2026 EMPLOYEE BENEFITS *Guide*

capk
Community Action Partnership *of* Kern

Employee Benefits Guide 2026

General Information

Core Benefits

Other Benefits

Miscellaneous

Click this icon in your benefits guide to watch a video explaining the associated topic.

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 30 for more details.

Please note that this guide provides highlights of the benefits available to you. You may find a complete description of each plan, including policy provisions, limitations, exclusions, and insurance contracts, in the summary plan descriptions and official plan documents. If a conflict arises between this guide and the official plan documents, the plan documents will govern. CAPK reserves the right to modify or terminate any of the described benefits at any time and for any reason. The descriptions of these benefits are not guarantees of current or future employment or benefits.

Welcome to Your Employee Benefits!

CAPK recognizes the importance of having a comprehensive benefits program. Our program is designed to provide you and your family a variety of plans with tools that promote health and wellness. We are committed to making every effort to provide benefits that support the lifestyles and needs of our employees.

Enrollment Information

Who May Enroll

If you are a full time employee working 30+ hours per week, you and your eligible dependents may participate in CAPK's benefits program. Your eligible dependents include:

- Legally married spouse
- Children under the age of 26, regardless of student or marital status and unmarried dependent child(ren) over the carrier age limits who are physically or mentally incapable of self-support
- Registered domestic partner

When You Can Enroll

As an eligible employee, you may enroll at the following times:

- As a new hire, you may participate in CAPK's benefits program on the first day of the month following your date of hire; you must enroll within 30 days from your date of hire
- Each year, during open enrollment
- Within 30 days of a qualifying event as defined by the IRS (see Making Changes To Enrollment below)

Making Changes to Enrollment

Our benefit plans are effective January 1st through December 31st of each year. There is an annual open enrollment period during which you can make new benefit elections for the following January 1st effective date. Once you make your benefit elections, you cannot change them during the year unless you experience a qualifying event as defined by the IRS. Examples include, but are not limited to the following:

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child
- A qualified medical child support order
- Death of a spouse or child
- A change in your dependent's eligibility status
- Loss of coverage from another health plan
- Change in your residence or workplace (if your benefit options change)
- Loss of coverage through Medicaid or Children's Health Insurance Program (CHIP)
- Becoming eligible for a state's premium assistance program under Medicaid or CHIP

Coverage for a new dependent is not automatic. If you experience a qualifying event, you have 30 days to update your coverage. Please contact the Benefits Office immediately following a qualifying event to complete the appropriate election forms. If you do not update your coverage within 30 days from the qualifying event, you must wait until the next annual open enrollment period to update your coverage.

Insurance Basics

Medical HMO

An HMO is a plan that offers coverage within a specific network of doctors and hospitals. Coverage under an HMO is only available through providers and facilities that are in-network. If you visit a doctor that is not in the HMO network, you are responsible for 100% of the cost of services unless you're seeking emergency medical treatment.

Who should consider opting for a HMO?

Someone who is looking to pay lower copays, and no coinsurance for in-network and covered services. HMOs are also great for patients who want a doctor dedicated to coordinating their care. Under an HMO plan, your primary care doctor (also called a primary care provider) will provide referrals when a specialist visit is necessary. An HMO could be a good option if your providers are contracted in the HMO network. An HMO plan may limit your ability to see doctors that you've seen in the past if they're not in-network.

Medical PPO

PPO plans typically have premiums and deductibles that are higher compared to HMO plans. They also offer greater flexibility, such as expanded networks and no referral requirements.

Who should consider opting for a PPO?

If you are looking for greater flexibility to book appointments with providers who are in the PPO network (as well as those out-of-network) without a referral. It's important to note that you may pay a higher rate if you choose to go out-of-network. If you travel often, or have covered dependents who live out of state a PPO plan might be a better fit.

Dental PPO (DPPO)

Similar to a medical PPO plan, a dental PPO allows you to choose an in-network or out-of-network provider. Remember, going out-of-network will be more costly than visiting an in-network dentist. If you need services or treatments that will cost $300 or more, it is strongly recommended to ask for a predetermination of benefits from your dentist to understand the cost of services. Please be advised that ID cards are not necessary, and DPPO members may not receive ID cards.

Insurance Basics (continued)

How to Find a Provider

How To Find an Anthem Medical Provider

1. Visit www.anthem.com/ca and click "Find Care"
2. You can log in to your Anthem portal or click on 'Select a plan for basic search' to search as a guest.
3. **Once prompted, complete the series of questions:**
4. **Select the type of plan or network:** Medical plan or Network (may also include dental, vision, or pharmacy benefits)
5. **Select the state where the plan or network is offered (For employee-sponsored plans, select the state where your employer's plan is contracted in. Most of the time, it's where the headquarters is located.):** California
6. **Select how you get health insurance:** Medical (Employer-Sponsored)
7. **Select a plan or network:** Blue Cross HMO (CACare) - Large Group
8. Click "Continue"
9. Enter your specific search criteria (provider name, address, zip code etc) and click "Search"
10. View your search results. From this page you can email or print your results or return to search to edit your criteria

How to Find a Kaiser Medical Provider:

1. **Based on where you reside please visit:**

   Northern California:

   https://healthy.kaiserpermanente.org/northern-california/doctors-locations#/simple-form

   Southern California:

   https://healthy.kaiserpermanente.org/southern-california/doctors-locations#/simple-form

2. **Call Kaiser Permanente Member Services phone number:** 800-464-4000.

Important Information about electing a PCP in Network (HMO) plans

All HMO enrollees must select a PCP and designate their PCP#. If you enter an invalid PCP# or leave this blank, you will be auto assigned to a provider based on your home zip code. If you receive an ID with an incorrect PCP listed, please contact your carrier member services to correct.

