

2026 BENEFITS

FOCUS ON BENEFITS



CONTENTS



MEDICARE PART D NOTICE

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

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GETTING STARTED

2026 BENEFITS

January 1, 2026 – December 31, 2026

The information in this booklet is a general outline of the benefits offered under the City of Roseville benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

The City of Roseville takes pride in offering a benefits program that provides flexibility for the diverse and changing needs of our employees and their families. We are pleased to provide you with the 2026 Employee Benefits Overview for eligible employees of the City of Roseville. Please review this guide carefully and retain this guide for the calendar year 2026 as an easy reference to your benefit plan offerings.

The City of Roseville offers you and your eligible dependents the following benefits:

- Medical, Dental and Vision Insurance
- Basic/Supplemental Life / Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Short-Term Disability (STD) Insurance
- Long-Term Disability (LTD) Insurance
- Flexible Spending Accounts (Medical and Dependent Care)
- Employee Assistance Program (EAP)
- Deferred Compensation

WHO'S ELIGIBLE FOR BENEFITS?



If you are a regular or limited term employee working 20 hours or more per week, you may enroll in the benefits program on your first day of employment for benefits eligible coverage starting the first of the month following your date of hire.

Your dependents are eligible for coverage under your health and welfare benefits package as long as they meet the requirements specified for each plan. Eligible dependents include:

- Your current spouse or state-registered domestic partner.

Definition of domestic partner pursuant to Family Code Section 297-297.5:

A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State, and at the time of filing, all of the following requirements are met:

1. Both persons have a common residence.
 2. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
 3. Both persons are capable of consenting to the domestic partnership.
 - “Have a common residence” means that both domestic partners share the same residence.
- Your natural children, stepchildren, domestic partner’s children, adopted children of which the employee is the legal guardian. In addition, such children must be:
 1. Under age 26 (medical, dental and vision coverage).
 2. Under age 20, or age 25 if a full-time student (optional life insurance).
 3. Your disabled children age 26 (medical, dental and vision coverage) or 20/25 (supplemental life insurance) or older. Such disabled children must meet the same conditions as listed above and, in addition, are physically or mentally disabled on the date coverage would otherwise end because of age and continue to be disabled. For medical coverage only, the enrollment of a disabled dependent child over the age of 26 is subject to CalPERS approval.
 4. A child for whom you are required to provide benefits by a court order and who satisfies the same conditions as listed above.

This is a brief description of the eligibility requirements and is not intended to modify or supersede the requirements of the plan documents. The plan documents will govern in the event of any conflict between this description and the plan documents.

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.

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

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

For example, if your divorce or dissolution occurred in 2022, yet you did not report it until 2025, 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 7, you will find a detailed list of Qualifying Life Events, which must be reported to the HR Department so we can make the appropriate change to your health coverage. All Qualifying Life Event changes must be made within 60 days from the date of the event. Proper documentation is required, such as a copy of the marriage/domestic partnership certificate, birth/adoption certificate, or divorce/dissolution of domestic partnership decree.

For further clarification, please contact Human Resources at (916) 774-5475.

CHANGING YOUR BENEFITS



You may change your health plan at the following times:

IF YOU MOVE

You must change plans if you move out of your health plan's service area. Until you make the change, your previous health plan may limit coverage to emergency or urgent care only. When you move or change employment, you may submit your health plan change up to 60 days after the move. The effective date of the change will be the first of the month following the date your Health Benefits Officer receives your request.

WHEN YOU RETIRE

You may change health plans within 60 days of your retirement date. You may select any health plan available in your residential ZIP Code area. If you are a working retiree, you can use the ZIP Code of a current employer for eligibility purposes. The effective date of the change will be the first of the month following the date your Health Benefits Officer receives your request.

If you are a working retiree enrolled in a Medicare Advantage plan, you must use your residential address for eligibility. You cannot use your work address or a P.O. Box to enroll.

WHEN YOU QUALIFY FOR MEDICARE

As a retiree, when you first become eligible for Medicare, you must request a change from a CalPERS Basic health plan to a CalPERS Medicare health plan. You may also change health plans within 60 days from the effective date of your Medicare enrollment. The effective date of the change will be the first of the month following the date your Health Benefits Officer receives your request.

DURING THE CALPERS OPEN ENROLLMENT PERIOD

Open Enrollment is held each fall, and changes become effective the following January 1. Additionally, if you did not include eligible family members in your initial health plan enrollment or add them within the applicable 60-day eligibility period, you may enroll them during the Open Enrollment period. To make changes during Open Enrollment, active members should contact their Health Benefits Officer. Retirees should contact CalPERS.

QUALIFYING LIFE EVENTS

Click to play video



LIFE HAPPENS

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

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

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

Below are examples of eligible qualifying life events that allow you to make certain changes to your benefit:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, dissolution of domestic partnership, and death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status, including the start or termination of employment by you or your spouse.
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child.
- An event that is a qualifying life event under the Health Insurance Portability and Accountability Act (HIPAA), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
 - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation;
 - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage.

Please contact Human Resources should any of the above apply to you to determine what changes can be made to your current enrollment.



MEDICAL

MAKE TIME FOR HEALTH

OUR PLANS

CalPERS Medical

[Click here to view your CalPERS Evidence of Coverage/SBC's!](#)

or visit www.calpers.ca.gov and click Members > Health Benefits > Plans and Rates > “View all Health plan Summary of Coverage and Evidence of Coverage Documents”.

Explore Your Benefits with my|CalPERS
Access your health information year-round, including available health plans and Open Enrollment updates, by logging in to myCalPERS at <https://my.calpers.ca.gov>.

