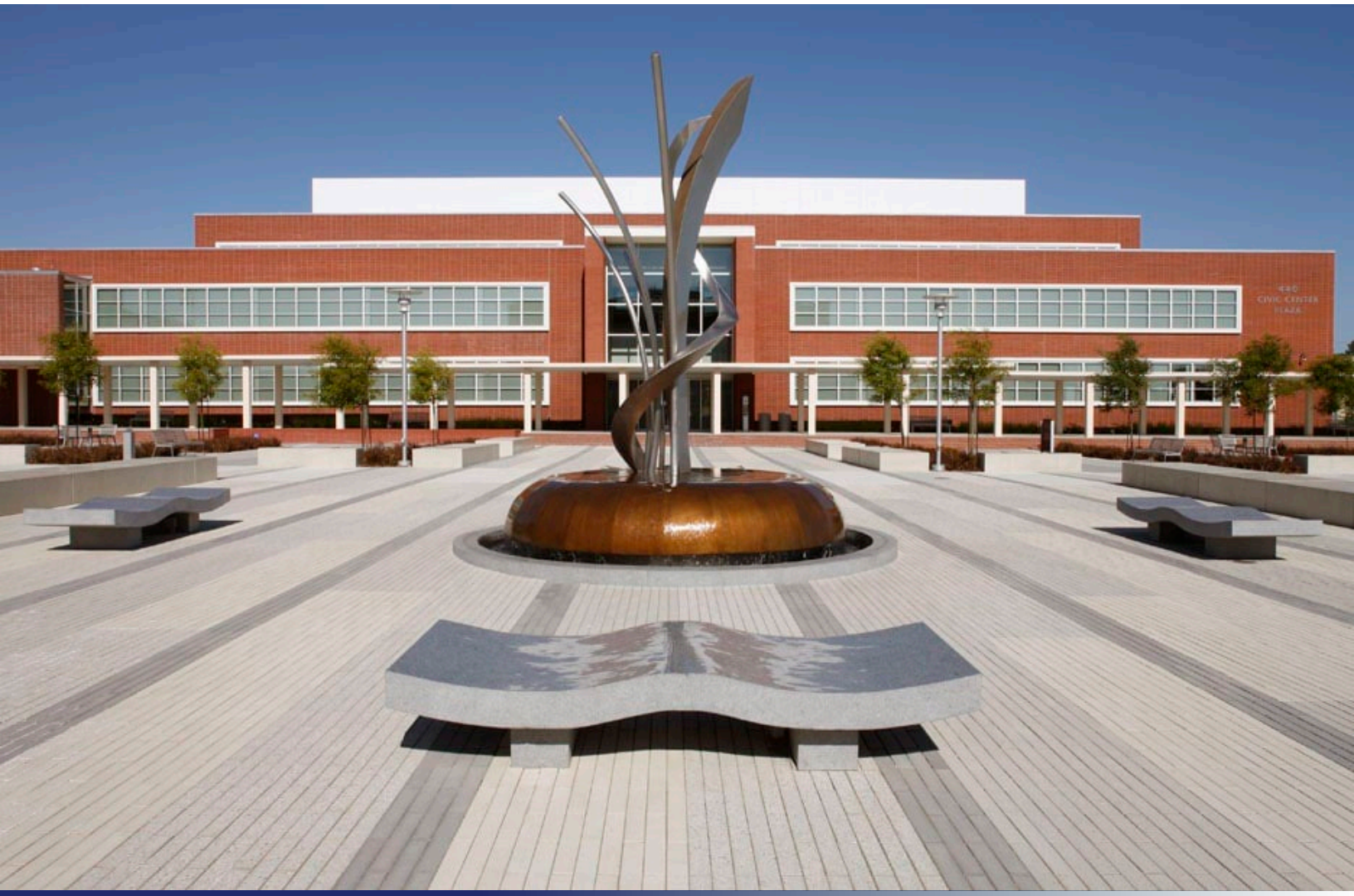
2026 BENEFITS OVERVIEW



CITY OF RICHMOND

CONTENTS

MEDICARE PART D NOTICE

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

GETTING STARTED

2026 BENEFITS

January 1, 2026
through
December 31, 2026

IMPORTANT NOTE:

This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, City of Richmond 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 insurance, AD&D, voluntary benefits and more.