If you decide to change your PCP at any time, you can do this by phone or online.

Information about the PPO plan

You have the option of choosing a primary care provider (PCP) to guide your care (it is recommended but not required). You can see a specialist without a referral.

Using in-network doctors and health care facilities may keep your costs lower.

You can choose out-of-network doctors or facilities, but your costs may be higher.

You'll pay an annual amount called a deductible before the plan begins to pay for covered costs. Once you meet your deductible, you pay a copay or coinsurance amount and the plan pays the rest of covered costs.

Once you meet an annual limit on your payments called an out-of-pocket maximum, your plan pays 100% of covered costs.

Insurance Basics (continued)

Finding a Dentist:

Step 1 - Know your Network - Classic PPO and Plus

Find the network name by looking at your ID card, plan materials, or calling customer connections at 800-487-5553.

Step 2: Go online

- Go to dentalnetwork.ameritas.com or ameritas.com – Find a Health Provider
- Enter your location and then choose the network name to search for a dental provider.

Step 3: Search providers

- Network providers charge 25-50% less than their regular rates. Dentists in green offer the most savings, closer to 50%.
- Use Additional Filters to search by provider name, practice/business name, or specialty.
- **Tip:** If you can't find a specific provider or location by name, search by ZIP Code or city.

Finding a EyeMed doctor:

1. Visit https://eyedoclocator.eyemedvisioncare.com/
2. You can choose to search by location or doctor
3. Under Network select "Insight Network"
4. Enter your Zip Code
5. Then click search, a list of relevant providers will populate.

Finding a VSP doctor:

1. Visit https://www.vsp.com/eye-doctor
2. You can choose to search by location or doctor
3. Enter your Zip Code
4. Then click search, a list of relevant providers will populate.

Paying For Your Coverage

- You and CAPK share in the cost of your Medical, Dental, and Vision benefits. Your contributions are deducted before taxes are withheld, which saves you tax dollars. Paying for benefits before-tax means your share of the costs are deducted before taxes are determined, resulting in more take-home pay for you.
- Basic Life and AD&D benefits are provided at no cost to you and are paid entirely by CAPK for employees who qualify.
- Any Voluntary Life Insurance benefits you elect will be paid by you at discounted group rates.
- Any additional Voluntary Benefit options you elect will be paid by you at discounted group rates.

Value Added Services

The following value added services are available to all employees enrolled in the corresponding carrier's coverage.

Anthem

Nurseline Benefits

Phone and/or video visits are an excellent option for convenient, accessible care when you don't need a doctor to see you in person. They are also a good choice when away from home or if you need short term prescription drug refills. CAPK provides telemedicine coverage with all medical plans.

Telemedicine - LiveHealth Online

When you're not feeling well you want to feel better fast. With LiveHealth Online, you don't need to make an appointment and there is no out of pocket costs to you. Just sign up at www.livehealthonline.com or use the app and see a board-certified doctor in a few minutes. A doctor can assess your condition, provide a treatment plan and even send a prescription to your pharmacy, if needed.

LiveHealth Online also provides services when you are feeling stressed, anxious or having a tough time coping. Schedule a virtual visit with a licensed therapist or board-certified psychiatrist. Appointments with a licensed therapist are typically available in 4 days or less and two weeks with a psychiatrist. These services are also provided to you at no cost to you.

The LiveHealth Online program is available to employees and their dependents that are enrolled.

Telemedicine visit cost are as follows:

Primary Care Visits & Non-Physician Specialist Visits: $0

Specialist Visits: $0

- **Anthem HMO 35 Plan**
  - $0 for Medical, Mental Health & Substance Use Disorder Service ;$45 copay for Specialist Care
- **Anthem 1700 PPO Plan**
  - **Medical services/Allergy visits** $55 until deductible met and then $0
  - **Mental Health & Substance Use Disorder Service** $0 once deductible is met, prior to deductible variable pricing based upon service. Therapy appointments (LMFT, psychologist) are $85-100. Psychiatry appts (only with a psychiatrist) are the $80-$185
  - **Specialist Care** $55 to $270 after deductible

Anthem Sydney app

https://www.sydneyhealth.com/

Kaiser Permanente

Virtual Visits

The next time you schedule an appointment at Kaiser Permanente, you may be offered a virtual visit with your doctor. All you need is a computer with a high-speed internet connection and a webcam or smartphone mobile device using the latest version of the KP Preventive Care App.

Advice Nurse

Get the care you need the way you want it. No matter which option you choose, your Kaiser providers can see your health history, update your medical record, and give you personalized care that fits your life. Call Kaiser at 866-454-8855 to make an appointment or speak to an advise nurse.

ChooseHealthy

The road to good health can take you well beyond your doctor's office. With Kaiser Permanente, you get a wide range of wellness resources. You may pay lower fees on many non-Kaiser Permanente services designed to help you get active and stay healthy. For more information about services available through ChooseHealthy call 877-335-2746 or visit kp.org/choosehealthy.