Health Maintenance Organization (HMO)

Under HMO plans, most services and medicines are covered with a small copay. Most HMOs require you to select a Primary Care Physician (PCP) to coordinate your care and require advance approval for some services, such as treatment by a specialist. Care must generally be obtained from in-network providers, or you may be required to pay out of pocket for the cost of services (except in the event of emergency or urgent care services). Not all HMO plans are available in all California counties.

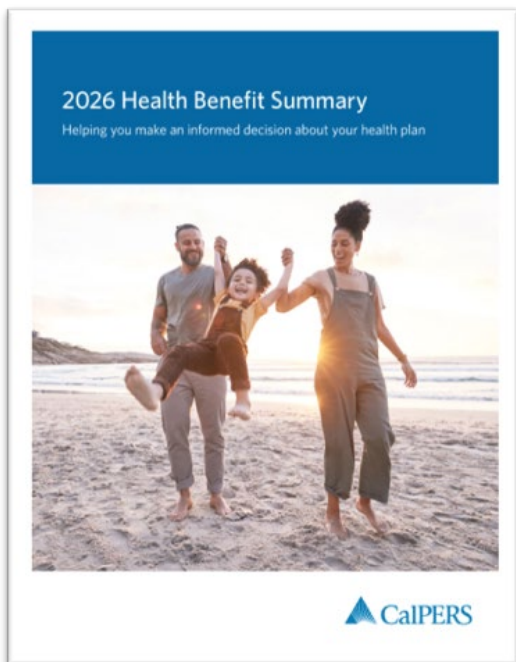
Preferred Provider Organization (PPO)

PPO plans are designed to provide choice, flexibility and value. A PPO plan is a managed care organization of medical doctors, hospitals, and health care providers who have contracted with your insurer to provide health care at reduced rates to you. Members have a choice of using network providers or going directly to any physician (non-network provider) without a referral. For most services, there is an annual deductible to meet before benefits apply. You are also responsible for a certain percentage of the charges (coinsurance), and the plan pays the balance up to the agreed upon amount. Non-network providers are typically covered at a lower benefit level requiring you to pay a higher percentage of the bill.

CALPERS MEDICAL BENEFITS

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

For a summary of the different plans, and additional information please review the [CalPERS Open Enrollment site](#). On this site you will find the Health Benefits Summary, Health Program Guide, and additional resources and information regarding your CalPERS Health Plan options.



CalPERS HEALTH BENEFIT SUMMARY

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

Why Would I Choose A PPO Plan?

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

Why Would I Choose An HMO Plan?

- You 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.

Explore Your Benefits With MyCalPERS

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

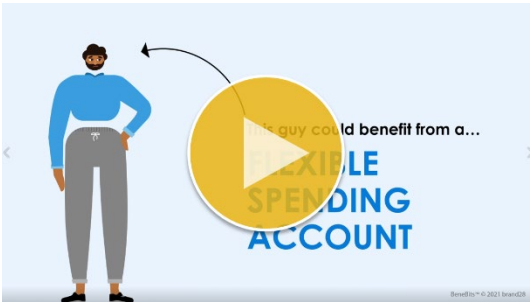
To find CalPERS health plans available in your area, search by zip code at calpers.ca.gov.

What's Changing In 2026?

- CalPERS is changing their Pharmacy from Optum to Caremark CVS. Please visit calpers.ca.gov for more information.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video



ARE YOU ELIGIBLE?

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

Find out more

- [BCC My SmartCare Website](#)
- [Eligible Expenses](#) – now include more over-the-counter items!
- [Ineligible Expenses](#)

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through Benefit Coordinators Corporation (BCC).

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 \$3,400, the 2026* annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 1/1/2026 and 3/15/2027 and claims must be submitted for reimbursement no later than 3/31/2027. If you don't spend all the money in your account by 3/15/2027, you forfeit the leftover balance.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

**IRS limits subject to change*

FSA TAX SAVINGS EXAMPLE

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

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

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

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

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

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)



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 Benefit Coordinators Corporation (BCC).

Here's how the Dependent Care Flexible Spending Account works

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

You can set aside up to \$7,500 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to \$3,750 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Expenses must be incurred between 1/1/2026 and 3/15/2027 and claims must be submitted for reimbursement no later than 03/31/2027. If you don't spend all the money in your account by 3/15/2027, you forfeit the leftover balance.

Please note: You must re-enroll in this program each year.



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.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA) - BCC RESOURCES



BCC MySmartCare MOBILE APP

Download SmartCare from the app store to:

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

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

NEED HELP?

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

Set up and manage your account online

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

Features of My SmartCare:

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

How to set up your online account:

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

Your FSA Debit Card

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

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

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

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

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

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



DENTAL

OUR PLANS

DELTA DENTAL PPO LOW PLAN

DELTA DENTAL PPO HIGH PLAN

Under the Delta Dental Preferred Provider Organization (PPO) plan, dental services are provided through the Delta Dental PPO network. However, you can choose to visit any dentist in any location inside or outside of the Delta Dental network. How much you pay for dental services depends on whether you choose a participating Delta Dental dentist. If you choose a non-participating dentist, you pay the difference between the amount the dentist receives from Delta Dental (the “allowable amount”) and the dentist’s charges.

We offer two Dental plans through Delta Dental.

Why Sign Up For Dental Coverage?