You'll find tips to help you understand medical coverage, save time and money on healthcare, 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

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

Eligible dependents

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

For additional information, please refer to the 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 40 hours per week, temporary employees not on City of Richmond's 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 60 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).

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

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

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

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

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

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

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

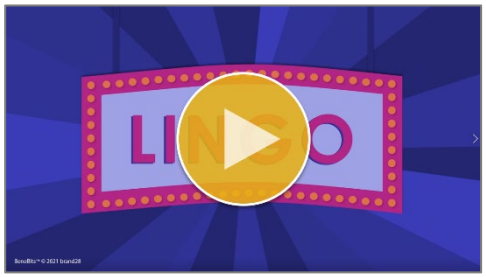
MEDICAL

OUR PLANS

CalPERS

All About Medical Plans

Play the Health Lingo Game!



We offer medical plans through CalPERS.

Which Plan Is Right For You?

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

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

KNOW WHERE TO GO

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

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$50**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$75**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$125**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$500 and up**

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
Surgery 	Ambulatory Surgery Center (ASC)	▪ Specializes in same-day surgeries ▪ Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more ▪ Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy 	Free-standing physical therapy center	▪ Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study 	Home testing	▪ Diagnoses sleep apnea and other conditions ▪ Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy 	Home or outpatient infusion therapy	▪ For drugs that must be delivered by intravenous injections, or epidurals ▪ Delivered by licensed infusion therapy provider ▪ Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay* **in-network*

How to find an alternative treatment facility

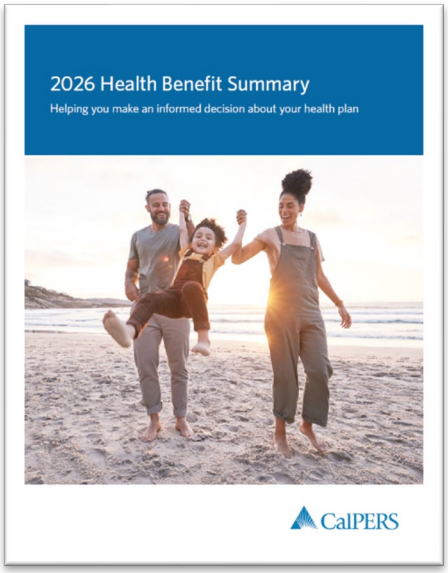
Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

CALPERS MEDICAL BENEFITS

It is City of Richmond'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. City of Richmond offers a choice of medical plans through CalPERS Medical.

For 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.



2026 HEALTH BENEFIT SUMMARY

Click the image above to view the 2026 CalPERS Health Benefit Summary.

Why would I choose an HMO plan?

- You don't want the extra responsibility of managing your own care.
- You do not want to pay the higher costs of a PPO.
- You do not want to get bills from providers.

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.

Explore your benefits with myCalPERS

Access your health information year-round and Open Enrollment updates by logging in to myCalPERS at my.calpers.ca.gov.

CALPERS DEPENDENT ELIGIBILITY VERIFICATION

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

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

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

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

On page 5, you will find a detailed list of Qualifying Life Events, which must be reported to the HR Department so we can make the appropriate change to your health coverage. All Qualifying Life Event changes must be made within **30** days/ **60** days (CalPERS) from the date of the event. Proper documentation is required, such as a copy of the marriage/domestic partnership certificate, birth/adoption certificate, or divorce/dissolution of domestic partnership decree.

For further clarification, please contact Human Resources at (510) 620-5471.

YOUR MONTHLY BENEFIT COSTS

Region 1 Premiums - View rates for Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

Note: Not all plans available in all Counties. To find CalPERS health Plans available in your area use: Health Plan Search by Zip Code.