Kaiser mobile app

https://healthy.kaiserpermanente.org/pages/mobile-app

Medical Benefits

	Anthem Classic HMO
Calendar Year Deductible	
• Individual	$0
• Family	$0
Calendar Year Out-of-Pocket Maximum	
• Individual	$2,500
• Family	$5,000
Lifetime Maximum Benefit	Unlimited
Health Benefits	**You Pay**
Office Visit *(Includes Specialists)*	$35 copay (Specialist copay is $45)
Lab and X-Ray	No charge
Imaging *(CT/PET scans, MRIs)*	$100 copay
Urgent Care Copay	$35 copay
Emergency Room	$100 copay
Emergency Medical Ambulance	$100 copay
Inpatient Hospital & Surgery	$750 copay
Outpatient Surgery	$375 copay
Chiropractic	$35 copay up to 60 days combined with physical therapy, occupational therapy and manipulative treatment
Acupuncture	$35 copay
Mental Health/Substance Abuse	
• Outpatient Visit	$35 Copay
• Inpatient Care	No charge
Pharmacy Benefits	**You Pay**
Retail Pharmacy *(Up to 30 Day Supply)*	
• Generic	$5 copay Tier 1a/$15 copay Tier 1b
• Brand *(Formulary/Preferred)*	$30 copay
• Brand *(Non-Formulary/Non-Preferred)*	$50 copay
• Speciality	30% up to $250/prescription
Mail Order Pharmacy *(Up to 90 Day Supply)*	
• Generic	$12.50 copay Tier 1a/$37.50 copay Tier 1b
• Brand *(Formulary/Preferred)*	$90 copay
• Brand *(Non-Formulary/Non Preferred)*	$150 copay

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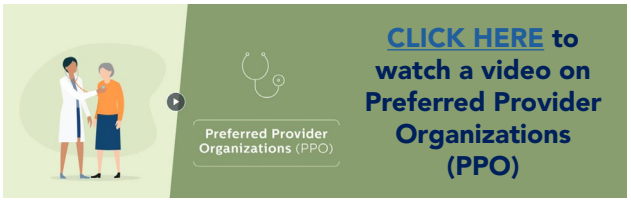
Medical Benefits (continued)

	Kaiser Traditional HMO
Calendar Year Deductible	
• Individual	$0
• Family	$0
Calendar Year Out-of-Pocket Maximum	
• Individual	$1,500
• Family	$3,000
Lifetime Maximum Benefit	Unlimited
Health Benefits	**You Pay**
Office Visit *(Includes Specialists)*	$25 copay
Hospital Coinsurance / Copay	$250 copay
Lab and X-Ray	No charge
Urgent Care Copay	$25 copay
Emergency Room	$100 copay if you are admitted directly to the hospital as an inpatient, you will pay the inpatient Cost Share
Emergency Medical Ambulance	No charge
Inpatient Hospital & Surgery	$250 copay
Outpatient Surgery	$25 copay
Mental Health/Substance Abuse	
• Outpatient Visit	$12 copay group/$25 copay individual
• Inpatient Care	$250 copay (per admission)
Prescription Drug Coverage	**You Pay**
Retail Pharmacy *(Up to 30 Day Supply)*	
• Generic	$15 copay
• Brand *(Formulary/Preferred)*	$30 copay
• Speciality	30% up to $150/prescription
Mail Order Pharmacy *(Up to 100 Day Supply)*	
• Generic	$30 copay
• Brand *(Formulary/Preferred)*	$60 copay

CLICK HERE to watch a video on PPO vs HMO



CLICK HERE to watch a video on Preferred Provider Organizations (PPO)

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Medical Benefits (continued)

High Deductible Health Plan with Health Savings Account Option

	Anthem HSA PPO	
	In-Network	Out-of-Network
Calendar Year Deductible		
• Individual	$1,700	
• Family	$3,400	
Calendar Year Out-of-Pocket Maximum		
• Individual	$2,500	$5,000
• Family	$5,000	$10,000
Lifetime Maximum Benefit	Unlimited	Unlimited
Health Benefits	**You Pay**	**You Pay**
Office Visit *(Includes Specialists)*	10%[1]	30%[1]
Coinsurance	10%[1]	30%[1]
Hospital Coinsurance / Copay	10%[1]	30% Up to $1,000 per day for non-emergency[1]
Lab and X-Ray	10%[1]	30%[1]
Urgent Care Copay	10%[1]	30%[1]
Emergency Room	10%[1]	paid as In-Network
Emergency Medical Ambulance	10%[1]	paid as In-Network
Inpatient Hospital & Surgery	10%[1]	30% Up to $1,000 per day for non-emergency[1]
Outpatient Surgery	10%[1]	30% $350 benefit max per admit[1]
Chiropractic	10%[1] up to 30 visits per calendar year	30%[1] up to 30 visits per calendar year
Acupuncture	10%[1] up to 20 visits per calendar year	30%[1] up to 20 visits per calendar year
Mental Health/Substance Abuse		
• Outpatient Visit	10%[1]	30%[1]
• Inpatient Care	10%[1]	30% Up to $1,000 per day for non-emergency[1]
Pharmacy Benefits	**You Pay**	**You Pay**
Retail Pharmacy *(Up to 30 Day Supply)*		
• Tier 1 - Generic	$10 copay[1]	30% up to $250[1]
• Tier 2 - Non-preferred Generic/Preferred Brand	$30 copay[1]	30% up to $250[1]
• Tier 3 - Non-preferred Brand and Generic	$50 copay[1]	30% up to $250[1]
• Tier 4 - Preferred Speciality	30% up to $150[1]	30% up to $250[1]
Mail Order Pharmacy *(Up to 90 Day Supply)*		
• Tier 1 - Preferred Generic	$10 copay[1]	Not covered
• Tier 2 - Non-preferred Generic/Preferred Brand	$60 copay[1]	Not covered
• Tier 3 - Non-preferred Brand and Generic	$100 copay[1]	Not covered
• Tier 4 - Preferred Speciality	30% up to $300[1]	Not covered

1 After the deductible

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Medical Benefits (continued)

How the Health Savings Account (HSA) Works

When you elect the Anthem HSA PPO Plan, you have the opportunity to establish and contribute to a Health Savings Account (HSA) - a tax-free savings account for healthcare expenses that earns interest. You can withdraw funds from an HSA to pay for eligible medical expenses such as deductibles, coinsurance and copays. Your account balance earns interest and the unused balance rolls over from year to year.