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

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

Dental insurance covers four types of treatments:

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

DELTA DENTAL – LOW PLAN & HIGH PLAN

DENTAL*	Low Plan		High Plan	
	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Calendar Year Maximum	\$1,500	\$1,000	\$2,000	\$1,500
Calendar Year Deductible Individual / Family	\$25 / \$75	\$50 / \$150	\$0 / \$0	\$25 / \$75
Diagnostic and Preventive¹ Oral Examinations X-Rays Teeth Cleaning Fluoride Treatment Space Maintainers Bitewings Sealants	100%	80%	100%	100%
Basic Services Amalgam/Composite Filings Periodontics (Gum disease) Endodontics (Root Canal) Extractions & Other Simple Oral Surgery	80%	60%	90%	80%
Major Services Crown Repair Restorative - Inlays and Crowns Prosthodontics	50%	50%	80%	70%
Implant Benefits	70% to \$1,500 Lifetime		70% to \$1,500 Lifetime	
Temporomandibular Joint (TMJ) Benefits	70% up to \$500 Lifetime		70% up to \$500 Lifetime	
Orthodontia Adults and Children up to age 26	50% up to \$1,500 Lifetime		50% up to \$3,000 Lifetime	

*Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.

** Non-Delta Dentists are reimbursed at the lesser of the submitted charge or the fee that satisfies the majority of dentists in the same geographical area with the same training (51st percentile of Usual, Customary and Reasonable)

¹Diagnostic and Preventive—2X per year

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description.

DELTACARE USA – DENTAL DHMO

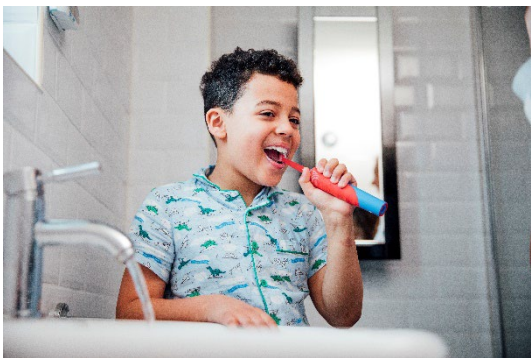
Under the DeltaCare USA plan, dental services are provided through the DeltaCare USA network. When you enroll, you select a contract dentist to provide services. The DeltaCare USA network consists of private practice dental facilities that have been carefully screened for quality.

There are no deductibles, and no annual or lifetime dollar maximums. Out-of-pocket costs are clearly defined, and out-of-area dental emergency coverage is up to \$100 per emergency.

DENTAL*	Enrollee Pays
Diagnostic and Preventive Oral Evaluation	No Cost
Prophylaxis Cleaning—Adult	No Cost
Additional Prophylaxis Cleaning—Adult	\$45
Restorative Amalgam Filing (1-4 Surfaces)	No Cost
Resin Based Composite Filling—Anterior (1-4 Surfaces)	No Cost
Resin Based Composite Filling—Posterior (1-4 Surfaces)	Up to \$85
Periodontics Gingivectomy—four or more contiguous teeth per quadrant	\$130
Osseous Surgery—four or more contiguous teeth per quadrant	\$280
Endodontics Pulp Cap—Direct (excluding final restoration)	No Cost
Root Canal Therapy Anterior (excluding final restoration)	\$55
Root Canal Therapy Bicuspid (excluding final restoration)	\$120
Prosthodontics Immediate Denture Maxillary/ Mandibular	\$165
Complete Denture Maxillary/ Mandibular	\$145
Crown and Bridge Crown—Porcelain/Ceramic Substrate	\$240
Crown—Porcelain Fused to High Noble Metal	\$240
Oral Surgery Extractions—Impacted tooth: Soft tissue	\$50
Extractions—Impacted tooth: Partial bony	\$70

*Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions. See the “Description of Benefits and Copayments” for a full list of your benefits.

DELTA DENTAL RESOURCES



FINDING A DELTA PROVIDER

To find a Delta Dental provider near you, please visit [deltadentalins.com](https://www.deltadentalins.com) and click “Find a Dentist.” For PPO plans choose “Delta Dental PPO” and for HMO plans choose “DeltaCare USA.”

SPECIAL OFFERS WITH 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.

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.

Virtual Dentistry

When you can't make it to the dentist's office or have an urgent questions outside of regular hours, you can still get expert dental advice, virtually. Virtual dentistry offers members convenient access to a Delta Dental dentist for answers to questions, quick checkups, second opinions, or other oral health needs in between visits to the dentist's office. Virtual assessments don't count towards exam frequency limitations and are a covered benefit for PPO members. Choose from photo assessments with a 24-hour turnaround for simple dental concerns, or live video visits for immediate care. Visit www1.deltadentalins.com/members/virtual-dentistry.html for more information.

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.

Amplifon & Qalsight Discounts

With the Amplifon discount, Delta Dental members get an average savings of 62% off the latest retail hearing aid price. PPO members may even be able to use their plan benefits in coordination with Amplifon discounts. There is also a QualSight discount for Delta Dental members. Members receive 40-50% off the national average price of traditional LASIK eye surgery when you use an experienced QualSight LASIK surgeon.



VISION

OUR PLANS

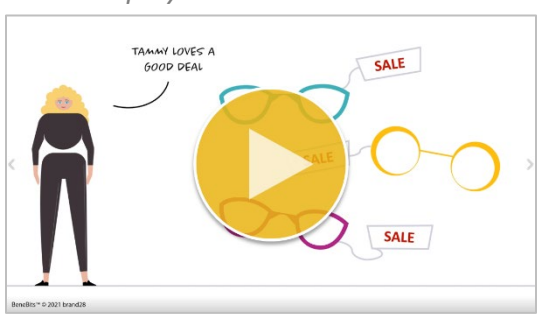
VSP Choice Plan

We offer one vision plan through Vision Service Plan (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



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

VISION

You are eligible for vision coverage through VSP Vision. VSP provides coverage for eye exams and materials, such as lenses and frames. VSP now covers standard progressive lenses in full.

