2023 BENEFITS

City of El Centro

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 Annual Notices section for more details.

GETTING STARTED

2023 BENEFITS
January 1, 2023
through
December 31, 2023

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

This guide provides an overview of your healthcare coverage, life, disability and more.

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

WHO'S ELIGIBLE FOR BENEFITS?

Employees

The City of El Centro defines "full-time benefit eligible" as employees who are regularly scheduled to work at least 30 hours a week for an indefinite period of time or is an elected City official.

Eligible dependents

- Legally married spouses (the person who you are legally married to under state law, including a same-sex spouse.)
- Natural, adopted or stepchildren, 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.
- Employees who work less than 30 hours per week, temporary employees or contract employees.

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.

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).

OPEN ENROLLMENT

Employees

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, unless you experience an eligible life event.

Any changes made during Open Enrollment will be effective on January 1, 2023.

CHANGING YOUR BENEFITS

What's a Qualifying Life Event?

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.

Employees

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

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

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

MEDICAL

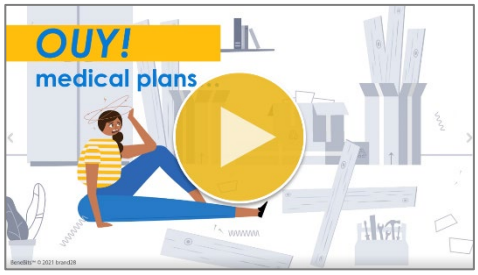
OUR PLANS

CORE PPO PLAN

BUY DOWN PPO PLAN

LIMITED PPO PLAN

All About Medical Plans



Click to play video

The City of El Centro offers 3 medical PPO plans through the Anthem PPO Network administered by Pinnacle TPA. 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/understand how the plans works.

Which Plan Is Right For You?

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

Consider the 3 PPO options:

- Do you want a lower deductible? Do you want to pay the least out of pocket at the doctor's office? Consider enrolling in the Core PPO Plan. The Core PPO Plan has the highest monthly premium cost.
- Want to save a little more in monthly premium and have a higher deductible? Consider enrolling in the Buy Down PPO Plan.
- Do you want to pay the lowest in monthly premium and are not using out of network doctors? Consider enrolling in the Limited PPO Plan. The Limited PPO Plan has the highest deductible and lowest monthly premium cost.

Medical PPO Core Plan

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Medical PPO Core Plan	
	In-Network	**Out-of-Network**
Annual Deductible Individual Family	$500 $1,500	
Annual Out-of-Pocket Maximum Individual Family	$2,500 $5,000	$6,000 $12,000
Office Visit Primary Care Specialist	$35 copay $35 copay	40% after deductible 40% after deductible
Telemedicine Doctor On Demand	$20 copay	Not Covered
Preventive Services	No Charge	40% after deductible
Chiropractic	10% after deductible	40% after deductible
Lab and X-ray	10% after deductible	40% after deductible
Urgent Care	$35 copay	40% after deductible
Emergency Room	$100 copay + 10% (copay waived if admitted)	$100 copay + 10% (copay waived if admitted)
Inpatient Hospitalization	10% after deductible	40% after deductible
Outpatient Surgery	10% after deductible	40% after deductible
	Prescription Drugs OPTUMRx	
Retail- 30 Day Supply Generic Preferred Brand Non-preferred Brand	$20 copay $40 copay $50 copay	$20 copay + cost of drug $40 copay + cost of drug $50 copay + cost of drug
Mail Order- 90 Day Supply Generic Preferred Brand Non-preferred Brand	$40 copay $80 copay $100 copay	$40 copay + cost of drug $80 copay + cost of drug $100 copay + cost of drug