The IRS limits the amount you can contribute to an HSA for 2026 to:

- **Employee:** $4,400
- **Family:** $8,750
- **Catch-up contribution (if you are 55 years of age or older):** $1,000

Your HSA contributions are taken out of your paycheck before you pay federal income taxes, Social Security taxes and most state taxes (excluding state taxes in AL, CA and NJ). You can change your contribution amount at any time during the course of the year.

Please note that you cannot participate in the Healthcare Flexible Spending Account (FSA) while participating in an HSA.

You're eligible to open an HSA if:

- You enroll in the high-deductible health plan.
- Your only coverage is a high-deductible health plan. If you are covered under your spouse's plan and that plan is not a high-deductible plan, you are not eligible to contribute to a HSA.
- You are not covered by a traditional Healthcare Flexible Spending Account (FSA) through your spouse.
- You have not signed up for Medicare coverage.

For more information or to set up an account, contact: Health Equity at 801.727.1000 employerservices@healthequity.com.

Examples of Eligible HSA Expenses

Medical

Providers (Doctors, Specialists, Nurses)

Prescription Drugs

Inpatient Hospital Services

Laboratory & X-Ray

Emergency Services

Acupuncture / Chiropractic

Dental

Providers (Dentists, Specialists, Orthodontists)

Teeth Cleaning

Dental Treatment

Orthodontia

Vision

Providers (Optometrists, Ophthalmologists)

Exams

Glasses

Contact Lenses

Lasik Surgery

Premiums

COBRA

Long-Term Care

Medicare

Ineligible HSA expenses include expenses that are not medical or health related, such as cosmetic surgery.

Dental

Dental PPO

Provides the option to use any dentists of your choice; however, using a participating provider from the Ameritas Network can reduce out-of-pocket costs for services. Major procedures may require pre-approval by Ameritas.

Plan Benefits	Ameritas PPO	
	In-Network	Out-of-Network
General Plan Information		
• Annual Deductible		
– Individual	$50	$75
– Family	$150	$225
• Waived for Preventive	Yes	No
• Annual Plan Maximum	$2,000	$1,000
Diagnostic and Preventive Services		
• Diagnostic and Preventive	100%	80%
• Oral Exams	100%	80%
• Bitewing X-rays	100%	80%
• Full Mouth X-rays	100%	80%
• Cleaning and Scaling	100%	80%
• Prophylaxis Treatments	100%	80%
• Fluoride Treatments	100%	80%
• Space Maintainers	100%	80%
• Sealants	100%	80%
Basic Services		
• Basic	80%	80%
• Oral Surgery *(Extractions and Other Surgical Procedures)*	80%	80%
• Endodontic Treatment	80%	80%
• Periodontic Treatment	80%	80%
Major Services		
• Major	50%	50%
• Crowns, Jackets and Cast Restorations	50%	50%
• Prosthodontic Benefits *(Fixed Bridges, Partial/Complete Dentures)*	50%	50%
• Implants	50%	50%
Orthodontia		
• Child Only	50% $1,000 Lifetime Maximum	50% $1,000 Lifetime Maximum

This plan combines the annual maximum between the dental and eye care plans.

For the maximum:

- The member can use up to $1,000 Non PPO - $2,000 PPO toward any covered dental expense.

The member can use up to $100 towards any covered eye care expense. Total benefits paid between the two coverages will not exceed $2,000.

For more information on Ameritas Dental please visit ameritas.com. To look up a dental provider please visit ameritas.com, Find A Provider, then Dental. Your provider network is Ameritas Classic.

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Vision

Plan Benefits	EyeMed through Ameritas	
	In-Network	Out-of-Network
General Plan Information		
• Exam	$10 copay	N/A
• Materials	$25 copay Glass Lenses	N/A
Benefit Frequency		
• Exam	12 months	12 months
• Lenses	12 months	12 months
• Frames	24 months	24 months
• Contacts	24 months	24 months
Covered Services		
• Examination	100% after exam copay	Reimbursed up to $35
• Single Vision Lens	Covered after copay	Reimbursed up to $25
• Bifocal Lens	Covered after copay	Reimbursed up to $40
• Trifocal Lenses	Covered after copay	Reimbursed up to $55
• Lenticular	20% discount	No benefit
• Standard Progressive	Standard: $65 - $110 plus lens deductible(after materials copay)	No benefit
Lens Options		
• UV Coating	$15 copay	No benefit
• Scratch Resistant Coating	$15	No benefit
• Anti-Reflective Coating	$45 - $68	No benefit
• Other Add-Ons and Services	Discounts available	No benefit
Contact Lenses		
• Medically Necessary	Covered after copay	Reimbursed up to $200
• Elective	Up to $130 allowance	Reimbursed up to $104
Frames	Up to $130 allowance	Reimbursed up to $65
Other Services		
• Corrective Vision Services *(Laser Surgery)*	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers	No benefit
• Second Pair of Glasses	Discount available	No benefit