VISION	VSP Choice Network	Non-Network
Exam	\$10 copay	Plan pays up to \$45
Single Lenses	Covered in Full	Plan pays up to \$30
Bifocal Lenses	Covered in Full	Plan pays up to \$50
Trifocal Lenses	Covered in Full	Plan pays up to \$65
Contact Lenses Fitting and Evaluation	Covered in Full*	N/A
Contact Lenses**		
Elective	Plan pays up to \$150	Plan pays up to \$105
Medically Necessary	Covered in Full***	Plan pays up to \$210
Frames	\$150 Allowance	Plan pays up to \$70
Benefit Frequency		
Exam		Every 12 Months
Lenses and Contacts**		Every 12 Months
Frames		Every 24 Months

*Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum \$60.00 copayment

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

***Subject to Copayment

You may receive benefits when using non-VSP providers by submitting your claims directly to VSP. Reimbursements will be made as indicated in the out-of-network schedule above. Find a VSP network doctor at www.vsp.com or call (800) 877-7195.

VSP SAVINGS AND RESOURCES



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

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

Extra Savings on Glasses and Sunglasses

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

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

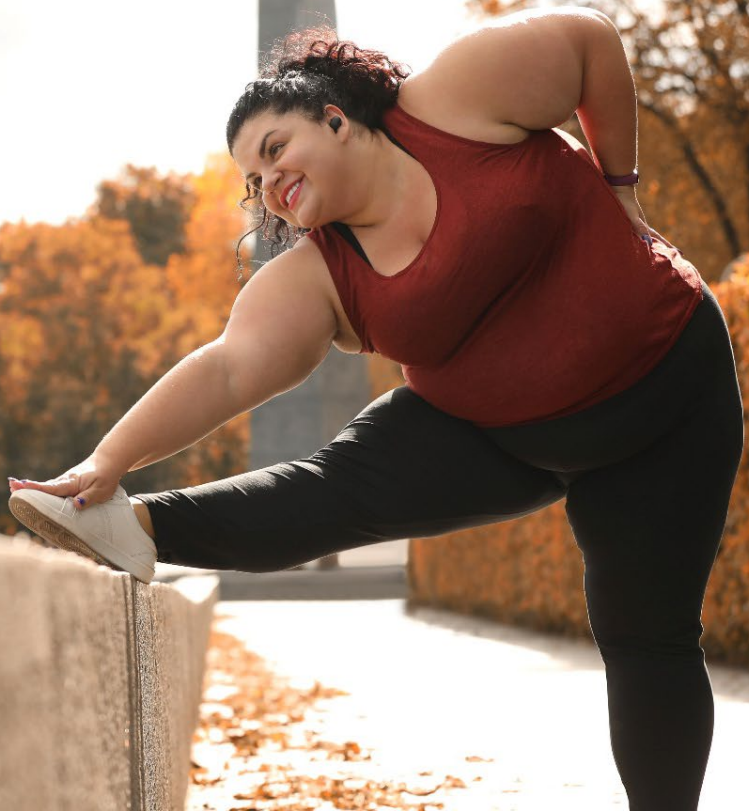
Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call (877)396-7194.

VSP Diabetic Eyecare Plus Program

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.

ENGAGE

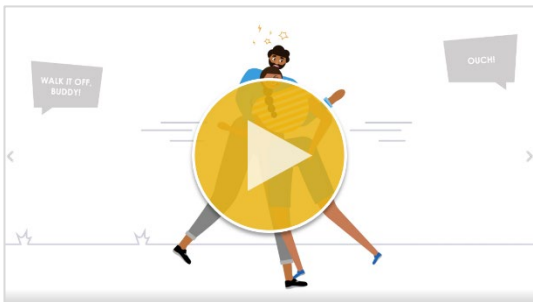


Maximize Your Healthcare

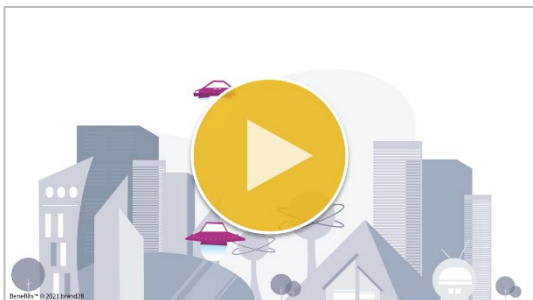
Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

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

Click to play video








Urgent Care vs ER



Virtual 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	<ul style="list-style-type: none"> Identifying symptoms Decide if immediate care is needed Home treatment options and advice 	24/7	\$0
Online visit 	Many non-emergency health conditions	<ul style="list-style-type: none"> Cold, flu, allergies Headache, migraine Skin conditions, rashes Minor injuries Mental health concerns 	24/7	\$
Office visit 	Routine medical care and overall health management	<ul style="list-style-type: none"> Preventive care Illnesses, injuries Managing existing conditions 	Office Hours	\$\$
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	<ul style="list-style-type: none"> Stitches Sprains Animal bites Ear-nose-throat infections 	Office Hours, or up to 24/7	\$\$\$
Emergency room 	Life-threatening conditions requiring immediate medical expertise	<ul style="list-style-type: none"> Suspected heart attack or stroke Major bone breaks Excessive bleeding Severe pain Difficulty breathing 	24/7	\$\$\$\$\$

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)	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Important part of the recovery process after an injury or surgery 	40 to 60% over a hospital setting*
Sleep study 	Home testing	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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*

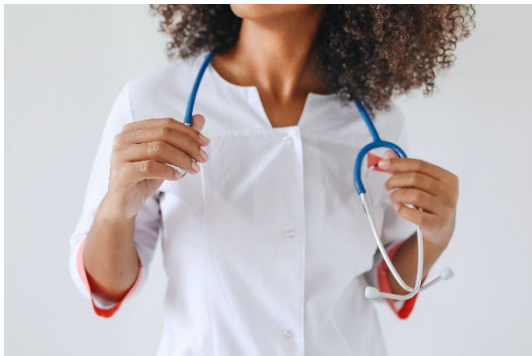
**in-network*

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](https://www.healthcarebluebook.com) and [healthgrades.com](https://www.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.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

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

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

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

What is Preventive Care?