Medical PPO Limited & Buy Down Plans

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Medical PPO Limited Plan		Medical PPO Buy Down Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Individual Family	$1,000 $3,000		$700 $2,100	
Annual Out-of-Pocket Maximum Individual Family	$4,000 $8,000	Not Covered Not Covered	$4,000 $8,000	$8,000 $16,000
Office Visit Primary Care Specialist	$35 copay $35 copay	Not Covered Not Covered	$35 copay $35 copay	50% after deductible 50% after deductible
Telemedicine Doctor On Demand	$20 copay	Not Covered	$20 copay	Not Covered
Preventive Services	No Charge	Not Covered	No Charge	50% after deductible
Chiropractic	20% after deductible	Not Covered	20% after deductible	50% after deductible
Lab and X-ray	20% after deductible	Not Covered	20% after deductible	50% after deductible
Urgent Care	$35 copay	Not Covered	$35 copay	50% after deductible
Emergency Room	$100 copay + 20% (copay waived if admitted)	$100 copay + 20% (copay waived if admitted)	$100 copay + 10% (copay waived if admitted)	$100 copay + 10% (copay waived if admitted)
Inpatient Hospitalization	20% after deductible	Not Covered	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	Not Covered	20% after deductible	50% after deductible
	Prescription Drugs OPTUMRx		Prescription Drugs OPTUMRx	
Retail- 30 Day Supply Generic Preferred Brand Non-preferred Brand	$20 copay $40 copay $50 copay	Not Covered Not Covered Not Covered	$20 copay $40 copay $50 copay	$20 copay + cost of drug $40 copay + cost of drug $50 copay + cost of drug
Mail Order- 90 Day Supply Generic Preferred Brand Non-preferred Brand	$40 copay $80 copay $100 copay	Not Covered Not Covered Not Covered	$40 copay $80 copay $100 copay	$40 copay + cost of drug $80 copay + cost of drug $100 copay + cost of drug

FIND A PROVIDER

FINDING A DOCTOR IS FAST AND EASY

With our Find a Doctor online tool, it's easy to look for doctors, hospitals, labs and other providers who are part of the Anthem Blue Cross network. Check if your favorite doctor is in the network or look for one near you.

Medical Anthem PPO Network

1. Go to www.anthem.com/ca
2. Click on **Find Care**
3. Click **Select a plan for basic search** button

Answer the questions in order from the dropdown menus:

4. **What type of care are you searching for?**
   - Medical Plan or Network
5. **What state do you want to search in?**
   (IMPORTANT: Must select California even if looking for out-of-state providers)
   - California
6. **What type of plan do you want to search with?**
   - Medical (Employer-Sponsored)
7. **Select a plan/network**
   - Prudent Buyer PPO/EPO

   (IMPORTANT: If CA is not selected above this option will not appear)
8. Click **Continue**

Fill out the search option:

9. Key in your **Zip Code** (outside of CA is ok)
10. Select the **Type of Provider** you are looking for (Physicians & Medical Professional, Urgent Care, etc.)

PRESCRIPTIONS DRUGS – OPTUMRX

Prescription Drugs

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Preferred Brand Name Drug
$$$	Non-Preferred Brand Name Drug

GOODRX

What is GoodRx? How can it help me save? GoodRx is a free price comparison resource that helps Americans save millions of dollars every month by finding them the lowest prescription prices at their local pharmacies. Visit goodrx.com to access coupons that can help you save up to 80% on almost all FDA-approved drugs—brand name and generic

OptumRx

Members have access to prescription drug coverage through OptumRx. optumrx.com is a fast, easy and secure way to get the information you need to make the most of your pharmacy benefit.

Website features and tools

Set up your online account at optumrx.com and:

- Compare medication prices at different pharmacies.
- Locate a network pharmacy.
- Manage medication for covered dependents and spouses.
- View real-time benefits and claims history.

If you use home delivery, you can:

- Transfer retail prescriptions to home delivery.
- Track orders.
- Refill home delivery prescriptions.

Understanding the formulary can save you money

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

What is a formulary?

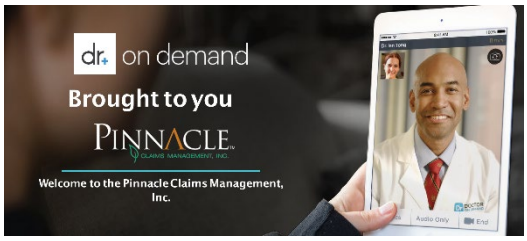
A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost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

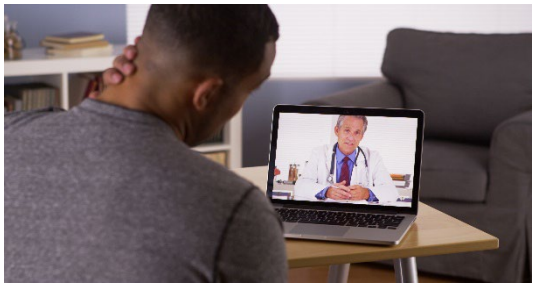
Get the most from your coverage

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

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

WHEN YOU NEED CARE NOW





GET THE CARE YOU NEED

Doctor On Demand doctors can treat many medical conditions, including:

- Urinary Tract Infection
- Skin Condition
- Rash
- Sinus Infection
- Ear Infection
- Cold
- Flu
- Headache
- Migraine
- Prescriptions & Refills
- Vomiting
- And more!