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Vision (continued)

vsp vision care

Plan Benefits	Vision Service Plan through Ameritas	
	In-Network	Out-of-Network
General Plan Information		
• Exam	$10 copay	$10 copay
• Materials	$25 copay Glass Lenses	$25 copay Glass Lenses
Benefit Frequency		
• Exam	12 months	12 months
• Lenses	12 months	12 months
• Frames	24 months	24 months
• Contacts	12 months	12 months
Covered Services		
• Examination	100% after exam copay	Reimbursed up to $43
• Single Vision Lens	Covered after copay	Reimbursed up to $26
• Bifocal Lens	Covered after copay	Reimbursed up to $43
• Trifocal Lenses	Covered after copay	Reimbursed up to $60
• Lenticular	Covered after copay	Reimbursed up to $91
• Standard Progressive	100% covered up to lined bifocal contracted fee allowance	Not covered
Lens Options		
• UV Coating	$16 copay	No benefit
• Scratch Resistant Coating	$17-$33	No benefit
• Anti-Reflective Coating	$43-$85	No benefit
• Other Add-Ons and Services	Discounts available	No benefit
Contact Lenses		
• Medically Necessary	Covered after copay	Reimbursed up to $210
• Elective	Up to $130 allowance	Reimbursed up to $100
Frames	Up to $130 allowance**	Reimbursed up to $40

** The Costco and Walmart allowance will be the wholesale equivalent.

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Tax Savings Benefits

Flexible Spending Accounts

These accounts allow you to pay for eligible healthcare and dependent care expenses with tax-free dollars.

	Flexible Spending Accounts (FSAs)
For Both Flexible Spending Accounts	
• Carrier	HealthEquity
• Plan Year	January 1 – December 31
• Primary Benefit	Using pre-tax money to pay for eligible healthcare and/or dependent care expenses reduces your taxable income and can help you save money on taxes
• Employee Contributions	Employees fund the FSAs; CAPK pays for administration costs
Healthcare Spending Account	
• Plan Benefits	Pre-tax contributions can be used to pay for qualified out-of-pocket medical, dental, vision and prescription drug expenses plan for you and your dependents; eligible expenses can include deductibles, copays, coinsurance and qualified health expenses not covered by your health plan
• Eligible Expenses	For a complete list of eligible healthcare expenses, go to HealthEquity website at www.healthequity.com
• Maximum Plan Year Contribution	$3,400*
• Paying for Eligible Expenses:	You can pay for eligible healthcare expenses directly from the Healthcare FSA using the CPI Debit Card *(keep receipts, as documentation to verify expense eligibility may be required)* You can also choose to be reimbursed via direct deposit or by check
Dependent Care Spending Account	
• Plan Benefits	Pre-tax contributions can be used to pay for qualified dependent care expenses incurred while you are working, including child care, elder care and other eligible dependent care
• Eligible Expenses	For a complete list of eligible dependent care expenses, go to the HealthEquity website at www.healthequity.com
• Maximum Plan Year Contribution	$7,500
• Paying for Eligible Expenses:	You pay your care provider directly, and then submit a claim to HealthEquity you can choose to be reimbursed via direct deposit or by check

Flexible Spending Account Rules

- You must designate how much money you wish to contribute annually to each account at the beginning of the Plan Year. Money set aside for one account cannot be moved to another account.
- You may change your annual contributions only if you experience a qualifying "change in family status," such as marriage, divorce, addition or loss of a dependent or a change in your spouse's employment.
- It is important to carefully review your estimated expenses before enrolling. Unspent funds remaining in the Dependent Care FSA after December 31 will be forfeited - referred to as the "Use It or Lose It Rule."
- There is a 90 day run-out period in the new plan year that allows participants to file claims for expenses incurred during the previous plan year.

Important!

Your FSA elections expire at the end of the plan year, on December 31st, and do not automatically roll over into the next plan year. You must re-enroll in the FSA every year you wish to participate.

CLICK HERE to watch a video on Flexible Spending Accounts (FSA)

Retirement

Your Retirement with Nationwide

Time is a key ingredient in building your retirement savings. The earlier you start to save - even if you only save small amounts of money· the more time your retirement account has the potential to grow. If you're in your 20's, retirement probably feels like a distant thought. And in many ways it is. However, contributing to your retirement plan beginning in your 20's can provide a significant savings advantage. That's because the sooner you begin contributing, the greater the opportunity you have to benefit from the long-term compounding of your money.

401(a) - CAPK Contributions plan

Eligibility: Benefit Eligible Employees who are 18 years of age or older will automatically be enrolled in the 401(a) immediately upon hire.

Contributions: CAPK makes a 5% contribution based on your compensation for eligible employees.

Vesting Schedule: Vesting refers to the amount of your account you can take with you when you leave employment at CAPK

Years of Service	Percent
Less than 2	0%
2	25%
3	50%
4	75%
5	100%

Tax Deferred Annuity 403(b) - Employee Contributions Plan

Eligibility: Employees are immediately eligible to contribute to the 403(b).

Contributions: Employees may elect to contribute any dollar amount they choose, on a pre-tax and post-tax basis, up to the maximum amount set by the IRS.

Vesting Schedule: Vesting refers to the amount of your account you can take with you when you leave employment at CAPK. Employees will take 100% of their 403(b) account with them when they leave employment at CAPK.

Rollovers: You may rollover funds from a prior employer's retirement plan or an IRA into the 403(b). In most cases it makes sense to consolidate your retirement savings into your current employer plan. Please contact Nationwide Call Center at: 833-268-7080 or nationwideretirementplans.com for assistance or questions with rollovers.

Basic Life and AD&D Coverage

CAPK provides all active employees with basic life insurance and accidental death and dismemberment (AD&D) coverage through UNUM. This benefit provides valuable income protection in the event that you suffer a severe accident or loss of life. An accelerated death benefit is also included in this policy. You must name a beneficiary for your Life and AD&D benefits. Beneficiary changes can be done at any time during the plan year.

