2025 – 2026 BENEFITS

Your Health, Wellbeing & Financial Future

1700 WEST 162nd STREET / GARDENA, CALIFORNIA 90247-3732 / WWW.CITYOFGARDENA.ORG / PHONE (310) 217-9500

January 2025

Dear Gardena Employees, Retirees, and Dependents:

Welcome to a new year of Benefits! Included within is information for the 2025-2026 Plan Year. We hope you are able to take time to review the information, to best utilize the benefits the City has to offer.

The comprehensive list of coverage for eligible members includes: medical, dental, vision, life insurance, and an Employee Assistance Program (EAP). Also provided are voluntary plans such as legal services, and participation in the City's 457 retirement plan, as well as access to credit unions.

Benefit-eligible employees are offered two health plan options, PPO and HMO, both of which offer rich benefits to help address member health needs, as well as the needs of their families. Please review plan options carefully so you may choose the option that fits your needs. The City has been able to add enhanced vision benefits, while once again keeping family rates the same, for the seventh year in a row.

We hope you and your family members continue to enjoy our comprehensive benefits package.

Sincerely,

Clint Osorio

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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

2025 - 2026 BENEFITS
February 1, 2025 through
January 31, 2026

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, The City of Gardena 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, retirement benefits, and more.

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

OPEN ENROLLMENT HIGHLIGHTS

While we've made every effort to make sure that this guide is thorough, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your carrier plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid and will always prevail. Please contact your HR team for more information.

Open Enrollment

The City's Open Enrollment period is January 13 – 24, 2025. Changes made during this Open Enrollment will be effective February 1, 2025 – January 31, 2026.

Open Enrollment Highlights

- **Cost of Coverage for Full-Time Employees** is remaining the same for Medical, Dental and Vision plans!
- **Cost of Coverage for Part-Time Employees** is decreasing for the Kaiser HMO Plan and increasing for the City PPO plan.
- **Vision Plan Benefit Enhancements**
    - Enhancement to the frequency of Frames, from once every 24 months to once every 12 months
- **The Flexible Spending Account (FSA) annual plan limit** for reimbursement of health-related expenses is $3,300 for 2025. You must enroll each plan year to participate in the FSA Program.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

- Full-Time Employees
- Part-Time Employees who worked an average of thirty (30) or more hours per week over the past twelve (12) months
- Retirees eligible for Post-Retirement Health Insurance Coverage

Ineligible Employees and Retirees include, but are not limited to: temporary employees, transitional subsidized employment (TSE) workers, interns, volunteers, part-time employees who have not worked an average of thirty (30) or more hours per week over the past twelve (12) months and retirees not eligible for Post-Retirement Health Insurance Coverage.

Eligible dependents

- Legally married spouse (same or opposite sex)
- Registered Domestic Partner (same or opposite sex)
- Natural, adopted or step children up to age 26
- Children over age 26 who are disabled and depend on you for support

Ineligible Dependents include, but are not limited to: parents, grandparents, siblings, aunts/uncles, nieces/nephews and grandchildren.

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

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.

DEPENDENT VERIFICATION

Adding dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You may be required to provide proof of the relationship by submitting the following documentation:

- Marriage Certificate or License
- Domestic Partner Affidavit
- Birth Certificate
- Court documents showing legal responsibility for adopted children, foster children, or children under legal guardianship
- Final decree of divorce

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period that takes place in the month of January.

New hire coverage begins on the 1st of the month following sixty (60) days of employment. Enrollment elections remain in place during the entire plan year, unless a qualifying life event takes place.

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).

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 31 days of the event.

Note: Per IRS guidelines, the effective date is subject to the type of qualifying event. For example: Birth of a dependent, the effective date will be the date of birth. For marriage, the effective date will be 1st of the month following the event.

MEDICAL

OUR PLANS

Kaiser HMO Plan

City Self-Insured PPO Plan

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.

MEDICAL PLAN OVERVIEW

WORDS TO KNOW

DEDUCTIBLE: The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.

OUT-OF-POCKET MAXIMUM: Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.

COINSURANCE: After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.

COPAY: A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.

IN-NETWORK / OUT-OF-NETWORK: In-network services will always be the lowest cost option. Out-of-network services will cost more, or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

Kaiser HMO Plan

The Kaiser HMO Plan offers health benefits including medical and prescription coverage. When you enroll in the Kaiser HMO plan, you agree to use only Kaiser doctors and facilities for all your medical care. Kaiser covers most services at 100% with no deductible. Members who travel out of state to a region with Kaiser presence are covered for full services. Otherwise, members are covered for urgent and emergency care only. Kaiser regions include covered zip codes in Hawaii, Washington, Oregon, Colorado, Maryland, Georgia, Virginia and Washington D.C. Please note that retirees are not eligible to remain on the Kaiser HMO Plan if they permanently move outside of Southern California.

City Self-Insured PPO Plan

The PPO plan offers health benefits including medical, dental, vision, and prescription coverage. The PPO plan offers you access to a large network of physicians who agree to discount their fees for a service. Under this plan, you are not required to select a Primary Care Physician and can access different physicians and specialists under your own discretion. While you may go to any doctor or hospital each time you need care, your copay or coinsurance will be lowest when you go to an in-network PPO provider.

Premium Split Option (PSO)

Employees not participating in the Premium Split Option as of December 31, 2017, are not eligible for the Premium Split Option. This option is only available to full-time employees who are currently enrolled in the PSO. Under the Premium Split Option, an employee will be reimbursed $782.88 per month for waiving health insurance coverage. During each Open Enrollment, employees are required to re-enroll and submit proof of other health coverage in order to remain enrolled in the PSO. At anytime should an employee choose to opt out of the PSO and enroll in City health coverage, they will become permanently ineligible to enroll in the PSO.