What is Doctor On Demand?

Doctor On Demand gives you the peace of mind of seeing a board-certified physician right away through your smart phone, tablet or any desktop computer with a front-facing camera. The U.S.- based doctors treat hundreds of issues using a live, secure video chat, including 18 of the top 20 reasons people visit urgent care and the Emergency Room. Mental health counseling is also available. Doctor on Demand doctors can send prescriptions to the pharmacy of your choice and can coordinate lab services as needed.

How do I get started?

Doctor On Demand is available from the App Store, Google Play, or online. Registration is easy.

Download the Doctor On Demand mobile app or visit the website at DoctorOnDemand.com. Follow the prompts to set up your account. You will not need to provide any payment information but you will need your health insurance ID card. When prompted to select your company, please select Pinnacle Claims Management. When prompted to enter your healthcare ID, enter your 9-digit HCID# beginning with the letter "W." You must also add the two-digit suffix to the end of the HCID, located on the back of the ID card above the member name field. Example: W0000123400.

When should you use Doctor On Demand?

Doctor On Demand does not replace your primary physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency
- When on vacation, a business trip or away from home

DoctorOnDemand.com | 800-997-6196

TREATMENT IN MEXICO

Need to Find a Provider?

See Human Resources for a listing of Mexico Panel Providers or contact Pinnacle Claims Management.

Pinnacle Claims Management

- mexicoprogram@pinnacletpa.com
- 928.627.3634

Procedures for Receiving Medical Treatment in Mexico

- Choose a provider from the participating provider listing. (Non-participating providers are not covered)
- Present your healthcare ID card along with a picture ID.
- The provider will verify the participant's coverage using Pinnacle's online tool.
- If you receive treatment before your eligibility is updated, you are required to pay for the services. The provider will reimburse you any monies collected, less the appropriate co-pay(s), once the provider verifies your eligibility. You have 30 days from the day of service to request a refund from the provider.

Medical Benefit

- $0.00 co-pay for Office Visits
- $0.00 co-pay per medication
- $5.00 co-pay per day for Lab and X-ray services
- $25.00 co-pay per Outpatient services
- $65.00 co-pay per Hospital Inpatient admission
- 15% co-pay on major surgical procedures

- Your physician is responsible for the management of all health care services including: laboratory, x-rays, pharmacy, surgery, hospitalization, and specialty care.

Prescription Drugs

- All medications must be dispensed only from a panel provider.
- Maximum of a 15-day supply per medication, except for maintenance medications.
- Over the counter medication is not covered.

Mandatory Generic Substitution

- The panel provider will prescribe and dispense the generic drug when medically appropriate. If you are prescribed a generic medication, but you request a brand name, you will be responsible for the full cost of the brand name medication.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Accounts

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

- www.goigoe.com
- Eligible Expenses – now include more over-the-counter items!
- 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 IGOE.

How the Healthcare FSA works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,050, the 2023 annual limit set by the IRS. 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 01/01/2023 and 12/31/2023 and claims must be submitted for reimbursement no later than 03/31/2024. If you don't spend all the money in your account, you can rollover up to $610 to use the following year. Any additional remaining balance will be forfeited.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

FSA TAX SAVINGS EXAMPLE

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

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

$120,000 Annual Pay, with $2,750 FSA Contribution

$660 24% Federal income tax	**$210** 7.65% FICA tax	**$870** Annual FSA tax savings

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

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

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

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

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

Here's how the IGOE Dependent Care FSA works

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

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

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

DENTAL

OUR PLANS

HIGH PPO PLAN

LOW PPO PLAN

DID YOU KNOW?

Keeping your teeth and gums healthy isn't the only reason you should practice preventive dental care. With good dental hygiene, you can greatly reduce your risk of getting cavities, gingivitis, periodontitis, and other dental problems.