Employer Provided Life Insurance	Employer Provided Accidental Death & Dismemberment
1.5 x base salary up to $200,000	1.5 x base salary up to $200,000

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Voluntary Life and AD&D Coverage

As an employee of CAPK, you have the option of purchasing additional life and AD&D coverage through UNUM. This voluntary policy enables you to purchase coverage for yourself and qualified dependents. When you enroll yourself and your dependents in this benefit, you pay the full cost through post-tax payroll deductions.

New Hires: If you apply for coverage that is above the Guaranteed Issue Amount, or if you are applying for coverage after experiencing a Qualifying Life Event, you must fill out a Medical Evidence of Insurability (EOI) form.

Current Employees: If you previously waived coverage, all benefit amounts are subject to full medical underwriting/EOI. All dependent child benefits are guaranteed issue.

	Employee	Spouse/DP	Child(ren) 6 months & older
Coverage Option	Increments of $10,000 up to 5x annual salary or $500,000	Increments of $5,000, up to 50% of the Employee's Voluntary Life Amount, not to exceed $100,000	$1,000 / $2,000 / $4,000 $5,000 / $10,000
Guarantee Issue Amount	$100,000	$25,000	$10,000
Maximum Amount	$500,000	$100,000	$10,000

Important Facts About Beneficiaries

Beneficiaries are individuals or entities that you select to receive benefits from your policy. If you do not have a beneficiary, benefits are paid to your estate. Here's what you need to know about beneficiaries:

- You can change your beneficiary designation at any time
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percentage(s) allocated
- To select or change your Life Insurance beneficiary please visit ADP Workforce Now

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Short Term Disability (STD) and Long Term Disability (LTD)

CAPK offers Short Term Disability (STD) and Long Term Disability (LTD) through Unum. Exempt employees are automatically enrolled and CAPK pays 100% of the premium. This benefit is not available for Non-Exempt employees. These coverages provide financial assistance if you are unable to work for an extended period of time due to an illness or injury. Below are key highlights of the plan.

Short Term Disability

	STD Plan Highlights
Coverage Option	Up to 80% of weekly covered earnings
Elimination Period	7 Days
Maximum Benefit	$2,550 Weekly
Maximum Benefit Duration	25 Weeks
Pre-existing Conditions	Does Not Apply

Long Term Disability

	LTD Plan Highlights
Coverage Option	Up to 60% of weekly covered earnings
Elimination Period	180 Days
Maximum Benefit	$11,000 Monthly
Maximum Benefit Duration	Varies - please see policy booklet
Pre-existing Conditions	3 month look back; 12 month exclusion of pre-existing condition

Voluntary Benefits

Voluntary Products

At CAPK eligible employees are offered the option to enroll in additional benefits; hospital indemnity, accident, critical illness and term life. All benefits offer portability options. In the event of serious illness or accident, UNUM gives you more ways to protect yourself, your family and your assets. Below is a brief summary of the plans. Please review the full benefit summaries and plan documents for more detailed information.

- Most benefits paid directly to you unless otherwise specified
- Individual coverage purchased through payroll deductions; plans are completely portable
- Most plans pay benefits regardless of other insurance coverage
- Most policies can be paid post tax allowing for the benefit to be received tax free

Group Hospital Indemnity

If you are admitted to the hospital for a covered accident or sickness, hospital indemnity insurance plans provide benefits that can help pay your out of pocket expenses:

- Hospital Admissions (1 day per year) $500
- Hospital Daily Stay (per day up to 90 days) $100
- Hospital Daily Stay - ICU (per day up to 30 days) Additive to Daily Stay

Accident Insurance

When an accident happens, the last thing you want to think about is how you are going to pay the bills. Accident insurance helps you pay for the medical and out-of-pocket costs that you may have after an accidental injury. Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging, and follow-up care.

Critical Illness Insurance

This plan is designed to help employees offset the financial impact of a catastrophic illness with lump sum benefits if an insured is diagnosed with a covered critical illness. The benefit amount is based on the coverage in effect on the date of diagnosis, or the date treatment is received according to the terms and provisions of the policy. Thus, please refer to the full benefit summary for examples of covered illness & payouts.

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Additional Benefits

Unum Secure Travel though Assist America

24/7 Services Anywhere in the World

Unum's travel assistance services are provided by Assist America, Inc., a leading provider of global emergency assistance services through employee benefit plans. Assist America's medically certified personnel are ready to help 24 hours a day, 365 days a year, and can connect you with pre-qualified, English-speaking and Western-trained medical providers anywhere in the world.

- Emergency medical evacuation, Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children, Assistance with the return of a vehicle
- Critical care monitoring, Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals, Passport replacement assistance

Within the U.S. 800-872-1414 - Outside the U.S. (U.S. access code) +609-986-1234 - Via e-mail: medservices@assistamerica.com

Earned Wage Access

Access your earned wages before payday with **RAIN! Through Rain's mobile app, employees will be able to access up to 50% of their paycheck before payday (excluding Sick, PTO/Vacation).**

- FREE ACH transfers to a bank account within 1-3 Business Days
- Only $3.99 to transfer instantly to a debit card
- Sign up with your CAPK email

Go to: https://www.rainapp.com/employees/
Support: care@rain.com, 424-369-7246

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Employee Assistance Program (EAP)

Just when you think you have it figured out, along comes a challenge! Whether those challenges are big or small, your EAP Support Program is available to help you and your family find a solution and restore peace of mind.

Call ComPsych any day, any time. Support is just a phone call away whenever you need support - at no additional cost to you. An advocate is ready to help assess your needs and develop a solution to help resolve your concerns. Advocates can also direct you to an array of resources in your community and online tools. You and your household members have up to three face-to-face sessions available to use. Call for a referral to a service in your community, or advice on topics such as:

- **Parenting:** Receive guidance on child development, sibling rivalry, separation anxiety and much more.
- **Senior care:** Learn about challenges and solutions associated with caring for an aging loved one.
- **Child care:** Whether you need care all day or just after school, find a place that's right for your family.
- **Pet care:** From grooming to boarding and veterinary services, find what you need to care for your pet.
- **Temporary back-up care:** Don't let an unplanned event get the best of you - find back-up child care.