Kaiser Permanente Senior Advantage Direct Bill

If you are ready to retire and are not eligible for Retiree Health Coverage under your bargaining group's Memorandum of Understanding (MOU), you can enroll in the City's Kaiser Senior Advantage plan. The benefit extends to City employees who are Medicare eligible. The employee must be age 65 and enroll in Medicare Parts A & B. The employee becomes responsible for the full premium cost and pays directly to Kaiser upon retiring. The retiree enjoys all the benefits under the City's Kaiser Plan. Contact Human Resources for more details.

Kaiser HMO Plan

You always pay the deductible and copayment. Employees enrolled in Kaiser will receive a member ID card that can also be used to fulfill prescriptions at a Kaiser pharmacy. When filling the prescription, a copay will be charged based on the type of prescription drug. For more information, visit www.kp.org/formulary.

	Kaiser HMO Plan
	In-Network
Calendar Year Deductible Individual Family Embedded/Aggregate[2]	 $0 $0 Embedded
Calendar Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[3]	 $1,500 $3,000 Embedded
Office Visit Primary Care Specialist	 $25 copay $25 copay
Preventive Services	No Charge
Chiropractic/Acupuncture	$10 copay per visit Combined up to 40 visits per year
Lab and X-ray	No Charge
Urgent Care	$25 copay per visit
Emergency Room	$100 copay per visit
Inpatient Hospitalization	No Charge
Outpatient Surgery	$25 copay per surgery
PRESCRIPTION DRUGS	
Calendar Year Deductible	$0 individual / $0 family
Out-of-Pocket Maximum	Combined with Medical
Retail Generic Drugs – 100-day supply Preferred/Non-preferred Brand – 100-day supply Specialty – 30-day supply	 $10 copay $30 copay $30 copay
Mail Order- 100 Day Supply Generic Drugs Preferred/Non-preferred Brand	 $10 copay $30 copay

[1]Out-of-pocket maximums accumulate on a calendar year from January 1 through December 31
[2] An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum. All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

City Self-Insured PPO Plan

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

	City Self-Insured PPO (Anthem Blue Cross administered by Pinnacle)	
	In-Network Benefits	**Out-of-Network Benefits**
Calendar Year Deductible[1] Individual Family Embedded/Aggregate[2]	 $500 $1,500 Embedded	 $2,000 $6,000 Embedded
Calendar Year Out-of-Pocket Max[1]	$2,500 per individual	Unlimited
Office Visit Primary Care – Pediatrician/OBGYN Primary Care – General Specialist	 $15 copay per visit (deductible waived) $25 copay per visit (deductible waived) $40 copay per visit (deductible waived)	 40% after deductible 40% after deductible 40% after deductible
Preventive Services	No Charge	40% after deductible
Chiropractic (20 visits/year) **Acupuncture (20 visits/year) –** limited to a max benefit of $30/visit	50% (deductible waived) 50% (deductible waived)	50% (deductible waived) 50% (deductible waived)
Lab and X-ray	20% after deductible	40% after deductible
Urgent Care	20% (deductible waived)	40% after deductible
Emergency Room	$100 copay then 100% (copay waived if admitted) (deductible waived)	
Inpatient Hospitalization	$250 copay then 20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
PRESCRIPTION DRUGS (OptumRx administered by RxBenefits)		
Out-of-Pocket Maximum Individual Family	 $4,100 $8,200	
Retail- 30-Day Supply Generic Drugs Preferred/Non-preferred Brand Specialty	 $15 copay $50 copay $50 copay	
Mail Order- 90-Day Supply Generic Drugs Preferred/Non-preferred Brand Specialty	 $30 copay $100 copay N/A	

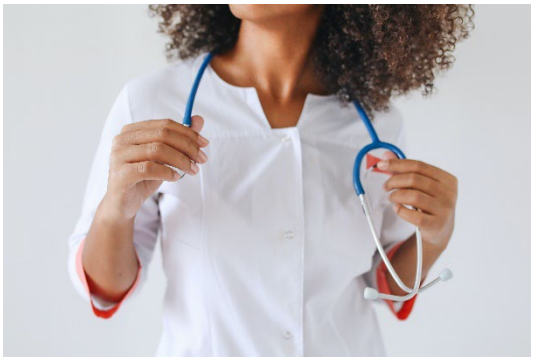
[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31

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

PRESCRIPTION DRUGS

Employees enrolled in the City Self-Insured PPO Plan will receive a medical card including prescription information. When filling the prescription, a copay will be charged based on the type of prescription drug. All retail pharmacy prescriptions will be filled by RxBenefits. If you take maintenance medications on a long-term basis, you will be allowed three (3) fills at a retail pharmacy. All subsequent fills of the medication should be processed by mail order through RxBenefits. For more information, visit www.RxBenefits.com. You can also email CustomerCare@rxbenefits.com or call (800) 334-8134. The OptumRx formulary may be found online at optumrx.com. You may also contact RxBenefits Member Services to learn whether a specific drug is covered.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

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

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

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

What is Preventive Care?

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

Visit **healthcare.gov/coverage/preventive-care-benefits/** for recommended guidelines.