Each plan's contact information and summaries and evidence of coverage documents can be found on page 16 of the Heath Benefit Summary.

CalPERS Health Plans	Single* Employee Contribution	2-Party* Employee Contribution	Family* Employee Contribution
Anthem Blue Cross Select HMO	$167.43	$334.86	$435.31
Anthem Blue Cross Traditional HMO	$443.22	$886.44	$1,152.37
Blue Shield Access+ HMO	$133.09	$266.18	$346.03
Blue Shield Access+ EPO	$133.09	$266.18	$346.03
Blue Shield Trio HMO	NO COST	NO COST	NO COST
Kaiser Permanente HMO	NO COST	NO COST	NO COST
Western Health Advantage HMO	NO COST	NO COST	NO COST
United Healthcare Signature Value Alliance HMO	$121.20	$242.40	$315.12
United Healthcare Signature Value Harmony HMO	NO COST	NO COST	NO COST
PERS Gold PPO	NO COST	NO COST	NO COST
PERS Platinum PPO	$501.28	$1,002.56	$1,303.32
PORAC PPO (only available for PORAC dues paying members)	NO COST	$80.28	NO COST

Employees covered under Fire (IAFF & RFMA) group will contribute an additional $125/month regardless of the medical plan they are enrolled in.
Employees covered under Management/Exec Management (IPFTE) group will contribute an additional $50/month regardless of the medical plan they are enrolled in.

Example: IAFF employee enrolls in PERS Platinum Single. Employee's monthly out-of-pocket cost is $626.28 ($501.28 + $125)

DENTAL

OUR PLAN

Delta Dental PPO

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.

We offer a dental plan through Delta Dental.

Why Sign Up For Dental Coverage?

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

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

Dental insurance covers four types of treatments:

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

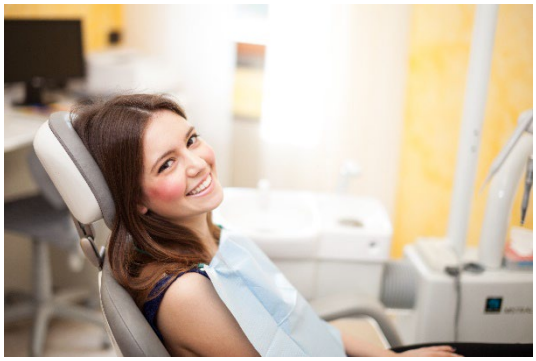
DELTA DENTAL PPO PLAN – ACTIVE EMPLOYEES

DELTA DENTAL PPO (CORE) PLAN		
	In-Network	**Premier/ Out-of-Network**
Annual Deductible (Ind./Fam.)	None	None
Annual Plan Maximum	$1,700	$1,500
Waiting Period	None	None
Diagnostic & Preventive Oral Exams Teeth Cleanings	100%	100%
Basic Services Fillings Root Canals Periodontics	90%	90%
Major Services Crowns	80%	80%
Orthodontia Adults Children (up to age 26)	50%; Lifetime Max $2,000	50%; Lifetime Max $2,000

What you need to know about this plan

Features:	Freedom to choose any provider, but generally higher out-of-pocket costs than other types of plans
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.

DELTA DENTAL RESOURCES



FINDING A DELTA PROVIDER

To find a Delta Dental provider near you, please visit deltadentalins.com and click "Find a Dentist". For PPO plans choose "Delta Dental PPO".

SmileWay® Wellness Benefits

If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings. Opt in by visiting www.deltadentalins.com/smileway or by calling Customer Service Monday through Friday.

Delta Dental Mobile App

Anyone can use Delta Dental Mobile without logging in to access our Find a Dentist and Toothbrush Timer tools, conveniently located on the home screen. You also have the option to save your ID card to the home screen for easy access without logging in. Log into the app to view your personal benefits.

Cost Estimator

Members can plan visits and compare costs before they receive their treatments. Estimates for each member are personalized based on benefits. Members can compare procedure costs at nearby dentists should members need to plan in terms of costs. Members can also receive a detailed explanation of their costs based on upcoming treatment.