For more information and to reach out for support:

- **Call:** 800-272-7255
- **Online:** www.guidanceresources.com
  - **Your web ID:** COM589

Employee Contributions

CAPK shares the cost of the medical, dental and vision benefits with you. Please note that your contributions are deducted before taxes are withheld which saves you tax dollars. Paying for benefits before-tax means that your share of the costs are deducted before taxes are determined, resulting in more take-home pay for you. The contributions listed below will be pro-rated for benefited Part-Year employees.

Medical		Monthly Cost	CAPK Monthly Cost	EE Monthly Cost	Per Paycheck Contribution (24 PP)		
					Full Year	Part Year (10) Jan - May	Part Year (9) Aug - Dec
Kaiser Permanente HMO 25	Employee	$916.45	$859.45	$57.00	$28.50	$42.75	$28.50
	Employee + Spouse	$1,924.54	$1,776.54	$148.00	$74.00	$111.00	$74.00
	Employee + Children	$1,741.25	$1,622.25	$119.00	$59.50	$89.25	$59.50
	Family	$2,657.70	$2,386.70	$271.00	$135.50	$203.25	$135.50
Anthem Blue Cross HMO 35	Employee	$1,209.04	$859.04	$350.00	$175.00	$262.50	$175.00
	Employee + Spouse	$2,538.97	$1,776.97	$762.00	$381.00	$571.50	$381.00
	Employee + Children	$2,176.26	$1,622.26	$554.00	$277.00	$415.50	$277.00
	Family	$3,627.09	$2,387.09	$1,240.00	$620.00	$930.00	$620.00
Anthem Blue Cross HDHP (PPO)	Employee	$1,162.00	$859.00	$303.00	$151.50	$227.25	$151.50
	Employee + Spouse	$2,556.39	$1,776.39	$780.00	$390.00	$585.00	$390.00
	Employee + Children	$2,091.59	$1,622.59	$469.00	$234.50	$351.75	$234.50
	Family	$3,602.19	$2,387.19	$1,215.00	$607.50	$911.25	$607.50

Ameritas Dental		Monthly Cost	CAPK Monthly Cost	EE Monthly Cost	Per Paycheck Contribution (24 PP)		
					Full Year	Part Year (10) Jan - May	Part Year (9) Aug - Dec
Ameritas DPPO	Employee Only	$34.03	$30.63	$3.40	$1.70	$2.55	$1.70
	Employee + One	$68.54	$47.88	$20.66	$10.33	$15.50	$10.33
	Family	$94.14	$60.68	$33.46	$16.73	$25.10	$16.73

Ameritas Vision		Monthly Cost	CAPK Monthly Cost	EE Monthly Cost	Per Paycheck Contribution (24 PP)		
					Full Year	Part Year (10) Jan - May	Part Year (9) Aug - Dec
EyeMed & VSP Network	Employee Only	$5.44	$4.90	$0.54	$0.27	$0.41	$0.27
	Employee + One	$10.24	$7.30	$2.94	$1.47	$2.21	$1.47
	Family	$14.94	$9.65	$5.29	$2.65	$3.97	$2.65

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Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Discrimination is Against the Law

Community Action Partnership of Kern complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). Community Action Partnership of Kern does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for a pregnancy hospital stay (for delivery) for a mother and her newborn may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at (661) 336-5236 ext. 2022.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan 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, please contact your carrier.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) 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, please contact your carrier

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Anthem and Kaiser Permanente. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Important Notices (continued)

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

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

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

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

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

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

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Important Notices (continued)

Each notice must include all of the following items: the covered employee's full name, address, phone number, and Social Security Number; the full name, address, phone number, and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of the Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

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

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

Important Notices (continued)

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information, visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee, organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

[1] http://www.socialsecurity.gov/

Important Notices (continued)

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination to remain eligible for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or a Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Human Resources
(661) 336-5236 ext. 2022

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

v Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources at (661) 336-5236 ext. 2022.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Community Action Partnership of Kern in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Open Enrollment for health insurance coverage through Covered California begins on November 1 of each year and ends on January 31 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com, KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

Open Enrollment for most other states begins on November 1 and closes on January 15 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.healthcare.gov.

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 you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.96% (for 2026) of your household income for the year, then that coverage for you is not Affordable. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan. If you receive premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, 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.

STATES WITH INDIVIDUAL MANDATE

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/Rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Important Notices (continued)

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name Community Action Partnership of Kern	**4. Employer Identification Number (EIN)** 95-2402760	
5. Employer address 1300 18th Street Suite 200	**6. Employer phone number** (661) 336-5236 Ext. 2022	
7. City Bakersfield	**8. State** CA	**9. ZIP code** 93301
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	**12. Email address** benefits@capk.org	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

Important Notices (continued)

Notice of Creditable Coverage: Information About Medicare Part D and Your Prescription Drug Coverage

Community Action Partnership of Kern has determined that the prescription drug coverage offered by the CalPERS is, on average for all plan participants, expected to pay out the same or more than what the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Please read this notice carefully and keep it where you can find it. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. NOTE: You are responsible for providing this notice to all Medicare eligible family members (or those about to become Medicare eligible).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends three months after the month in which he or she turned 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, when you finally do enroll, you may be subject to a late enrollment penalty added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases based on the number of full, uncovered months during which you went without either Medicare Part D or without "Creditable" prescription drug coverage from another plan, such as our plan.