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

Not all exams and tests are considered preventive

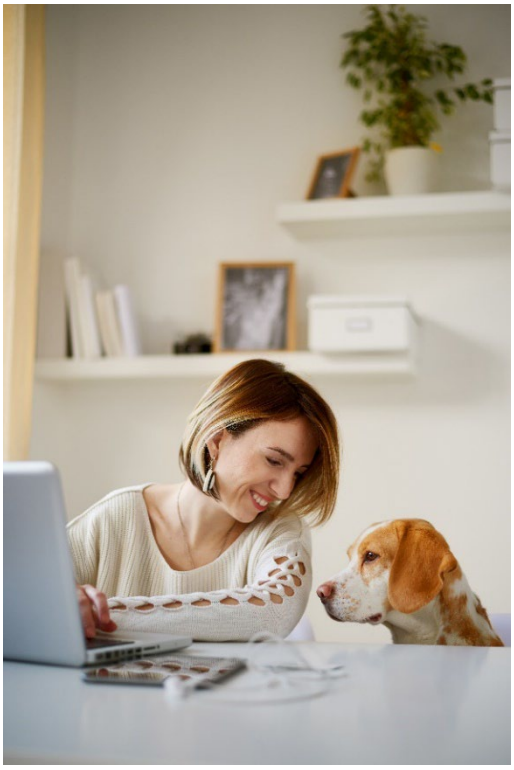
Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

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

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

PINNACLE – YOUR GUIDE TO BETTER HEALTH

PINNACLE™
CLAIMS MANAGEMENT, INC.



Contact Pinnacle

Phone Number:
(800) 649-9121; Available Monday-Friday 7:00am to 5:30pm PST

Email:
customerservice@pinnacletpa.com

Website:

healthview.pinnacletpa.com

Your Personal Online Portal – HealthView

You and your covered spouse and/or dependents are able to access your benefit information at anytime through HealthView

- Claims status and claims history
- Explanation of Benefits (EOBs)
- Review of plan documents and benefit information
- Provider Lookup
- View member profile
- Update contact information, family, or job change
- Order replacement ID cards
- Customer Service Access
    - Contact a Customer Service agent online with questions on eligibility, plan coverage or claim status. You will receive a response by the end of next business day.
- View your Flexible Spending Account

Logging in to HealthView

- Go to healthview.pinnacletpa.com to Log In or Register as New User
- Enter your Subscriber (Member/Health Care) ID Number located on your benefits ID card
- Enter your Suffix Number (the last two digits of your Subscriber ID number)
- Enter Password (New users click the Register Link to create a new account)

RIGHTWAY – YOUR CONCIERGE SERVICE

GAIN A 'DOCTOR IN THE FAMILY'

Rightway Health Guides are:

- A single point of entry into healthcare
- Dedicated to you
- Available through call or message
- Informed of your benefits plan
- Proven claims specialists
- A care team of certified doctors and nurses, benefit specialists, billing experts, and more!

Learn more:

Website: rightwayhealthcare.com

Phone Number: (833) 689-0308

Rightway navigates you to the highest-quality, most cost-effective care

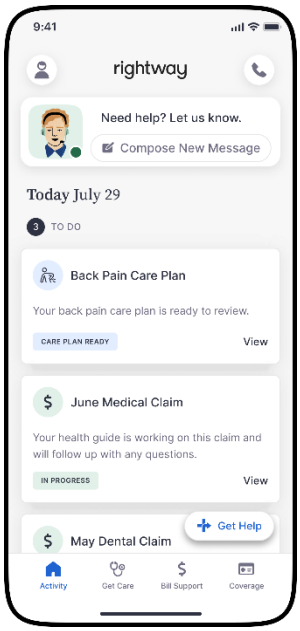
Pinnacle's concierge service is powered by Rightway Healthcare. Rightway will help to make sure you get the highest-quality and most complete care at the lowest cost. Rightway's health guides match you with the doctor you need, make an appointment for you, provide upfront pricing, and even dispute bills on your behalf.

What Rightway Health Guides do

Your Health Guide will provide:

- Concierge-level support
- Curated doctor recommendations
- Care plans and coordination
- Preventive care guidance
- Benefits information and tracking
- Bill explanations and resolutions
- Upfront pricing information
- Appointment scheduling
- Mayo Clinic educational resources

Learn more about Rightway in the video below! Scan the QR Code below to download the Rightway app!



Click to play video

ANDROID APP ON Google play

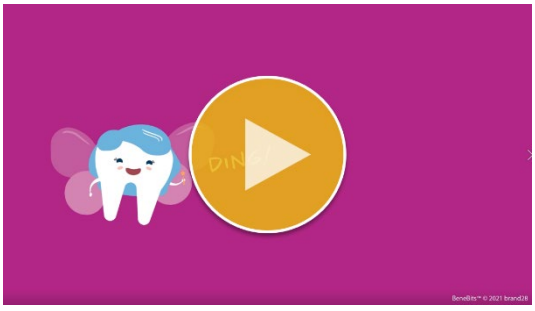
Available on the iPhone App Store

DENTAL

OUR PLANS

Dental PPO Plan

Click to play video



Why have 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. When you sign up for a City of Gardena medical plan, Kaiser or City Self-Insured PPO, you will receive dental coverage through the Dental PPO plan.

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 PPO Plan

The Dental PPO plan provides a multitude of dentists to choose from and you may change dentists at anytime. You may go to any dental provider who accepts Dental PPO insurance. Employees who enroll in the Kaiser HMO or the City Self-Insured plan will receive a separate dental ID card.