QualSight & Amplifon Discounts

With access to QualSight and Amplifon Hearing Health Care, you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at 8550248-2020 and Amplifon at 888-779-1429.

LifePerks

As a Delta Dental member, you have access to a wide variety of local and national offers and discounts to help you care for your whole body and maintain a healthy life. Register and learn more about LifePerks at discountmember.lifecare.com.

VISION

OUR PLAN

VSP

We offer a vision plan through VSP.

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

VSP SIGNATURE PLAN

VSP VISION PLAN		
	In-Network	**Out-of-Network**
Exams Benefit Materials Frequency	No Charge Once every **12** months	$50 allowance
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	No Charge No Charge No Charge Once every **12** months	$50 allowance $75 allowance $100 allowance
Frames Benefit Frequency	**$130** plan plays (20% discount over allowed amount) Once every **24** months	$70 allowance
Contacts (Elective) Conventional Medically Necessary Frequency	Up to $130 No Charge Once every **12** months	Up to $105 (In lieu of eyeglasses) $210

What you need to know about this plan

Features: Freedom to choose any provider, but generally higher out-of-pocket costs than other types of plans

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

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.

ONLINE SHOPPING

If you would like to purchase your eyewear online, go to eyeconic.com and use your allowance to purchase contacts or frames.

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.

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 EyeCare

This program provides coverage of additional eyecare services specifically for members with diabetic eye disease, glaucoma or age-related macular degeneration (AMD). Eligible members can receive both routine and follow-up medical eyecare from their VSP doctor—the doctor who already knows their eyes best.

The program also provides supplemental coverage for non-surgical medical eye conditions such as diabetic retinopathy, abnormal blood vessel growth on the eye (rubeosis), and diabetic macular edema. Members can self-refer, visit their VSP Provider as often as needed, and pay only a copay for services.

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 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 long-term disability benefits and a base amount of life insurance to help you recover from financial loss.

Life Insurance

CITY-PAID LIFE INSURANCE

A NOTE ABOUT TAXES

Company-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

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

Life Benefits	Basic Life Amount	AD&D Amount
Class 1: General and Executive Management Members (Other than Fire Management) and Police Management	**2x Annual Earnings up to $250,000**	N/A
Class 2: Fire Management Members	**1.5x Annual Earnings up to $250,000**	N/A
Class 3: City Council Members	**$25,000**	N/A
Class 4: Sworn Police Personnel	**$50,000**	Same as Life
Class 5: Uniformed Fire Personnel	**$50,000**	N/A
Class 6: All Other Members	**$30,000**	N/A
Class 7: Retired Members	**Under Age 70: 2x Annual Earnings up to $250,000 Over Age 70: 50% of original coverage**	
Class 8: City Manager	**2x Annual Earnings up to $750,000**	

VOLUNTARY LIFE INSURANCE

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

GUARANTEED ISSUE

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

The Standard Voluntary Life	
Employee	Increments of $10,000 up to Lesser of 6x Covered Annual Earnings or $300,000 Guaranteed Issue: $150,000
Spouse	Increments of $10,000 up to $300,000, with $10,000 minimum Guaranteed Issue: $30,000
Child(ren) Birth to Age 26	Birth To Age 26: $2,000, $5,000, Or $10,000 Guaranteed Issue: $10,000
Note: Benefit amount reduces to 65% at age 70.	

Monthly Rates	Current	
Life Benefit (Rates per $1,000)	**Employee**	**Spouse**
Under age 20	$0.066	$0.061
Age 20-24	$0.066	$0.061
Age 25-29	$0.066	$0.061
Age 30-34	$0.080	$0.080
Age 35-39	$0.096	$0.090
Age 40-44	$0.146	$0.115
Age 45-49	$0.233	$0.175
Age 50-54	$0.383	$0.266
Age 55-59	$0.667	$0.443
Age 60-64	$0.667	$0.669
Age 65-69	$1.270	$1.270
Age 70-74	$2.060	$2.060
Age 75+	$7.633	$7.654
Dependent Child(ren) (Rates per $1,000)	$0.20	

CITY PAID LONG-TERM DISABILITY INSURANCE (LTD)

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.