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from October 15 through December 7 of each year, as well as during what is known as a "Medicare Special Enrollment Period" which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage. Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available. Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before you enroll in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

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 current Community Action Partnership of Kern coverage will not be affected. If you keep this coverage and elect Medicare, the Community Action Partnership of Kern coverage will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current CalPERS coverage, be aware that you and your dependents may be unable to get this coverage back.

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances, some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would reduce their payment to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

If you are Medicare eligible and 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 creditable coverage. For example, if you go 19 months without creditable coverage, your premium may be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) the entire time you have Medicare prescription drug coverage.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

If you have questions about your Medicare eligibility or how you can get help to pay for it, you can call the Social Security Administration at 1-800-772-1213 or visit www.socialsecurity.gov.

Important Notices (continued)

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, dial 1-877-KIDS-NOW, or visit 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 with 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 (1-855-692-7447)

CALIFORNIA - Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 1-916-445-8322
Fax: 1-916-440-5676
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/chp
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA - Medicaid
GA HIPP Website: https://medicaid.georgia.gov/programs/third-party-liability/health-insurance-premium-payment-program-hipp
Phone: 1-678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 1-678-564-1162, Press 2

INDIANA - Medicaid
Website: https://www.in.gov/medicaid/ or
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid & CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
HIPP Phone: 1-888-346-9562

Important Notices (continued)

KANSAS - Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPAA Phone: 1-800-967-4660

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

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

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

MASSACHUSETTS - Medicaid & 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: 1-573-751-2005

MONTANA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA - Medicaid
Website: http://www.accessnebraska.ne.gov/
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA - Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

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

NEW JERSEY - Medicaid & CHIP
Medicaid Website:
https://www.nj.gov/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 1-609-631-2392
CHIP Website: https://njfamilycare.dhs.state.nj.us/
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: 1-919-855-4100

NORTH DAKOTA - Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP
Website: http://www.insureoklahoma.org/
Phone: 1-888-365-3742

OREGON - Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid & CHIP
Website: https://www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (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

Important Notices (continued)

TEXAS - Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH - Medicaid & 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: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA - Medicaid & CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
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/
http://mywvhipp.com/
Medicaid Phone: 1-304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid & 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

Contact Information

Plan	Phone Number	Website
Human Resources		
• Benefits Team	661-336-5236 ext. 2022	benefits@capk.org
Benefit Plans		
Anthem	800-727-2768	www.anthem.com/ca
LiveHealth Online	888-548-3432	www.livehealthonline.com
Kaiser	800-464-4000	www.kp.org
Ameritas Dental	800-487-5553	www.ameritas.com
Ameritas EyeMed Vision Plan	866-289-0614	www.eyemed.com
Ameritas VSP Vision Plan	800-877-7195	www.vsp.com
Unum		
• Life/AD&D Insurance	800-Ask-Unum (800-275-8686)	services.unum.com
• Voluntary Hospital Indemnity, Accident, Critical Illness	800-Ask-Unum (800-275-8686)	services.unum.com AskUnum@unum.com
• Short Term (STD) & Long Term (LTD) Disability	866-868-6737	www.unum.com
• Travel Assistance	800-872-1414	medservices@assistamerica.com
ComPsych EAP Counseling Services	800-272-7255	www.guidanceresources.com
HealthEquity Health Care and Dependent Care Flexible Spending Accounts	877-924-3967	www.healthequity.com
Nationwide	833-268-7080	nationwideretirementplans.com
Keenan & Associates *(Employee Benefits Consultant)*		
• Pam Cote	951-715-0190 ext. 1138	pcote@keenan.com
• Sista Duncan	916-859-7160 ext. 4261	sduncan@keenan.com

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children's Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Glossary (continued)

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

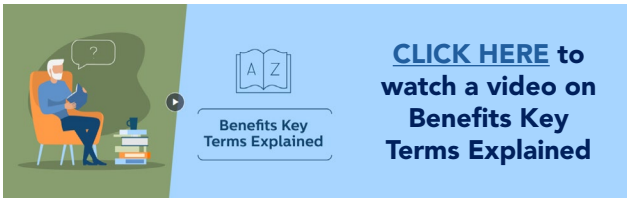
A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.



CLICK HERE to watch a video on Benefits Key Terms Explained

Frequently Asked Questions

What is a Deductible?

A deductible is the amount of money you or your dependents must pay toward a health claim before your organization's health plan makes any payments for health care services rendered.

What is Coinsurance?

Coinsurance is a provision in your health plan that describes the percentage of a medical bill that you must pay and that which the health plan must pay.

What is the Out-of-Pocket Maximum?

The maximum amount (includes deductible, coinsurance, copays, and prescription drug cost) that an insured will have to pay for covered expenses under a plan. Once the out-of-pocket maximum is reached, the plan will cover eligible expenses at 100%.

What is a Copay?

A fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

What is a Health Maintenance Organization (HMO)?

An HMO gives you access to certain doctors and hospitals within its network. A network is made up of providers that have agreed to lower their rates for plan members and also meet quality standards. But unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO's network.

What is a Preferred Provider Organization (PPO)?

A PPO is a group of hospitals and physicians that contract on a fee-for-service basis with insurance companies to provide comprehensive medical service.

What is In-Network?

Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members at a set rate. Health care providers are not able to charge insureds more than the negotiated fee set by the insurance provider.

What is Out-of-Network?

Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers, which usually results in a greater out-of-pocket expense to the patient.

What is an Explanation of Benefits (EOB)?

An EOB is a description your insurance carrier sends to you explaining the health care benefits that you received and the services for which your health care provider has requested payment.