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

	Dental PPO (Pinnacle)
Calendar Year Deductible **Individual** **Family**	 $50 $150
Calendar Plan Maximum[1] Per Individual	 $3,000
Diagnostic & Preventive[2]	No Charge
Basic Services	20% coinsurance
Major Services[3]	50% coinsurance
Orthodontia	20% coinsurance No Age Limit
Ortho Lifetime Max	$4,000

[1] The Calendar Plan Maximum will be increased by $250 each year, up to a maximum of $3,500, for participants who utilize the preventive dental program of the two cleanings per year and incurred no additional costs to the plan.
[2] Deductible is waived for Diagnostic & Preventive services
[3] Dental implants are covered under Major Services

VISION

OUR PLANS

EyeMed Vision Plan

Click to play video

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.

When you sign up for a City of Gardena medical plan, Kaiser or City Self-Insured PPO, you will receive vision coverage.

EyeMed Discounts

EyeMed members will be offered enhanced benefits, discounts on LASIK and PRK and hearing aids when visiting an EyeMed provider.

- Save up to $1,000 on LASIK procedures at LasikPlus, TLC Laser Eye Center and The LASIK Vision Institute, receive 15% off standard LAIK prices or 5% off promotional LASIK prices at providers in the U.S. Laser network
- Find a LASIK provider at eyemedlasik.com or call (800) 988-4221

Vision Plan

Employees enrolled in the City Self-Insured PPO plan or Kaiser Medical HMO plan will receive vision services through EyeMed. When making appointments, simply inform the provider of your vision coverage and they will contact EyeMed to verify your eligibility.

Eye360 – Members who choose an EyeMed PLUS provider will be offered additional benefits such as a $0 copay eye exam and an additional $50 added to their frame allowance. A PLUS provider is an eye doctor within the EyeMed network who offers these enhanced benefits. To find an In-Network PLUS provider, visit EyeMed's Provider Locator and look for the PLUS provider icon.

	EyeMed (Pinnacle)	
	In-Network	**Out-of-Network**
Routine Exam Exam Exam at Plus Provider	 $10 copay $0 copay	 Plan pays up to $40 Plan pays up to $40
Frames Retail Retail at Plus Provider	 $150 allowance + 20% off balance over $150 $200 allowance + 20% off balance over $200	 Plan pays up to $105 Plan pays up to $105
Lenses	Single: No Copay Bifocal: No Copay Trifocal: No Copay	Single: up to $30 Bifocal: up to $50 Trifocal: up to $70
Contacts Conventional Medically Necessary	 $150 allowance + 15% off balance over $150 $0 copay	 Plan pays up to $105 Plan pays up to $300
Frequency		
Exam	12 months	
Frames	12 months *(enhancement effective 2/1/25)*	
Lenses	12 months	
Contact Lenses (Elective)	12 months	

LIFE AND AD&D

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 AD&D 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 a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

CITY-PROVIDED LIFE AND AD&D INSURANCE

WHAT'S GUARANTEED ISSUE?

If you select coverage above a certain limit (the "guaranteed issue") or after your initial eligibility, you will need to provide additional information about your health status in order to qualify for the requested amount of coverage.

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 and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is through Lincoln Financial and is paid in full by the City.

Basic Life and AD&D Class Eligibility

Class 1	All Active Full time City Managers working at least 30 hours per week
Class 2	All Elected Officials working at least 30 hours per week
Class 3	Management employees, Mid management, and Confidential employees working at least 30 hours per week
Class 4	All Other Active Non-Sworn Full-Time Employees working at least 30 hours per week

Basic Life and AD&D Benefit

Employee Life Benefit: Class 1	1.5 x Basic Annual Earnings up to $300,000
Employee Life Benefit: Class 2	$50,000
Employee Life Benefit: Class 3	1.5 x Basic Annual Earnings up to $300,000
Employee Life Benefit: Class 4	$20,000
AD&D Benefit: All Classes	Same as Life

The benefit amounts above will be reduced if you are age 70 or older. Refer to the plan document for details.

CITY-PROVIDED LIFE AND AD&D INSURANCE, CONT.

WHAT'S GUARANTEED ISSUE?

If you select coverage above a certain limit (the "guaranteed issue") or after your initial eligibility, you will need to provide additional information about your health status in order to qualify for the requested amount of coverage.

Additional Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is through OneAmerica and is paid in full by the City.

Basic Life and AD&D Class Eligibility

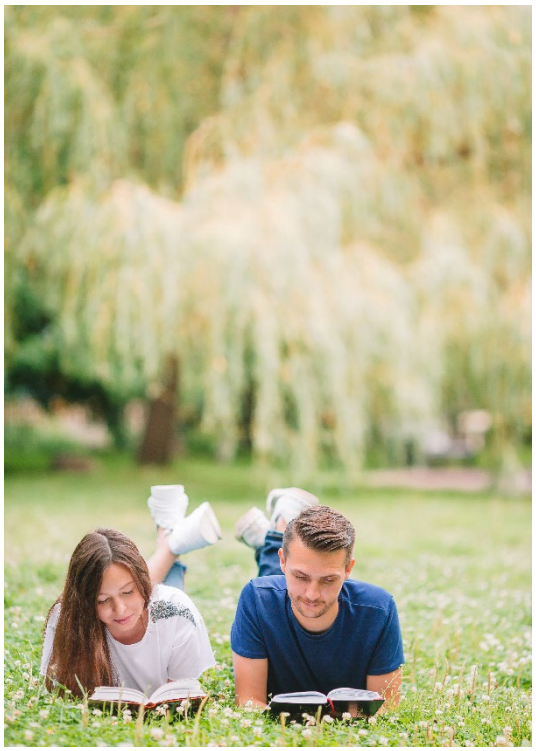
Class 1	All Eligible Full-Time Employees who are classifications under GMEA
Class 2	All Other Eligible Full-Time Employees

Basic Life and AD&D Benefit

Employee Life Benefit: Class 1	$20,000
Employee Life Benefit: Class 2	$10,000
AD&D Benefit: All Classes	Same as Life

The benefit amounts above will be reduced to 65% of original benefit if you are over age 65, 40% at age 70, and 25% at age 70. Refer to the plan document for details.