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

Eligibility	Class 1: General, Executive, Fire, or Police Management	Class 2: General Employee (Local 1021)
Elimination Period	30 Days	30 Days
Monthly Benefit	60% of monthly earnings	60% of monthly earnings
Maximum Monthly Benefit	$5,000	$3,000
Minimum Monthly Benefit	$50	$50

Note: The age at which the disability begins may affect the duration of the benefit.

THE STANDARD VALUE-ADDED SERVICES

The Life Services Toolkit

Visit the Life Services Toolkit website at standard.com/mytoolkit and enter username “assurance” for information and tools to help you make important life decisions.

Estate Planning Assistance

Online tools walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and health care agent forms.

Financial Planning

Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.

Health and Wellness

Timely articles about nutrition, stress management and wellness help employees, and their families lead healthy lives.

Identity Theft Protection

Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.

Funeral Arrangements

Use the website to calculate funeral costs, find funeral-related services and make decisions and about funeral arrangements in advance.

Services for Your Beneficiary

Life insurance beneficiaries can access services for 12 months after the date of death. Recipients of an Accelerated Benefit can access services for 12 months after the date of payment.

The following supportive services can help your beneficiary cope after a loss:

- Grief Support
- Legal Services
- Financial Assistance
- Support Services
- Online Resources

For beneficiary services, visit www.standard.com/mytoolkit username = support) or call the assistance line at (800) 378-5742

FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

- Healthcare Flexible Spending Account (FSA)
- Dependent Care Flexible Spending Account (DC FSA)
- Transit Benefits

Is it time for a “financial wellness” checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

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

- www.padmin.com
- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

DO YOU PAY FOR DEPENDENT CARE?

Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

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 P&A Group.

How the Flexible Spending Account 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 $3,300, the 2025 annual limit set by the IRS. The amount may change for 2026 and will be announced by the IRS later in 2025. 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.
- Participants have until the end of March to submit expenses incurred during the plan year. Unused account balances will not rollover, and will be forfeited. Remember, only contribute money you are confident you will use to pay for qualified expenses during the plan year.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

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 (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by P&A Group.

Here's how the Dependent Care FSA works*

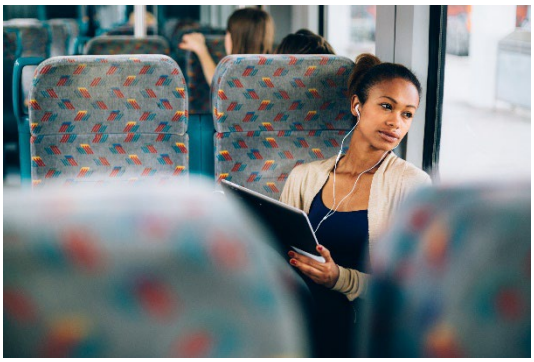
You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse 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 $3,250 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.

Note: Dependent care funds are not pre-loaded onto your card. The funds are accumulated through payroll contributions. i.e. You cannot use your debit card January 1st to pay for Dependent Care for the cost of that month.

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.

SAVE ON COMMUTE EXPENSES



Transportation Savings Account—up to $650 per month tax-free/ Parking Expense Account

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 P&A Group.

The account lets you set aside money—before it's taxed—through payroll deduction. Money in the account can be used in future months or plan years.

Parking Expense Account	Up to $325 per month (2025 limit per IRS)
Transportation Expense Account	Up to $325 per month (2025 limits per IRS)

Note: These amounts are evaluated annually by the IRS and are subject to change. You need to re-enroll in this program each year.