You can also reduce your risk of secondary problems caused by poor oral health such as diabetes, heart disease, osteoporosis, respiratory disease and even cancer.

The City of El Centro offers 2 dental plans through Delta Dental.

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

Dental

You always pay the deductible and coinsurance. The coinsurance (%) shows what you pay after the deductible. The deductible is waived for Diagnostic & Preventive and Orthodontics.

	Delta Dental High PPO Plan		Delta Dental Low PPO Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	$25 individual $75 family		$50 individual $150 family	
Annual Plan Maximum	$1,500		$1,500	
Waiting Period	None	None	None	None
Diagnostic & Preventive	20% (deductible waived)	20% (deductible waived)	20% (deductible waived)	20% (deductible waived)
Basic Services Fillings Root Canals Periodontics	20% after deductible 20% after deductible 20% after deductible	20% after deductible 20% after deductible 20% after deductible	20% after deductible 20% after deductible 20% after deductible	20% after deductible 20% after deductible 20% after deductible
Major Services	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Orthodontia Adult & Children	50% (deductible waived)	50% (deductible waived)	50% (deductible waived)	50% (deductible waived)
Ortho Lifetime Max	$1,500	$1,500 (combined with in-network)	$1,500	$1,500 (combined with in-network)

Important information about the PPO dental plans

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

Am I restricted to in-network providers? No

Do I have to select a primary dentist? No

Can I use my FSA? If you participate in a healthcare FSA, you can use your account to pay for dental expenses.

Where can I get more details? Visit www.deltadentalins.com or call 800.765.6003

VISION

OUR PLAN

VSP PPO PLAN

Vision

Click to play video

The City of El Centro offers a vision plan through VSP.

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.

You'll even find discounts on services like laser vision correction, routine retinal screening and sunglasses. Visit VSP's website to learn more.

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.

	Vision Service Plan	
	In-Network	**Out-of-Network**
Exams Benefit Materials Frequency	 $10 copay Every 12 months	 $50 allowance In-network limitations apply
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 $10 copay $10 copay $10 copay Every 12 months	 $50 allowance $75 allowance $100 allowance In-network limitations apply
Frames Benefit Frequency	 $120 allowance Every 24 months	 $70 allowance In-network limitations apply
Contacts (Elective) Benefit Frequency	 $120 allowance (in lieu of lenses and frames) Every 12 months	 Up to $105 In-network limitations apply

What you need to know about this plan

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

What other services are covered? The plan can also help you save money on laser vision correction, sunglasses and more

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

Where can I get more details? Visit www.vsp.com or call 800.877.7195

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.

The City of El Centro provides short and long-term disability benefits and a base amount of life and AD&D (coverage type and amount varies by job title and/or classification) insurance to help you recover from financial loss.

If you need additional coverage

The City of El Centro offers voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

EMPLOYER - PROVIDED LIFE AND AD&D INSURANCE

A NOTE ABOUT TAXES

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

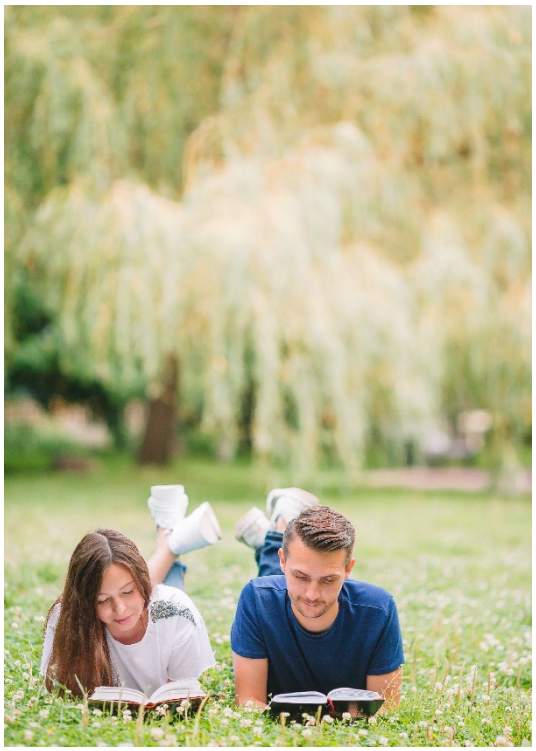
Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you were to pass away. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by The Hartford and premiums are paid in full by The City of El Centro.

