, and Potential Conversion Rights—A qualified beneficiary does not have to show they are insurable to elect continuation coverage; however, they must have been actually covered by the plan to be eligible for COBRA. The City of Mountain View reserves the right to verify eligibility status and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts. A qualified beneficiary will be required to pay all of the applicable premium plus a 2 percent administration charge for continuation coverage. These premiums may be adjusted in the future if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, the City of Mountain View will charge up to 150 percent of the applicable premium during the extended coverage period. There is a grace period of 30 days for the regularly scheduled monthly premiums. **This is the maximum grace period allowed as the plan does not provide for an extension of the grace period beyond what is required by law.** At the end of the continuation coverage, a qualified beneficiary must be allowed to enroll in an individual conversion health plan, if such conversion is available.

Cancellation of Continuation Coverage—The law provides that if elected and paid for, continuation coverage may end prior to the maximum continuation period for any of the following reasons:

- The City of Mountain View ceases to provide any group health insurance to any of its employees.
- Any required premium for continuation coverage is not paid in a timely manner.
- A qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary.
- A qualified beneficiary becomes, after the date of election, entitled to Medicare benefits (under Part A, Part B, or both).
- A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled.
- A qualified beneficiary notifies the City of Mountain View Finance and
- Administrative Services Department that they want to cancel continuation coverage.
- For cause, on the same basis that the plan terminates for cause, the coverage of similarly situated non-COBRA participants.

Special Right to Enroll in the Health Insurance Marketplace or with Another Employer Sponsored Group Health Plan—Upon the occurrence of a qualify event, there will be other health insurance coverage options available for you at that time. First, you will be able to buy individual health insurance through the **Health Insurance Marketplace** without a preexisting condition limitation or exclusion. In the Marketplace, you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll and purchase a plan. In addition, you could be eligible for a new tax credit that lowers your monthly premiums right away.

60-Day Marketplace Enrollment Period: You must enroll in an individual plan through the Marketplace within sixty (60) days of the exhaustion of your health insurance coverage as indicated above. A failure on your part to enroll within this 60-day period may result in your having to wait until the next Marketplace open enrollment period and going without health insurance until that time. For more information about health insurance options available through the Marketplace, visit www.healthcare.gov or call (800) 318-2596.

30-Day Enrollment in Another Group Health Plan: Upon exhaustion of your health insurance coverage, you may qualify for a special enrollment opportunity for another group health plan sponsored by another employer for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. This special enrollment period also lasts for 30 days from the exhaustion of your coverage. If you are eligible for another employer-sponsored health plan, please contact their benefits department immediately for plan information and procedures for enrollment. One of these options may cost less than health insurance continuation coverage with the City.

Notification of Address Change—To ensure that all covered individuals receive information properly and efficiently, it is important that you notify the City of Mountain View Human Resources Department, at the address

listed below, of any address change as soon as possible. Failure on your part to do so may result in delayed notifications or a loss of continuation coverage options.

Any Questions?—If any covered individual does not understand any part of this summary notice or has questions regarding COBRA or your obligations, please contact:

City of Mountain View
Human Resources Department
500 Castro Street
Mountain View, CA 94041
(650) 903-6309

Any questions regarding payment of premiums, time schedules for payment of premiums, etc., should be referred to:

City of Mountain View
Finance and Administrative Services Department
500 Castro Street
Mountain View, CA 94041
(650) 903-6316

Medicare Part D Notice

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

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

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 Mountain View has determined that the prescription drug coverage offered by the City of Mountain View 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 Mountain View coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under the City of Mountain View 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 Mountain View 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 the City of Mountain View 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 [or call the City of Mountain View at (650) 903-6309.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Mountain View 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](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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](https://www.socialsecurity.gov), or call them at 800-772-1213

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: | January 1, 2026 |
| Name of Entity/Sender: | City of Mountain View |
| Contact-Position/Office: | Human Resources |
| Address: | 500 Castro St., Mountain View, CA 94041 |
| Phone Number: | (650) 903-6309 |

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. Therefore, the deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator (650) 903-6309.

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 at (650) 903-6309.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in the City of Mountain View 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 the City of Mountain View 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 30 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 30 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 30-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 the City of Mountain View 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 Mountain View describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting (650) 903-6309.

Notice of Choice of Providers

The City of Mountain View generally allows 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at (650) 903-6309.

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

You do not need prior authorization from the City of Mountain View 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 the plan administrator at (650) 903-6309.

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% in 2026 of your modified adjusted household income.