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

Visit [cdc.gov/prevention](https://www.cdc.gov/prevention) for recommended guidelines.

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

Not all exams and tests are considered preventive

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

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

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

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video



THE FORMULARY DRUG TIERS DETERMINE YOUR COST

\$ Generic Drug

\$\$ Brand Name Drug

\$\$\$ Specialty Drug

Understanding the formulary can save you money

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

What is a formulary?

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

Get the most from your coverage

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

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



LINCOLN LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

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

Is your family protected?

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

We provide long-term disability benefits and life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary life coverage that you can purchase for yourself, your spouse, and your children and also offer voluntary short-term disability.

LINCOLN CITY-PROVIDED LIFE AND AD&D INSURANCE



A NOTE ABOUT TAXES

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

Basic Life and AD&D

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

Lincoln Basic Life and AD&D

2x base annual earnings up to a maximum of **\$500,000**

Spouse Benefit

Amount equal to **\$5,000**

Child(ren) Benefit

Birth to 26 years of age : **\$2,000**

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

LINCOLN 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.

ANNUAL LIMITED ENROLLMENT

If you currently have coverage, you may increase the coverage amount for yourself and your spouse during Open Enrollment by one increment each, without providing EOI. If you select coverage in an amount over one increment, you will be required to submit EOI.

Protecting those you leave behind

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

Lincoln Voluntary Life

Employee Increments of \$10,000 up to \$500,000
Guaranteed Issue: \$250,000

Spouse Increments of \$5,000 up to \$250,000
(not to exceed 100% of the employee's elected life benefit)

Guaranteed Issue: \$50,000

Child(ren) Flat \$10,000 (birth to age 26)

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

In the event of a serious or fatal accident

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

Coverage is provided by Lincoln and available for your spouse and/or child(ren).

Lincoln Voluntary AD&D

Employee Increments of \$10,000 up to \$500,000

Spouse Increments of \$5,000 up to \$250,000
(not to exceed 100% of the employee's elected life benefit)

Child(ren) Flat \$10,000 (birth to age 26)

Evidence of Insurability (EOI)

If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (enrolling more than 60 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Lincoln. You can find the form at Lincoln4Benefits.com, click on the Evidence of Insurability link, and follow the easy instructions on your screen.

LINCOLN VOLUNTARY SHORT-TERM DISABILITY INSURANCE (STD)



EXPECT THE UNEXPECTED

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

SUBMITTING A CLAIM

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

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

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

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

Eligibility	All Employee’s except Local 39 employees
Weekly Benefit Amount	Plan pays 66.7% of weekly earnings
Maximum Weekly Benefit	\$1,620
Benefits Begin After	
Accident	7 days of disability
Sickness	7 days of disability
Maximum Payment Period¹	8 weeks

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

Evidence of Insurability (EOI)

When you are first offered this coverage (and during approved open enrollment periods), you may be able to take advantage of this important coverage with no evidence of insurability (proof of health).

However, if you are a late entrant (enrolling more than 60 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Lincoln. You can find the form at Lincoln4Benefits.com, click on the Evidence of Insurability link, and follow the easy instructions on your screen.

LINCOLN 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.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. The City pays the entire cost of Core LTD coverage after the first 5 years of service for Classes 1, 2 & 3. Coverage is provided by Lincoln.

	Class 1	Class 2	Class 3	Class 4	Class 5
Eligibility	Management & Confidential Employees	Local 39 Employees	IBEW Employees	Sworn & Non-Sworn Police	Firefighters
Contributions	Employee pays for first 5 years of service, and thereafter the City pays	Employee pays for first 5 years of service, and thereafter the City pays	Employee pays for first 5 years of service, and thereafter the City pays	Employee pays	Employee pays
Elimination Period	60 Days				
Monthly Benefit					
Core Plan	60% of Monthly Earnings up to \$6,000				
Buy-Up Option	70% of Monthly Earnings up to \$11,000				
Minimum Monthly Benefit	\$100				

Evidence of Insurability (EOI)

If you elect Buy-Up Long-Term Disability coverage, or if you are a late entrant (enrolling more than 60 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Lincoln. You can find the form at Lincoln4Benefits.com, click on the Evidence of Insurability link, and follow the easy instructions on your screen.

LINCOLN VALUE ADDED SERVICES



WellnessPATH®

Lincoln WellnessPATH® provides tools and personalized steps to manage your financial life. From creating a budget to building an emergency fund to paying down debt, this easy-to-use online tool helps you turn information into action so you can focus on both short- and long-term goals, like saving for retirement. Contact your Human Resources contact to start using Lincoln WellnessPATH® today.

TravelConnect® Services

TravelConnect® services provide a wealth of medical, safety and travel-related services you can access while on a business or leisure trip more than 100 miles from home. It includes evacuation services, Travel Assistance services, and medical, dental and pharmacy referrals.

To access, call collect from anywhere in the world:

+1(603) 328-1955, or

Toll Free from US or Canada: (866) 525-1955.

LifeKeys® Services

This program provides access to a wide array of services to help you and your loved ones through life's ups and downs — and prepare you for whatever lies ahead. Services include online will preparation, access to GuidanceResources® Online, protection against identity theft, and guidance and support for your beneficiaries. It's easy to access LifeKeys® services. Just call (855)891-3684 or visit [GuidanceResources.com](https://www.guidanceresources.com).

(First-time user: Enter Web ID LifeKeys).