The Hartford Basic Life and AD&D

Coverage type and amount varies by job title and/or classification. Contact Human Resources for confirmation of your benefit amount.

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 (EOI) with additional information about your health in order for the insurance company to approve the amount of coverage. Guaranteed issue amounts are available only during your initial eligibility period.

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 Hartford and available for you, your spouse and/or child(ren).

The Hartford Voluntary Life

Employee	Increments of $5,000 up to $300,000 not to exceed 5 times annual earnings Guaranteed Issue: $50,000
Spouse	Increments of $5,000 up to $300,000 not to exceed 50% of employee benefit Guaranteed Issue: $10,000
Child(ren)	Increments of $5,000 up to $10,000 Guaranteed Issue: $10,000

Note: Benefit amount reduces to by 50% at age 70.

In the event of a serious or fatal accident

Voluntary AD&D insurance coverage 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 Hartford and is available for you, your spouse and/or child(ren).

The Hartford Voluntary AD&D

Employee	Increments of $10,000 up to $250,000 not to exceed 10 times annual earnings
Spouse	50% of your coverage amount
Child(ren)	15% of your coverage amount
Spouse & Child(ren)	Spouse 40% of your coverage amount Child(ren) 10% of your coverage amount

Evidence of Insurability (EOI)

If you elect Voluntary Life coverage above guaranteed issue amount after the date you become eligible, you must complete and submit EOI.

SHORT-TERM DISABILITY INSURANCE (STD)

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

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

STD payments may be reduced if you receive other benefits from other income sources, such as paid time off. The City of El Centro pays the cost of this coverage. Coverage is provided by The Hartford.

Weekly Benefit Amount	Plan pays 60% of covered weekly earnings
Maximum Weekly Benefit	$1,100
Benefits Begin After Accident Sickness	 14 days of disability 14 days of disability
Maximum Payment Period	24 weeks

EXPECT THE UNEXPECTED

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

SUBMITTING A CLAIM

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

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, LTD benefits begin after short-term disability benefits end. Payments may be reduced by income from other benefits you might receive while disabled, like worker's compensation and Social Security. The City of El Centro pays the cost of this coverage. Coverage is provided by The Hartford.

The Hartford LTD Plan

Monthly benefit amount	Plan pays 60% of covered monthly earnings up to a maximum of $3,000
Benefits begin	After 180 days of disability
Maximum payment period*	Social Security normal retirement age

*The age at which the disability begins may affect the duration of the benefits. Refer to the certificate of insurance for the maximum duration of benefits.

OTHER PLANS & PROGRAMS

OUR OTHER PLANS & PROGRAMS

Aetna Employee Assistance Program (EAP)

Aflac Voluntary Plan

ARAG Voluntary Legal Program

Deferred Compensation Plan 457

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy. The City of El Centro offers an Employee Assistance Program to help you.

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of this program if you or your family are having trouble managing the ups and downs of your day-to-day lives.

You're unique—and so are your benefit needs

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

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And for most plans, you get the added convenience of paying through payroll deduction.

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Contact the EAP

Aetna Resources for Living

- www.resourcesforliving.com
- 800.342.8111
- User Name: El Centro
- Password: eap

Help for you and your household members

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

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

No cost EAP resources

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

EMOTIONAL WELL-BEING SUPPORT

- You can access up to 6 counseling sessions per issue each year. You can also call 24 hours a day for in-the-moment emotional well-being support. Counseling sessions are available face to face or online with televideo. Services are free and confidential. The EAP is available to help with a wide range of issues

DAILY LIFE ASSISTANCE

- Competing day-to-day needs can make it tough to know where to start. Call the EAP for personalized guidance. We'll help you find resources

ONLINE RESOURCES

- Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more
- Discount Center - Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more
- myStrength - myStrength offers tools to improve your emotional health and help you overcome depression, anxiety, stress, substance misuse and/or chronic pain

LEGAL SERVICES

- You can get a free 30-minute consultation with a participating attorney for each new legal topic

FINANCIAL SERVICVES

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

OTHER SERVICES

- Identity theft services — One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration
- MindCheck online tools make it easy to improve your emotional well-being

AFLAC VOLUNTARY PLANS

THINGS TO CONSIDER

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

Personal Cancer Indemnity

Pays cash benefits when a covered person is diagnosed with cancer. Pays benefits for hospital confinement, medical imaging, radiation and chemotherapy, immunotherapy, experimental treatment, reconstructive surgery and National Cancer Institute (NCI) evaluation/consultation. Most benefits have no lifetime maximum. In addition, this policy pays a $5,000 First Occurrence Benefit (which increases by $500 each year the policy is in force, until a claim is filed) when a covered person is first diagnosed as having internal cancer. Also includes a yearly Cancer Screening Wellness Benefit of $40 or $75, a $100 mammography benefit and a $30 Pap smear benefit.