VOLUNTARY LIFE INSURANCE



GUARANTEED ISSUE

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

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. All Full-Time and Part-Time employees working at least 20 hours per week are eligible to have Voluntary Life coverage.

Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself. Coverage is through Lincoln Financial.

Voluntary Life

Employee	Increments of $10,000 up to Lesser of 5x covered annual earnings or $300,000. Guaranteed issue of $150,000.
Spouse	Increments of $5,000 up to Lesser of 50% of employee amount or $30,000. Guaranteed issue of $30,000.
Child(ren)	$5,000 (age 6 months to 26 years) $250 (age 1 day to 6 months)

The benefit amounts above will be reduced if you are age 70 or older. Refer to the plan document for details.

FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

- Health Care Flexible Spending Account (HC FSA)
- ScholarShare 529
- MissionSquare 457 Deferred Compensation Plan
- South Bay Credit Union
- Kinecta
- F&A Federal Credit Union

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.

We offer benefits and resources to help you make the most of your money now and in the future. You can increase your take-home pay by saving on taxes and and work toward your retirement goals.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Click to play video

QUALIFIED EXPENSE EXAMPLES

Below are a few examples of what you can use your Health Care FSA funds for:

- ✓ Acupuncture & Chiropractors
- ✓ Allergy medicine
- ✓ Bandages, for torn or injured skin
- ✓ Breast pumps
- ✓ Contact lenses
- ✓ Co-insurance / Co-payment amounts
- ✓ Deductibles
- ✓ Dental services and procedures
- ✓ Dentures
- ✓ Diabetic supplies
- ✓ Hearing aids
- ✓ Over-the-counter drugs
- ✓ Prescription drugs
- ✓ Vision services and procedures
- ✓ Wheelchairs

Visit www.irs.gov/publications/p502 for a full list of eligible healthcare expenses

QUESTIONS?

Pinnacle Claims Management, Inc.

Phone: (800) 649-9121
Website: healthview.pinnacletpa.com
Email: customerservice@pinnacletpa.com

Health Care FSA

This plan, administered by Pinnacle Claims Management, Inc., allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to **$3,300** this year. Minimum election amount is $100.

Important Considerations

- Expenses must be incurred between **2/1/25** and **4/15/26** (includes a 2.5 month grace period) and submitted for reimbursement no later than **4/15/26**.
- Annual deduction amounts are divided evenly among the remaining payrolls, twice per month.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- Unused amounts will be lost at the end of the grace period, so please plan carefully before making your election. The grace period allows employees to incur expenses through 4/15/26.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on The City's health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents. Questions about the tax status of your dependents should be addressed with your tax advisor.
- Keep your receipts in order to provide proof that your expenses were considered eligible for IRS purposes.

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

SMART EDUCATION BENEFITS

TAX-WISE BENEFITS

While 529 plan contributions are taxable, earnings and withdrawals are tax-free.

529 Education Savings Plan

Education is expensive, and many parents who save for a child's education don't have enough set aside at college time. A 529 plan can help you save for it. You can set aside money for qualified K–12 or college education costs and let it grow tax-deferred. ScholarShare will provide personalized guidance on selecting the best 529 plan for you, based on where you live and your investment preferences.

Benefits of Establishing a 529 Account

- **Affordable and convenient** – accounts can be opened quickly with as little as $25 and managed online or by mail
- **Return on contributions** grow tax-deferred
- **Withdrawals** are tax-free when used for qualified expenses
- **Flexibility** on funds to pay for tuition, required fees, books, supplies, room and board, and computers
- **Gifting** – anyone can contribute to the 529 account, so there are opportunities for others to give during birthdays, holidays, graduation, or other important occasions

To find out more information, visit www.scholarshare529.com or call (800) 544-5248.

GET TO KNOW YOUR 457 PLAN

MissionSquare RETIREMENT

ICMA-RC has changed its name to MissionSquare Retirement.

Deferred Compensation Plan

Your pension and Social Security may go far, but you will likely need more income for a truly comfortable future. That's where your 457 Deferred Compensation Plan comes in – see why it matters!

Easy to contribute – contributions are made through payroll deductions on a pre-tax basis that you select, up to the annual limits for contributions. Contribution amounts can be changed at any time.

2025 Limits	
Annual Deferral Limit for 457 Plans	$23,500
"Age 50" Catch-Up Limit	$7,500
"Pre-Retirement" Catch-Up Limit*	$23,500 ($47,000 total)

* Allows eligible participants to contribute an additional amount over the regular deferral limits in effect for the year (up to double) to make up for years in which they did not contribute the maximum amount they were eligible to contribute under their current employer's plan.

Loans – while still employed by the City, the plan allows you to borrow money from your account. The maximum loan amount is limited to half of your account balance or $50,000, whichever is less.

Wide Range of Investments – create your own mix of investments choosing from available options or consider a diversified target date fund. You can also get help with Guided Pathways® by visiting www.missionsq.org/guidedpathways.