FuneralPrep

Funeral planning through Lincoln Financial Group offers both pre-planning and at-need services at or near the time of need. You can access FuneralPrep by visiting the self-service online portal at [LincolnFuneralPrep.com](https://www.lincolnfundprep.com) or by connecting with a funeral planning consultant.

EmployeeConnectSM

EmployeeConnectSM offers professional, confidential services for both you and your loved ones. Receive up to 5 face-to-face counseling visits and one free 30-minute in person consultation per legal issue. It includes unlimited phone access 24/7 and web access to helpful articles, resources, and self-assessment tools. To access call (888) 628-4824 or visit

[GuidanceResources.com](https://www.guidanceresources.com).

- Username: LFGSupport
- Password: LFGSupport1



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
- Take time to spend with family and friends, take care of personal business, or just have a little extra "me time"
- Assist with and offer resources for financial and legal matters

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.

LINCOLN EMPLOYEECONNECT (EAP)



CONTACT EMPLOYEECONNECT

PHONE

(888) 628-4824

Available 24 hours a day

WEBSITE

www.guidanceresources.com

Username: LFGSupport

Password: LFGSupport1

Help for you and your household members

EmployeeConnect offers professional, confidential services to help you and your loved ones improve your quality of life. Lincoln's *EmployeeConnect* is here 24/7 to connect or refer you to a professional who can help with marriage, family and relationship issues; problems in the workplace; stress, anxiety and sadness; grief, loss, or responses to traumatic events; concerns about your use of alcohol or drugs; and financial and legal issues.

You and your household members are entitled to 5 face-to-face sessions or unlimited telephonic or online consultations for problem-solving support per individual, per incident, per policy year. You also receive one free 30-minute in-person legal consultation per legal issue (**25% off** subsequent meetings).

All services are confidential and in accordance with professional ethics and federal and state laws. Use of the EAP is strictly voluntary.

This EAP is offered to you in addition to the Anthem EAP Program.

Unlimited 24/7 Assistance

You and your family can access the following services anytime – online, on the mobile app, or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more
- Legal information and referrals for family law, estate planning, consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online Resources

EmployeeConnect offers a wide range of information and resources you can research and access on your own. Expert Advice and support tools are just a click away when you visit guidanceresources.com or download the *GuidanceNow* mobile app. You'll find:

- Article and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets, and more

CONCERN EMPLOYEE ASSISTANCE PROGRAM (EAP)



CONTACT THE EAP

PHONE

(800) 344-4222

Available 24 hours per day

WEBSITE

employees.concernhealth.com

Company Code: Roseville

(not case sensitive)

Click on “Get Services” to set up your confidential digital dashboard. **To request services for a child up to age 17, call Concern.**

All services are confidential and in accordance with professional ethics and federal and state laws. Use of the EAP is strictly voluntary.

All Eligible Employees and Dependents

The Employee Assistance Program (EAP) is designed to help with life’s many challenges. Concern is here 24/7 to connect or refer you to a professional who can help with marriage, family and relationship issues; problems in the workplace; stress, anxiety, and sadness; grief, loss, or responses to traumatic events; concerns about your use of alcohol or drugs. You can also access the online **OurRelationship** program designed to uncover, understand, and solve relationship issues that couples face. This resource is self-directed or guided by a program coach over a 4-6 week period. You can work separately, or as a couple to improve communication, emotional distance, trust, and other relationship areas.

All employees, their spouse/domestic partner, household members, and dependent children up to age 26 have access to up to 6 in-person or video counseling visits per issue, per year.

Public Safety

Public Safety employees often face extreme stressors in the course of their duties. Those traumatic events can result in profound, long-lasting effects.

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

All Police and Fire Units*, their spouse/domestic partner, household members, and dependent children up to age 26 have access to up to 8 in-person or video counseling visits per issue, per year.

Public Safety Specialty Program

In addition to access to Concern’s OurRelationship benefit, Counseling benefits, and Life Balance solutions, Public Safety employees have access to a specialty panel of trauma-trained counselors – many of whom are former public safety employees themselves. Concern’s Public Safety Specialty Panel is comprised of:

- Trauma-trained specialists
- Years of experience working with Public Safety
- Many are vetted by Public Safety peer review panels
- Located throughout central and Northern California
- All are passionate about supporting Public Safety employees and will quickly make themselves available to schedule appointments

**Reference the plan summary for full eligibility details.*

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

BETTERHELP



ACCESS BETTERHELP

Employees and eligible dependents can request Concern counseling, BetterHelp, and work/life services 24/7 by calling **(800) 344-4222** or visiting employees.concernhealth.com.

Company Code: **Roseville**

Virtual Behavioral Health Service

If you or a loved one is struggling with life's challenges, finding a mental health professional to talk to quickly can make a big difference. That's why your Concern Employee Assistance Program (EAP) is offering BetterHelp, a service that provides confidential counseling by text, audio, or video - whatever way feels right for you. BetterHelp is available to all employees and their dependents age 13 and older. Dependents age 13-17 must access services with the assistance of an adult.

How it works

Through your Concern EAP benefit, BetterHelp provides access to the nation's largest network of online therapists. Members can:

- Communicate using whatever modality makes them most comfortable — text, chat, phone, or video
- Switch back and forth between modalities while working with their counselor
- Make an easy connection by viewing a counselor's schedule online and selecting an appointment time
- Expect to connect with a counselor within 24 hours from referral

MISSIONSQUARE DEFERRED COMPENSATION



The Deferred Compensation Plan is an easy and convenient way to supplement your PERS retirement. It allows you to defer a portion of your salary through payroll deductions into the plan and invest it, on a tax-deferred basis. It is a tax-deferred, defined contribution, supplemental retirement program. Funds in the Deferred Compensation Plan are not subject to taxes until they are withdrawn from the Plan. At the time of withdrawal normal income taxes are due, but there is no IRS penalty, regardless of your age. Because of the tax-deferred status of the funds in the Deferred Compensation Plan, Federal law strictly limits access to these funds and under normal circumstances prohibits participants from withdrawing these funds while employed with the City.