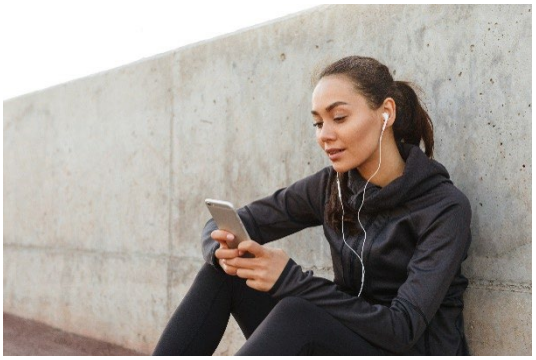
Hospital Intensive Care Protection

Pays a cash benefit when a covered person is confined in an Intensive Care Unit (ICU) - $700 or $800 per day for the first seven days and $1,200 or $1,300 per day for days 8—15. Includes a $350 per day benefit for confinement in a Sub-Acute ICU, as well as benefits for ground and air ambulance. An excellent policy to have if you are planning to have a baby, because family coverage can pay benefits to the mother as well as the baby.

Personal Accident Indemnity (Class B)

Pays a cash benefit when a covered person receives treatment for any kind of accident, on or off the job. Includes an Emergency Treatment benefit of $120 ($70 for children), an Initial Accident Hospitalization Benefit of $1,000 and benefits for ICU, ambulance, follow-up visits, physical therapy, diagnostic exams, rehabilitation, appliance, transportation and lodging. Also includes a yearly Wellness Benefit of $60 after one year of coverage, for getting an annual check-up (physical, immunizations, pap, mammogram) and Accidental Death and Dismemberment benefits of up to $150,000.

AFLAC VOLUNTARY PLANS



Specified Health Event Protection

Pays cash benefits for a covered person for coma, stroke, paralysis, heart attack, end-stage renal failure, major third degree burns, persistent vegetative state, coronary artery by-pass surgery and major human organ transplant. Includes coverage for hospital confinement, ambulance and a First Occurrence and Reoccurrence benefit. Continuing care treatments covered include dialysis, hospice care, extended care, physician visits, speech and physical therapy, home health and nursing home care, respiratory and occupational therapy, rehabilitation and dietary therapy/consultation. Also includes benefits for transportation, lodging and $150 for mammograms.

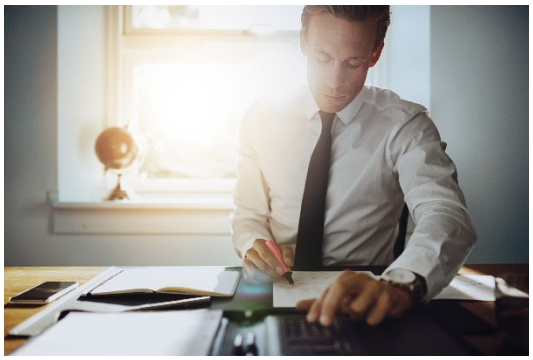
Critical Illness

Pays a cash benefit of up to $50,000 for the employee and up to $25,000 for the spouse, in the event of heart attack, stroke, end stage renal failure or organ transplant. Benefit of 25% for coronary artery bypass surgery. Children covered at no additional cost. Includes up to $200 per year for mammograms (frequency based on age) and $50 wellness benefit per year. Premiums depend on age and amount elected.

Personal Short Term Disability

Will your savings get you through a disability? City of El Centro employees do not pay into State Disability. This policy pays you a salary, should you become disabled—for off the job accidents and illnesses only. You choose the monthly amount, elimination (waiting) period and benefit period. Includes 6 or 8 weeks for maternity leave. Premiums are quoted individually and are based on annual salary, waiting period and benefit period.