Withdrawal Options – after separating from the City, you will be eligible to withdraw funds at anytime and will not be required to take withdrawals until after age 70 ½. The IRS implements a 10% penalty for early withdrawals.

ONLINE RESOURCES

- Manage your account on www.missionsq.org
- Tips and tools to help you save, invest, and retire on

MISSIONSQUARE'S MOBILE APP

- View your account balance, year-to-date account activity, retirement income projection and fund performance
- Change your fund selection and personal information
- Check out RealizeRetirement® financial education resource with variety of videos and tools to help you save for retirement

NEED HELP? Contact your local team, visit the plan's website: www.missionsq.org or call (800) 669-7400.

Marcus Marshall
Retirement Plan Specialist
(202) 759-7203
mmarshall@missionsq.org

HELPFUL INFORMATION ON CREDIT UNIONS

There are a handful of Credit Unions available to you. View this page to learn more about the resources and contact information for any questions.

Full Service

South Bay Credit Union offers your traditional savings and checking programs, auto loans, real estate loans, low-rate mortgages, VISA credit cards and more.

Website: www.southbaycu.com
Contact: Russell Cerpa, Manager of Strategic Alliances
Email: rcerpa@southbaycu.com
Office: (310) 374-3436
Mobile: (818) 800-9053
Fax: (424) 275-4391

Let's Connect

Kinecta is always here to provide more information and answer any questions. Kinecta offers a full range of banking and lending services with a handy mobile app and surcharge-free ATMs nationwide.

Website: www.kinecta.org
Email: Javier.Salazar@kinecta.com or David.villa@kinecta.org
Phone: (424) 392-2539

Protecting Your Future

F&A offers some of the best rates in the industry, mobile tech so you can make moves in a tap, education programs for your whole family, and ongoing fraud alerts to protect you.

Website: www.fafcu.org
Contact: Maria Betancourt, Membership Development Manager
Email: betancourtm@fafcu.org
Phone: (800) 222-1226 ext. 5235
Fax: (323) 980-8987

WELLBEING & BALANCE

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

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:

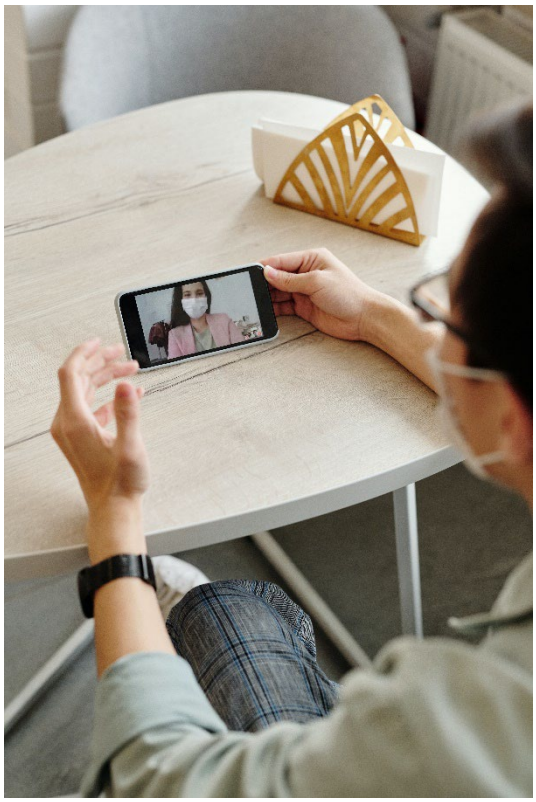
- Manage stress, chemical dependency, mental health and family issues
- Take care of personal business, such as family or financial stresses

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.

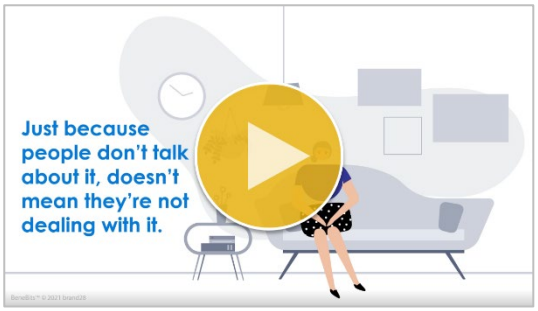
MENTAL HEALTH RESOURCES

These are challenging times, and we understand that you or people close to you may also be faced with additional work and family stresses. Feelings of isolation, depression or despair should never be taken lightly. This is a reminder that our medical plans include coverage for mental health care. And through our telemedicine provider, you can connect to a mental health provider within minutes, from any location, at any time.

	In-Network Mental Health Services	
	Outpatient	**Inpatient**
Kaiser Medical HMO Plan	$25 copay	No Charge
City Self-Insured PPO Plan	$25 copay	$250 copay then 20% after deductible



Click to play video



The EAP is here to help

If you're dealing with a little stress and anxiety or a lot; a relationship or substance abuse issue; financial worries; or the responsibility of caring for others; the Employee Assistance Program from can help. Learn more on the next page.

EMPLOYEE ASSISTANCE PROGRAM (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 REACH 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:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to six (6) consultations paid for by the City
- Unlimited web access to helpful articles, resources, and self-assessment tools.