WELLBEING & BALANCE

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

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

A Happier, Healthier You

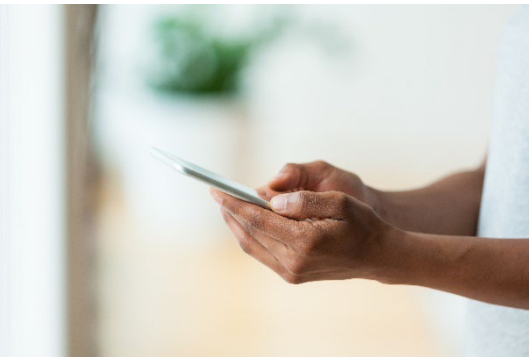
Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)



CONTACT THE EAP

Phone
(833) 954-1067

Website
AnthemEAP.com

Company Name
PRISM

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 **Anthem** can help you handle a wide variety of personal issue 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:

- General Employees: **5** Sessions per member per issue
- Sworn Fire & Police: **12** Sessions per member per issue
- Unlimited phone access 24/7
- In-person or video counseling for short-term issues
- Unlimited web access to helpful articles, resources, and self-assessment tools

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

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

Spot Pet Insurance

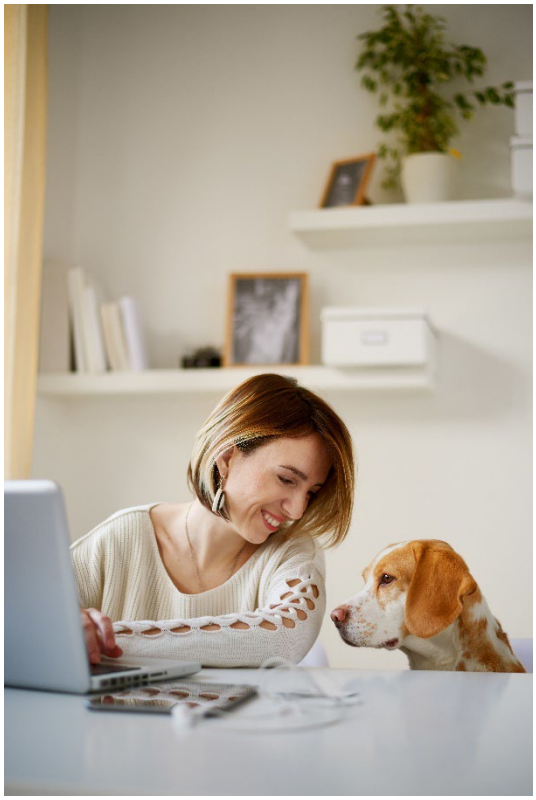
Deferred Compensation

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. 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.

PET INSURANCE



CONTACT INFORMATION

- Get a Quote at: petinsurance.com/affiliates/ciofrichmond
- Group Number: N2863
- Call: 877-738-7874

Note: Mention you are a City of Richmond employee or provide the group number to get preferred pricing

Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance through Nationwide prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications.

Vet Helpline

- 24/7 access to veterinary experts ($110 value)
- Available via phone, chat and email
- Unlimited help for everything from general pet questions to identifying urgent care need

PetRx Express

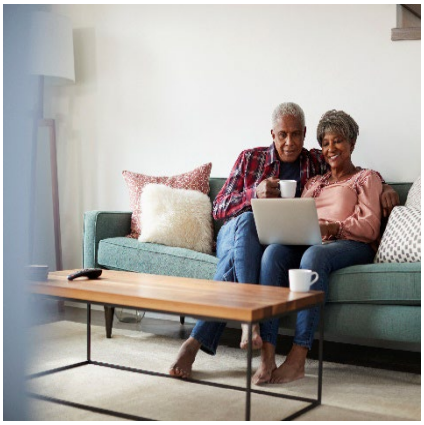
- Save time and money by filling pet prescriptions at participating in-store retail pharmacies across the United States
- Rx claims submitted directly to Nationwide
- More than 4,700 pharmacy locations
- Available via phone, chat and email