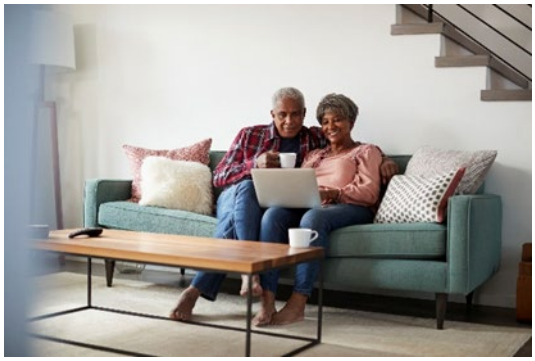
LEGAL PROGRAM



Legal Program

Do you have an attorney on retainer? Most people don't, so ARAG's voluntary group legal program offers you access to legal advice and even representation for an affordable monthly premium. Whether you need assistance reviewing a rental agreement, fighting a traffic ticket, creating a will, buying a house or navigating an IRS audit, legal coverage from ARAG offers reputable attorney assistance for you and your family.

DEFERRED COMPENSATION



Deferred Compensation Plan 457

Deferred Compensation 457 is a civil service retirement investment program deferring your income taxes up to 100% of your gross compensation or your annual dollar limit (whichever is less) until the funds from your investment are withdrawn, presumably when you are in a lower tax bracket. The program reduces your current taxes while simultaneously increasing your investments.

Maximum Salary Deferral	Up to $22,500 per year. If you're age 50, save an additional $7,500 per year. IRS limits are evaluated annually and may change.
Plan Availability	457 plans are available through Lincoln Financial Group, Nationwide and CalPERS.

IMPORTANT PLAN INFORMATION

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

- Your benefit contributions for the 2023 Plan Year.
- Contact information for our benefit carriers and vendors.
- A Benefits Glossary to help you understand important insurance terms.
- Health plan notices you are entitled to receive annually.

YOUR MONTHLY BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover. Your healthcare costs are deducted from your pay on a pre-tax basis.

	Core Plan	Buy Down Plan	Limited Plan
Monthly Premium			
Employee Only	$990.27	$920.30	$808.97
Employee + Spouse	$1,902.69	$1,811.70	$1,589.51
Employee + Children	$1,836.57	$1,753.97	$1,538.86
Employee + Family	$2,660.53	$2,471.25	$2,168.02
City's Contribution			
Employee Only	$754.56	$754.56	$754.56
Employee + Spouse	$1,271.61	$1,271.61	$1,271.61
Employee + Children	$1,231.09	$1,231.09	$1,231.09
Employee + Family	$1,734.42	$1,734.42	$1,734.42
Employee Cost Per Month			
Employee Only	$235.71	$165.74	$54.41
Employee + Spouse	$631.08	$540.09	$317.90
Employee + Children	$605.48	$522.88	$307.77
Employee + Family	$926.11	$736.83	$433.60
Employee Cost Per Pay Period			
Employee Only	$117.86	$82.87	$27.21
Employee + Spouse	$315.54	$270.05	$158.95
Employee + Children	$302.74	$261.44	$153.89
Employee + Family	$463.06	$368.42	$216.80

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website	Policy No.
Medical	Pinnacle Claims Management Anthem Network	800.649.9121	https://healthview.pinnacletpa.com/ www.anthem.com/ca	1144WA
Prescriptions	Optum Rx	866.632.8516	www.optumrx.com	BIN# 009117 PCN/Group# COEC
Telemedicine	Doctor On Demand	800.997.6196	www.DoctorOnDemand.com	Company: Pinnacle
Dental	Delta Dental	800.765.6003	www.deltadentalins.com	9683
Vision	Vision Service Plan	800.877.7195	www.vsp.com	12007340
Life, AD&D STD, LTD	The Hartford	800.523.2233	www.thehartfordatwork.com	876998
EAP	Aetna	800.342.8111	www.resourcesforliving.com	Username: El Centro Password: eap
Legal	ARAG	800.247.4184	www.ARAGLegalCenter.com	Access Code: 18160cec
FSA	IGOE	800.633.8818	www.goigoe.com	IGOECENTRO