CONTACT REACH

24/7 Crisis Line: (800) 273-5273

Website: www.reachline.com

Email: info@reachline.com

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional stress, anxiety, depression
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING

- Single and Step

FINANCIAL COACHING

- Money management and planning
- Credit

LEGAL CONSULTATION

- Family issues (marital, child custody, adoption)
- Personal Injury
- Will

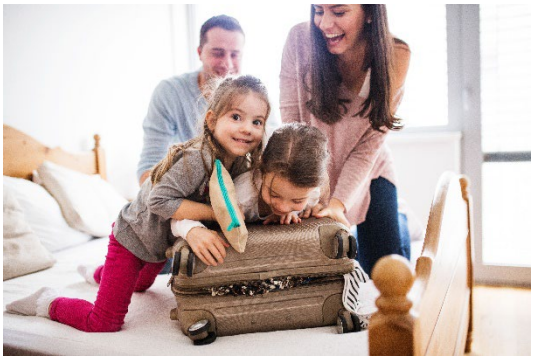
ELDERCARE RESOURCES

- Help with finding appropriate resources for retirement care support

ONLINE RESOURCES

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

LEGAL PLAN: PROTECT WHAT MATTERS MOST



Contact MetLaw

Contact (800) 821-4600 or www.members.legalplans.com

Hours of Operation: 8:00am – 8:00pm

Throughout our lives there may come a time when obtaining legal help is necessary. Whether getting married, buying or renting a home, starting a family or dealing with identity theft, having an experienced attorney provide legal advice makes dealing with life's key moments much easier.

Legal Insurance through MetLaw

Gives you extensive services and help with a wide variety of persona legal matters. For a monthly cost of $21 a month, MetLaw provides access to a network of accredited attorneys that are available to provide advice on personal legal matters or representation on legal services. In addition to you being covered, the plan extends coverage to your spouse and dependent children.

How the Plan Works

To find an attorney, visit www.members.legalplans.com or call (800) 821-6400 to speak with a service member that can match you with the right attorney and give you a case number.

Assistance Available

MetLaw attorneys can assist with various legal matters such as:

- Getting Married – Prenuptial Agreements, Name Change, Estate Planning
- Buying, Renting, or Selling a Home – Reviewing Contracts and Agreements, Preparing Deeds, Attending the Closing
- Starting a Family – Creating Wills, School and Administrative Hearings, Adoption
- Identity Theft – Access to Identity Theft Specialists, Proactive Identity Management, Access to Credit Monitoring
- Sending Kids to College – Security Deposit Assistance, Reviewing Leases, Student Loan Debt Assistance
- Caring for Aging Parents – Review of Medicare/Medicaid Documents, Nursing Home Agreements

IMPORTANT PLAN INFORMATION

Monthly Benefit Costs

Plan Contacts

Plan Documents

Annual Notices

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

- Your medical, dental and vision benefit contributions
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them

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, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

Full-Time Employees

Kaiser HMO	
EMPLOYEE ONLY	$0.00
EMPLOYEE + 1	$0.00
FAMILY	$494.00

City Self-Insured PPO	
EMPLOYEE ONLY	$0.00
EMPLOYEE + 1	$0.00
FAMILY	$494.00

Dental (included with Medical)	
EMPLOYEE ONLY	$0.00
EMPLOYEE + 1	$0.00
FAMILY	$0.00

Vision (Included with Medical)	
EMPLOYEE ONLY	$0.00
EMPLOYEE + 1	$0.00
FAMILY	$0.00

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify City of Gardena if your domestic partner is your tax dependent.

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, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

Part-Time Employees

Kaiser HMO	
EMPLOYEE ONLY	$743.12
EMPLOYEE + 1	$1,486.25
FAMILY	$2,103.04

City Self-Insured PPO	
EMPLOYEE ONLY	$125.00
EMPLOYEE + 1	$1,565.76
FAMILY	$2,465.42

Dental (included with Medical)	
EMPLOYEE ONLY	$0.00
EMPLOYEE + 1	$0.00
FAMILY	$0.00

Vision (Included with Medical)	
EMPLOYEE ONLY	$0.00
EMPLOYEE + 1	$0.00
FAMILY	$0.00

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify City of Gardena if your domestic partner is your tax dependent.

VOLUNTARY LIFE INSURANCE COSTS

If you elect voluntary coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck.

VOLUNTARY LIFE INSURANCE – MONTHLY RATE PER $1,000 OF COVERAGE

AGE	EMPLOYEE/SPOUSE RATE
<20	$0.068
20-24	$0.068
25-29	$0.068
30-34	$0.085
35-39	$0.105
40-44	$0.165
45-49	$0.285
50-54	$0.488
55-59	$0.848
60-64	$0.885
65-69	$1.568
70-74	$2.738
75+	$4.380

CALCULATE YOUR LIFE INSURANCE COST

1. Desired Coverage ($10,000 Increments for You, $5,000 Increments for Spouse)

You:	Spouse:

2. Divide Step 1 by 1,000 =

You:	Spouse:

3. Multiply Step 2 by Rate from Table =

You:	Spouse:

4. Multiply Step 4 by 12 and divide by 24 =

You:	Spouse:

5. Add You + Spouse from Step 4:

TOTAL COST PER PAYCHECK:

CHILD LIFE INSURANCE

COVERAGE AMOUNT	Rate per $5,000 of coverage
$5,000	$1.00

Premium includes all eligible children. Eligible children include dependent children under age 26 as long as you apply for and are approved for coverage for yourself.