Deductible	$250
Maximum Annual Dollar Amount	$7,500 No Lifetime Max
Network	Visit any Vet, anywhere, anytime
Key Plan Details (Covered)	• Accidents • Illnesses • Cancer • Hereditary/ Congenital Conditions • Dental Diseases • Behavioral Treatments • Rx Therapeutic Diets and Supplements

DEFERRED COMPENSATION PLAN 457 B

Retirement/Pension

It's never too early to start saving for retirement, and the City of Richmond is here to help! To support your retirement planning efforts, City of Richmond employees can save and invest tax-advantaged dollars for retirement with voluntary salary deferrals by means of the City's 457(b) deferred compensation plan, or ROTH IRA.



Getting Started or Looking for Advice?

For detailed information on your deferred compensation or ROTH, contact your plan representative.

Nancy Garrity, CalPERS 457 Account Manager Nancy.Garrity@voya.com (888) 713-8244 ext. 2 Customer Service: (800) 260-0659 Schedule one-on-one at www.calpers457.checkappointments.com Employee site: www.calpers457.com	**Julie VanTilburg,** CFP® Financial Planner julie.VanTilburg@LFG.com (800) 359-8892 ext. 104 Customer Service: (800) 359-8892 x104 Employee site: LincolnFinancial.com/Retirement	**Eugene Huang,** Financial Consultant Eugene.huang@voyafa.com (925) 708-2359 Customer Service: (800) 262-3862 Employee site: www.voya.com
Maritza E. Rogers, *CFP®*, CRPC Financial Planner Maritza.Rogers@LFG.com (650) 377-4106 Employee site: LincolnFinancial.com/Retirement		**Jose Anaya,** Retirement Plan Advisor (707) 292-1448 Jose.anaya@empower.com Customer Service: (855) 756-4738 Employee site: www.empower.com/login-v1

IMPORTANT PLAN INFORMATION

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

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

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website
Medical	CalPERS	888-225-7377	www.calpers.ca.gov
Dental	Delta Dental	800-765-6003	www.deltadentalins.com
Vision	VSP	800-877-7195	www.vsp.com
Life AD&D and Disability	The Standard	800-628-8600	www.standard.com
FSA and TSA	P&A Group	800-688-2611	www.padmin.com
Employee Assistance Program (EAP)	Anthem	833-954-1067	www.AnthemEAP.com Company Code: PRISM
Pet Insurance	Nationwide	877-738-7874	www.petinsurance.com

GLOSSARY

-A-

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

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

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

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

-B-

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

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

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

-C-

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

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

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

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

-D-

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

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

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

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

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

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

-E-

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

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

-F-

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

-G-

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

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

-H-

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

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

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

GLOSSARY

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

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

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

-S-

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

-T-

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

-U-

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

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

-V-

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

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

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals

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

COBRA CONTINUATION COVERAGE

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

SUMMARY OF BENEFITS AND COVERAGE NOTICE

Choosing your health plan is an important decision. To assist you with this process, each health plan available through the California Public Employees' Retirement System has produced a Summary of Benefits and Coverage (SBC). In addition, the federal government has compiled a glossary of common health terms. Together, these documents provide important information to help you better understand our health benefit coverage and more easily compare health plan options. To access the SBCs and glossary online, visit **www.calpers.ca.gov** and select **View Health Plan Rates** to access the **Plans & Rates** page, or visit any of they health plan websites below. To request a free paper copy of the SBC and glossary, contact each health plan directly.

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 9.02% in 2025 (9.96 in 2026) of your modified adjusted household income.

Medicare Part D Notice

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Richmond 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 Richmond has determined that the prescription drug coverage offered by health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Richmond 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 Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	01/01/2026
Name of Entity/Sender:	City of Richmond
Contact-Position/Office:	Human Resources
Address:	450 Civic Center Plaza, Richmond, CA 94804
Phone Number:	(510) 620-6803

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns and Mothers' Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in City of Richmond's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in City of Richmond'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 City of Richmond's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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

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 | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) 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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 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: 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. 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

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 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: 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

Notes