GLOSSARY

-A-

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

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

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

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

-B-

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

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

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

-C-

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

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

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

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

-D-

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

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

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

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

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

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

-E-

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

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

-F-

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

-G-

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

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

-H-

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

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

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

GLOSSARY

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

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

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

-S-

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

-T-

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

-U-

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

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

-V-

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

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

IMPORTANT PLAN INFORMATION

Medicare Part D Notice

Important Notice 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 your employer 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. Your employer has determined that the prescription drug coverage offered 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 employer's group health plan coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under your employer's group health plan 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 employer's group health plan 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 your employer's group health plan 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 your Human Resources Department for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2023
Name of Entity/Sender:	City of El Centro
Contact-Position/Office:	Human Resources
Address:	1275 Main Street, El Centro, CA 92243
Phone Number:	760-337-4548

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. You can contact your health plan's member services department for more information.

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in your employer's group 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 your employer's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 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 your employer's group 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 rights, you may add the dependent to your current coverage or change to another health plan.

Michelle's Law

The medical plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, contact your medical plan as soon as the need for the leave is recognized by the Human Resources Department. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

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

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

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

View a sample notice and consent form (PDF).

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

CURRENT PLAN DOCUMENTS

Important documents for our health plan are available upon request. Contact your Human Resources Department.

Summary Plan Descriptions

A Summary Plan Description (SPD) is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries. The SPD(s) is/are available upon request. Contact your Human Resources Department.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The plan SBC(s) is/are available, contact your Human Resources department.

Statement of Material Modifications

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

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, 2022. 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: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program 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://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program 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
Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid | Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms 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: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
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: HHSHIPPProgram@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://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | 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, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

Notice of Certain Deadline Extensions and Summary of Material Modifications

This document provides notice of the potential expiration of the deadline relief that began on March 1, 2020 and an explanation of how that expiration will affect certain deadlines tolled under prior guidance applicable to ERISA plans. Specifically deadlines cannot be tolled for longer than one-year, so depending on the date an individual action would have been required, some deadline extensions will be expiring on February 28, 2021. Whether deadlines are tolled or resume will depend on the specific date you were required to take action or provide notice to the plan. This is a Summary of Material Modifications ("Summary") to the extent those extensions applied to ERISA benefits under the City of El Centro Benefits Plan ("the Plan"). You should read and retain this Summary. If you need another copy of the SPD or if you have any questions regarding these changes to the Plan, please contact your human resources department during normal business hours.

End of Relief Period Extending Certain Deadlines in Response to the COVID-19 Crisis will Depend on the Date an Individual Action Would Have been Required with some Deadlines resuming Feb. 28, 2021

Multi-Agency guidance extended certain deadlines that apply to group health plans that fall within the COVID-19 outbreak period (March 1 – 60 days after National Emergency Ends). Those deadlines included and were limited to the following:

- The 30-day period to request special enrollment under HIPAA (or 60-day period as applicable to CHIP enrollment requests);
  - employees, spouses, and new dependents are allowed to enroll upon marriage, birth, adoption, or placement for adoption;
  - employees and dependents are allowed to enroll if they had declined coverage due to other health coverage and then lose eligibility or lose all employer contributions towards active coverage;
  - employees and their dependents are allowed to enroll upon loss of coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs;
- The 60-day election period for COBRA continuation coverage;
- The deadline for making COBRA premium payments;
- The 60-day deadline for individuals to notify a plan of a COBRA qualifying event or determination of disability;
- The deadline for individuals to file an ERISA benefit claim under the plan's claims procedure (including a H-FSA run out period deadline that ends during the outbreak period); or
- The deadline for claimants to file an appeal of an adverse benefit determination, a request for an external review, and to file information related to a request for external review for an ERISA plan.

The period that these deadlines can be tolled is limited to one year. On Feb. 28, 2021, one year from March 1, 2020, some of the above timelines will no longer be tolled.

Individual timeframes listed above that are subject to deadline relief will have the applicable deadlines disregarded only until the earlier of: (a) 1 year from the date they were first eligible for relief, or (b) 60 days after the announced end of the National Emergency (the end of the Outbreak Period). On those individualized applicable dates, the timeframes for employees/participants with periods that were previously tolled will resume.

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 9.12% in 2023 of your modified adjusted household income.

COBRA Initial General Notice

Important Information about Your COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to selected insurance carrier.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. See the "Important Contact Information" page, of this booklet, for plan contact information.