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website/Email	Policy #
Medical HMO	Kaiser	(800) 464-4000	www.kp.org	114189
Medical PPO	Pinnacle	(800) 649-9121	healthview.pinnacletpa.com	
Dental PPO	Pinnacle	(800) 649-9121	healthview.pinnacletpa.com	
Vision	EyeMed (Administered by Pinnacle)	(800) 649-9121	healthview.pinnacletpa.com www.eyemed.com	
Pharmacy Benefits Manager	RxBenefits	(800) 334-8134	www.rxbenefits.com CustomerCare@rxbenefits.com	RxBin: 610011
Care Navigator	Rightway Healthcare	(833) 689-0308	rightwayhealthcare.com	
Life and AD&D	Lincoln Financial	(800) 487-1485	www.lfg.org	10260340
Life and AD&D	OneAmerica	(800) 553-5318	www.oneamerica.com	G00616598
Employee Assistance Program (EAP)	REACH	(800) 273-5273	www.reachline.com	
457 Deferred Compensation Plan	MissionSquare	(800) 669-7400	www.missionsq.org	301351
Flexible Spending Account (FSA)	Pinnacle	(800) 649-9121	healthview.pinnacletpa.com	
Legal Plan	MetLife Legal	(800) 821-4600	www.members.legalplans.com	5965158
City of Gardena Employee Benefits				
City of Gardena		(310) 217-9688	www.cityofgardena.org	
Jessica Anderson	Senior Human Resources Analyst	(310) 965-2337	janderson@cityofgardena.org	
Jasmine Bermudez	Human Resources Coordinator	(310) 217-9542	jbermudez@cityofgardena.org	
Nathalie Perez	Human Resources Technician	(310) 965-2327	nathalie.perez@cityofgardena.org	
Carolina Ruiz-Ugaitafa	Human Resources Coordinator	(310) 217-9688	cruiz@cityofgardena.org	
Diana Schnur	Human Resources Manager	(310) 217-9586	dschnur@cityofgardena.org	

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available on the City's Intranet G.W.E.N. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available on the City's Intranet G.W.E.N.

- Kaiser HMO Plan
- City Self-Insured PPO Plan

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the . 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.

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.

2025 ANNUAL NOTICES

AVAILABILITY OF PRIVACY PRACTICE NOTICE

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

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in City of Gardena'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 Gardena'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 31 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 31 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 31 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 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 Gardena's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 31 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.

THE 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 for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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.

AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by City of Gardena represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

City of Gardena offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by City of Gardena are available by visiting our internet website. You may also request a copy from Human Resources.

NOTICE OF CHOICE OF PROVIDERS

The Kaiser HMO plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carriers directly.

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

MEDICARE PART D

Important Creditable Coverage Notice from City of Gardena 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 Gardena 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 Gardena has determined that the prescription drug coverage offered by City of Gardena's 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.

MEDICARE PART D, CONTINUED

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 through 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 and drop your current City of Gardena prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Since the existing prescription drug coverage under City of Gardena 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 Gardena prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Gardena and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the office listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Gardena 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:

Date:	February 1, 2025
Name of Entity:	City of Gardena
Contact:	Pinnacle Claims Management, Inc.
Address:	1700 West 162nd Street, Gardena, CA 90247
Phone:	(800) 649-9121

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).

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, 2024**. 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, 2024, 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

Notice About Nondiscrimination And Accessibility Requirements And Nondiscrimination Statement: Discrimination Is Against The Law

City of Gardena complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. City of Gardena does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

City of Gardena:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact **Language Line**.

If you believe that City of Gardena has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Contact: Language Line
Phone: (866) 874-3972
Email: languageaccess@longbeach.gov (document translation and interpretation available for Spanish, Khmer & Tagalog)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **Language Line** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file.

Taglines For Individuals With Limited English Proficiency Of Language Assistance Services

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (866) 874-3972.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (866) 874-3972.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (866) 874-3972.

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (866) 874-3972 번으로 전화해 주십시오.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (866) 874-3972.

French Creole (Haitian Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (866) 874-3972.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните(866) 874-3972.

Taglines For Individuals With Limited English Proficiency Of Language Assistance Services

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (866) 874-3972. رقم هاتف الصم والبكم:

Persian (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (866) 874-3972 تماس بگیرید.

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(866) 874-3972 まで、お電話にてご連絡ください。

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (866) 874-3972.

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le(866) 874-3972.

Panjabi
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (866) 874-3972 'ਤੇ ਕਾਲ ਕਰੋ।

Mon-Khmer, Cambodian
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (866) 874-3972.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (866) 874-3972.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), is a United States federal statute signed into law by President Barack Obama on March 23, 2010. The ACA was introduced to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of health care for individuals and the government. It introduced mechanisms such as mandates, subsidies, employer and employee reporting requirements, and insurance exchanges. The regulations under the ACA continue to evolve, and we want to make sure you're in the loop and aware of how you and the City are affected by these regulations.

Currently, both health insurance providers and employers with 50 or more full-time employees have reporting requirements to ensure they are meeting health care coverage obligations. The information-reporting obligations are meant to provide the IRS with policy details for each person covered under our health plans.

The City is required to report information such as:

- Your length of full-time status
- Proof of the minimal essential coverage offered
- Your coverage dates and how much you pay for coverage
- Taxpayer identification numbers for you and your dependents
- The addresses we have on file for you and your enrolled dependents

In addition to reporting this information to the IRS, we must also share this information with you in order to help you meet your tax filing requirements. You will receive a form 1095-C along with your W-2 form for the 2021 tax year no later than January 31, 2022. Please retain this document for your records, and provide it to your tax consultant when you complete your tax filing for the 2020 tax year.


CITY OF GARDENA
FREEWAY CITY
INCORPORATED 1930