457 Plan

The 457 Plan is authorized under Section 457 of the Internal Revenue Code. This plan is available to all benefited City of Roseville employees. Payroll deductions may be changed or stopped at any time. You can change your 457 deferred compensation contribution by processing a change in Oracle.

401(A)

The 401(a) Plan is administered by ICMA-RC, now known as MissionSquare and is authorized under Section 401(a) of the Internal Revenue Code. This plan is only available to employees in the Management/Confidential group within 60 days of initial hire. Once enrolled in the plan employees may not elect to opt out of contributions.

Limitation*	2026
Annual Deferral Limit	\$23,500
"Pre-Retirement" Catch-Up Limit	\$23,500
	(\$47,000 total)
"Age 50" Catch-Up Limit	\$7,500
	(\$31,000 total)

**IRS limits subject to change*

Limitation*	2026
Annual Deferral Limit	\$69,000



IMPORTANT PLAN INFORMATION

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

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

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 their 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 HR if your domestic partner is your tax dependent.

CITY CONTRIBUTIONS

Below are the 2026 City Contribution amounts for bargaining units **Local 39, Management Confidential, IBEW***, and **RPA (Non-Sworn)**.

Tier	Cafeteria Contribution
Employee Only (EE Only)	\$1,347.00
Employee Plus One Dependent (EE+1)	\$1,347.00
EE Plus Family (Family)	\$1,347.00

Tier	IBEW	RPA, LOCAL 39, MGMT/CONF
Employee Only (EE Only)	\$230.00	\$200.00
Employee Plus One Dependent (EE+1)	\$683.00	\$688.00
EE Plus Family (Family)	\$1,143	\$1,143.00

Seasonal Appointments	Cafeteria Contribution	Flex Credit
1500 Hour Temporary Employees	\$162	N/A

*IBEW (represented employees) – The City contributes one hundred dollars (\$100) monthly into employees deferred compensation plan. **Employees may choose to contribute this amount toward their medical plan.** This is an annual election made during open enrollment.

If you decide to decline to enroll in medical coverage and provide proof of other medical coverage, you will receive a \$150.00 per month cash-out option. Please note that by selecting this option of cash payment, it will be reported as taxable income. Please contact Human Resources at (916) 774-5475 for more information.

CITY CONTRIBUTIONS

Following are the 2026 City Contribution amounts for bargaining unit **RPOA (Sworn) and RFF**.

Tier	City Flex Plan Credit (combined with the Cafeteria Plan Allowance) covers:
Employee Only (EE Only)	Up to 100% of the Kaiser employee only premium, plus \$180 for dental/vision.
Employee Plus One Dependent (EE+1)	Up to 85% of the Kaiser employee plus one dependent premium, plus \$180 for dental/vision.
EE Plus Family (Family)	Up to 80% of the Kaiser family premium, plus \$180 for dental/vision.

If you decide to decline to enroll in medical coverage and provide proof of other medical coverage, you will receive a \$150.00 per month cash-out option. Please note that by selecting this option of cash payment, it will be reported as taxable income. Please contact Human Resources at (916) 774-5475 for more information.

HEALTH PREMIUM RATES

Monthly Health and Welfare Program Insurance Premium Rates 01/01/2026 through 12/31/2026

MEDICAL	Employee Only	Employee & 1 Dependent	Employee with 2 or more dependents
HMO's			
Anthem HMO Select	\$1,336.29	\$2,672.58	\$3,474.35
Anthem HMO Traditional	\$1,612.08	\$3,224.16	\$4,191.41
Blue Shield Access+	\$1,301.95	\$2,603.90	\$3,385.07
Blue Shield Trio ¹	\$1,166.58	\$2,333.16	\$3,033.11
Kaiser Permanente	\$1,168.86	\$2,337.72	\$3,039.04
UnitedHealthcare Alliance	\$1,290.06	\$2,580.12	\$3,354.16
UnitedHealthcare Harmony	\$1,133.09	\$2,266.18	\$2,946.03
Western Health Advantage	\$969.58	\$1,939.16	\$2,520.91
PPO's			
PERS Platinum	\$1,670.14	\$3,340.28	\$4,342.36
PERS Gold	\$1,120.58	\$2,241.16	\$2,913.51
PORAC ²	\$1,063.00	\$2,418.00	\$3,027.00

¹Only available in El Dorado, Nevada, Placer, Sacramento, and Yolo Counties

²Available only to members of Police Officer's Research Association of California (only RPOA and RFF members are eligible)

DELTA DENTAL	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
High Opt PPO	\$63.75	\$112.22	\$110.28	\$169.43
Low Opt PPO	\$43.43	\$78.03	\$73.97	\$115.15
DeltaCare	\$17.40	\$34.20	\$32.10	\$57.00

VISION	Employee Only	Employee & 1 Dependent	Employee with 2 or more dependents
Vision Service Plan (VSP)	\$7.49	\$10.86	\$19.48