Notice Regarding Wellness Program

The City of Mountain View's wellness program is a voluntary wellness program available to benefit-eligible employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which would include a blood test for glucose, HDL, LDL, triglycerides and total cholesterol. You are not required to complete an HRA or to participate in any blood tests or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to \$400 annually for participating in preapproved wellness activities. Although you are not required to complete an HRA or participate in any biometric screenings, employees who do so may be eligible to apply the wellness points earned toward earning the maximum of \$400 annual incentive.

If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Karin Davalos at (650) 903-6309.

The information from your HRA and/or the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You are also encouraged to share your results or concerns with your own doctor.

Notice of Availability of Alternative Standard for Wellness Plan

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at (650) 903-6309 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the City of Mountain View may use aggregate information it collects to design a program based on identified health risks in the workplace, City's wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual that may receive your personally identifiable health information is a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the City of Mountain View at (650) 903-6309

• 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, 2025**. Contact your State for more information on eligibility—

| |
|---|
| ALABAMA – Medicaid |
| Website: http://myalhipp.com/ Phone: 1-855-692-5447 |
| ALASKA – Medicaid |
| The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx |
| ARKANSAS – Medicaid |
| Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447) |
| CALIFORNIA – Medicaid |
| Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov |
| COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+) |
| Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442 |
| FLORIDA – Medicaid |
| Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268 |
| GEORGIA – Medicaid |
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, press 2 |

INDIANA – Medicaid

Health Insurance Premium Payment Program All other Medicaid Website: <https://www.in.gov/medicaid/> | <http://www.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: [iowa Medicaid | Health & Human Services](http://iowa.gov/Health%20&%20Human%20Services) | Medicaid Phone: 1-800-338-8366
 Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](http://iowa.gov/Hawki-Healthy%20and%20Well%20Kids%20in%20Iowa) | Hawki Phone: 1-800-257-8563
 HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](http://iowa.gov/Health%20Insurance%20Premium%20Payment%20(HIPP))
 HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/> | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

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

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/> | Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm> | Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
 Phone: 1-800-694-3084 | email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
 Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcftp.nv.gov> | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/> | Phone: 800-356-1561
 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: <http://www.njfamilycare.org/index.html>
 CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

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

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|---|
| NORTH CAROLINA – Medicaid |
| Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100 |
| NORTH DAKOTA – Medicaid |
| Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825 |
| OKLAHOMA – Medicaid and CHIP |
| Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 |
| OREGON – Medicaid and CHIP |
| Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075 |
| PENNSYLVANIA – Medicaid and CHIP |
| Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 |
| CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437) |
| RHODE ISLAND – Medicaid and CHIP |
| Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct Rlte Share Line) |
| SOUTH CAROLINA – Medicaid |
| Website: https://www.scdhhs.gov Phone: 1-888-549-0820 |
| SOUTH DAKOTA – Medicaid |
| Website: http://dss.sd.gov Phone: 1-888-828-0059 |
| TEXAS – Medicaid |
| Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493 |
| UTAH – Medicaid and CHIP |
| Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/ |
| VERMONT – Medicaid |
| Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427 |
| VIRGINIA – Medicaid and CHIP |
| Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 |
| WASHINGTON – Medicaid |
| Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 |
| WEST VIRGINIA – Medicaid and CHIP |
| Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| WISCONSIN – Medicaid and CHIP |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002 |
| WYOMING – Medicaid |
| Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269 |

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

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

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



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a **temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| | | | |
|---|--|---|----------------------|
| 3. Employer name City of Mountain View | | 4. Employer Identification Number (EIN) 94-6000379 | |
| 5. Employer address 500 Castro Street | | 6. Employer phone number (650) 903-6309 | |
| 7. City Mountain View | | 8. State CA | 9. ZIP code 94041 |
| 10. Who can we contact about employee health coverage at this job? Lindsey Bishop, Human Resources Manager | | | |
| 11. Phone number (if different from above) | | 12. Email address Lindsey.Bishop@mountainview.gov | |

Here is some basic information about health coverage offered by this employer:

•As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

Employees in regular, limited period, probationary, provisional appointments in the classified service who work a minimum of 20 hours per week, and employees in the unclassified service as Councilmembers, Council Appointees, department heads and subordinate attorneys.

•With respect to dependents:

We do offer coverage. Eligible dependents are:

Current spouse/registered domestic partner; Natural, adopted, foster, step or registered domestic partner's children up to age 26 (medical and vision only); Disabled children of any age enrolled prior to age 26.

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Notes:



City of
Mountain View