PLAN CONTACTS

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

Provider	Phone Number	Website	Policy No.
Anthem Blue Cross Select & Traditional HMO	(855) 839-4524	www.anthem.com/ca/calpers/	
Anthem Blue Cross PPO	(855) 839-4524	www.anthem.com/ca/calpers/	
Blue Shield	(800) 334-5847	www.blueshieldca.com/calpers	
Kaiser Permanente HMO	(800) 464-4000	mybenefits.kp.org/calpers/	
PORAC	(800) 937-6722	www.porac.org	
UnitedHealthcare Alliance HMO	(877) 359-3714	www.uhc.com/calpers	
Western Health Advantage	(888) 942-7377	www.westernhealth.com/calpers	
Delta Dental PPO	(888) 335-8227	www.deltadentalins.com	#00713
DeltaCare USA (HMO)	(800) 422-4234	www.deltadentalins.com	#70302
VSP	(800) 877-7195	www.vsp.com/	#12137687
Lincoln (Basic Life/AD&D, LTD & STD)	(877) 275-5462	www.mylincolnportal.com Company Code: LF1232CIT	Life/AD&D: #SA3-890-LF1232-01 STD: #GD3-890-LF1232-01 LTD: #GF3-890-LF1232-01
Lincoln Employee Connect (EAP)	(888) 628-4824	www.guidanceresources.com User Name: LFGSupport Password: LFGSupport1	
Concern EAP	(800) 344-4222	employees.concernhealth.com Company Code: Roseville	City of Roseville
Benefit Coordinators Corporation (BCC) (Flexible Spending Account)	(800) 685-6100	benefitcc.wealthcareportal.com	
MissionSquare/ICMA-RC (Deferred Compensation)	(800) 362-7272	www.icmarc.org	

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 for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum

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

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

Outpatient Care

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

-P-

Participating Pharmacy

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

Plan Year

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

Preferred Drug

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

Preventive Care Services

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

Primary Care Provider (PCP)

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

-S-

Short Term Disability Insurance

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

-T-

Telehealth / Telemedicine / Teledoc

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

-U-

UCR (Usual, Customary, and Reasonable)

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

Urgent Care

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

-V-

Vaccinations

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

Voluntary Benefit

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

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE “NO SURPRISES” RULES

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

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

[View a sample notice and consent form](#) (PDF).

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

MEDICARE PART D (PRESCRIPTION DRUG) THROUGH CALPERS

Medicare Part D is a voluntary federal outpatient prescription drug benefit available to everyone with Medicare. The Medicare Part D premium varies based on the prescription drug plan and is paid to your health carrier as part of the CalPERS health premium. As with Medicare Part B, if your income exceeds established thresholds, the SSA will assess an additional income-related monthly adjustment amount. Payment of this amount is mandatory to protect your Medicare enrollment and eligibility to remain enrolled in a CalPERS Medicare health plan.

To be enrolled in a CalPERS Medicare health plan, you cannot be enrolled in a non-CalPERS Medicare Part D plan.

CalPERS Health Plans and Medicare Part D

CalPERS participates in the Employer Group Waiver Plan (EGWP). EGWPs are Prescription Drug Plans governed by the CMS.

If you are a Medicare-eligible subscriber or dependent, you are automatically enrolled into EGWP. If for some reason, you chose to opt out of EGWP, you will be financially responsible for all of your prescription drug costs. In addition, if you enroll in a non-CalPERS Medicare Part D plan, you are no longer eligible to remain enrolled in a CalPERS Medicare health plan. Consequently, you and all of your covered dependents will be terminated. Contact the City of Roseville Human Resources Department for more details.

Medicare Part D Notice

Important Notice from City of Roseville 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 Roseville 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 Roseville has determined that the prescription drug coverage offered by CalPERS is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Roseville changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2026
Name of Entity/Sender:	City of Roseville
Contact-Position/Office:	Human Resources
Address:	311 Vernon Street, Roseville, CA 95678
Phone Number:	(916) 774-5475

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 our plans. If you would like more information on WHCRA benefits, please 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'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 the City's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days (60 days for CalPERS medical plans) 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 (60 days for CalPERS medical plans) 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 days (60 days for CalPERS medical plans) timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the City's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for City of Roseville 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.

Notice of Choice of Providers

HMO plans 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. Until you make this designation, your carrier will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier directly.

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

You do not need prior authorization from the City's plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your insurance carrier directly.

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.flmedicaidprecovery.com/flmedicaidprecovery.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/dfcr/> | 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.medicicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003 | TTY: Maine relay 711

Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms> Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

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

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084 | email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfrp.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.nifamilycare.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: 1-866-614-6005

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

PAPERWORK REDUCTION ACT STATEMENT

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

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

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.

ACA Disclaimer

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

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find private individual health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2024 for coverage starting as early as January 1, 2026.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does the Employment-Based Health Coverage We Offer to You Affect Your Eligibility for Premium Savings through the Marketplace?

Yes. If we have offered you health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and you may wish to enroll in our health plan if you are eligible. (Just because you received this Marketplace notice does not mean you are eligible.) However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if we do not offer coverage to you at all or do not offer coverage that meets certain standards. If the cost of self-only coverage under our health plan is more than 9.5% of your household income for the year, or if our health plan does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution—as well as your employee contribution—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information About the Health Insurance Marketplace?

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

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS

Part B: Information About Employer-Provided Health Plan Coverage

If you decide to complete an application for coverage in the Marketplace, you will be asked for information about our health plan coverage. The information below can help you complete your application for coverage in the Marketplace.

1. General Employer Information

Employer Name:	City of Roseville
Employer Identification Number (EIN):	94-6000409
Employer Street Address:	311 Vernon Street
Employer Phone Number:	(916) 774-5475
Employer City:	Roseville
Employer State:	CA
Employer ZIP Code:	95678
Who Can We Contact About Employee Health Coverage At This Job?	Human Resources
Email Address:	humanresources@roseville.ca.us

2. Eligibility. You may be asked whether you are currently eligible for our health plan coverage or whether you will become eligible for coverage within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting Human Resources at (916) 774-5475.

3. Minimum Value. If you are eligible for coverage under our health plan, you may be required to check a box indicating whether our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard

